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Deinstitutionalizing the "New Asylums": Telepsychiatry in the United States Correctional System

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Introduction

As the number of inmates suffering from mental illnesses increases in the United States jail and prison systems, an overhaul of how mental health is handled within the correctional system is necessary to combat this public health crisis.[1] A disturbing number of state prisoners, federal prisoners, and jail inmates have mental health issues. These issues vary from mood and personality disorders to psychotic disorders like schizophrenia and delusional disorder.[2] Although some inmates spend months or years within the United States correctional system, they are often provided with little to no mental health treatment and discharged in the same condition that contributed to their incarceration.[3] This lack of mental health care while incarcerated leads to poor compliance with mental health recommendations when released and increases the chances of recidivism.[4] While some correctional facilities do provide mental health services, there are far more that do not have the capabilities to do so due to various barriers. These barriers include understaffing, declining budgets, insufficient facilities, improper screening tools, and shortages of mental health professionals like psychiatrists and psychologists.[5] Of the many barriers to adequate mental health treatment in correctional facilities, budgetary constraints, understaffing, and lack of providers are three of the most common.[6] These three barriers may be dealt with jointly by encouraging States to adopt telepsychiatry. Telepsychiatry could fill gaps by providing much needed mental health care at a reduced cost and redistributing correctional facility staff

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[1] *Mental Health Information*, NATIONAL INSTITUTE OF MEDICINE, https://www.nimh.nih.gov/health/statistics/mental-illness.shtml (last visited Spring 2021).
[2] *Id*.
[3] Ed Lyon, *Imprisoning America's Mentally Ill*, PRISON LEGAL NEWS, (Feb. 7,2019) https://www.prisonlegalnews.org/news/2019/feb/4/imprisoning-americas-mentally-ill/.
[4] Jo Sahlin, *The Prison Problem: Recidivism Rates and Mental Health*, GOOD THERAPY, (May 20, 2018) https://www.goodtherapy.org/blog/prison-problem-recidivism-rates-mental-health-0520187.
[5] Jennifer Gonzalez & Nadine Connell, *Mental health of prisoners: identifying barriers to mental health treatment and medication continuity*, AMERICAN JOURNAL OF PUBLIC HEALTH ONLINE, (Dec.14, 2014) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4232131/.
[6] *Id*.

inappropriately used for mental health treatment.[7] Providing telepsychiatry in jails and prisons, for more than just the severely and seriously ill population, can turn the U.S. correctional system from the "new asylum" that it has become to the rehabilitative system it was always supposed to be.

Part I of this essay takes a comprehensive look at the history of how incarcerated individuals with mental illness have been and are being treated in the U.S. correctional system. It reviews the high cost associated with the below-average standard of care currently being provided to inmates with mental illness. Also, it examines the increased recidivism rates and barriers to care associated with treating this population. **Part II** of this essay provides insight into why the current policies and practices at the state and federal level geared towards addressing the mental health crisis in the U.S. correctional system are not sufficient. **Part III** of this essay looks to telemedicine, specifically telepsychiatry, as a solution to this public health crisis. With the standardized use of telepsychiatry, recidivism rates could decrease along with the cost associated with caring for inmates with mental illness. Additionally, telepsychiatry could address persistent barriers to care access, such as budget constraints and lack of providers.

Part I: Background

A. Mental Health in the U.S.A.

Mental illnesses are common in the United States and worldwide. This crisis is not linked exclusively to the criminal justice system. Nearly one in five U.S. adults live with a mental illness

[7] Joel Barthelemy, Controlling Prison Healthcare Costs with Telemedicine, GLOBAL MED.COM, (March 31,2019) https://www.globalmed.com/controlling-prison-healthcare-costs-with-telemedicine/.

(51.5 million in 2019).[8] The current COVID-19 pandemic and the economic downturn associated with it are expected to increase the incidents of mental illness in the coming years.[9]

Mental illnesses include many different conditions that vary in severity, ranging from mild to moderate to severe.[10] Two broad categories can be used to describe these conditions: any mental illness (AMI) and serious mental illness (SMI).[11] AMI encompasses all recognized mental illnesses, is defined as a mental, behavioral, or emotional disorder, and can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment. [12] SMI, a smaller and more severe subset of AMI, is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.[13]

According to the National Institute of Mental Health, in 2019, there were an estimated 51.5 million adults aged 18 or older in the U.S. with AMI, which represented 20.6% of all U.S. adults.[14] Among the 51.5 million adults with AMI, 23 million (44.8%) received mental health services in the past year.[15] In 2019, an estimated 13.1 million adults aged 18 or older in the U.S. with SMI represented 5.2% of all U.S. adults.[16] Among the 13.1 million adults with SMI, 8.6 million (65.5%) received mental health treatment in the past year.[17]

B. U.S. Correctional Population and Mental Illness

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[8] *Mental Health Information*, NATIONAL INSTITUTE OF MEDICINE, https://www.nimh.nih.gov/health/statistics/mental-illness.shtml (last visited Spring 2021).
[9] Barnali Bhattacharjee & Acharya Tathagata. *The COVID-19 Pandemic and its Effect on Mental Health in USA - A Review with Some Coping Strategies.* THE PSYCHIATRIC QUARTERLY vol. 91,4 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7443176/.
[10] *Mental Health Information*, NATIONAL INSTITUTE OF MEDICINE, https://www.nimh.nih.gov/health/statistics/mental-illness.shtml, (last visited Spring 2021).
[11] *Id*.
[12] *Id*.
[13] *Id*.
[14] *Id*.
[15] *Id*.
[16] *Id*.
[17] *Id*.

Serious mental illness has become so prevalent in the U.S. correctional system that jails and prisons are now commonly called "the new asylums."[18] From the 1960s to the present, the U.S. incarceration rate more than tripled, and around 2.2 million people are currently incarcerated nationwide.[19] During that same time period, the population of institutionalized mental patients shrank by 90 percent to under 60,000.[20] The policy and practice of deinstitutionalization pushed individuals with mental illness from federally and state-funded hospitals and long-term facilities to government-funded jails and prisons. A 2014 study found that the Los Angeles County Jail, Chicago's Cook County Jail, and the New York's Riker's Island Jail complex each held more mentally ill inmates than any remaining psychiatric hospitals in the United States.[21]

A March 2015 study estimated that 56% of state prisoners, 45% of federal prisoners, and 64% of jail inmates have mental health diagnoses.[22] Inmates with mental illness usually remain in the correctional system longer than inmates without such diagnoses. One study found that in Florida's Orange County Jail, the average stay for all inmates is 26 days; however, for mentally ill inmates, it is 51 days.[23] In New York's Riker's Island, the average stay for all inmates is 42 days; however, it is 215 days for mentally ill inmates.[24] Mentally ill inmates are incarcerated longer than other prisoners because many find it more difficult to understand and follow jail and prison rules.[25] Jail inmates were twice as likely (19% versus 9%) to be charged with facility rule violations.[26] In

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[18] *Serious Mental Illness Prevalence in Jails and Prisons*, THE TREATMENT ADVOCACY CENTER, *https://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3695*,(last visited Spring 2021).
[19] Ed Lyon, *Imprisoning America's Mentally Ill*, PRISON LEGAL NEWS, (Feb. 7,2019) https://www.prisonlegalnews.org/news/2019/feb/4/imprisoning-americas-mentally-ill/.
[20] *Id*.
[21] *Serious Mental Illness Prevalence in Jails and Prisons*, THE TREATMENT ADVOCACY CENTER, *https://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3695*,(last visited Spring 2021).
[22] KiDeuk Kim et al., *The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System*, URBAN.ORG, (April 7, 2015), https://www.urban.org/research/publication/processing-and-treatment-mentally-ill-persons-criminal-justice-system.
[22] *Id*.
[23] *Serious Mental Illness Prevalence in Jails and Prisons*, THE TREATMENT ADVOCACY CENTER, *https://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3695*,(last visited Spring 2021).
[24] *Id*.
[25] *Id*.
[26] *Id*.

Washington State prisons, mentally ill inmates accounted for 41% of infractions even though they constituted only 19% of the prison population.[27]

C. Monetary Cost Associated with Mentally Ill Inmates

Inmates with mental illness cost more than other prisoners for a variety of reasons. According to the National Association of Counties, nationwide, jails spend 2 to 3 times more on inmates who require mental health care than on inmates who don't have such needs.[28] A 2007 study in Broward County, Florida, found that it cost $80 a day to house a regular inmate but $130 a day for an inmate with mental illness.[29] A 2003 survey of Texas Prisons found that the average prisoner costs the state approximately $22,000 a year; however, the cost for prisoners with mental illness ranged from $30,000 to $50,000 a year."[30] Additionally, the National Alliance on Mental Health discovered that holding mentally ill people inside jails is more expensive than treating them in the community. [31] In Detroit, housing a mentally ill person in jail costs roughly $31,000 a year; however, the same person receiving treatment in the community would cost approximately $10,000 a year. [32] In Michigan, where mental illness afflicts a quarter of the state's 41,000 prisoners, it costs $95,000 a year to house each one, compared to $35,000 for prisoners without mental health problems.[33] For the mentally ill who are not incarcerated, Michigan state spends just $6,000 each per year, on average.[34]

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[27] *Id*.
[28] Rachel Riley, *The Cost of Caring for Mentally Ill Inmates*, THE GAZETTE (August 26, 2019), https://gazette.com/life/health/the-cost-of-caring-for-mentally-ill-inmates/article_86b44a74-7352-11e9-9170-b79662bf61ec.html.
[29] *Serious Mental Illness Prevalence in Jails and Prisons,* THE TREATMENT ADVOCACY CENTER, *https://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3695*,(last visited Spring 2021).
[30] *Id*.
[31] Rachel Riley, *The Cost of Caring for Mentally Ill Inmates*, THE GAZETTE (August 26, 2019), https://gazette.com/life/health/the-cost-of-caring-for-mentally-ill-inmates/article_86b44a74-7352-11e9-9170-b79662bf61ec.html.
[32] *Id*.
[33] Ed Lyon, *Imprisoning America's Mentally Ill*, PRISON LEGAL NEWS, (Feb. 7,2019) https://www.prisonlegalnews.org/news/2019/feb/4/imprisoning-americas-mentally-ill/.
[34] *Id*.

The cost associated with mentally ill inmates does not rise exclusively because of this population's mental health treatment. As was previously mentioned, the longer jail and prison stays associated with this population causes an increase in the cost of their care.[35] Mentally ill prisoners have higher rates of misconduct and accidents in jails and prisons, thereby incurring higher indirect or collateral costs.[36] Rule violations and fights have economic costs for correctional facilities, including staff time spent on discipline, the need for increased correctional staffing, physical and pharmaceutical resources spent on subduing violent prisoners, and treatment associated with injuries incurred in fights.[37]

A cost that is rarely considered is the cost of negligence stemming from the poor treatment of individuals with mental illness in the correctional system. What often results when this negligence is discovered is taxpayer-funded multimillion-dollar payouts to the victims and their families.[38] In 2015, the family of Michael Marshall sued the City of Denver and was awarded $5 million as a result. Marshall was a 50-year-old man who died days after he choked on his vomit and lost consciousness while pinned to the floor by deputies during a mental breakdown at Denver's downtown jail.[39] A similar multi-million dollar payout was made in July of 2017 when California County reached a $5 million settlement with the family of Andrew Holland.[40] Holland was a schizophrenic inmate at the San Luis Obispo County jail who died of an embolism after being strapped in a restraint chair for 46 hours.[41]

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[35] *Serious Mental Illness Prevalence in Jails and Prisons*, THE TREATMENT ADVOCACY CENTER, *https://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3695*,(last visited Spring 2021).
[36] KiDeuk Kim et al., *The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System*, URBAN.ORG, (April 7, 2015), https://www.urban.org/research/publication/processing-and-treatment-mentally-ill-persons-criminal-justice-system.
[37] *Id*.
[38] Rachel Riley, *The Cost of Caring for Mentally Ill Inmates*, THE GAZETTE (August 26, 2019) https://gazette.com/life/health/the-cost-of-caring-for-mentally-ill-inmates/article_86b44a74-7352-11e9-9170-b79662bf61ec.html
[39] *Id*.
[40] *Id*.
[41] *Id*.

D. Increased Rates of Recidivism and Re-institutionalization

Incarceration has been shown to worsen mental health symptoms.[42] Most institutions do not have the resources to treat the significant number of incarcerated individuals who require mental health care. Reduced mental health can lead to recidivism, meaning a recurrence of criminal behavior.[43] Although little research has been done to directly quantify the cost of recidivism among prisoners with mental illness, prior research indicates that prisoners with mental health problems have higher recidivism rates than those without mental health problems, thereby resulting in higher societal costs.[44] A 2009 study of the Texas state prison system examined the likelihood of returning to prison during a six-year period among recently released inmates with major psychiatric disorders, including major depressive disorder, bipolar disorder, schizophrenia, and non-schizophrenic psychotic disorders.[45] The researchers found that formerly incarcerated persons suffering from any of these disorders were substantially more likely to be reincarcerated, especially inmates with bipolar disorder.[46] Inmates with any major untreated psychiatric disorder were found to be 2.4 times more likely to have four or more repeat incarcerations than inmates with no major psychiatric disorder, and this same number rose to 3.3 for inmates with bipolar disorder. [47]

A 2010 study focused on Utah State prisoners released from 1998 to 2002 with serious mental illness found similar results.[48] This study concluded that offenders with severe mental illness returned to prison an average of 358 days sooner than offenders without a diagnosed mental

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[42] Jo Sahlin, *The Prison Problem: Recidivism Rates and Mental Health*, GOOD THERAPY, (May 20, 2018) https://www.goodtherapy.org/blog/prison-problem-recidivism-rates-mental-health-0520187.
[43] *Id*.
[44] KiDeuk Kim et al., *The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System*, URBAN.ORG, (April 7, 2015), https://www.urban.org/research/publication/processing-and-treatment-mentally-ill-persons-criminal-justice-system.
[45] Jacques Baillargeon et al., *Psychiatric Disorders and Repeat Incarcerations: The Revolving Prison Door*, AMERICAN JOURNAL OF PSYCHIATRY, (January 1, 2009) https://www.researchgate.net/publication/23560254_Psychiatric_Disorders_and_Repeat_Incarcerations_The_Revolving_Prison_Door
[46] *Id*.
[47] *Id*.
[48] Kristin Cloyes et al., *Time to Prison Return for Offenders With Serious Mental Illness Released From Prison: A Survival Analysis*, SAGE JOURNALS, (January 4, 2010) https://journals.sagepub.com/doi/10.1177/0093854809354370

illness.[49] That is nearly one year sooner than their counterpart. Additionally, 77% of offenders with severe mental illness were reincarcerated within 36 months, compared with 62 percent of offenders without severe mental illness. [50]

E. Barriers to Mental Health Care in Correctional Facilities

The prevalence of mental health disorders among prisoners has consistently exceeded rates of such disorders in psychiatric facilities, which should make correctional facilities in the U.S. some of the largest providers of mental health services.[51] Despite this fact, correctional facilities are not meant to be treatment-oriented, and as a result, many barriers limit inmates' access to adequate mental health care.[52] The three most common barriers are the shortage of qualified mental health professionals, the understaffing of correctional staff at facilities, and the decrease of funds available to correctional facilities.[53]

i. Shortage of Qualified Mental Health Professionals

A qualified mental health professional (QMHP) is a person in the human services field who is trained and experienced in providing psychiatric or mental health services to individuals who have a mental illness.[54] QMHPs includes many disciplines, such as psychiatrists, psychologists, licensed social workers, and licensed mental health counselors, to name a few.[55] In general, QMHPs in correctional institutions deal with high caseloads and comparably low pay.[56] A 2003

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[49] *Id*.
[50] *Id*.
[51] *Serious Mental Illness Prevalence in Jails and Prisons,* THE TREATMENT ADVOCACY CENTER, *https://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3695*,(last visited Spring 2021).
[52] Olivia Kolodziejczak & Samuel Sinclair, *Barriers and Facilitators to Effective Mental Health Care in Correctional Settings*, JOURNAL OF CORRECTIONAL HEALTH CARE, (June 24, 2018) https://journals.sagepub.com/doi/10.1177/1078345818781566?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed#articleCitationDownloadContainer
[53]Jennifer Gonzalez & Nadine Connell, *Mental health of prisoners: identifying barriers to mental health treatment and medication continuity*, AMERICAN JOURNAL OF PUBLIC HEALTH ONLINE, (Dec.14, 2014) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4232131/
[54] *Qualified Mental Health Professional-Adult (QMHP-A) definition*, THE LAW INSIDER, https://www.lawinsider.com/dictionary/qualified-mental-health-professional-adult-qmhp-a (Last visited Spring 2021)
[55] *Id*.
[56] Kolodziejczak & Sinclair, *supra* note 52.

study found that psychologists in the correctional system held caseloads of 60 to 80 clients while being paid on average $20,000 less than a comparable job in the community.[57] Psychologists and psychiatrists who can properly diagnose disorders are in short supply. In addition, the screening tools typically used in prison settings are not diagnostic tests geared at assessing mental health, but are instead used to gauge the security risk of a new inmate at the institution.[58] Finally, non-clinical correctional staff is often supplemented for QMHPs and instructed to conduct clinical tasks not within their scope.[59]

A recent study found that about half of rural communities in the United States do not have access to a psychologist, and 65 percent do not have a psychiatrist.[60] Due to the overwhelming caseloads, staff at many correctional facilities overuse psychotropic medications and sedative-hypnotic medications, to pacify and control (rather than individually treat) disruptive inmates and inmates with mental illness.[61] This focus on disruptive prisoners, coupled with inadequate staffing, often concentrates resources and generic treatment on inmates with SMI rather than the majority of the prison population with AMI.[62] The American Psychiatric Association (APA) advises that individual or group therapy and programs are among the essential services that should be provided as part of comprehensive prison mental health treatment in conjunction with an individualized medication regimen to improve treatment outcomes.[63] Unfortunately, with the lack of QMHPs, the best treatment offered is usually not comprehensive and far from the APAs advised standard.

ii. Shortage of Correctional Staff

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[57] *Id*.
[58] Gonzalez & Connell, *supra* note 53.
[59] Kolodziejczak & Sinclair, *supra* note 52.
[60] *Treatment Denied: The Mental Health Crisis in Federal Prisons*, THE MARSHAL PROJECT, (Nov. 21, 2018) https://www.themarshallproject.org/2018/11/21/treatment-denied-the-mental-health-crisis-in-federal-prisons.
[61] *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, HUMAN RIGHTS WATCH, (Oct, 21, 2003) https://www.hrw.org/report/2003/10/21/ill-equipped/us-prisons-and-offenders-mental-illness.
[62] *Id*.
[63] *Id*.

There has been a consistently steady growth in the inmate population, specifically in the population of inmates who have a mental illness; however, there has been no proportional growth in correctional staff. The correctional staffing crisis is one reason it is nearly impossible to allow services such as off-facility transportation for inmates to receive mental health treatment.[64] Prisons usually require two prison staff members to transport inmates, which generates a need to replace those two officers in the actual facility to avoid a security risk due to understaffing.[65] This is difficult for an already strained system. Additionally, when correctional staff is faced with the task of treating such large numbers of individuals with mental illness, some facilities have turned to overmedication as a solution for implementing control.[66] In the case of correctional staff shortage, we once again see the use of sedative and other psychiatric drugs to control and pacify problem inmates and maintain a certain level of order within an institution rather than to provide treatment.[67]

iii. Budget Cuts

The most significant barrier to mental health care in correctional facilities is budgetary constraints. Decreased funding for correctional facilities has implications on the ability to hire QMHPs and additional correctional staff. Despite the lucrative nature of the U.S. correctional system and the billions of dollars spent at the local, state and, federal level each year, jails and prisons still face regular budget cuts to operate in the green.[68] The benefits of using

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[64] Stacie Deslich et al., *Telepsychiatry in correctional facilities: using technology to improve access and decrease costs of mental health care in underserved populations* THE PERMANENTE JOURNAL, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3783076/.
[65] *Id*.
[66] Olivia Kolodziejczak & Samuel Sinclair, *Barriers and Facilitators to Effective Mental Health Care in Correctional Settings*, ("[f]or many who have the tough, day-to-day task of running these institutions, the best option is to heavily medicate them until they are released"), JOURNAL OF CORRECTIONAL HEALTH CARE, (June 24, 2018) https://journals.sagepub.com/doi/10.1177/1078345818781566?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed#articleCitationDownloadContainer
[67] *Id*.
[68] Local Spending on Jails Tops $25 Billion in Latest Nationwide Data, PEWTRUST.ORG, (Jan. 29, 2001) https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/01/local-spending-on-jails-tops-$25-billion-in-latest-nationwide-data.

pharmacotherapy, in conjunction with counseling and self-help groups, to treat mental health conditions in correctional settings have been largely accepted; however, many medications are expensive and therefore not offered widely within institutions.[69] Even if correctional facilities had the staff to facilitate transportation to off-site mental health clinics for treatment, budgetary constraints would not allow for the service. For example, the Lincoln County Detention Center in New Mexico spent $13,059.89 on thirty-one in-state transportation trips.[70] If correctional facilities were adhering to the APA's recommendation of weekly individual or group therapy and programs, transportation alone for the hundreds of inmates who require psychiatric services would break the budget.[71]

Part II: Policy and Practice

A. Targeted Efforts to Improve Mental Health in the U.S. Correctional System

i. Constitutionally…

Prisoners are entitled to proper and adequate mental health treatment under the Eighth Amendment of the United States Constitution, which prohibits "cruel and unusual punishments."[72] The government is obligated to provide medical care for those whom it is punishing by incarceration because failure to do so may produce physical torture, a lingering death, or at the very least pain and suffering, all of which are inconsistent with the Constitution.[73] In 1977, the Fourth Circuit set a well-received precedent when they explicitly held that the Eighth Amendment required treatment not only for prisoners' physical illnesses but for their psychological or psychiatric illnesses as well.[74] An inmate is

[69] Gonzalez & Connell, *supra* note 53.
[70] Dianne Stallings, *Prisoner Transport A Costly Dilemma*, RUIDOSO NEWS.COM (Mar. 26,2020) https://www.ruidosonews.com/story/news/2020/03/26/prisoner-transport-costly-dilemma/2911182001/.
[71] *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, HUMAN RIGHTS WATCH, (Oct, 21, 2003) https://www.hrw.org/report/2003/10/21/ill-equipped/us-prisons-and-offenders-mental-illness.
[72] USCS Const. Amend. 8
[73] *Estelle v. Gamble*, 429 U.S. 97, 103 (1976)
[74] *Bowring v. Godwin*, 551 F.2d 44, 46 (4th Cir. 1977)

> entitled to psychological or psychiatric treatment if a physician or other health care provider, exercising ordinary skill and care at the time of observation, concludes with reasonable medical certainty (1) that the prisoner's symptoms evidence a serious disease or injury; (2) that such disease or injury is curable or may be substantially alleviated; and (3) that the potential for harm to the prisoner by reason of delay or the denial of care would be substantial.[75]

Despite the constitutional support for mental health treatment in jails and prisons, many inmates are not receiving the services they need for three reasons. First, with overworked non-clinical staff conducting screenings, there is an incentive for employees to downgrade inmates to lower care levels.[76] Levels that do not require correctional facilities to provide regular psychiatric treatment.[77] Secondly, it is difficult to successfully advance a constitutional claim for a violation of one's Eight Amendment rights. To prove a constitutional violation, a prisoner must satisfy a two-part objective and subjective test.[78] From an objective standpoint, an inmate must prove that they have been deprived of the "minimal civilized measure of life's necessities."[79] Subjectively, an inmate must show that prison or medical personnel acted with deliberate indifference to his medical needs.[80] The subjective prong is challenging to prove because, to prove deliberate indifference, an inmate must show that the prison guard, doctor, or other personnel had a culpable mind in intentionally depriving him of appropriate medical care.[81] The failure to provide appropriate medical care, without the requisite intent, would not be considered cruel and unusual punishment.[82] Finally, there is no uniform guideline that highlights the basic components of what

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[75] 551 F.2d at 74.
[76] *Treatment Denied: The Mental Health Crisis in Federal Prisons*, THE MARSHAL PROJECT, (Nov. 21, 2018) https://www.themarshallproject.org/2018/11/21/treatment-denied-the-mental-health-crisis-in-federal-prisons.
[77] *Id*.
[78] Stephen Allen, *Mental Health Treatment and the Criminal Justice System*, 4 J. HEALTH & BIOMED. L. 153 (2008) https://plus.lexis.com/document/?pdmfid=1530671&crid=3440cbda-832a-4855-99ec-dd3b0d27604d&pddocfullpath=%2Fshared%2Fdocument%2Fanalytical-materials%2Furn%3AcontentItem%3A4T0N-NHW0-0240-Y0CD-00000-00&pdcontentcomponentid=290081&pdteaserkey=&pdislpamode=false&pdworkfolderlocatorid=NOT_SAVED_IN_WORKFOLDER&ecomp=mt4k&earg=sr1&prid=5b7df2d3-b7cb-4786-a073-70191a8f7840&cbc=0.
[79] *Id*.
[80] *Id*.
[81] *Wilson v. Seiter*, 501 U.S. 294, 297 (1991)
[82] Allen, *supra* note 78 at 167.

is needed for correctional mental health services to pass constitutional muster. In *Ruiz v. Estelle*, the U.S. District Court for the Eastern District of Texas provided that prison mental health services must include the following:

> First, there must be a systematic program for screening and evaluating inmates in order to identify those who require mental health treatment… Second…treatment must entail more than segregation and close supervision of the inmate patients…. Third, treatment requires the participation of trained mental health professionals, who must be employed in sufficient numbers to identify and treat in an individualized manner those treatable inmates suffering from serious mental disorders…. Fourth, accurate, complete, and confidential records of the mental health treatment process must be maintained. Fifth, prescription and administration of behavior-altering medications in dangerous amounts, by dangerous methods, or without appropriate supervision and periodic evaluations, is an unacceptable method of treatment. Sixth, a basic program for the identification, treatment, and supervision of inmates with suicidal tendencies is a necessary component of any mental health treatment program. [83]

However, *Ruiz v. Estelle* has a long litigation history of repeals and remands and holdings that are not binding in any state but Texas.

ii. At the State Level….

States have a genuine economic and public health interest in providing prisoners with needed mental health treatment. According to a Department of Justice study, nearly all U.S. state prison facilities reported providing mental health services to their inmates in the year 2000.[84] However, in most states, an individual must be both mentally ill and a significant danger to themselves or others for the system to compel treatment.[85] This means that despite court mandates for access to adequate health care in prisons, these mandates are limited to the severely and seriously mentally ill.[86] As a result of this sporadic access to treatment, a significant proportion of

[83] *Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D. Tex. 1980), aff'd in part, 679 F.2d 115 (5th Cir. 1982), cert. denied, 460 U.S. 1042 (1983)
[84] Allen, *supra* note 78 at 168.
[85] *Id*.
[86] Jennifer Gonzalez & Nadine Connell, *Mental health of prisoners: identifying barriers to mental health treatment and medication continuity*. AMERICAN JOURNAL OF PUBLIC HEALTH ONLINE (Dec.14, 2014) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4232131/.

inmates suffering from AMI would not receive the required assistance to increase stability upon discharge and decrease the chance of recidivism.[87]

iii. Federally….

Federal legislation has attempted to address mental health treatment in the criminal justice system but has had little success at lowering the population and the recidivism rate of inmates with mental illness. In 2007, the Second Chance Act was passed, which authorized grants for states to develop programs to assist prisoners in successfully reentering society.[88] There are many positives of the 2007 Act, like its broad scope, which does not limit aid to one segment of the prison population (like the SMI population), and its focus on reducing recidivism rates. The Act created several conditions and requirements for research and authorized grants for in-prison programs such as educational, employment, literacy training, and re-entry programs.[89] One of the main weaknesses of the Act is that although some funding is offered for in-prison educational programs, the majority of the funds are focused on successfully reintegrating prisoners into society, rather than on mental health treatment while individuals are incarcerated.[90]

The Mentally Ill Offender Treatment and Crime Reduction Act of 2004 (MIOTCRA) was a five-year grant program that authorized up to $50 million annually for community and state programs that involved collaboration between the mental health system and the criminal justice systems.[91] MIOTCRA was reauthorized by Congress many times and most recently received an

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[87] *Id*.
[88] Second Chance Act, H.R. 1593, 110th Cong. (2007).
[89] Allen, *supra* note 78 at 183.
[90] *Id*.
[91] Liesel Danjczek, *Comment: The Mentally Ill Offender Treatment and Crime Reduction Act and Its Inappropriate Non-Violent Offender Limitation*, 24 J. CONTEMP. HEALTH L. & POL'Y 69, https://plus.lexis.com/document/?pdmfid=1530671&crid=5b6e1f43-461b-483c-a513-6e96c9a4e12e&pddocfullpath=%2Fshared%2Fdocument%2Fanalytical-materials%2Furn%3AcontentItem%3A4SM6-C8D0-00CV-P0FY-00000-00&pdcontentcomponentid=138724&pdteaserkey=&pdislpamode=false&pdworkfolderlocatorid=NOT_SAVED_IN_WORKFOLDER&ecomp=mt4k&earg=sr1&prid=dec3c696-990f-4564-911d-b89ba7d2686c. (Last Visited Jan. 30, 2021)

increase in its operating budget for 2021.[92] Under MIOTCRA, grant money can be used for a variety of reasons, such as to create or expand mental health courts, to develop programs that support collaborative efforts between the mental health and criminal justice systems, or for programs that support collaboration between state and local governments regarding mentally ill offenders.[93] MIOTCRA encourages that funds be used for diversion programs and alternative prosecution and sentencing programs such as crisis intervention teams.[94] It also promotes using funds for in-jail or in-prison treatment and transitional re-entry services for when mentally ill offenders are released from jail or prison.[95] MIOTCRA stresses the importance of having adequate support services (such as mental health, substance abuse, housing, education, and job placement services) when mentally ill offenders rejoin society.[96]

Despite these Acts, the excessive number of people suffering from mental illness in jails and prisons, as well as, the high rates of recidivism within this segment of the population, strongly suggest that the criminal justice system is not providing effective treatments.[97] The ineffectiveness of these acts may lie in the fact that grant recipients can decide where they would like to target their mental health efforts.[98] Additionally, both of the Acts above placed heavy support and encouraged the placement of resources towards re-entry programs for inmates. [99] Successful legislation should focus on providing comprehensive mental health treatment while inmates are incarcerated, which should improve treatment compliance when individuals are released.[100]

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[92] *NAMI Celebrates Wins For Mental Health In COVID Relief And FY 2021 Federal Budget*, NAMI, (Dec. 22, 2020) *https://www.nami.org/About-NAMI/NAMI-News/2020/NAMI-Celebrates-Wins-for-Mental-Health-in-COVID-Relief-and-FY-2021-Federal-Budget*.
[93] Danjczek, *supra* note 91 at 79
[94] *Id.*
[95] *Id.*
[96] *Id.*
[97] Allen, *supra* note 78 at 168.
[98] Danjczek, *supra* note 91 at 83.
[99] *Id.*
[100] KiDeuk Kim et al., *The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System,* URBAN.ORG, (April 7, 2015), https://www.urban.org/research/publication/processing-and-treatment-mentally-ill-persons-criminal-justice-system.

Part III: Analyzing the Telepsychiatry Breakthrough

A. Telemedicine

Telemedicine involves the use of electronic communications and software to provide clinical services to patients without the need for an in-person visit.[101] Telepsychiatry is a subset of telemedicine and often involves providing a wide range of services such as psychiatric evaluations, therapy (individual, group, and family), patient education, and medication management.[102] Different states have different names for telepsychiatry, with the New York State Office of Mental Health favoring "telemental health" and other states favoring telebehavioral health or telepsychiatry.[103] Despite the varying names, the goals of telepsychiatry remain the same; to improve access to care, offer local care in a timely fashion, improve continuity of care, and to improve treatment compliance and coordination of care.[104] Telepsychiatry is multidisciplinary, including psychiatrists, psychiatric nurse practitioners, licensed mental health counselors, licensed clinical social workers, and other support staff. [105]

The standardized use of telepsychiatry in the U.S. correctional system could be the breakthrough needed to combat the mental health crisis within this system. Telepsychiatry can increase access to mental health services beyond the population of inmates suffering from SMI to inmates suffering from AMI. Despite this increase in access, telepsychiatry could reduce the cost of providing mental health treatment by offsetting the cost associated with transporting inmates to other facilities for services. Telepsychiatry could also reduce recidivism rates and the cost associated with them by providing medically recommended comprehensive psychiatric care

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[101] *What is Telepsychiatry?* AMERICAN PSYCHIATRIC ASSOCIATION.ORG https://www.psychiatry.org/patients-families/what-is-telepsychiatry, (last visited Spring 2021).
[102] *Id*.
[103] *Telemental Health Services*, NEW YORK STATE OFFICE OF MENTAL HEALTH, https://omh.ny.gov/omhweb/clinic_restructuring/telepsychiatry.html, (last visited Spring 2021).
[104] *Id*.
[105] *What is Telepsychiatry?*, AMERICAN PSYCHIATRIC ASSOCIATION.ORG https://www.psychiatry.org/patients-families/what-is-telepsychiatry, (last visited Spring 2021).

throughout an inmate's incarceration and linkage to community resources for continuity of care upon release. Finally, in providing professionals with the ability to work from anywhere, telepsychiatry can attract more QMHPs to fill gaps in even the most rural U.S. correctional facilities. With the assistance of Congress, telepsychiatry could be the first step in deinstitutionalizing the new asylums within the U.S. correctional system.

B. Learning from Telemedicine Statewide

Telemedicine for healthcare is a phenomenon that has already proven successful in some states, settings, and correctional facilities. In New York City, the nation's largest municipal health system, NYC Health + Hospitals teamed up with Cisco Telemedicine Technology to coordinate virtual visits for New York City's 12 municipal jails.[106] This system serves the jails' 55,000 annual residents and provides specialist services and primary care.[107] The introduction to telemedicine has increased service time and reduced some of the complexities that come with treating the correctional population.[108]

In 2016, the Medical University of South Carolina and the South Carolina Department of Corrections worked on creating telemedicine carts for four state prisons.[109] These telemedicine carts allow clinicians at the Charleston-based health system to examine inmates at any time via video feed, collect vital signs, make diagnoses, and prescribe medications.[110] Telemedicine carts are expected to reduce the state's annual bill for inmate medical care, which currently runs to almost $3,000 per inmate.[111] Each telehealth encounter that negates the need for transport to a local

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[106] Ecri Wicklund, *Telemedicine Helps NYC Jails Cut Costs and Complexity in Prisoner Care*, MY HEALTH INTELLIGENCE.COM, (Dec. 14, 2007) https://mhealthintelligence.com/news/telemedicine-helps-nyc-jails-cut-costs-and-complexity-in-prisoner-care.
[107] *Id*.
[108] *Id*.
[109] Ecri Wicklund, *Telemedicine Helps NYC Jails Cut Costs and Complexity in Prisoner Care*, MY HEALTH INTELLIGENCE.COM, (Dec. 14, 2007) https://mhealthintelligence.com/news/telemedicine-helps-nyc-jails-cut-costs-and-complexity-in-prisoner-care.
[110] *Id*.
[111] *Id*.

hospital saves thousands of dollars in healthcare costs, reduces ER crowding and security concerns at the hospital, and reduces staffing and security costs incurred by the prison when an inmate is transported elsewhere.[112]

The California Correctional Health Care Services (CCHCS) partnered with Global Med Technology and implemented telemedicine services for both primary care and specialty services.[113] As a result, they increased access to healthcare for their patient/inmate population, increased public safety, and decreased inmate off-site medical transportation costs.[114] From 2010 to 2018, CCHCS saw a more than ten-fold increase in telemedicine primary care encounters and a 111% increase in telemedicine specialty encounters.[115]

Between 1994 and 2008, the Texas Department of Criminal Justice (TDCJ), in conjunction with Texas Tech University Health Sciences Center and the University of Texas Medical Branch, implement a telemedicine program for inmates.[116] The TDCJ system operates 31 state prisons at the cost of $3 billion a year and spends approximately $581 million on healthcare per year.[117] The TDCJ reported that 85% of medical issues were resolved within the correctional facility by implementing a telemedicine program.[118] With transportation and guard costs estimated at $350 per visit, Texas saved an estimated $3,198,300 in one year through 9,138 inmate telemedicine encounters.[119] The program ultimately saved the TDCJ $780 million over 14 years.[120]

C. Telepsychiatry Will Increase Access to Mental Health Treatment

[112] *Id*.
[113] Joel Barthelemy, Controlling Prison Healthcare Costs with Telemedicine, GLOBAL MED.COM, (March 31, 2019) https://www.globalmed.com/controlling-prison-healthcare-costs-with-telemedicine/.
[114] *Id*.
[115] *Id*.
[116] *Id*.
[117] *Id*.
[118] *Id*.
[119] *Id*.
[120] *Id*.

Ever since deinstitutionalization led to an increase in the prison population, inmates in correctional facilities have long been provided with substandard and non-existent mental health care. A solution to this issue is the introduction of telepsychiatry to both federal and state jails and prisons in the U.S. correctional system. The utilization of telepsychiatry has been shown to overcome travel barriers, allowing inmates to meet with a treating psychiatrist and other practitioners via teleconference.[121] Providers can deliver care via telemedicine on their own schedules, rather than changing their workflows to accommodate when a prisoner or group of prisoners can be transported.[122] Additionally, telepsychiatry may attract QMHPs that are hesitant about the safety of providing care in a correctional facility.[123]

D. Telepsychiatry Will Cut Costs

The largest expense one can expect with the use of telepsychiatry is the start-up cost associated with obtaining the necessary equipment. The initial costs to start a telepsychiatry practice may reach several thousand dollars to acquire the software, hardware, and required infrastructure.[124] However, these programs have been shown to cut overall costs by reducing travel for providers and inmates, decreasing overutilization of other medical services such as laboratory work, increasing medication compliance, and speeding diagnosis via reduced waiting or consultation time.[125] A 2006 study examined the cost of providing tertiary mental health care via telepsychiatry compared with traditional methods.[126] It was found that the initial costs to begin a telepsychiatry service were around $6800; however, after providing telepsychiatric care for six

[121] Stacie Deslich et al., *Telepsychiatry in correctional facilities: using technology to improve access and decrease costs of mental health care in underserved populations*, THE PERMANENTE JOURNAL VOL. 17,3, (2013) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3783076/.
[122] Ecri Wicklund, *Telemedicine Helps NYC Jails Cut Costs and Complexity in Prisoner Care*, MY HEALTH INTELLIGENCE.COM, (Dec. 14, 2007) https://mhealthintelligence.com/news/telemedicine-helps-nyc-jails-cut-costs-and-complexity-in-prisoner-care.
[123] Deslich et al, *supra*. Note 121.
[124] Id.
[125] *Id*.
[126] *Id*.

months, costs remained under $7000. The costs of providing traditional face-to-face psychiatric services to the same population over the same six-month period would have been more than $25,000, primarily because of travel expenses.[127]

E. Telepsychiatry Will address the Correctional Facility Staff Shortage

Since inmates will be receiving mental health services on-site with telepsychiatry, correctional staff would no longer be divided between transporting inmates to and from health facilities for treatment.[128] The two-person transportation team that usually transports inmates (which generates a need to replace those two officers in prisons to avoid a security risk) can be reassigned to on-site duties, which addresses facility understaffing.[129] The money saved avoiding transportation cost can be diverted to hiring additional correctional facility staff.[130]

F. Congress Should Amend MIOTCRA to Provide Funding Specifically for a Standardized Telepsychiatry System.

Telepsychiatry may be a viable way to address the current public health crisis within the U.S. correctional system. The goal in utilizing telepsychiatry would be to provide incarcerated individuals with comprehensive mental health treatment from the moment they enter a correctional facility. This would be done with the hope that upon release, previously incarcerated individuals with a mental diagnosis will be psychiatrically stable and on medications if necessary. Having been provided with telepsychiatry while incarcerated, individuals would be able to personally recognize the benefits of treatment compliance. To ensure continuity of care, formally incarcerated individuals would be linked to an outpatient mental health clinic where mental health treatment

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[127] *Id*.
[128] Stacie Deslich et al., *Telepsychiatry in correctional facilities: using technology to improve access and decrease costs of mental health care in underserved populations*, THE PERMANENTE JOURNAL vol. 17,3 (2013) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3783076/.
[129] *Id*.
[130] Dianne Stallings, *Prisoner Transport A Costly Dilemma*, RUIDOSO NEWS.COM (Mar. 26,2020) https://www.ruidosonews.com/story/news/2020/03/26/prisoner-transport-costly-dilemma/2911182001/.

would be continued. All of these interventions combined will hopefully reduce recidivism rates and the population of individuals suffering from mental illness in the correctional system.

A practical model should begin from the moment an individual is sentenced to prison or jail for more than six months. When an individual is sentenced to jail or prison within the United States, they should be screened by correctional staff and a QMHP. Correctional staff would assess for safety (as is usually done), and QMHP's would conduct mental health assessments. Individuals known to the criminal justice system with a chronic mental illness may not require this initial assessment with a QMHP. This initial assessment with a QMHP would be conducted via telepsychiatry. This would be an inmates' first interaction with a QMHP licensed to assess for mental illness. From this initial evaluation, insight on the individual's history of illness should be obtained, and a telepsychiatry schedule that includes follow-up appointments should be created. Individuals suffering from SMI who are initially assessed by a QMHP, that is not a psychiatrist, psychiatric nurse practitioner, or psychiatric physician assistant (or any other professional that can prescribe medications), would be referred to one of the aforementioned disciplines (who would be on standby) by the end of the initial assessment with the QMHP. The purpose of this is to start psychotropic medications, if needed, as soon as possible. If inmates who would benefit from psychotropic medications are hesitant or unwilling to take them and are not a danger to themselves or others, psychoeducation on the potential benefits of treatment compliance would be provided.

All inmates found to have AMI or SMI will be allowed to participate in a correctional facilities telepsychiatry program. Both correctional staff and QMHPs should work with the inmate population to orient them to telepsychiatry. The range of service options offered through telepsychiatry should be vast and range from traditional therapy to creative arts and movement therapy. Telepsychiatry treatment programs should be individualized and vary between inmates.

Correctional facilities can incentivize inmate compliance with telepsychiatry sessions by providing "good behavior credit."

For the best outcome, Congress must amend MIOTCRA to provide guidelines for federal prisons and monetary incentives for state correctional facilities to adopt a standardized model similar to the one mentioned above. In implementing a standardized model, we can ensure that every participating correctional facility is doing its part to promote mental health and decrease recidivism rates.

G. Potential Barriers to Standardizing Telepsychiatry in Correctional Facilities

i. Various States Have Already Implemented Subpar Telepsychiatry programs.

In an effort to combat the shortage of mental health professionals, California began using telepsychiatry in their prisons under the Telepsychiatry Policy Addendum to the California Department of Corrections and Rehabilitation Mental Health Services Delivery System Program Guide (DSPG).[131] While California looked to embrace telepsychiatry, the DSPG has provisions that expressly state "…that telepsychiatry should not relieve prisons of their obligation to continue their efforts of recruiting full-time psychiatrists to work on-site at facilities."[132] Additionally, the DSPG guide provided that while telepsychiatry may be appropriate at certain levels of care, it is not appropriate at all levels of care. Finally, the DSPG instructed that telepsychiatry may supplement on-site psychiatry at correctional facilities, but it should not completely replace on-site psychiatry services.[133]

The issue with California's correctional telepsychiatry program is that it still relies on the delivery of in-person psychiatric services. Rather than expanding access by embracing a full telepsychiatry program, California continues to limit access by providing that telepsychiatry is

[131] *Coleman v. Brown*, 2018 U.S. Dist. LEXIS 155540 (E.D., Sep. 6, 2018).
[132] *Id.*
[133] *Id.*

only available to certain inmates.[134] The inmates who are not authorized to receive telepsychiatric services because they require a higher level of care must wait for services to be provided by an onsite, face-to-face psychiatrist.

ii. False Belief That In-person Psychiatric Services are Superior

California and many other States regard face-to-face psychiatric services as superior to telepsychiatry; however, this does not appear to be the case. No study has found behavioral health treatment delivered via telemedicine to be worse than or harmful in comparison to behavioral health treatment delivered in person.[135] A study with 186 adult male inmates was conducted to assess and compare inmates' perceptions of the therapeutic relationship, inmates' post-session mood, and their satisfaction with mental health services delivered through either a telemental health modality or face-to-face modality.[136] Of the 186 participants, 50 received face-to-face psychological services in a general population correctional facility, 36 received telemental health psychological services in a general population correctional facility,50 received face-to-face psychiatric services in a psychiatric prison, and 50 inmates received telemental health psychiatric services in a general population correctional facility.[137] The study concluded that there were no significant differences between telemental health and face-to-face delivery modalities for perceptions of the therapeutic relationship, post-session mood, or general satisfaction with services.[138] Telepsychiatry appears to offer an efficient means of service delivery without a loss in

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[134] Id.
[135] Brittany Lazur, et. al., *Telebehavioral Health: An Effective Alternative to In-Person Care*, MILBANK MEMORIAL FUND, (Oct. 15, 2020), https://www.milbank.org/publications/telebehavioral-health-an-effective-alternative-to-in-person-care/.
[136] Robert Morgan, et. al., *Does the Use of Telemental Health Alter the Treatment Experience? Inmates' Perceptions of Telemental Health Versus Face-to-Face Treatment Modalities*, JOURNAL OF CONSULTING AND CLINICAL PSYCHOLOGY, Vol. 76, No. 1, 158 (2008), https://www.researchgate.net/profile/Robert-Morgan-8/publication/5621894_Does_the_Use_of_Telemental_Health_Alter_the_Treatment_Experience_Inmates%27_Perceptions_of_Telemental_Health_Versus_Face-to-Face_Treatment_Modalities/links/0046352cecca5477c4000000/Does-the-Use-of-Telemental-Health-Alter-the-Treatment-Experience-Inmates-Perceptions-of-Telemental-Health-Versus-Face-to-Face-Treatment-Modalities.pdf.
[137] *Id.* at 159.
[138] *Id.* at 161.

the quality of the therapeutic relationship. Given the demand for mental health services in criminal justice settings, telepsychiatry affords opportunities to reach more clients without relocating service providers geographically or importing them physically into the service setting.[139] It is important to note that this study (like many others) failed to address whether telepsychiatry resulted in reduced inmate disciplinary actions, decreased incidence of harm to self or others, or improved mental health functioning and symptom management compared with face-to-face services.[140]

iii. Concerns with Reimbursement

In response to calls for flexibility and broader access to telemedicine services during the COVID-19 public health emergency, certain federal privacy regulations have been relaxed. Payment policies have been expanded as a result of actions taken by the Health and Human Services (HHS), Office for Civil Rights (OCR), and the Centers for Medicare & Medicaid Services (CMS).[141] The relaxing of CMS's policies allows for the broad flexibility to cover telehealth (including telepsychiatry) through Medicaid.[142] Additionally, federal approval is no longer required for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services.[143] As of now, originating site requirements are suspended, which means patients can receive and providers can provide telehealth services from anywhere, including their homes, no matter where they live. [144] Ordinarily,

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[139] *Id*.
[140] *Id*.
[141] Gabriela Weigel, et. al., *Opportunities and Barriers for Telemedicine in the U.S. During the COVID-19 Emergency and Beyond*, KISER FAMILY FOUNDATION, (May 11,2020). https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/.
[142] *COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies*, MEDICAID.GOV., (Jan. 26, 2021), https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf.
[143] Id.
[144] *Medicare Telemedicine Health Care Provider Fact Sheet*, CMS.GOV, (March 17,2020). https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet.

telehealth services must be delivered via a HIPAA-compliant platform, per federal law.[145] But during this public health emergency, they may be delivered through common video-calling applications, such as Skype or FaceTime, without fear of penalty; however, state medical privacy laws may still apply.[146] Finally, during this public health emergency, HHS will not be conducting audits to confirm that telehealth patients have an established relationship with the clinician.[147] That means a new patient who calls seeking an appointment can be provided with one via telehealth.[148]

Despite these changes, Medicaid has historically played a very limited role in covering inmate health care costs. In fact, federal law prohibits Medicaid payments for most health care services provided to individuals while incarcerated under a policy known as the "inmate exclusion."[149] Many prisons hire independent doctors or contract with hospital staff to provide care, with the majority of prisons creating a hybrid system.[150] When not mandated by the state, private insurers are free to decide which telehealth services their plans will cover. Therefore, changes to telehealth benefits as a result of COVID-19 vary by insurer.[151] In approximately 25 states, "…if telemedicine services are shown to be medically necessary and meet the same standards of care as in-person services, state-regulated private plans must cover telemedicine services if they would normally cover the service in-person, called "service parity." [152] However, fewer states require "payment parity," meaning telemedicine services to be reimbursed at the same rate as equivalent in-person services. As a result of this, telemedicine is typically reimbursed at

[145] *Id*.
[146] *Id*.
[147] *Id*.
[148] *Id*.
[149] Alexandra Gates et.al. *Health Coverage and Care for the Adult Criminal Justice-Involved Population*. KISER FAMILY FOUNDATION, (Sep. 5 2014), https://www.kff.org/uninsured/issue-brief/health-coverage-and-care-for-the-adult-criminal-justice-involved-population/.
[150] Gabriela Weigel et. al., *Opportunities and Barriers for Telemedicine in the U.S. During the COVID-19 Emergency and Beyond*, KISER FAMILY FOUNDATION, (May 11,2020). https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/.
[151] *Id*.
[152] *Id*.

lower rates than equivalent in-person care.[153] This is the most significant issue anticipated with the shift to telepsychiatry in correctional facilities. Mental health providers may be hesitant to provide services if compensation is at a lower rate than face-to-face services. With studies showing no significant differences between telepsychiatry services and face-to-face service for perceptions of the therapeutic relationship, post-session mood, or general satisfaction with services, the lower compensation rate may work as a deterrent to much-needed quality professionals.[154] In response to COVID-19, many states have enacted service and payment parity requirements for fully insured private plans.[155]

Conclusion

The successful use of telemedicine throughout the medical field is a signal that telepsychiatry is a viable option capable of expanding mental health access and care.[156] The standardized use of telepsychiatry in the U.S. correctional system could be the breakthrough needed to combat the mental health crisis within this system. Telepsychiatry could fill gaps by providing much needed mental health care at a reduced cost and redistributing correctional facility staff inappropriately used for mental health treatment.[157] Providing telepsychiatry in jails and

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[153] *Id.*

[154] Robert Morgan et. al., *Does the Use of Telemental Health Alter the Treatment Experience? Inmates' Perceptions of Telemental Health Versus Face-to-Face Treatment Modalities*, JOURNAL OF CONSULTING AND CLINICAL PSYCHOLOGY, Vol. 76, No. 1, 158 (2008), https://www.researchgate.net/profile/Robert-Morgan-8/publication/5621894_Does_the_Use_of_Telemental_Health_Alter_the_Treatment_Experience_Inmates%27_Perceptions_of_Telemental_Health_Versus_Face-to-Face_Treatment_Modalities/links/0046352cecca5477c4000000/Does-the-Use-of-Telemental-Health-Alter-the-Treatment-Experience-Inmates-Perceptions-of-Telemental-Health-Versus-Face-to-Face-Treatment-Modalities.pdf.

[155] Gabriela Weigel et. al., *Opportunities and Barriers for Telemedicine in the U.S. During the COVID-19 Emergency and Beyond*, KISER FAMILY FOUNDATION, (May 11,2020). https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/.

[156] Ecri Wicklund, *Telemedicine Helps NYC Jails Cut Costs and Complexity in Prisoner Care*, MY HEALTH INTELLIGENCE.COM, (Dec. 14, 2007) https://mhealthintelligence.com/news/telemedicine-helps-nyc-jails-cut-costs-and-complexity-in-prisoner-care.

[157] Joel Barthelemy, Controlling Prison Healthcare Costs with Telemedicine, GLOBAL MED.COM, (March 31,2019) https://www.globalmed.com/controlling-prison-healthcare-costs-with-telemedicine/.

prisons would be a step towards turning the U.S. correctional system from the “new asylum” that it has become to the rehabilitative system it was always supposed to be.