Correctional Settings and Prisoners' Rights (5000 words)

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Landmark Cases

a) *Pennsylvania DOC v. Yeskey* [118 S.Ct. 1952 (1998)]
b) *U.S. v. Georgia* [546 U.S. 151, (2006)]
c) *Baxstrom v. Herold* [383 U.S. 107, (1966)]
d) *Brown v. Plata* [134 S.Ct. 436 (2011)]
e) *Vitek v. Jones* [445 U.S. 480, (1980)]
f) *Washington v Harper* [494 U.S. 210, (1990)]
g) *Sandin v. Conner* [515 U.S. 472, (1995)]
h) *Sell v. US* [539 U.S. 166, (1997)]
i) *Estelle v. Gamble* [429 U.S. 1066, (1977)]
j) *Estelle v. Ruiz* [679 F.2d 1115, (1982)]
k) *Langley v. Coughlin* [715 F. Supp. 522 (1989)]
l) *Coleman v. Brown* [938 F. Supp. 2d 955 (2013)]
m) *Washington v. Glucksberg* [519 U.S. 1027, (1996)]
n) *Meacham v. Fano,* [427 U.S. 215, (1976)]
o) *Vacco v. Quill [521 U.S. 793, (1997)]*

Introduction

As of 2013, there were over 10 million people incarcerated worldwide (Walmsley, 2013), with over 1.6 million in United States (U.S.) prisons alone (Guerino, Harrison, & Sabol, 2011). The goals of corrections are twofold: (1) to provide public safety by removing offenders from the community or providing oversight of offenders allowed to remain in society, and (2) to "correct" offending behavior (i.e., facilitate inmate desistence from crime). Corrections is a controversial field necessitating a myriad of legal mandates that direct the manner in which correctional agencies must operate, and establish standards for the services that must be provided. In this chapter we review the various types of correctional settings, effects of imprisonment and prison culture as it impacts inmates functioning, offender rights, and due process issues as they relate to offenders.

Corrections and Landmark Cases

Corrections is a broad term that includes both community corrections (e.g., probation, parole), and institutional corrections (e.g., jail, prison). Jails house inmates awaiting trial or convicted of misdemeanor or low level felony offenses (i.e., generally consisting of sentences of 2 years or less). Prisons, on the other hand, house inmates convicted of felonies with sentences typically greater than 2 years. Within most prison systems there are so-called "super-max" facilities whereby inmates are further restricted. Segregated inmates are typically confined to their cells with the exception of approximately 1-hour per day out of cell time for exercise and showers. Other than appointments (e.g., medical, attorney visits), they remain in their cells. The specific circumstances (e.g., single vs. double celling, property, television, staff attitudes) vary significantly from on facility to another.

Regardless of the institutional setting, corrections departments are responsible for providing basic mental health services. Basic mental health services are distinguished from rehabilitative services. Basic mental health services have been described as analogous to a community mental health center model (see Fagan, 2003; Morgan, 2003; Dvoskin & Morgan, 2010) with the aim of assessing needs and providing services alleviating distress, reducing psychiatric symptomatology, and improving institutional functioning and coping. Rehabilitative services on the other hand aim to alter criminal behaviors, tendencies, and lifestyles for a reduction in criminal recidivism with concurrent increases in desistence and prosocial behavior, all aimed at successful community re-entry. Basic mental health services are necessarily available to all offenders in criminal justice settings, as mandated by public policy initiatives and litigation at state and federal levels (e.g., *Estelle v. Gamble, 1977; Estelle v. Ruiz, 1982*). *Estelle v. Ruiz* was

a class action lawsuit brought against the Texas Department of Criminal Justice (TDCJ) in 1972 whereby inmates alleged that the agency's management policies amounted to cruel and unusual punishment. Specifically, the claims were based on overcrowding (i.e., 2-3 inmates in cells designed for one), insufficient security staffing (e.g., not enough officers, use of inmates to supervise other inmates), insufficient medical staffing, unsafe working conditions, and excessive and arbitrary disciplinary procedures. In 1980, the U.S. District Court held that the conditions did constitute cruel and unusual punishment, agreeing that the prisons were overcrowded, there were not enough officers or medical professionals, inmates were deprived of due process rights in disciplinary proceedings, quality of physical and mental health care was inadequate, and inmates were frequently the victims of excessive physical force by correctional officers. The Court required the TDCJ to address these issues. The state of Texas appealed, but the District Court's ruling was upheld by the appellate court in 1982. The ensuing legal battle lasted two decades, and the resulting difficulties of enforcing rulings such as these led to the Prison Litigation Reform Act of 1996.

Although there had been a steady progression towards securing inmates' rights to timely, quality, physical and mental health care, *Estelle v. Ruiz* set forth objective means for meeting those goals. At a minimum, the following six requirements must be met: 1) There must be a system in place for the screening and evaluation of mental illness; 2) Treatment may not solely consist of seclusion or intensive supervision; 3) Trained mental health professionals must be involved in these processes; 4) Complete, accurate, and confidential records must be maintained; 5) Systematic safeguards against inappropriate/dangerous use of psychotropic medication must exist; and 6) Establishment of programs to prevent suicide (Metzner, 2002).

Shortly after the *Ruiz* case was filed, another Texas inmate filed suit alleging inadequate medical care that constituted a violation of his 8th Amendment rights. In 1976, J. W. Gamble sustained an injury on his prison assigned work duty. Over the course of the next three months Mr. Gamble was seen by several doctors to attend to this injury, although his requests were denied on occasion. Throughout this time, physicians failed to reach a consensus on the exact nature of Mr. Gamble's injury. Furthermore, he was disciplined more than once (i.e., placed in segregation) for refusing to work due to the severity of his pain. The District Court dismissed Mr. Gamble's claim; however, the Circuit Court reversed the decision based in part on the failure of Mr. Gamble's physicians to order an X-ray. The U.S. Supreme Court reversed the decision of the lower court and held that the care Mr. Gamble received, although inadequate, did not rise to the established standard of cruel and unusual punishment (e.g., deliberate indifference or malicious infliction of pain). Despite that outcome, the case made it clear that prison (and later jail) systems are prohibited from exhibiting "deliberate indifference" to the serious medical needs of captives.

An outcome similar to *Estelle v. Ruiz* was upheld in California (*Brown v Plata, 2011*). In this case, a class action lawsuit was brought against the State of California Department of Corrections and Rehabilitation (CDCR) alleging violation of prisoners' 8th Amendment rights (e.g., inadequate medical resources). After years of unsuccessful efforts to remedy these deficiencies, Federal judges eventually ruled these violations were primarily due to overcrowding, and ordered each facility to release enough prisoners to keep the inmate population within a certain percentage of its design capacity. The state appealed this decision, claiming that the mandated release violated the Prison Litigation Reform Act. The Supreme

Court affirmed the lower court's decision and held that judicial interference was necessary to protect the 8th Amendment rights of the prisoners.

Running parallel to the *Plata* case, CDCR was also subject to a court order dealing solely with mental health care. In the case of *Coleman v. Brown*, (2013), the Court ordered a wide range of improvements, and established a Court Monitor to supervise compliance with the court's orders.

Inmates with mental illness are afforded some protections similar to civil psychiatric patients (non-offenders; *Baxstrom v Herold,* 1966). In *Baxstrom v. Herold*, Johnnie Baxstrom was determined to be mentally ill while he was incarcerated, and was subsequently transferred to Dannemora State Hospital (a forensic psychiatric hospital). His sentence expired while at Dannemora; however, the Department of Mental Hygiene believed he was too dangerous to be transferred to a civil hospital. State Courts dismissed Baxtrom's writs of *habeas corpus*, and his requests for transfer to a civil facility were denied as being outside the court's power. The U.S. Supreme Court held that Baxtrom was denied equal protection because he was not afforded the benefits of a jury review of his sanity (as afforded others who were civilly committed). In addition, other individuals who were civilly committed to hospitals run by the Department of Corrections were committed only after judicial determination that they were too dangerous to be committed to a civil facility. As Baxstrom's placement in Dannemora happened at the behest of administrative officials, the Court determined Baxtrom had been denied equal protection in this regard as well.

Beyond mental health needs, jails and prisons are responsible for providing for the physical health needs of inmates (e.g., *Estelle v. Gamble*), later including inmate disability accommodations under the *Americans with Disabilities Act* (ADA; 1990) (see *U.S. v Georgia,*

2006). In *U.S. v. Georgia*, Tony Goodman, who required the use of a wheelchair, sued the State of Georgia, alleging that certain prison conditions (e.g., cell not wide enough for maneuvering his wheelchair, denied access to classes and programs) violated his Title II rights under the ADA. The state of Georgia claimed "sovereign immunity." The Supreme Court ruled that Title II supersedes 11th Amendment claims to sovereign immunity when violations of the 8th Amendment are involved.

Community corrections aims to keep offenders in the community, where they can maintain occupational functioning and remain connected to social networks. Not surprisingly, rehabilitative programs are more effective when provided to offenders in the community rather than those incarcerated. Related to community corrections are diversion programs, which afford offenders an opportunity to avoid conviction and correctional sentencing. Of frequent debate is who is and who is not eligible for diversion programs. The Pennsylvania Department of Corrections was faced with this issue in 1998 (*Pennsylvania DOC v Yeskey,* 1998). Ronald Yeskey was initially admitted into a first time offenders Boot Camp, after completion of which he would have been eligible for early release. He was later denied admission into the boot camp due to a medical history of hypertension. Yeskey claimed this denial was a violation of Title II of the ADA (e.g., prohibiting disability-based discrimination of otherwise qualified individuals). The District Court ruled that Title II protection did not extend to prison inmates, and the Circuit Court overturned that decision. The Supreme Court affirmed the Circuit Court's ruling, making it clear that the ADA applies to corrections, and likely by extension diversion program decisions as well. It should be noted that the contours of the ADA's application to jails and prisons remain unclear, especially as they apply to non-architectural aspects of the ADA.

Imprisonment and Prison culture

Although it was once generally accepted that incarceration adversely affected inmates' psychological functioning (Cohen & Taylor, 1972; Mitford, 1973), it has since been demonstrated that inmates' mental health functioning can actually improve over the course of incarceration (see Bonta & Gendreau, 1990; Bukstel & Kilman, 1980; Zamble & Porporino, 1990; Harding & Zimmerman, 1989; Taylor et al., 2010; Hassan et al., 2011). In fact, although inmates experience an increase in psychiatric symptoms (i.e. anxiety and depression) immediately following incarceration, these symptoms typically dissipate after a period of adjustment (MacKenzie & Goodstein, 1985). A meta-analytic review of 15 studies corroborated these findings (Walker et al., 2014). Thus, imprisonment is not necessarily psychologically harmful, and some system and individual differences (e.g., correctional environment, presence of mental illness, resiliency) likely influence an offender's ability to adjust to incarceration (Gendreau & Thériault, 2011; Gendreau & Bonta, 1984; Bukstel & Kilmann, 1980). Offenders suffering from mental illness (OMI's) are the exception, as it appears that the length of incarceration is negatively associated with OMI's mental health functioning, (e.g., Bauer, 2012).

Even if prisoners are able to adjust to prison, less clear are the effects of that adjustment (i.e., institutionalization) upon inmate functioning after release. Gang membership, for example, may lead to a safer prison experience (i.e., adjustment), but create or reinforce skills (i.e., increased violence and prison misconduct) that do not translate to community success (see Gaes, Wallace, Gilman, Klein-Saffran, & Suppa, 2001; Griffin & Hepburn, 2006). Further, it is commonly recognized in the correctional treatment literature that exposing low risk offenders to treatment with moderate to high risk offenders essentially makes low risk offenders worse (see for example Latessa, Lovins, & Smith, 2010 and Smith & Gendreau, 2012). Findings such as this led to the development of the risk principle in the Risk-Need-Responsivity (see Andrews & Bonta, 2010

for a thorough review of this model), whereby it is recommended that interventions be provided consistent with an offenders level of risk, thereby avoiding exposing low risk offenders to correctional interventions (including incarceration) with moderate to high risk offenders which subsequently increases their criminal risk.

Of increasing concern with regard to inmate functioning is the reliance on segregation for disciplining and managing inmate behavior. Much has been written about potential adverse and harmful effects of administrative segregation (AS; see Grassian, 2006; Haney, 2009; Kupers, 2008). Opponents to the use of segregation cite literature that suggests that segregation is harmful and can cause “lasting emotional damage” (Kupers, 2008, p. 1006). Consequently, Grassian (1983) coined the term SHU Syndrome. This purported syndrome represents a constellation of symptoms and mental health deficits that are alleged to result from long-term placement in segregated housing. Many studies, however, have failed to demonstrate significant effects resulting from the use of AS (see for example Gendreau & Bonta, 1984; Bonta & Gendreau, 1995; Suedfeld, Ramirez, Deaton, & Baker-Brown, 1982; Zinger, Wichmann, & Andrews, 2001). Even more compelling are the results from O’Keefe and colleagues (2010) obtained from the most sophisticated segregation study to date. Contrary to the researchers’ hypotheses, results indicated that AS confinement of one year was generally not associated with the onset of psychological symptoms or cognitive impairment for mentally ill and non-mentally ill inmates, nor did inmates with mental illness fair worse in administrative segregation than their non-mentally ill peers. On the other hand, there was no evidence that inmates with serious mental illness improved while in segregated housing. Similarly, results of a meta-analytic review of the segregation literature found small to moderate effects across a variety of mental health and

behavioral domains suggesting that AS may not produce any more negative effects than those produced by incarceration more generally (Morgan et al., 2016).

The questions of potential harm caused by long-term segregated housing remains ripe for continued investigation. Obviously, this is very difficult research to conduct. For example, ethics preclude random assignment of inmates to segregation. Few studies to date have adequately controlled for pre-existing mental illness, nor have they allowed for a determination of the degree to which distress is caused by incarceration itself as opposed to segregation. Further, it seems likely that there are significant individual differences in how inmates respond to segregation. The authors (RM and JD) have observed inmates who appeared to have an extremely negative response to segregation, and others who appear to prefer this form of incarceration for various reasons, including personal safety. Finally, the specific conditions of segregation (e.g., staff attitudes, cleanliness and noise of the environment, the presence of individual TV's, etc.) vary widely across institutions, such that it is difficult to directly compare inmates' experiences in different facilities.

Increasingly, states are creating secure treatment units for inmates with SMI who pose a serious risk of harm to others. In some cases (e.g., New York, Oregon) these programs were voluntary or negotiated as settlements of class actions. In other states (e.g., California), these units were created by court order. Although there are differences, these programs tend to have a number of common characteristics, including significant increases in out of cell time and group therapy.

Finally, some states (e.g., Michigan) have made significant changes in the manner in which segregated housing units are managed. For example, increasing pro-social stimulation and use of contingency management strategies to reinforce pro-social behavior have significantly reduced

lengths of stay in segregation, resulting in reduced populations of segregated prisoners. (Bauman, C., personal communication).

Prisoner Rights

Right to treatment. As previously noted, correctional institutions are mandated to provide adequate health care, including mental health care. Relatedly, inmates have a right to treatment as found in several state and federal cases.

Although inmates are entitled to treatment of their physical and mental health needs, there exists a tension between decisions made about their treatment and their right to freedom from excessive interference by the government. *Turner v. Safley* (1987) established a set of guidelines for assessing the legal validity of prison regulations that infringe upon an inmate's rights: 1) There must be a logical association between the regulation and the government interest it purports to serve; 2) The existence of other avenues through which the inmate may exercise their right; 3) The impact of any accommodations on institutional resources; and 4) The existence of other avenues through which the goals of the institution may be met without infringing upon the rights of the inmate. By way of comparison, decisions regarding the rights of individuals who are civilly committed are frequently governed by the "professional judgment" standard, which fails to take into account the dual roles that medical professionals frequently fulfill when employed by institutions such as state hospitals (i.e., treatment providers and government representatives; Stefan, 1992).

Right to die. Although death row has been a hotly contested legal issue, an inmate's right to die has not been as frequently debated. Nevertheless, the right to die appears to be an increasingly common request, whether it be for death row inmates (Schildkraut, 2013) or those suffering from terminal illness (Stone, Papadopoulos, & Kelly, 2012). Although questions

regarding the right to die in prison remain to be settled, relying on non-prison decisions will likely provide a foundation for future legal decisions. In *Vacco v. Quill*, Dr. Quill and colleagues, as well as three terminally ill patients challenged the constitutionality of New York's ban on physician-assisted suicide. They claimed that the ban on physician-assisted suicide violated the due process clause of the 14th Amendment. The District Court ruled in favor of the state of New York, and the Supreme Court affirmed the decision on the grounds that laws against physician assisted suicide protect the state's interest in preserving medical ethics, protecting vulnerable populations such as the disabled and terminally ill, and preserving human life. In a similar case (*Washington v Glucksberg*, 1996), it was claimed that laws against physician assisted suicide deprived terminally ill adults of their freedom to choose death over life. The Supreme Court held that the right to assisted suicide is not among the "fundamental liberty interests" protected by the amendment.

Prison Rape Elimination Act (PREA). Rape is prominent in popular media portrayals of life in prison (see, e.g., *The Shawshank Redemption*, *American Me*, *American History X*) such that it is an immediate concern for most individuals sentenced to prison. In the United States it has been estimated that up to 30% of male inmates may be exposed to unwanted sexual contact (Mariner, 2001), an unacceptable situation necessitating governmental intervention. As a result, the Prison Rape Elimination Act (PREA) of 2003 was passed. PREA "provide[s] for the analysis of the incidence and effects of prison rape in Federal, State, and local institutions and to provide information, resources, recommendations and funding to protect individuals from prison rape" (Prison Rape Elimination Act, 2003). This act is the first time the U.S. government has passed laws to deal with sexual assaults that occur within correctional institutions.

A number of factors have been identified as increasing inmates' risk of sexual assault while incarcerated (e.g., prior sexual victimization, small stature or appearing physically weak, identification as gay or transgender; Dumond, 2003). Of particular concern is the vulnerability of inmates with a history of mental illness. Prior treatment for a range of mental disorders (i.e., depression, anxiety, posttraumatic stress disorder, schizophrenia, and bipolar disorder) has been associated with an increased likelihood of abusive sexual contact for both male and female inmates (Wolff, Shi, Blitz, & Siegel, 2007).

Due Process Issues

Prisoners with serious mental illnesses (SMI), whether they are held in jails or prisons, are typically entitled to the same due process protections as other inmates and detainees, with some exceptions. These exceptions affect due process rights in two opposing directions. On one hand, serious mental illness can result in abrogation of rights that are routinely granted to other prisoners. On the other hand, there are some due process rights that are specifically afforded to prisoners with serious mental illness.

Abrogated Rights. While seldom mentioned in legal or mental health literature, having a serious mental illness can dramatically limit a person's rights to a speedy trial, pre-trial release (e.g., bail, bond, or personal recognizance), and in some cases the right to file motions or agree to plea bargains.

According to a study by Axelson (1992[1]), psychotic defendants remain in jail 6 ½ times longer than other detainees, despite having fewer and less serious charges. While this study is admittedly dated, there is no reason to believe that these results would be any different today,

[1] Psychotic versus nonpsychotic misdemeanants in a large county jail: An analysis of pretrial treatment by the legal system. Axelson, Gary L.; Wahl, Otto F. International Journal of Law and Psychiatry, Vol 15(4), 1992, 379-386.

except perhaps in jurisdictions with mental health courts. Defendants with SMI are often viewed as less likely to appear for court proceedings. While this belief is unfounded (CSG, 2015a), this criterion is often used by pre-trial release agencies in denying pre-trial release to people with SMI. Subsequent studies by the Council of State Governments in Franklin County, Ohio (CSG, 2015) and New York City (CSG, 2012) have confirmed that jail detainees and inmates remain in jail significantly longer if they have a serious mental disorder.

Fortunately, efforts are currently underway by organizations such as the Council on State Government's Justice Center and the Arnold Foundation to improve pre-trial release possibilities for defendants with SMI. (CSG, 2015a)

Rights are especially likely to be affected, ironically, when a defendant is found to be incompetent to stand trial. While this finding stems from a defendant's rights to counsel and a fair trial, the consequences of a finding of incompetence often work very much to the defendant's disadvantage. For example, in many jurisdictions, defendants are precluded from or limited in their ability to file pre-trial motions. Most importantly, they are denied the ability to agree to a plea bargain, which in many cases (e.g., misdemeanors and low level felonies) could result in sentences of "time served" that would have resulted in the person's immediate release from custody. Further, the trial process is stalled for the entire time that the defendant is held as incompetent. Ironically, one of the authors (JD) has served as an expert witness in several cases in which states were accused of holding incompetent defendants in jail for months or even years, in spite of a court order requiring their transfer to a psychiatric hospital for treatment.

Rights Specific to Prisoners with SMI. While a prisoner's rights to treatment may include access to inpatient care, inmates also have a right to refuse transfer to outside psychiatric hospitals absent certain requirements. In 1976, the Supreme Court had ruled (*Meacham v. Fano,*

1976) that inmates could be transferred from one institution to another without due process, deferring to the discretion of prison officials. However, *Vitek v. Jones* (1980) afforded inmates a right to administrative due process when the intended transfer was to a psychiatric hospital.

In our opinion, the *Vitek* decision has become less and less important over time, for several reasons. First, prisons throughout the US have implemented routine classification committee hearings for transfers from prion to prison; hearings that typically meet a test for administrative due process. Second, inpatient beds are typically too few in number to accommodate all of the prisoners who might profit from inpatient treatment. Third, inmates who adamantly refuse inpatient transfers all too often end up in various forms of segregated housing, despite the fact that this form of housing is often counter-therapeutic and unlikely to meet the inmate's clinical needs. Fourth, as we will explain below, prisons now have other mechanisms by which they can involuntarily medicate some psychotic inmates, which reduces some institutional motivation for transfer to an inpatient hospital. Fifth, when inmates are afforded due process, because of the typically high threshold for involuntary transfer to a hospital, the decision is, in our experience, extremely likely to be upheld.

Ironically, the rights of prisoners are far more likely to be violated by the absence of inpatient psychiatric beds than by involuntary transfer to a hospital.

Prisoners also have rights to due process before they can be forced to take psychotropic medications on a non-emergency basis. However, these rights do not necessarily extend to judicial review. In fact, in *Washington v. Harper* (1990) the Court ruled that the Due Process Clause allows states to involuntary medicate an inmate with serious mental illness, so long as the inmate is deemed dangerous to self or others and the medication is in the inmate's best medical interests. The decision to medicate over objection does not require judicial hearing, instead

requiring only an administrative due process, in the form of a special committee consisting of a psychiatrist, a psychologist, and a Center official, none of whom may be currently involved in the inmate's diagnosis or treatment.[2]

Pre-trial detainees can also be involuntarily medicated, even if they do not pose a risk to self or others. In *Sell v US* (1997), the Court opined that involuntarily medicating incompetent defendants could be an appropriate means of furthering the state's interest in bringing to trial those charged with serious crimes. However, the level of due process in such cases under *Sell* is significantly greater (i.e., judicial due process) than under a *Harper* analysis, which requires only administrative due process. Further, *Sell* requires that the following conditions be met:

1. An important government issue must be at stake and only a case-by-case inquiry can determine whether the government's interest is mitigated by the possibility of a long civil commitment for the treatment of the mental illness or by the fact that long periods of confinement have already been served, as this would be subtracted from any criminal sentence.
2. There must be a substantial probability that the medication will enable the defendant to become competent without substantial undermining side effects.
3. The medication must be necessary to restore the defendant's competency, with no alternative, less intrusive procedures available that would produce the same results.

Other rights may also be due to prisoners with SMI under the ADA (*Pennsylvania DOC v. Yetsky*, 1998; *US v. Georgia*, 2006). Specifically, the ADA requires that qualified individuals

[2] In addition, the inmate has the right to notice of the hearing, the right to attend, present evidence, and cross-examine witnesses, the right to representation by a disinterested lay adviser versed in the psychological issues, the right to appeal to the Center's Superintendent, and the right to periodic review of any involuntary medication ordered.

with disabilities, including prisoners, not be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity. (42 U.S.C. § 12132; 28 C.F.R. § 35.130(a)). Further, among others, the ADA's Title II regulations require correctional entities to administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified prisoners with disabilities and to make reasonable modifications to policies, practices, and procedures when necessary to avoid discrimination on the basis of disability. *See* 28 C.F.R. §§ 35.130(b)(7), (d) (1991); *Pa. Dep't of Corr. v. Yeskey*, 524 U.S. 206, 210 (1998); *Chisolm v. McManimon*, 275 F.3d 315, 324-25 (3d Cir. 2001). Nevertheless, to date, the contours of the ADA, as applied to mental disabilities in prisons and jails, have yet to be fully articulated by courts.

Conclusion

Correctional agencies have a clear constitutional duty to provide treatment for serious mental illnesses and psychiatric crises. Whether these illnesses and crises pre-existed incarceration or were caused or exacerbated by incarceration does not matter. Further, statutory law prohibits discrimination and mandates accommodation of psychiatric disabilities, Perhaps more importantly, public policy mandates adequate treatment of mental illness and psychiatric crises in jails and prisons. Untreated or undertreated, these conditions can interfere with an inmate's ability to profit from correctional programs, and in extreme cases can endanger inmates, detainees, officers, and eventually the community.

Brief Review of Key Concepts

1. Prisons and jails have a constitutional duty to avoid being "deliberately indifferent" to "serious medical and psychiatric problems."

2. Inmates have a right to treatment, to include health and mental health treatment.
3. However, this duty sets a relatively low bar, and has never been held to require a standard of care that is even close to optimal care that may be available in the community.
4. Research regarding the effects of segregation on the mental health of prisoners is inconclusive at best. Significant variance in the conditions of segregation contributes to the difficulty in drawing sweeping conclusions about the practice; however, more studies of the use of long-term segregation are desperately needed.
5. Jails and prisons, even at their best, are not particularly good places to treat SMI. Under the best of circumstances, jail and prison psychiatrists have extremely large caseloads, and prisoners in our experience are far less likely to take psychotropic medication in prison as opposed to hospitals. Further, it is extremely difficult to create a truly therapeutic environment in jails and prisons.
6. While the constitution establishes a "floor" for inmate rights, we would argue that improving conditions in jails and prisons, well beyond the constitutional minimum, is simply good public policy.

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