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**ANNALS OF HEALTH LAW**  
*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 28, STUDENT ISSUE 2

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*Advance Directive*

Editors' Note

The *Annals of Health Law and Life Sciences* is proud to present the twenty-second issue of our online, student-written publication, *Advance Directive*. The *Spring 2019 Advance Directive* examines the legal landscape of behavioral and mental healthcare from a variety of perspectives.

This *Spring 2019 Advanced Directive* issue will dive into a broad spectrum of topics within the current conversation taking place in the United States surrounding mental and behavioral health. The authors have drawn upon personal and professional interests and experiences to help our readers better understand the complex and often misunderstood area of healthcare, while identifying key areas for action and change.

First, we consider the perspectives of healthcare providers and their patients alike, looking to the current application process for physician licensure and considering its impact on physicians who face their own mental health diagnoses. We then look to nursing homes to evaluate the training and resources necessary to identify and treat behavioral and mental health issues appropriately in those settings - arguing for more robust compliance programs.

The topic of opioids plays an interesting role in the mental and behavioral health landscape of the United States. To help limit the effects of opioid mismanagement, this Issue argues for the classification of the drug Gabapentin, a popular prescription drug used for pain management, as a Schedule V controlled substance. We then look at the conflict surrounding necessary access to opioid drugs, in an evaluation of Section three of the CARA 2.0 Act of 2018 and its constraints on physicians' ability to prescribe opioids.

This Issue turns to make a critical assessment of problems surrounding mental healthcare within the American prison system. First, through an examination of how the Hispanic/Latinx population is treated while imprisoned, and the necessity of cultural competency to reduce mental health treatment disparities among Hispanic/Latinx inmates. Next, this *Advance Directive* Issue advocates for Illinois to separately fund a forensic psychiatry facility where all of the state's severely mentally ill inmates can receive personalized mental health treatment outside of ill-equipped jails and prisons. We then explore the particular mental and behavioral health struggles of female inmates incarcerated while pregnant to exemplify a need for the implementation of increased behavioral and mental healthcare in prisons, with specific attention given to pregnant inmates – a prison sub-population most in need of this type of care.

The Issue then looks to the condition and treatment of postpartum depression and psychosis and the various state approaches to prosecuting cases of infanticide. Using Illinois as a model, we explore what is possible for states and for women who commit felonies during a period of postpartum mental illness.

We move to the broader topic of mental health education in schools, and how proactive educational curriculum can help alleviate mental health issues in adults. Finally, this Issue looks at the proactive efforts to be made nationwide in an effort to push the Mental Health Parity Addiction and Equity Act to fulfill its intended purpose.

We would like to thank Kara Simon, our Technical Production Editor. Without her knowledge and commitment, this Issue would not have been possible. We would like to give a special thanks to our *Annals* Editor-in-Chief, Mary Hannosh, for her leadership and support. The *Annals* Executive Board Members: Kaleigh Ward, Allyson Thompson, and Chloe Cunningham, and the *Annals* Senior Editors: Abigail Elmer, Victoire Iradukunda, John Meyer, and Jessica Sweeb for providing additional 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 Lawrence Singer, Megan Bess, and Kristin Finn for their guidance and support.

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

Sincerely,

Lianne Foley  
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# Stay Out of My Mind: Privacy of Physician Mental Health Treatment in Licensing Applications

*Hannah Lehmann*

“Physicians are appropriately afraid they could lose their license or have restrictions on their license. So of course they are hesitant to seek care.” – Dr. Katherine Gold, professor at the University of Michigan in Ann Arbor.<sup>1</sup>

## I. INTRODUCTION

The goal of state medical licensing boards (MLBs) is to protect patient safety by ensuring that physicians possess the mental and physical health required to provide competent care.<sup>2</sup> MLBs frequently ask questions regarding past and current mental illnesses that may affect a physician’s ability to practice in order to ensure that her mental health will not threaten patient safety.<sup>3</sup> Despite these questions on licensing applications, physicians have an alarmingly high suicide rate, with approximately 400 doctors committing suicide each year in the United States.<sup>4</sup> A survey of surgeons

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1. Ronnie Cohen, *Doctors May Fear Losing Their License for Seeking Mental Health Care*, REUTERS (Oct. 10, 2017), <https://www.reuters.com/article/us-health-mentalhealth-physician-licensu/doctors-may-fear-losing-their-license-for-seeking-mental-health-care-idUSKBN1CF2N9>.

2. Herbert Hendin, et al., *Licensing and Physician Mental Health: Problems and Possibilities*, 93 J. MED. LICENSURE & DISCIPLINE 6, 6 (2007).

3. Robert Nellis, *Physician Licensing Laws Keep Doctors from Seeking Care*, MAYO CLINIC (Oct. 2, 2017), <https://newsnetwork.mayoclinic.org/discussion/physician-licensing-laws-keep-doctors-from-seeking-care/>; Robin Schroeder, et al., *Do State Medical Board Applications Violate the Americans with Disabilities Act?*, 84 ACAD. MED. 776, 776 (June 2009).

4. Pamela Wible, *When Doctors Commit Suicide, It’s Often Hushed Up*, THE WASHINGTON POST (July 14, 2014), [https://www.washingtonpost.com/national/health-science/when-doctors-commit-suicide-its-often-hushed-up/2014/07/14/d8f6eda8-e0fb-11e3-9743-bb9b59cde7b9\\_story.html?utm\\_term=.77a3fb9dd9d5](https://www.washingtonpost.com/national/health-science/when-doctors-commit-suicide-its-often-hushed-up/2014/07/14/d8f6eda8-e0fb-11e3-9743-bb9b59cde7b9_story.html?utm_term=.77a3fb9dd9d5).

revealed that one out of sixteen surgeons contemplated suicide within the past year, but only 26 percent of those surgeons sought psychiatric or psychologic treatment.<sup>5</sup> Even more concerning, one out of every three physicians does not consistently seek medical care.<sup>6</sup>

Many physicians with mental illnesses have elected to self-treat by writing their own prescriptions or paying cash for therapy visits to avoid having mental health treatment on their insurance record.<sup>7</sup> Individuals with mental illnesses face stigma from the general public, which serves as a barrier for many people from receiving mental health treatment.<sup>8</sup> In addition, some physicians who seek treatment may elect to drive hours or use aliases to avoid stigma from their peers.<sup>9</sup> A recent study by the Mayo Clinic found that 40 percent of physicians were reluctant to seek treatment for mental health because they were worried about the repercussions it may have on their licensing.<sup>10</sup>

Physician reluctance to seek mental health treatment can be strongly attributed to the questions on licensing applications about past mental health treatments or diagnoses.<sup>11</sup> These questions may limit a physician's ability to practice medicine if they have or have had a mental illness.<sup>12</sup> Several experts agreed that strict regulations surrounding physician mental health may

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5. Andrew et al., *Physician Suicide*, MEDSCAPE (Aug. 1, 2018), <https://emedicine.medscape.com/article/806779-overview>.

6. *Id.*

7. Julianne Story & David Solberg, *Barriers to Mental Illness and Substance Abuse Treatment Among Physicians and the Impact on Patient Care*, 114 MO. MED. 91, 91 (2017).

8. Claire Henderson, et. al., *Mental Illness Stigma, Help Seeking, and Public Health Programs*, AM. PUB. HEALTH ASS'N. (Apr. 10, 2013), <https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2012.301056>.

9. Shannon Firth, *Docs' Mental Health: Do State Boards Have a Right to Ask?*, MEDPAGE TODAY (July 19, 2018), <https://www.medpagetoday.com/publichealthpolicy/generalprofessionalissues/74104>.

10. Cohen, *supra* note 1.

11. Nellis, *supra* note 3.

12. Nellis, *supra* note 3.

discourage physicians from getting the help that they need.<sup>13</sup> In an effort to promote physician well-being and patient safety, MLBs must stop asking questions about mental illnesses on licensing applications as it discourages a physician's willingness to seek help.<sup>14</sup> Instead, MLBs should determine if a physician is actually impaired by her mental illness.<sup>15</sup> If the physician is impaired by her mental illness, her license should only be revoked or limited if she poses a threat to patient safety.<sup>16</sup> An MLB should not prevent a physician who affirmatively answers questions about mental illness from obtaining a licensing to practice medicine if it cannot prove that a physician poses a threat to patient safety.<sup>17</sup>

This article will first discuss how MLBs currently address physician mental health in licensing board applications. It will then explore recent attempted changes by the American Medical Association (AMA) to improve a physician's access to mental health treatment. It will then argue that questions related to a physician's mental illness diagnoses or treatments should be prohibited. Such changes are in line with the Americans with Disabilities Act (ADA) and privacy concerns about asking questions regarding an applicant's mental health and requiring applicants to submit records from mental health treatment they have received.

## II. PRESENT TREATMENT OF PHYSICIANS WITH MENTAL HEALTH ISSUES

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13. Claudia Center, et al., *Confronting Depression and Suicide in Physicians*, JAMA NETWORK (June 18, 2003), <https://jamanetwork.com/journals/jama/article-abstract/196774>.

14. See Nellis, *supra* note 3.

15. Phyllis Coleman & Ronald A. Shellow, *Restricting Medical Licenses Based on Illness is Wrong – Reporting Makes it Worse*, 9 J. L. & HEALTH 147, 165 (1994-95) [hereinafter Coleman].

16. *Id.*

17. *Id.* at 148-49.



MLBs play a large role throughout the course of a physician's career.<sup>18</sup> MLBs handle physician licensing and review disciplinary proceedings.<sup>19</sup> In terms of licensing, MLBs process and decide a physician's application for an initial license, applications for renewing a license, and applications from physicians seeking to obtain a license in a different state.<sup>20</sup> A physician may be denied or limited in her scope to practice if the MLB deems that the physician is impaired after reviewing her licensing application.<sup>21</sup>

Under the Federation of State Medical Boards (FSMB), a physician is deemed impaired if she is unable to practice with reasonable skill and safety due to mental illness, physical illness or condition, or habitual abuse of drugs, alcohol, or other impairing substances.<sup>22</sup> The FSMB, however, has advised MLBs to avoid questions about mental health history on licensing applications and renewals.<sup>23</sup> The FSMB has stated that asking about past mental health history may violate the Americans with Disabilities Act (ADA).<sup>24</sup> Physicians, just like all individuals, are more likely to recover from a mental illness with proper mental health treatment.<sup>25</sup> The chance for recovery from a mental illness increases more if she seeks treatment right away.<sup>26</sup> The FSMB has found that questions on mental illness may prevent

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18. See Yuri N. Walker, *Protecting the Public: The Impact of the Americans with Disabilities Act on Licensure Considerations Involving Mentally Impaired Medical and Legal Professionals*, 25 J. LEGAL MED. 441, 444-45 (2004).

19. *Id.* at 449-50.

20. *Id.*

21. *Id.* at 462.

22. *Id.*; FEDERATION OF STATE MEDICAL BOARDS, POLICY ON PHYSICIAN IMPAIRMENT 7 (April 2011),

<https://www.fsmb.org/siteassets/advocacy/policies/physician-impairment.pdf>.

23. Cohen, *supra* note 1; FEDERATION OF STATE MEDICAL BOARDS, PHYSICIAN WELLNESS AND BURNOUT 12-15 (April 2018), [www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf](https://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf) [hereinafter *Physician Wellness and Burnout*].

24. Cohen, *supra* note 1; *Physician Wellness and Burnout*, *supra* note 23. at 12-15.

25. Andrew, *supra* note 5.

26. Andrew, *supra* note 5.

physicians from seeking treatment.<sup>27</sup> The FSMB recommends that MLBs only ask about current mental health issues on the initial license application.<sup>28</sup> Not asking about mental illnesses in licensing applications could remove the fear and stigma that a physician with past or current mental illnesses face and would allow her to obtain treatment if she need it.<sup>29</sup> Reducing stigma through changing policies and procedures, such as the licensing process, can help physicians feel safe in seeking mental health treatment.<sup>30</sup>

Most MLBs ask questions about past or current mental illnesses on their licensing applications or in the licensing renewal applications.<sup>31</sup> However, the way that MLBs address physicians' mental health varies and can be unpredictable.<sup>32</sup> MLBs typically ask about past mental health diagnoses, treatments, or hospitalizations related to mental health.<sup>33</sup> Oftentimes, if an applying physician reports that she has a history of mental health treatment, information about that treatment must be sent to the MLB to determine if further action is needed.<sup>34</sup> Some MLBs may require a physician to provide explanations from her treating health care provider, a sworn affidavit about the physician's treatment, or documentation of their diagnosis, treatment, and

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27. Firth, *supra* note 9 (discussing how the FSMB acknowledges research indicating that MLB questioning on mental health discourages physicians from seeking mental health treatment, and how as of April 2018, the FSMB is working to address this issue).

28. Firth, *supra* note 9.

29. See Andrew, *supra* note 5; see also Katherine Gold & Edward Goldman, *Fear of Stigma or Sanction Keeps Many Doctors From Revealing Mental Health Issues, Study Finds*, U. MICH. INSTITUTE FOR HEALTHCARE POLICY & INNOVATION <https://ihpi.umich.edu/news/fear-stigma-or-sanction-keeps-many-doctors-revealing-mental-health-issues-study-finds> (last visited, April 30, 2019).

30. Christine Moutier, *Physician Mental Health: An Evidence Based Approach to Change*, 104 J. MED. REG. 7, 9-10 (July 2018).

31. James T.R. Jones, et al., *Medical Licensure Questions About Mental Illness and Compliance with the Americans with Disabilities Act*, 46 J. Am. Acad. Psy. Law. 458, 460 (2018).

32. See, e.g., Lauren Love, *State Medical Licensing Boards' Practices May Hurt Physician Mental Health*, U. MICH. HEALTH LAB (June 14, 2017 6:00 AM), <https://labblog.uofmhealth.org/industry-dx/state-medical-licensing-boards-practices-may-hurt-physician-mental-health>.

33. Firth, *supra* note 9.

34. Firth, *supra* note 9.

prognosis.<sup>35</sup> Other MLBs require a physician to undergo mandatory psychiatric evaluations.<sup>36</sup> Some MLBs will even sanction a physician for having mental illnesses.<sup>37</sup> The deep inquiry that MLBs often take into a physician's mental health can delay the physician's ability to get a license and cause physicians to pay significant expenses before they are licensed.<sup>38</sup>

*A. Encouragement for Change from the AMA*

According to the AMA, an impaired physician is one "who is unable to practice medicine with reasonable skill and safety to patients because of mental illness or excessive use or abuse of drugs, including alcohol".<sup>39</sup> In 2017, the AMA adopted a policy that gave physicians with mental illnesses an easier way to access mental health treatment.<sup>40</sup> The AMA policy calls for MLBs to evaluate physical and mental health similarly, and ensure that a previously diagnosed mental health condition will not automatically be considered an impairment to a physician's ability to practice.<sup>41</sup>

More recently, at the 2018 AMA Annual House of Delegates Meeting in Chicago, AMA delegates urged MLBs to require disclosure of a mental health condition only if the condition currently impairs the physician's

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35. Schroeder, et al., *supra* note 3, at 778-79.

36. Firth, *supra* note 9.

37. Cohen, *supra* note 1.

38. Jennifer Boyd, et al., *State Psychology Licensure Questions About Mental Illness and Compliance with the Americans with Disabilities Act*, 86 AM. J. OF ORTHOPSYCHIATRY 620, 621 (2016).

39. Walker, *supra* note 18.

40. Kelly Jakubek, *AMA Adopts Policy to Improve Physician Access to Mental Health Care*, AM. MED. ASS'N. (June 14, 2017), <https://www.ama-assn.org/press-center/press-releases/ama-adopts-policy-improve-physician-access-mental-health-care>; Access to Mental Health Services, D-345.997 <https://policysearch.ama-assn.org/policyfinder/detail/physician%20mental%20health?uri=%2FAMADoc%2Fdirectives.xml-0-11168.xml>

41. *Id.*

judgment.<sup>42</sup> Under this proposal, the definition of an impaired physician would state that a physician is impaired if the mental illness affects her ability to practice medicine in a competent, ethical, and professional way, or if the physician poses a threat to public health.<sup>43</sup> The AMA members who supported this proposed policy wanted to promote changes to MLB questioning to improve physician wellness by eliminating barriers that prevent physicians from getting the mental health care they need.<sup>44</sup>

### III. THE ADA PROHIBITS MLBS FROM DISCRIMINATING AGAINST DISABLED PHYSICIANS

MLBs should not ask about mental health on licensing applications nor should they require a physician to submit extensive documentation detailing her past mental illness treatment. Doing so prevents physicians from seeking mental health treatment.<sup>45</sup> Supporters of questions about a physician's mental illness claim that these questions protect patients,<sup>46</sup> and not doing so would put patients at risk of receiving inadequate care.<sup>47</sup> There is a lack of evidence to show that a physician's mental health diagnosis and treatment impairs that physician's ability to safely and competently practice medicine.<sup>48</sup> For example, according to the American Psychiatric Association (APA), having a psychiatric history is not an accurate predictor of an applicant's mental fitness.<sup>49</sup>

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42. Brendan Murphy, *Medical Boards Must Avoid Contributing to Mental Health Stigma*, AMA (June 13, 2018), <https://www.ama-assn.org/residents-students/transition-practice/medical-boards-must-avoid-contributing-mental-health-stigma>.

43. *Id.*

44. *Id.*

45. *Id.*

46. Swapnil S. Mehta & Matthew L. Edwards, *Suffering in Silence: Mental Health Stigma and Physicians' Licensing Fears*, AM. J. OF PSYCHIATRY RESIDENTS' J. 1, 3 (Nov. 2018).

47. *Id.*

48. *Id.*; Boyd, et al., *supra* note 38, at 622.

49. Boyd, et al., *supra* note 38, at 622.

Questions concerning physician mental health can only be asked if they are able to withstand an analysis under the ADA.<sup>50</sup> Some forms of questioning about mental illness on license applications have been limited by some courts claiming that the questions violate the ADA.<sup>51</sup> Removing questions about mental health illnesses would move the focus of the licensure proceeding from the physician to patient safety.<sup>52</sup> This will allow physicians to seek treatment without hide it or without having to withhold treatment altogether in fear that it would have repercussions on their licensing application.<sup>53</sup>

#### *A. Mental Illness is a Disability Under the ADA*

The ADA was enacted to prevent discrimination against an individual with a physical or mental illness.<sup>54</sup> Under the ADA, a person is disabled if she has a physical or mental impairment that substantially limits one or more major life activities, a record of the impairment, or is regarded as having such an impairment.<sup>55</sup> The ADA protects individuals with disabilities who meet the essential eligibility requirements for the receipt of services or the

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50. *See, e.g.*, *ACLU v. Individual Members of the Ind. State Bd. of Law Examiners*, LEXIS 106337 (S.D. Ind. 2011); *see also, e.g.*, *Doe v. Nominating Commission for the Fifteenth Judicial Circuit of Florida*, 906 F.Supp. 1534, 1544-45 (S.D. Fla. 1995).

51. Sarah J. Polfliet, *A National Analysis of Medical Licensure Applications*, 36 J. AM. ACAD. PSYCHIATRY LAW 369, 370 (2008) (citing to *Medical Society of New Jersey v. Jacobs*, where the Medical Society of New Jersey accused the New Jersey Boards of Medical Examiners of asking questions that violated Title II of the Americans with Disabilities Act); *Medical Society of New Jersey v. Jacobs*, 1993 WL 413016 (D. N.J. 1993).

52. Kara Gavin, *Study: Physicians Don't Report or Treat Their Own Mental Illness Due to Stigma*, U. MICH. HEALTH LAB (Sept. 26, 2016 6:00 AM), <https://labblog.uofmhealth.org/industry-dx/study-physicians-dont-report-or-treat-their-own-mental-illness-due-to-stigma>.

53. *See* Gold & Goldman, *supra* note 29.

54. Brenda T. Strama, *Impaired and/or Disruptive Practitioners*, AHLA SEMINAR MATERIALS (June 19, 2000).

55. Americans with Disabilities Act of 1990, 42 U.S.C. § 12102(1) (1990).

participation in programs or activities provided by a public entity.<sup>56</sup> Under the 2008 ADA Amendments, the scope of mental disabilities that fall under ADA coverage was broadened to include those that inhibit reading, concentrating, thinking, and communicating with others.<sup>57</sup> The ADA protects employees who, despite their disability, can perform the essential functions and requirements of their job with or without reasonable accommodation.<sup>58</sup>

Under the Department of Justice's (DOJ) regulations that implemented the ADA, MLBs are considered to fall within the scope of the ADA and must comply with its restrictions.<sup>59</sup> MLBs are subject to compliance with the ADA under Title II.<sup>60</sup> Under Title II, "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied benefits, services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."<sup>61</sup> State and local agencies are to operate programs so that they are accessible and usable to individuals with disabilities.<sup>62</sup> MLBs are subject to the requirements of the ADA because they are run by state governments to provide benefits, services, and programs.<sup>63</sup> Certification and licensing programs that subject qualified but disabled individuals to discrimination based on their disability are

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56. Americans with Disabilities Act of 1990, 42 U.S.C. § 12131(2) (1990).

57. Americans with Disabilities Act Amendments Act of 2008, 42 U.S.C.A. § 12101 (2008).

58. Laura F. Rothstein, *The Employer's Duty to Accommodate Performance and Conduct Deficiencies of Individuals with Mental Impairments Under Disability Discrimination Laws*, 47 SYRACUSE L. REV. 531, 563 (1997) [hereinafter L. Rothstein].

59. Walker, *supra* note 18, at 450; Schroeder, et al., *supra* note 3, at 777.

60. The Americans with Disabilities Act, 42 U.S.C. § 12132 (1990); Lauren E. Chanatry & Jack Cronin, *Professional Licensing Issues: Title II of the ADA Applied to State and Local Professional Licensing*, SOUTHEAST ADA CENTER AND BURTON BLATT INSTITUTE (Updated August 2017).

61. The Americans with Disabilities Act, 42 U.S.C. § 12132 (1990); Chanatry & Cronin, *supra* note 60.

62. The Americans with Disabilities Act 42 U.S.C. § 12148(a)(1) (1990); Chanatry & Cronin, *supra* note 60.

63. Chanatry & Cronin, *supra* note 60.

therefore prohibited under the ADA.<sup>64</sup>

The ADA prohibits licensing boards from using procedures and standards that screen out disabled individuals and prevent them from being gainfully employed.<sup>65</sup> However, MLBs are permitted to revoke the license of a disabled physician if, while practicing medicine, that individual poses a danger to the public.<sup>66</sup> Before limiting a physician's license, the MLB should determine if that physician is actually impaired by her mental illness.<sup>67</sup> MLBs should only revoke or limit a physician's license if she poses a risk of endangering the general public.<sup>68</sup> A physician who poses a threat to the general public fails to conform to the accepted standards within the medical community.<sup>69</sup> MLBs should not prevent a physician who has a mental illness from obtaining a licensing to practice medicine, unless the MLB can prove that the physician poses a threat to public health.<sup>70</sup>

Some physicians with mental illnesses choose to seek protection under the ADA from MLB repercussions.<sup>71</sup> Individuals with mental illnesses are a suspect class under the ADA.<sup>72</sup> MLBs must show that disability inquiries on licensing applications are necessary in order for such questions to pass an

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64. Americans with Disabilities Act Title II Regulations, 28 C.F.R. § 35.130(b)(6) (2010).

65. Walker, *supra* note 18, at 455.

66. Benjamin T. Friesen, *Guttman v. Khalsa*, 44 URB. LAW. 915, 915 (Fall 2012).

67. Coleman, *supra* note 15, at 165; Love, *supra* note 32 (discussing how MLBs fail to ask if physicians have an impairment that affects the way they practice medicine and instead focus on broader questions that prevent physicians from seeking care and intrude on physician privacy).

68. Coleman, *supra* note 15, at 165; *see In re Guess*, 327 N.C. 46, 53 (N.C. 1990) (discussing how the North Carolina legislature, in enacting N.C.G.S. § 90-14(a)(6), intended to prevent public harm by allowing the North Carolina Board of Medical Examiners to revoke a physician's license if the physician deviates from acceptable medical practice).

69. Coleman, *supra* note 15, at 148-49; *see Guess*, 327 N.C. at 53; *see* Peter Moffett and Gergory Moore, *The Standard of Care: Legal History and Definitions: The Bad and Good News*, 9 W. J. OF EMERGENCY MED., 109, 110-11 (Feb. 2011) (explaining that the standard of care for physicians has evolved in recent years, and that pursuing treatment that might not be custom is not enough to break the standard of care).

70. Coleman, *supra* note 15, at 148-49.

71. Walker, *supra* note 18, at 162-63.

72. *Id.*

analysis under the ADA.<sup>73</sup> Courts currently disagree on what standard to use when applying the necessity test to licensing applications.<sup>74</sup> Courts have handled the necessity test either through a strict scrutiny standard or relaxed scrutiny standard.<sup>75</sup> Some courts have found that broad questions on licensing applications violate the ADA.<sup>76</sup> Other courts have found that narrowly tailored questions about mental health on licensing applications are permissible under the ADA, but fail to give much guidance on how narrow these questions need to be.<sup>77</sup> Without a judgment defining the scope of MLB questioning, MLBs will continue to question about a physician's mental health history and treatment.<sup>78</sup> MLBs do not uniformly alter their questioning on mental health history because courts vary from state to state.<sup>79</sup> What may be grounds for sanctions in one state may be ignored in another state.<sup>80</sup>

Even with the instruction from courts to limit the scope of questions on mental illness, many MLBs fail to limit these questions.<sup>81</sup> In a recent study by the Mayo Clinic only about one-third of physician licensing applications had questions regarding mental illness that were limited to current impairments from mental health conditions or did not ask about mental health

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73. Jon Bauer, *The Character of the Questions and the Fitness of the Process: Mental Health, Bar Admissions and the Americans with Disabilities Act*, 49 UCLA L. REV. 93, 126 (2001) (explaining that in the ten years after the ADA went into effect, ten courts nearly uniformly agreed that Title II of the ADA applies to state examining boards, and that these boards must justify disability inquiries in licensing applications by a showing of necessity); see ABPLA, *What is Medical Malpractice?*, <https://www.abpla.org/what-is-malpractice> (last visited April 30, 2019) (explaining examples of medical malpractice, which requires a physician to violate the standard of care, including failure to diagnose or misdiagnose, improper medication or dosage, failure to recognize symptoms, and poor follow-up).

74. *Id.* at 138.

75. *Id.*

76. See, e.g., *Med. Soc'y of New Jersey v. Jacobs*, 1993 WL 413016 (D.N.J. Oct. 5, 1993); *Ellen S. v. Florida Board of Bar Examiners*, 859 F. Supp. 1489 (S.D. Fla. 1994).

77. L. Rothstein, *supra* note 58, at 538-41.

78. Firth, *supra* note 9.

79. Firth, *supra* note 9.

80. Walker, *supra* note 18, at 445-46.

81. Polfliet, *supra* note 51, at 370-71.



conditions altogether.<sup>82</sup> MLBs that are found to limit questioning to current mental illnesses or do not question about the physician's mental illness are in compliance with the AMA, the APA, and FSMB's policies and recommendations, and the ADA.<sup>83</sup> The remainder of the MLBs ask questions about current and past mental illnesses, which may violate the aforementioned policies and recommendations.<sup>84</sup> In states that ask about past mental health conditions, physicians were less likely to seek mental health treatment for illnesses they may have.<sup>85</sup> These inconsistencies make it more difficult for physicians to seek mental health treatment.<sup>86</sup> Physicians would have an easier time receiving necessary mental health treatment if MLBs consistently limited mental health questioning to current impairments.<sup>87</sup>

#### *B. MLBs Ignore the ADA's Confidentiality Requirement*

Under the ADA, employers are not permitted to require employees to disclose information about mental illnesses they may have or treatment that employees are seeking for mental illnesses.<sup>88</sup> The confidentiality requirement for the ADA applies to entrance exams, medical exams, and

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82. Liselotte N. Dyrbye, et al., *Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions*, MAYO CLINIC PROCEEDINGS (Oct. 2017), [https://www.mayoclinicproceedings.org/article/S0025-6196\(17\)30522-0/fulltext](https://www.mayoclinicproceedings.org/article/S0025-6196(17)30522-0/fulltext) (finding that only sixteen out of the forty-eight studied MLBs asked about a physician's mental health history within the past year or not at all; the remaining states asked for a more expansive history on the physician's mental health).

83. Nellis, *supra* note 3.

84. Nellis, *supra* note 3.

85. Firth, *supra* note 9 (discussing the study performed by Sarah Polfliet, M.D. which found that there was a 21% increase in physician reluctance to seek mental health treatment in states that asked more expansive questions about their mental health history).

86. Firth, *supra* note 9; Boyd, et al., *supra* note 36 at 622 (explaining how licensure applicants often do not get mental health treatment so they can avoid answering "yes" to the application questions about mental health impairments and treatment).

87. See e.g., Moutier, *supra* note 30 at 10.

88. ADA, *Mental Health Conditions in the Workplace and the ADA*, <http://adata.org/factsheet/health> (last visited March 15, 2019).

voluntary health programs.<sup>89</sup> Employees have the choice to disclose any mental health issues to their employers.<sup>90</sup> MLBs oftentimes require physicians who indicate they have or have had mental illnesses to provide extensive information about their treatment.<sup>91</sup> This information may include medical records, affidavits about treatment, or statements from the treating provider.<sup>92</sup> Forcing physicians to disclose their mental health history as well as provide records for proof of treatment violates privacy requirements between a patient (in this case the physician) and psychotherapist.<sup>93</sup>

The right to privacy is not an absolute right.<sup>94</sup> To determine if there is a right to privacy for a personal issue, such as mental illness, courts apply a balancing test which looks at the sensitivity of the personal information and the burden on the state.<sup>95</sup> The outcome of these cases depends on the physician's disability.<sup>96</sup> A MLB violates the ADA when it fails this balancing test.<sup>97</sup> In most instances, the MLBs actions fail to pass this test, however MLBs are permitted to continue to ask extensive questions about mental health issues a physician has had in the past.<sup>98</sup>

Some state governments have the final determination on what questions will be on MLB licensing applications.<sup>99</sup> In many states, MLB records are open to the public.<sup>100</sup> In these states, the public has access to notes from

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89. Regulations to Implement the Equal Employment Provisions of the Americans with Disabilities Act, 29 C.F.R. § 1630.14 (2018).

90. *Id.*

91. Firth, *supra* note 9.

92. Firth, *supra* note 9.

93. Sherri Morgan & Carolyn I. Polowy, *Social Workers and Psychotherapist-Patient Privilege: Jaffee v. Redmond Revisited*, NAT'L ASS'N OF SOC. WORKERS (2005).

94. Phyllis Coleman & Ronald A. Shellow, *Ask About Conduct, Not Mental Illness: A Proposal for Bar Examiners and Medical Boards to Comply with the ADA and Constitution*, 20 J. LEGIS. 271, 291 (1994).

95. *Id.*

96. *Id.* (discussing how the level of scrutiny in the balancing test depends on the disability).

97. *Id.*

98. *Id.*

99. Firth, *supra* note 9.

100. Firth, *supra* note 9.

MLB meetings, including meetings on a physician's mental illness.<sup>101</sup>

#### IV. CONCLUSION

In order to encourage physicians to seek mental health treatment licensing applications should focus on patient safety, and likewise, the conditions that physicians have that may impact care patients receive. Determining if a physician is impaired by her mental illness is the first step for MLB to take in an effort to distinguish between physicians who pose a threat to public health and those who do not. Physicians who do not pose a threat to public health should not have their licenses revoked or limited, and MLBs should not prevent a physician who has a mental illness from obtaining a licensing to practice medicine if that physician does not pose a threat to public health.

State medical boards should not scrutinize physicians for any old, mild, or well-controlled mental illnesses they may have. Instead of limiting or revoking a physician's license for a mental illness she may have, state medical boards should check in with physicians who report mental illnesses. Research supports that this could ensure that the physician is receiving treatment for her mental illnesses and that neither the treatment nor the illness is preventing the physician from providing safe and effective treatment to the patient. Treatment of physician mental illnesses is crucial; many lives can be saved if physicians are able to access mental health treatment without having to worry about the professional repercussions and stigma they face when MLBs knowingly violate the ADA.

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101. Firth, *supra* note 9.

# Mental Health in the Aging Population

*Nicole Shamoon*

## I. INTRODUCTION

The world's population is aging rapidly as a result of people living longer.<sup>1</sup> Between 2015 and 2050, the percentage of individuals 60 years or over (aging population) is estimated to nearly double from about 12 percent to 22 percent.<sup>2</sup> In other words, by 2050 the global aging population will increase from about 900 million to two billion people.<sup>3</sup> Living longer brings many opportunities for the aging population to continue contributing to society as volunteers, loved ones, business owners, and employees.<sup>4</sup> However, the quality and extent of those contributions depends on health.<sup>5</sup> One in four adults aged 65 and older experience a mental health problem such as depression, anxiety, schizophrenia, or dementia.<sup>6</sup> Additionally, individuals 85 and older have the highest suicide rate of any age group, especially among older white males, who have a suicide rate almost six times that of the general population.<sup>7</sup>

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1. *Ageing and Health*, WORLD HEALTH ORG. (Feb. 5, 2018), <https://www.who.int/news-room/fact-sheets/detail/ageing-and-health>.

2. *Id.*

3. *Id.*

4. *Mental Health of Older Adults*, WORLD HEALTH ORG., <http://origin.who.int/mediacentre/factsheets/fs381/en/> (last updated Dec. 2017) [hereinafter *Mental Health of Older Adults*].

5. *Id.*

6. Katelyn Newman, *A Look Into Older Adults' State of Mind*, U.S. NEWS & WORLD REP. (Oct. 11, 2017 12:01 AM), <https://www.usnews.com/news/best-states/articles/2017-10-11/older-adults-struggle-to-get-adequate-mental-health-care>.

7. *Id.*

Mental health problems are often under-identified by health care professionals within the aging population, and the stigma surrounding mental health disorders discourages individuals to seek help.<sup>8</sup> Most behavioral health issues in older adults are identified and treated in primary care settings, instead of specialty behavioral health settings, and are often ignored or not managed properly in long-term care facilities or nursing homes<sup>9</sup> (nursing home).<sup>10</sup> Nursing homes tend to lack the proper training and resources necessary to identify and treat behavioral and mental health issues. Nursing homes must implement effective compliance programs in order to help improve upon the quality of care and outcomes surrounding mental health issues in the aging populations as staff will become better trained in trauma informed care and will follow appropriate written rules and procedures. This article will first discuss how residents with mental health conditions are less likely to get admitted into top quality nursing homes.<sup>11</sup> It will then discuss how mental health issues are treated in nursing homes. Finally, it will show how an effective compliance program can improve quality and outcomes in nursing homes for aging populations with mental health conditions.

## II. THE CMS RATING SYSTEM AND WHAT MAKES A TOP QUALITY MEDICARE NURSING HOME

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8. *Mental Health of Older Adults*, *supra* note 4.

9. See David C. Grabowski et al., *Quality of Mental Health Care for Nursing Home Residents: A Literature Review*, 67 *MED. CARE RES. & REV.* 627, 627-656 (2010) (discussing the high proportion of nursing home residents with a mental illness and the quality of mental health care in nursing homes) [hereinafter *Grabowski*].

10. In the interest of brevity, nursing homes will be used to refer to long-term care facilities, nursing homes, skilled nursing, and assisted living homes.

11. *The 5-Star Rating System: Care and Quality Improvement in Nursing Homes*, HEALTH DIRECT SERVS. (July 20, 2018), <https://www.hdrxservices.com/blog/the-5-star-rating-system-care-and-quality-improvement-in-nursing-homes/>. Nursing facilities can achieve a five star rating that is set by the Centers for Medicare and Medicaid and awarded to facilities based on health inspections, staffing, and quality measures.

The Centers for Medicare & Medicaid Services (CMS) enhanced its Nursing Home Compare public reporting site in 2008.<sup>12</sup> The Nursing Home Compare public reporting site created a five-star quality rating system to provide information for residents and their families in order to help them make meaningful decisions regarding the care of loved ones.<sup>13</sup> Nursing homes given a five-star rating indicate to consumers above average quality; in contrast, nursing homes given a one-star rating indicate quality that is below average.<sup>14</sup> Additionally, there is a separate rating regarding the three dimensions of nursing home quality: health inspections, staffing, and quality measures (QMs).<sup>15</sup> To calculate the rating, the system takes into account how many residents are taking psychiatric medications and gives negative treatment to those nursing homes with residents taking these medications.<sup>16</sup> The current system does not take into account an individual's circumstances, such as whether a resident needs medication to stabilize a long battle with depression or whether that resident is unnecessarily being given such medication.<sup>17</sup> A consequence of this five-star rating system is that nursing homes in some communities have started rejecting individuals with mental health conditions or require medication in an effort to keep the nursing homes' rating high.<sup>18</sup> Although the system was established with admirable intentions to help residents and families, it has had a negative effect.<sup>19</sup>

### III. MENTAL HEALTH AS A BARRIER TO TOP QUALITY NURSING HOMES

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12. *Id.*

13. *Id.*

14. *Id.*

15. Grabowski, *supra* note 9.

16. *Id.*

17. *Id.*

18. Daniel D. Sewell, *Nursing Homes Are Turning Away Patients with Mental Health Issues*, CARE FOR YOUR MIND (Nov. 29, 2016), <http://careforyourmind.org/nursing-homes-are-turning-away-patients-with-mental-health-issues/>.

19. *Id.*

Prospective residents with behavioral and mental health disorders are more likely to be rejected from top-quality nursing homes and admitted to lower quality homes compared to residents without these disorders.<sup>20</sup> From 2012-2014, public health researchers at the University of Rochester School of Medicine and Dentistry in New York looked at data on more than 3.7 million admissions to 15,600 homes in the United States.<sup>21</sup> They found that the more serious mental health issue a resident had, the less likely that resident would be admitted to a nursing home with a Medicare quality rating of five.<sup>22</sup> Compared to residents without mental health issues, residents with depression and anxiety were eight percent less likely to be admitted to a five-star nursing home.<sup>23</sup> Moreover, residents with bipolar disorder, substance abuse disorders, schizophrenia, and personality disorders were 11, 27, 28, and 32 percent less likely to be admitted to a five-star nursing home, respectively.<sup>24</sup> This is an example of the disparity in care for residents with mental health problems and those without, as even residents with common and treatable issues such as anxiety and depression are less likely to get into higher-ranking nursing homes.<sup>25</sup>

Nursing homes that care for a greater number of residents with a serious mental illness (SMI) results in generally lower quality nursing for all residents.<sup>26</sup> The Center for Gerontology and Healthcare Research looked at secondary nursing home level data from 2000 to 2008 to examine whether

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20. Lisa Rapaport, *Top-Quality Nursing Homes Harder to Access with Mental Health Issues*, REUTERS (Mar. 23, 2018 4:40 PM), <https://www.reuters.com/article/us-health-psychiatry-nursing-homes/top-quality-nursing-homes-harder-to-access-with-mental-health-issues-idUSKBN1GZ36V>.

21. *Id.*

22. *Id.*

23. *Id.*

24. *Id.*

25. *Id.*

26. Momotazur Rahman et al., *Serious Mental Illness and Nursing Home Quality of Care*, 48 HEALTH SERVS. RES. 1279, 1279-1298 (2013) (researching the effect of a nursing home's share of residents with a serious mental illness on the quality of care).

greater SMI among residents lead to lower quality of care for all residents.<sup>27</sup> Researchers found that when a nursing home had a greater share of SMI residents, there was lower quality of care in the nursing home and greater hospitalization rates among non-SMI residents, as a result of over-worked staff spending more time with SMI residents.<sup>28</sup> Researchers also suggested that residents with SMI are less likely to have resources or the support of friends and family to voice concerns on the residents' behalf or to advocate for a better nursing home.<sup>29</sup>

Depression has been under-recognized and inadequately treated in nursing homes.<sup>30</sup> About 20 percent of all nursing home residents have major depression and an additional 30 percent have depressive symptoms.<sup>31</sup> As a result, almost half of nursing home residents are prescribed anti-depressants even if taking those medications do not show positive results.<sup>32</sup> Moreover, depression cannot be treated in a "one size fits all" fashion and should not be treated with the same antidepressant for all residents.<sup>33</sup> Resident depression can be associated with a history of depression, or can be related to dementia, diabetes, stroke, or other health conditions.<sup>34</sup> Research has demonstrated that restoring residents' control over some activities in their life can reduce depression.<sup>35</sup>

Furthermore, anxiety is also common among the aging population and

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27. *Id.*

28. *Id.*

29. *Id.*

30. Adam Simning & Kelsey V. Simons, *Treatment of Depression in Nursing Home Residents without Significant Cognitive Impairment: A Systematic Review*, 29 INT'L PSYCHOGERIATRICS 209, 209-226 (2016) (discussing depression in nursing home residents).

31. Jules Rosen, *A Doctor's View: Depression in Long-Term Care Residents*, CATH. HEALTH ASS'N OF THE U.S. (Nov. - Dec. 2014), <https://www.chausa.org/publications/health-progress/article/november-december-2014/a-doctor%27s-view-depression-in-long-term-care-residents>.

32. *Id.*

33. *Id.*

34. *Id.*

35. *Id.*



nursing homes do not adequately screen or treat the condition.<sup>36</sup> Anxiety can have negative effects in nursing home residents, leading to depression, poorer health, declining ability to independently carry out tasks, and decreased life satisfaction.<sup>37</sup> About 3.5 percent of nursing home residents with anxiety receive some type of psychological support for anxiety, while 6.8 percent receive some type of medication.<sup>38</sup>

In 2015, dementia affected five percent of the aging population worldwide, or 47 million people, and is predicted to affect as many as 75 million people by the year 2030 and 132 million people by 2050.<sup>39</sup> It is critical for nursing homes to treat dementia, as many of these residents are currently subject to financial, sexual, or physical abuse in nursing homes.<sup>40</sup> Over two-thirds of long-term care residents who have dementia are diagnosed with bipolar disorder and just over half of the residents in this group had dementia before being diagnosed with bipolar.<sup>41</sup> This is problematic because residents who were diagnosed with dementia before

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36. Alexandra S. Creighton et al., *Anxiety Disorders In Seniors Living In Long-Term Home Presents A Problem*, ANXIETY (June 13, 2016), <https://www.anxiety.org/anxiety-in-long-term-care-home>.

37. *Id.*

38. *Id.*

39. *Global Action Plan on The Public Health Response To Dementia*, WORLD HEALTH ORG, at 2, <https://apps.who.int/iris/bitstream/handle/10665/259615/9789241513487-eng.pdf;jsessionid=7BCA5AB4A29164E0218735364FC9A7FF?sequence=1>.

40. *See Alzheimer's Society's View on Mistreatment and Abuse of People With Dementia*, ALZHEIMER'S SOC'Y, <https://www.alzheimers.org.uk/about-us/policy-and-influencing/what-we-think/mistreatment-and-abuse-people-dementia?documentID=422> (last updated Jan. 2015) (defining physical abuse can occur when patients are unnecessarily medicated with anti-psychosis to sedate patients); Financial abuse occurs when nursing home staff steal money or valuables from patients because they may not remember what they had or where they placed valuables. *Alzheimer's Abuse*, NURSING HOME ABUSE GUIDE, <https://nursinghomeabuseguide.com/abuse-injuries/patient-with-alzheimers/alzheimers-abuse/> (last visited Apr. 30, 2019).

41. *See* Ryan M. Carnahan & Elena M. Letuchy, *Bipolar Disorder in Nursing Homes: Impact on Antipsychotic Use, Diagnosis Patterns, and New Diagnoses in People with Dementia*, 26 THE AM. J. OF GERIATRIC PSYCHIATRY 2, 2-10 (2018) (discussing how most negatively impacted nursing homes have larger proportions of residents with bipolar disorder, but may not provide more mental health-specific care than other homes).

bipolar disorder received non-specific bipolar diagnoses.<sup>42</sup> This may occur because some residents have not yet reached the threshold for a proper bipolar diagnosis and the symptoms typically associated with bipolar disorder could also be symptoms of dementia.<sup>43</sup> Improving outcomes for the aging population in nursing homes involves providing more targeted care toward mental health issues.<sup>44</sup>

#### IV. THE 2019 NURSING HOME COMPLIANCE PROGRAM MANDATE

Section 6102 of the Patient Protection and Affordable Care Act (ACA) mandated that skilled nursing facilities (SNF) and nursing homes, as a condition for participation in Medicare and Medicaid, must adopt and implement a compliance program “that is effective in preventing and detecting criminal, civil, and administrative violations...and in promoting quality of care...”<sup>45</sup> The governing regulation was issued by CMS on October 4, 2016 and gave nursing homes until November 28, 2019 to meet the compliance program requirements.<sup>46</sup> On that date, state survey agencies will begin assessing nursing homes’ compliance with establishing an effective compliance program.<sup>47</sup> To analyze a program’s effectiveness, state surveyors will look for the seven elements of an effective compliance program that the mandate identifies,<sup>48</sup> which will be discussed below. Although these general guidelines aim at promoting quality of care in nursing

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42. *Id.*

43. *Id.*

44. *Id.*

45. Tom Herrmann, *The Deadline Is Fast Approaching for Meeting the Legal Mandate for an Effective Nursing Home Compliance Program*, STRATEGIC MGMT. SERVS. (Sept. 2018), <https://compliance.com/publications/the-deadline-is-fast-approaching-for-meeting-the-legal-mandate-for-an-effective-nursing-home-compliance-program/>.

46. *Id.*

47. *Id.*

48. *Id.*

homes,<sup>49</sup> an effective compliance program must also improve upon the quality of care and outcomes surrounding mental health conditions in the aging populations.

#### V. EFFECTIVE COMPLIANCE PROGRAM AS A SOLUTION

To improve the situation of nursing home residents, there should be a greater focus on residents' suffering related to anxiety, depression, and psychosocial conditions.<sup>50</sup> An effective compliance program in nursing homes can improve the quality of care and outcomes surrounding the identification and treatment of behavioral and mental health issues in the aging population. The seven fundamental elements of an effective compliance program include: 1) Implementing written policies, procedures, and standards of conduct; 2) Designating a compliance officer and compliance committee; 3) Conducting effective training and education; 4) Developing effective lines of communication; 5) Conducting internal monitoring and auditing; 6) Responding promptly to detected offenses and undertaking corrective action; and 7) Enforcing standards through well-publicized disciplinary guidelines.<sup>51</sup> This article will only be looking at implementing written policies and procedures, training and education, and auditing and monitoring because these are proactive steps any nursing home can take to ensure change.

##### *A. Implementing written policies, procedures, and standards*

The federal government requires nursing homes to conduct Preadmission

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49. Herrmann, *supra* note 45.

50. Newman, *supra* note 6.

51. Valerie Jackson, *Seven Fundamental Elements of an Effective Compliance Program*, JACKSON LEWIS (Nov. 20, 2018), <https://www.healthcareworkplaceupdate.com/healthcare/seven-fundamental-elements-of-an-effective-compliance-program/>.

Screening and Resident Review (PASSR) to evaluate residents for SMI and to find the most appropriate setting for the residents' needs where appropriate services will be provided.<sup>52</sup> However, nursing homes should take it one step further and implement written policies and procedures regarding common mental health conditions to better prepare for the entry of residents.

Depression and anxiety are common mental health conditions in the aging population in nursing homes and these conditions have been treated ineffectively with medication.<sup>53</sup> One major risk factor for depression and anxiety in the aging population is isolation and loneliness.<sup>54</sup> Instead of only medicating residents, nursing home should implement a policy that partners with nearby schools to have students visit individuals in the nursing homes on a certain day each week.<sup>55</sup> Residents who do not see family members often benefit from intergeneration programs that give the residents a purpose and opportunity to engage in their community, learn from each other, and form a friendship.<sup>56</sup> If a nursing home is struggling to find adequate partners, then it could instead partner with a nearby university campus.<sup>57</sup> Being near a campus would give students an opportunity to volunteer more often at the nursing home and give residents an opportunity to build relationships with the community to combat feelings of isolation and loneliness.<sup>58</sup>

Most nursing homes have some sort of pet policy either allowing or

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52. *Preadmission Screening and Resident Review*, MEDICAID, <https://www.medicaid.gov/medicaid/ltss/institutional/pasrr/index.html> (last visited Apr. 30, 2019).

53. Simning & Simons, *supra* note 30, at 1.

54. *Mental Health of Older Adults*, *supra* note 4.

55. *Skip School Visitation Program*, SKIP, <https://www.goskip.org/our-programs/school-visitation/> (last visited Apr. 30, 2019) (illustrating the success of a partnership between junior high schools and nursing home).

56. *Id.*

57. Catherine Misczuk, *Is the Future of Senior Housing on College Campuses?*, SENIOR CARE ADVICE, <https://seniorcareadvice.com/is-the-future-of-senior-housing-on-college-campuses.htm> (last visited Apr. 30, 2019).

58. *Id.*

prohibiting nursing home residents to have their own pets.<sup>59</sup> If not, another written policy and procedure to battle feelings of isolation and loneliness is to partner with local pet stores to bring animals, such as dogs, to the nursing home.<sup>60</sup> While this should be supplemented with policies regarding vaccination requirements and precautions in place to ensure safe interactions, the emotional benefits to residents from having an animal on site would provide valuable companionship.<sup>61</sup>

Additionally, because dementia residents can be subject to financial and physical abuse in nursing homes, there should be written policies and procedures about medication.<sup>62</sup> Each resident with dementia who receives antipsychotic medication must be given a proper diagnosis from an in-person physician appointment that is re-assessed every six months to ensure employees are not using the drugs as chemical restraints to sedate the residents in order to control them.<sup>63</sup> The resident receiving the medication should be made aware of the risks and should be able to object and inquire what the medicine is used for, how much is going to be used, and for what purpose.<sup>64</sup>

### *B. Training and education*

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59. Carolyn Crist, *Pets in Nursing Homes Bring Both Benefits and Risks*, REUTERS (Apr. 12, 2018), <https://www.reuters.com/article/us-health-pets-nursing-homes/pets-in-nursing-homes-bring-both-benefits-and-risks-idUSKBN1HJ2BS>.

60. Ernie Ward, *Pets Help Cure Loneliness in Seniors*, PET HEALTH NETWORK, <http://www.pethealthnetwork.com/news-blogs/a-vets-life/pets-help-cure-loneliness-seniors> (last visited Apr. 30, 2019).

61. *Id.*

62. Lauren Ellerman, *Why Nursing Home Policies and Procedures are so Important*, FRITH LAW FIRM (July 26, 2016), <https://frithlawfirm.com/blog/medical/nursing-homes/why-nursing-home-policies-and-procedures-are-so-important/>.

63. Hannah Flamm, *Why are Nursing Homes Drugging Dementia Patients Without their Consent?*, THE WASHINGTON POST (Aug. 10, 2018), [https://www.washingtonpost.com/outlook/2018/08/10/8baff64a-9a63-11e8-8d5e-c6c594024954\\_story.html?noredirect=on&utm\\_term=.edbbf298b1aa](https://www.washingtonpost.com/outlook/2018/08/10/8baff64a-9a63-11e8-8d5e-c6c594024954_story.html?noredirect=on&utm_term=.edbbf298b1aa).

64. *Id.*

Nursing homes should employ an integrated model for health care delivery.<sup>65</sup> Integrated care is the “the systematic coordination of general and behavioral healthcare which integrates mental health, substance abuse, and primary care services to produce the best (and most effective) outcomes.”<sup>66</sup> Staff should be trained to utilize effective strategies in helping residents with specific mental health conditions.<sup>67</sup> There should be a licensed clinical social worker (LCSW) trained to communicate effectively with residents and anticipate needs to make residents feel more comfortable so that conditions such as depression and anxiety are not exacerbated.<sup>68</sup> Staff should also be trained and educated on telehealth and offer telehealth as an option to residents who are unable to leave the nursing home, but could benefit from additional care.<sup>69</sup>

An effective compliance program should implement training and education to nurses and staff on Trauma Informed Care (TIC) to recognize the symptoms of mental health conditions, collaborate with the resident to promote long-term care, and respond to those who have experienced trauma.<sup>70</sup> TIC generally focuses on: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, and cultural, historical and gender issues.<sup>71</sup> As a result of properly identifying conditions, nurses and staff will be better equipped to

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65. *What is Integrated Care?*, CTR. FOR INTEGRATED HEALTH SYS., <https://www.integration.samhsa.gov/about-us/what-is-integrated-care> (last visited Apr. 30, 2019).

66. *Id.*

67. Natalie Truesdell, *How Integrative Care Improves Life for Nursing Home Patients With Mental Health Diagnoses*, MAINE HEALTH ACCESS FOUND. (Mar. 23, 2012), <http://www.mehaf.org/news-room/blog/how-integrative-care-improves-life-nursing-home-patients-mental-health-diagnoses/>.

68. *Id.*

69. *Id.*

70. *What is Trauma-Informed Care for Mood Disorders?*, TREATMENT PLACEMENT SPECIALISTS, <https://www.treatmentplacementspecialists.com/about/resources/the-value-of-trauma-informed-care-for-mood-disorders/> (last visited Apr. 30, 2019).

71. *Id.*

provide care to the residents, and ultimately improve mental health outcomes for the aging population.<sup>72</sup>

The CDC-Kaiser Permanente Adverse Childhood Experiences Study (ACE) studied the relationship between life traumas and how they impact health status and behaviors later in life.<sup>73</sup> In the study, a single adverse childhood event (ACE) represents a negative experience in childhood such as an instance of abuse, a particular household challenge, or an instance of neglect.<sup>74</sup> The study found that almost two-thirds of participants reported at least one ACE, and more than one in five reported three or more ACEs.<sup>75</sup> In addition, the study found that the more ACEs an individual experienced, the greater the risk that individual would later develop conditions such as depression, anxiety, and alcoholism.<sup>76</sup> Training nurses and staff to ask questions, recognize residents' traumatic past, and understand their life experiences will allow nurses and staff to provide effective care, create an environment where the resident feels safe and secure, and improve outcomes.<sup>77</sup>

To implement TIC, a nursing homes must train staff on ways to get to know the individuals they care for by utilizing resident records, interviews, and questionnaires to learn more about the resident's trauma history, illness and pain patterns, as well as spiritual preferences.<sup>78</sup> When staff better

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72. *Id.*

73. *About the CDC-Kaiser ACE Study*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/violenceprevention/childabuseandneglect/cestudy/about.html> (last reviewed June 14, 2016).

74. *Id.*

75. *Id.*

76. *Id.*

77. Cathy Koetting, *Trauma-Informed Care: Helping Patients with a Painful Past*, 4 J. OF CHRISTIAN NURSING 206, 206-213 (2016) (discussing how trauma-informed care recognizes and responds to the long-term health effects of the experience of trauma in patients' lives).

78. Tracey Gendron and Gigi Amateau, *Trauma-informed Care in Nursing Home: Reconnecting to Sources of Strength*, HEALTHINSIGHT (July 24, 2018), at 42,

understand their residents' trauma history, they will be able to pick up on signals that they may be suffering from a mental health condition.<sup>79</sup> Nursing homes can also familiarize staff with outside resources to suggest to residents.<sup>80</sup> For example, if a resident at a nursing home has depression, staff could refer the resident to resources such as Mental Health America, or support groups and online communities that could improve the resident's condition.<sup>81</sup> Overall, effective staff training on TIC could alleviate mental health issues.

### *C. Auditing and monitoring*

The United States loses up to 20 billion dollars each year as a result of fraud in the mental health sector.<sup>82</sup> Fraud in the mental health sector increases costs and harms vulnerable populations who are not receiving adequate care for their mental health services, but are still being billed.<sup>83</sup> For example, two psychological services companies that contracted with nursing homes in Louisiana, Mississippi, Alabama, and Florida submitted more than 25.2 million dollars in claims to Medicare for psychological tests on nursing home residents that were unnecessary or never provided.<sup>84</sup> To combat this fraud, nursing homes should conduct not-for-cause audits to determine whether there has been any fraud.<sup>85</sup> Additionally, to ensure that residents who

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[https://www.lsqin.org/wp-content/uploads/2018/05/Trauma\\_informed-care-VCU\\_Final-handout.pdf](https://www.lsqin.org/wp-content/uploads/2018/05/Trauma_informed-care-VCU_Final-handout.pdf).

79. *Id.* at 6.

80. *Id.* at 43.

81. *Id.* at 43.

82. Andria Jacobs, *Mental Health Fraud Exact High Human and Financial Costs*, AJMC (Mar. 11, 2016), <https://www.ajmc.com/contributor/andria-jacobs-rn-ms-cen-cphq/2016/03/mental-health-fraud-exacts-high-human-and-financial-costs>.

83. *Id.*

84. Emily Mongan, *Psychologists charged in \$25 million nursing home fraud scheme*, MCKNIGHT'S LONG-TERM CARE NEWS (Oct. 26, 2015), <https://www.mcknights.com/news/psychologists-charged-in-25-million-nursing-home-fraud-scheme/>.

85. Jacqueline LaPointe, *CMS Boosting Audits to Combat Medicaid Fraud, Improper Payments*, REV CYCLE INTELLIGENCE (June 27, 2018),



do have mental health issues are receiving the psychological services they need, there should be continuing assessments performed by nursing home administrators that list standard criteria for these medical conditions.<sup>86</sup> Some benefits of psychological services to residents include decreased depression and anxiety, more involvement in activities, and reduced irritability.<sup>87</sup>

## VI. CONCLUSION

Mental health issues have not been addressed appropriately within the aging population.<sup>88</sup> Oftentimes the elderly will mask emotions and not reveal how they feel, or caretakers will attribute the residents' depression, anxiety, or other mental health issues to other chronic conditions the resident has.<sup>89</sup> Implementing TIC alongside an effective compliance program can address mental health issues within the aging population by properly training staff,<sup>90</sup> implementing policies and procedures to assess mental health conditions and promote companionship,<sup>91</sup> and promoting open lines of communication for residents to voice concerns.<sup>92</sup>

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<https://revcycleintelligence.com/news/cms-boosting-audits-to-combat-medicaid-fraud-improper-payments/>.

86. Mongan, *supra* note 84.

87. Mongan, *supra* note 84.

88. Adinah East, *Four Common Mental Illnesses in the Elderly: Learn the Risk Factors and Symptoms to Watch for*, CARING PEOPLE (Mar. 27, 2018), <https://caringpeopleinc.com/blog/mental-illnesses-in-the-elderly/>.

89. *Id.*

90. *What is Trauma-Informed Care for Mood Disorders?*, *supra* note 70.

91. Ward, *supra* note 60.

92. Jackson, *supra* note 51.

# In the Wake of the Opioid Epidemic: A Call for the Reclassification of Gabapentin as a Controlled Substance in Illinois

*Carrie Park*

## I. INTRODUCTION

In the United States, 2.1 million individuals have been diagnosed with opioid use disorder.<sup>1</sup> This disorder consists of abuse of illicit and prescription medications, leading to more state and federal expenditures to address increasing morbidity and mortality rates.<sup>2</sup> The Centers for Disease Control and Prevention (CDC) estimates the total economic burden of prescription opioid misuse alone in the United States is \$78.5 billion a year.<sup>3</sup> This includes the costs of healthcare, lost productivity, addiction treatment, as well as criminal justice involvement.<sup>4</sup> Some strategies pertaining to combatting opioid abuse include limiting prescription days' supply, quantity dispensed, dosage adjustments, and requiring the use of Prescription Drug Monitoring Programs (PDMPs).<sup>5</sup> Tighter regulations have proved difficult for individuals with opioid use disorder to obtain opioids without a legitimate medical need.<sup>6</sup>

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1. Alyssa M. Peckham et al., *Gabapentin Use, Abuse, and the US Opioid Epidemic: The Case for Reclassification as a Controlled Substance and the Need for Pharmacovigilance*, 11 RISK MGMT. AND HEALTHCARE POLICY 109, 109 (2018).

2. *Id.*

3. *Opioid Overdose Crisis*, NAT'L INST. ON DRUG ABUSE (Jan. 2019), <http://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis>.

4. *Id.*

5. Peckham et al., *supra* note 1.

6. Peckham et al., *supra* note 1.

The United States Drug Enforcement Administration (DEA) classifies drugs with abuse potential into five distinct schedules depending on the drug's acceptable medical use and potential for abuse.<sup>7</sup> Schedule I controlled substances have no currently accepted medical use, and a high dependency and abuse potential, while Schedule II controlled substances have accepted medical use, but a high dependency and abuse potential.<sup>8</sup> As the drug schedule number increases, the drug's potential for abuse decreases, with Schedule V controlled substances having the least potential for abuse.<sup>9</sup> Drugs that do not have a potential for abuse are categorized as non-controlled substances.<sup>10</sup> Currently, the DEA has classified gabapentin as a non-controlled substance.<sup>11</sup>

Amid the opioid epidemic, clinicians have been prescribing the alternative, non-opioid, gabapentin, for various conditions as a means to address patients' pain concerns.<sup>12</sup> Gabapentin, a prescription medication approved by the Food and Drug Administration (FDA) for the treatment of neuropathic pain and epileptic disorders, has become a popular choice for pain management in the United States.<sup>13</sup> Such popularity has led to gabapentin's dangerous prevalence on the street of America. The state of Illinois must follow in the footsteps of states, like Kentucky, and classify gabapentin as a Schedule V controlled substance.<sup>14</sup>

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7. *Drug Scheduling*, DRUG ENF'T ADMIN. (2019), <http://www.dea.gov/drug-scheduling>.

8. *Id.*

9. *Id.*

10. *Gabapentin*, DRUG ENF'T ADMIN. DIVERSION CONTROL DIV. (Oct. 2018), [http://www.deadiversion.usdoj.gov/drug\\_chem\\_info/gabapentin.pdf](http://www.deadiversion.usdoj.gov/drug_chem_info/gabapentin.pdf).

11. *Id.*

12. Peckham et al., *supra* note 1; *Doctors Sound the Alarm on "Opioid Alternative" Gabapentin*, CBS NEWS (Apr. 3, 2018), <http://www.cbsnews.com/news/gabapentin-opioid-alternative-doctors-warning-about-drug/>.

13. *Gabapentin*, *supra* note 10.

14. *Gabapentin*, *supra* note 10. (Stating that gabapentin has been encountered by law enforcement, documented in national crime lab reports, reported to poison control centers and diverted for illicit use. The 2016 annual report of the American Association of Poison Control Centers' National Poison Data System reported that gabapentin was detected in a

This article will address the importance of reclassifying the prescription gabapentin as a controlled substance in Illinois by first highlighting gabapentin and its potential for abuse, and how the federal government and other states are addressing the potential for prescription gabapentin abuse amid the opioid crisis through national initiatives and state-based Prescription Drug Monitoring Programs (PDMPs). It will then turn to analyze Illinois's current, ineffective approach towards regulating gabapentin prescription use, and ultimately call for the reclassification of gabapentin as a controlled substance in Illinois.

## II. GABAPENTIN AND ITS POTENTIAL FOR ABUSE

Gabapentin is an analog of the neurotransmitter gamma-aminobutyric acid (GABA).<sup>15</sup> As a GABA analog, gabapentin is structurally similar to GABA and mimics GABA functions.<sup>16</sup> GABA is an inhibitory neurotransmitter—meaning that it blocks nerve impulses and reduces nerve cell activity.<sup>17</sup> Interestingly, gabapentin does not bind to GABA, benzodiazepine, opioid, or cannabinoid receptors, but can increase GABA and decrease glutamate concentrations, driving feelings of relaxation and euphoria.<sup>18</sup> It was first approved by the FDA in 1993 as an anti-epileptic, and also approved in 2004

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total of 168 fatalities from 2012 to 2016. Of those 168 fatalities, gabapentin was the primary cause of death in 23 individuals. Total exposure calls resulting from gabapentin increased from 5,889 in 2012 to 20,064 in 2016.).

15. Rachel V. Smith et al., *Gabapentin Misuse, Abuse and Diversion: A Systematic Review*, 111 ADDICTION 1160, 1160 (2016).

16. *Id.*

17. Connie Wu et al., *GABA Receptors in Brain Development, Function and Injury*, 30 METAB. BRAIN DIS. 367, 367 (2015).

18. Smith et al., *supra* note 15; Kejia Cai et al., *The Impact of Gabapentin Administration on Brain GABA and Glutamate Concentrations: A 7T H-MRS Study*, 37 NEUROPSYCHOPHARMACOLOGY 2764, 2765 (2012) (Research pertaining to gabapentin's effects on GABA and glutamate enzymes reveals a complex pattern of activity as well as an incomplete explanation for gabapentin's anticonvulsant effects); Udo Bonnet et al., *On the Addictive Power of Gabapentinoids: A Mini-Review*, 30 PSYCHIATR. DANUB. 142, 142 (2018).

as an analgesic for post-herpetic neuralgia, nerve pain associated with shingles.<sup>19</sup> However, gabapentin is widely used off-label to treat various conditions, including drug and alcohol addiction, anxiety, bipolar disorder, and insomnia.<sup>20</sup> Such off-label use is accounted for more than 90 percent of its sales.<sup>21</sup>

Since its FDA-approval, gabapentin has generally been viewed by prescribers as a safe alternative to addictive opioid medications for pain management,<sup>22</sup> and presumed to have no abuse potential.<sup>23</sup> However, although gabapentin is not currently a federally scheduled drug, its pharmacological composition plays an important factor towards its potential for abuse.<sup>24</sup> Gabapentin is a potentiator, meaning it has the capability to increase the effects as well as side effects of concomitantly administered drugs, like opioids.<sup>25</sup> It is also a cousin of pregabalin, a federally-classified Schedule V drug under the federal Controlled Substances Act, in both its chemical structure and pharmacological activity.<sup>26</sup> Like pregabalin, gabapentin use is associated with sedative and psychedelic effects.<sup>27</sup> Further side effects of gabapentin include dizziness, somnolence, and ataxia.<sup>28</sup>

A 2016 international study conducted by the Center on Drug and Alcohol

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19. Cai et al., *supra* note 18.

20. Cai et al., *supra* note 18.

21. Cai et al., *supra* note 18.

22. Corky Siemaszko, *Health Officials Are Sounding an Alarm on the Drug Gabapentin. And It's Not Even an Opioid*, NBC NEWS (Apr. 1, 2018), <http://www.nbcnews.com/storyline/americas-heroin-epidemic/health-officials-are-sounding-alarm-drug-gabapentin-it-s-not-n861111>.

23. Smith et al., *supra* note 15.

24. *Gabapentin*, *supra* note 10 (Gabapentin is currently not controlled under the federal Controlled Substances Act of 1970).

25. Siemaszko, *supra* note 22.

26. *Gabapentin*, *supra* note 10.

27. *Gabapentin*, *supra* note 10.

28. Neurontin [package insert]. New York, NY: Pfizer; 2017; *Ataxia*, MAYO CLINIC (Mar. 8, 2018), <http://www.mayoclinic.org/diseases-conditions/ataxia/symptoms-causes/syc-20355652> (Ataxia affects muscle coordination and symptoms include poor coordination, unsteady gait, change in speech or involuntary back-and-forth eye movements).

Research at the University of Kentucky College of Medicine, found that the prevalence of gabapentin misuse occurred in 40 to 65 percent of individuals prescribed gabapentin, and between 15 to 22 percent of populations pertaining to opioid abusers.<sup>29</sup> Such misuse was attributed to recreational use, self-medication or intentional self-harm.<sup>30</sup> Gabapentin was misused alone or in combination with substances, like opioids, benzodiazepines and alcohol due to its potentiate qualities.<sup>31</sup> The study further found that individuals taking gabapentin took doses higher than they were prescribed.<sup>32</sup> According to the American Association of Poison Control Centers (AAPCC), total exposure calls to poison control centers as a result of gabapentin use increased from 4,889 in 2012 to 20,064 in 2016.<sup>33</sup> From 2006 and 2015, gabapentin's abuse rate grossly rose by nearly 400 percent.<sup>34</sup> Furthermore, the illicit distribution of gabapentin in 2016 increased approximately 6.5-fold from reports in 2007.<sup>35</sup>

### III. FEDERAL-LEVEL EFFORTS TO ADDRESS POTENTIAL GABAPENTIN MISUSE AND ABUSE

Since 2018, the Federal Drug Administration (FDA) has been investigating whether the drug class that includes gabapentin is an addiction

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29. Smith et al., *supra* note 15.

30. Smith et al., *supra* note 15.

31. Smith et al., *supra* note 15.

32. Smith et al., *supra* note 15.

33. *Gabapentin*, *supra* note 10.

34. *Drug Epidemic Ensnarers 25-Year-Old Pill for Nerve Pain*, CLEVELAND.COM (May 4, 2018), [http://www.cleveland.com/nation/index.ssf/2018/05/drug\\_epidemic\\_ensnarers\\_25-year.html](http://www.cleveland.com/nation/index.ssf/2018/05/drug_epidemic_ensnarers_25-year.html).

35. *Gabapentin*, *supra* note 10 (Drug analysis reports were obtained from the National Forensic Laboratory Information System (NFLIS). The NFLIS collects drug analysis information from state, local and other federal forensic laboratories. 2,219 reports of illicit gabapentin distribution were collected by the NFLIS in 2016).

threat.<sup>36</sup> FDA Commissioner Scott Gottlieb stated that some literature suggests clinicians may be prescribing these medications off-label as alternatives to opioids, outside approved indications.<sup>37</sup> The FDA's preliminary findings show that misuse and abuse of this drug class continue to increase, especially for gabapentin.<sup>38</sup> In order to understand changes in how patients are using drugs like gabapentin, the FDA has looked at various social media websites where opioid users share methods and motivations for misusing and abusing these drugs.<sup>39</sup> The FDA has further vowed to investigate and respond to signs of abuse.<sup>40</sup>

In April 2018, the National Institutes of Health (NIH) launched the Helping to End Addiction Long-term Initiative (HEAL).<sup>41</sup> The goal of the HEAL Initiative is to bolster research to improve treatments for opioid misuse and addiction,<sup>42</sup> as well as to enhance pain management.<sup>43</sup> Health and Human Services (HHS) also launched a comprehensive strategy to empower local communities to fight the opioid crisis.<sup>44</sup> The strategy included taking measures to provide better (1) prevention, treatment, and recovery services,<sup>45</sup> (2) data on the epidemic, (3) pain management, (4)

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36. Joyce Frieden, *FDA Investigating Misuse, Abuse of Gabapentinoids*, MEDPAGE TODAY (Feb. 15, 2018), <http://www.medpagetoday.com/psychiatry/addictions/71191>.

37. *Id.*

38. *Id.*

39. *Id.*

40. *Id.*

41. *HEAL Initiative Research Plan*, NAT'L INST. OF HEALTH (Jan. 31, 2019), <http://www.nih.gov/research-training/medical-research-initiatives/heal-initiative>.

42. *Id.* (Including expanding therapeutic options for opioid addiction, overdose prevention and reversal, developing new or improved prevention and treatment strategies for addiction, and optimizing effective treatment strategies for opioid addiction).

43. *Id.* (Including understanding the biological underpinnings of chronic pain, accelerating the discovery and pre-clinical development of non-addictive pain treatments, advancing new non-addictive pain treatments through the clinical pipeline, and establishing the best pain management strategies for acute and chronic pain conditions).

44. *5-Point Strategy to Combat the Opioid Crisis*, U.S. DEP'T OF HEALTH AND HUMAN SERVS. (Aug. 7, 2018), <http://www.hhs.gov/opioids/about-the-epidemic/hhs-response/index.html>.

45. *Id.* (HHS issued over \$800 million in grants in 2017 to support treatment, prevention, and recovery efforts).

targeting of overdose-reversing drugs,<sup>46</sup> and (5) research on pain and addiction.<sup>47</sup> The NIH categorized these measures in short term deliverables (within three to five years) and longer-term deliverables (over five years).<sup>48</sup>

#### IV. STATE-LEVEL EFFORTS TO ADDRESS GABAPENTIN MISUSE AND ABUSE

##### *A. Kentucky Classifies Gabapentin as a Schedule V Controlled Substance*

On July 1, 2017, Kentucky became the first state to classify gabapentin as a Schedule V controlled substance after the drug was involved in over one-third of Kentucky's fatal overdoses in 2016.<sup>49</sup> Schedule V controlled substances are controlled substances that have a low potential for abuse relative to substances listed in Schedule IV, and consists primarily of preparations containing limited quantities of certain narcotics.<sup>50</sup> Prescriptions for Schedule V controlled substances are limited to an expiration date of six months from their issuance date, and a maximum of five refills.<sup>51</sup>

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46. *Id.* (President Trump's 2019 Budget includes \$74 million in new investments to support goal of targeting availability of lifesaving overdose-reversing drugs).

47. *Id.*

48. *Id.* (HEAL's short term deliverables include evidence for the non-pharmacological management of multiple acute and chronic pain conditions, and a comprehensive dataset for the research community to reveal factors that predict transition or resilience to chronic pain. Longer term deliverables include pharmaceutical programs that can provide research, development and premarket approval for overdose reversal agents, and novel medications to treat withdrawal, craving, and relapse).

49. Siemaszko, *supra* note 22; Christine Vestal, *Abuse of Opioid Alternative Gabapentin is on the Rise*, HUFF. POST (May 10, 2018), [http://www.huffingtonpost.com/entry/abuse-of-opioid-alternative-gabapentin-is-on-the-rise\\_us\\_5af463ebe4b05919d1e1d121](http://www.huffingtonpost.com/entry/abuse-of-opioid-alternative-gabapentin-is-on-the-rise_us_5af463ebe4b05919d1e1d121); *Important Notice: Gabapentin Becomes a Schedule 5 Controlled Substance in Kentucky*, KY. LEGIS. RESEARCH COMM'N (Mar. 3, 2017),

<http://chfs.ky.gov/agencies/os/oig/dai/deppb/Documents/KentuckyGabapentinFactSheet.pdf>.

50. Vestal, *supra* note 49; DRUG ENFORCEMENT ADMINISTRATION DIVERSION CONTROL DIVISION, <http://www.deadiversion.usdoj.gov/schedules/> (last visited Feb. 11, 2019).

51. 21 C.F.R. § 1306.22(a) (2010).



*B. Michigan, Tennessee, and West Virginia Follow Suit*

Other states have followed in Kentucky's footsteps by changing gabapentin's classification from a non-controlled substance to a Schedule V medication.<sup>52</sup> For instance, on January 9, 2019 Michigan's Department of Licensing and Regulatory Affairs categorized gabapentin as a Schedule V controlled substance after identifying gabapentin as an emerging threat in the state.<sup>53</sup> In addition to the schedule change, new training standard requirements for prescribers and dispensers of opioids and controlled substances were implemented.<sup>54</sup> Such standards include training on alternative pain management treatments,<sup>55</sup> patient counseling pertaining to effects and risks of controlled substances use, proper prescription disposal requirements,<sup>56</sup> stigma of addiction, utilizing the Michigan Automated Prescription System,<sup>57</sup> and state and federal controlled substance dispensing laws.<sup>58</sup> Other states that have taken such measures include Tennessee,<sup>59</sup> and

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52. *Gabapentin Scheduled as Controlled Substance to Help With State's Opioid Epidemic*, MICH. DEP'T OF LICENSING AND REGULATORY AFFAIRS (Jan. 9, 2019), <http://www.michigan.gov/lara/0,4601,7-154-89505-487050--,00.html>.

53. *Id.*

54. *Id.*

55. Rene Wisely, *Accepting Chronic Pain: Strategies Offer Alternative to Opioids*, UNIV. OF MICH. MED. (NOV. 21, 2018), <http://healthblog.uofmhealth.org/health-management/accepting-chronic-pain-strategies-offer-alternative-to-opioids> (Discussing alternative pain management treatments, like taking anti-inflammatory drugs, such as Advil, or engaging in psychological interventions aimed at reducing pain severity).

56. *Michigan Opioid Laws: Frequently Asked Questions (FAQs)*, MICH. DEP'T OF LICENSING AND REGULATORY AFFAIRS (Mar. 6, 2019), [http://www.michigan.gov/documents/lara/LARA\\_DHHS\\_Opioid\\_Laws\\_FAQ\\_05-02-2018\\_622175\\_7.pdf](http://www.michigan.gov/documents/lara/LARA_DHHS_Opioid_Laws_FAQ_05-02-2018_622175_7.pdf) (Proper prescription disposal requirements include counseling on how to properly dispose of an expired, unused, or unwanted controlled substance).

57. *Id.* (Licensed prescribers are required to register with MAPS prior to prescribing or dispensing a controlled substance and are also required to request and review a MAPS report prior to prescribing a controlled substance that exceeds a 3-day supply in the outpatient setting, with certain exemptions. Prescribers may only request a MAPS report on individuals who are bona-fide current patients of that prescriber.

58. *Gabapentin Scheduled as Controlled Substance to Help With State's Opioid Epidemic*, *supra* note 52.

59. *Gabapentin Will Be a Schedule V Controlled Substance in Tennessee Effective July 1, 2018*, TENN. STATE GOV'T (June 2018),

West Virginia.<sup>60</sup>

### *C. States Monitoring Gabapentin Through PDMPs*

Another approach several states have taken include only mandated reporting to a Prescription Drug Monitoring Program (PDMP) without reclassifying gabapentin as a controlled substance.<sup>61</sup> PDMPs are state-operated electronic database systems containing information pertaining to federally-classified controlled substances filled at retail pharmacies within that state.<sup>62</sup> Each state, but Missouri, has its own PDMP.<sup>63</sup> 46 states also participate in the collaborative PMP Interconnect, an interstate group fostering prescription drug data sharing across state lines.<sup>64</sup> Research indicates that PDMPs may reduce prescribing behavior, and prescription drug overdoses, although it is unknown whether PDMPs reduce overall opioid deaths.<sup>65</sup> PDMP data has been incorporated in identifying trends in prescription patterns, including high-risk patterns of prescription drug users.<sup>66</sup> Within the past several years, Illinois, Massachusetts, Minnesota, Ohio, Tennessee, Virginia, and Wyoming began requiring prescribers and pharmacists to check PDMPs before respectively prescribing and dispensing

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<http://www.tn.gov/content/dam/tn/health/healthprofboards/New%20Statue%20Gabapentin%2006-18.pdf>.

60. JoAnn Snoderly, *New Laws on Opioids and Gabapentin Go Into Effect*, THE EXPONENT TELEGRAM (June 7, 2018), [http://www.wvnews.com/theet/news/new-laws-on-opioids-and-gabapentin-go-into-effect/article\\_b9013859-8871-50e9-a460-2b69f3c4b73a.html](http://www.wvnews.com/theet/news/new-laws-on-opioids-and-gabapentin-go-into-effect/article_b9013859-8871-50e9-a460-2b69f3c4b73a.html).

61. Peckham, *supra* note 1.

62. Jessica Reichert et al., *Opioid Prescribing in Illinois: Examining Prescription Drug Monitoring Program Data*, ILL. CRIM. JUS. INFO. AUTH. (May 21, 2018), <http://www.icjia.state.il.us/articles/opioid-prescribing-in-illinois-examining-prescription-drug-monitoring-program-data>.

63. Jessica Davis, *Opioid Epidemic: Why Aren't Prescription Drug Monitoring Programs More Effective?*, HEALTHCARE IT NEWS (Apr. 30, 2018), <http://www.healthcareitnews.com/news/opioid-epidemic-why-arent-prescription-drug-monitoring-programs-more-effective>.

64. *Id.*

65. Reichert et al., *supra* note 62.

66. Reichert et al., *supra* note 62.

gabapentin to ensure patients were not already receiving it or another similar medication from other health care professionals.<sup>67</sup> PDMPs allow prescribers and pharmacists to view all controlled medications a patient receives, alerting them if a patient may be abusing these medications.<sup>68</sup> Depending on the state, a PDMP can make prescription information for individual patients available to in-state pharmacies and prescribers within a day.<sup>69</sup>

However, it is yet to be determined whether PDMP use truly impacts the opioid crisis.<sup>70</sup> Furthermore, researchers identified various issues impacted by PDMPs.<sup>71</sup> One such issue pertains to the “chilling effect,”<sup>72</sup> due to the potentially negative influence of drug enforcement agents monitoring practitioners’ prescribing behaviors.<sup>73</sup> Another issue pertains to varying regulations and requirements on a state-by-state basis.<sup>74</sup> Furthermore, PDMPs are not easily integrated into prescriber’s workflow.<sup>75</sup> In many instances, prescribers are required to leave a patient’s electronic health record (EHR) screen, log into the state’s website, search for the patient’s name (possibly making several selections due to name variation), and return to the EHR to complete their work.<sup>76</sup> In addition to such challenges integrating different software models, a lack of data standardization, as well as a lack of

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67. Vestal, *supra* note 49.

68. Kara Gavin, *Prescription Tracking Tackles Misuse of Opioids and Other Drugs – But Results Vary*, UNIV. OF MICH. HEALTH LAB (July 19, 2017, 12:00 PM) <http://labblog.uofmhealth.org/rounds/prescription-tracking-tackles-misuse-of-opioids-and-other-drugs-but-results-vary>.

69. *Id.*

70. Davis, *supra* note 63 (According to a 2017 study by the University of Texas Health Science Center at San Antonio, PDMP use effects remained mixed).

71. Davis, *supra* note 63.

72. Richard M. Reisman et al., *Prescription Opioid Usage and Abuse Relationships: An Evaluation of State Prescription Drug Monitoring Program Efficacy*, 3 *SUBSTANCE ABUSE: RESEARCH & TREATMENT* 41, 42 (2009) (Discussing the “chilling effect” that deters prescribers from prescribing opioids and controlled medications that may successfully treat a patient’s pain).

73. Davis, *supra* note 63.

74. Davis, *supra* note 63.

75. Davis, *supra* note 63.

76. Davis, *supra* note 63.

a unique patient identifier that could transcend state borders, limits information shared between states.<sup>77</sup> Thus, PDMPs alone are not enough to not only combat the opioid epidemic, but also monitor potential for abuse of non-opiates, like gabapentin.

*D. Illinois's Current Gabapentin Oversight: Only Mandated Reporting to PMP*

Illinois implemented its state-specific PDMP through the Illinois Prescription Monitoring Program (PMP) legislation, enacted in 1981 and operational in 1968.<sup>78</sup> The mission of PMP is to improve prescribers' as well as pharmacists' ability to review a patient's controlled substance prescription history, furthering assistance in effectively treating patients.<sup>79</sup> The PMP allows practitioners and pharmacists to identify potential "opioid shoppers" and "doctor shopping" behavior.<sup>80</sup> "Opioid shoppers" are defined as individuals receiving opioid prescriptions from three or more prescribers as well as three or more pharmacies within a 90-day period.<sup>81</sup> "Doctor shopping" pertains to a patient's behavior of visiting multiple practitioners for multiple controlled substances.<sup>82</sup> Although the concept of "doctor shopping" is associated with an increased risk of patients misusing controlled substances, reasons other than misuse may explain why patients exhibit this behavior.<sup>83</sup> For instance, some patients report long doctor office waiting times, inconvenient doctor office locations and hours, or even poor

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77. Davis, *supra* note 63.

78. Reichert et al., *supra* note 62.

79. Reichert et al., *supra* note 62; ILL. PRESCRIPTION MONITORING PROGRAM, <http://www.ilpmp.org/aboutus.php> (last visited Apr. 30, 2019).

80. Reichert et al., *supra* note 62.

81. Reichert et al., *supra* note 62.

82. Reichert et al., *supra* note 62; Randy Sansone et al., *Doctor Shopping — A Phenomenon of Many Themes*, 9 INNOV. CLIN. NEUROSCI. 42, 42-43 (2012).

83. Reichert et al., *supra* note 62.

communication with practitioners as reasons for “doctor shopping.”<sup>84</sup> However, like many other states' PDMP, Illinois's sole implementation of mandatory gabapentin prescription reporting in PMP, without more, is not enough to resolve the gabapentin crisis striking Illinois.

#### V. CONCLUSION

By reclassifying gabapentin as a controlled substance, Illinois will further efforts to fight the national opioid epidemic as a whole and protect its residents. Through such a reclassification, Illinois will align its efforts with one of the U.S. Department of Health and Human Services' (HHS) main priorities in tackling the opioid crisis: advancing better practices for pain management.<sup>85</sup> It is, however, important to acknowledge unintended consequences of decisive actions to reduce prescription opioid abuse.<sup>86</sup> Such actions may lead to prescription opioid abusers turning to alternative, potentially dangerous substances, or may change clinicians' prescribing patterns, implicating their patients.<sup>87</sup>

However, these unintended consequences are outweighed by potential benefits from reclassifying gabapentin as a controlled substance. Pharmacological pain management does not solely pertain to opioid prescriptions.<sup>88</sup> Because gabapentin, a non-opioid, may greatly heighten sedative and addictive effects when taken in conjunction with prescribed opioids,<sup>89</sup> stricter measures in Illinois must be taken in making prescription

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84. Reichert et al., *supra* note 62.

85. *Opioid Overdose Crisis*, *supra* note 3. (HHS's four other priorities in response to the opioid crisis include: (1) improving access to treatment and recovery services; (2) promoting use of overdose-reversing drugs; (3) strengthening understanding of the epidemic through better public health surveillance; and (4) providing support for research on pain and addiction).

86. Douglas C. Throckmorton et al., *The FDA and the Next Wave of Drug Abuse — Proactive Pharmacovigilance*, 397 NEW ENG. J. MED. 205, 205 (2018).

87. *Id.*

88. *Gabapentin*, *supra* note 10.

89. Siemaszko, *supra* note 22.

and distribution decisions of gabapentin. Even the Food and Drug Administration admits the increased concern about possible abuse of gabapentin, irrespective of their appropriate use for pain, alone or in combination with opioids and other prescription drugs.<sup>90</sup> Relying on databases, like the PMP, without more, will detract from Illinois's efforts to combatting the opioid crisis. Thus, Illinois must reclassify gabapentin as a controlled substance to sustain appropriate use of the medication while also curtailing prescription drug abuse as a whole.

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90. Throckmorton et al., *supra* note 86.



# The CARA 2.0 Act of 2018 and the Three-Day Limit Opioid Prescriptions for Acute Pain Management: Diminishing Quality of Patient's Care and Increasing Demands on Physician's Time

Jacalyn Smith

## I. INTRODUCTION

Beginning in the early 1990s, opioids became a common way to relieve pain.<sup>1</sup> Patients were often prescribed opioids for routine procedures and acute pain management.<sup>2</sup> However, prolonged or repeated exposure to opioids can lead to dependency and overdose.<sup>3</sup> Currently, opioid addiction and overdose are the leading cause of accidental deaths in the United States.<sup>4</sup> In 2016 alone, over 40,000 Americans died from opioid overdoses.<sup>5</sup>

The federal government, individual states, and health care providers struggle to combat opioid addiction and misuse.<sup>6</sup> Opioids like oxycodone,

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1. Andrew Rosenblum, et al., *Opioids and the Treatment of Chronic Pain: Controversies, Current Status, and Future Directions*, 16(5) EXP CLIN PSYCHOPHARMACOL 405, 407 (2008).

2. Kevin Joy, *What These 10 Studies Taught Us About Opioid Addiction in 2017*, UNIVERSITY OF MICHIGAN HEALTH LAW (Dec. 20, 2017), <https://labblog.uofmhealth.org/rounds/what-these-10-studies-taught-us-about-opioid-addiction-2017>.

3. Rosenblum, *supra* note 1, at 10.

4. Fiza Pirani, *Opioids Now Kill More Americans Than Guns or Breast Cancer*, CDC Says, THE ATLANTA JOURNAL-CONSTITUTION (Dec. 21, 2017), [www.ajc.com/news/health-med-fit-science/opioids-now-kill-more-americans-than-guns-breast-cancer-cdc-says/DUx1KS33P4sbyzgj9T9rrN/](http://www.ajc.com/news/health-med-fit-science/opioids-now-kill-more-americans-than-guns-breast-cancer-cdc-says/DUx1KS33P4sbyzgj9T9rrN/).

5. *Id.*

6. See Kao-Ping Chua, et al., *Opioid Prescribing Limits for Acute Pain: Potential Problems with Design and Implementation*, 321 JAMA 643, 643-44 (Jan. 31, 2019) (stating that as “of November 2018, a total of 32 states have enacted legislation that limits the duration of opioid prescriptions to patients with acute pain or to patients new to opioids”).



Vicodin, morphine, and codeine are legally available.<sup>7</sup> When taken in small doses for a controlled period of time, opioid pain relievers are safe and effective.<sup>8</sup> Because the severity of each patient's pain is different, the appropriate duration and amount of an opioid prescription for acute pain is unclear.<sup>9</sup> According to Henry Dorkin, the President of Massachusetts Medical Society (MMS), "battling the opioid epidemic calls for an attack on many fronts, not the least of which is reducing new cases of opioid use disorder among our patients."<sup>10</sup>

The Comprehensive Addiction and Recovery Act 2.0 Act of 2018 (CARA 2.0 Act of 2018) is based on: (1) the original CARA (passed in 2016), (2) the Centers for Disease Control (CDC) guidelines, and (3) state legislatures.<sup>11</sup> While CARA 2.0 Act of 2018 continues CARA's general mission of decreasing opioid addiction, this new iteration significantly restricts health care providers' ability to prescribe opioids for acute pain management.<sup>12</sup> The CARA 2.0 Act of 2018 seeks to curtail the opioid epidemic;<sup>13</sup> however, it actually decreases the overall quality of care that patients receive.<sup>14</sup> This

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7. *Opioids*, NAT'L INSTITUTE OF DRUG ABUSE, [www.drugabuse.gov/drugs-abuse/opioids](http://www.drugabuse.gov/drugs-abuse/opioids) (last visited Apr. 28, 2019).

8. Rosenblum, *supra* note 1, at 1.

9. See Pino & Covington, *infra* note 37.

10. Marilyn Serafini, *The Physicians' Quandry with Opioids: Pain versus Addiction*, NEW ENGLAND J MEDICINE CATALYST (Apr. 26, 2018), <https://catalyst.nejm.org/quandary-opioids-chronic-pain-addiction/>.

11. Ctrs. for Disease Control & Prevention, *2018 Annual Surveillance Report of Drug-Related Risks and Outcomes*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (2018), [www.cdc.gov/drugoverdose/pdf/pubs/2018-cdc-drug-surveillance-report.pdf](http://www.cdc.gov/drugoverdose/pdf/pubs/2018-cdc-drug-surveillance-report.pdf).

12. The CARA 2.0 Act of 2018 defines acute pain management is defined as "pain with abrupt onset and caused by an injury or other process that is not going." It does not include chronic pain, pain being treated as part of cancer care, hospice, or other end-of-life care, or pain being treated as part of palliative care. Comprehensive Addiction and Recovery Act, 42 U.S.C § 290bb-25g.

13. See *President Donald J. Trump's Initiative to Stop Opioid Abuse and Reduce Drug Supply and Demand*, White House (Oct. 24, 2018), [www.whitehouse.gov/briefings-statements/president-donald-j-trumps-initiative-stop-opioid-abuse-reduce-drug-supply-demand-2/](http://www.whitehouse.gov/briefings-statements/president-donald-j-trumps-initiative-stop-opioid-abuse-reduce-drug-supply-demand-2/).

14. Jacob Gross and Debra Gordon, *The Strengths and Weaknesses of Current U.S. Policy to Address Pain*, 109 AM J PUB HEALTH 66, 66-72 (Jan. 2019).

article focuses on section three of the CARA 2.0 Act of 2018, which places additional restraints on physicians' ability to prescribe opioids for acute pain management.<sup>15</sup>

First, this article will address the changes to the substance of the original CARA. Next, it will illustrate the additional physical and emotional stress placed on physicians by analyzing the impact of the limit on physician's work load and patient care. This article will demonstrate the unintended consequences of the CARA 2.0 Act of 2018, including an increased black market for opioids. Finally, it will argue that the three-day limit hinders patient recovery time. Ultimately the CARA 2.0 Act of 2018 claims to improve patient care by decreasing opioid pills available, but in reality, it negatively impacts the quality of care physicians provide and the overall well-being of patients.

## II. COMPREHENSIVE ADDICTION AND RECOVERY ACT 2016 AND 2018.

In 2016, Congress enacted the Comprehensive Addiction and Recovery Act (CARA).<sup>16</sup> CARA called for the Secretary of Health and Human Services (HHS) to raise public awareness about opioid use disorders, specifically it included the association between prescription opioid misuse, the risks of fentanyl, and the dangers of heroin.<sup>17</sup> In February 2018, eight senators introduced the Comprehensive Addiction and Recovery Act (the CARA 2.0

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15. *Id.*

16. CARA, 42 U.S.C § 201 (2016).

17. CARA, 42 U.S.C § 201 (2016); see Lacey Collins, et al., *Trends in the Medical Supply of Fentanyl and Fentanyl Analogues: The United States 2006 to 2017*, 123 PREVENTIVE MEDICINE 95, 95-100. (The effects of fentanyl include euphoria, sedation, nausea, and respiratory depression; however, fentanyl has "a rapid onset and short duration of action." The potency of fentanyl means that even one small dose may be lethal); see also *Heroin*, NAT'L INSTITUTE ON DRUG ABUSE, [www.drugabuse.gov/publications/research-reports/heroin/what-are-long-term-effects-heroin-use](http://www.drugabuse.gov/publications/research-reports/heroin/what-are-long-term-effects-heroin-use). (last updated June 2018). (The long-term effects of heroin use include changes to the physical structure of the brain that may affect "decision-making abilities, the ability to regulate behavior, and response to stressful situations.").

Act of 2018).<sup>18</sup> In October 2018, President Trump signed the CARA 2.0 Act of 2018 into law, which marked the Trump administration's first policy regarding the opioid crisis.<sup>19</sup> The new law amended and expanded several provisions of the original CARA.<sup>20</sup> It allows first responders to administer naloxone and authorizes HHS to expand medication-assisted treatment.<sup>21</sup> Additionally, it enables recovery community organizations (RCOs) to establish treatment programs, mental health providers, treatment systems, and other recovery supports.<sup>22</sup>

Moreover, the CARA 2.0 Act of 2018 allows physician assistants (PAs) and nurse practitioners (NPs) to prescribe buprenorphine under the direction of a qualified physician.<sup>23</sup> It also waives the current requirement that physicians can only treat 100 patients with buprenorphine.<sup>24</sup> Under this new federal regulation, physicians may apply to prescribe buprenorphine to up to

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18. The CARA 2.0 Act of 2018 was introduced by Sens. Rob Portman (R-OH), Sheldon Whitehouse (D-RI), Shelley Moore Capito (R-WV), Amy Klobuchar (D-MN), Dan Sullivan (R-AK), Maggie Hassan (D-NH), Bill Cassidy (R-LA), and Maria Cantwell (D-WA). Comprehensive Addiction and Recovery Act, 42 U.S.C § 290bb–25g (2018).

19. Jennifer Garvin, *Congress Passes Bipartisan Opioid Legislation*, ADA NEWS (Oct. 4, 2018), [www.ada.org/en/publications/ada-news/2018-archive/october/congress-passes-bipartisan-opioid-legislation](http://www.ada.org/en/publications/ada-news/2018-archive/october/congress-passes-bipartisan-opioid-legislation).

20. *See generally*, Comprehensive Addiction and Recovery Act, 42 U.S.C § 290bb–25g.

21. *Comprehensive Addiction and Recovery Act (CARA) 2.0 of 2018: A Section-by-Section Analysis*, NAT'L ASSN OF STATE ALCOHOL & DRUG ABUSE DIRS., 1, 2 (2018), <http://nasadad.org/wp-content/uploads/2018/03/CARA-2.0-Section-by-Section-March-2018.pdf>; *see Opioid Overdose Reversal with Naloxone*, NAT'L INSTITUTE OF DRUG ABUSE, [www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio](http://www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio). (explaining naloxone is “a medication designed to rapidly reverse opioid overdose.”).

22. NAT'L ASSN OF STATE ALCOHOL & DRUG ABUSE DIRS., *supra* note 21.

23. *Qualify for Nurse Practitioners (NPs) and Physician Assistants (PAs) Waiver infra* note 72

24. NAT'L ASSN OF STATE ALCOHOL & DRUG ABUSE DIRS., *supra* note 21; *see* Kathleen Broglio, *Prescribing Opioids in Primary Care: Avoiding Perils and Pitfalls*, 39 THE NURSE PRACTITIONER 30, 30-37, (2014); *see also* *What Exactly is Buprenorphine?*, THE NAT'L ALLIANCE OF ADVOCATES FOR BUPRENORPHINE TREATMENT, [www.naabt.org/faq\\_answers.cfm?ID=2](http://www.naabt.org/faq_answers.cfm?ID=2) (last visited Apr. 1, 2019) (defining buprenorphine as a medication that creating the typical opioid effects of euphoria, but at a lower rate in order to discontinue the patient's misuse of opioids).

275 patients.<sup>25</sup> Physicians may only apply for the higher limit if they have experience with buprenorphine, specifically, that they have prescribed it to 100 patients for at least one year.<sup>26</sup> The CARA 2.0 Act of 2018 also provides treatment options for veterans dishonorably discharged because of an opioid addiction, and infants born with Fetal Alcohol Spectrum disorder or other substance abuse symptoms.<sup>27</sup> These changes represent an attempt to treat those already addicted to opioids.

#### A. CARA 2.0 Section Three

One of the most drastic changes of the CARA 2.0 Act of 2018 is section three, which prohibits the Attorney General from registering or renewing the registration of any practitioner who prescribes more than a three-day supply of an opioid in schedule II, III, or IV for acute pain management.<sup>28</sup> Section three defines acute pain as “pain with abrupt onset and caused by an injury or other process that is not on-going.”<sup>29</sup>

The medical community and the legislature both agree that opioids are overprescribed,<sup>30</sup> however, most of the CARA 2.0 Act of 2018 is based on one source: the CDC’s prescribing guidelines.<sup>31</sup> The American Medical Association (AMA) maintains that the CDC expressly meant for its guidelines to be suggestive, not prescriptive.<sup>32</sup> The CDC’s guidelines are

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25. *Apply to Increase Patient Limits*, SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMINISTRATION (Feb. 19, 2017), [www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management/increase-patient-limits](http://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management/increase-patient-limits).

26. *Id.*

27. NAT’L ASSN OF STATE ALCOHOL & DRUG ABUSE DIRS, *supra* note 21.

28. Comprehensive Addiction and Recovery Act (CARA) 2.0 of 2018, at 3.

29. Comprehensive Addiction and Recovery Act (CARA) 2.0 of 2018.

30. Nabarun Dasgupta, et al., *Opioid Crisis: No Easy Fix to Its Social and Economic Determinants*, 108 Am J Public Health 182, 182-86 (Feb. 2018).

31. See *Guideline for Prescribing Opioids for Chronic Pain Management*, CTRS FOR DISEASE CONTROL (2016), url: [hereinafter *Guideline for Prescribing Opioids for Chronic Pain Management*]; see also *Opioids for Acute Pain What You Need to Know*, CTRS FOR DISEASE CONTROL (Aug. 31, 2017), [www.cdc.gov/drugoverdose/patients/materials.html](http://www.cdc.gov/drugoverdose/patients/materials.html).

32. Jeffery Singer, *The AMA Gets it Right by Defending Evidence-Based Medicine and Patient, Physician Autonomy*, CATO AT LIBERTY (May 30, 2018),

recommendations for primary care providers, but do not offer any guidance for specialists.<sup>33</sup> Often, specialists consult with patients after surgery or for ongoing acute pain management.<sup>34</sup> Therefore, section three of the CARA 2.0 Act does not adequately address all health care providers who prescribe opioids for acute pain management.

Furthermore, the three-day limit established in the CARA 2.0 Act of 2018 is not supported by published research or other clinical evidence. Prior to the CARA 2.0 Act of 2018, patients were often prescribed a three- to six- month supply of opioids for procedures requiring acute pain management.<sup>35</sup> In a 2017 study, the University of Michigan Health Labs found that less than ten percent of patients prescribed a 30-day supply of opioid therapy actually took the full supply.<sup>36</sup> Prescribing patients more opioid therapy than necessary can result in leftover pills that are available for inappropriate use.<sup>37</sup> The need to curtail opioid prescriptions is apparent, yet the Department of Defense Military Health System Data Repository found that the average opioid prescription length lies between four to nine days for general surgery procedures, four to 13 days for women's health procedures, and six to 15 days for musculoskeletal procedures.<sup>38</sup> According to Dr. Richard Hurley, president of the Texas Pain Society, the three-day limit "is an arbitrary duration that would be **totally inadequate** for any major operation that

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[www.cato.org/blog/unfairly-accused-ama-actually-shows-backbone-defense-evidence-based-medicine-patient-physician](http://www.cato.org/blog/unfairly-accused-ama-actually-shows-backbone-defense-evidence-based-medicine-patient-physician).

33. *Prescribing Policies: States Confront Opioid Overdose Epidemic*, NAT'L CONFERENCE OF STATE LEGIS. (Oct. 21, 2018), [www.ncsl.org/research/health/prescribing-policies-states-confront-opioid-overdose-epidemic.aspx](http://www.ncsl.org/research/health/prescribing-policies-states-confront-opioid-overdose-epidemic.aspx).

34. *Id.*

35. Joy, *supra* note 2.

36. Joy, *supra* note 2.

37. Carlos Pino & Melissa Covington, *Prescription of Opioids for Acute Pain in Opioid Naïve Patients*, UPTODATE (last visited Feb. 16 2019),

[www.uptodate.com/contents/prescription-of-opioids-for-acute-pain-in-opioid-naive-patients](http://www.uptodate.com/contents/prescription-of-opioids-for-acute-pain-in-opioid-naive-patients).

38. R.E. Scully, et al., *Defining Optimal Length of Opioid Pain Medication Prescription After Common Surgical Procedures*, 1 JAMA SURG. 37, 37-43 (2018).

causes severe pain.”<sup>39</sup> He further stated that the three day limit “was developed by those who have never been in the trenches and have never experienced severe pain before....the limit does not take into account the diagnosis, etiology of pain, and the overall time it takes for the body to heal.”<sup>40</sup> While restricting opioid prescriptions to a three-day supply may reduce the number of prescriptions written, research does not support the prospective benefits of this arbitrary limit.<sup>41</sup>

The CARA 2.0 Act of 2018 focuses only on the duration of opioid prescriptions and completely disregards other factors that may lead to misuse and addiction, including choice of opioid and dosage.<sup>42</sup> For example, most opioid prescribing guidelines suggest either 5 mg pills of oxycodone or an equivalent dose of hydrocodone or tramadol.<sup>43</sup> A universal recommendation for opioid prescription is impractical because physicians must consider the patient’s age, gender, genetics, and co-existing health conditions when determining the choice and dose of opioid.<sup>44</sup> Physicians must consider multiple factors about the choice of opioid, including the strength of the receptor binding, the potential of drug-to-drug interactions, and the drug metabolism.<sup>45</sup> The CARA 2.0 Act of 2018 solely focuses on the quantity of opioid prescriptions written for acute pain management rather than the type and amount of opioid prescribed.<sup>46</sup>

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39. *Federal Bill Would Limit Opioid Scripts for Acute Pain*, TEXAS MED. ASS’N, [www.texmed.org/Template.aspx?id=47668](http://www.texmed.org/Template.aspx?id=47668) (last updated Jun. 19, 2018) (emphasis added).

40. *Federal Bill Would Limit Opioid Scripts for Acute Pain*, *supra* note 39.

41. Kate M. Nicholson, et al., *Overzealous Use of the CDC’s Opioid Prescribing Guideline is Harming Pain Patients*, STAT (Dec. 6, 2018) [www.statnews.com/2018/12/06/overzealous-use-cdc-opioid-prescribing-guideline/](http://www.statnews.com/2018/12/06/overzealous-use-cdc-opioid-prescribing-guideline/)

42. *See generally* NAT’L ASSN OF STATE ALCOHOL & DRUG ABUSE DIRS, *supra* note 21.

43. Pino & Covington, *supra* note 37.

44. Pino & Covington, *supra* note 37.

45. Pino & Covington, *supra* note 37.

46. NAT’L ASSN OF STATE ALCOHOL & DRUG ABUSE DIRS, *supra* note 21.

### III. PHYSICAL AND EMOTIONAL STRESS ON PHYSICIANS AND HEALTH CARE PROVIDERS

The CARA 2.0 Act of 2018 places unnecessary demands on physicians' already full schedules. On average, a physician sees 20 patients per day.<sup>47</sup> A physician's decision about how they allocate their work-day has important implications for the quality of care and patient trust in their provider.<sup>48</sup> The new legislature requires all licensed or registered practitioners to consult with their state's Prescription Drug Monitoring Program (PDMP) before prescribing a schedule II, III, or IV controlled substance.<sup>49</sup> A PDMP is an electronic database that records controlled substance prescriptions within the state.<sup>50</sup> They are used to "improve prescribing behavior, inform clinical practice, and protect patients who are at risk for substance use disorders."<sup>51</sup> Under the CARA 2.0 Act of 2018, prescribing physicians must check the PDMP every three months after an initial prescription, as long as opioid therapy continues.<sup>52</sup> Such provisions prevent patients from obtaining multiple prescriptions;<sup>53</sup> however, these safeguards would be equally effective with a five or a seven day supply of opioids.<sup>54</sup> The rigidity of the three-day limit undermines a physician's ability to evaluate each individual's symptoms and pain tolerance.<sup>55</sup> According to Robin Hamill-Ruth, M.D., past

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47. Lenny Bernstein, *How Many Patients Should Your Doctor See Each Day?*, THE WASHINGTON POST (May 22, 2014), [www.washingtonpost.com/news/to-your-health/wp/2014/05/22/how-many-patients-should-your-doctor-see-each-day/?utm\\_term=.ff67ec63bf27](http://www.washingtonpost.com/news/to-your-health/wp/2014/05/22/how-many-patients-should-your-doctor-see-each-day/?utm_term=.ff67ec63bf27).

48. Ming Tai-Seale, et al., *Time Allocation in Primary Care Office Visits*, 42(5) HEALTH SERV. RES., 1871, 1871 (2008).

49. NAT'L ASSN OF STATE ALCOHOL & DRUG ABUSE DIRS., *supra* note 21.

50. *Opioid Summary*, Academy of Managed Care Pharmacy (Jul. 1, 2018), [www.amcp.org/WorkArea/DownloadAsset.aspx?id=23763\\_](http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=23763_)

51. *Id.*

52. NAT'L ASSN OF STATE ALCOHOL & DRUG ABUSE DIRS., *supra* note 21.

53. See Lev Facher, *New Opioid Bill Would Impose Sweeping Limits on Some Prescriptions, Boost Funding*, STAT (Feb. 27, 2018) [www.statnews.com/2018/02/27/cara-opioid-crisis-bill/](http://www.statnews.com/2018/02/27/cara-opioid-crisis-bill/)

54. NAT'L ASSN OF STATE ALCOHOL & DRUG ABUSE DIRS., *supra* note 21.

55. Pino & Covington, *supra* note 37.

president of the American Board of Pain Medicine, “the effective dosage often depends on how individuals metabolize drugs and some need more to achieve the same effect.”<sup>56</sup> As a result, the three-day limit takes the focus away from acute pain management and places an unnecessary emphasis on preventing addiction.<sup>57</sup>

Most importantly, the CARA 2.0 Act of 2018’s three-day limit on opioid prescriptions undermines the patient-physician relationship. The physician-patient relationship is based on mutual trust and respect.<sup>58</sup> Pain duration and intensity depend “on the type of injury or surgical procedure, patient demographics, cultural or ethnic factors, prior history with substance use, and history of anxiety or depression.”<sup>59</sup> According to the AMA, a strict three-day limit mis-states the actual recommendation of the CDC.<sup>60</sup> It ignores the CDC’s guideline that states “clinical decision-making should be based on a relationship between the clinician and patient, and the understanding of the clinical situation, functioning and life context.”<sup>61</sup> Applying a blanket three-day limit severely impacts a physician’s ability to treat his or her patient.<sup>62</sup> For example, the Drug Enforcement Administration (DEA) and some state medical boards are using the CDC’s dosage guidelines as a “proxy or red flag to identify physician ‘over-prescribers’ without considering the medical conditions or needs of these physicians’ patients.”<sup>63</sup> Physicians may also

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56. Marilyn Serafini, *The Physicians’ Quandary with Opioids: Pain versus Addiction*, NEJM CATALYST (April 26, 2018), <https://catalyst.nejm.org/quandary-opioids-chronic-pain-addiction/>.

57. *Id.*

58. American Medical Association, § 1.1.1 *Patient-Physician Relationships*, AMA PRINCIPLES OF MED ETHICS 1, 1,

59. Pino & Covington, *supra* note 37.

60. Singer, *supra* note 32.

61. Singer, *supra* note 32.

62. Kate M. Nicholson et. al., *Overzealous Use of the CDC’s Opioid Prescribing Guidelines is Harming Pain Patients*, STAT (Dec. 6, 2018).

[www.statnews.com/2018/12/06/overzealous-use-cdc-opioid-prescribing-guideline/](http://www.statnews.com/2018/12/06/overzealous-use-cdc-opioid-prescribing-guideline/).

63. *Id.*



“refuse to prescribe any opioids because of the fear of sanctions.”<sup>64</sup> Likewise, patients may be hesitant to share details about their prior opioid use because they fear that the stigma surrounding opioids may prevent them from receiving an effective pain management treatment.<sup>65</sup> Therefore, the three-day limit on opioid prescriptions hinders physicians’ ability to effectively treat patients and results in a break down of the patient-physician relationship, which is vital to providing quality care.

Proponents of CARA 2.0 argue that the new legislature allows PAs and NPs to lighten the burden on physicians.<sup>66</sup> The 2016 version of CARA temporarily allowed PAs and NPs to prescribe buprenorphine under the direction of a qualified physician.<sup>67</sup> Under the 2018 update, this provision is permanent.<sup>68</sup> The CARA 2.0 Act of 2018 however, does not extend the authority of PAs and NPs in a way that alleviates the additional burdens on physicians.<sup>69</sup> Qualified PAs and NPs are only allowed to prescribe buprenorphine in office-based settings for patients with an opioid use disorder.<sup>70</sup> In order to qualify, a PA or an NP must be licensed under state law to prescribe schedule III, IV, or V medications for pain.<sup>71</sup> Given the severity of the opioid epidemic, shifting the burden of opioid-therapy

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64. *What New Opioid Laws Mean for Pain Relief*, HARVARD HEALTH LETTER (Oct. 2018), [www.health.harvard.edu/pain/what-new-opioid-laws-mean-for-pain-relief](http://www.health.harvard.edu/pain/what-new-opioid-laws-mean-for-pain-relief).

65. See Zoe Paschkis & Mertie L. Potter, *Acute Pain Management for Inpatients with Opioid Use Disorder*, 115 AM. J NURSING 24, 24-32 (2015).

66. Jenna Herman, *Prescriptive Authority Update 2017*, CONTEMPORARY CLINIC: PHARMACY TIMES (Jun 3, 2017), <http://contemporaryclinic.pharmacytimes.com/journals/issue/2017/june2017/prescriptive-authority-update-2017>.

67. NAT’L ASSN OF STATE ALCOHOL & DRUG ABUSE DIRS, *supra* note 21, at 2.

68. NAT’L ASSN OF STATE ALCOHOL & DRUG ABUSE DIRS, *supra* note 18, at 2.

69. Randall Steven Hudspeth, *Safe Opioid Prescribing for Adults by Nurse Practitioners*, 12 J FOR NURSE PRACTITIONERS 141, 141-48 (Mar. 2016).

70. *Id.*

71. See *PA Prescribing*, AAPA (2017), [www.aapa.org/wp-content/uploads/2017/03/f-833-48256527\\_dk6DMjRR\\_Prescribing\\_IB\\_2017\\_FINAL.pdf](http://www.aapa.org/wp-content/uploads/2017/03/f-833-48256527_dk6DMjRR_Prescribing_IB_2017_FINAL.pdf); see also Erin Cusack, *Explaining the New DEA Rule: APRNs & Prescribing for Opioid Disorders*, TEXAS NURSE PRACTITIONERS (Feb. 27, 2018), [www.texasnp.org/news/388701/Explaining-the-New-DEA-Rule-APRNs--Prescribing-for-Opioid-Disorders.htm](http://www.texasnp.org/news/388701/Explaining-the-New-DEA-Rule-APRNs--Prescribing-for-Opioid-Disorders.htm).

prescriptions to health care providers who have significantly less training and clinical experience than qualified physicians negatively impacts the quality of patient care.<sup>72</sup> PAs and NPs are only required to complete 24 hours of “appropriate education through a qualified provider.”<sup>73</sup> Although they must “demonstrate the ability to treat and manage opioid use disorders” through other training, neither the original CARA or the CARA 2.0 Act of 2018 outlines what is “other training” and how much is necessary.<sup>74</sup> Providing PAs and NPs a greater role in prescribing opioids for acute pain may, on the surface, appear to be an effective solution.<sup>75</sup> To the contrary, physicians possess the knowledge and clinical experience to determine (1) whether opioids are an appropriate treatment, (2) how many days a patient may need the prescription, and (3) whether the patient requires additional supervision.<sup>76</sup> In solidifying this provision, the CARA 2.0 Act of 2018 minimizes the important role that physicians play in prescribing pain relievers to patients.

Finally, the three-day limit on opioid prescriptions for acute pain management does not prevent patients from obtaining opioids outside of their doctor’s office.<sup>77</sup> Given that opioids are an effective pain management tool, the government’s restriction on access to opioids may only increase the

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72. See *Qualify for Nurse Practitioners (NPs) and Physician Assistants (PAs) Waiver*, SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN (April 22, 2019), [www.samhsa.gov/medication-assisted-treatment/training-materials-resources/qualify-np-pa-waivers](http://www.samhsa.gov/medication-assisted-treatment/training-materials-resources/qualify-np-pa-waivers) (establishes that NPs and PAs are required to obtain “no fewer than 24 hours of initial training” regarding CARA.).

73. *Id.*

74. *Id.*

75. Sandeep Jauhar, *Nurses Are Not Doctors*, N.Y. TIMES (Apr. 29, 2014), [www.nytimes.com/2014/04/30/opinion/nurses-are-not-doctors.html?\\_r=0](http://www.nytimes.com/2014/04/30/opinion/nurses-are-not-doctors.html?_r=0).

76. *Massachusetts Medical Society Opioid Therapy and Physician Communication Guidelines*, MASSACHUSETTS MED SOCIETY (last visited Apr. 23, 2019), [www.massmed.org/Patient-Care/Health-Topics/Massachusetts-Medical-Society-Opioid-Therapy-and-Physician-Communication-Guidelines/#.XKj1hOs3m8o](http://www.massmed.org/Patient-Care/Health-Topics/Massachusetts-Medical-Society-Opioid-Therapy-and-Physician-Communication-Guidelines/#.XKj1hOs3m8o).

77. See J.K. Phillips, *Trends in Opioid Use, Harms, and Treatment*, Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use. (Jul. 13, 2017).

demand for opioids on the black market.<sup>78</sup> The National Survey on Drug Use and Health found that “pain reliever abuse rates have been flat since 2002”.<sup>79</sup> Heroin abuse rates only increased after opioid prescription rates started to decline.<sup>80</sup> Restricting the number of prescribed opioids to three-day supplies may reduce the number of prescriptions, but there is no correlation to demonstrate that patients will not seek opioids from other sources to treat their pain.<sup>81</sup>

*A. Three-day limit diminishes patient’s overall quality of care*

Not only does the three-day provision place unnecessary demands on physician time and potentially encourage patients to seek opioids through illegal means,<sup>82</sup> it can also prolong the patient’s recovery time.<sup>83</sup> Opioids are typically prescribed after procedures like a wisdom tooth extraction, outpatient medical procedures, or for a broken bone,<sup>84</sup> when patients typically experience acute pain as their body heals.<sup>85</sup> The CDC recommends that patients consult with their physician about their pain; however, it offers little guidance for patients whose acute pain is more severe.<sup>86</sup> Patients who

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78. J.J. Rich, *Congress Needs an Opioid Intervention: Lawmakers Intend to Spend Billions of Dollars and Pile on Even More Red Tape to Paper over the Conundrums Government Itself Created*, REASON FOUNDATION (Nov. 2018), <https://reason.com/archives/2018/10/18/congress-needs-an-opioid-inter>.

79. *Id.*

80. *Id.*

81. Nicholson, *supra* note 41; *see also* Facher, *supra* note 53.

82. Kelly Dineen & James DuBois, *Between a Rock and a Hard Place: Can Physicians Prescribe Opioids to Treat Pain Adequately While Avoiding Legal Sanction?*, 42 Am J Law Med 7, 7-10 (2016); *see* Jay Greene, *Opioid Laws Hit Physicians, Patients in Unintended Ways*, MODERN HEALTHCARE (Jul. 30, 2018), [www.modernhealthcare.com/article/20180730/NEWS/180739995/opioid-laws-hit-physicians-patients-in-unintended-ways](http://www.modernhealthcare.com/article/20180730/NEWS/180739995/opioid-laws-hit-physicians-patients-in-unintended-ways).

83. *See* Pino & Covington, *infra* note 37.

84. *Guideline for Prescribing Opioids for Chronic Pain Management*, *supra* note 31 at 2.

85. Ctrs. for Disease Control, *supra* note 11.

86. Ctrs. for Disease Control, *supra* note 11; *see* Nancy Wells, et al, *Improving the Quality of Care Through Pain Assessment and Management*, PATIENT SAFETY AND QUALITY: AN EVIDENCE-BASED HANDBOOK FOR NURSES, (2008) (establishes that pain is common after

require more than a three-day supply of opioids must schedule additional appointments.<sup>87</sup> In order to obtain an additional prescription, patients will be paying for those extra office visits in addition to the prescriptions themselves.<sup>88</sup> Especially for patients who have recently undergone a surgery and are in pain to the point that they need an additional supply of opioids, the three-day limit hinders their recovery and lengthens the amount of time they are away from work, school, or family.<sup>89</sup>

#### IV. CONCLUSION

Overall, the CARA 2.0 Act of 2018 presents an over-simplified solution to a complicated problem. Opioid addiction and misuse in the United States has reached epidemic levels, yet opioids can be an effective tool to manage both acute and chronic pain. Placing a strict three-day limit on opioid prescriptions, like the CARA 2.0 Act of 2018 does, impedes a physician's ability to effectively treat his or her patient. It unnecessarily adds significant burdens to both physicians and patients, including demands on physicians' time, additional financial costs to patients, and inadvertently creates a black market for opioids.

The CARA 2.0 Act of 2018 seeks to reduce the number of patients who become addicted to opioids by decreasing the number of opioids prescribed. This approach does not benefit overall patient care because it applies a blanket approach. Legislators have failed to recognize that each patient's pain, symptoms, and response to medication is different. Therefore, the decision for the type, dose, and duration of an opioid prescription should be matter decided between a patient and his or her care provider. A three- day

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surgery and "recent data suggest 80 percent of patients experience pain postoperatively with between 11 and 20 percent experiencing severe pain.").

87. *What New Opioid Laws Mean for Pain Relief*, *supra* note 64; *see* Chua, *supra* note 6.

88. *What New Opioid Laws Mean for Pain Relief*, *supra* note 64.

89. *See* Chua, *supra* note 6.

limit on opioid prescriptions based solely on the CDC's guidelines only decreases the quality of care that patient's receive and places unnecessary demands on already over-worked physicians.

# Imprisoned Hispanic/Latinx Individuals Need Access to Culturally Competent Mental Health Treatment

*Why a lack of cultural competency means Hispanic/Latinx inmates  
are not receiving necessary mental health treatment*

*Pilar G. Mendez\**

“Before I built a wall I’d ask to know,  
What I was walling in or walling out.”  
–Robert Frost, “*Mending Wall*”<sup>1</sup>

## I. INTRODUCTION

Four-in-ten Hispanic/Latinx individuals living in the United States said that they had serious concerns about their place in “Trump’s” America after the 2016 election.<sup>2</sup> One research study found that President Trump’s immigration policies have created psychological stress, and symptoms of anxiety and depression, for nearly two-thirds of Hispanic/Latinx parents, both citizens and undocumented immigrants.<sup>3</sup> Despite the public and

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1. ROBERT FROST, COMPLETE POEMS OF ROBERT FROST (Henry Holt & Co. ed., St. Martin’s Paperbacks, 2002) (1916).

2. Pew Research Center Staff, *Latinos and the New Trump Administration*, PEW RESEARCH CENTER 1, 4 (Feb. 23, 2017), [https://pewhispanic.org/wp-content/uploads/sites/5/2017/02/Latinos\\_Trump\\_FULLREPORT.pdf](https://pewhispanic.org/wp-content/uploads/sites/5/2017/02/Latinos_Trump_FULLREPORT.pdf).

3. Caitlyn Phung, *Trump immigration policies take mental toll on Latino parents, study finds*, G.W. HATCHET (Mar. 22, 2018), <https://gwhatchet.com/2018/03/22/trump-immigration-policies-take-mental-toll-on-latino-parents-study-finds/>.

political mischaracterizations that Hispanic/Latinx immigrant communities are riddled with “criminals, rapists, drug dealers, etc.,”<sup>4</sup> research has shown that the involvement of Hispanic/Latinx immigrants in crime is less than that of U.S. citizens and any other racial or ethnic group.<sup>5</sup> In fact, Hispanic/Latinx individuals are disproportionately incarcerated, being convicted for minor non-violent offenses and/or are first time offenders.<sup>6</sup>

Moreover, Hispanic/Latinx individuals are incarcerated in both U.S. state and federal prisons 2.6 times greater than whites.<sup>7</sup> Because of this, Hispanic/Latinx inmates have been found to be the fastest growing minority group incarcerated.<sup>8</sup> A primary way to reduce mental health treatment disparities among Hispanic/Latinx inmates is introducing cultural competency care. While more research is needed in this area, this article merely scratches the surface at understanding the intersections of these issues. A lack of cultural competency within the U.S. criminal justice system has been found to exacerbate incarceration for Hispanic/Latinx individuals living with mental illness.<sup>9</sup> Once incarcerated, Hispanic/Latinx inmates are

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4. Michelle Ye Hee Lee, *Donald Trump’s False Comments Connecting Mexican Immigrants and Crime*, WASHINGTON POST (Jul. 8, 2015), [https://www.washingtonpost.com/news/fact-checker/wp/2015/07/08/donald-trumps-false-comments-connecting-mexican-immigrants-and-crime/?utm\\_term=.057ac4c92797](https://www.washingtonpost.com/news/fact-checker/wp/2015/07/08/donald-trumps-false-comments-connecting-mexican-immigrants-and-crime/?utm_term=.057ac4c92797) (quoting President Trump’s presidential announcement speech on July 6, 2015).

5. Jose Luis Morin, *Latino/as and U.S. Prisons*, IN BEHIND BARS: LATINOS/AS AND PRISON IN THE U.S. 17, 29 (Suzanne Oboler ed., 2009).

6. *Id.*; “In New York City, Hispanics/Latinx are arrested nearly four times as often as whites for drug possession, even though government records consistently indicate that whites are more likely than any other racial or ethnic group to use and sell drugs. Additionally, in California, Hispanics/Latinx were disproportionately represented in drug arrests in all cities within Los Angeles and Orange County, along with fifteen other major cities across the state. Finally, in Alhambra, a city with a population of 85,949, Latinos made up only 35.5% of the population but 74.6% of marijuana arrests.” Aaron Cantú, *Latinos and Mass Incarceration: The Dust Under the Rug*, LATINO REBELS (Jan. 7, 2014, 10:41 AM), <https://latinorebels.com/2014/01/07/latinos-and-mass-incarceration-the-dust-under-the-rug/>.

7. Morin, *supra* note 5, at 17-18.

8. Morin, *supra* note 5, at 17.

9. Primm, *infra* note 32, at 560-61.

not receiving necessary mental health treatment.<sup>10</sup> Thus a cycle perpetuates and Hispanic/Latinx individuals have not been at the forefront of the lack of cultural competency in prisons debate.<sup>11</sup> The current perceptions of Hispanics/Latinx and a deeply rooted history of racial bias in this country confirm the need for tailored, culturally appropriate solutions to some of the U.S.'s primary problems, namely, a growing Hispanic/Latinx inmate population who lack culturally competent mental health treatment.

The choices made by the U.S. to vilify and instill fear through hateful rhetoric about an entire racial/ethnic group,<sup>12</sup> and to incarcerate at higher rates rather than treat mental illnesses has burdened Hispanic/Latinx communities, increased stigma, and decreased resources for individuals seeking treatment.<sup>13</sup> This article looks at the criminal justice system as an

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10. Kaba, *infra* note 37, at 1915; PAULA M. DITTON, U.S. DEP'T OF JUSTICE BUREAU OF JUSTICE STATISTICS, OFFICE OF JUSTICE PROGRAMS, MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS, STATE AND FEDERAL, 9 (Jul. 1999), [https://prisonlegalnews.org/media/publications/bojs\\_mental\\_health\\_and\\_treatment\\_of\\_inmates\\_and\\_probationers\\_1999.pdf](https://prisonlegalnews.org/media/publications/bojs_mental_health_and_treatment_of_inmates_and_probationers_1999.pdf).

11. See Cantú, *supra* note 6 (comparing how a number of influential African-Americans have spoken out against mass incarceration, Hispanic/Latinx leaders have proven inept); see also Nancy E. Walker et al., *Lost Opportunities: The Reality of Latinos in the U.S. Criminal Justice System*, NAT'L. COUNCIL OF LA RAZA/UNIDOSUS v (noting that Hispanics/Latinx were rarely included in policy debates in the criminal justice field and virtually invisible in the majority of key studies and publications in the field, with a number of states and federal agencies not collecting nor publishing Hispanic/Latinx criminal justice data up until 2004).

12. See e.g., Bobby Azarian, *A Neuroscientist Explains How Trump's Rhetoric Can Warp a Person's Brain Into Thinking Domestic Terrorism is Justifiable*, RAW STORY (Nov. 1, 2018, 3:41 PM), <https://rawstory.com/2018/11/neuroscientist-explains-trumps-rhetoric-can-warp-persons-brain-thinking-domestic-terrorism-justifiable/> (discussing how Donald Trump's political tactic of choice is fear mongering, framing minority groups like Hispanics/Latinx as being an existential threat to Americans); Yascha Mounk, *Trump's Speech Was Too Effective for Comfort*, SLATE (Jan. 8, 2019, 10:52 PM), <https://slate.com/news-and-politics/2019/01/trumps-immigration-speech-wall-effective.html> (commenting on Donald Trump's address to the nation being filled with habitual lies and misrepresentations to instill fear in the hearts of millions of viewers); Adam Goodman, *The Core of Donald Trump's Immigration Policy? Fear*, WASHINGTON POST (Aug. 24, 2017), <https://washingtonpost.com/news/made-by-history/wp/2017/08/24/the-core-of-donald-trumps-immigration-policy-fear/> (discussing Donald Trump's immigration policy as using draconian rhetoric and harsh proposals in the hopes of scaring people into the shadows or out of the country).

13. See Primm, *infra* note 32, at 560-61 (discussing the lack of mental health services available in jails and prisons leading to dramatic increases of individuals with mental illness



incubator of racial bias and lack of cultural competency, particularly for Hispanic/Latinx inmates who need necessary mental health treatment. Part II of this article illustrates mental illness and the Hispanic/Latinx community, including the historical and sociocultural factors that make up this diverse group. Part III highlights U.S. incarceration, lack of cultural competency, and racial bias as leading factors in Hispanic/Latinx individuals forgoing mental health treatment or not being able to receive treatment at all. Finally, Part IV argues that the primary solution to improving mental health care for Hispanic/Latinx inmates is increasing cultural competency of criminal justice personnel and mental health providers by looking at the state of Pennsylvania as a “case study” for why cultural competency in prisons is vital.

## II. MENTAL ILLNESS AND THE HISPANIC/LATINX COMMUNITY

According to the United States Census Bureau, Hispanic or Latino/a (Hispanic/Latinx) refers to an ethnic social construct of individuals who identify as “Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.”<sup>14</sup> There has been a steady growth of Hispanic/Latinx residents in the U.S., being 17.8 percent of the total population, and projected to comprise of 28.6 percent of the total

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being involved with the criminal justice system); *see also* Elizabeth Tobin Tyler & Bradley Brockmann, *Returning Home: Incarceration, Reentry, Stigma and the Perpetuation of Racial and Socioeconomic Health Inequity*, 45 J. L. MEDICINE & ETHICS 545, 545 (2017) (describing the intersections of race, incarceration, and health disparities and the role of law and public policy in shaping disparate impact).

14. Karen R. Humes et al., *Overview of race and Hispanic origin: 2010*, U.S. CENSUS BUREAU 1, 2 (Mar. 2011), <http://census.gov/prod/cen2010/briefs/c2010br-02.pdf>; Latinx is the gender-neutral alternative to Latino/Latina used by an increasing number of scholars, activists, and journalists. It is a more inclusive term for individuals of intersecting identities. Tanisha Love Ramirez & Zeba Blay, *Why People Are Using The Term 'Latinx'*, HUFFINGTON POST, [https://huffingtonpost.com/entry/why-people-are-using-the-term-latinx\\_us\\_57753328e4b0cc0fa136a159](https://huffingtonpost.com/entry/why-people-are-using-the-term-latinx_us_57753328e4b0cc0fa136a159) (last updated Oct. 17, 2017).

population within the next decade.<sup>15</sup> Nearly two-thirds, 64 percent, of Hispanics/Latinx individuals in the U.S. were born in the U.S.<sup>16</sup> The composition of the U.S. Hispanic/Latinx population is predominated by those of Mexican origin at 64 percent, while Puerto Ricans and Cubans represent 9 percent and 3.5 percent of the Hispanic population, respectively.<sup>17</sup>

*A. Historical and Sociocultural Factors of the Hispanic/Latinx Community*

The U.S. Hispanic/Latinx population is heterogeneous in their historical and sociocultural makeup, and it often goes unnoticed.<sup>18</sup> To better understand their mental health needs, which in turn, will allow for tailored, culturally appropriate services, it is important to examine both the shared and unique experiences of different groups of Hispanic/Latinx individuals.<sup>19</sup> Hispanics/Latinx are highly concentrated in the Southwest region, New York, Florida, and Illinois.<sup>20</sup> Immigrants from Cuba, Mexico, and Central America are drawn to the Southwest and Florida because of its proximity to their home countries, employment opportunities, and established Hispanic/Latinx communities, which may help them find jobs.<sup>21</sup> In general, Hispanics/Latinx are considered to be family oriented, have less formal

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15. U.S. CENSUS BUREAU, FACTS FOR FEATURES: HISPANIC HERITAGE MONTH 2017, <https://census.gov/newsroom/facts-for-features/2017/hispanic-heritage.html> (last updated Aug. 3, 2018).

16. Jeanne Batalova & Aaron Terrazas, *Frequently Requested Statistics on Immigrants and Immigration in the United States*, MIGRATION POL. INST. (Dec. 9, 2010), <https://migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states-1/>.

17. Seth Motel & Eileen Patten, *The 10 Largest Hispanic Origin groups: Characteristics, Rankings, Top Counties*, PEW RESEARCH CENTER 4, <https://diversity.va.gov/calendar/files/hhm-pew-research.pdf> (last updated Jul. 12, 2012).

18. U.S. DEP'T OF HEALTH AND HUMAN SERVICES OFFICE OF THE SURGEON GENERAL, *Mental Health in Hispanic Americans*, in MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY 127, 129 (Aug. 2001) [hereinafter HHS OFFICE OF THE SURGEON GENERAL].

19. *Id.*

20. *Id.* at 131; Approximately half of all Hispanics/Latinx live in California and Texas. *Id.* at 130.

21. *Id.* at 130-31.

education than the national average, and suffer from more health concerns than whites.<sup>22</sup> Hispanics/Latinx are also less likely to receive child support, more likely to have uninsured children, and the most likely to report being in fair or poor health.<sup>23</sup> Moreover, the economic status of Hispanic/Latinx individuals parallels the political and historical circumstances of their immigration to the U.S.<sup>24</sup>

### *B. Mental Health*

In 2012-2013, over 8.9 million Hispanics/Latinx in the U.S. had a diagnosable mental illness.<sup>25</sup> Yet, in 2014, only 8.3 percent of Hispanics/Latinx received some type of mental health treatment or counseling, compared to 18 percent of whites.<sup>26</sup> Moreover, Hispanics/Latinx are more likely to report poor communication with their health care provider, a factor often attributed to Hispanics/Latinx forgoing treatment.<sup>27</sup> Additionally, the American Psychological Association (APA) found that bilingual patients were evaluated differently in English and Spanish when it came to depression and anxiety questionnaires, potentially leading to under-

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22. *Id.* at 131-32.

23. *Hispanic Prisoners in the United States*, THE SENTENCING PROJECT (Aug. 2003), <https://static.prisonpolicy.org/scans/sp/1051.pdf>.

24. HHS OFFICE OF THE SURGEON GENERAL, *supra* note 20, at 132 (“Cuban Americans are more affluent in standing than Puerto Ricans and Mexican Americans, as reflected in median family incomes (Cubans, \$39,530; Puerto Ricans, \$28,953; Mexicans, \$27,883), the percentage of persons below the poverty line (Puerto Ricans, 31%; Mexicans, 27%; Cubans, 14%) and the unemployment rates of persons 16 years and older (Puerto Ricans, 7%; Mexicans, 7%; Cubans, 5%). It has been documented that elite Cuban immigrants have contributed in part to the relatively strong economic status of Cuban Americans. This experience stands in contrast to those of Mexican, Puerto Rican, and Central American heritage, most of whom came to the United States as unskilled laborers.”); Moreover, the shared lived experience of immigrating or experiencing difficult social conditions in one’s new environment has been cited as both a factor in adhering to family ties and a common misconception about the U.S. Hispanic/Latinx population. *Id.* at 133.

25. *Latino/Hispanic Communities and Mental Health*, MENTAL HEALTH AM., (Nov. 5, 2013), <https://mentalhealthamerica.net/issues/latinohispanic-communities-and-mental-health>.

26. *Id.*

27. *Id.*

or misdiagnoses.<sup>28</sup> U.S. studies have also linked depression and anxiety with Type 2 diabetes and obesity in the Hispanic/Latinx community, common and costly chronic diseases amongst Hispanics/Latinx.<sup>29</sup>

Research is scarce as to whether or not Hispanic/Latinx individuals or communities have a negative attitude toward mental health care, which is commonly cited as the reason Hispanics/Latinx have lower treatment and access to care rates.<sup>30</sup> Instead, the research suggests that structural barriers, including incarceration, language, not wanting to be labeled as “*loco*” (crazy), economic status, and not wanting to discuss private matters in public, have played more of a role in forgoing mental health treatment than general attitudes.<sup>31</sup>

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28. Sadie F. Dingfelder, *Closing the gap for Latino patients*, 36 AM. PSYCHOLOGICAL ASS'N. (Jan. 2005), <http://apa.org/monitor/jan05/closingthegap.aspx>; NAT'L ALLIANCE ON MENTAL ILLNESS, *Latino Mental Health*, <https://nami.org/Find-Support/Diverse-Communities/Latino-Mental-Health> (last visited Apr. 24, 2019) (explaining how Hispanics/Latinx may describe the symptoms of depression as “*nervios*” (nervousness), tiredness, or a physical ailment); Hispanic/Latinx inmates in particular often report physical problems like stomach pains and headaches instead of expressing that they might be depressed, or they attribute symptoms to drug use rather than mental illness, as this carries less cultural stigma. Erika Parkard, *Cultural education goes both ways in U.S. prisons*, 36 AM. PSYCHOLOGICAL ASS'N. (Nov. 2005), <https://apa.org/monitor/nov05/prisons.aspx>; Reena Kapoor et al., *Cultural competence in correctional mental health*, 36 INTERNAT'L J. LAW AND PSYCHIATRY 273, 274 (2013).

29. Humberto Marin et al., *Mental Illness in Hispanics: A Review of the Literature*, 4 FOCUS 23, 26 (2006).

30. NATIONAL ALLIANCE ON MENTAL ILLNESS, *supra* note 28.

31. NATIONAL ALLIANCE ON MENTAL ILLNESS, *supra* note 28. These characteristics also shape how one enters into treatment and the perceptions of effectiveness of treatment. Individuals ordered into mental health care, either by family member pressure or legally coerced by issuance of court orders for commitment, are more likely to be Hispanic/Latinx compared to persons who entered into care independently. *People ordered into mental health care less likely to perceive it as helpful*, SCIENCE DAILY (Oct. 15, 2018), <https://sciencedaily.com/releases/2018/10/181015113542.htm>.

### III. INCARCERATION AND RACIAL BIAS AS ADDITIONAL BARRIERS TO HISPANIC/LATINX INDIVIDUALS RECEIVING CARE

The failure of Hispanic/Latinx inmates receiving adequate mental health care can be explained by several factors, including rates of incarceration and racial bias.<sup>32</sup>

#### *A. Incarceration*

In a nation that professes a devotion to liberty, freedom, and justice for all,<sup>33</sup> there are 302,900 Hispanic/Latinx individuals in federal and state prisons and local jails, making up slightly over 15 percent of the U.S. inmate population.<sup>34</sup> Hispanics/Latinx are also the fastest growing incarcerated group in state and federal prisons, increasing from 10.9 percent in 1985 to 15.6 percent in 2001.<sup>35</sup> As a result, one of every six Hispanic/Latinx males and one of every 45 Hispanic/Latinx females born in 2007 can expect to go to prison in his, her, or their lifetime.<sup>36</sup>

Generally, the U.S. incarcerates more individuals with severe mental illness than it hospitalizes, and access to care for persons with mental health concerns is inextricably linked to the U.S. criminal justice system.<sup>37</sup> The

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32. Allen J. Beck, Jennifer C. Karberg, & Paige M. Harrison, *Prison and Jail Inmates at Midyear 2001*, U.S. DEPT. OF JUSTICE BUREAU OF JUSTICE STATISTICS 1, 12, <https://bjs.gov/content/pub/pdf/pjim01.pdf> (last updated May 10, 2002); Annelle B. Primm et al., *Race and Ethnicity, Mental Health Services and Cultural Competence in the Criminal Justice System: Are we Ready to Change?*, 41 COMM. MENTAL HEALTH J. 557, 557 (2005).

33. Booker, *infra* note 45.

34. Beck, *supra* note 32, at 12.

35. THE SENTENCING PROJECT, *supra* note 23; PAIGE M. HARRISON & ALLEN J. BECK, U.S. DEP'T OF JUSTICE BUREAU OF JUSTICE STATISTICS, PRISONERS IN 2001, 11 (July 2002), <https://bjs.gov/content/pub/pdf/p01.pdf>.

36. MARC MAUER & RYAN S. KING, THE SENTENCING PROJECT, UNEVEN JUSTICE: STATE RATES OF INCARCERATION BY RACE AND ETHNICITY 2 (Jul. 2007), <https://sentencingproject.org/wp-content/uploads/2016/01/Uneven-Justice-State-Rates-of-Incarceration-by-Race-and-Ethnicity.pdf>.

37. *Id.* For example, “in 2014, the Cook County [of Illinois] Jail housed more inmates suffering from mental illness than the population of any psychiatric hospital in the United States, making it arguably the nation’s largest mental health facility.” TREATMENT

U.S. Department of Justice estimates that over half of all U.S. inmates suffer from a mental health concern.<sup>38</sup> Yet, groups at highest risk for incarceration – young black and Hispanic/Latinx men – have particularly low rates of meeting with mental health professionals.<sup>39</sup> Of all federal and state prisoners, Hispanic/Latinx inmates are the least likely to receive treatment for substance abuse, receiving less than half the treatment of whites.<sup>40</sup> Incarcerating Hispanic/Latinx individuals with mental illness at such alarming rates has lasting implications upon release, on inmates’ families, and creates burdens on state and local budgets and the health care and justice systems at large.<sup>41</sup>

### B. Racial bias

About half of Hispanics/Latinx in the U.S. (52 percent) have experienced

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ADVOCACY CENTER, ILLINOIS, <https://treatmentadvocacycenter.org/illinois> (last visited Apr. 24, 2019); Fatos Kaba et al., *Disparities in Mental Health Referral and Diagnosis in the New York City Jail Mental Health Service*, 105 AM J. PUBLIC HEALTH 1911, 1911 (Sept. 2015).

38. Press Release, U.S. Dep’t of Justice Bureau of Justice Statistics, Study Finds More Than Half of All Prison and Jail Inmates Have Mental Health Problems (Sept. 6, 2006) (“The findings represent inmates’ reporting symptoms” they experienced in the last year, “rather than an official diagnosis of a mental illness.”); Other studies have found the rate of mental illness among prison inmates to be three times higher than that of the general population. Lori A. Marschke, *Proving deliberate indifference: Next to impossible for mentally ill inmates*, 39 VALPARAISO U. L. REV. 487, 487 (2004).

39. Kaba, *supra* note 37, at 1915.

40. These rates are Hispanic/Latinx: 19 percent; Black: 25.7 percent; White: 39.5 percent. CHRISTOPHER J. MUMOLA, U.S. DEP’T OF JUSTICE BUREAU OF JUSTICE STATISTICS, SUBSTANCE ABUSE AND TREATMENT, STATE AND FEDERAL PRISONERS, 1997, 13 (Jan. 1999), <https://bjs.gov/content/pub/pdf/satsfp97.pdf>.

41. *Access to Mental Health Care and Incarceration*, MENTAL HEALTH AM., <http://www.mentalhealthamerica.net/issues/access-mental-health-care-and-incarceration> (last visited Apr. 24, 2019); NAT’L ALLIANCE ON MENTAL ILLNESS, *Jailing People with Mental Illness* <https://nami.org/Learn-More/Public-Policy/Jailing-People-with-Mental-Illness> (last visited Apr. 24, 2019); About 50 percent of all U.S. inmates reenter prisons within three years of release because of inadequate treatment and rehabilitation in the community. Anasseril E. Daniel, *Care of the Mentally Ill in Prisons: Challenges and Solutions*, 35 J. AM. ACAD. PSYCHIATRY L. 406, 406 (2007). Moreover, about half of inmates battling addiction are convicted of a new crime within three years, and inmates with a mix of mental illness and addiction are significantly less likely than others to find stable housing, work, and family support after leaving prison. The Spotlight Team, *There May Be No Worse Place For Mentally Ill People to Receive Treatment Than Prison*, BOSTON GLOBE (Nov. 25, 2016), [https://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).

discrimination or have been treated unfairly because of their race or ethnicity.<sup>42</sup> Research by the National Hispanic Media Coalition found that bias and flawed information affect many American's social and political decisions.<sup>43</sup> Citing to a 2015 research study on New York City's jail mental health, the author pointed out that at Rikers Island Prison Complex, "...white men were directed towards mental health services, while younger black and Hispanic[/Latinx] men were directed to solitary confinement, and self-harm. I don't think that fact reflects different rates of mental illness, I think it demonstrates racial bias."<sup>44</sup> Furthermore, despite little movement with criminal justice reform efforts, politicians are not blind to the detrimental effects of racial bias in our justice system. Senator and Presidential Candidate Cory Booker (D-New Jersey) wrote in a recent Washington Post opinion about the unfair disparity of sentencing for black and brown people, stating that

[U]naddressed racial bias in our justice system at all levels...has created a system where inputs and outcomes are more dependent on race and class than on guilt or innocence. It's created a justice system that is anything but just...You can tell a lot about a country by who it incarcerates. Some countries imprison journalists. Others political opponents. We imprison the poor, the addicted, the mentally ill, the survivors of abuse and sexual assault, and black and brown people. Our broken system is a cancer on the soul of our nation that preys upon our most marginalized populations.<sup>45</sup>

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42. Jens M. Krogstad & Gustavo Lopez, *Roughly Half of Hispanics Have Experienced Discrimination*, PEW RESEARCH CENTER: FACT TANK NEWS IN THE NUMBERS (June 29, 2016), <http://www.pewresearch.org/fact-tank/2016/06/29/roughly-half-of-hispanics-have-experienced-discrimination/>.

43. NATL. HISPANIC MEDIA COALITION, HATE SPEECH, INCITEMENT, AND HATE CRIMES IN THE U.S. (May 12, 2012), <http://nhmc.org/hate-speech-incitement-and-hate-crimes-in-the-u-s/>.

44. Manuel Villa, *The Mental Health Crisis Facing Women in Prison*, MARSHALL PROJECT (June 22, 2017), <https://themarshallproject.org/2017/06/22/the-mental-health-crisis-facing-women-in-prison>.

45. Cory Booker, *It's Time For the Next Step in Criminal Justice Reform*, WASHINGTON POST (Mar. 10, 2019), [https://washingtonpost.com/opinions/2019/03/10/cory-booker-its-time-next-step-criminal-justice-reform/?utm\\_term=.5f2b388de303](https://washingtonpost.com/opinions/2019/03/10/cory-booker-its-time-next-step-criminal-justice-reform/?utm_term=.5f2b388de303).

Focusing on ways to reduce racism in a culturally appropriate and competent manner is vital considering the disproportionate number of Hispanic/Latinx individuals incarcerated in the U.S. The racial makeup in prison necessitates mental health professionals working *with* Hispanic/Latinx inmates to ensure the provision of mental health treatment.<sup>46</sup>

#### IV. CULTURAL COMPETENCE AS A SOLUTION TO IMPROVED (AND INCREASED) MENTAL HEALTH TREATMENT

Cultural competency in criminal justice has been identified as a solution to ascertain the benefits of training, employment, and skills of mental health professionals in prisons.<sup>47</sup> It is the ability to meet the social, cultural, and linguistic needs of diverse populations groups.<sup>48</sup> “Culture” is a term that goes beyond race and ethnicity, as it encompasses a person’s norms, values, age, disability status, gender identity and expression, national origin, and religious and spiritual beliefs.<sup>49</sup> Cultural competence in correctional settings has been growing in importance as prison systems seek to improve mental health assessment and treatment.<sup>50</sup> Unfortunately, research has shown a lack of cultural competence in mental health care providers, resulting in misdiagnosis and inadequate treatment.<sup>51</sup> Moreover, culture, in the very broad sense of the term, can be a significant factor influencing individuals’ perceptions about the existence or cause of their own mental illness and their

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46. Kapoor, *supra* note 28, at 274.

47. Kapoor, *supra* note 28, at 275.

48. SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., CULTURAL COMPETENCE, <https://samhsa.gov/capt/applying-strategic-prevention/cultural-competence> (last updated Nov. 10, 2016); *Cultural Competence in Health Care: Is it important for people with chronic conditions?*, GEORGETOWN U. HEALTH POLICY INST. (Feb. 2004), <https://hpi.georgetown.edu/agingsociety/pubhtml/cultural/cultural.html>.

49. AM. SPEECH-LANGUAGE-HEARING ASS’N, *Cultural Competence*, <https://asha.org/Practice-Portal/Professional-Issues/Cultural-Competence/> (last visited Apr. 24, 2019).

50. Primm, *supra* note 32, at 567.

51. NATIONAL ALLIANCE ON MENTAL ILLNESS, *supra* note 28.



ability to seek treatment.<sup>52</sup>

A cultural competency framework accounts not only for an institutionalization of values and principles that will surpass difference and improve understanding, but demands the criminal justice system to (1) value diversity, (2) conduct routine self-assessment, (3) manage difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to the diverse, cultural contexts of the communities incarcerated.<sup>53</sup> An understanding of cultural competency is critical for mental health treatment in jails and prisons because “decision-makers must be able to respond to the client’s humanity...and view culture from the individual’s perspective, avoid[ing] misinterpretation of culture as stereotype.”<sup>54</sup>

Yet, evaluation of mental health services among incarcerated individuals, particularly Hispanics/Latinx, through a cultural competency lens is scarce.<sup>55</sup> For instance, the American Psychiatric Association mandated the need for culturally competent systems of care, and the American Bar Association created a model curriculum on building community trust and cross-cultural communication.<sup>56</sup> Still, this has yet to benefit those incarcerated with little to no access to mental health treatment.<sup>57</sup> One study found that at every point of contact in the criminal justice system, Hispanic/Latinx participants

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52. Sean D. O’Brien, *When life depends on it: Supplementary guidelines for the mitigation function of defense teams in death penalty cases*, 36 HOFSTRA L. REV. 693, 754-55 (2008).

53. *Conceptual Frameworks/Models, Guiding Values and Principles*, NATL. CTR. FOR CULTURAL COMPETENCE, <https://nccc.georgetown.edu/foundations/framework.php> (last visited Apr. 24, 2019).

54. Michael L. Perlin & Valerie McClain, “*Where Souls Are Forgotten*”: *Cultural Competencies, Forensic Evaluations, and International Human Rights*, 15 PSYCHOLOGY, PUB. POLICY, & L. 257, 258-59 (2009).

55. Primm, *supra* note 32, at 566.

56. Primm, *supra* note 32, at 567; CULTURAL COMPETENCE AND PUBLIC DEFENSE MICHIGAN WORKGROUP, *BEYOND DIVERSITY: THE ROLE OF CULTURAL COMPETENCE IN AN EFFECTIVE MICHIGAN PUBLIC DEFENSE SYSTEM* 1, 6 (Apr. 2011),

<http://racialequitytools.org/resourcefiles/Culturalcompetence.pdf> [hereinafter CULTURAL COMPETENCE AND PUBLIC DEFENSE MICHIGAN WORKGROUP]. The ABA’s Criminal Justice Section created this model curriculum for judicial, prosecutorial, and defense agencies alike.

57. Primm, *supra* note 32, at 565-66.

reported inadequate cultural competence,<sup>58</sup> not only when accessing health services but in the majority of interactions with prison personnel.<sup>59</sup>

The state of Pennsylvania has looked at the role of cultural competency in its own criminal justice system and found it imperative to institute system-wide reform to ensure individuals were receiving necessary mental health treatment.<sup>60</sup> Pennsylvania found that prison staff, and especially mental health practitioners, need to have a baseline understanding of an inmate's beliefs about the criminal justice system to help address mental health concerns, cultural identity differences and, if applicable, immigrant experiences.<sup>61</sup> To effectively provide mental health treatment for Hispanic/Latinx inmates, Pennsylvania determined it needed, among other recommendations, more trained Spanish-speaking interpreters at every point of contact, bilingual and bi/multicultural mental health therapists and substance abuse treatment counselors, objective instruments to assess and screen for risk, psychological, and mental health concerns, and high quality cultural diversity and competency training for all justice system personnel,

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58. Inadequate cultural competence has been considered as attitudes, policies, and practices destructive to others, biased systems with low to no capacity to work with others, an assumption of cultural superiority, and forced assimilation/segregation. VISTACAMPUS, *Cultural Competence*, <https://vistacampus.gov/book/export/html/11068> (last visited Apr. 24, 2019). It has been studied in the child welfare context as the realization of not being able to “just practice your practice,” to consider your own place in the system and seek to shift what is not working (think actions, behaviors, and impact). That is, for instance, hiring community members, and doing more when providing services to clients, to better understand where they are coming from. One study participant discussed a lack of resources and states that “people knew exactly what the issues were and what they should be doing.” Patricia Johnston, *When cultural competence is inadequate: an opportunity for a new approach to child welfare in Nunavut*, Thesis, University of British Columbia, i, 90, 114 (Aug. 27, 2009); Susana Rinderle, *Cultural Competence: What's in a Name?*, WORKFORCE (Aug. 23, 2013), <https://workforce.com/2013/08/23/cultural-competence-whats-name/>. However, inadequate cultural competence can also be a misnomer as it implies there needing to be some sort of end point or box to be checked once “cultural competency” has been accomplished. “Providing the best, most appropriate services to a variety of people and populations is a moving target – fluid, contextual, and evolving.” *Id.*

59. Primm, *supra* note 32, at 566.

60. PUBLIC HEALTH MANAGEMENT CORPORATION, AN ASSESSMENT OF THE NEEDS OF LATINO YOUTH INVOLVED IN THE JUVENILE JUSTICE SYSTEM ii (May 26, 2009).

61. *Id.* at 34.

from police staff to its court system.<sup>62</sup>

Given this, cultural competency in the justice system would require systematic training of all personnel, direction by leadership and advisory groups, policies and principles that address treatment, linguistic assistance (language, illiteracy), and accountability.<sup>63</sup> A system-wide approach is necessary, and includes the buy-in from law enforcement, jail intake and treatment, courts, correctional settings, and community re-entry, not just the medical/public health community working with the criminal justice system.<sup>64</sup> These recommended changes from Pennsylvania can be scaled up to effectively meet the needs of Hispanic/Latinx inmates nationwide through culturally competent means, as these findings are not a single state's concern.

Some researchers consider cultural competency to simply mean linguistic or cultural diversity resulting in increased social tension, social segregation, workplace issues, and civil disengagement.<sup>65</sup> However, cultural competency

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62. *Id.* at ii-iii; Moreover, it determined that prevention and outreach through partnerships with Hispanic/Latinx service organizations and community leaders, and a coordination of efforts is necessary to improve Hispanic/Latinx contact with schools, community organizations, mental health providers, the police, the courts, and social service providers, to name a few; *Id.* at iii.

63. Primm, *supra* note 32, at 567-68.

64. Primm, *supra* note 32, at 567; For example, "Luis, a 15-year-old Latin[x male] with no previous record, was arrested for possessing less than ½ ounce of marijuana. During Luis' disposition hearing, the judge ordered him and his caseworker into chambers. As the judge talked to Luis, he noticed that the youth was not looking directly at him. The judge ordered the youth to look at him, which Luis did. But, as time progressed, Luis looked down again. The loss of eye contact infuriated the judge, whose words and tone of voice became harsher. The caseworker attempted to explain that Luis' downcast eyes were a sign of respect in his culture — youth who are being reprimanded in Luis' culture bow their heads to show their embarrassment at their actions. He explained that "staring down" authority figures is considered to be highly disrespectful. The judge, however, took Luis' downcast eyes as an admission of guilt, and sentenced him to two years in a juvenile facility." FRANCISCO A. VILLARRUEL ET AL., MICHIGAN STATE U. ¿DONDE ESTA LAW JUSTICIA? A CALL TO ACTION ON BEHALF OF LATINO AND LATINA YOUTH IN THE U.S. JUSTICE SYSTEM 53 (2002).

65. Andrew Button, *The Disadvantages of Cultural Diversity*, CLASSROOM, <https://www.theclassroom.com/the-disadvantages-of-cultural-diversity-12082787.html> (last visited Apr. 24, 2019); Eryl Quilao et al., Presentation on *This Language Thing: The Pros & Cons of Speaking One's Native Dialect at Work* at U. MARYLAND MED. CTR. (Oct. 19, 2010).

is a core requirement for mental health professionals, allowing for a person-centered approach (individualized, one-on-one assistance) to identify mental health concerns and find the best possible approach to treatment.<sup>66</sup> Despite the vast need of mental health services for many Hispanic/Latinx inmates, alone, a culturally competent approach may be insufficient to reach this goal as treatment is undermined by clinician shortages, diminishing access to medication and treatment, and widespread use of segregation as discipline.<sup>67</sup> Ensuring clinicians have the basic principles and ideas that serve as building blocks for culturally competent care in correctional mental health is only one step in the right direction.<sup>68</sup>

#### V. CONCLUSION

Cultural competency suggests a deeper understanding of how Hispanic/Latinx inmates' cultural background affects what they are willing to share with mental health professionals and justice personnel, and how certain practices or actions in federal and state prisons are perceived by other races, communities, and countries.<sup>69</sup> Understanding these concerns with a culturally competent approach, through improved research and data collection on Hispanic/Latinx inmates, will allow for a more effective targeting of policy and programs for increased access to care initiatives while incarcerated, and eliminate inequalities in Hispanic/Latinx mental health

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66. Kamaldeep Bhui et al., *Cultural competence in mental health care: a review of model evaluations*, 7 BMC HEALTH SRVS. RESEARCH 1, 1 (2007); Fabiana Franco, *The Challenge of Cultural Competence in Minority Mental Health Care*, GOODTHERAPY BLOG (Jul. 28, 2017), <https://goodtherapy.org/blog/challenge-of-cultural-competence-in-minority-mental-health-care-0728174>.

67. The Spotlight Team, *supra* note 41; Considered to be a “culture ruled by aggression and fear,” trust and openness between inmates, justice personnel, and mental health professionals is almost non-existent. The Spotlight Team, *supra* note 41.

68. Kapoor, *supra* note 28, at 274.

69. CULTURAL COMPETENCE AND PUBLIC DEFENSE MICHIGAN WORKGROUP, *supra* note 56, at 6.

treatment.<sup>70</sup>

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70. Marcia Carteret, *Addressing Disparities in Mental Health Care for Latinos*, DIMENSIONS OF CULTURE (May 16, 2016), <http://dimensionsofculture.com/2016/05/addressing-disparities-in-mental-health-care-for-latinos/>; Steven R. López et al., *La CLave to Increase Psychosis Literacy of Spanish-Speaking Community Residents and Family Caregivers*, 77 J. CONSULT CLIN. PSYCHOLOGY 763, 770 (Aug. 2009) (describing a psychoeducational program to increase Spanish-speaking person's literacy of psychosis).

# How to Provide Adequate Mental Healthcare in the IL Criminal Justice System

*Nicolette Taber*

## I. INTRODUCTION

There is a troubling lack of access to mental health care in our nation's criminal justice system.<sup>1</sup> After a gradual nationwide closure of psychiatric institutions during the twentieth century, jails in large cities such as Los Angeles and Chicago are now the country's largest providers of psychiatric care.<sup>2</sup> American jails have about 1.7 million annual contacts with seriously mentally ill individuals and have a daily responsibility for about 112,000.<sup>3</sup> Unfortunately, thousands of mentally ill inmates face delayed diagnoses, ineffective and abusive care, and violence.<sup>4</sup> This large population of mentally ill inmates is particularly vulnerable and faces steep recidivism rates.<sup>5</sup>

Illinois has continuously struggled to provide adequate mental health care

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1. AM. C.L. UNION, *Medical and Mental Healthcare*, [www.aclu.org/issues/prisoners-rights/medical-and-mental-health-care](http://www.aclu.org/issues/prisoners-rights/medical-and-mental-health-care) (last visited Feb. 9, 2019).

2. Alisa Roth, *A 'Hellish World': The Mental Health Crisis Overwhelming America's Prisons*, THE GUARDIAN (Mar. 31, 2018), [www.theguardian.com/society/2018/mar/31/mental-health-care-crisis-overwhelming-prison-jail](http://www.theguardian.com/society/2018/mar/31/mental-health-care-crisis-overwhelming-prison-jail).

3. Edward P. Mulvey & Carol A. Schubert, *Mentally Ill Individuals in Jails and Prisons*, 46 CRIME & JUST. 231, 232 (2017).

4. Maggie Puniewska, *The Prison System is Designed to Ignore Mental Health*, TONIC (Jun. 1, 2017, 12:00 PM), [https://tonic.vice.com/en\\_us/article/bj8gy4/the-prison-system-is-designed-to-ignore-mental-illness](https://tonic.vice.com/en_us/article/bj8gy4/the-prison-system-is-designed-to-ignore-mental-illness).

5. Shauhin Talesh, *Mental Health Court Judges as Dynamic Risk Managers: A New Conceptualization of the Role of Judges*, 57 DEPAUL L. REV. 93, 102 (2007).

to its mentally ill inmates.<sup>6</sup> In 2007, an inmate filed a lawsuit against the Illinois Department of Corrections (IDOC) alleging IDOC's inadequate mental healthcare constituted cruel and unusual punishment.<sup>7</sup> A federal judge recently ruled in that case that the state corrections department has failed to properly care for the needs of mentally ill patients.<sup>8</sup> This is particularly alarming because Cook County Jail houses more inmates suffering from mental illness than the population of any psychiatric hospital nationwide.<sup>9</sup> The grossly inadequate staffing levels within Illinois prisons fail to provide adequate mental health treatment to all of those inmates who need it.<sup>10</sup> This inadequacy of mental health care for Illinois' mentally ill prisoners can no longer be ignored.

Instead of continuing to place severely mentally ill individuals into jails and prisons, Illinois must consider funding separate forensic psychiatry facilities where all of the state's severely mentally ill can receive personalized mental health treatment.<sup>11</sup> Providing additional mental health

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6. Jaclyn Driscoll, *Judge Rules Illinois Prisons Still Not Properly Caring For Mentally Ill Inmates*, NPR ILL. (Oct. 31, 2018), [www.nprillinois.org/post/judge-rules-illinois-prisons-still-not-properly-caring-mentally-ill-inmates#stream/0](http://www.nprillinois.org/post/judge-rules-illinois-prisons-still-not-properly-caring-mentally-ill-inmates#stream/0).

7. *Id.*; *Rasho v. Walker*, No. 07-1298, slip op. at 1 (C.D. Ill. 2018).

8. *Rasho*, slip op. at 7; Driscoll, *supra* note 6.

9. In its study of mentally ill individuals in prisons, the Treatment Advocacy Center found that the mentally ill population faced a 2.7 to 1 likelihood of incarceration versus hospitalization in Illinois. Among its top policy recommendations for Illinois, TAC suggested the state to stop eliminating public psychiatric beds and restore a sufficient number of beds to create access to inpatient care for qualifying individuals in crisis. TREATMENT ADVOCACY CTR., *Illinois*, [www.treatmentadvocacycenter.org/browse-by-state/illinois](http://www.treatmentadvocacycenter.org/browse-by-state/illinois) (last visited Apr. 12, 2019).

10. Christine Herman, *Illinois Prison Monitor 'Absolutely Convinced' Mentally Ill Inmates Abused*, ST. LOUIS PUB. RADIO (Dec. 7, 2018), <https://news.stlpublicradio.org/post/illinois-prison-monitor-absolutely-convinced-mentally-ill-inmates-abused#stream/0>.

11. Illinois already has two facilities, the Chester Mental Health Center and Elgin Mental Health Center, which house individuals declared unfit to stand trial or not guilty by reason of insanity by a criminal court. See *Chester Mental Health Center*, ILL. DEP'T OF HUM. SERV., [www.dhs.state.il.us/page.aspx?item=86377](http://www.dhs.state.il.us/page.aspx?item=86377), (last visited Apr. 28, 2019) ("the center is designed to provide care and treatment for all adult males...who require a greater degree of structure and security...The center does not admit recipients directly from the community.").

resources within prisons could be beneficial to some prisoners, but due to the overwhelmingly inadequate environment inherent to prison life, this would not be beneficial to the system's most vulnerable. Though Illinois has taken its first steps to improve care through the Mental Health Courts (MHC) and a new facility in Joliet, it is not enough. Illinois should continue to build separate facilities for its severely mentally ill inmates. Prisons will never be mental health centers, which is why Illinois must construct separate mental health facilities to properly care for its most vulnerable prisoners.

Part I of this article discusses the history of mental healthcare in the Illinois criminal justice system. It highlights the issues the IDOC has faced as well as the financial burden created when incarcerating severely mentally ill prisoners. Part II addresses Illinois' recent attempts at providing better mental health care and assistance for prisoners. Then, Part III discusses the main argument that the state of Illinois should fund and build separate mental health facilities in order to provide adequate mental health care to the state's severely mentally ill prisoners. Finally, Part IV concludes by reiterating why the state of Illinois should invest in multiple mental health facilities as an alternative for its severely mentally ill inmates in order to provide the proper care they require.

## II. HISTORY OF MENTAL HEALTHCARE IN THE ILLINOIS CRIMINAL JUSTICE SYSTEM

Mentally ill prisoners' right to treatment is founded in the Eighth Amendment of the U.S. Constitution's prohibition of cruel and unusual

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However, in 2017, the IDOC pledged to expand the Elgin Center to offer hospital-quality psychiatric care to state inmates previously treated inside prisons. Gaby Neal, *Elgin Mental Health Center Offers High-Level Psychiatric Care*, HC+O NEWS (Dec. 15, 2017), <http://hconews.com/2017/12/15/elgin-mental-health-center/>. This article is advocating for more facilities such as the proposed expansion of the Elgin Center.



punishment.<sup>12</sup> Illinois does not have an attractive track record in ensuring its prisoners' Eighth Amendment rights are protected.<sup>13</sup> In 2007, a prisoner filed a *pro se* complaint against the IDOC, alleging the IDOC had violated his Eighth Amendment rights by providing him insufficient medical treatment for his mental illness.<sup>14</sup> This lawsuit eventually turned into a class action lawsuit on behalf of all mentally ill prisoners in Illinois.<sup>15</sup> The mentally ill inmates in IDOC facilities were allegedly chronically underdiagnosed and undertreated, subjected to brutality, housed in horrific living conditions, and were mocked and derided for their illness.<sup>16</sup> IDOC settled this lawsuit in 2018.<sup>17</sup> The settlement requires prison officials to provide 11,000 mentally ill state prisoners with adequate mental health care.<sup>18</sup> In order to comply with this settlement, Illinois must find ways to better accommodate its population of thousands of mentally ill prisoners.<sup>19</sup>

The overall cost of incarcerating prisoners with serious mental illness in

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12. Kathryn A. Burns, *Psychiatry Behind Bars: Practicing In Jails And Prisons*, 10 CURRENT PSYCHIATRY 15, 16 (2011). The Eighth Amendment is interpreted to prohibit certain types of actions by the government. See Stuart B. Klein, *Prisoners' Rights to Physical and Mental Health Care: A Modern Expansion of the Eighth Amendment's Cruel and Unusual Punishment Clause*, 7 FORDHAM URB. L.J. 1, 1 (1979) (discussing the eighth amendment's ban on cruel and unusual punishment in the context of the American criminal justice system). The Eighth Amendment's ban on cruel and unusual punishment and the Due Process Clause of the Fourteenth Amendment provide the basis for the prisoner's right to receive psychiatric care. *Id.* at 1.

13. See Derek Gilna, *Illinois DOC Settles Lawsuit Over Mental Health Treatment*, PRISON LEGAL NEWS (Aug. 2, 2016), [www.prisonlegalnews.org/news/2016/aug/2/illinois-doc-settles-lawsuit-over-mental-health-treatment/](http://www.prisonlegalnews.org/news/2016/aug/2/illinois-doc-settles-lawsuit-over-mental-health-treatment/) (detailing the *Rasho* case and Illinois' recent history of failing to provide adequate mental health care); See also Dylan Walsh, *Does Bad Health Care Constitute Cruel and Unusual Punishment?*, THE ATLANTIC (Jun. 17, 2017), [www.theatlantic.com/politics/archive/2017/06/illinois-prisons-health-care/530400/](http://www.theatlantic.com/politics/archive/2017/06/illinois-prisons-health-care/530400/) (explaining a class action suit in Illinois arguing the medical treatment inside the state's corrections system puts inmates at risk of pain, injury, and death).

14. *Rasho*, slip op. at 2.

15. *Id.*

16. Gilna, *supra* note 13.

17. Gilna, *supra* note 13.

18. Gilna, *supra* note 13.

19. Gilna, *supra* note 13.

the state of Illinois exceeds \$190 million per year.<sup>20</sup> Despite these high costs and multiple judiciary rulings, the IDOC is clearly failing to properly care for its sizable mentally ill population.<sup>21</sup> One simple reason why Illinois continually fails to provide adequate mental health care is because prison personnel are not traditionally equipped to handle the severely mentally ill.<sup>22</sup>

Prisons were never intended to be the largest mental health provider in the nation.<sup>23</sup> Without the proper treatment, mentally ill prisoners suffer painful symptoms and their conditions can deteriorate.<sup>24</sup> Mental illness impairs prisoners' ability to properly cope with the extraordinary difficulties of prison, to be obedient, and to follow the rules of prison life.<sup>25</sup> Security personnel usually find mentally ill prisoners as disruptive and often subject them to solitary confinement which only further aggravates their mental illness.<sup>26</sup> Typically, when a prisoner deteriorates to the point they require hospital treatment, they are immediately returned to the prison's toxic environment as soon as they are stabilized.<sup>27</sup> Consequently, the mentally ill face higher rates of recidivism when prisons are inadequately staffed and funded.<sup>28</sup>

Mentally ill individuals suffer when they are placed in an environment

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20. Hanke Heun-Johnson et al., *The Cost of Mental Illness: Illinois Facts and Figures*, USC 34 (May 2018), <https://healthpolicy.usc.edu/wp-content/uploads/2018/07/IL-Facts-and-Figures.pdf>.

21. Herman, *supra* note 10.

22. H. R. WATCH, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness* (Oct. 21, 2003), [www.hrw.org/report/2003/10/21/ill-equipped/us-prisons-and-offenders-mental-illness#](http://www.hrw.org/report/2003/10/21/ill-equipped/us-prisons-and-offenders-mental-illness#).

23. *Id.*; See also Matt Ford, *America's Largest Mental Hospital is a Jail*, THE ATLANTIC (Jun. 8, 2015), [www.theatlantic.com/politics/archive/2015/06/americas-largest-mental-hospital-is-a-jail/395012/](http://www.theatlantic.com/politics/archive/2015/06/americas-largest-mental-hospital-is-a-jail/395012/) (detailing the struggles of Cook County Jail as one of the nation's leading mental health care providers).

24. H. R. WATCH, *supra* note 22.

25. H. R. WATCH, *supra* note 22.

26. H. R. WATCH, *supra* note 22.

27. H. R. WATCH, *supra* note 22.

28. Talesh, *supra* note 5, at 102; H. R. WATCH, *supra* note 22.

which is not properly equipped to care for them.<sup>29</sup> A federally-appointed court monitor issued a report in 2017 regarding the IDOC's treatment of mentally ill prisoners, and its findings characterized the care as "grossly insufficient" and "extremely poor" in quality.<sup>30</sup> The monitor found that, due to the large number of mentally ill prisoners confined within these improperly-equipped prisons, there was insufficient psychiatric staff, problems with continuation of medications upon entry into prison, failure to follow up on powerful psychiatric medication, forced medications, enormous backlogs in psychiatric evaluations, deterioration of mentally ill prisoners in solitary confinement, and a lack of planning for the treatment of virtually all prisoners with a mental illness.<sup>31</sup> Illinois has a detailed history of failing to properly care for its mentally ill inmates, and despite a realization of that failure, few attempts until very recently have been made to effectuate real change.

### III. RECENT ATTEMPTS IN THE CRIMINAL JUSTICE SYSTEM TO HELP PROPERLY CARE FOR ILLINOIS' MENTALLY ILL

In part due to the multitude of lawsuits and news articles concerning IDOC's inadequate treatment of its mentally ill inmates, the Illinois state government has attempted to make a positive difference in its care of mentally ill prisoners by adopting MHCs and proposing construction of a new mental health facility.<sup>32</sup> In 2008, the Illinois legislature passed the

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29. EQUIP FOR EQUALITY, *Report: Illinois' Treatment of Mentally Ill Prisoners "Exceedingly Poor and Often Dangerous"* (Sept. 5, 2017), [www.equipforequality.org/news-item/report-illinois-treatment-mentally-ill-prisoners-exceedingly-poor-often-dangerous/](http://www.equipforequality.org/news-item/report-illinois-treatment-mentally-ill-prisoners-exceedingly-poor-often-dangerous/).

30. *Id.*

31. *Id.*

32. *See* Mental Health Court Treatment Act, 730 ILCS 168/5 (2008) (discussing the need for a criminal justice system program to help reduce recidivism amongst the mentally ill); Bob Okon, *Illinois plans inmate treatment in Joliet*, *The Herald-News* (Aug. 23, 2018),

Mental Health Court Treatment Act, which authorized the Chief Judge of each judicial circuit to establish a mental health court program.<sup>33</sup> MHC programs have been successful in making accessible medications and treatments to facilitate recovery from chronic mental illness, but the programs still face issues with recidivism and lack of funding.<sup>34</sup>

MHCs are designed to serve the unique challenges of people with serious mental illnesses.<sup>35</sup> The judiciary recognized the growing amount of severely mentally ill individuals appearing before them but could not provide alternate routes of treatment because many of those individuals did not meet the legal standards for incompetency or insanity.<sup>36</sup> MHCs have specialized dockets which provide the opportunity for individualized treatment plans and highly involved judges.<sup>37</sup> Even with providing crisis intervention to in- and out-patient treatments, partial hospitalization, inpatient hospitalization for substance abuse, and more, there are still high rates of recidivism within MHCs.<sup>38</sup> For example, in a recent study of MHCs, thirty-one percent of

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[www.theherald-news.com/2018/08/23/illinois-plans-inmate-treatment-in-joliet/amtnng8x/](http://www.theherald-news.com/2018/08/23/illinois-plans-inmate-treatment-in-joliet/amtnng8x/), (reviewing the proposal for the new Joliet mental health facility).

33. 730 ILCS 168/15 (2008).

34. Tracy Hahn, *Mental Health Courts in Illinois*, ILL. CRIM. JUST. INFO. AUTHORITY (Oct. 22, 2015), [www.icjia.state.il.us/articles/mental-health-courts-in-illinois](http://www.icjia.state.il.us/articles/mental-health-courts-in-illinois).

35. Arthur J. Lurigio, et al., *A Statewide Examination of Mental Health Courts in Illinois: Program Characteristics and Operations*, ICJIA 4 (Oct. 2015), [www.icjia.state.il.us/assets/articles/mhc\\_report\\_1015.pdf](http://www.icjia.state.il.us/assets/articles/mhc_report_1015.pdf).

36. Between 15 and 20 percent of the correctional population suffers from a serious mental illness. *Id.* at 8. Instead of going to jail or prison, individuals found not guilty by reason of insanity are hospitalized in a state institution until they are deemed safe to release to the public. See Mac McClelland, *When 'Not Guilty' is a Life Sentence*, NY TIMES (Sept. 27, 2017), [www.nytimes.com/2017/09/27/magazine/when-not-guilty-is-a-life-sentence.html](http://www.nytimes.com/2017/09/27/magazine/when-not-guilty-is-a-life-sentence.html) (discussing the indeterminant timelines of release of individuals deemed not guilty by reason of insanity residing in state institutions). Therefore, mentally ill offenders who fail to meet this legal standard are still sent to prisons which are not properly equipped to handle their needs. See generally Herman, *infra* note 10.

37. Hahn, *supra* note 34. The individualized nature of MHCs is reflected in the parties involved in these matters: prosecutors, defense attorneys, probate officers, and mental health professionals are all involved in a “team approach” to provide comprehensive case management strategies. Lurigio, et al., *supra* note 35, at 4.

38. Lurigio, et al., *supra* note 35, at 6.

individuals processed through MHCs were rearrested for a felony and half were rearrested for a felony or misdemeanor offense.<sup>39</sup> While these courts might provide a method of relief for the mentally ill in Illinois, it is not sufficiently providing the services needed to provide effective rehabilitation.

In addition to implementing MHCs to assist the mentally ill in court proceedings, Illinois has also taken its first step in providing better mental health facilities for its prisoners.<sup>40</sup> In August of 2018, Illinois released plans that it is building a separate mental health facility within the criminal justice system.<sup>41</sup> The IDOC announced it will build a \$150 million inpatient facility in Joliet by mid-2021.<sup>42</sup> This new facility, titled the Joliet Treatment Center, will provide 250 beds with more than 400 employees including doctors, psychiatrists, occupational and physical therapists, and nurses.<sup>43</sup> This new 180,000 square-foot center will treat both men and women.<sup>44</sup> While it is designed to function like a typical hospital, and not a prison facility, it will still include security features to allow for the separation or isolation of inmates if needed.<sup>45</sup> According to IDOC officials, this new facility will provide varying levels of care with the intention of addressing care needs –

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39. Hahn, *supra* note 37. This Illinois Criminal Justice Information Authority-backed study sent out a survey to each circuit court in Illinois. Hahn, *supra* note 37. Of the state's 23 court circuits, 19 completed the survey. Only nine had operational MHCs, and six reported no plans for MHC implementation. Hahn, *supra* note 37. The jurisdictions that had little to no interest in establishing an MHC were smaller and rural with populations that had a lower prevalence of mental illness. Hahn, *supra* note 37.

40. Okon, *supra* note 32.

41. Okon, *supra* note 32. It is also important to note that this new facility was created in compliance with the IDOC's settlement agreement to provide adequate mental health care to its mentally ill prisoners. *Id.*

42. Okon, *supra* note 32; See also WGN, *Illinois To Build \$150M Prison Mental-Health Unit* (Aug. 22, 2018, 11:44 AM), <https://wgntv.com/2018/08/22/illinois-to-build-150m-prison-mental-health-unit/> (further explaining Illinois' mental health facility).

43. Alicia Fabbre, *Officials Break Ground On \$150M Inmate Hospital In Joliet*, CHICAGO TRIBUNE (Mar. 18, 2019, 7:00 PM), [www.chicagotribune.com/suburbs/daily-southtown/news/ct-sta-new-joliet-health-facility-st-0319-story.html](http://www.chicagotribune.com/suburbs/daily-southtown/news/ct-sta-new-joliet-health-facility-st-0319-story.html).

44. WGN, *supra* note 42.

45. Fabbre, *supra* note 43.

not to serve as a punitive measure.<sup>46</sup> This new development is a significant sign that the Illinois government is open to reforming the ways in which it administers mental health care within its prison system.<sup>47</sup>

IV. PRISONS WILL NEVER BE TREATMENT CENTERS: ILLINOIS MUST  
CONSTRUCT SEPARATE FACILITIES TO PROPERLY CARE FOR ITS SEVERELY  
MENTALLY ILL INMATES

Instead of continuing to place severely mentally ill inmates into prisons and jails, Illinois should instead fund separate psychiatric facilities to properly treat these individuals. As evidenced by its proposed Joliet Treatment Center, the Illinois state government recognizes the need for better mental healthcare within the IDOC.<sup>48</sup> This new type of facility would address all of the issues raised by inadequate prison mental health care. For example, in order to combat staffing issues, each member of this facility would be trained in psychology, social work, or medicine.<sup>49</sup> This way, every individual working with an inmate would have extensive training in dealing with the mentally ill and would be able to understand and appreciate the wider landscape and environment in which they practice.<sup>50</sup> In an effort to humanize the mentally ill individuals placed in these facilities, each person would be called a “patient” instead of “prisoner,” reflecting the rehabilitative and therapeutic nature of the facility.<sup>51</sup> Additionally, an emphasis on

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46. Fabbre, *supra* note 43.

47. “Illinois is mending, improving and setting right its treatment of offenders with mental illness,” said Sen. Pat McGuire, a Democrat from Joliet. Fabbre, *supra* note 43. Sen. McGuire had lobbied for repurposing the former Illinois Youth Center for the new treatment center. Fabbre, *supra* note 43.

48. WGN, *supra* note 42.

49. Burns, *supra* note 12, at 15.

50. Burns, *supra* note 12, at 16.

51. See generally MICH. MED., *Forensic Psychiatry Fellowship*,  
<https://medicine.umich.edu/dept/psychiatry/education/fellowships/forensic-psychiatry->

pharmacotherapy, instead of solitary confinement, would provide individuals with opportunity to grow and fight their illness.<sup>52</sup>

This proposed system incorporates many aspects of the Center for Forensic Psychiatry (CFP) in the State of Michigan.<sup>53</sup> CFP is a 210-bed psychiatric facility that provides diagnostic care and psychiatric treatment for criminal defendants “adjudicated incompetent to stand trial or acquitted by reason of insanity.”<sup>54</sup> The Michigan criminal courts commit individuals to CFP.<sup>55</sup> Depending on the severity of mental illness, some defendants have stayed at the facility for up to 20 years.<sup>56</sup> Although CFP recently expanded its capacity by opening an eighth unit with 34 beds, there is still an immense imbalance between supply and demand of its treatment.<sup>57</sup> Michigan established CFP to provide personalized mental health care for the severely mentally ill, but because of decreased funding and lack of space, defendants continue to remain in county jail awaiting transfer.<sup>58</sup> Illinois must provide

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fellowship (demonstrating that individuals who are committed to Michigan’s Center for Forensic Psychiatry (by court order) are called patients, not prisoners).

52. See generally Jennifer M. Reingle Gonzalez & Nadine M. Connell, *Mental Health of Prisoners: Identifying Barriers to Mental Health Treatment and Medication Continuity*, 104 AM J PUB. HEALTH 2328, 2329 (2014) (discussing the benefits of pharmacotherapy and issues resulting from solitary confinement).

53. MICH. DEP’T OF HEALTH & HUM. SERVS., *Brief History*, [www.michigan.gov/mdhhs/0,5885,7-339-71550\\_2941\\_4868\\_4896\\_62743\\_62744-290291--,00.html](http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4896_62743_62744-290291--,00.html) (last visited Feb. 9, 2019).

54. *Id.*

55. Julie Swidwa, *Forensic Center Director Shares Prosecutors’ Concerns*, THE HERALD PALLADIUM (Jan. 29, 2017), [www.heraldpalladium.com/news/local/forensic-center-director-shares-prosecutors-concerns/article\\_d3363889-7d41-5175-820f-5022dc5d455d.html](http://www.heraldpalladium.com/news/local/forensic-center-director-shares-prosecutors-concerns/article_d3363889-7d41-5175-820f-5022dc5d455d.html).

56. *Id.*

57. *Id.*

58. OAKLAND PRESS, *Competency Cases Move Through Michigan Court System Slowly* (Nov. 29, 2017), [www.theoaklandpress.com/news/nation-world-news/competency-cases-move-through-michigan-court-system-slowly/article\\_df1feb67-23de-5018-aaea-31179472cc10.html](http://www.theoaklandpress.com/news/nation-world-news/competency-cases-move-through-michigan-court-system-slowly/article_df1feb67-23de-5018-aaea-31179472cc10.html). See also Justin A. Hinkley, *Michigan mental health nurses say OT hurts patient care*, DETROIT FREE PRESS (Oct. 8, 2015, 9:29 A.M.), [www.freep.com/story/news/local/michigan/2015/10/08/michigan-mental-health-nurses-say-ot-hurts-patient-care/73571680/](http://www.freep.com/story/news/local/michigan/2015/10/08/michigan-mental-health-nurses-say-ot-hurts-patient-care/73571680/) (detailing how nurses working in Michigan psychiatric

additional funding to construct more separate mental health facilities such as CFP to accommodate the state's severely mentally ill inmate population.

While Illinois prepares to fund and construct these facilities, mentally ill individuals who remain in prisons and jails must have immediate access to adequate mental health care.<sup>59</sup> It is crucial to provide properly-trained mental health professionals within jails and prisons until a solution, such as state-wide forensic psychiatry centers, can be properly and thoroughly implemented.<sup>60</sup> In addition to providing more training to prison officials, Illinois should provide inmates a guaranteed right to treatment, routine screenings and evaluations, suicide prevention, pharmacotherapy, and more.<sup>61</sup>

A major obstacle to the proposed system is whether Illinois can generate the funding required for such a large-scale project. As evidenced by the \$150 million price tag on the Joliet Treatment Center, the Illinois state government recognizes money must be spent in order to properly serve the state's mentally ill population.<sup>62</sup> However, Illinois faces a historically high budget deficit in the upcoming fiscal year, which may deter public leaders from allocating funds to mentally ill individuals in the criminal justice system.<sup>63</sup> It is crucial for both the legislature and the general public to understand how much money Illinois already spends on improperly caring for the mentally ill

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hospitals are overworked and overstressed, with some nurses having to work double shifts in order to properly care for the state's psychiatric patients).

59. Burns, *supra* note 12, at 15.

60. Burns, *supra* note 12, at 16.

61. Burns, *supra* note 12, at 20.

62. Okon, *supra* note 32.

63. See Peter Hancock, *Report: Illinois Budget Woes Worse Than Previously Thought*, THE PANTAGRAPH (Feb. 10, 2019), [www.pantagraph.com/news/state-and-regional/govt-and-politics/report-illinois-budget-woes-worse-than-previously-thought/article\\_aec0c7aa-d9b0-55d2-aefb-84c868fd63d7.html](http://www.pantagraph.com/news/state-and-regional/govt-and-politics/report-illinois-budget-woes-worse-than-previously-thought/article_aec0c7aa-d9b0-55d2-aefb-84c868fd63d7.html) (detailing the potential \$3.2 billion budget deficit in Illinois).



individuals in prisons and jails.<sup>64</sup> In the long run, the state would save money by providing the severely mentally ill with the proper rehabilitative treatment they deserve instead of continually placing them within an environment unequipped to meet their needs.<sup>65</sup> Illinois should fix this economic debacle to benefit this plan by directing funds to go towards rehabilitation and treatment services instead of lengthy stays in inadequate prisons. Having a governor and legislature that prioritizes mental health treatment, which was promised on the 2018 gubernatorial campaign trail, may alleviate this plan's budgetary constraints.<sup>66</sup>

Despite the potential benefits of removing severely mentally ill inmates from the stressors of prison life and placing them into a facility equipped to handle their mental health needs, constructing separate mental health facilities within the criminal justice system may not be considered an ethical solution to this problem.<sup>67</sup> Some critics have called bringing back the "asylum" as labeling the mentally ill as hopeless and separating them from the rest of the population until death.<sup>68</sup> While this type of treatment may not alleviate all of the complex issues associated with mental illness in the criminal justice system, separate, patient-focused facilities will undoubtedly

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64. See generally Heun-Johnson, et al., *supra* note 20 ("The overall cost of incarceration of the 8000+ prisoners with serious mental illness in the state of Illinois exceeds \$190 million per year.").

65. See Mary Giliberti, *Treatment, Not Jail: It's Time To Step Up*, NAMI (May 5, 2015), [www.nami.org/Blogs/From-the-Executive-Director/May-2015/Treatment,-Not-Jail-It's-Time-to-Step-Up](http://www.nami.org/Blogs/From-the-Executive-Director/May-2015/Treatment,-Not-Jail-It's-Time-to-Step-Up) (discussing the high costs associated with incarcerating a mentally ill person compared to providing community mental health services).

66. See Dave Dahl, *Pritzker Calls For Higher Priority For Mental Health Treatment*, WJBC (Sept. 14, 2018), [www.wjbc.com/2018/09/14/pritzker-calls-for-higher-priority-for-mental-health-treatment/](http://www.wjbc.com/2018/09/14/pritzker-calls-for-higher-priority-for-mental-health-treatment/) (discussing then-candidate Pritzker's call for higher priority for mental health treatment in Illinois).

67. Lloyd Sederer, *No Asylum for Asylums*, U.S. NEWS (May 20, 2015, 10:25 AM), [www.usnews.com/opinion/blogs/policy-dose/2015/05/20/bringing-back-asylums-will-not-help-mentally-ill-people](http://www.usnews.com/opinion/blogs/policy-dose/2015/05/20/bringing-back-asylums-will-not-help-mentally-ill-people).

68. *Id.*

help society's most vulnerable.<sup>69</sup> The prison system, as it stands now, is simply not equipped to provide effective treatment to the severely mentally ill.<sup>70</sup>

While there are legitimate budgetary and ethical concerns about implementing this type of model in Illinois, when taking all things considered, it is absolutely necessary to construct separate mental health facilities to provide a safe and therapeutic space to rehabilitate Illinois' severely mentally ill inmates.<sup>71</sup> This cannot be guaranteed by treating severely mentally ill inmates in prison cells.<sup>72</sup> Illinois continues to spend an astronomical amount on housing mentally ill inmates in its prison system,<sup>73</sup> yet it fails at providing constitutionally-sufficient treatment.<sup>74</sup> Therefore, the logical and ethical next step to make here is to implement separate facilities that will properly care for the state's most vulnerable mentally ill prisoners.

#### V. CONCLUSION

Illinois should build multiple mental health facilities within the IDOC to administer the proper care that the severely mentally ill prisoners deserve. Multiple studies prove prisons are not the proper environments for the mentally ill. Instead, severely mentally ill individuals deserve to receive their court-mandated sentence in a facility that is properly equipped to handle their unique needs. If the purpose of the criminal justice system is to rehabilitate people to become functioning members of society, then placing the severely

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69. See Dominic A. Sisti et al., *Improving Long-Term Psychiatric Care: Bring Back the Asylum*, 313 JAMA 243, 244 (2015) (detailing how not all mentally ill individuals would benefit from separate facilities, but those who are the most chronically ill will benefit from integrative, patient-focused care).

70. *Id.* at 243.

71. Prisons are the "anathema to the goals of psychiatric recovery: it is often unsafe, violent, and designed to both control and punish." *Id.* at 243.

72. H. R. WATCH, *supra* note 22.

73. Heun-Johnson et al., *supra* note 20.

74. Gilna, *supra* note 13.

mentally ill into facilities that are equipped to address their needs is crucial. While a lack of funding may prevent numerous large-scale facilities from opening up state-wide, having a few facilities that can offset the bulging mentally ill population of Cook County jail would help preserve numerous lives. These mental health facilities, in combination with MHCs and additional mental health services within jails and prisons, will tremendously help rehabilitate Illinois' mentally ill population.

# Pregnant and Imprisoned: An Unmet Mental Health Need

*Jessica Fenton*

## I. INTRODUCTION

Despite recent increases in the prevalence of behavioral and mental healthcare, there is one sub-group that seems to be left behind: pregnant prison inmates.<sup>1</sup> Women in the criminal justice system are arguably one of the most vulnerable groups in our society, and pregnancies among incarcerated women are notably more high-risk than that of un-incarcerated women.<sup>2</sup> This added risk is largely attributable to the unplanned nature of the pregnancies, which is further confounded by a lack of prenatal care, prevalence of domestic violence and drug/alcohol abuse, and poor overall wellness and nutrition.<sup>3</sup> The national trend of improving mental health is at odds with studies that suggest that prison populations are perhaps the most “in need” of behavioral or mental healthcare services.<sup>4</sup> Indeed, the current

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1. *Committee Opinion: Health Care for Pregnant and Postpartum Incarcerated Women and Adolescent Females*, AM. C. OBSTETRICIANS & GYNECOLOGISTS (Nov. 2011) (noting that “women in the criminal justice system are among the most vulnerable in our society. Pregnancies among incarcerated women are often unplanned and high-risk and are compromised by a lack of prenatal care, poor nutrition, domestic violence, mental illness, and drug and alcohol abuse.”).

2. *Id.*

3. *Id.*

4. *See generally* Soumyadeep Mukherjee, et al., *Mental Health Issues Among Pregnant Women in Correctional Facilities: A Systematic Review*, 54 *WOMEN & HEALTH* 816, 816-838 (2014) (offering an example of a systematic study review which found that “tobacco use among pregnant inmates exceeded 50%, with some studies reporting as high as 84%. Alcohol use was common; 36% of the inmates used illicit drugs in one study. Depression and anxiety levels were high—some studies reported depression among 80% of inmates. Findings suggest that mental health among pregnant prisoners is a huge concern that has not been adequately addressed.”).

trend of improving behavioral and mental healthcare has brought relief to many individuals, and yet there exists a strange paradox whereby one of the most vulnerable subgroups of the population receives arguably the most substandard care.<sup>5</sup> This needs to change. Policy makers must prioritize improved behavioral and mental health care in prisons, and allocate increased funding to help alleviate the unique stresses and susceptibilities of pregnant inmates.

Unfortunately, instead of taking a step in the right direction, many states have actually cut funding for behavioral and mental health (BMH) care in prisons.<sup>6</sup> The decision to reduce or cut BMH care in prisons has the capacity to do more harm than good, particularly for pregnant inmates.<sup>7</sup> Further, pulling away from care plans that prioritize BMH care may actually serve to increase costs to the public through recidivism.<sup>8</sup> In addition to actual costs, policy makers must not ignore the immeasurable costs to inmates who are denied this much needed care, such as emotional distress and lasting degradation of self-worth.<sup>9</sup> At any given time, it is estimated that up to ten percent of incarcerated women are pregnant while serving their sentence.<sup>10</sup> Of this population, at least 90 percent of these women will have to endure the labor and birthing process while in prison.<sup>11</sup> As such, policy makers must consider mandating the implementation of increased BMH care in prisons, with specific attention given to pregnant inmates – a prison sub-population most in need of BMH care. Policy makers should focus on improving areas left lacking in the current system by exploring the viability of prison nursery programs, considering

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5. *Id.*

6. *Id.*

7. *Id.*

8. Palsha, *infra* note 46.

9. Mukherjee, *supra* note 4.

10. Michele Eliason & Stephan Arndt, *Pregnant Inmates: A Growing Concern*, 15 J. ADDICTIONS NURSING 163, 163-170 (2004).

11. *Id.* (citing Greenfeld & Snell, 1999).

community programs over traditional approaches, and pressuring prisons to provide BMH care that is specifically tailored to address the unique stresses and circumstances of pregnancy.

Section I of this article will first look at the prevalence of mental health issues amongst the pregnant inmate population. Section II will transition into an exploration of a few targeted studies aimed at addressing the behavioral and mental experience of these women in prisons. In Section III, this article will review failed attempts at addressing this unmet need via past policy attempts. Section IV will explore the true costs associated with cutting BMH care for pregnant prison inmates. Finally, Section V of this article will conclude with recommendations/suggestions on how policy makers can improve the availability of BMH care for prison inmate and pregnant prison inmates.

## II. PREVALENCE OF MENTAL HEALTH ISSUES AMONG PREGNANT PRISON INMATES

Despite the fact that the rate of pregnancy among female inmates is rapidly on the rise, “very little empirical research has been conducted on pregnant inmates.”<sup>12</sup> Because the majority of women who find themselves pregnant whilst incarcerated suffer from recurrent substance use disorders and associated mental health issues,<sup>13</sup> it has become increasingly important to evaluate the BMH care needs of this population and ensure that appropriate care is available.<sup>14</sup>

While very few studies have been devoted to exploring the unique behavioral and mental experience of pregnant women in prisons, one particularly enlightening study conducted in 2014 helps to shed light on the

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12. *Id.*

13. Mukherjee, *supra* note 4 (noting that pregnant inmates suffer disproportionately from substance abuse, anxiety, depression, and PTSD, among others).

14. Eliason, *supra* note 10.

issue.<sup>15</sup> In this study, researchers at the Robert Stempel College of Public Health & Social Work relied on the World Health Organization's (WHO) definition of mental health when completing their systematic review, describing "mental health" as a "a state of well-being that allows individuals to realize their own abilities and adjust with daily life's stresses."<sup>16</sup> When this state of well-being is not recognized, a series of resultant mental disorders, typically characterized by some "combination of alterations in thought, emotions, behavior, and interpersonal relationships," can begin to manifest.<sup>17</sup> These exact manifestations are extremely common among female inmates, and experts estimate that up to 84 percent of incarcerated women suffer from mental health disorders, though many of these experts contend that the true figure lays somewhere in the range of 30 to 84 percent.<sup>18</sup> The fact that such a huge "data gap" exists between these estimated percentages suggests that there is not only a mental health crisis at play, but a crisis for which experts have difficulty properly quantifying.<sup>19</sup> This furthers the argument for increased resources aimed at addressing the mysterious issue of BMH care for pregnant inmates. If these figures or disparities seem alarming, consider this: not only are the rates of mental health problems among female inmates significantly higher than that of male inmates, but they are also monumentally higher than rates for *unincarcerated* women.<sup>20</sup> Faced with these unshakable statistics, policy

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15. Mukherjee, *supra* note 4.

16. Mukherjee, *supra* note 4; see also *Mental Health: A State of Well-Being*, WHO (AUG 2014), [https://www.who.int/features/factfiles/mental\\_health/en/](https://www.who.int/features/factfiles/mental_health/en/).

17. Mukherjee, *supra* note 4.

18. Mukherjee, *supra* note 4.

19. Mukherjee, *supra* note 4. (explaining that estimates for female inmates who suffer from mental health disorders are somewhere in the wide range of 30 to 84 percent, with no further specificity given considering the limited data available).

20. Mukherjee, *supra* note 4. (noting that, according to a Bureau of Justice Statistics report from 2006, the rates of mental illness amongst prisoners in the U.S. were 61% for females and 44% for males. These rates differed across prison-type, with Federal prisons reflecting rates of 73% and 55%, respectively, and State prisons at 75% and 63%, respectively).

makers must recognize the unique psychological struggles of pregnant women in prisons and devote additional resources toward increasing the quality of BMH care provided to these women.

Policy makers must not ignore the striking prevalence of mental disorders among female inmates, including substance abuse, anxiety, depression, and post-traumatic stress disorder (PTSD).<sup>21</sup> In addition to these disorders, incarcerated women also suffer from significantly higher rates of schizophrenia, major depression, and personality disorders than the general population.<sup>22</sup> Each of these mental health issues can be prompted or exacerbated by pregnancy, and further intensified by the stressful environment notorious to prison life.<sup>23</sup> The rate of suicide is known to increase postpartum, and this risk becomes especially concerning among young mothers and those with psychiatric diagnoses.<sup>24</sup> Policy makers should demonstrate that they value the lives of pregnant inmates by implementing meaningful BMH care programs aimed at reducing the psychological suffering that is currently exacerbated by lackluster prison programs in many states<sup>25</sup>.

Unsurprisingly, the immense stress of incarceration causes pregnant women to find themselves at high-risk for mental health problems, particularly those associated with lasting adverse outcomes.<sup>26</sup> The majority of women in prison are indeed substance abusers, with many reporting substance abuse immediately prior to incarceration.<sup>27</sup> For women with substance use disorders, the possibility of relapsing or overdosing shortly

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21. Mukherjee, *supra* note 4.

22. Mukherjee, *supra* note 4.

23. Mukherjee, *supra* note 4.

24. Caitlin E. Martin, et al., *Behavioral Health in Pregnancy and Postpartum*, CONTEMP. OBGYN (Dec. 10, 2018), <https://www.contemporaryobgyn.net/pregnancy-and-birth/behavioral-health-pregnancy-and-postpartum>.

25. Farrington, *infra* note 71; Eliason, *supra* note 10; Schlafer, *supra* note 34.

26. Mukherjee, *supra* note 4 (summarizing the problem by noting that “incarceration-induced stress makes pregnant women in correctional facilities a high-risk group for mental health problems, resulting in adverse maternal and fetal outcomes”).

27. Eliason, *supra* note 10.



after giving birth is common.<sup>28</sup> The majority of pregnant inmates are considerably younger than their non-pregnant counterparts, and their age, substance abuse history, pregnancy, and incarceration increase their susceptibility to mental illnesses.<sup>29</sup> Society is in desperate need of improvements to the behavioral and mental health care provided to pregnant inmates,<sup>30</sup> and policy makers must take notice. More specifically, policy makers must act swiftly to improve BMH care by allocating additional resources and reformulating existing prison programs to be more cognizant of the unique circumstances and hardships that pregnant inmates face.

Of these hardships, alcohol use, illicit drug use, increased anxiety, and depression are common among pregnant inmates, with studies estimating that the latter affected nearly 80 percent of these women.<sup>31</sup> With so much demonstrated need, why is it then that mental health concerns among pregnant female inmates are not being adequately addressed?<sup>32</sup> The answer is unclear, and the current state of affairs at many prisons may prove to be at odds with the guaranteed rights afforded to inmates.<sup>33</sup> Under the Eighth Amendment to the U.S. Constitution, prisons and jails are required to offer prenatal care to pregnant inmates.<sup>34</sup> Unfortunately, the level of prenatal

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28. Eliason, *supra* note 10.

29. Eliason, *supra* note 10.

30. Mukherjee, *supra* note 4 (explaining that, based on a 2014 study, more than 50 percent of pregnant inmates used tobacco while pregnant – a much higher rate than is observable among un-incarcerated pregnant women).

31. Mukherjee, *supra* note 4.

32. Mukherjee, *supra* note 4.

33. See, e.g., Brenda J. Van Den Bergh, et al., *Imprisonment and Women's Health: Concerns About Gender Sensitivity, Human Rights and Public Health*, WHO (Jul. 6, 2011), <https://www.who.int/bulletin/volumes/89/9/10-082842/en/> (explaining that “a close look at the needs of women in prison and related health aspects raised issues of gender inequity and insensitivity, of human rights neglect and showed a general lack of public health concern.”).

34. Rebecca Schlafer & Laurel Davis, *Pregnant, in Prison and Facing Health Risks: Prenatal Care for Incarcerated Women*, THE CONVERSATION (Feb. 19, 2016), <https://theconversation.com/pregnant-in-prison-and-facing-health-risks-prenatal-care-for-incarcerated-women-45034>.

care afforded to these women is up to the discretion of individual states, as there are no federal standards in place.<sup>35</sup> Nevertheless, these facilities have a duty to provide medical services, including mental health services, and to provide protection from harm, as these are basic human rights of every prisoner with a mental illness.<sup>36</sup> However, less than half of the correctional facilities in the United States provide adequate care,<sup>37</sup> and there have been many documented cases of prenatal neglect by correctional institutions.<sup>38</sup> Many prisons fail to make adjustments to women's diets to accommodate their increased nutritional needs, and oftentimes prisons fail to create opportunities for appropriate exercise.<sup>39</sup> In the case of work requirements, many prisons fail to make appropriate modifications to ensure safety for the mother and unborn child.<sup>40</sup> More devastatingly, many pregnant inmates feel pressure to "opt out" of receiving care altogether to avoid humiliating treatment by health care staff.<sup>41</sup> These trends and statistics are unacceptable. The extent of mental health issues during pregnancy, paired with the already high prevalence of mental problems among female inmates, results in a prison population – pregnant female inmates – that is at higher risk of mental-health disorders.<sup>42</sup> Allocating increased funding for improved behavioral and mental health care in prisons is a necessary step in working to alleviate this unfair burden placed on the shoulders of pregnant inmates.

Fortunately, some states such as California provide more thoughtful care

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35. *Id.*

36. *Position Statement 56: Mental Health Treatment in Correctional Facilities*, MENTAL HEALTH AM. (Mar. 7, 2015), <http://www.mentalhealthamerica.net/positions/correctional-facility-treatment> [hereinafter PS56].

37. Mukherjee, *supra* note 4.

38. Eliason, *supra* note 10 (offering the example of Amnesty International, which has documented several cases of prenatal neglect by correctional institutions that resulted in stillbirths and miscarriages).

39. Shlafer, *supra* note 34.

40. Shlafer, *supra* note 34.

41. Shlafer, *supra* note 34.

42. Mukherjee, *supra* note 4.

to pregnant inmates,<sup>43</sup> but many others provide lackluster care that is inadequate in terms of quality, duration, and type – with little devotion to providing behavioral and mental health care.<sup>44</sup> This lack of care can be seen as particularly harmful when considering how many stressors pregnancy women are exposed to in prison, such as social isolation, psychological stress, and the inability to engage in crucial “bonding” with their babies after delivery.<sup>45</sup> While bonding may seem like a luxury to some, it is critical for mother-infant attachment.<sup>46</sup> In fact, children who are born to inmates are more likely to grow up and commit crimes themselves, especially when deprived of an appropriate nurturing environment.<sup>47</sup> Unfortunately, most women who give birth in prison – especially those who are isolated from their infants just days after birth – can expect long separations from their babies before ever being able to build such a bond.<sup>48</sup>

The time period immediately following delivery is one of the most sensitive times for pregnant women, and mental illness often manifests shortly after giving birth.<sup>49</sup> The American Psychological Association (APA) noted that up to one in every seven women can expect to experience some form of post-partum depression during this time period.<sup>50</sup> Notably,

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43. *Pregnant Women in California Prisons and Jails: A Guide for Prisoners and Legal Advocates*, 3 LEGAL SERVICES FOR PRISONERS WITH CHILDREN 1, 1 (2006) (providing a guideline of pregnant inmates’ rights while incarcerated in California prisons).

44. Shlafer, *supra* note 34.

45. Shlafer, *supra* note 34.

46. Rebecca Palsha, *Pregnant in Prison: What Happens to a Baby Born in Prison*, ALASKA DEPT. OF CORRECTIONS (Oct. 28, 2016),

<http://www.correct.state.ak.us/blog/akdoctoday/2016/10/31/pregnant-in-prison-what-happens-to-a-baby-born-in-prison-ktuu-channel-2-news/>.

47. *Id.*

48. Eliason, *supra* note 10; Palsha, *supra* note 46 (explaining that most women who give birth while incarcerated will need to “hand their baby to a family member or friends. If no one can help, then the baby goes to the Office of Children’s Services.”).

49. McKenna Flores & Jaylen Bohman, *Pregnancy & Prison: The Untold Story of Women Who Give Birth Behind Bars*, UNIVERSE NARRATIVES (Apr. 27, 2017),

<https://universe.byu.edu/narratives/pregnancy-prison/> (Noting that, according to the American Psychological Association, up to 1 in 7 women experience PPD shortly after giving birth).

50. *Id.*

the APA further explains that the risk of developing post-partum depression and other mental illnesses increases if the new mother is “experiencing particular stressful life events in addition to the pregnancy, or if they don’t have the support of family and friends.”<sup>51</sup> This is the exact type of stressful environment that prisons cultivate.<sup>52</sup> As a result, mental illness flourishes, especially when paired with the fact that most prisons are not accommodating to bolstering a woman’s support system after delivery.<sup>53</sup> In addition to having a diminished support system to help quell the grasp of mental illness, almost 50 percent of pregnant inmates report having lost an important relationship within the last year, with 80 percent admitting that they were without a partner – all of which contribute to feelings of isolation which arguably foster the development of mental illness.<sup>54</sup> If policy makers took a step in the right direction by allocating increased funding and devoting adequate resources to the BMH care needs of pregnant inmates, these feelings of isolation (and the mental illnesses that follow) would likely be mitigated.

To address the need for increased BMH care for pregnant inmates, some states have developed prison nursery programs, which provide a means for incarcerated mothers to spend more time with their babies.<sup>55</sup> In these programs, women are given support, education, and an opportunity to bond with their child in a safe environment with appropriate supervision.<sup>56</sup> Depending on the state, these programs vary in terms of how much time mothers are allowed to stay with their infants; North Dakota allows for 30

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51. *Id.* (revealing that “most prisons don’t allow any extra contact from the women’s support system after delivery. This, along with the added stress of imprisonment could explain why so many incarcerated women experience PPD.”).

52. *Id.*

53. *Id.*

54. Mukherjee, *supra* note 4.

55. Shlafer, *supra* note 34.

56. Shlafer, *supra* note 34.

days, whereas Washington allows up to 30 months.<sup>57</sup> Regardless of the duration, research has demonstrated that “quality prison nursery programs promote infant health and development, improve mother-child attachment and reduce recidivism.”<sup>58</sup> With these meaningful benefits in mind, policy makers should incentivize the creation of prison nurseries and aim to establish these programs as “standard” offerings provided to all pregnant inmates.

Additionally, policy makers would be wise to heed to the recommendations of WHO and UNODC, who have recommended that prison care should not only address mental illness, but place a special emphasis on substance abuse and PTSD – common problems faced by the pregnant inmate population.<sup>59</sup> Policy makers must also aim to provide appropriate health care to female inmates in a manner that is both effective and humane,<sup>60</sup> which can rationally be extended to providing to pregnant female inmates with adequate BMH care and the opportunity to bond with their infant in a prison nursery or other community based program. Offering these programs to pregnant inmates, instead of keeping them in traditional prisons where their health needs are ignored, will “not only facilitate reintegration into the society but will also result in better pregnancy and mental health outcomes.”<sup>61</sup>

### III. FAILED ATTEMPTS AT RESOLUTION

Faced with compelling information about the struggles of pregnant women in prisons, the Federal Bureau of Prisons (FBP), amid mounting criticism and legal pressure, released a new policy in 2014 aimed at

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57. Shlafer, *supra* note 34.

58. Shlafer, *supra* note 34.

59. Mukherjee, *supra* note 4, at 837 (citing WHO et al., 2011).

60. Mukherjee, *supra* note 4, at 837 (pointing to the recommendations of WHO and UNODC, which note that prison health service should address mental illness, and also meet the “gender-specific health care needs” of female inmates in a humane manner.)

61. Mukherjee, *supra* note 4, at 838.

providing better care for inmates suffering from mental health issues.<sup>62</sup> Unfortunately, the aim of this policy fell short, as evidenced by recent data showing that the FBP only achieved “better” care in this area by lowering the number of inmates who qualify as “in need” of mental health care services – not by actually expanding treatment.<sup>63</sup> More shockingly, as of February 2018, the FBP had only classified three percent of inmates as suffering from a mental illness severe enough to warrant regular treatment.<sup>64</sup> When comparing this figure with established rates of mental illness among pregnant female inmates (between 60 and 75 percent), an incredible disparity is revealed.<sup>65</sup>

The FBP’s release of this new policy amounted to little more than a publicity maneuver, as the policy did not add any funding or resources needed to implement the policy to its fullest extent.<sup>66</sup> In an attempt to fulfill the requirement of providing BMH care despite a lack of resources, many prisons gave into the temptation to “downplay” inmates’ true mental health conditions.<sup>67</sup> While arguably unethical, this was done in order to qualify fewer inmates for BMH care, which allowed prisons to satisfy the mandatory BMH care provision and operate within budget constraints.<sup>68</sup> Downplaying inmates’ BMH conditions caused inmates who would otherwise be declared as “in need” of mental health care to instead be considered *not* in need.<sup>69</sup> The FBP has even confirmed that, since

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62. Christie Thompson & Taylor Elizabeth Eldridge, *No One to Talk You Down: Inside Federal Prisons’ Dangerous Failure to Treat Inmates with Mental-Health Disorders*, WASH. POST (Nov. 21, 2018), [https://www.washingtonpost.com/news/national/wp/2018/11/21/feature/federal-prisons-were-told-to-improve-inmates-access-to-mental-health-care-theyve-failed-miserably/?utm\\_term=.96b9d549ab9f](https://www.washingtonpost.com/news/national/wp/2018/11/21/feature/federal-prisons-were-told-to-improve-inmates-access-to-mental-health-care-theyve-failed-miserably/?utm_term=.96b9d549ab9f).

63. *Id.*

64. *Id.*

65. Mukherjee, *supra* note 4.

66. Thompson, *supra* note 62.

67. Thompson, *supra* note 62.

68. Thompson, *supra* note 62.

69. Thompson, *supra* note 62.

implementing the policy, mental-health staffing has not increased.<sup>70</sup>

In some states, prisons are cutting mental health, substance abuse, and prisoner re-entry programs in order to accommodate six-figure shortfalls in state health care and pharmaceuticals budgets.<sup>71</sup> In other states, overcrowding is making the administration of mental health services challenging, primarily due to poor classification and separation of prisoner classes.<sup>72</sup> Consequently, overcrowding has the effect of increasing vulnerability to, and exacerbating the intensity of, mental illnesses.<sup>73</sup>

Unfortunately, when a prison's mental health care department becomes overloaded, it becomes incredibly difficult for inmates – including pregnant inmates – to receive appropriate care.<sup>74</sup> Many women find themselves suffering for long durations while they wait for their name to rise to the top of the waiting list in order to finally see a counselor.<sup>75</sup> Women suffering from post-partum depression are given no special treatment or priority when seeking out behavioral or mental health care services.<sup>76</sup> Instead, they are made to “wait in the back of the line” with other inmates, despite the seriousness of their illness.<sup>77</sup> While the detrimental effects of underfunded and insufficient prison mental health services for pregnant inmates should not be overlooked, another key question remains: do these “cost cuts” to inmate mental health services actually save money? The answer: probably

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70. Thompson, *supra* note 62.

71. Brendan Farrington, *Florida Prisons to Cut Programs Due to Health Care Cost Hike*, AP NEWS (May 2, 2018), <https://www.usnews.com/news/best-states/florida/articles/2018-05-02/florida-prisons-to-cut-programs-due-to-health-care-cost-hike>. (offering Florida as an example, as several Florida prisons are “cutting mental health, substance abuse and re-entry programs to help make up for a \$50 million shortfall in its health care and pharmaceuticals budgets”).

72. PS56, *supra* note 36 (explaining the process, where “in order to see a mental health professional, an inmate has to put in a request, and then is put on a long waiting list until counselors have an opening. Women with post-partum depression aren't given any special treatment).

73. PS56, *supra* note 36.

74. Flores, *supra* note 49.

75. Flores, *supra* note 49.

76. Flores, *supra* note 49.

77. Flores, *supra* note 49.

not.

When considering that 12 percent of females in the general population exhibit symptoms of a mental disorder compared to 60–75 percent among female prisoners,<sup>78</sup> it becomes quite apparent that there is an unmet need for BMH care for incarcerated women.<sup>79</sup> Yet, access to meaningful BMH care remains more easily attainable for women outside of prisons than those inside – which can be particularly problematic for pregnant inmates who are arguably in most need of such care. Policy makers must consider mandating the implementation of increased BMH care in prisons, with specific attention given to pregnant inmates – a prison sub-population most in-need of BMH care. Specifically, policy makers should invest in the creation of community programs designed to allow pregnant prison inmates to serve their sentences with adequate BMH care. Providing this care promises to result in better health outcomes for mother and baby, as well as better financial outcomes for states.<sup>80</sup>

#### IV. RECIDIVISM & OTHER COSTS OF CUTTING CARE

Faced with the compelling evidence demonstrating that pregnant women in prisons are particularly in need of mental and behavioral health care services,<sup>81</sup> it becomes difficult to see a valid reason why pregnant women are repeatedly being denied such care. The answer rests with the lack of proper funds.<sup>82</sup> As with most well-deserving programs, cuts to behavioral and mental health services in prisons have been the direct result of budget

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78. Mukherjee, *supra* note 4, at 835 (citing James & Glaze, 2006).

79. Mukherjee, *supra* note 4 (summarizing the problem by noting that “incarceration-induced stress makes pregnant women in correctional facilities a high-risk group for mental health problems, resulting in adverse maternal and fetal outcomes”).

80. Giliberti, *supra* note 92 (explaining that housing an inmate with mental illness in jail costs three times the amount it costs for community mental health services, and stressing that “it doesn’t take a rocket scientist to realize the absurdity of a system in which the cost of incarcerating a person with mental illness is three times the cost of incarcerating a person without one”).

81. Giliberti, *supra* note 92.

82. Giliberti, *supra* note 92.



problems and the inability to properly fund prison programs.<sup>83</sup>

Unfortunately, the short-term benefit of cutting costs that would otherwise be dedicated to providing BMH care seems to be outweighed by the long-term problem of recidivism.<sup>84</sup> In a research study conducted by Amy Blank Wilson of the Mandel School of Applied Social Sciences, researchers found that the rates of recidivism were highest among inmates who suffered from both mental illness and substance abuse.<sup>85</sup> As demonstrated earlier in this article, pregnant female inmates find themselves uniquely predisposed to this exact pairing of diagnoses.<sup>86</sup> Although very few studies have been dedicated to evaluating the mental health needs of pregnant women in prisons,<sup>87</sup> the few that do exist conclude, quite compellingly, that “the simultaneous presence of two stressors, pregnancy and incarceration, render incarcerated pregnant women extremely vulnerable to mental health issues including substance use.”<sup>88</sup> When considering these facts in the aggregate, it becomes plausible to conclude that the subpopulation of pregnant female inmates is at increased risk for recidivism, which of course comes at a high cost to the public.<sup>89</sup> Karla Hicks, a social worker at the Department of Corrections in Hiland, Alaska, has posited that prison nursery programs have the potential to actually “reduce the recidivism rate of women prisoners and reduce the number of children born to inmates who then grow up and commit

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83. *See generally*, Farrington, *supra* note 71.

84. Amy Wilson, *Study Finds Higher Rates of Jail Recidivism Among People with Co-occurring Severe Mental Illness and Substance Use Disorders*, CTR. FOR EVIDENCE-BASED PRAC. (Feb. 1, 2012), <https://www.centerforebp.case.edu/stories/study-finds-higher-rates-of-jail-recidivism-among-people-with-co-occurring-severe-mental-illness-and-substance-use-disorders>.

85. Wilson, *supra* note 84; Amy Wilson, *Examining the Impact of Mental Illness and Substance Use on Recidivism in a County Jail*, 34 *INTERN. J. OF LAW AND PSYCH.*, 264, 264-68 (2011).

86. Eliason, *supra* note 10.

87. *See generally*, Mukherjee, *supra* note 4.

88. Mukherjee, *supra* note 4, at 836.

89. Palsha, *supra* note 46; Giliberti, *infra* note 92.

crimes”.<sup>90</sup> In making her argument, Hicks stresses that “any dollar that we can spend to keep a child out of the system would benefit society as a whole”.<sup>91</sup>

Indeed, cutting costs for BMH care in prisons might not be a cost-save at all. In fact, housing an inmate with mental illness in jail costs \$31,000 annually, while community mental health services cost about \$10,000.<sup>92</sup> Given the risks of recidivism, relapse, and adverse child outcomes,<sup>93</sup> some states have moved in the direction of providing improved BMH environments for pregnant inmates.<sup>94</sup> States like California, for example, divert pregnant women to community programs if they have substance abuse problems, no history of violent crimes, and relatively short prison sentences.<sup>95</sup> These community programs, an alternative to the traditional prison experience, are typically “less expensive than prison and provide healthier prenatal environments”.<sup>96</sup> However, there has been little research to date on the overall effectiveness of these community programs for pregnant women,<sup>97</sup> and more resources should therefore be devoted to adequately measuring which options – alternative and traditional – best serve the BMH needs of the pregnant inmate population. Policy makers should aim to develop comprehensive programs designed to mimic existing and successful models offered by forward-thinking states.

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90. Palsha, *supra* note 46.

91. Palsha, *supra* note 46.

92. Mary Giliberti, *Treatment, Not Jail: It's Time to Step Up*, NAT'L ALLIANCE ON MENTAL HEALTH (May 5, 2015), <https://www.nami.org/Blogs/From-the-Executive-Director/May-2015/Treatment,-Not-Jail-It's-Time-to-Step-Up>.

93. Palsha, *supra* note 46. (explaining that when babies are separated from their mothers in prison, a cycle of incarceration in families is created. This cycle can cause children born to inmates to grow up to be criminals themselves).

94. Eliason, *supra* note 10, at 169.

95. Eliason, *supra* note 10, at 169 (citing Fulco, 2001).

96. Eliason, *supra* note 10, at 169.

97. Eliason, *supra* note 10, at 169.

## V. CONCLUSION

In summary, prison nursery programs, community based programs, and traditional prisons who accommodate the needs of pregnant inmates and provide quality prenatal care to incarcerated women are going in the right direction.<sup>98</sup> These programs are great examples of policy changes with the potential to make a monumentally positive effect in the lives of these women, children, and the public at large.<sup>99</sup> As such, policy makers should aim to make these types of programs “standard” offerings that are provided to all pregnant inmates. Allocating increased funding for improved behavioral and mental health care in prisons may help to alleviate the unique stresses and susceptibilities of pregnant inmates. Without intervention, pregnant inmates stand to continue suffering in silence – the results of which can be both personally and financially disastrous. As such, policy makers must consider mandating the implementation of increased BMH care in prisons, with specific attention given to the unique needs and circumstances of pregnant inmates.

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98. Schlafer, *supra* note 34.

99. Schlafer, *supra* note 34.

# Criminal Prosecution and the Postpartum Period: A Call for More Effective Application of the Insanity Defense

*Christina Perez-Tineo*

## I. INTRODUCTION

On the evening of March 29, 1985, Debra Lynn Gindorf walked into the Zion, Illinois police station and stated that she wanted to turn herself in.<sup>1</sup> Gindorf's hands were shaking and her eyes were glassy, but she otherwise seemed normal and spoke clearly when she stated that she killed her infant and small child the prior morning.<sup>2</sup> Neighbors stated that even a year before the incident they met Gindorf regularly for meals, playdates, and babysat each other's children.<sup>3</sup> They said she kept a clean apartment and her children always looked well-fed and taken care of.<sup>4</sup> However, the end of 1984 and beginning of 1985 presented significant challenges for Gindorf. She finalized her divorce with her ex-husband in June 1984 and he admitted to beating her several times, once violently attacking her in December 1984 in front of her daughter while she was eight months pregnant.<sup>5</sup> Weeks later, her son was born and over the course of the next months, neighbors noticed she no longer wanted to spend time with them and she began to isolate herself.<sup>6</sup> Then, on March 29, 1985, she crushed three boxes of sleeping tablets, each containing thirty-two individual tablets, and divided the powder into three

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1. *People v. Gindorf*, 512 N.E.2d 770, 772 (Ill. App. Ct. 1987).
  2. *Id.* (stating that her daughter was 23 months and her son was 3 months old).
  3. *Id.* at 773.
  4. *Id.*
  5. *Id.* at 773.
  6. *Id.*

piles.<sup>7</sup> One went into her son's formula, one went into her daughter's juice box, and one went into a glass of Southern Comfort.<sup>8</sup> While her two children died that night, Gindorf was only rendered unconscious.<sup>9</sup> When she woke up and realized her children were dead, she inhaled fumes from her gas stove, cut her wrists, and tried to smother herself with a pillow.<sup>10</sup> When none of her efforts were successful, she went to the police.<sup>11</sup> At her bench trial, the judge largely disregarded any expert testimony regarding her mental state at the time of the event and Gindorf was found guilty but mentally ill, and sentenced to life in prison.<sup>12</sup>

This case demonstrates the way courts misunderstand the condition of postpartum depression and psychosis and ignore attempts to provide factfinders insight into the condition.<sup>13</sup> However, Illinois has recently enacted a law that enables greater flexibility in sentencing for women who commit felonies while affected by postpartum depression and psychosis.<sup>14</sup> This new approach serves as an example of what is possible for states and for women who commit felonies during a period of postpartum mental illness.<sup>15</sup> Moreover, the law serves as a call to action for Illinois courts to be more receptive to expert testimony regarding postpartum depression and psychosis and for legislatures to shift toward a more nuanced standard for the insanity defense.<sup>16</sup>

This Article begins by discussing the prevalence of postpartum mental

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7. *Id.* at 772

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.* at 772.

12. *Id.* at 772, 777.

13. *See infra* notes 28-32 and accompanying text.

14. Title of Stature, 725 ILL. COMP. STAT. 5/122-1 (2018).

15. The terms "women" "woman" and "mother" will be used as a shorthand throughout this article while recognizing that individuals who do not identify as women can give birth and experience the associated postpartum symptoms.

16. Title of Stature, 725 ILL. COMP. STAT. 5/122-1 (2018).

illness, followed by a description of postpartum mental illnesses and a discussion of theories on their etiology. Second, it will provide an overview of the insanity defense, its limitations, and how courts in Illinois have been particularly unwilling to hear evidence of mental illness in cases where mothers kill their children. Lastly, it will highlight Illinois' new legislative efforts and argue that given the more generous approach now taken at the post-conviction stage, trial courts should adopt measures consistent with this approach to hear expert testimony on the effects of postpartum depression and psychosis.

This Article will only address postpartum depression and postpartum psychosis. The terms "postpartum depression" and "postpartum psychosis" will be referred to individually or, when appropriate, referred to jointly as "postpartum mental illness." While the lack of preventive resources must be remedied in order to identify mothers at risk of harming themselves or their children, this topic is beyond the scope of this article. However, it is mentioned here to raise the issue as one that must be addressed and advocated for going forward.

## II. OVERVIEW OF POSTPARTUM MENTAL ILLNESS

Up to one in nine women experience postpartum depression and one to two in 1000 women experience postpartum psychosis.<sup>17</sup> Of women diagnosed with postpartum psychosis, roughly four percent commit or

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17. Dorothy Sit, et al., *A Review of Postpartum Psychosis*, 15(4) JOURNAL OF WOMEN'S HEALTH 352, 352-68 (2006); Jean Y. Ko, et al., *Trends in Postpartum Depressive Symptoms - 27 States, 2004, 2008, and 2012*, CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 17, 2017), [https://www.cdc.gov/mmwr/volumes/66/wr/mm6606a1.htm?s\\_cid=mm6606a1\\_w#suggestedcitation](https://www.cdc.gov/mmwr/volumes/66/wr/mm6606a1.htm?s_cid=mm6606a1_w#suggestedcitation).

attempt to commit infanticide.<sup>18</sup> Women who experience any kind of postpartum illness can be hesitant to seek treatment on their own due to stigma and fear that their child will be taken from them.<sup>19</sup> This leads to significant undertreatment and underdiagnosis.<sup>20</sup> Further, the medical community has not reached a consensus on how and when to assess for postpartum depression, which causes difficulty in defining it and establishing prevalence rates.<sup>21</sup>

However, for those that do endanger their children and themselves, courts have yet to respond in ways that constructively address their unique circumstances. Traditionally, courts have recognized postpartum illness in two ways: (1) the insanity defense in the trial phase, and (2) as a mitigating factor in the sentencing phase.<sup>22</sup> The insanity defense carries stringent standards, which leads to an overall lack of success in criminal trials.<sup>23</sup> Therefore, in cases of postpartum psychosis, women receive life sentences in prison for crimes committed while suffering from severe mental illness.<sup>24</sup>

#### *A. Terminology and Postpartum Psychiatric Conditions*

Health professionals recognize three types of postpartum conditions: (1)

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18. Rachel L. Carmickle, *Postpartum Illness and Sentencing: Why the Insanity Defense Is Not Enough for Mothers with Postpartum Depression, Anxiety, and Psychosis*, 37 J. Legal Med. 578, 586 (2017); see also *Infanticide*, ENGLISH OXFORD LIVING DICTIONARIES, <https://en.oxforddictionaries.com/definition/infanticide>, (last visited Apr. 5, 2019) (defining "infanticide" as "The crime of a mother killing her child within a year of birth" and "A person who kills an infant, especially their own child.").

19. *Id.* at 588.

20. See Ko, *supra* note 15 (noting that nearly 60% of women with depressive symptoms do not receive a clinical diagnosis, and 50% of women with a diagnosis do not receive any treatment).

21. JOAN C. CHRISLER & INGRID JOHNSTON-ROBLEDO, RAGING HORMONES? FEMINIST PERSPECTIVES ON PREMENSTRUAL SYNDROME AND POSTPARTUM DEPRESSION, RETHINKING MENTAL HEALTH AND DISORDER: FEMINIST PERSPECTIVES 180 (Mary Ballou & Laura S. Brown eds., 2002).

22. Carmickle, *supra* note 16, at 589.

23. *Id.*

24. See, e.g., *supra* note 1.

the baby blues, (2) postpartum depression, and (3) postpartum psychosis.<sup>25</sup> Baby blues is the most common and least severe, affecting fifty to eighty-five percent of women and is characterized by irritability, anxiety, and tearfulness.<sup>26</sup> It typically only lasts about two weeks.<sup>27</sup>

Postpartum depression is the second most common postpartum illness affecting three to thirty percent of new mothers and is characterized by depressed or sad mood, feelings of guilt, sleep disturbance, fatigue, change in appetite, poor concentration, and suicidal thoughts.<sup>28</sup> These symptoms usually develop between two weeks and six months postpartum and may last as long as six to twelve months after childbirth.<sup>29</sup>

Lastly, as noted above, postpartum psychosis affects up to two percent of new mothers and is characterized by extreme emotional lability, mania, disorganization, and/or the experience of hallucinations and delusions.<sup>30</sup> Women begin experiencing these symptoms as early as the first two to three days after delivery.<sup>31</sup> The majority of women with postpartum psychosis develop symptoms within the first two weeks after delivery.<sup>32</sup>

### *B. Etiology*

While there is no clear, singular cause for postpartum mental illness, it is believed to be caused by dramatic shifts in the hormonal environment whose effects are exacerbated by environmental factors or a previous history of

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25. *Postpartum Psychiatric Disorders*, MGH CENTER FOR WOMEN'S MENTAL HEALTH (last visited Feb. 9, 2019), <https://womensmentalhealth.org/specialty-clinics/postpartum-psychiatric-disorders/>; Stacey A. Tovino, *Scientific Understanding of Postpartum Illness: Improving Health Law and Policy?*, 33 *Harvard J. L. & Med.* 99, 102 (2010).

26. *Postpartum Psychiatric Disorders*, *supra* note 23.

27. Tovino, *supra* note 23, at 102.

28. Tovino, *supra* note 23, at 102.

29. Tovino, *supra* note 23, at 102.

30. Tovino, *supra* note 23, at 102-03.

31. *Postpartum Psychiatric Disorders*, *supra* note 23.

32. *Postpartum Psychiatric Disorders*, *supra* note 23.



mental illness.<sup>33</sup> In a key biological study by the National Institute of Mental Health, scientists pharmacologically simulated pregnancy, childbirth, and the postpartum period and found that women with a history of postpartum depression developed significant mood symptoms during the period of significant hormone level changes while none of the women in the control group developed symptoms.<sup>34</sup> Based on these findings, the investigators suggested that women with a history of postpartum depression are more sensitive to mood destabilization when there are significant changes to their gonadal steroid levels.<sup>35</sup> In addition, a previous personal history or family history of mood disorders has been strongly associated with all types of postpartum mental illness.<sup>36</sup> It is also very common for those who experience postpartum symptoms to experience them with a subsequent pregnancy.<sup>37</sup> The study reported rates of recurrence to be fifty percent for women who report experiencing postpartum depression and as high as seventy percent for women who experience postpartum psychosis.<sup>38</sup> The etiology of this condition is further complicated by a history of other mental illnesses.

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33. See *Postpartum Psychiatric Disorders*, *supra* note 23 (stating that the postpartum period is characterized by rapid shifts in the hormonal environment and some women are particularly sensitive to those changes and that marital dissatisfaction, inadequate social supports, and stressful life events during pregnancy all increase the likelihood of postpartum depression); see also Tovino, *supra* note 23, at 119 (detailing findings from study which found that prevalence rates for postpartum depression are higher among single mothers, mothers who have lower educational attainment, lower levels of social support, and women who have low-income status or financial hardship); see also Dorothy Sit, et al., *A Review of Postpartum Psychosis*, 15(4) JOURNAL OF WOMEN'S HEALTH 352, 353 (2006) (reporting that among patients who experience postpartum psychosis immediately after childbirth, 72% – 88% have bipolar illness or schizoaffective disorder but that hormone shifts, obstetric complications, sleep deprivation, and increased environmental stress are possible contributing factors to the onset of illness).

34. Sophie Grigoriadis & Sarah Romans, *Postpartum Psychiatric Disorders: What Do We Know and Where Do We Go?*, 2 Current Psychiatric Rev. 151, 152 (2006).

35. *Id.*

36. *Id.*

37. *Id.*

38. *Id.*; see, e.g., *Yates v. State*, 171 S.W. 215, 217 (Tex. App. 2005) (after the birth of her fourth child in five, Andrea Yates, reported to a psychiatrist that she had had visions and had heard voices since the birth of her first child).

Women with a history of major depression are at risk for relapse during the postpartum period at rates as high as thirty percent and twenty to twenty-five percent of women with bipolar disorder will experience a relapse during the postpartum period.<sup>39</sup> Lastly, there are those that believe sociocultural factors can be just as important contributors as biological factors for mothers who are dealing with the effects of a major life change without any support.<sup>40</sup> Moreover, studies show that women with postpartum psychosis are often victims of domestic violence or abusive childhoods and often have histories of abandonment or substance abuse.<sup>41</sup>

However, postpartum depression is not permanent.<sup>42</sup> More than half of its symptoms cease after one year and the majority cease within four years.<sup>43</sup>

### III. THE INSANITY DEFENSE

Women who commit infanticide are usually charged under state murder and manslaughter statutes.<sup>44</sup> Since the 1980s, courts have permitted mothers with postpartum psychosis to assert the insanity defense which is usually

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39. Grigoriadis & Romans, *supra* note 32, at 152; *see also* Melissa L. Nau, *Postpartum Psychosis and the Courts*, 40 J. Am. Acad. Psychiatry L. 318, 319 (2003) (reporting findings from a study that found the rate of postpartum psychosis in mothers with bipolar disorder was 26%).

40. *See* CHRISLER & JOHNSTON-ROBLED0, *supra* note 19 (noting that postpartum depression may be culture-bound in that it appears in some cultures but not others); *see also* Grigoriadis & Romans, *supra* note 32, at 155-56 (2006) (suggesting that postpartum depression is culture bound in that women in Western societies are often isolated after childbirth and can have difficulty adjusting to their new roles depending on their stage in life).

41. Nau, *supra* note 37, at 319; *see, e.g.*, Emilie Le Baeu Lucchesi, *When Giving Birth Leads to Psychosis, Then to Infanticide*, THE ATLANTIC (Sep. 6, 2018), <https://www.theatlantic.com/family/archive/2018/09/postpartum-psychosis-infanticide-when-mothers-kill-their-children/569386/> (stating that Kimberlyn Bolanos, who stabbed her child to death, was a crack cocaine user and bipolar).

42. Carmickle, *supra* note 16, at 588.

43. *Id.*

44. Margaret Ryznar, *A Crime of Its Own? A Proposal for Achieving Greater Sentencing Consistency in Neonaticide and Infanticide Cases*, 47 U.S.F. L. Rev. 459, 469 (2013).

either the *M’Naghten* or the Model Penal Code (MPC) test.<sup>45</sup> Under the *M’Naghten* test:

To establish a defense on the ground of insanity, it must be clearly proved that, at the time of committing the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know that what he was doing was wrong.<sup>46</sup>

This defense breaks down into two prongs: (1) the “cognitive” test, which requires that the mental illness prevented the actor from understanding or “knowing” the nature of the acts she was committing; and (2) the “morality” test, which requires that even if the actor did “know” the nature of her actions, she did not understand that what she was doing was wrong.<sup>47</sup>

The MPC instead requires that at the time the act was committed and because of some mental illness, the person lacked “substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law.”<sup>48</sup> The wording of the MPC test is meant to provide greater flexibility and enable mental health experts to testify regarding the deeper sense of cognition.<sup>49</sup>

Lastly, in some states, if the defense fails to meet its burden for proving insanity, the factfinder can return a verdict of “guilty but mentally ill” (GBMI).<sup>50</sup> Under this standard, the defendant will begin the criminal sentence in a mental health facility until she “recovers,” and then serve the

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45. Nau, *supra* note 37, at 319.

46. State v. Johnson, 399 A.2d 469, 472 (R.I. 1979).

47. George Parnham, *Beyond the Andrea Yates Verdict: Mental Health and the Law*, 49 Tex. Tech L. Rev. 847, 849 (2017).

48. Model Penal Code § 4.01 Mental Disease or Defect Excluding Responsibility.

49. JOSHUA DRESSLER & STEPHEN GARVEY, *CRIMINAL LAW: CASES AND MATERIALS* 567 (7th ed. 2016); *see also* Clark v. Arizona, 548 U.S. 735, 751 (2006) (states that have adopted a version of the MPC test are Arkansas, Connecticut, Georgia, Hawaii, Kentucky, Maryland, Massachusetts, Oregon, Rhode Island, Vermont, West Virginia, Wisconsin, Wyoming, and the District of Columbia).

50. Parnham, *supra* note 36, at 851.

rest of her sentence in prison.<sup>51</sup>

The *M'Naghten* test is widely criticized because it focuses on a defendant's *knowledge* of the nature, quality, and wrongfulness of her conduct rather than her *appreciation* of the wrongfulness of her conduct required for the MPC test.<sup>52</sup> While the difference may not seem significant, it is particularly important in cases of infanticide. For example, a woman who kills her child in a state of postpartum psychosis might *know* that the specific act will cause death but she may not *appreciate* the wrongfulness in the deeper sense the MPC test allows.<sup>53</sup>

In the case of Andrea Yates, she explained to a jail psychiatrist that since she had been marked by Satan, the only way to save her children from the fires and torment of hell was to kill them.<sup>54</sup> Similarly, in *State v. Wilhoite*, an Illinois case, the defendant attempted to throw her 14-month-old son out the window while saying, "We have been saved and are going to heaven."<sup>55</sup> In both of these instances, Yates and Wilhoite may not meet the *M'Naghten* insanity standard because arguably they *knew* what they were doing was wrong. However, they may still qualify for the MPC insanity standard because while they *knew* their conduct was wrong, they did not *appreciate* the wrongfulness because they were committing these acts for what they believed to be a greater purpose.

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51. Parnham, *supra* note 36, at 851.

52. *Id.* at 656-57; *see also* Clark v. Arizona, 548 U.S. 735, 751 (2006) (states that use the full M'Naghten test are Alabama, California, Colorado, Florida, Iowa, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, Tennessee, and Washington. States that use the morality prong of the M'Naghten test are Arizona, Delaware, Indiana, Illinois, Louisiana, Maine, Ohio, South Carolina, South Dakota, and Texas).

53. Nau, *supra* note 37, at 319.

54. Renata Salecl, *The Real of Crime: Psychoanalysis and Infanticide*, 24 Cardozo L. Rev. 2467, 2472 (2003).

55. *See* People v. Wilhoite, 592 N.E.2d 48, 49 (1991) (The defendant was found guilty by reason of insanity).

When a person is found “not guilty by reason of insanity” (NGRI), unlike being found not guilty from other defenses, the person is not released and instead is usually committed to a mental health facility.<sup>56</sup> The duration of the sentence may not be related to the period of time that would have been imposed upon a guilty verdict without application of the insanity defense, but instead until the person is found to be “no longer mentally ill.”<sup>57</sup> In the case of Andrea Yates, a jury found her NGRI on July 26, 2006.<sup>58</sup> Since then, she has resided at a mental health facility where she undergoes yearly reviews to determine whether she constitutes a danger to others.<sup>59</sup> However, according to her lawyer, she is unlikely to ever be released because at each of these reviews she refuses to ask for release.<sup>60</sup>

#### IV. DISCONNECT BETWEEN LEGAL AND MEDICAL APPROACHES TO POSTPARTUM DEPRESSION

The intersection of law and medicine in the courts creates a tension between the judicial system and the mental health expert.<sup>61</sup> Advocates want to provide juries with the tools to make informed decisions but courts are sensitive to the psychiatrist usurping the role of the jury in criminal trials.<sup>62</sup>

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56. Daniel W. Shuman, *Insanity and Related Defenses*, Psychiatric and Psychological Evidence § 12:1; see also Paul Robinson, *Insanity*, 2 Crim. L. Def. § 173(g) (2018) (stating that while usually individuals are committed, some states are beginning to believe that involuntary commitment is unconstitutional).

57. Shuman, *supra* note 60.

58. *Id.* at 858.

59. *Id.* at 858.

60. Tara West, *Killer Mother Andrea Yates Is Doing 'Remarkably Well' In Mental Hospital After Murdering Her Five Children*, INQUISITR (Sep. 2, 2016) <https://www.inquisitr.com/3477985/killer-mother-andrea-yates-is-doing-remarkably-well-in-mental-hospital-after-murdering-her-five-children/>.

61. See DRESSLER, *supra* note 52, at 659-60.

62. See *United States v. Brawner*, 471 F.2d 969, 978-79 (D.C. Cir. 1972) (expressing concerns over the Durham "product" test which the court found gave too much power to experts); see Beth E. Bookwalter, *Throwing the Bath Water Out with the Baby: Wrongful Exclusion of Expert Testimony on Neonaticide Syndrome*, 78 B.U. L. Rev. 1185, 1194 (1998) (arguing the necessity of experts to allow the jury to comprehend the defendant's psychological reactions and allow the defendant to present a complete case).

This issue is exacerbated by the fact that the Diagnostic and Statistical Manual of Mental Disorders (DSM) does not recognize postpartum disorders as their own, distinct category of mental illness.<sup>63</sup> Instead, the fifth edition states that “psychosis, anxiety, and depression may all present in a mother in the postpartum period and contends that postpartum illness may fall into any of the aforementioned categories.”<sup>64</sup> As a consequence, there is no authority that a lawyer or expert can cite to establish postpartum psychosis as a mental illness. Further, courts in Illinois are always free to disregard experts or bar their testimony leaving out important context on postpartum mental illness and allowing juries or the judge in bench trials to form conclusions based on their understanding of postpartum mental illness.<sup>65</sup>

In *M’Naghten* jurisdictions, insanity can be challenging to prove because postpartum psychosis is episodic, meaning that mothers can alternate between lucidity and hallucinations or delusions.<sup>66</sup> For example, the fact that Andrea Yates calmly called 9-1-1 to report her crime and waited for the police to come, was used to show she knew what she did was wrong.<sup>67</sup>

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63. Walker, *supra* note 65, at 197; see also *DSM5: Frequently Asked Questions*, AMERICAN PSYCHIATRIC ASSOCIATION (last visited Apr. 5, 2019), <https://www.psychiatry.org/psychiatrists/practice/dsm/feedback-and-questions/frequently-asked-questions> (stating that “the Diagnostic and Statistical Manual of Mental Disorders (DSM) is the handbook used by health care professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders.”).

64. Carmickle, *supra* note 16, at 582.

65. See *People v. Gindorf*, 512 N.E. 770, 778 (Ill. App. Ct. 1987) (stating that lay opinions made shortly before and after an incident that a defendant appears normal may overcome an expert opinion that a defendant is insane); see also *Wilhoite*, *supra* note 57, at 53-54 (stating that the weight to be given an expert’s opinion on sanity is measured by the reasons given for the conclusion and the factual details supporting it.. Expert testimony is of no weight and must be disregarded, when it is contrary to common sense, undisputed facts, or where the opinion admits ignoring much of the best evidence available); see also *People v. Hulitt*, 838 N.E.2d 148, 150 (Ill. App. Ct. 2005) (stating that admissibility is based on whether the expert is to testify to facts requiring scientific knowledge not within the common knowledge of the jury).

66. Rabia Belt, *When God Demands Blood: Unusual Minds and the Troubled Juridical Ties of Religion, Madness, and Culpability*, 69 U. MIAMI L. REV. 755, 793 (2015).

67. Parnham, *supra* note 36, at 853.

Similarly, Kimberlynn Bolanos appeared lucid when she went to a Dollar Store with her son and purchased knives and razor blades one day in May 2013.<sup>68</sup> She used these to stab her son and herself multiple times a day later.<sup>69</sup> The episodic nature of postpartum psychosis is not common knowledge and is exactly the type of information an expert should be allowed to explain to the judge and jury.

#### V. IMPLICATIONS FOR CRIMINAL TRIALS AND SENTENCING IN ILLINOIS

Two cases in Illinois are important to highlight why courts should re-examine their approach to cases in which mothers commit violent acts in the postpartum period.

First, the case of *People v. Hulitt* demonstrates the court's dismissal of postpartum illness as a legitimate consideration.<sup>70</sup> In this case, Hulitt stuffed a sock in her daughter's mouth and wrapped tape around her mouth and neck.<sup>71</sup> Her daughter suffocated to death and Hulitt admitted she caused her daughter's death.<sup>72</sup> Prior to trial, Hulitt disclosed her intention to call a psychologist as a witness who would testify that although she may not be legally insane, she did suffer from postpartum depression at the time.<sup>73</sup> Hulitt intended to use this testimony to support her argument for reasonable doubt rather than an insanity or GBMI defense.<sup>74</sup> However, the trial court concluded that "anyone with any sense could understand that she would be depressed" and psychological evidence was not necessary.<sup>75</sup> The court bolstered this statement by noting that the defendant's state of mind is a

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68. Le Baeu Lucchesi, *supra* note 39.

69. Le Baeu Lucchesi *supra* note 39.

70. *People v. Hulitt*, 838 N.E.2d 148, 151 (Ill. App. Ct. 2005).

71. *Id.* at 150.

72. *Id.*

73. *Id.* at 150-51.

74. *Id.* at 151.

75. *Id.*

question for the jury to determine and psychiatric evidence regarding intent or lack thereof should only be admitted regarding facts requiring scientific knowledge not within the common knowledge of the jury.<sup>76</sup> Therefore, the court further stated that any jury was more than capable of determining that the defendant was simply “depressed and/or overwhelmed” and “had trouble coping with three children.”<sup>77</sup> Through this reasoning, the court demonstrates a gross misunderstanding of postpartum mental illness and, as noted, highlights the need for expert testimony to explain the seriousness of postpartum mental illness. Further, as indicated, social and environmental factors can exacerbate postpartum mental illness.<sup>78</sup> Rather than allow expert testimony to explain these factors to better understand Hulitt’s possible mental state at the time her crime was committed, her mental state was instead invalidated and disregarded by the court. She was found guilty and sentenced to thirty years in prison.<sup>79</sup>

While the *Hulitt* case is the most explicit rejection of expert testimony in this context, in the case discussed in the introduction of this article, *People v. Gindorf*, the defendant was allowed to admit testimony from two experts who would speak to her psychotic state at the time she fed her two children crushed sleeping pills.<sup>80</sup> However, during her bench trial the trial court gave less weight to all the experts’ testimony and reached its conclusion based primarily on “the testimony of witnesses who saw the defendant before the incident, the writings of defendant, the essence of her statement to the police,

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76. *Id.* at 152.

77. *Id.* at 153

78. *See supra* note 40.

79. Hulitt, *supra* note 67, at 150; *see also Internet Inmate Status*, ILLINOIS DEPARTMENT OF CORRECTIONS (last visited Apr. 8, 2019),

[https://www.idoc.state.il.us/subsections/search/inms\\_print.asp?idoc=R75326](https://www.idoc.state.il.us/subsections/search/inms_print.asp?idoc=R75326), (reporting that Hulitt is still incarcerated and her projected discharge date is 2032).

80. Gindorf, *supra* note 1, at 773.



and defendant's troubled personal history.”<sup>81</sup> The court found these statements more credible because witnesses testified that the defendant “seemed more depressed, tired, and quiet than usual,” but nothing unusual stood out to them about her behavior.<sup>82</sup> Despite the court finding this testimony more compelling, as noted previously, studies show that postpartum psychosis is often episodic in nature.<sup>83</sup> Like the case in *Hulitt*, assumptions about postpartum mental illness as “common knowledge” disregard the complex nature of the condition. Gindorf was found GBMI and sentenced to natural life imprisonment.<sup>84</sup> However, more than twenty years later, in 2009, Governor Patrick Quinn commuted her sentence to forty-eight years and she was immediately eligible for parole.<sup>85</sup> While the Governor would not comment on his motivations for commuting her sentence, this was an important acknowledgement that postpartum psychosis can be a relevant factor to consider when women kill their children.<sup>86</sup>

## VI. POSTPARTUM MENTAL ILLNESS AS MITIGATING FACTOR

The most recent step forward in establishing postpartum psychosis as a factor in criminal cases was a law enacted in 2018 which included postpartum depression and psychosis as mitigating factors in post-conviction relief and

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81. *Id.* at 777

82. *Id.* at 778; *see also Id.* at 773 (stating that before giving birth to her second child, defendant had strong relationships with her neighbors such that she would eat with them or babysit their kids however she was also a survivor of domestic violence committed by her ex-husband).

83. *See* Belt, *supra* note 66.

84. *Id.* at 772.

85. Quinn Shortens Sentence of Woman Who Killed Kids, NBC CHICAGO (Jul. 14, 2009), <https://www.nbcchicago.com/news/local/Quinn-Shortens-Sentence-of-Woman-Who-Killed-Kids-050109.html>.

86. Monique Garcia, *Mom's Life Sentence is Cut*, CHICAGO TRIBUNE (May 2, 2009) <https://www.chicagotribune.com/news/ct-xpm-2009-05-02-0905010363-story.html??dssReturn=true>.

provided definitions of both conditions.<sup>87</sup> This is the first law of its kind in the United States, and though it has not yet been applied to a case involving postpartum psychosis, it has major implications.<sup>88</sup>

First, the law allows women who were convicted of a felony, but who did not have evidence of postpartum mental illness presented at their trial or sentencing, to apply for post-conviction sentence reduction.<sup>89</sup> While this law will be a resource for women going forward, it is unlikely that most who are currently incarcerated would be successful because it limits applications for relief to applications filed within six months after the conclusion of proceedings unless they can show the delay was not due to “culpable negligence.”<sup>90</sup> This presents a significant barrier for women who are currently incarcerated because they may not even know this law was enacted or may not have the resources to submit this application.

Nevertheless, perhaps the more significant development is the addition of these postpartum illnesses as mitigating factors and the inclusion of definitions for these conditions. As previously stated, the field of psychiatry has not classified postpartum psychosis as a distinct condition.<sup>91</sup> That is, for example, the DSM-IV links postpartum depression to brief psychotic disorders or conditions such as major depression, mania, or psychosis (e.g.,

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87. Petition in the Trial Court, 725 ILCS 5/122-1; see also *U.S. National Legislative Action*, POSTPARTUM SUPPORT INTERNATIONAL (last visited Apr. 9, 2019), <https://www.postpartum.net/professionals/legislation/>.

88. Katherine L. Wisner & Cara Angelotta, *Accounting for Postpartum Depression in Criminal Sentencing is the Right Move*, THE HILL (Feb. 6, 2018), <https://thehill.com/opinion/healthcare/372545-making-postpartum-depression-a-mitigating-factor-sentencing-crimes-is>; see also Postpartum Support International, *supra* note 92.

89. See Title of Statute, 725 ILCS 5/122-1(a)(3)(B)-(E) (stating the conditions for post-conviction mitigation); see also Wisner & Angelotta, *supra* note 93.

90. Petition in the Trial Court, 725 ILCS 5/122-1 (c) (“When a defendant has a sentence other than death, no proceedings under this Article shall be commenced more than 6 months after the conclusion of proceedings in the United States Supreme Court, unless the petitioner alleges facts showing that the delay was not due to his or her culpable negligence.”).

91. Shashi Rai, et al., *Postpartum Psychiatric Disorders: Early Diagnosis and Management*, 57 *Indian J Psychiatry* S216, S216 (2015).

major depression with postpartum onset).<sup>92</sup> Further limiting the characterization, this description only applies if onset occurred within four weeks postpartum.<sup>93</sup> As noted above, there is broad agreement that these symptoms can last significantly longer—as much as a year or more.<sup>94</sup>

In contrast, the new Illinois law defines the postpartum period as “up to [twelve] months after delivery,” and notes that features of postpartum psychosis can include “losing touch with reality, distorted thinking, delusions, auditory and visual hallucinations, paranoia, hyperactivity and rapid speech, or mania.”<sup>95</sup> This broader definition provides greater opportunities for relief and serve as an example for legislative efforts in the future both in Illinois and in other states. Moreover, if women are successful in gaining relief through this approach, it will demonstrate to courts that postpartum mental illness is a legitimate condition, beyond common knowledge, requiring expert testimony.

## VII. CONCLUSION

Courts in Illinois have historically been resistant to admitting expert testimony on psychiatric condition in cases where mothers kill their children. The new post-conviction mitigation statute is an important first step in giving women in this situation a chance to provide a fuller picture of their mental condition. However, there is still work to be done at the trial court level. Courts should recognize this newly enacted law is an acknowledgement that postpartum symptoms are a genuine factor in certain kinds of cases and that postpartum symptoms are outside the realm of common knowledge so that experts can inform fact finders in these cases. While these acts may be

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92. *Id.* at S217

93. *Id.*

94. *See* Tovino, *supra* note 29.

95. Petition in the Trial Court, 725 ILCS 5/122-1.

grizzly and tragic, criminal prosecution must be based on a full understanding of the facts and circumstances of the case at hand.



# Mental Health in Illinois Public Schools: The Current Framework, New Legislation and Challenges with its Practical Implication

*Elizabeth Heredia*

## I. AN INTRODUCTION TO THE MENTAL HEALTH CRISIS AMONGST ADOLESCENTS IN ILLINOIS

More than 300 million people around the world have been diagnosed with a mental illness.<sup>1</sup> Mental illness impacts many areas of an affected individual's life, including everyday life, social and family life, academic and workplace performance.<sup>2</sup> Mental illness affects more than just adults.<sup>3</sup> According to one study, roughly 20 percent of children between the ages of 13 and 18 have been diagnosed with a mental health condition in the United States.<sup>4</sup> Because many adults later diagnosed with mental illnesses displayed symptoms in childhood,<sup>5</sup> early treatment and prevention are crucial to managing these lifelong conditions.<sup>6</sup> A child's school experience may be

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1. See WORLD HEALTH ORGANIZATION (WHO), *Mental Disorders: Key Facts* (Apr. 9, 2018), [www.who.int/en/news-room/fact-sheets/detail/mental-disorders](http://www.who.int/en/news-room/fact-sheets/detail/mental-disorders) (defining mental disorders to include depression, bipolar disorder, schizophrenia, dementia, intellectual disabilities and developmental disorders) [hereinafter *WHO Key Facts*]; see also World Health Organization (WHO), *Mental Health In the Workplace Information Sheet* (Sept. 2017), [www.who.int/mental\\_health/in\\_the\\_workplace/en/](http://www.who.int/mental_health/in_the_workplace/en/) (writing that these statistics reflect global mental health diagnoses) [hereinafter *WHO Mental Health*].

2. NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI), *Mental Health Conditions: Recovery and Wellness* (2019), [www.nami.org/learn-more/mental-health-conditions](http://www.nami.org/learn-more/mental-health-conditions).

3. NAMI, *Mental Health Facts: Children & Teens* (2019), [www.nami.org/NAMI/media/NAMI-Media/Infographics/Children-MH-Facts-NAMI.pdf](http://www.nami.org/NAMI/media/NAMI-Media/Infographics/Children-MH-Facts-NAMI.pdf).

4. *Id.*

5. NAMI, *Teens & Young Adults*, [www.nami.org/find-support/teens-and-young-adults](http://www.nami.org/find-support/teens-and-young-adults) [hereinafter *NAMI: Teens & Young Adults*].

6. Jung-Ah Min, et al., *Mental Health Promotion and Illness Prevention: A Challenge for Psychiatrists*, 10 *PSYCHIATRY INVESTIGATION* 307, 307 (Dec. 16, 2013).

influenced by mental health issues because a child may face school discipline referrals, school avoidance, suspension, or may drop out of school altogether as a result of unaddressed mental health issues.<sup>7</sup> As education is one of the most formative and important experiences of one's life,<sup>8</sup> negative experiences in school have lasting impacts on a child's life.<sup>9</sup>

The State of Illinois ranks high amongst the States in terms of lower prevalence of mental illness and higher rates of access to care<sup>10</sup>, yet youth in Illinois still struggle with mental health issues.<sup>11</sup> According to the 2015 High School Risk Behavior Survey, 17 percent of adolescents in Illinois have seriously considered attempting suicide, and ten percent had actually attempted suicide within the last 12 months.<sup>12</sup> Other evidence shows that suicide is the third leading cause of death for individuals between the ages of 15 and 35 in Illinois.<sup>13</sup> Unsurprisingly, children who experience social and

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7. Child Mind Institute, *Mental Health Impacts in Schools* (2016), <https://childmind.org/report/2016-childrens-mental-health-report/mental-health-impacts-schools/>.

8. See Michael Greenstone & Adam Looney, *The Importance of Education: An Economics View*, EDUC. WEEK (Nov. 5, 2012), [www.edweek.org/ew/articles/2012/11/07/11greenstone\\_ep.h32.html](http://www.edweek.org/ew/articles/2012/11/07/11greenstone_ep.h32.html) (writing that education is significantly linked with many life, including salary, life expectancy, marital status, and more); see also Anthea Lipsett, *Early Schooling Matters Most for Children*, THE GUARDIAN (Nov. 27, 2008), [www.theguardian.com/education/2008/nov/27/primary-school-importance](http://www.theguardian.com/education/2008/nov/27/primary-school-importance) (writing that obtaining quality schools at an early age impacts children more than their gender or family background).

9. See *id.* (discussing that children who drop out of school are more likely to go to jail than children who stay in school).

10. See MICHELE HELLEBUYCK, ET AL., *THE STATE OF MENTAL HEALTH IN AMERICA 10-11* (2019) (reporting that Illinois is ranked sixth highest amongst states with lower prevalence of mental illness and higher rates of access to care for adults, and 15th amongst states with lower prevalence of mental illness and higher rates of access to care for youth).

11. See Vikki Ortiz, *Teens Are Anxious and Depressed, and Turning to the School Nurse for Help. But Most Illinois Schools Don't Have One*, CHICAGO TRIBUNE (Aug. 23, 2018), [www.chicagotribune.com/lifestyles/ct-life-school-nurses-mental-health-20180822-story.html](http://www.chicagotribune.com/lifestyles/ct-life-school-nurses-mental-health-20180822-story.html) (describing interviews with Illinois public school nurses where students often visit the nurse's office for help with mental illness).

12. Kristen Nuyen, *There is a Mental Health Crisis in Illinois: How Do We Fix It?*, CHI. TRIBUNE (Aug. 31, 2018), [www.chicagotribune.com/news/opinion/letters/ct-letters-mental-health-school-nurse-teens-20180831-story.html](http://www.chicagotribune.com/news/opinion/letters/ct-letters-mental-health-school-nurse-teens-20180831-story.html).

13. American Foundation for Suicide Prevention (AFSP), *Suicide Facts & Figures: Illinois 2018*, <https://afsp.org/about-suicide/state-fact-sheets/#Illinois>.

emotional issues have difficulties succeeding in school.<sup>14</sup> Together, this data shows that there are significant changes that must be made in order to ensure the quality of adolescent mental health in Illinois is improved. While Illinois has taken steps in the right direction to accomplish this by working to pass House Bill 0205 ( the “Bill”), Illinois must adjust the language of this Bill in order to properly address mental health issues in its schools.

This article aims to draw attention to the current mental health crisis facing the adolescent population in Illinois. This article will first assess the current framework and newly proposed legislation Illinois utilizes to combat mental health issues in its public school system, followed by an analysis of where this framework and new legislation succeed, and where improvement is needed. Finally, it will suggest solutions to improve upon the newly proposed legislation in order to ensure that it is sufficiently implemented by adjusting the language of the Bill to include a specific time frame by which the legislation must come into effect, specifics regarding who the legislation applies to and what exactly it will constitute, and how this legislation will be funded.

## II. MENTAL HEALTH IN ILLINOIS PUBLIC SCHOOLS: THE CURRENT FRAMEWORK AND NEW LEGISLATION

In 2003, Illinois passed the Children’s Mental Health Plan<sup>15</sup> (the Plan) in order to repair the fragmented children’s mental health system in Illinois.<sup>16</sup> The Children’s Mental Health Plan required the State of Illinois to: “develop a Children’s Mental Health Plan containing short-term and long-term

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14. ILL. CHILD. MENTAL HEALTH PARTNERSHIP (ICMHP), ADDRESSING UNMET MENTAL HEALTH NEEDS OF SCHOOL AGE CHILDREN: GUIDELINES FOR SCHOOL-COMMUNITY PARTNERSHIPS 4 [hereinafter *ICMHP Addressing Unmet Mental Health Needs*].

15. Children’s Mental Health Act of 2003, 405 ILCS 49/5 (2007).

16. Christina LePage, *PROTECT: Collaboration in Action – Improving Children’s Mental Health in Illinois*, Nat’l Ass’n of Soc. Workers: Illinois Chapter (Apr. 25, 2016), <http://naswil.org/news/chapter-news/featured/protect-collaboration-in-action-improving-childrens-mental-health-in-illinois/>.



recommendations to provide comprehensive, coordinated mental health prevention, early intervention and treatment services for children from birth through age 18.”<sup>17</sup> Thus, the Plan would focus on the prevention, early intervention and treatment, of mental health issues in children.<sup>18</sup>

The statute indicates a non-exhaustive list of ways to accomplish these goals, including creating coordinated provider services, making protocols for children screening and assessment, budgeting for children’s mental health prevention, building a workforce that is prepared to provide mental health services for children, and more.<sup>19</sup> Additionally, the Plan includes “guidelines for incorporating social and emotional development into school learning standards and educational programs.”<sup>20</sup> Each part of the statute is essentially aimed to reform the Illinois mental health system for children in order to address issues with the children’s mental health system.<sup>21</sup> While Illinois has taken steps in the right direction through implementing the Plan and similar legislation, Illinois must continue to make improvements in order to address the mental health crisis in its schools.

After the legislation was passed, the Illinois Children’s Mental Health Partnership (ICMHP) was formed in order to achieve the goals of state child mental health reform.<sup>22</sup> The ICMHP is a collaboration of agencies, policymakers, individuals, providers and advocates whose focus is to identify needs and gaps in the current system, and recommend solutions to improve children’s mental health in Illinois.<sup>23</sup> The ICMHP is tasked with submitting an annual report to the Governor in order to provide updates on the

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17. Children’s Mental Health Act of 2003, 405 ILCS 49/5 (2007).

18. LePage, *supra* note 16.

19. Children’s Mental Health Act of 2003, 405 ILCS 49/5 (2007).

20. Children’s Mental Health Act of 2003, 405 ILCS 49/5 (2007).

21. ICMHP *Addressing Unmet Mental Health Needs*, *supra* note 14, at 3; LePage, *supra* note 16.

22. ICMHP *Addressing Unmet Mental Health Needs*, *supra* note 14, at 3.

23. Illinois Children’s Mental Health Partnership (ICMHP), *Who We Are*, <http://icmhp.org/about-icmhp/who-we-are/> [hereinafter ICMHP *Who We Are*].

partnership's progress on plan implementation, as well as recommendations and revisions for the future of the plan.<sup>24</sup>

The ICMHP has worked to implement the goals of the Plan by creating a number of programs and campaigns.<sup>25</sup> ICMHP has helped reduce stigma and encouraged mental health discussion and awareness through the "Say It Out Loud" campaign, educated residents through its various publications, added home and community services to the Medicaid-funded service array, and increased the capacity of home visit programs to identify and address mental health concerns through early childhood mental health consultation.<sup>26</sup> Additionally, it has improved students' abilities to manage their emotions through the Social and Emotional Standards Program, reduced recidivism rates for youths discharged from correctional facilities through providing community service supports, and reduced the number of psychiatric hospitalizations in children through a statewide expansion of the Screening Assessment and Support Services (SASS) Program.<sup>27</sup> Most importantly, the ICMHP created the Illinois Social and Emotional Standards Program.<sup>28</sup> This program aims to provide students with the tools to manage their emotions and address mental health concerns<sup>29</sup> by providing benchmarks in the form of goals for social and emotional learning that students should meet depending on their level in school (i.e. elementary, late elementary, middle/junior high, early high school, and late high school).<sup>30</sup>

Recently, Illinois has followed the lead of other states,<sup>31</sup> and is working to

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24. Illinois Department of Human Services, *1722 Illinois Children's Mental Health Partnership (ICMHP)*, (Aug. 8, 2018), [www.dhs.state.il.us/page.aspx?item=110539](http://www.dhs.state.il.us/page.aspx?item=110539).

25. ICMHP *Who We Are*, *supra* note 23.

26. ICMHP *Who We Are*, *supra* note 23.

27. ICMHP *Who We Are*, *supra* note 23.

28. ICMHP *Who We Are*, *supra* note 23.

29. ICMHP *Who We Are*, *supra* note 23.

30. ILLINOIS STATE BOARD OF EDUCATION (ISBE), *Learning Standards: Social/Emotional Learning Standards*, [www.isbe.net/pages/social-emotional-learning-standards.aspx](http://www.isbe.net/pages/social-emotional-learning-standards.aspx) [hereinafter ISBE: *Learning Standards*].

31. See Franzi Ross, *New York and Virginia Pave the Way with Mental Health Education Laws*, MENTAL HEALTH FIRST AID (June 29, 2018),

pass legislation requiring mental health curriculum (the Curriculum) in Illinois public schools.<sup>32</sup> Illinois House Bill 0205 has been proposed to amend the Illinois Critical Health Problems and Comprehensive Education Act in order to accomplish this goal.<sup>33</sup> The amending language is as follows: “The instruction on mental health and illness must evaluate the multiple dimensions of health by reviewing the relationship between physical and mental health so as to enhance student understanding, attitudes, and behaviors that promote health, well-being, and human dignity.”<sup>34</sup> Thus, the Bill lays out the requirement for the instruction of mental health curriculum in Illinois public schools, which the original statute did not include.<sup>35</sup> The Bill has received bipartisan support, and was unanimously passed by a House committee in February 2019.<sup>36</sup> While Illinois has taken steps in the right direction by working to pass the Bill, Illinois must adjust the language of this Bill in order to properly address mental health issues in its schools.

### III. WHERE THE CURRENT FRAMEWORK AND NEW LEGISLATION SUCCEED AND WHERE THEY FALL SHORT

Arguably, each of the programs implemented as a result of the Plan have improved children’s mental health in Illinois, as evidenced by Illinois’ high

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[www.mentalhealthfirstaid.org/external/2018/06/new-york-virginia-pave-way-with-mental-health-education-laws/](http://www.mentalhealthfirstaid.org/external/2018/06/new-york-virginia-pave-way-with-mental-health-education-laws/) (reporting that in June 2018, New York and Virginia became the first states to require mental health education in its public schools).

32. Benjamin Yount, *Plan to Require Mental Health Classes in Illinois Schools Clears First Statehouse Hurdle*, Ill. News Network (Feb. 26, 2019), [www.ilnews.org/news/schools/plan-to-require-mental-health-classes-in-illinois-schools-clears/article\\_c48a0c5c-39c4-11e9-b553-7bb4a33935f8.html](http://www.ilnews.org/news/schools/plan-to-require-mental-health-classes-in-illinois-schools-clears/article_c48a0c5c-39c4-11e9-b553-7bb4a33935f8.html).

33. Critical Health Problems and Comprehensive Health Education Program, 105 ILCS 110/3 (2015).

34. H.B. 0205, 101st Leg., 2d Spec. Sess. (Ill. 2019).

35. Critical Health Problems and Comprehensive Health Education Program, 105 ILCS 110/3 (2015).

36. Yount, *supra* note 32.

ranking amongst states with a lower prevalence of mental illness and a higher rate of access to care in the youth population.<sup>37</sup> However, the fact remains that children in Illinois still face mental health issues, leading to the current youth mental health crisis in the State.<sup>38</sup>

Nearly one fourth of adolescents in Illinois reported signs of depression for two or more weeks in a row severe enough to keep them from enjoying regular activities.<sup>39</sup> This occurs more frequently in Chicago, Illinois, where one third of students reported the same signs.<sup>40</sup> In Illinois, 20 percent of ninth graders will not graduate from high school, which correlates with the percentage of students with serious emotional challenges or those in special education.<sup>41</sup> In 2008, over 1,000 students were expelled and 240,000 students were suspended in Illinois schools, with approximately 2,000 students transferred to alternative programs, many of which were likely due to untreated mental health issues.<sup>42</sup> Illinois school nurses have also expressed concern over the growing number of students with mental illnesses, and do not have the resources to adequately treat them due to budget constraints and understaffing.<sup>43</sup> These statistics make it evident that the current system is failing Illinois adolescents.

Illinois has taken steps to ameliorate the mental health crisis by working to pass legislation which would mandate the Curriculum in its public schools.<sup>44</sup> While mandating this Curriculum is a step in the right direction to

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37. See HELLEBUYCK, ET AL., *supra* note 10, at 11 (ranking Illinois 15 out of 50 states and the District of Columbia).

38. HELLEBUYCK, ET AL., *supra* note 10, at 11.

39. ICMHP *Addressing Unmet Mental Health Needs*, *supra* note 14.

40. ICMHP *Addressing Unmet Mental Health Needs*, *supra* note 14.

41. ICMHP *Addressing Unmet Mental Health Needs*, *supra* note 14, at 4.

42. ICMHP *Addressing Unmet Mental Health Needs*, *supra* note 14.

43. See Ortiz, *supra* note 11 (writing that the 700 Illinois school nurses working at 3,796 Illinois public schools have become inundated with students with varying mental health needs, putting pressure on school nurses to learn new information about how to treat adolescents with mental illnesses, including children's mental health histories, medication side effects and complications).

44. Yount *supra* note 32.

solve the current mental health crisis, the vague language of House Bill 0205 leaves open the possibility of significant challenges in its implication, and therefore the language of the Bill must be adjusted in order to properly address mental health issues in schools. The Bill reads: “The instruction on mental health and illness must evaluate the multiple dimensions of health by reviewing the relationship between physical and mental health so as to enhance student understanding, attitudes, and behaviors that promote health, well-being, and human dignity.”<sup>45</sup> The ambiguous language does not include the specific ways this will be carried out,<sup>46</sup> thus leaving it vulnerable for attack or implementation.

This language reflects similar legislation passed in New York which required mental health education at the elementary, middle, and high school levels.<sup>47</sup> The New York law does not describe the specific type of curriculum that must take place, but rather that health education in the state “must recognize the multiple dimensions of health and include the relationships of physical and mental health.”<sup>48</sup> In Virginia, state senator Creigh Deeds sponsored a similar bill mandating mental health curriculum requirements for ninth and tenth grade high school students.<sup>49</sup> Senator Deeds explained that the details of the curriculum will be set forth by the Virginia Board of Education and are quite broad.<sup>50</sup>

In Illinois, the broad language of the Bill 0205 will create challenges with its implication. First, the Bill does not provide a specific time frame in which

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45. H.B. 0205, 101st Leg., 2d Spec. Sess. (Ill. 2019).

46. H.B. 0205, 101st Leg., 2d Spec. Sess. (Ill. 2019).

47. Ellie Kaufman, *New York, Virginia Become First to Require Mental Health Education in Schools*, CNN (July 2, 2018), [www.cnn.com/2018/07/02/health/mental-health-schools-bn/index.html](http://www.cnn.com/2018/07/02/health/mental-health-schools-bn/index.html).

48. *Id.*

49. *All Things Considered: New Virginia Law Mandates Mental Health Education in Public Schools*, NPR (July 5, 2018), [www.npr.org/2018/07/05/626300290/new-virginia-law-mandates-mental-health-education-in-public-schools](http://www.npr.org/2018/07/05/626300290/new-virginia-law-mandates-mental-health-education-in-public-schools).

50. *Id.*

this new Curriculum will be mandated.<sup>51</sup> Leaving out important information about time frame implementation may cause delays in bringing this Curriculum requirement to fruition. Second, the Bill does not lay out any specific Curriculum requirements, nor indicate which students will be required to participate in the mental health curriculum.<sup>52</sup> Failing to provide these details may cause confusion amongst school districts attempting to interpret dense statutory language. Third, and likely most significantly, the Bill does not provide for any additional funding, nor indicate how funding for these programs is to take place.<sup>53</sup> Illinois has historically struggled to fund its education system,<sup>54</sup> and not providing a source of funding for new curriculum may cause issues in implementing curriculum requirements. The the lack of specificities in House Bill 0205 will likely lead to many challenges, which only highlights the importance of amending the language of the Bill.

#### IV. PROPOSED SOLUTIONS

In order to improve upon the existing framework and ensure that House Bill 0205 is implemented without challenges, the State of Illinois must adjust the language of the Bill to include precise provisions detailing the process by which it will be implemented. First, lawmakers should revise the language of the Bill to include a specific time period for its implementation. The Bill should include a two-year implementation period. This two year period reflects the fact that while it is pertinent that these changes happen as soon as possible in order to address the current crisis,<sup>55</sup> changing curriculum in

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51. H.B. 0205, 101st Leg., 2d Spec. Sess. (Ill. 2019).

52. H.B. 0205, 101st Leg., 2d Spec. Sess. (Ill. 2019).

53. H.B. 0205, 101st Leg., 2d Spec. Sess. (Ill. 2019).

54. See Rachel Otwell, *Illinois Education Funding Fixes Still Top Priority*, NPR ILL. (Dec. 4, 2018), [www.nprillinois.org/post/illinois-education-funding-fixes-still-top-priority#stream/0](http://www.nprillinois.org/post/illinois-education-funding-fixes-still-top-priority#stream/0) (writing that the two-year state budget impasse negatively impacted the education system).

55. Ortiz, *supra* note 11.

schools presents many challenges.<sup>56</sup> One of the most pressing challenges is that many in schools are simply resistant to curriculum change.<sup>57</sup> Particularly, teachers may see changes to their curriculum as a risk to their autonomy, making them especially resistant to curriculum change.<sup>58</sup> Some professionals suggest that the most effective strategies to modernize school curricula include small, gradual changes to curriculum with ample opportunity to review and change curriculum.<sup>59</sup> Thus, a two-year time frame is adequate to ensure this requirement is implemented relatively soon, with enough time to allow for instructors, students and families to adjust.<sup>60</sup>

Second, more details about how the curriculum will be implemented must be outlined in the Bill in order for the Bill to properly address the mental health crisis in Illinois.<sup>61</sup> Under this solution, the Bill should set forth which groups of students must partake in this Curriculum. Research has shown that many adults later diagnosed with mental illnesses exhibited symptoms in childhood.<sup>62</sup> Thus, early treatment and prevention are necessary to manage these lifelong conditions.<sup>63</sup> In order to ensure that the Curriculum encourages early intervention, this requirement should apply to children beginning in kindergarten, extending through their senior years of high school, mirroring the mental health curriculum requirement in New York.<sup>64</sup> By providing mental health education early, children will be more likely to recognize the

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56. Olaf Jorgenson, *Why Curriculum Change is Difficult and Necessary*, Nat'l Ass'n of Indep. Sch. (2006), [www.nais.org/magazine/independent-school/summer-2006/why-curriculum-change-is-difficult-and-necessary/](http://www.nais.org/magazine/independent-school/summer-2006/why-curriculum-change-is-difficult-and-necessary/).

57. *Id.*

58. *Id.*

59. *Id.*

60. *Id.*

61. Ortiz, *supra* note 11.

62. NAMI: *Teens & Young Adults*, *supra* note 5.

63. Min, et al., *supra* note 6.

64. Kaufman, *supra* note 47.

signs of mental illness,<sup>65</sup> and thus have more positive life outcomes.<sup>66</sup>

In addition to explicitly stating which groups of students this Curriculum applies to, the Bill should set forth what the curriculum will look like at each grade level. While changing and mandating the curriculum may be met with initial pushback,<sup>67</sup> setting clear standards will help achieve the goals of the Bill. As the Plan has already provided explicit learning benchmarks through its Social and Emotional Standards program, the Illinois Department of Education should develop strict curriculum requirements that coincide with the Social and Emotional Standards requirements in order to ensure that the program is effective.<sup>68</sup> For example, in the Social and Emotional Standards program, the exact goals and learning standards are set forth for each grade level, beginning with early elementary and ending with late high school.<sup>69</sup> Similar to that program, the Bill should include learning goals for each age group, specifically stating what each group is to learn each year.

The final and most challenging solution is to adjust the language of the Bill to set forth how the Curriculum will be funded. As Illinois has historically faced significant budget issues,<sup>70</sup> specifically in the Department

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65. See Nancy Barile, *The Importance of Mental Health Awareness in Schools*, WESTERN GOVERNORS U., [www.wgu.edu/heyteach/article/importance-mental-health-awareness-schools1810.html](http://www.wgu.edu/heyteach/article/importance-mental-health-awareness-schools1810.html) (writing that some experts discuss that early intervention and education of mental health could result in more positive outcomes for mentally ill students) (last visited Apr. 3, 2019).

66. Mental Health America (MHA), *Prevention and Early Intervention in Mental Health*, [www.mentalhealthamerica.net/issues/prevention-and-early-intervention-mental-health](http://www.mentalhealthamerica.net/issues/prevention-and-early-intervention-mental-health) (last visited Apr. 3, 2019).

67. Jorgenson *supra* note 56; See also Stephanie Banchemo, School-Standards Pushback, WALL STREET J (May 8, 2012), [www.wsj.com/articles/SB10001424052702303630404577390431072241906](http://www.wsj.com/articles/SB10001424052702303630404577390431072241906) (writing that the adoption of Common Core national math and reading standards had been under attack by conservative groups).

68. ISBE: *Learning Standards*, *supra* note 30.

69. ISBE: *Learning Standards*, *supra* note 30.

70. Ted Dabrowski & John Klingner, *The History of Illinois' Fiscal Crisis*, ILL. POL'Y, [www.illinoispolicy.org/reports/the-history-of-illinois-fiscal-crisis/](http://www.illinoispolicy.org/reports/the-history-of-illinois-fiscal-crisis/) (Last visited Apr. 3, 2019).



of Education,<sup>71</sup> not providing details of any funding presents significant challenges.<sup>72</sup> Thus, Illinois should work to receive federal grant money to fund this curriculum in order to ensure this is not an issue, although this may be difficult to achieve. Illinois legislators must adjust the language of House Bill 0205 to include these specific provisions in order to properly address the adolescent mental health crisis in Illinois and ensure its passage without challenges.

#### V. CONCLUSION

In 2003, the State of Illinois was one of the first states to pass legislation aimed exclusively at improving children's mental health.<sup>73</sup> In the years following, Illinois created a series of partnerships and initiatives implementing the objectives of the plan.<sup>74</sup> These initiatives may have contributed to Illinois' fairly high mental health quality ranking, however there are gaps in the system, and improvement is necessary.<sup>75</sup> While mandating mental health curriculum is a step in the right direction, the vague language of House Bill 0205 leaves open the possibility of significant challenges in its implication, and the language of the Bill must be adjusted in order to ensure the mental health crisis is addressed.

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71. See Matt Masterson, *Education Funding Shows Dismal Past for Illinois, Hope for Future*, WTTW (Feb. 27, 2018), <https://news.wttw.com/2018/02/27/education-funding-report-shows-dismal-past-illinois-hope-future> (reporting that Illinois has historically ranked lowest amongst states for having the largest disparities in student funding depending on student wealth).

72. Otwell, *supra* note 54.

73. ICMHP *Addressing Unmet Mental Health Needs*, *supra* note 14, at 3.

74. ICMHP *Addressing Unmet Mental Health Needs*, *supra* note 14, at 3.

75. Ortiz, *supra* note 11.

# The Mental Health Parity Act Cannot Act Alone

*Rachel Kemel*

## I. INTRODUCTION: STATES MUST LOOK TO ILLINOIS FOR MENTAL HEALTH LEGISLATION

The ten year anniversary of the Mental Health Parity Addiction and Equity Act (the Parity Act)<sup>1</sup> brought criticism from experts, arguing states had failed to properly implement the law.<sup>2</sup> The Parity Act was created to provide mental health services, but experts argued many states provide lackluster services for mental health.<sup>3</sup> Mental health care is still an ignored aspect of the healthcare industry.<sup>4</sup> Many Americans do not receive proper medical

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1. The Parity Act was enacted by Congress to prevent group health plans and health insurance issuers that provide mental health and substance use disorder benefits from imposing limitations compared to medical-surgical coverage. *The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Jan. 29, 2010), <https://www.cms.gov/newsroom/fact-sheets/mental-health-parity-and-addiction-equity-act-2008-mhpaea> [hereinafter MHPAEA].

2. Steven Johnson, *Mental Health Parity Remains a Challenge 10 Years After Landmark Law*, MOD. HEALTHCARE (Oct. 5, 2018), <https://www.modernhealthcare.com/article/20181005/NEWS/181009925>. States are improperly enforcing the Parity Act through, first, their reliance on traditional tools to enforce parity for state-regulated commercial plans—this is reactive and is often not sufficient for parity enforcement. Second, states are not implementing severe penalties for violations to compel compliance. Third, states use consumer complaints as the main enforcement tool but, this is often not effective because consumers do not usually know about the Parity Act, the rights it provides, or how to exercise their rights. This is true even if the state has a more straightforward complaint-filing system. Lindsey Vuolo, et al., *Evaluating The Promise And Potential Of The Parity Act On Its Tenth Anniversary*, HEALTH AFF. BLOG (October 18, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20181009.356245/full/>.

3. Johnson, *supra* note 2.

4. *The State of Mental Health in America: Mental Health Facts, Stats, and Data*, MENTAL HEALTH AM., <http://www.mentalhealthamerica.net/issues/state-mental-health-america> (last visited Mar. 20, 2019).

health care, and fewer receive proper treatment for mental illness, with only 43 percent of Americans diagnosed with mental illnesses obtaining treatment.<sup>5</sup> By fulfilling the Parity Act's purpose, states can ensure that mental health is as much a priority in American healthcare as physical health.

States must take initiative to improve mental health laws, because only implementing the federal law has proven to not be enough.<sup>6</sup> The next decade of the Parity Act presents an opportunity for states to progress through the development of legislation requiring analysis and reporting of mental health, the ability for consumers to file mental health complaints, and the provision of mental health education. These potential improvements will provide states the ability to meet the fundamental goal of the Parity Act.<sup>7</sup> States cannot merely satisfy the bare minimum of the Parity Act if they truly wish to see an improvement in mental health. This article will first look to the Parity Act itself and why it was created, then why the Parity Act does not work on its own. It will then look at the enforcement tools states must adopt to create effective mental health programs, and how Illinois created legislation to properly develop mental health programs. In order to enforce the Parity Act's purpose, and not just the letter of the Act, states must implement new parity laws and programs to properly address mental health.

## II. THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Congress passed the Mental Health Parity and Addiction Equity Act (the Parity Act), which took effect in January 2010.<sup>8</sup> The Parity Act was created to fill in the gaps left behind by the original Mental Health Parity Act.<sup>9</sup> The

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5. Cheryl Weinstock, *Gaps Remain in U.S. State Policies on Suicide Prevention Training*, REUTERS (May 9, 2018), <https://www.reuters.com/article/us-health-suicide-prevention/gaps-remain-in-us-state-policies-on-suicide-prevention-training-idUSKBN1IA2VU>.

6. Johnson, *supra* note 2.

7. *See* MHPAEA, *supra* note 1.

8. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 1.

9. Until 1996, insurance companies were not required to cover mental health care. This meant that access to treatment for mental health was incredibly limited. On September 26,

goal of the original Mental Health Parity Act was to prevent health insurance companies and their group health plans from excluding mental health or substance abuse disorder benefits.<sup>10</sup> However, insurance companies immediately tried to evade the requirements of the law.<sup>11</sup> Thus, Congress enacted the Parity Act to combat barriers to mental health services.<sup>12</sup>

The Parity Act turned ten in 2018.<sup>13</sup> In honor of this milestone, ParityTrack evaluated the states' enforcement of the Parity Act.<sup>14</sup> The evaluation revealed there had been improvement since the Act's implementation in mental health care access nationwide.<sup>15</sup> However, state enforcement of the Parity Act was found to be subpar.<sup>16</sup> ParityTrack conducted a survey about the implementation of the Parity Act and how

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1996, Congress passed the Mental Health Parity Act (MHPA). The MHPA required annual or lifetime dollar limits on mental health benefits to be no lower than any such dollar limits for medical and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan. Colleen Barry, et al., *A Political History of Federal Mental Health and Addiction Insurance Parity*, 88 MILBANK Q. 404 (2010).

10. Mental Health Parity Act, 29 U.S.C. § 1185a (2007) (detailing what is also known as the Paul Wellstone & Pete Domenici Mental Health Parity & Addiction Equity Act of 2008); Sarah Goodell, *Health Policy Brief of Mental Health Parity*, HEALTH AFF. (Apr. 3, 2014), <https://www.healthaffairs.org/doi/10.1377/hpb20140403.871424/full/>.

11. *See How Does the New Mental Health Parity Law Affect My Insurance Coverage?*, AM. PSYCHOL. ASS'N, [https://cdn.ymaws.com/www.nyspa.org/resource/resmgr/Advocacy/APA\\_ParityLaw\\_consumers.pdf](https://cdn.ymaws.com/www.nyspa.org/resource/resmgr/Advocacy/APA_ParityLaw_consumers.pdf) (last visited Mar. 20, 2019) (explaining that prior to the Parity Act, insurance companies would raise deductibles, shorten the day and visit limits, and increase out-of-pocket maximums).

12. Goodell, *supra* note 10.

13. *See* MHPAEA, *supra* note 1.

14. ParityTrack was created in 2014 to ensure that mental health resources are accessible through state and federal laws. *Our Mission*, PARITYTRACK, <https://www.paritytrack.org/about/mission-statement/> (last visited Apr. 30, 2019); *The Mental Health Parity and Addiction Equity Act 10th Anniversary*, PARITYTRACK [https://www.paritytrack.org/mhpaea-10thanniversary/?utm\\_source=tkf&utm\\_medium=offline&utm\\_campaign=mhpaea10&utm\\_content=anniversary](https://www.paritytrack.org/mhpaea-10thanniversary/?utm_source=tkf&utm_medium=offline&utm_campaign=mhpaea10&utm_content=anniversary) (last visited Mar. 28, 2019).

15. Robin Gelburd, *The Mental Health Parity Act: 10 Years Later*, AM. J. MANAGED CARE (Nov. 22, 2018), <https://www.ajmc.com/contributor/robin-gelburd-jd/2018/11/the-mental-health-parity-act-10-years-later>.

16. Johnson, *supra* note 2.

mental health programs were being enforced.<sup>17</sup> Unfortunately, Illinois was the only state to have an A rating.<sup>18</sup> In fact, the next highest grade was a C, which only seven states received.<sup>19</sup> Forty-three states received a failing grade of F, which illustrates the majority of states' attitude towards mental health.<sup>20</sup> Poor implementation of the Parity Act means poor mental health programs, which leads to poor mental health.<sup>21</sup>

### III. THE PARITY ACT DOES NOT WORK ON ITS OWN

The Parity Act by itself cannot provide mental health coverage.<sup>22</sup> States need to take the initiative to ensure mental health care services are available and utilized. In a study for Health Affairs, five states were examined to determine common problems in enforcing the Parity Act.<sup>23</sup> The commonalities found were: lack of effective enforcement tools for the statutes; an ineffective mental health complaints process; lack of awareness about the Parity Act and the rights it affords; insufficient patient access to treatment, and lack of political will to strengthen enforcement.<sup>24</sup> The study shows that states struggled in the same areas with implementing the Parity

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17. Megan Douglas, et al., *Evaluating State Mental Health and Addiction Parity Statutes: A Technical Report*, THE KENNEDY FORUM (2018). The grades were assigned based on two phases: the first phase consisted of a panel of experts who considered and assigned value to the practical impact of specific legal provisions, which led to the creation of ten questions which were weighed equally for a total of ten points. In phase two, a list of relevant state statutes were compiled from numerous sources, and the state statutes were then evaluated based on the expert's ten questions. Each states' scores were compiled together for a maximum total of one hundred points. A state was assigned a grade from "A" to "F", with an A = 100-90, B = 89-80, and so on.

18. *Evaluating State Mental Health and Addiction Parity Statutes: State Report Card* for Illinois, PARITY TRACK, <https://www.paritytrack.org/mhpaea-10th-anniversary/> (select "Parity Reports", followed by the sub-category "State Reports", then follow "Statutory" to access the National Statutory Landscape, select Illinois) (last visited Mar. 20, 2019).

19. Douglas, et al., *supra* note 18, at 10.

20. Douglas, et al., *supra* note 18, at 10.

21. See Douglas, et al., *supra* note 18, at 10.

22. Johnson, *supra* note 2.

23. Vuolo, et al., *supra* note 2 (evaluating Illinois, Maryland, New Jersey, New York, and Ohio).

24. Vuolo, et al., *supra* note 2.

Act and to have sufficient mental health services, these commonalities must be addressed.<sup>25</sup> The Parity Act does not have specific mechanisms to assist states in combating these key issues, but if states create enforcement tools, they can have constant assurance that their mental health programs are working.<sup>26</sup>

In a study conducted for ParityTrack, it was once again found that states had the same reasons regarding improper implementation.<sup>27</sup> For example, regulators were unable to completely assess parity compliance through form review, and consumers did not understand how to access treatment nor know their rights.<sup>28</sup> The study found that consumers do not understand their mental health rights, thus they do not understand what resources are available nor what they are entitled to demand.<sup>29</sup> If more individuals were aware of the rights afforded to them by the Parity Act, mental health services could be more readily demanded.<sup>30</sup>

#### IV. ENFORCEMENT TOOLS

##### *A. Reporting of Mental Health Data*

The Parity Act does not provide all the necessary tools that states need to

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25. Vuolo, et al., *supra* note 2.

26. See MHPAEA, *supra* note 1.

27. Ellen Weber, et al., *Addiction Solutions Campaign Parity Tracking Project: Making Parity a Reality* (2018), [https://lac.org/wp-content/uploads/2017/06/ES\\_ParityTrackingReport\\_ASC.pdf](https://lac.org/wp-content/uploads/2017/06/ES_ParityTrackingReport_ASC.pdf) (evaluating plans in New York and Maryland).

28. *Id.*

29. *See id.*

30. The ParityTrack website includes a “Know Your Rights” tab to better inform the general public regarding what parity is and common violations regarding mental health parity.) See *What is Parity?*, PARITYTRACK, <https://www.paritytrack.org/know-your-rights/what-is-parity/> (select “Know Your Rights”, followed by the sub-category “What is Parity?”) (last visited Apr. 25, 2019); see *Common Violations*, PARITYTRACK, <https://www.paritytrack.org/know-your-rights/common-violations/> (select “Know Your Rights”, followed by the sub-category “Common Violations”) (last visited Apr. 25, 2019).

ensure that mental health services are available. States must create their own systems to ensure compliance. Through analyzing data and requiring reporting, states can confirm whether local governments are maintaining enforcement through new laws and the creation of new programs.<sup>31</sup>

In 2012, Massachusetts' legislature required state agencies to implement and enforce the federal parity law due to consumer advocacy.<sup>32</sup> The Massachusetts Division of Insurance and Office of Medicaid have the responsibility to issue regulations that administer parity enforcement.<sup>33</sup> These regulations must "lay out an annual compliance reporting and certification process for health plans and establish a complaint process through which health plan members and providers may report alleged parity violations to the agencies."<sup>34</sup> Through this, Massachusetts' legislature has provided a basis for mental health parity by providing their agencies with the proper tools to handle enforcement.

The Connecticut legislature enacted a law that required the Connecticut Insurance Department to have stronger parity enforcement in the wake of the Sandy Hook tragedy.<sup>35</sup> Since 2014, Connecticut has required every health insurance carrier that can issue individual or group policies to have an annual review of its practices and procedures.<sup>36</sup> The carriers must determine compliance with both state and federal health parity requirements, and compile their report into a survey which is submitted to the Connecticut Insurance Department.<sup>37</sup> While Connecticut has taken steps towards

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31. *See infra* statutes cited *supra* Part IV, Section A.

32. Goodman, *supra* note 35.

33. Goodman, *supra* note 35.

34. Goodman, *supra* note 35.

35. Laura Goodman, *Mental Health Parity: Advocacy Is Increasing State Enforcement*, COMMUNITY CATALYSTS & HEALTH L. ADVOCs. (June 2013), [https://www.communitycatalyst.org/doc-store/publications/mh-parity-state-enforcement\\_062013.pdf](https://www.communitycatalyst.org/doc-store/publications/mh-parity-state-enforcement_062013.pdf).

36. *Mental Health Parity Annual Compliance Survey Certifications*, ST. CONN. INS. DEP'T, <https://portal.ct.gov/CID/Consumer-Resources/Mental-Health-Parity-Annual-Compliance-Survey-Certifications> (last visited Mar. 20, 2019).

37. *Id.*

providing a stable foundation for mental health parity, a tragedy such as Sandy Hook should not be a motivator for states to become more active.

In May 2017, Colorado passed the Behavioral Health Care Ombudsperson Parity Reports,<sup>38</sup> requiring the commissioner of insurance to report on compliance and establish an office to assist residents in accessing behavioral health care.<sup>39</sup> In August 2017, Delaware passed the Supported Decision Making Act which sets annual reporting requirements for insurance carriers on their coverage for behavioral health and substance abuse disorder.<sup>40</sup> Similarly, New York passed the Mental Health And Substance Use Disorder Parity Report Act to ensure compliance of insurers and health plans with state and federal requirements for the provision of mental health and substance abuse disorder treatment and claims.<sup>41</sup>

Some states appear to be responding to the ParityTrack grading system and taking steps towards better enforcement. In January 2019, Tennessee passed legislation which will require the Tennessee Department of Health to issue a report, no later than January 31, 2020, regarding compliance with the Parity Act.<sup>42</sup> New Jersey is currently reviewing House Bill A-2301 which

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38. H.B. 18-1357, *supra* note 31 (detailing the Behavioral Health Care Ombudsperson Parity Reports).

39. The commissioner of insurance is the chief executive of the Division of Insurance, and is tasked with overseeing the regulation of the Colorado insurance industry. *Colorado Commissioner of Insurance*, BALLOTPEDIA, [https://ballotpedia.org/Colorado\\_Commissioner\\_of\\_Insurance](https://ballotpedia.org/Colorado_Commissioner_of_Insurance). (last visited April 5, 2019).

40. Supported Decision-Making Act, *supra* note 31; *see* S.B. 3694-C, 2017 Gen. Assemb., Reg. Sess. (Ny. 2017) (detailing the Mental Health and Substance Use Disorder Parity Report Act) [hereinafter Mental Health And Substance Use Disorder Parity Report Act].

41. *See* Mental Health And Substance Use Disorder Parity Report Act, *supra* note 40 (explaining that insurers and health plans are expected to show compliance through providing the superintendent a mental health parity report that includes, in part: rates of utilization review for mental health and substance use disorder claims as compared to medical and surgical claims, the number of prior or concurrent authorization requests for mental health services and for substance use disorder services and the number of denials for such requests, and more).

42. S.B. 2165, 110th Gen. Assemb., Reg. Sess. (Tn. 2018) [hereinafter TN Public Charter 1012].



would require insurance companies to file annual reports to state regulators detailing how they assess and ensure their mental health coverage is on par with how and what they pay for physical care.<sup>43</sup> New Jersey was one of the states that received an “F” grading during the 10-year anniversary review,<sup>44</sup> but appears to be attempting to improve their foundation to guarantee that their local governments are providing adequate mental health services.<sup>45</sup>

States must create an effective system for local governments to report their mental health data as a way to determine where mental health programs need the most improvement. Through this enforcement tool, states can ensure compliance with the purpose of the Parity Act by securing the availability and access of mental health services at all levels and creating a stable foundation for mental health care. But, providing the departments with mental health parity authority cannot be the only steps.

### *B. Ability to File Complaints Surrounding Mental Health*

Complaints need to be more accessible so states can learn about common consumer issues.<sup>46</sup> By allowing individuals to make complaints, states can have first-hand accounts of which services work and which must be improved.<sup>47</sup> A study done by Reader, for BMJ Quality & Safety, found rigorous investigations into patient complaints helped identify issues

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43. H.B. A-2031, Assemb. Comm. Substitute for Assemb., 218th Leg (Nj. 2018); Lilo Stainton, *New Jersey Comes Closer to Approving Mental-Health Parity Law*, N.J. SPOTLIGHT (Jan. 18, 2019), <https://www.njspotlight.com/stories/19/01/17/new-jersey-comes-closer-to-approving-mental-health-parity-law/> [hereinafter Parity in New Jersey].

44. Lilo H. Stainton, *New Jersey Gets Report Card ‘F’ For Lack Of Parity In Insurance Coverage Of Mental Health*, N.J. SPOTLIGHT (Oct. 5, 2018), <https://www.njspotlight.com/stories/18/10/04/nj-gets-report-card-f-for-lack-of-parity-in-insurance-coverage-of-mental-health/>.

45. H.B. A-2031, *supra* note 43.

46. Meredith Munn, *Consumer Complaints: Crucial Tool for Improving Health Care*, COMMUNITY CATALYST <https://www.communitycatalyst.org/resources/tools/body/Consumer-Complaints-Improving-Healthcare-FINAL.pdf>.

47. *Id.*

surrounding patient safety.<sup>48</sup> But to analyze the data, patient complaints must not only be offered, but also be standardized in how they are analyzed and interpreted.<sup>49</sup>

States can improve their complaint systems through legislation. In New York, a behavioral health ombudsman program was developed to improve their complaint system.<sup>50</sup> New York's attorney general has created a consumer healthcare hotline which allows consumers to file complaints about parity violations.<sup>51</sup> It allows citizens the space to air their grievances and provides the state a source directly from the consumer detailing the success (or failure) of their programs.<sup>52</sup> The federal government has also created avenues for individuals to file complaints specifically for mental health.<sup>53</sup> The National Alliance on Mental Illness provides resources to counsel individuals on how they should handle being denied coverage.<sup>54</sup> The Department of Health and Human Services has created a new federal website to assist individuals in filing complaints by directing them to the correct agency.<sup>55</sup> For general health complaints, consumers can file complaints with their state agencies, which can either be the Department/Division of Insurance or the Attorney General's Office.<sup>56</sup>

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48. Tom W. Reader, et al., *Patient Complaints in Healthcare Systems: A Systematic Review and Coding Taxonomy*, 23 *BMJ QUALITY & SAFETY* 678, 678 (2014).

49. *Id.*

50. N.Y. MENTAL HYG. §33.27 (Consol. 2018).

51. *Health Care Bureau*, N.Y. ST. ATT'Y GEN., <https://ag.ny.gov/bureau/health-care-bureau> (last visited Mar. 20, 2019).

52. *Id.*

53. *What To Do If You're Denied Care By Your Insurance*, NAT'L ALLIANCE ON MENTAL ILLNESS, <https://www.nami.org/Find-Support/Living-with-a-Mental-Health-Condition/Understanding-Health-Insurance/What-to-Do-If-You-re-Denied-Care-By-Your-Insurance> (last visited Mar. 20, 2019).

54. *Id.*

55. *Mental Health and Addiction Insurance Help*, U.S. DEP'T HEALTH & HUM. SERVS., <https://www.hhs.gov/programs/topic-sites/mental-health-parity/mental-health-and-addiction-insurance-help/index.html> (last visited Feb. 12, 2019).

56. *Consumer Complaints Toolkit: Health Insurance Resources for Health Advocates, Health Providers and Enrollment Assistors*, COMMUNITY CATALYST,

Allowing citizens to make complaints will help break down barriers to access.<sup>57</sup> For example, there are still avenues where insurance companies can deny individuals coverage by claiming a patient's mental illness treatment is no longer "medically necessary".<sup>58</sup> The Parity Act allows for an insurer to require the mental health service be deemed "medically necessary" and thus will deny the patient coverage unless this rigorous medical necessity standard is met.<sup>59</sup> By establishing systems that allow patient complaints to be more readily accessible, states will be able to properly identify and attack such issues. If more states adopt these practices, understanding of the current landscape of mental health treatment will improve, and disparities in care can be properly addressed.

### *C. Mental Health Education*

Mental illness fosters a stigma that prevents individuals from understanding their illness and seeking out care.<sup>60</sup> If the public is provided educational tools, states will enable citizens to better understand not only how to access resources to improve their mental health, but foster a conversation that will reduce the negative connotations surrounding mental illness.

Mental health training is a burgeoning area for all health professionals.<sup>61</sup>

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<https://www.communitycatalyst.org/resources/tools/consumer-complaints-toolkit> (last visited Mar. 20, 2019).

57. Munn, *supra* note 46.

58. Jenny Gold, *Advocates Say Mental Health 'Parity' Law Is Not Fulfilling Its Promise*, KAISER HEALTH NEWS (Aug. 3, 2015), <https://khn.org/news/advocates-say-mental-health-parity-law-is-not-fulfilling-its-promise/>.

59. *Id.*

60. Margarita Tartakovsky, *What Prevents People From Seeking Mental Health Treatment?*, PSYCH CENTRAL, <https://psychcentral.com/blog/what-prevents-people-from-seeking-mental-health-treatment/> (last updated July 8, 2018); *see Mental Health Information: Statistics*, NAT'L INST. MENTAL HEALTH, <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml> (last visited Mar. 20, 2019) (stating that in 2016, the National Institute of Mental Health found that around 18.3 percent of Americans have a mental illness, while 4.2 percent have a serious mental illness).

61. *See* Weinstock, *supra* note 5.

By properly training health care professionals in dealing with mental illness, the healthcare field will become more open and accepting towards treating mental health as a legitimate health condition like physical health.<sup>62</sup> Currently, ten states require mental health and behavioral health professionals to attend suicide prevention training,<sup>63</sup> but only three of these states include other types of health professionals in this training.<sup>64</sup> Indiana is alone in requiring that only emergency medical providers must have training.<sup>65</sup> And while training is available, seven states do not require the training, but merely encourage it.<sup>66</sup> More states need to require mental health training for their health care professionals to ensure mental health is considered as important as physical health. By allowing physical and mental health to be equals, states will help reduce the stigma surrounding mental health.

Education programming can also be placed in school systems to help provide resources early in people's lives. In July 2018, New York and Virginia became the first states to require mental health to be part of the school curriculum.<sup>67</sup> New York enacted legislation to assist in updating the health curriculum to include mental health for elementary, middle, and high schools.<sup>68</sup> Virginia's law requires mental health education to be included in the physical education and health curriculum for ninth and tenth graders.<sup>69</sup>

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62. Tartakovsky, *supra* note 60.

63. Weinstock, *supra* note 5 (the ten states include: California, Indiana, Kentucky, Nevada, New Hampshire, Pennsylvania, Tennessee, Utah, Washington and West Virginia).

64. Weinstock, *supra* note 5 (the three states include: Nevada, Washington and West Virginia).

65. Weinstock, *supra* note 5.

66. Weinstock, *supra* note 5 (the seven states requiring training include: Colorado, Hawaii, Illinois, Indiana, Louisiana, Michigan and Montana).

67. Ellie Kaufman, *New York, Virginia Become First to Require Mental Health Education in Schools*, CNN (July 2, 2018), <https://www.cnn.com/2018/07/02/health/mental-health-schools-bn/index.html>.

68. *Id.*

69. *Id.*

States must enact similar laws because it starts the mental health conversation early, thus reducing the stigma, which is key in mental health, since many feel they should not seek out care due to shame or embarrassment.<sup>70</sup>

While states have been creating educational programs for mental health,<sup>71</sup> the federal government has also taken a positive step forward regarding mental health services.<sup>72</sup> Congress re-introduced the Mental Health in Schools Act (MHSA) in 2017.<sup>73</sup> The MHSA would build on the current program, known as the Safe Schools/Healthy Students program, and work towards improving the relationship between local education and community programs, as well as provide funding in order to bring qualified mental health and substance abuse professionals to schools at no charge.<sup>74</sup> The MHSA would assist “communities to create comprehensive, evidence-based, age and culture appropriate, trauma-informed services that incorporate strategies of positive behavioral interventions and supports”.<sup>75</sup> If Congress creates a more comprehensive mental health education system, as it could with the MHSA,<sup>76</sup> individuals would better understand their own mental health. And with understanding, individuals will be better prepared to pursue care. The MHSA will help advance the Parity Act’s goals by providing a space for students to learn more about mental health in a safe environment.<sup>77</sup> By encouraging early learning, states can help reduce the mental health stigma.<sup>78</sup> If Congress is unsuccessful in passing the MHSA, states would benefit from adopting

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70. Tartakovsky, *supra* note 60.

71. See Weinstock, *supra* note 5; see Kaufman, *supra* note 67.

72. Mental Health In Schools Act, S. 1370/H.R. 2913 (2018); *Mental Health In Schools Act*, NAT’L COUNCIL FOR BEHAVIORAL HEALTH, <https://www.thenationalcouncil.org/wp-content/uploads/2018/04/Mental-Health-in-Schools-Act-FINAL.pdf> (last visited Mar. 20, 2019) [herein Mental Health In Schools Act].

73. Mental Health In Schools Act, *supra* note 72. The Mental Health in Schools Act was originally introduced in 2015, where both the Senate and House of Representatives referred it to health committees.

74. Mental Health In Schools Act, *supra* note 72.

75. Mental Health In Schools Act, *supra* note 72 at 1.

76. Mental Health In Schools Act, *supra* note 72.

77. Mental Health In Schools Act, *supra* note 72.

78. Taratkovsky, *supra* note 60; NAT’L INST. MENTAL HEALTH, *supra* note 60.

similar legislation to assist in their mental health programs because providing more mental health education will allow individuals to learn more about an important part of their health.

#### V. AN EXAMPLE OF MENTAL HEALTH DONE RIGHT: ILLINOIS

Illinois was the only state to get an A on the 10-year anniversary survey.<sup>79</sup> This result came as a shock to many – not only that Illinois did so well, but that other states had done poorly in comparison.<sup>80</sup> Illinois's success stems from going beyond simply requiring the bare minimum of the Parity Act.<sup>81</sup>

Illinois has continued to improve its mental health care, through not only implementation of the Parity Act, but also its own programs.<sup>82</sup> In May 2018, Illinois received approval from the federal government to utilize two billion dollars over five years to provide “more community-based and home-based care for mental illness, attacking the heroin and opioid epidemic, and moving mental health care away from emergency rooms, jails, and prisons.”<sup>83</sup> Illinois actively seeks out funding not only improve mental health care, but to address the rising opioid epidemic.

In July 2010, Illinois enacted the Mental Health Parity Taskforce,<sup>84</sup> and

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79. Douglas, et al., *supra* note 18, at 10.

80. Douglas, et al., *supra* note 18, at 10.

81. Mental Health Parity Taskforce, 215 Ill. Comp. Stat. 5/370c (2010); The Counties Code, 55 Ill. Comp. Stat. 5/5-1069.3 (2015); *Mental Health and Addiction Parity in Illinois*, KENNEDY FORUM, <http://thekennedyforumillinois.org/wp-content/uploads/2015/12/Summary-of-HB-1-Parity-Provisions.pdf> (last visited Mar. 20, 2019) [hereinafter Parity in Illinois].

82. See Derrick Blakley, *\$2 Billion To Be Used Toward Illinois Medicaid Funds For Mental Health Programs*, CBS CHICAGO (May 7, 2018), <https://chicago.cbslocal.com/2018/05/07/2-billion-to-be-used-toward-illinois-medicaid-funds-for-mental-health-programs/>.

83. *Id.*

84. Parity in Illinois, *supra* note 81 (noting that Illinois passed this law to set a certain minimum level of benefits that insurance companies must provide for mental health services).

the Pharmacy Practice Act in September 2015.<sup>85</sup> The Pharmacy Practice Act requires the Illinois Department of Insurance (DOI) to enforce the demands of state and federal parity laws.<sup>86</sup> It also developed a plan for a Consumer Education Campaign about mental health and addiction and required the DOI to issue a report to the General Assembly regarding the Campaign's success.<sup>87</sup> Additionally, the Pharmacy Practice Act created a Parity Education Fund for the DOI to provide financial assistance for the Campaign.<sup>88</sup> Illinois' Department of Public Health also created a location for citizens to file complaints regarding mental health community centers and accredited mental health centers.<sup>89</sup>

Additionally, Illinois established a system for local health plans to require analyses and submit reports. In August 2018, Illinois passed the Amendment to Bill 1707, which requires health plans to submit parity compliance analyses to the Illinois DOI and the Illinois Department of Healthcare and Family Services.<sup>90</sup> It also requires expanded access to substance abuse disorder treatment and for departments to perform market-conduct examinations and parity compliance audits and then report enforcement annually to the General Assembly.<sup>91</sup> Finally, it closed a loophole in Illinois law that allowed school health plans to discriminate against mental health and substance abuse disorder.<sup>92</sup> Illinois highlights the importance of not only creating new laws, but reviewing what exists and building on top of it.

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85. The Pharmacy Practice Act, 225 Ill. Comp. Stat. 85/19 (2017) [hereinafter the Pharmacy Practice Act].

86. Parity in Illinois, *supra* note 81.

87. Parity in Illinois, *supra* note 81.

88. Pharmacy Practice Act, *supra* note 85.

89. *File a Complaint*, ILL. DEP'T PUB. HEALTH, <http://www.dph.illinois.gov/topics-services/health-care-regulation/complaints> (last visited Feb. 12, 2019).

90. Amendment to Bill 1707, 2018 Ill. Legis. Serv. P.A. 100-1024 (S.B. 1707) (West).

91. *Id.*

92. *Big Win for Illinois Families: IL House Passes Strongest Mental Health Parity Law in the Nation*, KENNEDY F. ILL. (May 31, 2018) <http://thekennedyforumillinois.org/big-win-for-illinois-families-il-house-passes-strongest-mental-health-parity-law-in-the-nation/> (revising the previous law's loophole which allowed school district health plans to discriminate against mental health and addiction coverage).

In an effort to ensure mental health becomes a fundamental part of healthcare, Illinois has worked on expanding its basic benefits for insurance plans to help establish that mental health is vital as physical health.<sup>93</sup> Illinois passed the Access to Care and Treatment (ACT) Plan in August 2018, which expands mental health services, as well as combat the opioid crisis.<sup>94</sup> The ACT Plan marked Illinois as the first and only state in the US to get approval for a revised Essential Health Benefit (EHB)-benchmark.<sup>95</sup> Essentially, the EHB-benchmark plan is the “basic set of insurance benefits that most health plans sold in the individual and small group markets in Illinois must cover”.<sup>96</sup> By adopting an EHB-benchmark to include expanded mental health services, Illinois helps mental health become part of the standard practice for insurance.<sup>97</sup> Illinois is constantly working towards establishing mental health as a basic healthcare aspect, one that is on par with physical health.

Overall, Illinois has implemented multiple programs and statutes to assist its mental health care.<sup>98</sup> Illinois institute laws that fulfill the spirit of the Parity Act, not just the letter.<sup>99</sup> Though Illinois is not perfect in its administration of mental health services, its current system provides an

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93. See Blakley, *supra* note 82.

94. The Access to Care and Treatment Plan (2018), *see* Blakley, *supra* note 82.

95. Blakley, *supra* note 82.

96. Kevin Schwaller, *Illinois Becomes First State to Change Essential Health Benefit-Benchmark Plan*, CENT. ILL. PROUD (Aug. 27, 2018), <https://www.centralillinoisproud.com/news/local-news/illinois-becomes-first-state-to-change-essential-health-benefit-benchmark-plan/1399465999> (explaining that basic essential insurance benefits include: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care); Ctr. for Consumer Info. & Ins. Oversight, *Information on Essential Health Benefits (EHB) Benchmark Plans*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/ccio/resources/data-resources/ehb.html> (last visited Mar. 20, 2019).

97. See Blakley, *supra* note 82.

98. See Parity in Illinois, *supra* note 81.

99. See MHPAEA, *supra* note 1.



example for states to follow and sends an important message: providing mental health services is not an impossible task.<sup>100</sup>

## VI. CONCLUSION

Through proper enforcement of The Parity Act, states will take a crucial step needed to improve mental health programs. State laws must ensure enforcement through requirements of data collection and reporting through establishing departments which will collect data and determine the best courses of action for improvement. States also must ensure consumers have, and are aware of, a sufficient complaint system that is also easy to understand. This will allow states to figure out the areas of mental health care in need of the most improvement. Finally, by educating consumers, there will be awareness not only of how to approach mental illness, but what services are available. By passing laws like the MHSA, states will bring mental health into the forefront of consumers' minds and bring a better overall understanding to the care individuals need.<sup>101</sup> States can look to Illinois as an example of what is possible in the realm of mental health care.<sup>102</sup> Going forward, it is imperative that states do not merely implement the Parity Act as it was written, but remember the purpose of the Parity Act and ensure mental health care is available to all.

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100. Douglas, et al., *supra* note 18, at 10.

101. *See* The Mental Health In Schools Act, *supra* note 72.

102. *See* Parity in Illinois, *supra* note 81.