

2005

Comment: Mental Health Treatment and Mistreatment in Prisons

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Recommended Citation

Kosak, Joyce (2005) "Comment: Mental Health Treatment and Mistreatment in Prisons," *William Mitchell Law Review*: Vol. 32: Iss. 1, Article 4.

Available at: <http://open.mitchellhamline.edu/wmlr/vol32/iss1/4>

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COMMENT: MENTAL HEALTH TREATMENT AND MISTREATMENT IN PRISONS

Joyce Kosak[†]

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I. INTRODUCTION

As the population in prisons grows, and correspondingly the need for mental health services increases, reports continue to show that mental health treatment provided in most prisons falls below acceptable standards ethically, morally, and constitutionally.¹ Not

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1. See generally HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS (2003), available at <http://www.hrw.org/reports/2003/usa1003/usa1003.pdf> [hereinafter ILL-EQUIPPED] (reporting on widely observed problems with adult prisoners in the U.S. who suffered from mental illnesses).

only do prisoners rarely receive the necessary treatment, many times the prison system worsens the condition of the offender suffering from a mental illness.² Not only do prison inmates have a constitutional right to treatment, doctors have an ethical obligation to provide adequate care to their patients, and society has a moral obligation to provide the resources necessary to adequately staff and supply prison health care systems.³ Additionally, society's greatest opportunity to modify future behavior occurs when the mentally ill offender is in prison, because rarely do other treatment alternatives exist for the offender after release from prison.⁴

In an effort to demonstrate the devastating nature of inadequate mental health treatment in prison, this Comment reviews the case of Mark Walker,⁵ a prisoner in the Montana prison system.⁶ By discussing the size of the prison population and estimated burden of the mental health needs in the prison in Part III, the author hopes to establish the scope of the impacted population, thereby providing a foundation for the importance of this issue in Part IV.⁷

Focusing on the constitutional rights of prisoners, in Part V this Comment reviews the major case law regarding prisoners' rights to mental health treatment, how prisoners can use the court system to enforce these rights, and the roadblocks to this enforcement—both those established by Congress and those that exist simply by the nature of our distributed court system.⁸ Finally, in Part VI, this Comment reviews a sampling of court cases that have resulted in improved mental health treatment programs in prison systems.⁹

II. AN EXAMPLE OF MENTAL HEALTH TREATMENT IN PRISON

Mark Walker arrived at the Montana State Prison (MSP) on February 5, 1999, after having spent seven months in the Colorado

2. *Id.* at 153.

3. *See generally* Fred Cohen & Joel Dvoskin, *Inmates with Mental Disorders: A Guide to Law and Practice*, 16 MENTAL & PHYSICAL DISABILITY L. REP. 462 (1992) (presenting a model and rationale for mental health treatment in prisons).

4. ILL-EQUIPPED, *supra* note 1, at 192.

5. Walker v. State, 68 P.3d 872 (Mont. 2003).

6. *See infra* Part II.

7. *See infra* Parts III, IV.

8. *See infra* Part V.

9. *See infra* Part VI.

prison system.¹⁰ While incarcerated in the Colorado system, Walker was diagnosed with bipolar disorder and stabilized on 900 milligrams of lithium a day.¹¹ His mood was stable and the prison staff did not file any major disciplinary write-ups.¹² Unfortunately, Walker's experience in the Montana system was more eventful.

Almost immediately upon arriving at MSP, Walker began complaining of stomach pains due to the lithium and requested food to take with his medication.¹³ Dr. David Schaefer, a MSP staff psychiatrist, was told of this as early as February 20, 1999, two weeks after Walker's move to MSP.¹⁴ Not until March 11, 1999, did Dr. Schaefer actually see Walker, however, and then for less than thirty minutes.¹⁵ By this time Walker had stopped taking the lithium.¹⁶ After reviewing Walker's medical file and without any psychological testing, Dr. Schaefer stopped prescribing lithium for Walker.¹⁷ Dr. Schaefer believed that Walker had an antisocial personality with narcissistic traits rather than bipolar disorder.¹⁸ Soon after, Walker began receiving write-ups for serious disciplinary issues, starting at two a month and increasing to eleven a month.¹⁹

Dr. Schoening, another doctor at MSP, diagnosed Walker as a self-mutilator and explained that self-mutilators in prison generally injure themselves to get to a less restrictive setting in the prison.²⁰ Even though Walker's self-harm always resulted in a transfer to a more restrictive area, Dr. Schoening determined that Walker's actions were an attempt to control his situation.²¹ Dr. Schoening also attributed Walker's action of yelling all night long, and then being assaulted by the inmate at whom he was yelling, to poor judgment, not psychosis.²²

Over a five-day span in October 1999, Walker attempted suicide three times.²³ Dr. Schaefer evaluated Walker again after the

10. *Walker*, 68 P.3d at 874.

11. *Id.*

12. *Id.*

13. *Id.*

14. *Id.* at 880.

15. *Id.*

16. *Id.*

17. *Id.*

18. *Id.*

19. *Id.* at 874-75.

20. *Id.* at 880.

21. *Id.* at 881.

22. *Id.*

23. *Id.* at 875.

first suicide attempt and determined that Walker was at chronic risk of harming himself, but reported that hopefully Walker “will fall short of killing himself.”²⁴ He ordered Walker return to the maximum security area of the prison.²⁵ To address his dangerous behavior, the prison ordered a series of Behavior Management Plans (BMPs).²⁶ In a BMP, Walker was put in isolation and “privileges.” His clothing, mattress, pillow, and all of his personal items were taken away.²⁷ During some BMPs, the water to Walker’s sink and toilet would be turned off, depriving the inmate of drinking water, except during regular intervals determined by prison guards.²⁸ Walker’s BMPs lasted days at a time, and sometimes for weeks.²⁹ The privileges would be returned one by one as his behavior improved.³⁰

All BMPs were implemented in the isolation area of the prison, where each cell had only a cement bed, a cement table or desk, a stainless steel sink, a stainless steel toilet, and a stainless steel plate that served as a mirror.³¹ The cell did not have a window to the outside, so no natural light entered the cell.³² The cells were rarely cleaned, even when an inmate left and a new inmate was placed in the cell.³³ Blood, vomit, feces, and other debris had often contaminated the cells for long periods of time.³⁴ During one of Walker’s stays, a large amount of dried blood was on the wall because the previous inhabitant of that cell had smashed his head against the wall until he required hospitalization.³⁵ No recreation yard time was allowed for inmates in this area.³⁶ When a BMP was in force, an inmate was served only cold food that was unwrapped and passed through the same cell entry-slot as did the toilet cleaning tools.³⁷

Throughout his stay at MSP, Walker was placed on BMPs, and

24. *Id.* at 880.

25. *Id.*

26. *Id.* at 875.

27. *Id.*

28. *Id.* at 876.

29. *Id.*

30. *Id.*

31. *Id.* at 875.

32. *Id.*

33. *Id.* at 883.

34. *Id.*

35. *Id.*

36. *Id.* at 875.

37. *Id.* at 877.

with each BMP his behavior deteriorated.³⁸ At one point he screamed for two days straight.³⁹ He received over 100 write-ups and spent six months in lockdown.⁴⁰ In January 2000, while on another BMP, Walker filed a pro se petition by dictating it to a neighboring inmate who was allowed the privilege of a pencil and paper.⁴¹

In preparation for the hearing, Walker, along with his treatment history, was reviewed by two psychiatrists.⁴² During the hearings, each of these doctors gave the opinion that Walker was effectively treated with lithium while in Colorado, but was neglected and ignored at MSP.⁴³ One doctor described the treatment Walker received as negligent and scandalous.⁴⁴ Another found it “absolutely clear,” based on the psychological records from Colorado and Montana, as well as the depositions of other inmates regarding Walker’s behavior, that Walker suffered from a serious mental illness.⁴⁵ That same doctor found it to be “inexcusable” that Walker was not medicated, especially considering the effectiveness of his treatment by medication in the past.⁴⁶ The doctor concluded that MSP’s diagnosis that Walker did not have a serious mental illness was “preposterous and fell below the ethical standards for practicing medicine”⁴⁷

The Montana Supreme Court was outraged. It found that, under the state constitutional right to human dignity, the prison deliberately disregarded the risk of harm to Walker by providing what the prison knew to be constitutionally inadequate mental health treatment.⁴⁸ This state right to human dignity provides even greater protection than the federal and state prohibition against cruel and inhumane punishment.⁴⁹ The court held that violations of basic rights under the federal and state constitutions would continue as long as the prison policies regarding BMPs remained

38. *Id.* at 882.

39. *Id.*

40. *Id.* at 877.

41. *Id.*

42. *Id.*

43. *Id.* at 881.

44. *Id.*

45. *Id.*

46. *Id.*

47. *Id.*

48. *Id.* at 884.

49. *Id.* at 883.

in place.⁵⁰ The court also held that prison officials at MSP created conditions that exacerbated the inmates' mental illnesses or destroyed their sanity.⁵¹ The court remanded the case to the district court for entry of an order directing MSP to make operations conform to the ruling and to provide a report on changes made within 180 days.⁵²

So what happened? No further decisions have been published from this case, from the district court, the Montana Supreme Court, or other courts. However, the Montana Department of Corrections (DOC) released a statement just two days after the Montana Supreme Court's decision was issued.⁵³ The DOC's statement disputed the findings of the court: "The prison uses such management plans to try and control inmates' disruptive, dangerous behavior," and "[t]he Court based its decision on the premise that Walker was mentally ill, but the DOC's correctional experts who evaluated the inmate concluded he was not mentally ill."⁵⁴ The statement complained that the courts should not interfere with prison management, but then went on to say that "[t]he Court ruled that behavior management plans violate inmates' rights to human dignity, but did not give the prisons any realistic alternative to control these behaviors"⁵⁵ Despite the medical findings of the doctors in the Colorado Prison System and two doctors whose opinions were relied upon by the Montana Supreme Court, the DOC continued to deny Walker's illness and stood by the inhumane BMP methods.⁵⁶

However, the Montana Department of Corrections 2005 Legislative Report indicated that changes in the mental health treatment for prisoners had occurred. First, a new intake facility was created, at three times the size of the previous unit, allowing the prison to "assess the needs of each offender and strategically place that individual in the appropriate facility."⁵⁷ The funding for

50. *Id.* at 885.

51. *Id.*

52. *Id.*

53. See DIANA KOCH, MONT. DEP'T OF CORR., CORRECTIONS RESPONSE TO MONTANA SUPREME COURT DECISION (May 1, 2003), available at <http://www.cor.state.mt.us/news/NewsReleases/Archives/ResponsetoSupremeCourtDecision.htm>.

54. *Id.*

55. *Id.*

56. *See id.*

57. MONT. DEP'T OF CORR., A REPORT TO THE 2005 LEGISLATURE 18 (2005),

this new unit was provided by the fifty-eighth session of the Montana Legislature,⁵⁸ which met in 2003-2004, but it is unclear whether the funding was a result of this case decision. The report also notes that “[c]orrections in Montana faces some stiff challenges in the area of . . . mental health services for offenders,” but does not provide any explanation about what those challenges are or how they will be addressed.⁵⁹ In addition, in Montana Women’s Prison, Medical and Mental Health Services became one unit in an effort to “provide more comprehensive health care to the prisoners.”⁶⁰

Mark Walker’s experience in MSP illustrates several of the issues commonly faced by prisoners in need of mental health treatment. These issues include the delay in receiving mental health treatment,⁶¹ the inadequate time mental health staff spend with prison inmates for both diagnosis and treatment,⁶² and the failure of prison guards to identify and refer prisoners in a mental health crisis.⁶³

III. AFFECTED POPULATION

How often can something as extreme as what happened to Mark Walker really occur? Most people are aware that the U.S. prison population grew significantly in the 1980s and 1990s.⁶⁴ Today that population continues to increase. In 2004, the prison and jail population in the United States grew to over 2,100,000.⁶⁵ Surprisingly, the prison population is greater than the total population of fifteen separate states or the District of Columbia.⁶⁶

available at <http://www.cor.state.mt.us/Resources/Reports/2005LegislativeReport.pdf>.

58. *Id.*

59. *Id.* at 5.

60. *Id.* at 21.

61. *See infra* text accompanying notes 128-133.

62. *See infra* text accompanying note 139.

63. *See infra* text accompanying notes 134-135.

64. In fact, the prison population grew by more than a factor of four during this period, from 302,000 in 1979 to 1,319,000 in the year 2001. THOMAS P. BONZCAR, U.S. DEP’T OF JUSTICE, SPECIAL REPORT: PREVALENCE OF IMPRISONMENT IN THE U.S. POPULATION, 1974-2001, 2 (2003) *available at* <http://www.ojp.usdoj.gov/bjs/pub/pdf/piusp01.pdf>.

65. PAIGE M. HARRISON & ALLEN J. BECK, U.S. DEP’T OF JUSTICE, PRISON AND JAIL INMATES AT MIDYEAR 2004, 1 (2005), *available at* <http://www.ojp.usdoj.gov/bjs/pub/pdf/pjim04.pdf>.

66. U.S. CENSUS BUREAU, ANNUAL POPULATION ESTIMATES 2000-2004 (2004),

From July 2003 through June 2004, the population of prisons under state jurisdiction grew by 1.6%, and those under federal jurisdiction grew by 5.1%.⁶⁷ At midyear 2004, the United States incarcerated one out of every 138 of its residents, either in prison or jail.⁶⁸ As the number of inmates increases, so does the demand for services, including mental health care.

A. *Rates of Mental Illness in Prison*

The ever-increasing size of the prison population indicates a growing need for treatment of mental illness in prisons. At any one time in the United States, approximately 5% of the population suffers from a mental illness.⁶⁹ Compared to the general American population of similar age, prisoners are two to four times more likely to suffer from a psychotic illness or major depression, and about ten times as likely to have an antisocial personality disorder.⁷⁰ In a study based on self-reporting by state and federal inmates, as well as those in local jails, the Bureau of Justice Statistics reported that in 1997, 16% of those in state prisons and local jails suffered from a severe mental illness.⁷¹ The rate in federal prisons was lower, at 7%.⁷² In a study of a smaller group of incarcerated parents, the percentages for both state (14%) and federal (6%) prisons were similar.⁷³ No studies indicate why the rate of mental

available at <http://www.census.gov/popest/states/tables/NST-EST2004-01.pdf>. The fifteen states are Alaska, Delaware, Hawaii, Idaho, Maine, Montana, Nebraska, New Hampshire, New Mexico, North Dakota, Rhode Island, South Dakota, Vermont, West Virginia, and Wyoming. *Id.*

67. HARRISON & BECK, *supra* note 65, at 1.

68. *Id.* at 2.

69. R. C. Kessler et al., *A Methodology for Estimating the 12-Month Prevalence of Serious Mental Illness*, in MENTAL HEALTH, UNITED STATES 1999, at 99 (R.W. Manderscheid & M.J. Henderson eds. 1999).

70. Seena Fazel & John Danesh, *Serious Mental Disorder in 23,000 Prisoners: A Systematic Review of 62 Surveys*, 359 THE LANCET 545, 548 (2002).

71. PAULA M. DITTON, U.S. DEP'T OF JUSTICE, MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS 1 (1999), *available at* <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf> (the percentages were either based on inmates reporting a mental condition or on inmates having had an overnight stay in a mental hospital). Most studies defined "severe mental illness" as psychotic illnesses, schizophrenia, mania, major depression, and antisocial personality disorder. *Id.* at 2.

72. *Id.* at 1.

73. CHRISTOPHER J. MUMOLA, U.S. DEP'T OF JUSTICE, INCARCERATED PARENTS AND THEIR CHILDREN 9 (2000), *available at* <http://www.ojp.usdoj.gov/bjs/pub/pdf/iptc.pdf>.

illness in federal prisons is less than half of that in state prisons, but one possibility includes the types of crimes charged under federal statutes. These include financial and large-scale trafficking crimes. Those with mental illnesses may not be able to function at a high enough level to be able to plan and commit these types of crimes.

Based on the population totals of June 30, 2004, the United States held an estimate of 304,263 mentally ill prisoners.⁷⁴ Because these statistics are based on self-reporting studies, the actual numbers may be even higher.⁷⁵ Indeed, the National Commission on Correctional Health Care reports higher rates of mental illness, estimating that 2.3% to 3.9% of those in state prisons have schizophrenia or another psychotic disorder, between 13.1% and 18.6% have a major depressive disorder, and another 2.1% to 4.3% have a bipolar disorder.⁷⁶ NAMI (formerly known as the National Alliance for the Mentally Ill) reported in 1999 that the number of inmates with mental illness in prison was three times that of the number of non-incarcerated people hospitalized with such illnesses.⁷⁷

As the population that may suffer in prison through inadequate treatment and indifference grows, so must our vigilance in monitoring to ensure their right to treatment is met.

B. Impact of Mentally Ill Offenders

Besides the ethical, moral, and constitutional reasons for providing treatment to prisoners, by treating inmates with a mental illness, both prisons and the public can be made safer. Studies have indicated that those with a mental illness may be more likely

74. This number was derived by using the population of prisoners in federal custody of 169,370, multiplied by 6.5%, which is the average of the rates in federal prisons, 7% and 6%, and then adding the population of inmates in state and local jail custody, 1,241,034 and 713,990, respectively, multiplied by 15%, the average of the rates in state prisons, 16% and 14%. See HARRISON AND BECK, *supra* note 65, Table 1.

75. See COUNCIL OF STATE GOV'TS, CRIMINAL JUSTICE / MENTAL HEALTH CONSENSUS PROJECT 105 (2002), available at http://www.soros.org/initiatives/justice/articles_publications/publications/cj_mh_consensus_20020601 (follow "Mental Health Consensus Project" hyperlink) (noting that prisoners, particularly those with mental health issues, are often unreliable in their reporting of factual information including that regarding their mental illness).

76. NAT'L COMM'N ON CORR. HEALTH CARE, 1 THE HEALTH STATUS OF SOON-TO-BE-RELEASED INMATES: A REPORT TO CONGRESS 22 (2002).

77. NAMI, CRIMINALIZATION OF THE MENTALLY ILL 1 (2001).

to commit a crime than those without such illness. For example, a study conducted in the state of New York found that men in the public mental health system were four times more likely to be incarcerated than other men; women were six times more likely to be.⁷⁸ In state prisons, inmates with a mental illness are slightly more likely to be incarcerated for a violent offense (53%) when compared to inmates without a mental illness (46%).⁷⁹ Although some argue these studies do not show a significant link between mental illness and violent crime, and many are concerned about the stigma these studies may place on those with mental illness, these studies provide an additional argument for treatment in prison.

Treatment can improve safety in prisons by reducing the number of disciplinary infractions. Inmates with mental illness are more likely than other inmates to cause violent disciplinary problems while in prison or jail, as Mark Walker demonstrated.⁸⁰ One study showed that while 25% of state prisoners without mental illness reported involvement in a fight, 36% of state prisoners with a mental illness reported the same.⁸¹ In the local jail populations, 6% of those prisoners without mental illness reported being in two or more fights.⁸² When examining prisoners with mental illness, that percentage increases to 10%.⁸³ Approximately 52% of prisoners without mental illness report being charged with breaking prison rules, compared to 62% of prisoners with mental illness.⁸⁴ A 1996 study reported that while inmates with a serious mental illness made up 18.7% of the prison population, they accounted for 41% of the infractions.⁸⁵

Providing mental health treatment to those in prison may impact the safety of the public in the future. Government studies suggest that, although offenders with mental illness are no more

78. Judith F. Cox et al., *A Five-Year Population Study of Persons Involved in the Mental Health and Local Correctional Systems*, 28 J. BEHAV. HEALTH SERVICES & RES. 177-87 (2001) (analyzing data from the mental health and criminal justice systems of twenty-five New York counties).

79. DITTON, *supra* note 71, at 1.

80. *Id.* at 9.

81. *Id.*

82. *Id.*

83. *Id.*

84. *Id.*

85. ILL-EQUIPPED, *supra* note 1, at 59-60 (citing R. JEMELKA ET AL., PREVALENCE OF PSYCHIATRIC DISABILITY AMONG PRISONERS (1996)).

likely to be recidivists than offenders without mental illness, they might be more likely to commit violent crimes after release. Of repeat offenders, 53% of state inmates with a mental illness had a current or past sentence for a violent crime, compared to 45% of those inmates without a mental illness.⁸⁶ The comparison among state jailed inmates is 46% to 32%, and among federal prisoners, it is 44% to 22%.⁸⁷

Congressional findings, issued in the Mentally Ill Offender Treatment and Crime Reduction Act of 2004, indicate that most of the prisoners with a mental illness are responsive to intervention that integrates “treatment, rehabilitation, and support services.”⁸⁸ Because of this responsiveness, along with the likelihood of violent recidivism, prisons should be taking advantage of the time available to treat their inmates.

IV. INADEQUACY OF TREATMENT IN PRISONS

Despite these reasons for providing treatment, many inmates with mental health needs do not receive the necessary treatment, or even minimal treatment.⁸⁹ Among state and federal inmates, only 60% of those in need reported receiving treatment while incarcerated.⁹⁰ Half said they had received prescription medication, and 44% received counseling or therapy.⁹¹ Roughly one-quarter reported being admitted overnight to a mental hospital or treatment program.⁹² Among those in local jails, only 41% of those with mental illness received any form of treatment.⁹³ Of those receiving treatment, one-third had been given medication, and only 16% had received counseling or therapy while in jail.⁹⁴

Prisons in the United States do not provide all aspects of an effective mental health care system. In most prison systems, what is

86. DITTON, *supra* note 71, at 5.

87. *Id.*

88. Mentally Ill Offender Treatment and Crime Reduction Act of 2004, Pub. L. No. 108-414 § 2(6). This Act was passed to establish mental health courts, but, as of the writing of this Comment, it remains unfunded in the proposed federal budget for 2006.

89. *See supra* Part II.

90. DITTON, *supra* note 71, at 9.

91. *Id.*

92. *Id.*

93. *Id.*

94. *Id.*

provided is ineffective due to lack of funding, inadequate staffing to meet the needs of the entire prison population, lack of training for the health care and security staff, and lack of procedures to identify and track the needs of prisoners.⁹⁵ Even with the best intentions, a prison system that does not have the necessary resources, adequate training, and skills, cannot provide effective mental health treatment to its prisoners.⁹⁶

Organizations, such as the National Commission on Correctional Health Care (NCCHC), individual correctional mental health experts, and courts, have defined general guidelines regarding what is needed for a positive mental health treatment program; however, no prison system meets all of those guidelines.⁹⁷ Specifically, NCCHC's guidelines include screening all prisoners for mental illness at the time of entry to identify mental illness that arises during incarceration, providing a range of mental health treatment services including therapeutic interventions other than medication, maintaining adequate and confidential clinical records, and providing different levels of care, including emergency psychiatric services, intermediate levels of care, and "outpatient" services.⁹⁸ The American Psychiatric Association indicates that mental health therapies provided to offenders should be multidisciplinary and also consistent with generally accepted mental health practices seen outside of the prison system.⁹⁹ These services include verbal interventions, individual and group therapy as appropriate, and "[p]rograms that provide productive, out-of-cell activity and teach necessary psychosocial and living skills"¹⁰⁰

The Supreme Court has not provided detailed guidelines regarding what is constitutionally required. Circuit courts are more likely to lay out specifics for the prisons to follow. For example, in

95. ILL-EQUIPPED, *supra* note 1, at 94.

96. *Id.*

97. *Id.*

98. *Id.*; see also FRED COHEN, THE MENTALLY DISORDERED INMATE AND THE LAW, apps. A-1 to 31 (1998) (comparing standards for mental health treatment and due process issued by the American Bar Association, American Correctional Association, American Psychiatric Association, American Psychological Association, American Public Health Association, and the National Commission on Correctional Health Care).

99. AM. PSYCHIATRIC ASS'N, PSYCHIATRIC SERVICES IN JAILS AND PRISONS 46 (2d ed. 2000).

100. *Id.*

Ruiz v. Estelle, the United States District Court for the Southern District of Texas laid out six minimum standards for complying with the Eighth Amendment regarding mental health treatment.¹⁰¹ First, a systematic program for screening and evaluating inmates must be utilized to identify those who require mental health treatment.¹⁰² Second, the treatment provided must be more than just segregation and close supervision.¹⁰³ Third, the prison must have a sufficient number of trained mental health professionals participating in the treatment of prisoners, who must be treated in an individualized manner.¹⁰⁴ Fourth, complete and accurate records of the mental health treatment process must be maintained.¹⁰⁵ Fifth, prescription and administration of behavior-altering medications in dangerous amounts is not an acceptable method of treatment, without appropriate supervision and periodic evaluations.¹⁰⁶ Finally, a program of identification, treatment, and supervision of inmates with suicidal ideations is necessary.¹⁰⁷

Psychiatrists, psychologists, counselors, nurses, and recreational/occupational therapists are all necessary to provide effective mental health services for the wide range of mental health issues found in the prison system.¹⁰⁸ But no specific requirements exist as to the number of these professionals needed for each prison or prisoner. According to the American Psychiatric Association, the goal should be to “provide the same level of mental health services to each patient in the criminal justice process that should be available to the community.”¹⁰⁹ Therefore, for example, the caseload of each full-time psychiatrist would be no more than 150 patients on psychotropic medication at any one time.¹¹⁰ Other experts have recommended anywhere from 75 patients to 200

101. *Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D. Tex. 1980), *aff'd in part, rev'd in part*, 679 F.2d 1115 (5th Cir. 1982), *reh'g granted, amended in part, vacated in part*, 688 F.2d 266 (5th Cir. 1982), *cert. denied*, 460 U.S. 1042 (1983).

102. *Id.* at 1339. *But see, e.g.*, *Estate of Novack v. County of Wood*, 226 F.3d 525, 532 (7th Cir. 2000) (holding that the Eighth Amendment was not violated even though prison officials failed to properly evaluate an inmate's mental health and prevent him from committing suicide).

103. *Ruiz*, 503 F. Supp. at 1339.

104. *Id.*

105. *Id.*

106. *Id.*

107. *Id.*

108. ILL-EQUIPPED, *supra* note 1, at 95.

109. AM. PSYCHIATRIC ASS'N, *supra* note 99, at 6.

110. *See id.* at 7-8.

patients per full-time psychiatrist.¹¹¹ Such a caseload provides adequate time for diagnosis and development of individualized treatment plans.¹¹² A study by Human Rights Watch (HRW) of U.S. prisons, however, found almost no prisons that approached this staffing level.¹¹³

HRW found that the Iowa Department of Corrections had three psychiatrists and thirty psychologists to treat the estimated 1800 to 2000 mentally ill prisoners.¹¹⁴ At the Wyoming State Penitentiary, one psychiatrist works on-site for two days a month. In those two days, he sees twenty-five prisoners, while an average of thirty-two new prisoners are referred to him each month.¹¹⁵ A 1997 report on New York state prisons found that the staffing had not kept pace with the rise in the prison population and that resources had not increased in years.¹¹⁶

Questions also exist regarding the qualifications and competence of the prison mental health staff.¹¹⁷ The most recent study of this issue, in 1988, found that 40% of mental health staff in prisons had less than a master's degree.¹¹⁸ The HRW report also raised the concern that mental health crises arise on weekends and evenings, when the mental health staff is not working.¹¹⁹ Usually the only alternative for prison guards is to isolate the prisoner, which often exacerbates the condition.¹²⁰

Identifying which prisoners need treatment is another trouble spot. Logically, identification of mental health needs would take place at intake, when a prisoner is first admitted to a facility after conviction or transfer from another institution.¹²¹ The intake process provides the prison staff with the information necessary to determine the proper placement of the prisoner in the prison community, such as gang affiliation, personality, and propensity for

111. ILL-EQUIPPED, *supra* note 1, at 95.

112. *Id.*

113. *Id.*

114. *Id.* (citing Telephone Interview with Harbans Deol, Medical Director, Iowa Department of Corrections (June 14, 2002)).

115. *Id.* at 96.

116. *Id.* (citing NEW YORK STATE OFFICE OF MENTAL HEALTH, TASK FORCE ON THE FUTURE OF FORENSIC SERVICES—REPORT OF THE SUBCOMMITTEE ON PRISON MENTAL HEALTH SERVICES 9-11 (1997)).

117. *See id.* at 99.

118. *Id.*

119. *Id.* at 100.

120. *Id.* at 43.

121. *See id.* at 101.

violence.¹²² Because each prisoner automatically goes through intake, many prisons have found this time to be appropriate to screen inmates for mental health needs as well.¹²³ However, according to the Department of Justice, as of 2000, thirty-two percent of state correctional facilities do not provide mental health screening of each inmate at intake.¹²⁴

Although the recommended guidelines indicate that screening of every prisoner should be done, no standards exist regarding how this screening should occur. Often, screening for mental illness consists of a questionnaire for the prisoner to complete, but no standards exist for the questionnaires used, or for the training of staff who administer the process.¹²⁵ The screening questionnaire can vary from system to system or even prison to prison. In a state-of-the-art program, the Michigan Bureau of Forensic Mental Health Services created a comprehensive prison-screening infrastructure.¹²⁶ However, even this agency reported that, despite its efforts, six to eight inmates a month were processed through screening without a proper identification of their need for mental health treatment.¹²⁷

Prison systems across the nation have consistently been found not to provide timely access to mental health care, presumably because of lack of mental health staff. Prisoners complain of waiting anywhere from days to months to see a mental health professional after requesting a meeting or to have their medications adjusted.¹²⁸ A 1998 report on the Wyoming State Penitentiary found that out of ninety-five people referred for mental health services over three months, only six were actually evaluated.¹²⁹ In Alabama, where mental health services are outsourced to a private company, mental health staff is present at

122. See PATRICIA L. HARDYMAN ET AL., NAT'L INST. OF CORR., PRISONER INTAKE SYSTEMS: ASSESSING NEEDS AND CLASSIFYING PRISONERS 8-12 (2004), <http://www.nicic.org/pubs/2004/019033.pdf>.

123. See *id.*

124. BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, SOURCEBOOK OF CRIMINAL JUSTICE STATISTICS 529 (2003), available at <http://www.albany.edu/sourcebook/pdf/section6.pdf> [hereinafter CRIMINAL JUSTICE STATISTICS 2002].

125. ILL-EQUIPPED, *supra* note 1, at 101.

126. *Id.*

127. *Id.*

128. *Id.* at 103-04.

129. *Id.* at 104.

the prisons only one to two days per week.¹³⁰ When a prisoner has a mental health emergency on a day when the staff is not present, he or she is placed in isolation until the staff's next scheduled day.¹³¹ As of June 2002, fewer than half of all state prisons provided twenty-four-hour mental health care.¹³² Three states did not provide twenty-four-hour care in any of their prisons: Rhode Island (seven prisons total), Nebraska (nine prisons), and Missouri (twenty-eight prisons).¹³³

Prisoners often go untreated because security staff, or under-qualified and/or understaffed medical personnel, believe the prisoners are either faking their symptoms or are being manipulative.¹³⁴ These prisoners are often improperly diagnosed as "malingering."¹³⁵ When prisoners do receive treatment, it often consists only of medication.¹³⁶ For example, an investigation at the Putnamville Correctional Facility in Indiana found that eight of twelve prisoners whose health records were examined were taking psychotropic medication, and they were without individualized treatment plans.¹³⁷ On average, 9.7% of all inmates in the United States were receiving psychotropic medications in June 2000, but in the most extreme states, over 20% received these medications.¹³⁸

The HRW report also details instances where effectiveness of medication is not documented or followed up on, prescriptions are written by doctors who have never seen the patient personally, medications are administered inconsistently, side effects are not monitored, and medications are discontinued rather than tapered off, giving rise to serious reactions from withdrawal.¹³⁹ Although this treatment may not meet the ethical obligations of the doctors that provide this "treatment," it is constitutional.

130. *Id.* at 105 (citing KATHRYN BURNS & JANE HADDAD, MENTAL HEALTH CARE IN THE ALABAMA DEPARTMENT OF CORRECTIONS 66 (2000)).

131. *Id.*

132. CRIMINAL JUSTICE STATISTICS 2002, *supra* note 124, at 529.

133. *Id.*

134. ILL-EQUIPPED, *supra* note 1, at 106.

135. *Id.*

136. *See id.* at 109.

137. *Id.* at 112 (citing Kevin Corcoran, *Prison Mental Health Care: "Absolutely Atrocious,"* INDIANAPOLIS TIMES, Sept. 17, 1997).

138. CRIMINAL JUSTICE STATISTICS 2002, *supra* note 124, at 530. The percentage of inmates receiving psychotropic medication in the four most extreme states were Montana, at 21.4%, Maine, at 23.5%, Vermont, at 28.3%, and North Dakota, at 39.3%. *Id.*

139. ILL-EQUIPPED, *supra* note 1, at 115-20.

V. RIGHTS OF PRISONERS TO TREATMENT

A. *Constitutional Rights of Prisoners*

Although inmates have a right to treatment of their mental illnesses, the prison staff must run an entire prison system, and therefore balance the needs of all the prisoners as well as enforce a safe environment. In *Pell v. Procunier*,¹⁴⁰ the Supreme Court explained the concerns that arise about legal challenges to the treatment of prisoners:

An important function of the corrections system is the deterrence of crime. The premise is that by confining criminal offenders in a facility where they are isolated from the rest of society, a condition that most people presumably find undesirable, they and others will be deterred from committing additional criminal offenses. This isolation, of course, also serves a protective function by quarantining criminal offenders for a given period of time while, it is hoped, the rehabilitative processes of the corrections system work to correct the offender's demonstrated criminal proclivity. Thus, since most offenders will eventually return to society, another paramount objective of the corrections system is the rehabilitation of those committed to its custody. Finally, central to all other corrections goals is the institutional consideration of internal security within the corrections facilities themselves. It is in the light of these legitimate penal objectives that a court must assess challenges to prison regulations based on asserted constitutional rights of prisoners.¹⁴¹

Prisoners do not enjoy full constitutional protection. Furthermore, there is continued infringement of the constitutional rights they do have, "for the sake of proper prison administration."¹⁴² The Supreme Court wrote elsewhere, "Lawful incarceration brings about the necessary withdrawal or limitation of many privileges and rights, a retraction justified by the

140. 417 U.S. 817 (1974).

141. *Id.* at 822-23.

142. *Johnson v. California*, 125 S. Ct. 1141, 1149 (2005) (citing *Turner v. Safley*, 482 U.S. 78, 89 (1987)); *see also* *Bell v. Wolfish*, 441 U.S. 520 (1979) (finding that measures limiting a prisoner's rights for the purpose of ensuring the security and order of the institution are not unconstitutional).

considerations underlying our penal system.”¹⁴³ Unfortunately, the Prisoner Litigation Reform Act¹⁴⁴ further limits the ability of inmates to find relief when their rights are violated.¹⁴⁵

B. Constitutional Rights of Prisoners to Healthcare

The cruel and unusual punishment clause of the Eighth Amendment requires the government to provide care for prisoners’ serious medical needs, including mental health care:¹⁴⁶

An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce “physical torture or a lingering death” The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency¹⁴⁷

Despite their right to treatment, prisoners do not have a right to define the timing or the type of medical care they receive. In Mark Walker’s situation, he wanted to continue taking his medication.¹⁴⁸ After drawing attention to himself by discontinuing the lithium, he was given a different diagnosis.¹⁴⁹ He suffered inhumane treatment and attempted suicide three times before filing a lawsuit and finally being diagnosed correctly *again*.¹⁵⁰

143. Price v. Johnston, 334 U.S. 266, 285 (1948); *see also* Cruz v. Beto, 405 U.S. 319, 321 (1972) (“[R]acial segregation, which is unconstitutional outside prisons, is unconstitutional within prisons, save for the necessities of prison security and discipline.”).

144. 42 U.S.C. § 1997e (2000).

145. *Id.* § 1997e(e) (“No Federal civil action may be brought by a prisoner confined in a jail, prison, or other correctional facility, for mental or emotional injury suffered while in custody without a prior showing of physical injury.”).

146. Estelle v. Gamble, 429 U.S. 97, 102-04 (1976); *see also* Bowring v. Godwin, 551 F.2d 44, 47 (4th Cir. 1977) (arguing that failure to provide treatment may violate the Eighth Amendment, as well as the Fourteenth Amendment’s Due Process Clause, for deprivation of life); Ruiz v. Estelle, 503 F. Supp. 1265, 1328 (S.D. Tex. 1980), *stay denied in part, granted in part*, 650 F.2d 555 (5th Cir. 1981), *stay denied in part, granted in part*, 666 F.2d 854 (5th Cir. 1982), *aff’d in part, rev’d in part*, 679 F.2d 1115 (5th Cir. 1982), *opinion amended in part, vacated in part*, 688 F.2d 266 (5th Cir. 1982), *cert. denied*, 460 U.S. 1042 (1983) (arguing the duty to provide medical care mandated by the Eighth Amendment “is a direct consequence of the state’s legitimate power to deprive a person of his freedom for a violation of its penal laws”); Cohen & Dvoskin, *supra* note 3, at 462.

147. *Gamble*, 429 U.S. at 103 (citations omitted).

148. *See* ILL-EQUIPPED, *supra* note 1, at 93.

149. Walker v. State, 68 P.3d 872 (Mont. 2003).

150. *Id.* at 875.

The State is only obligated to provide treatment for “serious” health issues, but various definitions exist for what is considered “serious.” According to the Tenth Circuit, the obviousness test defines a medical need as serious if it is “one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor’s attention.”¹⁵¹ The Ninth Circuit defined a serious medical need as a condition that “could result in further significant injury or the unnecessary and wanton infliction of pain” if left untreated, and “an injury that a reasonable doctor or patient would find important and worthy of comment or treatment, [or] the presence of a medical condition that significantly affects an individual’s daily activities”¹⁵² Clearly the Ninth Circuit definition provides corrections staff with a more detailed test and is therefore easier to follow. But by either definition, the availability of treatment may come down to the specific doctor, medical staff, or even trained prison guard, and how that person views the symptoms described or exhibited by the inmate.

Prison measures for providing medical treatment are evaluated against a standard of deliberate indifference, including a determination of whether there is an “unnecessary and wanton infliction of pain.”¹⁵³ According to case law, deliberate indifference indicates an unnecessary and wanton infliction of pain, whether it is “manifested by prison doctors in their response to the prisoner’s needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed.”¹⁵⁴ When prison officials find an obvious need for mental health treatment, a failure to provide treatment constitutes deliberate indifference.¹⁵⁵ This indifference creates a cause of action under 42 United States Code section 1983.¹⁵⁶ An *inadvertent* failure to provide adequate medical care, however, does not create a cause of action, because it “cannot be said to constitute ‘an unnecessary and wanton infliction of pain’ or

151. Ramos v. Lamm, 639 F.2d 559, 575 (10th Cir. 1980), *cert. denied*, 450 U.S. 1041 (1981) (quoting Laaman v. Helgemoe, 437 F. Supp. 269, 311 (D.N.H. 1997)).

152. McGuckin v. Smith, 974 F.2d 1050, 1059-60 (9th Cir. 1992) (citing Wood v. Housewright, 900 F.2d 1332, 1337-41 (9th Cir. 1990)).

153. Gregg v. Georgia, 428 U.S. 153, 172-73 (1976).

154. Estelle v. Gamble, 429 U.S. 97, 104-05 (1976).

155. Farmer v. Brennan, 511 U.S. 825, 842 (1994).

156. *Gamble*, 429 U.S. at 105 (citing 42 U.S.C. § 1983 (1970)).

to be ‘repugnant to the conscience of mankind.’”¹⁵⁷ Deliberate indifference means that the prison official was “aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference.”¹⁵⁸ Therefore, if a prisoner is receiving medical treatment, even if the treatment is not helping and better treatment options exist, the courts will not find an Eighth Amendment violation. If the prison is providing medical care, then there is no deliberate indifference. A court will not consider the viability of other treatment options because that is best left to the doctors. A difference in medical opinion does not amount to deliberate indifference.¹⁵⁹ Only where the difference in medical opinion leads to such a serious illness that even a lay person could identify it, such as what happened in the case of Mark Walker, will the court find an obligation by the state prison.¹⁶⁰

For example, in *Estelle v. Gamble*,¹⁶¹ Gamble suffered from a back injury and complained of the treatment he received.¹⁶² Although this case deals with physical ailments rather than mental, the courts have held that the right to physical and mental health treatments are the same.¹⁶³ Gamble was seen by prison medical personnel seventeen times.¹⁶⁴ He was checked for a hernia, given pain pills and muscle relaxants, and diagnosed with a lower back strain, but the pain continued.¹⁶⁵ After a month, despite Gamble’s assertions that the pain had not diminished, he was certified by the doctors for light work, although the doctors also continued to prescribe pain medication.¹⁶⁶ No additional steps were taken for further diagnosis.¹⁶⁷

157. *Id.* at 105-06.

158. *Farmer*, 511 U.S. at 837.

159. *See Sanchez v. Vild*, 891 F.2d 240, 242 (9th Cir. 1989); *see also Franklin v. Oregon*, 662 F.2d 1337, 1344 (9th Cir. 1981).

160. *Ramos v. Lamm*, 639 F.2d 559, 575 (10th Cir. 1980), *cert. denied*, 450 U.S. 1041 (1981) (quoting *Laaman v. Helgemoe*, 437 F. Supp. 269, 311 (D.N.H. 1997)).

161. 429 U.S. 97 (1976).

162. *Id.* at 98.

163. *See, e.g., Jones 'El v. Berge*, 164 F. Supp. 2d 1096 (W.D. Wis. 2001) (holding that the Eighth Amendment similarly protects the rights of prisoners to be treated both for physical and mental health ailments).

164. *Gamble*, 429 U.S. at 97.

165. *Id.* at 99.

166. *Id.* at 100.

167. *Id.*

Gamble was taken before a disciplinary committee for refusing to work.¹⁶⁸ After hearing his complaints, the committee ordered he be seen by another doctor.¹⁶⁹ This doctor performed a urinalysis, a blood test, and a blood pressure measurement.¹⁷⁰ The doctor prescribed medication for high blood pressure and continued the back pain medication.¹⁷¹ After another two months of being prescribed pain medication, Gamble was again brought before the disciplinary committee for refusing to work.¹⁷² The original doctor testified that he was in “first class” medical condition.¹⁷³ The committee placed Gamble in solitary confinement without any further medical examination or testimony.¹⁷⁴ Another month passed before he was properly diagnosed and treated during a hospitalization for an unrelated heart condition.¹⁷⁵

Gamble filed suit, contending that the doctors should have done more to diagnose and treat his back pain.¹⁷⁶ An x-ray was never taken, and he argued that other tests should have been conducted “that would have led to an appropriate diagnosis and treatment for the daily pain and suffering he was experiencing.”¹⁷⁷ The court held, however, that the prison staff was not deliberately indifferent to Gamble and his injury. “A medical decision not to order an X-ray, or like measures, does not represent cruel and unusual punishment. At most it is medical malpractice”¹⁷⁸

Malpractice claims do not constitute an Eighth Amendment violation, but rather fall under state court jurisdiction for torts.¹⁷⁹ The Eighth Amendment does not require the most progressive health treatment available.¹⁸⁰

168. *Id.*

169. *Id.*

170. *Id.*

171. *Id.*

172. *Id.* at 101.

173. *Id.*

174. *Id.*

175. *Id.*

176. *Id.* at 107.

177. *Id.*

178. *Id.*

179. *Id.*

180. *See Rhodes v. Chapman*, 452 U.S. 337, 349 (1991) (noting that the Constitution does not mandate comfortable prisons); *Anderson v. Romero*, 72 F.3d 518, 524 (7th Cir. 1995) (asserting that the Eighth Amendment does not require the most humane and progressive prison administration possible); *Woodall v. Foti*, 648 F.2d 268, 272 (5th Cir. 1981) (arguing that the Eighth Amendment merely requires medical necessity, not desirability).

The court condones the stance that malpractice by prison doctors is constitutional. It is when the constitutional rights of prisoners do not provide for adequate treatment, such as those in *Estelle v. Gamble*, that the system truly fails. Although prison doctors have an ethical duty to provide adequate treatment, a lack of training, resources, and availability can hamper their efforts to do so.¹⁸¹ The Prison Litigation Reform Act, discussed below, prevents inmates from using the court system to obtain adequate care.¹⁸²

C. *Right to Object to Treatment Methods*

Just like anyone else, prisoners have an opinion about their treatment. They may believe they need treatment when their doctor does not, may believe they would do better under a different treatment plan, or may object to any treatment at all. However, unlike people outside of prison, they cannot simply seek a second or third opinion. How can prisoners object to the treatment they are, or are not, receiving?

Procedural due process ensures that legitimate government actions are administered fairly. *Vitek v. Jones* is the leading case regarding the procedural due process rights of prisoners questioning an ordered transfer from a prison to a mental hospital for treatment.¹⁸³ In *Vitek*, the prisoner did not want to be transferred from his current prison environment.¹⁸⁴ Noting that commitment for ordinary citizens to a mental hospital triggers “a massive curtailment of liberty” which requires due process protection, the Supreme Court reviewed some of the liberty impacts on a prisoner.¹⁸⁵ When a prisoner is sent to a separate mental treatment facility, the freedom that the inmate had is further curtailed, and stigmatizing consequences also follow.¹⁸⁶ The court recognized the major change to the prisoner’s life caused by the transfer.¹⁸⁷ To provide protection to the liberty

181. ILL-EQUIPPED, *supra* note 1, at 94.

182. See 42 U.S.C. § 1997e(a) (2000) (“[N]o action shall be brought with respect to prison conditions . . . by a prisoner confined in any jail, prison, or other correctional facility until such administrative remedies as are available are exhausted.”).

183. 445 U.S. 480 (1980).

184. *Id.* at 484.

185. *Id.* at 491-92 (citing *Humphrey v. Cady*, 405 U.S. 504, 509 (1972)).

186. *Id.* at 492.

187. *Id.*

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interest of the inmates, prison officials must at a minimum provide prisoners with procedures to protect their due process interests:

- A. When a transfer to a mental hospital is being considered, provide written notice to the prisoner, providing effective and timely notice of all of his rights;
- B. Provide a hearing after a certain time frame from the notice, giving the prisoner time to prepare, at which disclosure of the evidence being relied upon for the transfer and at which an opportunity to be heard in person and to present documentary evidence is given;
- C. Provide the prisoner with an opportunity at the hearing to present testimony of witnesses for his defense, and to confront and cross-examine witnesses called by the state, except upon a finding, not arbitrarily made, of good cause for not permitting such presentation, confrontation, or cross-examination;
- D. The hearing must be heard by an independent decisionmaker, although not necessarily from outside the prison or hospital administration;
- E. After the hearing, a written statement should be created by the factfinder as to the evidence relied on and the reasons for transferring the inmate;
- F. If the inmate is unable financially to hire his own legal counsel for this hearing, the state must provide him with one.¹⁸⁸

The court explained that, even though treatment decisions are inherently medical, the intricacies of a psychiatric diagnosis “justify the requirement of adversary hearings,” which balance the State’s strong interest in segregating and treating the mentally ill with an inmate’s strong liberty interest.¹⁸⁹

In *Washington v. Harper*, the Supreme Court addressed the nature of a hearing held when a prisoner does not acquiesce to the prescribed treatment.¹⁹⁰ Certain factors guide the decision on

188. *Id.* at 494-95 (citing *Miller v. Vitek*, 437 F. Supp. 569, 575 (D. Neb. 1977)).

189. *Id.* at 495.

190. 494 U.S. 210 (1990). The same due process rights are extended to inmates who are not yet sentenced but detained for trial. *See Riggins v. Nevada*, 504 U.S. 127, 134-35 (1992).

whether or not due process requirements are met: “the private interests at stake in a governmental decision, the governmental interests involved, and the value of the procedural requirements in determining what process is due under the Fourteenth Amendment.”¹⁹¹ Although those factors have not changed since *Vitek*, the court seems to have changed its mind on the adversarial nature of the proceedings.

The procedures in *Washington v. Harper* provide the inmate with twenty-four-hour notice of a hearing to determine whether or not he will be forcibly medicated, during which time he will not be medicated, and an opportunity to be heard at that hearing.¹⁹² The hearing does not need to be conducted by the rules of evidence, and the standard of proof may be a simple preponderance of the evidence.¹⁹³ The court also noted that state law provides the prisoner with an ability to have judicial review of the committee’s decision.¹⁹⁴ The prisoner does not have a right to legal counsel.¹⁹⁵ Due to the nature of the decision to be made, they found that having a “lay adviser who understands the psychiatric issues involved is sufficient protection.”¹⁹⁶

The Court determined that the decision regarding forcible treatment can be made by a panel of medical professionals, without hearing any legal arguments regarding the liberty interest of the prisoner.¹⁹⁷ The Court explained that the “Constitution does not prohibit the state from permitting medical personnel to make the decision under fair procedural mechanisms,” and the Due Process Clause does not require that the neutral trier of fact, a committee in this case, be a judicial or administrative officer.¹⁹⁸ Although the committee members do not have to come from outside the prison staff, the people cannot be involved in the inmate’s current treatment or diagnosis.¹⁹⁹ The Court also expressed concern regarding the impact of requiring judicial hearings for these

191. *Harper*, 494 U.S. at 229 (citing *Hewitt v. Helms*, 459 U.S. 472, 473 (1983); *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976)).

192. *Id.* at 216.

193. *Id.* at 233.

194. *Id.*

195. *Id.*

196. *Id.*; see also *Vitek v. Jones*, 445 U.S. 499, 500 (1980) (Powell, J., concurring) (asserting the presence of a legal counsel is not necessary).

197. *Harper*, 494 U.S. at 227.

198. *Id.*

199. *Id.* at 233.

decisions, stating that they would “divert scarce prison resources, both money and the staff’s time, from the care and treatment of mentally ill inmates.”²⁰⁰

The implication is that the decisions to be made at these hearings, which are held in an effort to protect the legal rights of prisoners, are medical, not legal ones. The court said as such in its holding, when citing *Walters v. National Association of Radiation Survivors*:²⁰¹ “[I]t is less than crystal clear why *lawyers* must be available to identify possible errors in *medical* judgment.”²⁰² But how can doctors balance an individual’s liberty right with their own medical recommendations? Is the medical staff at these hearings trained on liberty interests, or how to identify or balance opposing interests? Why does the transfer of a prisoner for treatment demand greater protection of liberty interests than forcible treatment of a prisoner? Additionally, why does the exercising of a liberty right have to be in someone’s personal best interest?

D. Legislative Impacts on Prisoners’ Right to Mental Health Treatment

Although the Constitution provides prisoners with a right to health care and mental health treatment, their ability to use the courts to enforce their rights is limited through the Prison Litigation Reform Act (PLRA).²⁰³ The PLRA imposes significant barriers to prisoners who try to file grievances with the courts, and also limits the courts’ ability to address the issues they are able to see.

First, PLRA takes several steps to inhibit the filing of claims by prisoners. Prisoners must first exhaust their administrative remedies within the prison system.²⁰⁴ Before filing a claim in court, the prisoners must follow the grievance procedures in their prison, even if the relief sought cannot be obtained through this process.²⁰⁵ Once those avenues have been taken, the prisoner must then pay

200. *Id.* at 227 (citing *Parham v. J.R.*, 442 U.S. 605, 606 (1979)).

201. 473 U.S. 305 (1985).

202. *Id.* at 336.

203. 42 U.S.C. § 1997e (2000).

204. *Id.* § 1997e(a).

205. *See Booth v. Churner*, 532 U.S. 731, 731 (2001); *see also Porter v. Nussle*, 534 U.S. 516, 516-17 (2002) (stating that despite an agency’s inability to provide relief sought, or that administrative rules prohibit most inmate claims, the total exhaustion rule still applies).

filing fees to bring his civil action to court.²⁰⁶ If the prisoner cannot pay the total fees, a partial payment must be made, followed by incremental payments until the filing fee has been completely paid.²⁰⁷ The trial court must screen out prisoners' civil complaints that do not contain a physical-injury component.²⁰⁸ The court may also dismiss cases through standard grounds, for example, the court may find them frivolous or malicious, because the case fails to state a claim upon which relief can be granted, or the claim seeks damages from someone with immunity.²⁰⁹ Finally, the PLRA limits the amount of attorney's fees that can be awarded when a prisoner wins on his or her civil claim under 42 United States Code section 1988, likely discouraging many attorneys from providing assistance in these claims.²¹⁰

Second, the PLRA curbs a court's ability to provide relief. A preliminary injunction ordered in an unconstitutional confinement conditions case automatically expires ninety days after being issued.²¹¹ Prospective relief ordered after a finding for the prisoner must be narrowly tailored, extend no further than necessary, and be the least restrictive means available.²¹² Any prospective relief ordered will then terminate after two years upon motion of any party.²¹³ To continue the injunction, a court must issue:

206. 28 U.S.C. § 1915(b)(1) (2000).

207. *Id.* § 1915(b)(1)-(2). To begin payment of the filing fee, the prisoner must pay twenty percent of whichever is greater: (1) the average monthly deposits to the prisoner's trust-fund account, or (2) the average monthly balance in that account during the six months preceding the filing of the complaint or appeal. *Id.* § 1915(b)(1). However, if the prisoner lacks the assets or the means to pay the initial fee, he or she can still file the complaint or appeal. *Id.* § 1915(b)(4).

208. 42 U.S.C. § 1997e(e).

209. 28 U.S.C. § 1915(e)(2) (applying to persons proceeding in forma pauperis in the district court or on appeal); *id.* § 1915A(b) (applying to prisoners' lawsuits filed against a governmental entity or official); 42 U.S.C. § 1997e(c) (applying to cases contesting the legality of prison conditions under 42 U.S.C. § 1983 or some other federal law).

210. 42 U.S.C. § 1997e(d).

211. 18 U.S.C. § 3626(a)(2) (2000). If the court makes the following findings necessary to grant prospective relief, the preliminary injunction will not expire at the 90 day mark: the injunction is (1) necessary to remedy a violation of a federal right, (2) is narrowly drawn, (3) extends no further than necessary to remedy the federal-right violation, and (4) is the least intrusive means of doing so. *Id.* § 3626(a)(1)(A), (a)(2).

212. *Id.* § 3626(a)(2). A defendant can move for immediate dismissal if the court does not provide their findings of these requirements. *Id.* § 3626(b)(1)(B)(2).

213. *Id.* § 3626(b)(1)(A)(i).

written findings based on the record that prospective relief remains necessary to correct a current and ongoing violation of the Federal right, extends no further than necessary to correct the violation of the Federal right, and that the prospective relief is narrowly drawn and the least intrusive means to correct the violation.²¹⁴

Although not directly attributable to the PLRA, the number of cases brought by prisoners against the corrections system has dropped significantly since PLRA's passage in 1996.²¹⁵ The number of new prisoner cases filed in federal district courts dropped from 41,215 in 1996 to 25,805 in 2000.²¹⁶

E. Impact of Guidelines and Court Orders

Prison officials are only required to provide the most basic care to have a program considered constitutionally acceptable.²¹⁷ Although guidelines are laid out for prison officials on what should be done by various professional organizations, these guidelines go beyond what courts have found to be constitutionally required, and therefore no impetus exists for the prison officials to follow them.²¹⁸ Additionally, court orders are only performed on prisons or prison systems that have been found to have violated constitutional rights; no court master looks to determine if that other prisons comply with whatever new standard is set by a court decision. Also, because most prisons are state prisons and the court decisions are made by state courts, prisons in other states are not required to adhere to them. Other state prisons have no need to worry unless one of their inmates with a mental illness actually manages to have his or

214. *Id.* § 3626 (b) (3).

215. See Christopher E. Smith & Christopher E. Nelson, *Perceptions of the Consequences of the Prison Litigation Reform Act: A Comparison of State Attorneys General and Federal District Judges*, JUST. SYS. J. 295, 299 (2002), available at http://www.findarticles.com/p/articles/mi_qa4043/is_200201/ai_n9026034/pg_2.

216. See Todd Marti, *From the Government's Perspective: Has PLRA Worked? Yes!*, 13 CORRECTIONAL L. REP. 69 (2002).

217. See COHEN, *supra* note 98, at 2-8. The minimal components are generally understood to include a systematic program for screening, treatment consisting of more than just segregation and close supervision, treatment by trained mental health professionals, accurate and confidential record-keeping, prescription and administration of medications as necessary, and a basic program for identification, treatment, and supervision of inmates with suicidal tendencies. *Id.*

218. Compare *supra* text accompanying note 217, with *supra* text accompanying note 98.

her case heard on the merits by a court.

VI. MANDATED RESOLUTIONS

What have the courts done to address the claims raised by inmates regarding access to mental health treatment once a violation of constitutional rights has been found? With due process violations, clearly they have developed resolutions through a clear definition of minimum process requirements.²¹⁹ But “[f]ederal courts are not instruments for prison reform, and federal judges are not prison administrators.”²²⁰

Where Eighth Amendment violations have been found, a court generally points the way and leaves the details to the parties involved. For example, in *Casey v. Lewis*,²²¹ the federal district court of Arizona ordered the parties to meet and discuss proposals to remedy the areas in need within the state prisons’ mental health care system.²²² Four months were allowed for the parties to agree upon a proposed remedy and file it with the court.²²³ Guidelines were given for what the plan had to address, such as staffing levels, facilities, medication administration, and monitoring.²²⁴

One of the most famous cases of prisoner abuse and neglect is *Madrid v. Gomez*,²²⁵ dealing with the conditions at Pelican Bay State Prison in California.²²⁶ The prison opened and operated for five years without *any* psychiatrists on its staff.²²⁷ Systematic deficiencies in mental health care delivery were found.²²⁸ Here, the Eighth Amendment violation remedy was addressed through the appointment of a special master to work with the parties in developing a remedial plan.²²⁹ This master was appointed to work with the parties in developing a remedial plan.²³⁰ Every thirty days, the court was to receive a status update from the master, and at 120

219. *See Vitek v. Jones*, 445 U.S. 480 (1980).

220. *Madrid v. Gomez*, 889 F. Supp. 1146, 1279 (N.D. Cal. 1995).

221. 834 F. Supp. 1477 (D. Ariz. 1993).

222. *Id.* at 1553.

223. *Id.*

224. *Id.*

225. 889 F. Supp. 1146 (N.D. Cal. 1995).

226. *Id.*

227. *Id.* at 1214.

228. *Id.* at 1216-17.

229. *Id.* at 1282-83.

230. *Id.*

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days the parties were to jointly submit an agreed-upon plan.²³¹

In another case, after finding Eighth and Fourteenth Amendment violations of the rights of prisoners with serious mental health disorders by the California Department of Corrections, the magistrate's recommendations were accepted by the United States District Court.²³² Again, a special master was appointed.²³³ Development and implementation of two remedial plans were required within thirty days.²³⁴ The first plan dealt with the development and implementation of standardized screening forms and protocols; the second concerned medication protocols.²³⁵ Additional plans were required within sixty and ninety days.²³⁶

The appointment of a special master allows for a monitored environment, where the improvements made are studied and documented. This allows for greater assurance that the mental health treatment issues have improved, rather than the situation we are faced with in the Mark Walker case. There we have only assurances from the Montana State Prison, the prison that denied Walker was ever mentally ill to begin with and the prison that put him in an isolation cell contaminated with blood, vomit, and feces, that they are providing adequate treatment.²³⁷

VII. CONCLUSION

The size of the prison population in need of mental health treatment is staggering. We have a duty, constitutionally, morally, and ethically, to provide treatment to meet the needs of these inmates. We know what the needs are and how to meet them. Organizations such as NCCHC and APA have provided detailed guidelines regarding what is necessary to provide the necessary mental health treatment, such as screening all prisoners for mental illness at the time of entry and arising during incarceration, providing a range of mental health treatment services including therapeutic interventions other than medication, adequate and confidential clinical records, and providing different levels of care,

231. *Id.* at 1283.

232. *Coleman v. Wilson*, 912 F. Supp. 1282, 1324 (E.D. Cal. 1995).

233. *Id.*

234. *Id.* at 1323.

235. *Id.*

236. *Id.*

237. *See KOCH, supra* note 53.

including emergency psychiatric services, intermediate levels of care, and “outpatient” services.²³⁸ The U.S. prisons must implement these guidelines so we do not have more stories like that of Mark Walker.

238. *See supra* Part IV.