

ENFORCED MEDICATION IN JAILS AND PRISONS: THE NEW ASYLUMS

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INTRODUCTION

The earliest mental hospitals were known as asylums because they served as a refuge from the stresses of community life and from the possibility of criminal punishment.¹ Nonetheless, those imprisoned often included mentally ill individuals who received no effective treatment.² “Asylums” eventually took on the negative connotation of being large overcrowded warehouses filled with mentally ill individuals who did not receive effective treatment.³ Later in the 20th century the social policy of de-hospitalization contributed to the increasing numbers of mentally ill persons in jails and prisons.⁴ Attempts were made to provide inmates with the mental health services that they needed, including hospitalization.⁵

Today hospitalization is becoming less available to inmates in need of this service in part, it is said, to contain state budgets.⁶

For those who are severely psychotic and refusing antipsychotic medication, it is proposed, and in some correctional systems practiced, to administer enforced medication in non-medical correctional facilities (NMCF), thereby obviating the need for hospitalization.⁷ This would provide those most severely disturbed inmates with the antipsychotic medicine that they need but deprive them of the level and quality of mental health services that is afforded to non-incarcerated individuals with the

¹ See JAMES N. BUTCHER ET AL., *ABNORMAL PSYCHOLOGY: CORE CONCEPTS* 13 (2d ed. 2011).

² *Id.*

³ See *id.*

⁴ See Rockwell Schulz & Gregory Greenberg, *Theory and Framework for Evaluating the Implementation of Change*, in *INNOVATING IN COMMUNITY MENTAL HEALTH* 19, 19–20 (Rockwell Schulz & James R. Greenley eds., 1995).

⁵ See E. FULLER TORREY ET AL., *TREATMENT ADVOCACY CTR. & NAT'L SHERIFFS' ASS'N, THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN PRISONS AND JAILS: A STATE SURVEY 19 (2014)*, available at <http://tacereports.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf> (quoting a prison psychiatrist who indicates that there are too many mentally ill patients to care for, and stating the various mental health services available to prisoners).

⁶ See, e.g., Alana Horowitz, *Mental Illness Soars in Prisons, Jails While Inmates Suffer*, HUFFINGTON POST (Feb. 4, 2013, 12:58 PM), http://www.huffingtonpost.com/2013/02/04/mental-illness-prisons-jails-inmates_n_2610062.html.

⁷ See Patricia E. Sindel, *Fourteenth Amendment: The Right to Refuse Antipsychotic Drugs Masked by Prison Bars*, 81 J. CRIM. L. & CRIMINOLOGY 952, 966 (1991); e.g., TORREY ET AL., *supra* note 5, at 20.

same mental conditions.⁸ Enforced medication in jails and prisons ensures these facilities will devolve into society's "new asylums[.]"⁹ This article notes that even the "Joint Report" recently published by the Treatment Advocacy Center and the National Sheriff's Center promotes enforced medication without hospitalization, in effect contributing to the devolution of jails and prisons into the "new asylums[.]" and providing an excusing and convenient alternative to the continuing withdrawal of appropriate mental health services for those with the greatest need.¹⁰ The remedy proposed here for this harmful trend is to ensure that individuals in need of enforced medication will have this service provided in the appropriate place, i.e., in a mental hospital.

I. A BRIEF HISTORY OF THE ASYLUM

In ancient times a statue of a god, an altar, or a temple could serve as an asylum.¹¹ Removal of a person from such a place of protection or refuge constituted a sacrilege.¹² Later, Christian churches served this function and were called sanctuaries.¹³ In recent centuries asylums came to refer more commonly to institutions, such as orphanages and mental institutions, which provided care and relief for certain classes of people.¹⁴

In 18th century England the historic prison reformer John Howard observed the plight of the mentally ill in English jails:

[I]n some few gaols are confined idiots and lunatics. These serve for sport to idle visitants at assizes, and other times of general resort. Many of the bridewells are crowded and offensive, because

⁸ See generally Anasseril E. Daniel, *Care of the Mentally Ill in Prisons: Challenges and Solutions*, 35 J. AM. ACAD. PSYCHIATRY L. 406, 406–08 (2007) (highlighting the challenges for prisons in administering mental health and the high cost for such care in general).

⁹ See TORREY ET AL., *supra* note 5, at 6.

¹⁰ See *id.* at 6–7.

¹¹ WILLIAM SMITH, A DICTIONARY OF GREEK AND ROMAN ANTIQUITIES 165 (William Smith ed., 1870).

¹² See generally *id.* (explaining how some asylums afforded protections to "slaves, debtors and criminals, who fled to them for refuge.").

¹³ JAMES C. ROBERTSON, HISTORY OF THE CHRISTIAN CHURCH: FROM THE ELECTION OF POPE GREGORY THE GREAT TO THE CONCORDAT OF WORMS 227–28 (1856).

¹⁴ See ISHTLA SINGH, THE HISTORY OF ENGLISH: A STUDENT'S GUIDE 23 (2013); *Orphanage Pathfinder: From Almshouse To Asylum*, CARNEGIE LIBR. OF PITT., <http://www.carnegielibrary.org/research/pittsburgh/history/orphanages/orphan.html> (last updated Nov. 2014).

the rooms which were designed for prisoners are occupied by the insane. Where these are not kept separate, they disturb and terrify other prisoners. No care is taken of them, although it is probable that by medicines, and proper regimen, some of them might be restored to their senses, and to usefulness in life.¹⁵

Many mentally ill in the late 18th century were in jails or prisons without any meaningful institutional support, few asylums existed for the mentally ill, and no attempt at treatment was offered.¹⁶ Demonical possession and other beliefs did not support rational approaches to mental illness.¹⁷ Physician Philippe Pinel is most famously known for freeing mentally ill patients from chains, first at the male asylum *Bicêtre* and then at the female asylum of *Salpêtrière*, where he was director.¹⁸ He looked for more rational causes of mental illness such as hereditary and psychosocial stresses.¹⁹ Consequently he relinquished the use of purging and bloodletting, and introduced therapy that included interaction with patients and discussing their problems with them.²⁰ A paradigm shift was born, that would change the asylums from places of refuge that were custodial and prison-like into settings wherein more serious attempts at rational treatment could begin to take place.²¹ Note that it was the emphasis on treatment and welfare of the patients and withdrawal of excessive restraint that began to distinguish

¹⁵ John Howard, *State of the Prisons 1777*, in DOCUMENTARY HISTORY OF PSYCHIATRY: A SOURCE BOOK ON HISTORICAL PRINCIPLES 454, 459 (Charles E. Goshen ed., 1967).

¹⁶ *Id.*; see TORREY ET AL., *supra* note 5, at 6, 9.

¹⁷ Justin C. Wilson, Comment, *Will Full Benefits Parity Create Real Parity? -- Congress's Second Attempt At Ending Discrimination Against Mental Illness: The Paul Wellstone and Pete Domenici Mental Health And Addiction Equity Act of 2008*, 3 ST. LOUIS U. J. HEALTH L. & POL'Y 343, 346 (2010).

¹⁸ Ezra Susser & Michaeline Bresnahan, *Global Mental Health and Social Justice*, in MENTAL HEALTH AND HUMAN RIGHTS: VISION, PRAXIS, AND COURAGE 195, 196 (Michael Dudley et al. eds., 2012).

¹⁹ Gordon Hickish et al., *Preface to the Second Edition of PHILIPPE PINEL, MEDICO-PHILOSOPHICAL TREATISE ON MENTAL ALIENATION*, at xxii (2d ed. 2008) (1809); Gordon Hickish et al., *Introduction to the First Edition to PHILIPPE PINEL, MEDICO-PHILOSOPHICAL TREATISE ON MENTAL ALIENATION* xxix (2d ed. 2008) (1809).

²⁰ Dora Weiner, *Foreword to PHILIPPE PINEL, MEDICO-PHILOSOPHICAL TREATISE ON MENTAL ALIENATION* x (2d ed. 2008) (1809); Gordon Hickish et al., *Introduction to the First Edition, supra* note 19, at xxix.

²¹ See generally Gordon Hickish et al., *Introduction to the First Edition, supra* note 19, at xxxii (explaining how the goal of his study was to identify the best kinds of treatments for patients with various ailments).

therapeutic from penal institutions.²²

With the advent of modern psychopharmacotherapy in the 1950s and 1960s, increased attention was focused on patients' liberty interests, the de-hospitalization and community mental health movements.²³ As the 20th century approached its end, hospital beds were increasingly reduced and entire hospitals were shut down.²⁴ Many persons with serious mental illness adapted remarkably well to living in the community, especially when given adequate treatment and support.²⁵ Others failed and were essentially diverted into the criminal justice system.²⁶

Already three decades ago Lamb and others²⁷ observed this "criminalization" of the mentally ill taking place and offered a thoughtful proposal for a range of helpful mental health services for jail inmates including hospitalization: "Many [jail] inmates will be found on evaluation to need voluntary or involuntary hospitalization. Sufficient beds should be available to them in local or state hospitals, and these hospitals must be willing to take these patients, who are often considered undesirable by many inpatient facilities."²⁸ Now thirty years later, the need for the option of mental hospitalization is even more acute, at least for a small subset of severely disturbed inmates, yet their serious need for hospital level of care goes unattended.²⁹

What followed the topical and prophetic appeal by Lamb and colleagues, however, was even more mentally ill persons flowing into jails and prisons and even fewer mental hospital beds available for those most in need.³⁰ By 2010 it became known that more mentally ill persons were in jails and prisons than in

²² See E. FULLER TORREY ET AL., TREATMENT ADVOCACY CTR. & NAT'L SHERIFFS' ASS'N, MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES 2 (2010), available at http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.

²³ *Id.*

²⁴ *Id.*

²⁵ See Jeffrey R. Bedell et al., *Current Approaches to Assessment and Treatment of Persons With Serious Mental Illness*, INT'L J. PSYCHOSOCIAL REHABILITATION, http://www.psychosocial.com/psr/assessment_treatment.html (last visited Mar. 20, 2015).

²⁶ TORREY ET AL., *supra* note 22, at 3–4.

²⁷ *Id.* at 3; H. Richard Lamb et al., *Psychiatric Needs in Local Jails: Emergency Issues*, 141 AM. J. PSYCHIATRY 774, 774 (1984).

²⁸ Lamb et al., *supra* note 27, at 775.

²⁹ See TORREY ET AL., *supra* note 22, at 1.

³⁰ *Id.* at 1, 8; Lamb et al., *supra* note 27, at 774.

hospitals.³¹ In 2012 the number of inmates with severe mental illness in jails and prisons was 356,268, compared with 35,000 patients with severe mental illness in state psychiatric hospitals, the number incarcerated tenfold the number hospitalized.³² With so many severely mentally ill in jails and prisons for whom hospital care is unavailable, these facilities are becoming known as America's "new asylums[.]"³³ A partial "remedy" increasingly proposed and practiced today is administering enforced antipsychotic medication to the most severely, psychotically, dangerously, treatment refusing or resistant mentally ill inmates in the facilities where they are incarcerated, thereby seeming to obviate the necessity of hospital transfer.³⁴ Such practice will provide an excuse for politicians and administrators to continue to shamelessly diminish if not eliminate hospital services for those mentally disturbed inmates who most require this level of care; further defining facilities for pretrial detention and post-trial punishment as the "new asylums."³⁵

II. DEFINITIONS

Before advancing this discussion further some definitions should be helpful. "Jails" denotes facilities whose primary purpose is to detain criminal defendants awaiting trial whereas "prisons" house convicted felons who have been sentenced to prison for punishment.³⁶ Accordingly detainees are jail inmates, prisoners are prison inmates, and "inmates" refers to either or both jail detainees and prisoners.³⁷ A mental hospital is a facility where the primary purpose is to treat mentally ill persons whose mental disorder is so severe that inpatient psychiatric treatment is required.³⁸ In this discussion a psychiatric unit that is staffed,

³¹ TORREY ET AL., *supra* note 22, at 8.

³² TORREY ET AL., *supra* note 5, at 4–5.

³³ *Id.* at 4.

³⁴ See Chuck Weller, *Forced Administration of Antipsychotic Drugs to Civilly Committed Mental Patients in Nevada: A Remedy Without a Clear Statutory Authorization*, 11 NEV. L.J. 759, 760–61 (2011).

³⁵ Alan R. Felthous, *The Treatment of Persons with Mental Illness in Prisons and Jails: An Untimely Report*, PSYCHIATRIC TIMES (Aug. 13, 2014), <http://www.psychiatrictimes.com/forensic-psychiatry/treatment-persons-mental-illness-prisons-and-jails-untimely-report>.

³⁶ *What is the Difference Between Jails and Prisons?*, BUREAU OF JUST. STAT., <http://www.bjs.gov/index.cfm?ty=qa&iid=322> (last visited Mar. 3, 2015).

³⁷ See *id.*

³⁸ See NAT'L ASS'N FOR SOC. WORKERS, *SOCIAL WORKERS IN PSYCHIATRIC HOSPITALS* 1 (2011).

equipped, and programmed so as to provide intensive psychiatric inpatient treatment would serve as a mental hospital, but not the typical jail or prison infirmary, unless the infirmary is sufficiently developed that it is actually equivalent to a mental hospital unit or a psychiatric inpatient unit of a general hospital.

“Enforced medication” means the administration of a psychotropic medication despite the patient’s objection and willful noncompliance.³⁹ Medication can be administered orally if the individual complies by swallowing it, or by intramuscular, intravenous, or rarely by tube feeding administration.⁴⁰ Most typically the individual in need of enforced medication is acutely disturbed or having an exacerbation of chronic mental illness, such that he is psychotic and because of his psychotic and irrational thinking does not appreciate his need for medication to treat his psychosis, and he therefore is refusing to accept needed medication.⁴¹ In other situations the administration of medication might be considered involuntary without amounting to the specific and narrow definition used here for enforced medication.⁴² For example, an offender who must comply with prescribed medication as a condition of probation or parole is medicated involuntarily, but this is not the mentally unstable and acute condition for which hospitalization is indicated.⁴³

III. THE MISAPPLICATION OF *VITEK* IN SUPPORT OF ENFORCED MEDICATION IN NON-MEDICAL CORRECTIONAL FACILITIES

The United States Supreme Court in its *Vitek* decision, established procedural safeguards against improper transfer of a prisoner to a mental hospital: the Court did not support enforced medication in non-medical correctional facilities.⁴⁴ Yet the Ninth

³⁹ See Alan Armstrong, *Enforced Medication and Virtue-Ethics*, 6 J. PSYCHIATRIC & MENTAL HEALTH NURSING 329, 329 (1999).

⁴⁰ *The Administration of Medicines*, NURSING TIMES (Nov. 19, 2007), <http://www.nursingtimes.net/nursing-practice/specialisms/prescribing/the-administration-of-medicines/288560.article>; see M. Christina Beckwith et al., *A Guide to Drug Therapy in Patients with Enteral Feeding Tubes: Dosage Form Selection and Administration Methods*, 39 HOSP. PHARMACY 225, 225 (2004).

⁴¹ See, e.g., Gary DeLands, *Involuntary Administration of Anti-Psychotic Medication in Jails*, NAT’L SHERIFFS’ ASS’N INST. FOR JAIL OPERATIONS, <http://www.jailtraining.org/node/93> (last visited Mar. 23, 2015).

⁴² See Alan R. Felthous, *The Involuntary Medication of Jared Loughner and Pretrial Jail Detainees in Nonmedical Correctional Facilities*, 40 J. AM. ACAD. PSYCHIATRY & L. 98, 108 (2012).

⁴³ *Id.*

⁴⁴ *Vitek v. Jones*, 445 U.S. 480, 493–94 (1980).

Circuit recently referenced *Vitek* in support of its authorization for defendant Jared Lee Loughner to be involuntarily medicated while in a non-medical correctional facility.⁴⁵

Mr. Jared Lee Loughner, the mentally ill offender whose mass shooting in Tucson, Arizona, left six persons dead and thirteen others wounded pled guilty to nineteen charges and is now serving seven consecutive life terms and an additional 140 years in prison.⁴⁶ At one point during the year-long hospitalization and involuntary medication appeal procedures, the Ninth Circuit authorized Loughner's involuntary medication while he was still in a non-medical correctional facility awaiting the final appellate decision.⁴⁷ Although he was already being involuntarily medicated based on *Harper*, the decision to allow involuntary medication in the non-medical correctional facility⁴⁸ was supported without explanation by referencing the U.S. Supreme Court's *Vitek* decision, which prohibited transfer of a prisoner to a hospital without certain due process protections.⁴⁹ *Vitek* did not authorize involuntary medication in a non-medical correctional facility.⁵⁰

Although *Vitek* did not authorize enforced medication in a non-medical correctional facility, from this decision together with its *Harper* decision, the U.S. Supreme Court apparently found that mental hospital transfer requires greater protection of liberty interests than enforced medication.⁵¹ Involuntary transfer of a sentenced prisoner involves his liberty interests protected by the Due Process Clause of the Fourteenth Amendment.⁵² An adversarial hearing is constitutionally required before hospital transfer.⁵³ The Court found the procedure, not the justification

⁴⁵ See *United States v. Loughner*, 672 F.3d 731, 755 (9th Cir. 2012); Felthous, *supra* note 42, at 106 (for further analysis of this otherwise little noticed order and its potential application to the practice of enforced medication in non-medical correctional facilities); see also Alan R. Felthous, *The Ninth Circuit's Loughner Decision Neglected Medically Appropriate Treatment*, 41 J. AM. ACAD. PSYCHIATRY & L. 105, 110 (2013).

⁴⁶ Felthous, *supra* note 42, at 98; Felthous, *supra* note 45, at 111; *Jared Lee Loughner Sentenced to Life in Prison for Arizona Shootings*, GUARDIAN (Nov. 8, 2012, 3:02 PM), <http://www.guardian.co.uk/world/2012/nov/08/jared-loughner-life-prison-gabrielle-giffords-attack>.

⁴⁷ See Felthous, *supra* note 42, at 99.

⁴⁸ *Id.* at 99, 106.

⁴⁹ *Vitek*, 445 U.S. at 482, 489, 493–494; Felthous, *supra* note 42, at 106.

⁵⁰ *Vitek*, 445 U.S. at 489–90.

⁵¹ See *id.* at 493, 494; Felthous, *supra* note 42, at 103

⁵² *Vitek*, 445 U.S. at 493, 494; Felthous, *supra* note 42, at 103.

⁵³ *Vitek*, 445 U.S. at 487–88, 493.

for transfer in Nebraska law, to be unconstitutional.⁵⁴ Nebraska statutory law provided the justification that was not questioned by the High Court: Transfer was permitted to provide treatment for a person who “suffers from a . . . mental disease or defect” when the person “cannot be given proper treatment in that facility”⁵⁵ Even though enforced medication was not mentioned in *Vitek*, in light of the Ninth Circuit’s *Loughner* order and the current trend towards enforced medication without transfer,⁵⁶ the question arises: What if prisoners are medicated with force in prison, such that the Nebraska justification for transfer no longer exists? If the only purpose for hospitalization is erroneously assumed to be the enforced administration of needed medication, then what was once a justification for hospitalization, with sad irony, becomes a bar to appropriate hospitalization.

Again the High Court in *Vitek* was mute regarding enforced medication.⁵⁷ It was explicit however in its concern for other restrictions on a prisoner’s liberty interests through hospitalization.⁵⁸ Hospitalization was thought to deprive the prisoner of liberty through greater restriction of the prisoner’s activities, required behavioral modification, and by causing stigma.⁵⁹ Depending on specific custodial conditions, each of these assumed deprivations of liberty is arguable. In many jail settings as well as some prison units, inmates’ activities are much more restricted than they would be in a hospital.⁶⁰ Jail and prison disciplinary measures are deliberately stressful, if not harmful for those with serious mental illness, in comparison with behavioral therapy.⁶¹ And an inmate’s un-medicated psychotic condition with disturbed and disturbing behavior must be much more stigmatizing for staff and fellow inmates alike than appropriate hospital treatment would be.⁶²

Even though the appropriate use of antipsychotic medication can be liberating because it frees up a psychotic patient to think

⁵⁴ *Id.* at 489–91; Felthous, *supra* note 42, at 103.

⁵⁵ NEB. REV. STAT. ANN., § 83-180(2) (LexisNexis 2015); *Vitek*, 445 U.S. at 483.

⁵⁶ *See* *United States v. Loughner*, 672 F.3d 731, 743, 744–45, 752, 755 (9th Cir. 2012).

⁵⁷ Felthous, *supra* note 42, at 103.

⁵⁸ *Vitek*, 445 U.S. at 489–91.

⁵⁹ *Id.* at 487, 490–91; Felthous, *supra* note 42, at 103.

⁶⁰ Felthous, *supra* note 42, at 107, 108.

⁶¹ *Id.* at 103.

⁶² *Id.*

more clearly and realistically, its administration against the individual's expressed wish not to take the medication is regarded as a deprivation of liberty.⁶³ If medication is given by force in a hospital and not in a non-medical correctional facility, hospitalization could be conceived of as one necessary step towards enforced medication. If this had been a liberty concern of the High Court in *Vitek*, however, the Court did not express such concern among its other concerns over deprivation of liberty through hospitalization.⁶⁴

Although about hospitalization and not about enforced medication, the *Vitek* decision may well have had the unintended consequence of opening the door to enforced medication without hospitalization.⁶⁵ The only justification in Nebraska law for transferring a prisoner from a prison facility to a hospital was that a needed treatment could not be provided in the prison facility.⁶⁶ Where the treatment is enforced medication, and enforced medication can be physically administered in the prison facility, then there may be no reason to transfer the inmate to a hospital.⁶⁷ The *Vitek* decision made hospitalization more restrictive without considering enforced medication, which was not at issue.⁶⁸ Not with the *Harper* decision itself, but with its subsequent loose applications to non-medical correctional facilities, *Vitek* together with *Harper* in effect supported a measure that is more depriving of liberty than hospitalization, enforced medication without hospitalization.⁶⁹

The Supreme Court based its *Vitek* decision in part on its concern over the "stigma" of hospitalization.⁷⁰ Arguably the stigma spawned from an inmate's disturbed and disturbing behavior from un-medicated psychosis would be greater than that

⁶³ See *id.* at 103, 107, 108.

⁶⁴ See *Vitek*, 445 U.S. at 487–88, 490–91, 493–94.

⁶⁵ See *id.* at 487–88, 493–94.

⁶⁶ NEB. REV. STAT. ANN., § 83-180(2) (LexisNexis 2015); *Vitek*, 445 U.S. at 487–88, 489–90.

⁶⁷ See generally *Vitek*, 445 U.S. at 495–96 (explaining that the decision whether to transfer an inmate to a medical hospital is a medical one, implying that treatments that can be administered in the prison effectively would negate the need for transfer); Felthous, *supra* note 35 (discussing the expansion of "the practice of involuntary medication in jail and prison facilities, thereby further reducing the perceived need for and use of mental hospitalization.").

⁶⁸ See generally *Vitek*, 445 U.S. at 491–92, 495–97 (highlighting that this case concerns only involuntary commitment).

⁶⁹ See *Washington v. Harper*, 494 U.S. 210, 217–18 (1990); Felthous, *supra* note 35.

⁷⁰ *Vitek*, 445 U.S. at 492.

attached to hospitalization.⁷¹ Within a non-medical correctional facility, the procedure of enforced medication may well be more stigmatizing than hospitalization. Obviously stigma is associated with indictment or conviction of a criminal offense for which the individual is incarcerated.⁷² Then because of this status, he is denied hospitalization that would be provided to anyone else who suffers from the same extreme mental condition but is not incarcerated.⁷³ Far more damaging to the individual than stigma from any other cause is the “legitimization” and institutionalization of administering enforced medication without hospitalization.⁷⁴ Although this was not the issue for the Supreme Court in *Vitek*, together with its subsequent *Harper* decision and its broader than intended application,⁷⁵ the Court in effect set the table for this particular serving.

IV. THE MISBEGOTTEN *JOINT REPORT*

A. *A Problem Found in the Solution*

The approach of the *Joint Report* to ensuring that medication refusing inmates are treated might well be termed “molecular minimalist.”⁷⁶ The timely administration of antipsychotic medication can be critically important, a fact duly emphasized in the *Joint Report*.⁷⁷ Unfortunately medication is the report’s only behind-the-bars treatment consideration.⁷⁸ A properly programmed and staffed hospital unit provides much more in the way of acceptable and effective treatment than medication alone.⁷⁹ The *Joint Report* encourages only enforced medication without a word of support for other treatments and approaches that distinguish hospitals from jails and prisons.⁸⁰ Medication alone will benefit some severely disturbed inmates who are desperately in need of pharmacotherapy, but without hospitalization their condition will have improved despite the deprivation of the comprehensive and intensive treatment that

⁷¹ Felthous, *supra* note 35.

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *See id.*

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *See id.*

⁷⁹ *Id.*

⁸⁰ *Id.*

only a hospital unit can provide.⁸¹

In 2014 the Treatment Advocacy Center and the National Sheriff's Center published a report of a national survey of "Treatment of Persons with Mental Illness in Prisons and Jails[.]"⁸² This *Joint Report* acknowledged the poor access to proper mental health services in many jails and prisons with the number of seriously mentally ill incarcerated persons continuing to rise.⁸³ This *Joint Report* identified the root of this problem as the dramatic reduction in hospital services with inadequate mental health services in the community resulting in increasing numbers of seriously mentally ill persons entering jails and prisons.⁸⁴ Once incarcerated the availability of hospital services is scant to nonexistent, a deficiency that ought to have been emphasized as another equally egregious root of the problem of systemic neglect of seriously mentally ill inmates.⁸⁵ Instead, the *Joint Report* redefined the problem and already suggested its predetermined "solution" in the opening paragraph of the report itself:

Prisons and jails have become America's "new asylums": The number of individuals with serious mental illness in prisons and jails now exceeds the number in state psychiatric hospitals tenfold. Most of the mentally ill individuals in prisons and jails would have been treated in the state psychiatric hospitals in the years before the deinstitutionalization movement led to the closing of the hospitals, a trend that continues even today. The treatment of mentally ill individuals in prisons and jails is critical, especially since such individuals are vulnerable and often abused while incarcerated. Untreated, their psychiatric illness often gets worse, and they leave prison or jail sicker than when they entered. Individuals in prison and jails have a right to receive medical care, and this right pertains to serious mental illness just as it pertains to tuberculosis, diabetes, or hypertension. The right to treatment has been affirmed by the U.S. Supreme Court.⁸⁶

Already in its opening paragraph the *Joint Report* implies that the seriously mentally ill ought to receive treatment where they

⁸¹ *Id.*

⁸² TORREY ET AL., *supra* note 5, at 1.

⁸³ *Id.* at 6, 27, 67.

⁸⁴ *Id.* at 12.

⁸⁵ Felthous, *supra* note 35.

⁸⁶ TORREY ET AL., *supra* note 5, at 6.

are housed, i.e., in jail or prison facilities.⁸⁷ While de-hospitalization led to this plight, the withdrawal of hospital services from jails and prisons, an equally important element of the systemic neglect of the seriously mentally ill, is not even hinted at.⁸⁸ Certainly seriously mentally ill persons should receive appropriate treatment while they are incarcerated; but in some cases appropriate treatment requires hospitalization.⁸⁹ This is as true for mental illness as it is for medical disorders.⁹⁰ Like most with a serious mental disorder, most inmates with tuberculosis, diabetes, or hypertension can be treated in correctional facilities without hospitalization.⁹¹ In some instances, however, such medical conditions can become so extraordinarily infectious, destabilized, acute and precipitous, and their decline is fraught with such high risk that the only proper treatment is within a hospital.⁹² Unfortunately this misguided opening statement that tacitly but effectively dismisses the role of hospitalization during custody, sets the tone for the remainder of the report.

What was surveyed and how were the data gathered? In surveying treatment practices, the focus was on those seriously mentally ill inmates who refuse treatment.⁹³ In jails and prisons what are the treatment practices for each state and what are the consequences when such inmates are not treated? For most domains of information, data were gathered from other publications or collections of information. For example the 2012 Directory (73rd Edition) of the American Correctional Association was accessed to determine the average daily population numbers for state prisons.⁹⁴

Exactly how the study determined treatment practices within each state is unclear. Examples given under the “Methods” section concern jail procedures for obtaining authorization to medicate inmates over their objection, not procedures for effecting timely hospitalization, although seeking involuntary commitment is mentioned.⁹⁵ It is not clear how policies and practices are

⁸⁷ *See id.*

⁸⁸ *See id.*

⁸⁹ *See id.* at 57, 106.

⁹⁰ *Id.* at 6, 105.

⁹¹ *Id.* at 106.

⁹² *Id.* at 43, 106.

⁹³ *Id.* at 6.

⁹⁴ *Id.* at 23.

⁹⁵ *Id.* at 24.

distinguished, but the most relevant information from jails appears to have been obtained through interviews with “sheriffs, jail administrators, corrections officers, prosecutors, public defenders, county mental health departments, and staff and contracted professionals providing mental health services in jails, including psychiatrists, nurses, and social workers.”⁹⁶ There is no information about the nature of these interviews: whether they were conducted over the telephone or in person, whether they were free-wheeling or structured, what types of questions were asked, the proportion of different persons of the various disciplines who were interviewed from various jails, prisons or state correctional facilities, and how individual facilities or counties were selected for these interviews.⁹⁷

The survey is not at all quantitative and no numerical data are presented, no percentages, no absolute numbers, no tables.⁹⁸ Although presented as a survey of policies and practices, with ample room for inaccuracies in representation, it is essentially an opinion survey.⁹⁹ The emphasis on dysfunction and inadequacy in delivering mental health services to mentally disturbed inmates is an important focus, a fair consideration of the full spectrum of services would have been more useful.

What is missing from this survey and report is an examination of effective mental health services that are provided in jails and prisons. Some inmates benefit from hospital treatment and many others receive effective treatment within non-medical correctional facilities.¹⁰⁰ Many may receive helpful treatment that they would not have had, had they not been incarcerated.¹⁰¹ If the delivery of mental health services within the criminal justice system is to be improved, a comprehensive examination would consider not only

⁹⁶ *Id.*

⁹⁷ *See generally id.* (failing to reveal the interviewing process itself, while providing only the results).

⁹⁸ *See generally id.* (relying on qualitative, rather than quantitative, methods like numerical breakdowns of data).

⁹⁹ *See generally id.* (finding that the authors only report the opinions of those interviewed, as there is no quantitative data presented).

¹⁰⁰ *See generally* HOLLY HILLS ET AL., U.S. DEP’T OF JUST., EFFECTIVE PRISON MENTAL HEALTH SERVICE: GUIDELINES TO EXPAND AND IMPROVE TREATMENT 8, 9 (2004) (discussing the “effectiveness of specialized mental health units for the care of inmates with serious mental illness . . . who are not in need of hospital-level care . . .”).

¹⁰¹ *See generally id.* at 5 (noting the large amount of people entering prisons that did not have the healthcare services or financial and social stability “that contribute to mental health and stability.”).

the failures of detention and correctional services but also their successes, with the aim of improving and expanding successful interventions including hospital treatment for those in need of this level of care.

The *Joint Report* was presented as the first national survey of treatment practices for mentally ill persons in U.S. jails and prisons.¹⁰² It focused on seriously mentally ill individuals in correctional facilities.¹⁰³ Enforced medication in non-medical correctional facilities would obviate the need for hospital care, which even when available tends to be delayed for unacceptably long periods,¹⁰⁴ another argument for initiating enforced medication without hospitalizing acutely disturbed inmates.

This bias towards enforcing medication involuntarily in jails and prisons rather than providing hospitalization is evident throughout the entirety of the *Joint Report*, as seen in the opening paragraph noted above, in the gathering and presenting of the survey data, and in the report's final recommendations.¹⁰⁵ The data are gathered and presented in such a way as to recommend enforced medication in jails and prisons without considering the appropriateness of hospital care.¹⁰⁶ Findings are presented as concise summarizing statements.¹⁰⁷ The survey results for jails in a number of states begins with the following statement which pertains to inmates who were refusing treatment:

State law does not prohibit [the state's] county jails from administering medication involuntarily on a nonemergency basis. Therefore, county jails could use a *Washington v. Harper* administrative proceeding to authorize involuntary medication for an inmate who is suffering from a mental disorder, is gravely disabled, or poses a likelihood of serious harm to self or others.¹⁰⁸

¹⁰² TORREY ET AL., *supra* note 5, at 6.

¹⁰³ *Id.*

¹⁰⁴ *See id.* at 104. *See generally* Sindel, *supra* note 7, at 966 (discussing how the treatment of schizophrenia with antipsychotic drugs reduces the need for hospitalizations).

¹⁰⁵ *See* TORREY ET AL., *supra* note 5, at 6, 8, 23, 103–04, 106.

¹⁰⁶ *See, e.g., id.* at 28–29 (highlighting Alaska as an example that the report's findings only list the involuntary medication laws of each state's prisons and jails with no discussion of each state's psychiatric hospitals).

¹⁰⁷ *See, e.g., id.* (highlighting Alaska as just one example that the report's findings are brief summaries of the state laws governing forced medication of inmates).

¹⁰⁸ *Id.* at 32, 43, 45, 48–50, 53, 60, 63–65, 69, 71, 75, 86, 89.

Noting that mechanisms already available are underutilized or nonfunctional, the paragraph then ends dismissively of hospitalization as an effective option.¹⁰⁹

From interviews a consensus of sheriffs and correctional administrators was reached on three points: 1) The numbers of incarcerated mentally ill persons continue to rise and the severity of their illness is worsening; 2) for those who need hospital-level care, correctional officers feel that they must provide this care; and 3) the closure of state psychiatric hospitals without provision of proper post-release aftercare is the root of the problem of more persons with mental illness of increasing severity ending up in jails and prisons.¹¹⁰ Here and elsewhere in this report, the implication is that this increase in seriously mentally ill persons being incarcerated is the direct result of the reduction in hospital services without adequate services for them in the community.¹¹¹ A major part of the problem, the tap root of the problem as it were is indeed the public policy of increasing withdrawal of community hospital services without adequate community mental health services.

If the problem is understood as seriously mentally ill persons not receiving the level and quality of mental health services that they need, then there are two components of this problem: firstly, the failure of the mental health system providing the appropriate spectrum of services for mentally ill persons in the community leading to their incarceration in increasing numbers, fully recognized in the *Joint Report* as described above; but secondly, and just as importantly, the failure of the criminal justice system to provide this spectrum of services, including hospitalization, once mentally ill persons are incarcerated and in need of such services.¹¹² Although recognized in the survey results of individual states, the *Joint Report* disappointingly did not find a consensus that hospital care is becoming less available for seriously and acutely mentally ill inmates.¹¹³ Responsible sheriffs and jail administrators, one would hope, would have been equally concerned about the withdrawal of hospital care from destabilized

¹⁰⁹ See generally *id.* at 32, 43, 45, 49, 60, 71, 75, 86, 89 (demonstrating that most states, but not all, dismiss hospitalization as a realistic option).

¹¹⁰ *Id.* at 6.

¹¹¹ See *id.*

¹¹² See *id.* at 18–19.

¹¹³ See *id.* at 33, 50, 90, 92, 101–02 (only the survey results for California, Kansas, Texas, and Vermont specifically discuss the availability of beds in state hospitals).

mentally ill inmates. Understandably employees within the criminal justice system may have little influence on public policies outside of this system. When such services are withdrawn from inmates for whose health and safety they are accountable, however, correctional officials should be moved by appropriate concern to remedy the severe neglect of their wards.¹¹⁴

Instead of recognizing and attempting to correct this growing critical need, the surveyors and those surveyed in effect redefined this component of the problem from failure to hospitalize to failure to enforce medication without hospitalization. They recommend that psychotic and medication refusing inmates be subjected to instead of hospital transfer, enforced medication in a non-medical correctional facility.¹¹⁵ The clinical reasons for reserving this most intrusive treatment for hospital care are the same as for treating a non-inmate with a similar condition in a hospital. To deprive a mentally ill inmate of the same level of treatment that would be afforded anyone else, amounts to “treating” this class of disabled persons with deliberate indifference because the insufficient treatment given inmates is so obvious.¹¹⁶

The *Joint Report* concluded with six recommendations for addressing the treatment needs of inmates with serious mental illness in jails and prisons.¹¹⁷ Increasing the number of available hospital beds was not one of these recommendations.¹¹⁸ No measure for expediting hospital transfer was offered as a recommendation for improved mental health services.¹¹⁹ Enabling hospital care was ignored as a potential response to the increasing unavailability of this level of service.¹²⁰ The explanation of this apparent truism includes not a word about hospitalization¹²¹ for such extremely disturbed persons who would be hospitalized were they not incarcerated. Instead of

¹¹⁴ See *id.* at 6.

¹¹⁵ See *id.* at 106, 108–09 (finding that the report goes as far as creating a model law for correctional facilities to involuntarily medicate inmates while offering nothing comparable toward hospital transfers).

¹¹⁶ See Lori A. Marschke, *Proving Deliberate Indifference: Next to Impossible for Mentally Ill Inmates*, 39 VAL. U. L. REV. 487, 519 (2004).

¹¹⁷ See TORREY ET AL., *supra* note 5, at 105–07.

¹¹⁸ See *id.*

¹¹⁹ See *id.*

¹²⁰ See *id.*

¹²¹ *Id.* at 105–06 (finding nowhere in this section of the text the word “hospitalization”).

hospitalizing decompensated inmates who are in need of hospital care, legislation is recommended that would permit involuntary medication.¹²² A “model law” that is patterned after the *Harper* decision is provided for drafting such legislation.¹²³

To be discussed in Section X, the interpretation and application of the *Harper* decision has been overgeneralized.¹²⁴ The *Joint Report* took the path of overgeneralization without any attempt to distinguish the specific enforced medication policy for the Special Offender Center (SOC) of the Washington State Prison System whose purpose was “to diagnose and treat convicted felons with serious mental disorders[,]”¹²⁵ also referred to as a hospital, from non-medical jail and prison facilities.¹²⁶ A jail or prison unit could conceivably enhance the quality of care provided in its infirmary in order to approximate a hospital or “special offender center,” a separate arguable issue (see Section V), but no attempt to find justification based upon structural, staffing, and programming changes was made in the *Report*.¹²⁷

Why, one might ask, did those surveyed in the *Joint Report* seek improvement through enforced medication in jail and prison facilities, and not through restoration of the proper and standard approach of hospitalization? As already illustrated here, the project was biased in favor of the first approach, so the results may have been a function of how the questions were asked, how the data was gathered. Moreover, sheriffs and jail administrators might well have preferred an approach that does not require the staff inconvenience of having to transport an inmate to a hospital and having to wait in the admission area. From the standpoint of staff convenience, enforced medication without transfer can seem more expedient. For similar reasons other professionals who were surveyed might well have observed the unnecessary delays and experienced the obstacles in arranging for hospitalization, could favor in-house enforced medication. The advantage of

¹²² See *id.* at 108.

¹²³ *Id.*

¹²⁴ See discussion *infra* Part X.

¹²⁵ *Washington v. Harper*, 494 U.S. 210, 214 (1990). See generally TORREY ET AL., *supra* note 5 (the report does not distinguish the Special Offender Center of the Washington State prison system).

¹²⁶ See generally James W. Hicks, *Legal Regulation of Psychiatry*, in PRINCIPLES AND PRACTICE OF FORENSIC PSYCHIATRY 850, 861–62 (Richard Rosner ed., 2d ed. 2003) (highlighting that the *Harper* decision is applicable to hospitals, and makes no explicit distinction for non-medical jail and prison facilities); Felthous, *supra* note 35.

¹²⁷ See discussion *infra* Part V.

hospital treatment is lost, if hospitalization is unduly delayed or blocked. Well-meaning but frustrated administrators and clinicians then understandably redefine the problem to one that seems more solvable: the problem then becomes the obstacles to enforced medication within non-medical correctional facilities, not the obstacles to hospitalization.¹²⁸

Where the problem of untreated psychotic inmates is in urgent need of relief, a somewhat reasonable solution would have both an emergent and a long-term component. Perhaps as a temporary measure, in-house enforced medication could be implemented temporarily only as a less than satisfactory stopgap measure while plans are being designed and implemented to ensure that in the near future such inmates will receive medically appropriate hospital care. The *Joint Report* gave no hint of a recommendation to achieve more appropriate care for such inmates.¹²⁹ Its recommendation for enforced medication in non-medical jail and prison facilities was absolute,¹³⁰ and the real cause of the problem, withdrawal of hospital services for those in need, had faded into oblivion.

Lamenting the transformation of jails and prisons into the “new asylums,” the *Joint Report* ends as it begins, with a recommendation that would further devolve correctional facilities into the asylums of an earlier era, when hospitals provided medication but little else in the way of effective and humanitarian treatment that would distinguish them from other correctional facilities.¹³¹

B. Hospitalization is Not Recommended in the Joint Report

Not only is availability of hospital level treatment not mentioned among the options for providing treatment for jail and prison inmates with serious mental illness, the *Joint Report* states that state requirements for involuntary medication to be

¹²⁸ See generally TORREY ET AL., *supra* note 5, at 6 (highlighting that this report, unlike many, addresses the root cause of the problem as the closing of hospitals).

¹²⁹ See *id.* at 105–07 (the joint report states that appropriate treatment needs to be given to inmates, but besides stating that state laws need to be amended, gives no further recommendation).

¹³⁰ See *id.* at 108–09, 111 (the *Joint Report's* model law indicates that it recommends enforced medication in nonmedical jails and prisons in certain situations).

¹³¹ *Id.* at 6, 105–06.

administered only in a hospital setting are unnecessary.¹³² In other words without even raising the possibility that an extremely deteriorated mental condition could warrant hospitalization, the *Joint Report* excludes the need to administer medication involuntarily as such a condition, furthering its recommendation that even when medication needs to be given involuntary, this ought to be done outside of a hospital setting.¹³³

In this regard the *Joint Report* does not make the critically important distinction between involuntary and enforced medication.¹³⁴ An offender who takes medication as an outpatient as a court ordered requirement of conditional release from a hospital having been found not guilty by reason of insanity, or as a term of probation or parole, does so under legal compulsion and therefore not voluntarily.¹³⁵ Such involuntary administration of medication can occur outside of a hospital and is not what is referred to here as enforced medication.¹³⁶ An appropriate response to the individual who takes medication involuntarily as a court ordered condition of hospital release and refuses adherence is to hospitalize the patient so that he can be properly medicated, physically enforced if need be. It is the capacity for physical enforcement of medication that ought to take place in a hospital, not necessarily every manner of involuntary treatment, but the *Joint Report* fails to make this critical distinction. To be clear, as used here, enforced medication includes initiating antipsychotic medication to the medication refusing severely psychotic individual, even though once legally compelled he may not physically resist.¹³⁷ The need for physical enforcement is highest in this circumstance, thus the capacity for humane and safe administration must be present, distinguishing the need for enforced, but not necessarily all manner of involuntary medication, taking place in a hospital.

Without an appreciation for the purposes and nature of mental

¹³² See *id.* at 106.

¹³³ *Id.*

¹³⁴ See generally *id.* at 109–11 (making no mention of enforced medication, but rather only using the word involuntary).

¹³⁵ See *id.* at 25; Steven S. Sharfstein, *Individual Rights Must be Balanced with 'Caring Coercion,'* MENTAL ILLNESS POL'Y ORG. (Sept. 2, 2005), <http://mentalillnesspolicy.org/aot/caring-coercion.html> (stating that mandatory outpatient treatment is coercive).

¹³⁶ See, e.g., TORREY ET AL., *supra* note 5, at 106 (discussing the administration of medication on an inmate); Sharfstein, *supra* note 135 (discussing involuntary medication as part of a parole agreement).

¹³⁷ Felthous, *supra* note 42, at 108–09.

hospitalization, one might imagine that the physical enforcement of antipsychotic medication administration can take place in a non-medical correctional facility. This is true, as all that is needed is the medication, syringe and needle, and enough staff to physically restrain the individual. There is however much more involved in properly enforced medication than its simple physical administration: staff in sufficient numbers and with sufficient training to effectively encourage medication compliance without reliance on administration against physical resistance and to carefully monitor for desired and adverse side effects twenty-four hours of the day as the medication is titrated, for example.¹³⁸ The enforced initiation of antipsychotic medication is far more likely to result in acute, sometimes life-threatening side effects than “involuntary” continuance of a medication that the person has already been safely stabilized on.¹³⁹ Alas, the *Joint Report* seems only interested in the physical administration of medication, not the safe and humane administration that is best provided in a hospital setting.

C. A Question of Trial Incompetence

Also not recognized in the *Joint Report* is the fact that many medication-refusing psychotic jail detainees would likely be found incompetent to stand trial were their competence to be addressed.¹⁴⁰ For some of these defendants their competence is eventually addressed and they receive the treatment that they require, often in a hospital with a competence restoration program.¹⁴¹ This sometimes occurs only after extensive delays, months to years, before the inmate’s competence is addressed and he is transferred to a hospital.¹⁴²

Not to be elaborated on here, sound clinical considerations

¹³⁸ See generally *id.* at 110 (describing the procedures for administering enforced medication in “properly resourced and staffed” prisons).

¹³⁹ See generally *id.* at 101, 108–09 (using the *Loughner* case as an example that the involuntary continuance of his medication was safer than alternative choices).

¹⁴⁰ See Alan R. Felthous, *Advice from Inside: How to Solve the Problem of Mental Illness in Jail*, SAINT LOUIS MAG. (Oct. 22, 2010, 9:46 AM), <http://www.stlmag.com/Advice-From-Inside-How-to-Solve-the-Problem-of-Mental-Illness-in-Jail/>.

¹⁴¹ See *id.*; *Best Practices Model*, MENTAL COMPETENCY, <http://www.mentalcompetency.org/model/model-sec-VI.html> (last visited Mar. 19, 2015).

¹⁴² See Felthous, *supra* note 140.

require enforced medication for inmates who are psychotic and dangerous or whose serious mental illness is deteriorating despite reasonable attempts at treatment.¹⁴³ Their competency to stand trial may need to be addressed before proceeding with prosecution.¹⁴⁴

Addressing their incompetence can often be handled more responsibly and efficiently. Although several commentators have addressed various aspects of this problem and offered solutions with demonstrated positive results,¹⁴⁵ the *Joint Report* gave no consideration to the jail inmate who is in need of a competency determination and/or transfer to a restoration program,¹⁴⁶ perhaps again because hospitalization did not exist in their problem-solving toolbox.

Within the results of the survey, the *Joint Report* observed that attempts at hospitalization can create delays in providing needed medication.¹⁴⁷ Hospital occasioned delays are then part of the argument for enforced medication of inmates wherever they happen to be, including in non-medical jail and prison facilities.¹⁴⁸ Not mentioned is that state law may, except in extreme emergencies, disallow enforced medication of a hospitalized patient during emergency detention and prior to a formal civil commitment hearing, or prior to a due process procedure, for authorization of involuntary medication.¹⁴⁹ On the other hand, a

¹⁴³ See TORREY ET AL., *supra* note 5, at 109.

¹⁴⁴ Annette Christy et al., *Factors Affecting Jail Detention of Defendants Adjudicated Incompetent to Proceed*, 28 BEHAV. SCI. & L. 707, 707 (2010).

¹⁴⁵ *Id.* at 707–09, 713, 715; see Michael J. Finkle et al., *Competency Courts: A Creative Solution for Restoring Competency to the Competency Process*, 27 BEHAV. SCI. & L. 767, 777, 784 (2009); Maureen C. Olley et al., *Mentally Ill Individuals in Limbo: Obstacles and Opportunities for Providing Psychiatric Services to Corrections Inmates with Mental Illness*, 27 BEHAV. SCI. & L. 811, 811, 822, 829 (2009). Such reports serve to refute the fatalism of contemporary wisdom that new psychiatric beds cannot be opened for psychiatrically disturbed inmates in need of such service and that their transfer cannot be expedited and made efficient and timely. For a reasoned approach to the psychotic jail inmate whose mental condition is deteriorating although he does not manifest evidence of imminent dangerousness. See Felthous, *supra* note 140.

¹⁴⁶ See TORREY ET AL., *supra* note 5, at 110 (failing to mention competency or the need for competency restoration programs in its recommendations, but rather states that inmates may receive advice from a competent lay advisor).

¹⁴⁷ See *id.* at 36–37, 57, 100 (giving examples of states where attempts at hospitalizing inmates takes weeks to months).

¹⁴⁸ See *id.* at 106, 108 (discussing how enforced medication can be administered in non-medical jail and prison facilities).

¹⁴⁹ See generally Jack Hanna & Susan Hillenbrand, AM. BAR ASS'N, ABA STANDARDS FOR CRIMINAL JUSTICE, TREATMENT OF PRISONERS 194–96 (3d ed.

balanced analysis of this issue would also recognize that inmates can be transferred to a hospital within only a day or two of initiating hospital transfer. Even where two levels of judicial review are required, one for hospital transfer, the other for initiating enforced medication, any delay in initiating pharmacotherapy should be negligible compared with that for initiating such treatment for persons outside of the criminal justice system.

V. TRANSFORMING NON-MEDICAL CORRECTIONAL FACILITIES INTO HOSPITALS: AN UNREALISTIC PROPOSAL

If transferring the psychotic, treatment-refusing inmate to a hospital is not feasible, as the *Joint Report* suggests,¹⁵⁰ why not bring the hospital, in effect, to the jail or prison facility where the inmate is housed? If complete treatment that is provided in a hospital is delivered to an inmate while he is in a jail or prison unit, then transfer to a hospital would be unnecessary to provide this same level and quality of treatment.

Already many large jails and some prison facilities have infirmaries that usefully provide more intensive care and treatment and better observation for inmates with medical or mental conditions than could be provided to inmates housed in the general jail/prison population.¹⁵¹ As useful as such facilities are, they are not equivalent to hospital wards. As an inmate's medical or mental condition further deteriorate or become more complicated, hospital transfer becomes necessary despite the existence for such mid-level treatment units.

Hypothetically, if such a unit could be staffed and programmed such that it provides exactly the same services that are afforded within a modern psychiatric unit or mental hospital, then there would be no clinical need to transfer the inmate to a hospital. In accomplishing this transformation one must bear in mind that a

2011) (where the ABA guidelines require that forced medication administered in an emergency situation be discontinued until the required proceedings have occurred).

¹⁵⁰ See TORREY ET AL., *supra* note 5, at 101–02 (stating that there are more psychotic inmates in custody than available beds in psychiatric hospitals, proving that it is impossible to transfer all of these inmates to hospitals).

¹⁵¹ See generally John J. Gibbons & Nicholas de B. Katzenbach, *Prison Reform: Commission on Safety and Abuse in America's Prisons: Confronting Confinement*, 22 WASH. U. J.L. & POL'Y 385, 473–75 (2006) (describing states that have opened mental health units in order to house difficult patients and proposing changes to prisons to aid mentally ill prisoners).

modern security hospital includes services that do not exist in rapid assessment and stabilization psychiatric units of general hospitals such as training in activities of daily living and competence restoration programs for trial incompetent detainees.¹⁵² Creation of a bona fide proper hospital unit within a non-medical correctional facility is a possibility but it would be at considerable expense, likely defeating the hope for budgetary savings from obviating hospital transfer. Recreating a hospital unit in a correctional facility was not envisioned or mentioned in the *Joint Report* nor by any of the Supreme Court landmark cases that required that the administration of enforced medication be appropriate.¹⁵³

More likely than duplicating a hospital unit, local authorities could simply develop policy to permit enforced medication in that part of the facility that at least distantly is more similar to a hospital unit than any other section of the facility. Then inmates in such a facility which might be dubbed a “super infirmary” could be given enforced medication. In considering a state’s many independent lockups, city and county jails, most such facilities would not have an infirmary that is at all similar to those in large metropolitan jails.

This leaves basically three possibilities for enforced medication in these more remote, under-resourced detainment facilities. First, provide enforced medication within the facility despite absence of a section that is suitable as an infirmary. This would be the lowest quality of care, but nothing in the *Joint Report* would discourage such practice.¹⁵⁴ The level of care would even be inferior to that provided in the infirmary of a large modern jail. Second, have arrangements in place for transfer of the inmate in need of enforced medication to a large jail where he could be given enforced medication in a super infirmary. This approach could be challenged by the need to overcome the barrier of separately administered facilities having to cooperate and to

¹⁵² See Reena Kapoor, *Commentary: Jail-Based Competency Restoration*, 39 J. AM. ACAD. PSYCHIATRY L. 311, 311 (2011) (stating that a hospital typically offers “greater freedom of movement for the defendant/patient, an explicitly stated mission of providing treatment rather than punishment, and more access to programs such as group and individual psychotherapy” than would a jail).

¹⁵³ See TORREY ET AL., *supra* note 5, at 6–7; *infra* Part XIV–XV (discussing the Supreme Court landmark cases).

¹⁵⁴ See TORREY ET AL., *supra* note 5, at 106 (stating that although particular states “have provisions in their laws stating that involuntary medication can be given only in a hospital setting,” a hospital setting is not necessary).

arrive at a mutually agreeable funding arrangement. Of course if jail administrators and officers are inconvenienced by the task of inmate transport, super infirmary treatment reintroduces the time and expense of this needed service. There is also the practical and unavoidable matter of capacity for a few super infirmaries to accommodate the need for enforced medication throughout the state. If hospitals can become backlogged with inpatients, much smaller super infirmaries could easily and quickly lose bed capacity, recreating the very problem that the super infirmary was designed to overcome. The number of inmates who require enforced medication throughout a state is unpredictable and can be expected to ebb and flow over time. Creation of a surplus of super infirmary beds to accommodate such contingencies could be more challenging and cost ineffective than simply equipping hospitals that are already in place to accommodate fluctuating number of inmates in need of enforced medication.

A third approach would be to retain the option of hospital transfer for inmates detained in facilities without a super infirmary. If those facilities with a super-infirmary were to provide enforced medication in house, this would hopefully ease the hospital congestion and allow for efficient hospital transfer of inmates from all other facilities. This optimistic assumption discounts other factors that contribute to withdrawal of hospital services including the drive to reduce hospital costs without thinking through consequences. At any rate, this approach would create another disparity in quality of care afforded the most acutely disturbed inmates: Paradoxically inmates from less resourced, often remotely located jails would receive appropriate level of services whereas their counterparts in jails with super infirmaries would receive a lower quality of treatment.

The federal and individual state prison systems do not have the administrative barriers that exist between independently run jails.¹⁵⁵ Thus, it should be easier administratively to transfer prisoners between facilities within the same prison system. Being uniformly larger facilities than most jails, prison systems may be more likely to have their own medical treatment facilities, but may have little in the way of onsite medical and mental health resources. Thus, the virtues and vices of enforced

¹⁵⁵ See *id.* at 24 (stating that prison policies are consistent within each state, but jail policies within a state are not necessarily consistent and can vary widely).

medication in infirmaries are generally the same in prisons as they are in jails. As a rule enforced medication outside of a hospital unit amounts to providing less in the way of mental health services to a class of individuals because they happen to be incarcerated.

VI. POTENTIAL CONSEQUENCES OF THE *JOINT REPORT*

One can expect that the *Joint Report* will be used to advance the molecular minimalist approach to the treatment of dangerously psychotic inmates, further marginalizing hospitalization as the appropriate level and quality of treatment for them. Curious then was the commentary by David Rubinow that, while generally a favorable review of the *Report*, disfavored treatment in hospitals and prisons.¹⁵⁶ This was expressed in his concluding statement as a speculation about what Dorothea Dix would advocate for were she alive:

The irony is that were Dorothea Dix alive today, she would not be advocating for more state hospital beds. Rather, she would insist that both our humanity and financial advantage would be served by administering the treatments that we have today, *not in hospitals and certainly not in prisons*, but in a community demonstrating respect for the basic rights of its citizens.¹⁵⁷

While improved outpatient community services is a needed and worthy cause, it is hard to believe that such a champion for patient welfare as Dorothea Dix would deny treatment for the severely mentally ill who are in prisons and hospitals. No doubt more robust outpatient services would reduce rates of mental illness relapse and criminal recidivism acts that lead to institutional care. It is unreasonable to expect however that outpatient services alone would completely obviate the need for a full range of mental health services with jail/prison confinement. One explanation for the impressive success of conditional release programs for insanity acquittees is their flexibility in allowing for involuntary hospitalization for medication non-compliance or early signs of decompensation, a measure that is not used for most seriously mentally ill in the community or in correctional

¹⁵⁶ David R. Rubinow, *Out of Sight, Out of Mind: Mental Illness Behind Bars*, 171 AM. J. PSYCHIATRY 1041, 1043 (2014).

¹⁵⁷ *Id.* (emphasis added).

facilities.¹⁵⁸ Rather than actually arguing against all treatment within institutions, perhaps Rubinow is using rhetoric to argue that the mentally ill should not be hospitalized or imprisoned in the first place.

Within this statement, whether rhetorical or not, he provides evidence that de-hospitalization of the mentally ill is served by a synergy of humanitarian and cost reduction motivations.¹⁵⁹ Libertarian interests have led to the implementation of the “least restrictive alternative” approach to treating and managing persons with serious mental illness.¹⁶⁰ Extreme hospital libertarianism has no doubt contributed to the current transinstitutionalization of the mentally ill, with much less popular resistance to closing hospitals than prisons.¹⁶¹ As the critical purpose and value of hospitalization has lost popular appreciation, so too has hospitalization become less valued among the range of mental health services offered within jails and prisons.¹⁶² If our “humanity” disfavors hospitalizing even the most seriously mentally ill, policy makers and administrators can in “good conscience” reduce the mental health budget by discontinuing hospital services.

¹⁵⁸ The September 2014 Special Issue of Behavioral Sciences & the Law is dedicated to the subject of conditional release, see Michael J. Vitacco et al., *Introduction to this Special Issue: Conditional Release*, 32 BEHAV. SCI. & L. 553, 553 (2014); see also Debbie Green et al., *Factors Associated with Recommitment of NGR I Acquittes to a Forensic Hospital*, 32 BEHAV. SCI. & L. 608, 608, 615 (2014) (stating that patients recommitted to a forensic hospital were recommitted due to events like “non-compliance with treatment, drug or alcohol use, rearrests, and, in some cases, physical violence and/or threatening behavior.”); Gina M. Maguno-Mire et al., *What Factors are Related to Success on Conditional Release/Discharge? Findings from the New Orleans Forensic Aftercare Clinic: 2002-2013*, 32 BEHAV. SCI. & L. 641, 641, 643 (2014) (explaining the concept of conditional release and detailing that “[p]revious failure on conditional release, non-adherence to treatment, dangerousness, and prior violent charges predicted revocation.”); Daniel J. Marshall et al., *Predicting Voluntary and Involuntary Readmissions to Forensic Hospitals by Insanity Acquittes in Maryland*, 32 BEHAV. SCI. & L. 627, 629 (2014) (providing several reasons for revocation of conditional release amongst insanity acquittes, including non-compliance with treatment, supervision, or medications).

¹⁵⁹ Rubinow, *supra* note 156, at 1043.

¹⁶⁰ Michael L. Perlin, *“Their Promises of Paradise”: Will Olmstead v. L.C. Resuscitate the Constitutional “Least Restrictive Alternative” Principle in Mental Disability Law?* 37 HOUS. L. REV. 999, 1022–23 & n.162 (2000).

¹⁶¹ See Steven Raphael & Michael A. Stoll, *Assessing the Contribution of the Deinstitutionalization of the Mentally Ill to Growth in the U.S. Incarceration Rate*, 42 J. LEGAL STUD. 187, 219 (2013).

¹⁶² MEIGHAN B. HAUPT, THE VITAL ROLE OF STATE PSYCHIATRIC HOSPITALS 6 (Joe Parks & Alan Q. Radke eds., 2014).

To deny appropriate treatment for persons in hospitals and prisons is not an expression of humanity but indifference. To deny hospitalization to those most urgently and seriously in need of such service categorically takes libertarianism to its irrational extreme. Many psychotic individuals who would initially refuse antipsychotic medication would not oppose hospitalization and those who would often do so because they lack insight into their psychosis. It is the very treatment they oppose that would provide them with the most fundamental liberty, the freedom to think rationally. If hospitalization constrains autonomy by enforced medication, enforced medication in a non-medical facility would increase constraint with its anti-therapeutic emphasis on discipline and punishment. To advocate enforced medication in such a facility in order to “protect the individual’s autonomy rights” is either hypocritical or naïve regarding genuine compassion for the individual’s welfare and respect for his genuine autonomy, both mental and physical.

The *Joint Report* advocates for improved range of mental health services, including hospital care in the community, and yet serves to catalyze the continuing withdrawal of hospital care for incarcerated individuals.¹⁶³ Together with the political motive of budgetary control by reducing hospital costs without risking push back from those who are adversely affected,¹⁶⁴ such neglect of the purpose and value of hospital care will likely serve to further deprive mental patients in general from this level of care, for non-inmates an additional, untoward effect from the perspective of the *Report*. In any event the continued misinterpretation and misapplication of the *Harper* decision¹⁶⁵ together with the “empirical” findings of the *Joint Report*¹⁶⁶ will sadly result in further reduction of hospital services for those inmates most in need. And clinical, correctional, administrative, legal practitioners will justify what they have become comfortable doing, providing enforced medication in non-medical correctional settings.

¹⁶³ See TORREY ET AL., *supra* note 5, at 105–07 (beginning with the premise that the severely mentally ill belong in hospitals, not in prison/jail, but continuing on to promote appropriate treatment in prison/jails, jail diversion programs, assisted outpatient treatment, and other treatment options other than hospitalization).

¹⁶⁴ Rubinow, *supra* note 156, at 1042.

¹⁶⁵ *Washington v. Harper*, 494 U.S. 210, 236 (1990); see *infra* Part X.

¹⁶⁶ See TORREY ET AL., *supra* note 5, at 27–100 (presenting data for each state and the District of Columbia).

VII. THE EQUIVALENCY PRINCIPLE

The American Psychiatric Association (APA) has encouraged mental health services within jails and prisons to correspond to those provided to individuals in the community.¹⁶⁷ Although it is impossible to provide exactly the same services that are available for every mental condition in every correctional facility, there must at least be a sincere effort to prioritize and address the most emergent and consequential conditions: suicidality and psychosis. Specifically the equivalency principle as articulated in the Second Edition of “Psychiatric Services in Jails and Prisons” reads as follows:

The fundamental policy goal for correctional mental health care is to provide the same level of mental health services to each patient in the criminal justice process that should be available in the community.¹⁶⁸

What is meant by mental health services that “*should* be available in the community”?¹⁶⁹ A downward perspective might be that correctional facilities have some leeway to set their own standard of care even if lower than otherwise expected, allowing the community to model itself after the improvised correctional model. A more realistic interpretation is based on the realization that not all communities provide the appropriate level of care, but correctional systems should nonetheless endeavor to do so. If there is any doubt about this, hopefully the third edition now in preparation, will clarify this matter in the direction of appropriate community care whether outside or inside of correctional bars for the most severely, acutely, psychotically disturbed individuals. In the community, if an acutely psychotic, un-medicated individual who, because of his psychosis, presents in a hospital emergency department the most appropriate care is initiation and titration of antipsychotic medication in the hospital.¹⁷⁰ If because of psychotic denial of mental illness he refuses medication, this strengthens the indication for hospital care. The level and quality of care for conditions of such

¹⁶⁷ AM. PSYCHIATRIC ASS'N, PSYCHIATRIC SERVICES IN JAILS AND PRISONS 6 (2d ed. 2000).

¹⁶⁸ *Id.*

¹⁶⁹ *Id.* (emphasis added).

¹⁷⁰ ANTHONY F. LEHMAN ET AL., PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH SCHIZOPHRENIA 11 (2d ed. 2004).

extremity should be no less simply because the afflicted individual is incarcerated.

Although not all correctional programs that provide mental health services seek and obtain accreditation, accreditation standards also include the equivalency principle though with different wording.¹⁷¹ For both jails¹⁷² and prisons,¹⁷³ basic mental health services should be provided, meaning in part: “[c]orrectional facilities that provide for the needs of patients requiring psychiatric hospitalization levels of care are expected to *mirror* treatment provided in inpatient settings in the community.”¹⁷⁴

While this standard appears consistent with the principle of equivalency, specifically with respect to the need for hospitalization, it does not explicitly require hospital access.¹⁷⁵ Also like the APA policy goal, it does not provide indications for hospital level of care.¹⁷⁶ One would hope that correctional systems would not respond by simply adding window dressing to their infirmaries in order to render them more hospital-like, for the purpose of enforced medication.

Without addressing whether enforced medication was only constitutional in a hospital or could be administered in a non-medical correctional facility, the Supreme Court’s *Harper* decision pertained only to a policy that was for a specialized treatment unit. Although referred to elsewhere as a “hospital,” the opinion

¹⁷¹ See NAT’L COMM’N ON CORR. HEALTH CARE, STANDARD FOR HEALTH SERVICES IN JAILS 117 (2014) [hereinafter STANDARD FOR HEALTH SERVICES IN JAILS]; NAT’L COMM’N ON CORR. HEALTH CARE, STANDARD FOR HEALTH SERVICES IN PRISONS 117, 163 (2014) [hereinafter STANDARD FOR HEALTH SERVICES IN PRISONS].

¹⁷² See STANDARD FOR HEALTH SERVICES IN JAILS, *supra* note 171, at 116–17.

¹⁷³ See STANDARD FOR HEALTH SERVICES IN PRISONS, *supra* note 171, at 116–17.

¹⁷⁴ STANDARDS FOR HEALTH SERVICES IN JAILS, *supra* note 171, at 117 (emphasis added); STANDARDS FOR HEALTH SERVICES IN PRISONS, *supra* note 171, at 117 (emphasis added).

¹⁷⁵ See STANDARDS FOR HEALTH SERVICES IN JAILS, *supra* note 171, at 116–17; STANDARDS FOR HEALTH SERVICES IN PRISONS, *supra* note 171, at 116–17.

¹⁷⁶ See AM. PSYCHIATRIC ASS’N, *supra* note 167, at 6 (encouraging facilities to participate in an accreditation program like that sponsored by the National Commission on Correctional Health Care, but, as noted, that standard does not include specific indications for hospital-level care); STANDARD FOR HEALTH SERVICES IN JAILS, *supra* note 171, at 116 (stating only that certain care should be provided when indicated, but not listing out what these indications might be); STANDARD FOR HEALTH SERVICES IN PRISONS, *supra* note 171, at 116 (stating only that certain care should be provided when indicated, but not listing out what these indications might be).

itself does not refer to this unit as a hospital and does not provide information about whether the specialized treatment unit was licensed or accredited as a hospital, or about features that render it hospital-like or especially suitable for the appropriate administration of enforced medication.¹⁷⁷ Certainly more clarity from the Supreme Court as to what constitutes an appropriate setting for the appropriate administration of enforced medication will be helpful, if such clarity is informed by a genuine appreciation of the equivalency principle and the preferred community practice for the most serious and emergent psychiatric conditions.

Note that neither the APA policy goals nor the National Commission on Correctional Health Care (NCCHC) accreditation requirements explicitly require availability of a mental hospital or ward among the services that should correspond to that which is available in the community.¹⁷⁸ One would hope that this was based on the historical evolution of unequal correctional systems throughout the country, and going forward health organizations will not be guided by the molecular minimalist approach of the *Joint Report*, or the political pressure to reduce mental health budgets by eliminating the most needed services.

VIII. THE LACK OF PROFESSIONAL INTEREST IN THE NEEDS OF THE MOST SEVERELY MENTALLY ILL IN JAILS AND PRISONS

Allen Frances recently called out groups that advocate for greater support for the “worried well” but not for the needs of the seriously mentally ill or for hospital beds to meet their needs.¹⁷⁹ Frances cites DJ Jaffe, Executive Director of Mental Illness Policy Org., who faulted the following as organizations that should be expected to support the needs of the seriously mentally ill but who do not: Substance Abuse and Mental Health Services Administration, the National Coalition of Mental Health Recovery, the Bazelon Center for Mental Health Law, American Civil Liberties Union, National Disability Rights Network, State Disability Rights organizations, Mental Health America, National

¹⁷⁷ See TORREY ET AL., *supra* note 5, at 8; *Washington v. Harper*, 494 U.S. 210, 214 (1990).

¹⁷⁸ See AM. PSYCHIATRIC ASS'N, *supra* note 167, at 6; STANDARD FOR HEALTH SERVICES IN JAILS, *supra* note 171, at 116; STANDARD FOR HEALTH SERVICES IN PRISONS, *supra* note 171, at 116.

¹⁷⁹ Allen Frances, *The Hall of Shame: Who is Failing the Severely Ill?*, PSYCHIATRIC TIMES, Oct. 1, 2014, at 32.

Council for Community Behavioral Health, National Alliance on Mental illness, the American Psychiatric Association, American Psychological Association, and Celebrity-Center Advocacy Organizations such as the Rosalynn Carter Symposium on Mental Health Policy and Patrick Kennedy's One Mind Research.¹⁸⁰ These mental health legal, clinical, and consumer organizations support some worthy causes within the mental health field, but by ignoring the immediate needs of the most severely disordered and disabled of the mentally ill, their selected causes serve to distract, attentively and financially, from the higher level of care that a minority of those who are mentally ill require. Frances praises law enforcement agencies such as the New York State Association of Chiefs of Police and the National Sheriffs' Association for advocating for increasing the number of hospital beds and directing attention to the seriously mentally ill.¹⁸¹ Kudos to Jaffe and Frances for their bold critique of organizations to which Congress has ceded control of mental health policy,¹⁸² at the expense and peril of the most seriously mentally disordered persons. Unfortunately Frances had not yet taken notice that even the National Sheriff's Association, that supports increasing the number of civil hospital beds, fails to support increasing available hospital beds for the population about which they should be most concerned: the severely mentally ill inmates of jails and prisons who are in dire need of a higher level of service than they are receiving.¹⁸³

Perhaps even more remarkable than the lack of interest in hospital care for the most severely psychotically disordered inmates by mental health organizations and advocacy groups is the neglect of hospital care by academic psychiatry. One might hope that textbooks on correctional psychiatry and correctional mental health would devote at least a single chapter to this most important component of mental health services within a correctional system. Hospital treatment is barely addressed in such respected and referenced texts.¹⁸⁴

¹⁸⁰ *Id.*

¹⁸¹ *Id.*

¹⁸² *See id.*

¹⁸³ As evidenced by the *Joint Report* that the National Sheriff's Organization cosponsored, TORREY ET AL., *supra* note 5, at 6.

¹⁸⁴ Examples of correctional mental health texts with no chapter on hospital care, the highest level of correctional mental health care, include: HANDBOOK OF CORRECTIONAL MENTAL HEALTH i–iii, (Charles L. Scott ed., 2d ed. 2010) (finding that the table of contents lists no chapters regarding hospital care); HENRY J.

Rather the emphasis in such texts is on providing psychiatric and other mental health services *in* jails and prisons, not in correctional hospital facilities.¹⁸⁵ If academic psychiatry does not consider hospital care important enough to be addressed, it should be of little surprise if mental health organizations also neglect such services in prioritizing issues in need of advocacy.

Maier and Fulton gave some discussion to the forensic security hospital as well as management and treatment of mentally disturbed inmates in a correctional system.¹⁸⁶ In 1998 they maintained that “[t]he need to create hospital units to meet the needs of each patient type [within security hospitals is] painfully clear.”¹⁸⁷ Thus their contribution stands as an exception to the more general neglect of correctional hospital care in the literature of correctional psychiatry.

Although not given chapter-level attention, Steadman, McCarty and Morrissey considered hospitalization as a useful service in the community that could favorably affect psychotically disturbed individuals who, without such services, might have ended up in jail.¹⁸⁸ Their observation and supporting example is

STEADMAN ET AL., *THE MENTALLY ILL IN JAIL: PLANNING FOR ESSENTIAL SERVICES* xi–xiii, 212–13 (John Monahan et al. eds., 1989) (only mentioning hospital beds in two paragraphs in a chapter on care for the mentally ill in Boulder County, Colorado); *CORRECTIONAL PSYCHIATRY: PRACTICE GUIDELINES AND STRATEGIES* T-1–T-15 (Ole J. Thienhaus & Melissa Piasecki eds., 2007) (the table of contents lists no chapter, or even chapter sub-headings regarding hospital care); *CORRECTIONAL PSYCHIATRY: PRACTICE GUIDELINES AND STRATEGIES VOL. II* T-1–T-11 (Ole J. Thienhaus & Melissa Piasecki eds., 2013) (giving only one page to the topic of “Involuntary Transfer of Mentally Ill Inmates to a Psychiatric Hospital[,]” and no chapters dedicated to hospital care) [hereinafter *CORRECTIONAL PSYCHIATRY VOL. II*].

¹⁸⁵ See *HANDBOOK OF CORRECTIONAL MENTAL HEALTH*, *supra* note 184, at i–iii (including chapters on “Conducting Mental Health Assessments in Correctional Settings” and “Pharmacotherapy in Correctional Settings” amongst many others); *STEADMAN ET AL.*, *supra* note 184, at xi–xiii (including chapters titled “Varieties of Jail Mental Health Programs” and “A Practical Guide for Mental Health Service Providers in Local Jails” amongst many others); *CORRECTIONAL PSYCHIATRY: PRACTICE GUIDELINES AND STRATEGIES*, *supra* note 184, at T-1–T-15 (including a chapter on “Mental Health Care of Juveniles in Adult Correctional Facilities” amongst many others); *CORRECTIONAL PSYCHIATRY VOL. II*, *supra* note 184, at T-1–T-11 (including a chapter on “Treatment of Psychopathy in Correctional Settings” amongst several others).

¹⁸⁶ Gary J. Maier & Louis Fulton, *Inpatient Treatment of Offenders with Mental Disorders*, in *TREATMENT OF OFFENDERS WITH MENTAL DISORDERS* 126, 133–35 (Robert M. Wettstein ed., 1998).

¹⁸⁷ *Id.* at 135.

¹⁸⁸ *STEADMAN ET AL.*, *supra* note 184, at 212–13 (“Paradoxically, one of the most crucial elements in a community support system is the psychiatric hospital. However comprehensive the community programs may be, there will

consistent with the contention of the *Joint Report* that unavailability of hospital care in the community has led to increasing numbers of severely mentally ill persons in jails and prisons and that the solution must include restoring the availability of hospital treatment in the community. The point of this present article, which seems to be lost to the correctional mental health field in general, is that for some seriously mentally ill individuals their need for hospital treatment can be compelling regardless of which side of the bars they find themselves. If mental health advocacy groups and correctional psychiatry academicians neglect the purpose and value of hospital treatment, it should be of no surprise if policymakers also neglect to give priority to this critical level of treatment.

IX. ANOSOGNOSIA AS A CRITERION FOR INVOLUNTARY TREATMENT

In risk analysis concerning enforced or involuntary medication, Brakel and Davis argue that courts have emphasized and exaggerated the side effects of antipsychotic medications, while understating their benefits.¹⁸⁹ Based upon such distorted premises, courts and legislatures have created criteria for overriding a patient's treatment refusal that have led to untoward consequences from inadequate and delayed treatment.¹⁹⁰ They further argue that the severely mentally ill who refuse medication do so because of anosognosia,¹⁹¹ the inability to recognize that one is mentally disordered, itself a symptom of the illness.¹⁹² Therefore, they propose improving the

remain a handful of patients who cannot be cared for outside of a hospital." It is paradoxical that this fact is qualified as "paradoxical," but the authors provided a specific example. Provision of sufficient public hospital beds in Bolder County, Colorado resulted in a substantial reduction in the number of psychotic inmates in the Bolder County Jail. The authors conclude that "it is of prime importance for the community that this level of care be available.").

¹⁸⁹ Samuel Jan Brakel & John M. Davis, *Overriding Mental Health Treatment Refusals: How Much Process is "Due?"* 52 ST. LOUIS L.J. 501, 502–03 (2008).

¹⁹⁰ *See, e.g., id.* at 577 (pointing out the absurdity of laws that allow any number of patients to assert their right to refuse treatment, thereby creating what Brakel & Davis call a situation in which patients will forever be "wards-untreated-until-a-formal-legal-disposition-of-their-case-is-made-and-possibly-never-be-treated-in-the-event-they-are-found-competent-to-refuse-or-that-there-is-credible-evidence-they-would-refuse-if-competent-or-that-treatment-is-not-in-their-best-medical-interest.").

¹⁹¹ *Id.* at 505.

¹⁹² *Id.*

possibility of needed pharmacotherapy by expanding criteria for overriding treatment refusal to include incapacity to make treatment decisions as a growing number of states have done for involuntary hospitalization.¹⁹³ If anosognosia is a mental incapacity due to psychotic disorder, with consequent treatment refusal that can justify overriding a person's refusal of antipsychotic pharmacotherapy and hospitalization in the community, the same anosognosia that causes a psychotic inmate to refuse treatment ought to justify appropriate treatment, i.e., hospitalization and enforced medication. Some inmates, like some psychotic individuals who present in a community hospital's emergency department, would accept hospitalization but not the pharmacotherapy that is necessary for effective treatment. In each instance it is the anosognosia and medication refusal that contributes to the necessity of hospital admission.

X. THE SUPREME COURT HAS NOT APPLIED *HARPER* TO NON-MEDICAL JAILS

The Supreme Court's *Bell v. Wolfish*¹⁹⁴ opinion was issued before its *Harper*¹⁹⁵ decision, but it has been referenced to suggest that a *Harper* procedure can be constitutionally adopted by jails.¹⁹⁶ The *Bell* decision had nothing to do with enforced medication.¹⁹⁷ It addressed the matter of discipline and punishment and distinguished between punishment that would violate Due Process and measures needed to maintain safety and security.¹⁹⁸ In this latter respect, policies and procedures in jails can be constitutionally acceptable as they are in prisons. Those who wish to bring *Harper* procedures into jails note that the *Harper* procedure in prison was justified by the prison's need to maintain safety and order, a need that is, under *Bell*, equally applicable to jails.¹⁹⁹

The similarity of circumstance between enforced medication in

¹⁹³ *Id.* at 576–77.

¹⁹⁴ *Bell v. Wolfish*, 441 U.S. 520 (1978).

¹⁹⁵ *Washington v. Harper*, 494 U.S. 210 (1990).

¹⁹⁶ *Id.* at 223–24.

¹⁹⁷ *See Bell*, 441 U.S. at 523 (the case is about the scope of an individual's rights during confinement prior to trial, but there is no discussion of medication within the Court's decision).

¹⁹⁸ *See id.* at 544, 560–61.

¹⁹⁹ *See Harper*, 494 U.S. at 223; *Bell*, 441 U.S. at 546–47 (quoting *Pell v. Procunier*, 417 U.S. 817, 823 (1974)).

jails and prisons is made more facilely because discussions of the *Harper* case describe Walter Harper as a prisoner and his enforced medications as taking place in a prison.²⁰⁰ The critical distinction that is lost in such discussion is that the involuntary medication policy that was addressed in *Harper*, Policy 600.30, pertained to the SOC within the Washington State Department of Corrections where Walter Harper was treated.²⁰¹ The Court did not state whether the SOC was licensed or accredited as a hospital or to what extent its treatments, programs and staffing correspond to that of an acceptable hospital mental health care unit.²⁰² In any event, the approved policy did not apply to non-medical correctional units, the rest of the prison system and certainly not jails.²⁰³ It did not apply to facilities whose primary purpose is security and punishment, but rather to a facility dedicated to assessment and treatment.²⁰⁴

There is simply no jurisprudence on the proposition advanced here: That the most severely psychotic and medication-refusing mental patients be treated in a hospital. An operational criterion for effecting this is the standard of reserving enforced medication to such inmates in a hospital setting. This fundamental principle simply does not come before the courts to be adjudicated, even where enforced medication is the issue, with the *Loughner* case being a prime example.²⁰⁵

XI. HOSPITAL TRANSFER DELAYS: CAUSES AND REMEDIES

From jails and prisons the two most common explanations for delay in hospital transfer are the requirement for a court hearing and the shortage of hospital beds. From the author's experience and from published reports the court hearing need not be a reason for delay.²⁰⁶ In St. Louis, Missouri, at least prior to

²⁰⁰ *Harper*, 494 U.S. at 213–14.

²⁰¹ *Id.* at 214.

²⁰² Felthous, *supra* note 42, at 101.

²⁰³ *See id.* at 103.

²⁰⁴ *Id.*

²⁰⁵ *See United States v. Loughner*, 672 F.3d 731, 735–36 (9th Cir. 2012) (explaining the procedural history of the case and introducing the main issue of involuntary medication).

²⁰⁶ *See ABA Criminal Justice Mental Health Standards*, 7-4.2, A.B.A. (1984) (stating that “[i]ncompetence evaluations have been misused to ‘short-circuit’ more complex civil commitment proceedings, to avoid prolonged trial, or to obtain information to support a later defense . . . it is improper conduct for either prosecuting or defense attorney to move for evaluation for any

eliminating state hospitalization for pretrial detainees, from the author's personal knowledge hospitalization for those mentally disordered inmates who met emergency detention criteria was generally accomplished within twenty-four to forty-eight hours.²⁰⁷ Hospitalization with legal protection of due process rights was handled efficiently even with a two-step process requiring initial review by a probate commissioner, then final review and approval by the probate court.²⁰⁸ Parenthetically, but importantly, this properly working system was not registered in the *Joint Report*.²⁰⁹ Where the court docket is full, prioritization based upon urgency of need may be required, but there is no good reason that emergency hospitalization should be delayed because of the necessity of a court hearing.

Better yet would be a procedure whereby the inmate in need of emergency hospitalization is actually hospitalized with the responsiveness that his urgent condition requires. This may mean a medical screen before transport to the mental hospital, but emergency mental hospitalization is not denied a jail detainee or a prisoner simply because he happens to be incarcerated. An affidavit would be completed at the NMCF to initiate the process, and a hearing would be required prior to extending the involuntary hospitalization by civil commitment. At first blush, this might seem contrary to the purpose of *Vitek*,²¹⁰ but all procedural rights would be protected. The expense of the hearing should be borne by the county of the originating NMCF or by the state, but not by the county wherein the receiving hospital is located. Then mentally ill inmates would have both the possibility of emergency hospitalization and protection of their

unacceptable reason.”).

²⁰⁷ See Felthous, *supra* note 140.

²⁰⁸ See MO. DEPT. OF MENTAL HEALTH, REFERENCE GUIDE FOR CIVIL INVOLUNTARY DETENTION 4 (2009) (stating that any adult could file an application with the probate court for the ninety-six hour commitment of another. They would first have to file an application and an affidavit alleging under oath that a particular person suffers from a mental disorder and presented a likelihood of serious harm to themselves or others. Then if the probate court found that the person met the criteria the probate court would issue an order and a warrant for the person to be taken into custody and transported to a mental health facility).

²⁰⁹ See TORREY ET AL., *supra* note 5, at 63–65 (providing no mention of this process existing in the section on Missouri).

²¹⁰ *Vitek v. Jones*, 445 U.S. 480, 493–95 (1980) (concluding “that a convicted felon also is entitled to the benefit of procedures appropriate in the circumstances before he is found to have a mental disease and transferred to a mental hospital.”).

liberty interests and procedural rights that is allowed citizens who are not incarcerated.

Over and over again the refrain is heard that there are an insufficient number of hospital beds, as the reason that inmates in need of hospitalization are not hospitalized. There are too few hospital beds, the refrain continues, because of state budgetary restrictions. Stewards of the public coffers must plan and allocate resources judicially, but the most extreme needs can be prioritized appropriately. If state funding supports indefinite commitment of sexual offenders after they have served their sentence,²¹¹ for example, there should be support for providing the appropriate level of treatment to the most severely disturbed individuals who through incarceration become totally dependent on the state or county for their medical or mental health needs. States should open up more hospital beds to meet the need. Where state legislatures and administrators fail to fulfill their responsibilities, courts can step in as occurred recently in the state of Washington.²¹²

XII. THE NEED FOR TIMELY ANTIPSYCHOTIC TREATMENT

One of the most persuasive arguments for initiating enforced treatment in the non-medical correctional facility where an individual is housed is to reduce unnecessary delay. Correctional mental health professionals are all too familiar with cases of psychotically disordered inmates who have languished for months, in some cases years, until they are transferred to a hospital to have their much needed treatment begun. Further support for the reality of this serious problem of delayed treatment can be found in the *Joint Report*.²¹³ Allowing an inmate to remain untreated is not humanitarian or caring, but cruel and harmful. Untreated psychosis runs the risk of harm to self and others, to worsening of the psychosis and mental

²¹¹ See Bill Mears, *Supreme Court: Sex Offenders Can be Held Indefinitely*, CNN (May 17, 2010, 12:10 PM), <http://www.cnn.com/2010/CRIME/05/17/scotus.sex.offenders/> (stating the Supreme Court has ruled that the federal government can keep certain sex offenders behind bars indefinitely, so accordingly states may as well if they choose to).

²¹² See *Det. of D.W. v. Dep't of Soc. and Health Servs.*, 332 P.3d 423, 424, 428 (Wash. 2014) (the Supreme Court of Washington held that Involuntary Treatment Act "does not authorize psychiatric boarding as a method to avoid overcrowding certified evaluation and treatment facilities.").

²¹³ See TORREY ET AL., *supra* note 5, at 15.

disability. Advocates of in-house enforced antipsychotic medication reason that this would enable prompt initiation of the needed treatment that is delayed by creating the extra step of hospital transfer and its requisite, separate court approval.²¹⁴ Lengthy delay in initiating antipsychotic medication is irresponsible. It could amount to deliberate indifference or cruel and unusual punishment for inmates who are already sentenced. Timely initiation of antipsychotic pharmacotherapy can reduce the violent behavior and the need for physical restraints.²¹⁵ Beyond the obvious harms from failure to initiate timely treatment, temporization may actually cause physical damage to the brain.²¹⁶ Delays in providing proper antipsychotic treatment can result in treatment resistance, that is, once treatment is initiated after a lengthy period of non-treatment, the brain may have undergone changes that render it less amenable to antipsychotic pharmacotherapy.²¹⁷ The longer a person's psychosis goes untreated, the poorer the outcome.²¹⁸

Decrease in temporal and occipito-temporal gray matter volume has been demonstrated by Magnetic Resonance Imaging (MRI) to be associated with the duration of untreated psychosis in schizophrenic subjects.²¹⁹ It has been suggested that such structural changes in the brain resulting from withholding treatment contribute to poor treatment response and worsened prognosis.²²⁰ Contrary evidence indicates that the loss of gray matter volume in schizophrenic subjects is a function of

²¹⁴ See Malini Patel & Daniel W. Hardy, *Encouraging Pursuit of Court-Ordered Treatment in a State Hospital*, 52 PSYCHIATRIC SERV. 1656, 1657 (2001) (stating that intervention that comes early on is beneficial).

²¹⁵ *Id.* at 1656; see Mary E. Muscari, *What is the Best Pharmacotherapy for Violent or Aggressive Behavior?*, MEDSCAPE (Oct. 4, 2006), <http://www.medscape.com/viewarticle/545247>.

²¹⁶ See Patel & Hardy, *supra* note 214, at 1656.

²¹⁷ *Id.*; see Seong S. Shim, *Treatment Resistant Schizophrenia*, PSYCHIATRIC TIMES (Aug. 17, 2009), <http://www.psychiatristimes.com/schizophrenia/treatment-resistant-schizophrenia/page/01>.

²¹⁸ David Fraguas et al., *Duration of Untreated Psychosis Predicts Functional and Clinical Outcome in Children and Adolescents with First-Episode Psychosis: A 2-year Longitudinal Study*, 152 SCHIZOPHRENIA RES. 130, 130 (2014); Xiaofeng Guo et al., *Duration of Untreated Psychosis is Associated with Temporal and Occipitotemporal Gray Matter Volume Decrease in Treatment Naïve Schizophrenia*, 8 PLOS ONE 1, 1 (2013).

²¹⁹ Guo et al., *supra* note 218, at 3, 5; Sander V. Haijma et al., *Brain Volumes in Schizophrenia: A Meta-Analysis in Over 18,000 Subjects*, 39 SCHIZOPHRENIA BULL. 1129, 1133 (2013).

²²⁰ Guo, *supra* note 218, at 5.

cumulative exposure to antipsychotic medication and not to duration or severity of the illness.²²¹ The possibility that the amount of antipsychotic medication used to treat schizophrenia can result in decreased gray matter volume needs further investigation. This furthers the argument for timely initiation of antipsychotic pharmacotherapy to obviate the need for higher doses to bring psychotic symptoms under control. Meanwhile the increasing resistance of psychotic symptoms to antipsychotic medication with prolonged medication deprivation remains a strong reason for initiating antipsychotic medication in a timely manner when indicated by the individual's psychotic state, including enforced medication when the individual refuses without rational reason.

XIII. THE SUPREME COURT AFFIRMS AN INMATE'S RIGHT TO TREATMENT IN PRISONS AND JAILS

The United States Supreme Court in *Estelle v. Gamble* established a right to treatment for prisoners that is protected by the United States Constitution.²²² If prison officials are deliberately indifferent to a prisoner's medical needs, they may be violating his right not to be subjected to cruel and unusual punishment after conviction and sentencing.²²³ Although *Estelle v. Gamble* concerns prisoners' medical and not mental health needs, lower courts have found no distinction between medical and mental health needs in this regard.²²⁴

Similarly pre-trial jail inmates have a right to treatment, as they too have a right not to be subjected to deliberate indifference. This is based not on the right not to be subject to cruel and unusual punishment, as pretrial detainees are not being punished, but rather as the right not to be punished whatsoever.²²⁵ Pre-trial detainees are protected from deliberate indifference through the Due Process Clause of the Fourteenth

²²¹ P. Fusar-Poli et al., *Progressive Brain Changes in Schizophrenia Related to Antipsychotic Treatment? A Meta-Analysis of Longitudinal MRI Studies*, 37 NEUROSCIENCE BIOBEHAVIORAL REV. 1680, 1688 (2013); see Haijma, *supra* note 219, at 1133.

²²² *Estelle v. Gamble*, 429 U.S. 97, 104–05 (1976).

²²³ *Id.*

²²⁴ HANDBOOK OF CORRECTIONAL MENTAL HEALTH, *supra* note 184, at 72.

²²⁵ See *Bell v. Wolfish*, 441 U.S. 520, 545 (1979) (pretrial detainees “retain at least those constitutional rights that we have held are enjoyed by convicted prisoners[.]” which would include the constitutional right against cruel and unusual punishment).

Amendment.²²⁶

Although the U.S. Supreme Court has not addressed an inmate's right to receive an appropriate level of mental health services that includes mental hospitalization, both medical and mental hospitalization could logically be subject to deliberate indifference analysis. Inmates can suffer or be harmed by withholding hospital services whether in response to severe medical or mental health needs. If enforced medication is administered in a NMCF, it may be argued, any need to be hospitalized based solely on the need for enforced medication would be mitigated by its administration without hospital transfer. But not every medical, surgical, and invasive psychiatric procedure should be given outside of a hospital simply because it can physically be done. Inmates with extreme medical and mental health service needs are no less entitled to hospital services because they happen to be incarcerated. If anything their incarceration adds to the government's responsibility to ensure that such urgent and severe needs are met in a timely and appropriate manner.

The United States Supreme Court has found that both pre-trial detainees and sentenced prisoners have a constitutional right to treatment.²²⁷ It has also held that the administration of involuntary psychotropic medication must be medically appropriate.²²⁸ Now it remains for the Court to address whether inmates in need of enforced antipsychotic medication have a right to be treated in an appropriate facility, i.e., a mental hospital or ward rather than a NMCF.

XIV. THE SUPREME COURT AUTHORIZES APPROPRIATELY ENFORCED MEDICATION IN JAILS AND PRISONS

The United States Supreme Court's authorization to medicate mentally disordered inmates is overgeneralized such as to diminish the quality of treatment afforded mentally disordered persons in jails and prisons. The overgeneralization usually takes the form of interpreting the Supreme Court's *Harper* decision²²⁹ as allowing enforced medication in non-medical correctional facilities, i.e., jails and prison units. In order to

²²⁶ See *Revere v. Mass. Gen. Hosp.*, 463 U.S. 239, 244–46 (1983).

²²⁷ See *supra* text accompanying notes 223–27.

²²⁸ *Sell v. United States*, 539 U.S. 166, 181 (2003).

²²⁹ *Washington v. Harper*, 494 U.S. 210, 236 (1990).

analyze the Supreme Court's position on involuntary medication in correctional settings, its entire trilogy of treatment refusing landmark cases—*Riggins*, *Harper*, and *Sell*—must be examined.²³⁰

Riggins involved a pre-trial jail detainee who protested the administration of thioridazine, an antipsychotic medication, to treat his mental disorder, a treatment from which he had reportedly benefitted in the past.²³¹ Citing its earlier *Harper* opinion, to be discussed below, the Court found that involuntary medication must be in the inmate's medical interest and must be medically appropriate, regardless whether the pretrial detainee is competent, or, in a later case, incompetent to stand trial.²³² Of this trilogy of cases, only David Riggins was clearly and only being treated while in jail and not in a hospital.²³³ To be stressed, Riggins was never found incompetent to stand trial and he was not being medicated for competence restoration.²³⁴

The Court did not comment on the fact that David Riggins was involuntarily medicated while he was in jail and not in a hospital.²³⁵ The Court found that the administration of thioridazine was “medically appropriate,” without mentioning whether involuntary medication in a jail and not in a hospital was appropriate.²³⁶ As observed before, the place in which Riggins was involuntarily medicated was apparently of no concern to the defense, the state or the *amici*.²³⁷ He had not been court ordered to be involuntarily medicated for competence restoration after refusing medication.²³⁸

Sell was the second landmark Supreme Court decision following *Riggins* to deal with the involuntary medication of a pretrial detainee.²³⁹ The difference from David Riggins is that *Sell* was actually adjudicated as incompetent to stand trial and

²³⁰ See Braden A. Borger, Comment, *Sell v. United States: The Appropriate Standard for Involuntarily Administering Antipsychotic Drugs to Dangerous Detainees for Trial*, 35 SETON HALL L. REV. 1099, 1101 (2005).

²³¹ *Riggins v. Nevada*, 504 U.S. 127, 129–30 (1992) (the case states that “Mellaril is the trade name for thioridazine,” and the opinion from then on calls it “Mellaril”).

²³² *Id.* at 133, 135.

²³³ Felthous, *supra* note 45, at 110.

²³⁴ *Id.*

²³⁵ *Id.* at 111.

²³⁶ *Id.*; *Riggins*, 504 U.S. at 133.

²³⁷ Felthous, *supra* note 45, at 111.

²³⁸ *Id.*

²³⁹ *Sell v. United States*, 539 U.S. 166 (2003).

the purpose of his medication was to restore his competence.²⁴⁰ To be emphasized is that in both *Riggins* and *Sell*, the United States Supreme court required that involuntary medication, if otherwise justified, must be medically appropriate.²⁴¹ The Court provided four criteria to be followed in a competence restoration hearing one of which was medical appropriateness.²⁴² Specifically the Court stated, “the court must conclude that administration of the drugs is *medically appropriate*, i.e., in the patient’s best medical interest in light of his medical condition.”²⁴³ Obviously the selection of the drug must be medically appropriate, but here the term was “administration” meaning as well, how the drug is given, reasonably including the controlled circumstances for administration such as the place in which medication is given, although the Court did not provide a definition of “administration.”²⁴⁴ Medically appropriate administration may be desirable for treatment and restoration of competence generally, but if medication is to be given involuntarily, its administration must be appropriate. Even though place of involuntary medication was not specified by the Court in *Sell*,²⁴⁵ the most appropriate place for appropriate administration would be in a hospital.

Now we turn to *Harper*, chronologically the first in the trilogy and foremost as authority cited to justify involuntary medication of both pretrial detainees, convicted, and sentenced prisoners.²⁴⁶ Although frequently cited to justify involuntary medication of inmates, the constitutionally required procedures were not specified by the *Harper* decision.²⁴⁷ The Supreme Court did not specify which of all the procedures in the policy of the mental health unit in which Walter Harper was treated were constitutionally required.²⁴⁸ One only knows that the policy in its entirety was constitutional.

The United States Supreme Court found Policy 600.30, allowing for involuntary medication in certain circumstances, to be constitutional:

²⁴⁰ *Id.* at 169, 171–72.

²⁴¹ *Id.* at 181; *Riggins*, 504 U.S. at 135.

²⁴² *Sell*, 539 U.S. at 180–81.

²⁴³ *Id.* at 181.

²⁴⁴ *See id.*

²⁴⁵ *Id.*

²⁴⁶ *Washington v. Harper*, 494 U.S. 210 (1990).

²⁴⁷ *See id.* at 222–23, 227.

²⁴⁸ *Id.*

[G]iven the requirements of the prison environment, the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest. Policy 600.30 comports with these requirements[.]²⁴⁹

This policy pertained only to the special treatment unit in which Mr. Harper was housed, not to a non-medical correctional facility and not to the rest of the prison system.²⁵⁰

The Supreme Court's holding much more explicitly required that the involuntarily administered medication be in the inmate's medical interests than did the policy itself.²⁵¹ This holding did not specify that the inmate's medical interests are served by enforced administration of the medicine in an appropriate facility, not just any facility.²⁵² Perhaps, as in the civil context, it was implicitly assumed that it would be in the inmate's medical interest and medically appropriate to provide this level of treatment in a hospital. In the civil realm, legal regulations for enforced medication to acutely disturbed persons do not necessarily specify that such treatment must occur in a hospital,²⁵³ presumably as with other medical procedures involving risk, it is assumed that this treatment would occur only within a hospital. Pinals and Hoge have observed that the involuntary treatment of treatment-refusing patients occurs within a psychiatric facility.²⁵⁴ In some jurisdictions civil patients can be involuntarily medicated only after they have been committed to a psychiatric inpatient setting.²⁵⁵

²⁴⁹ *Id.* at 227.

²⁵⁰ *See id.* at 214–15 (showing it was the Special Offender Center's specific policy).

²⁵¹ *Id.* at 215, 222–23, 227.

²⁵² *Id.* 222–23, 227 (showing the lack of administration standards).

²⁵³ *See generally* Debra A. Pinals, & Stephen K. Hoge, *Treatment Refusal in Psychiatric Practice*, in *PRINCIPALS AND PRACTICE OF FORENSIC PSYCHIATRY* 129, 129–31 (Richard Rosner ed., 2d ed. 2003) (stating that the rules governing treatment refusal, and accordingly the rules governing enforced medication, can differ based on whether a facility is private or public and based on the jurisdiction).

²⁵⁴ *See id.* at 129.

²⁵⁵ *See* Robert T.M. Phillips & Carol Caplan, *Administrative and Staffing Problems for Psychiatric Services in Correctional and Forensic Settings*, in *PRINCIPLES AND PRACTICE OF FORENSIC PSYCHIATRY* 505, 508 (Richard Rosner ed., 2d ed. 2003) (stating that patients involuntarily committed did not have a right to refuse comparable to that of a patient who was committed voluntarily).

Without explicitly addressing the nature of the facility in which enforced medication should take place, the Supreme Court consistently found that such procedure must be medically appropriate.²⁵⁶ In *Harper*, the Court held that such “treatment [must be] in the inmate’s medical interest.”²⁵⁷ For a pretrial detainee who is competent to stand trial, involuntary medication must be medically appropriate, more specifically the “administration” of the antipsychotic medication must be “medically appropriate.”²⁵⁸ Also for the purpose of competence restoration, enforced “administration of the drugs [must be] *medically appropriate*, i.e., in the patient’s best medical interest.”²⁵⁹ Any hearing for enforced medication, whether administrative or judicial, whether pretrial or post-conviction, must consider the medical appropriateness of the procedure.²⁶⁰

Medical appropriateness of enforced medication includes not only the medically appropriate selection of the medicine to be administered, but of its administration, including how and where the medication is involuntarily administered.²⁶¹ In his concurring opinion in *Riggins*, Justice Kennedy stated, “[i]f the State cannot render the defendant competent without involuntary medication, then it must resort to civil commitment, if appropriate, unless the defendant becomes competent through other means[;]” that civil commitment is usually to a hospital, certainly not to a NMCF, for treatment.²⁶² The majorities in *Harper*, *Riggins*, and *Sell* have not so explicitly considered the medically appropriate setting for medically appropriate involuntary administration of medication.²⁶³ Particularly today as correctional medicine policy and practice slides down the slippery slope away from the appropriate utilization of hospital services, any hearing on enforced medication, whether under *Harper* or *Sell*, ought to address the appropriate place as a component of medically appropriate administration.

²⁵⁶ See *Sell v. United States*, 539 U.S. 166, 181 (2003); *Riggins v. Nevada*, 504 U.S. 127, 135 (1992); *Harper*, 494 U.S. at 227.

²⁵⁷ *Harper*, 494 U.S. at 227.

²⁵⁸ *Riggins*, 504 U.S. at 133.

²⁵⁹ *Sell*, 539 U.S. at 181 (emphasis omitted).

²⁶⁰ See *Sell*, 539 U.S. at 181; *Riggins*, 504 U.S. at 135; *Harper*, 494 U.S. at 227.

²⁶¹ See, e.g., Felthous, *supra* note 45, at 109.

²⁶² *Riggins*, 504 U.S. at 145 (Kennedy, J., concurring).

²⁶³ See generally *Sell*, 539 U.S. 166; *Riggins*, 504 U.S. 127; *Harper*, 494 U.S. 210 (nowhere in these opinions is the setting truly considered).

In *Sell*, the Supreme Court held that the administrative of antipsychotic medication must be appropriate when given involuntarily for trial competence restoration.²⁶⁴ Of course, for restoration, but also if the medication is enforced without the inmate's consent for any reason, including treating severe mental illness with its attending risks, its administration should be appropriate. This would logically mean that the selection of the medication itself, the manner in which it is administered, but also the setting where the medication ought to be appropriate. Yet the Supreme Court has not yet explicitly addressed the appropriate place for medication to be administered involuntarily. But clearly the Court has not authorized inappropriate place of administration of enforced medication to inmates, even as "appropriate" remains to be defined.

XV. COURT FINDS THAT THE PROPER PLACE FOR INVOLUNTARY TREATMENT IS IN A MENTAL HOSPITAL

There is a logjam of mentally ill persons in urgent need of enforced mental health services in both the civil and the criminal mental health systems due to lack of hospital beds.²⁶⁵ Among the consequences of the inability to effect mental hospital admission outside of the criminal justice system is the backup of patients in general hospital emergency rooms with delays of hours or even days until they can be transferred for hospital care.²⁶⁶ The Supreme Court of the state of Washington recently found this practice to be unconstitutional, forcing the state government to relieve the hospital bed shortage by appropriately funding the creation of more hospital beds.²⁶⁷

In re Detention of D.W. did not involve an inmate in a non-medical correctional facility receiving enforced medication on site rather than in a hospital; it involved detention of persons in emergency rooms until hospitalization could be effected.²⁶⁸ Despite this and other differences in the two situations involving enforced treatment, the commonalities point to principles that should apply regardless whether the individual had passed through a sally port. We begin with the differences.

²⁶⁴ *Sell*, 539 U.S. at 169, 181.

²⁶⁵ See *supra* text accompany notes 30–33.

²⁶⁶ See *In re Det. of D.W.*, 332 P.3d 423, 424 (Wash. 2014).

²⁶⁷ See *id.* at 428.

²⁶⁸ *Id.* at 424.

Obviously a hospital emergency room is different from a non-medical correctional facility. In some ways an emergency department may be the most appropriate setting for assessing and treating mentally disordered persons, for example, where acute delirium is part of the initial presentation. Depending on the condition of the individual and the non-medical correctional facility of comparison, an emergency department may be a better setting for initiating emergency treatment or enforced medication.

The legal status of the mentally disordered individual is another obvious difference. Those in emergency rooms in Washington are subject to the State's Involuntary Treatment Act,²⁶⁹ whereas those in jails or prisons are involuntarily detained for reasons in the criminal law that have nothing to do with mental illness or treatment. With respect to the present discussion, *In re Detention of D.W.* involved emergency room detention as an alternative to immediate hospitalization, not explicitly enforced medication,²⁷⁰ although one might expect in emergencies, emergency medication would be administered to a patient who is involuntarily detained in an emergency department because of a mental disorder. The Washington case involved individuals who were certified as in need of hospitalization²⁷¹ whereas in a NMCF the enforced medication can occur without even the initial affidavit in support of hospitalization. If the emergency room patient is not certified and detained, he leaves the facility without treatment and without safety measures provided by a hospital whether in an emergency room or a mental health unit. The NMCF inmate who is not given enforced medication remains incarcerated. A dramatic difference is that the emergency room patient is held up for hours or a few days, whereas the NMCF mentally ill inmate may in some cases not receive appropriate hospital care for months or years, or in some cases not at all, the last outcome made more likely by providing enforced medication in the NMCF.

The commonalities between these two situations suggest principles that could equally be applied to inmates who are denied indicated hospitalization. Both adverse scenarios are caused by insufficient bed capacity in suitable mental hospitals. Both should be correctable, as will occur for emergency room

²⁶⁹ *Id.*

²⁷⁰ *Id.*

²⁷¹ *See id.*

patients in Washington, by ensuring available hospital beds. The Washington court stated that “[p]atients may not be warehoused without treatment because of lack of funds. ‘Lack of funds, staff or facilities cannot justify the State’s failure to provide [such persons] with [the] treatment necessary for rehabilitation.’”²⁷²

From the court’s summary of the facts, it is unclear whether those detained in emergency rooms were receiving “no psychiatric care,” as claimed by Washington State Mental Health Commissioner Adams²⁷³ or “less care than they would if they were in an evaluation and treatment center [and] it’s actually a more restrictive environment[,]”²⁷⁴ as Nathan Hinrichs, Supervisor of the Designated Mental Health Professional (DMHP) in Pierce County, Washington testified.²⁷⁵ The latter two adversities from emergency room detention are just as valid as holding mentally ill inmates in NMCFs and withholding hospitalization. Thus, the same arguments for prompt hospital care could be made for mentally disordered inmates who refuse needed antipsychotic medication.

Admittedly *Detention of D.W.* better fits within the civil right to treatment jurisprudence than hospital deprived inmates would. This is because right to treatment litigation is rooted somewhat paradoxically in the right to refuse treatment. Landmark right to treatment cases involved patient litigants who were protesting their involuntary civil commitment.²⁷⁶ Credited with originating the right to treatment principle, Morton Birnbaum argued that if an individual is hospitalized involuntarily, depriving him of his liberty, then substantive due process necessitates providing the institutionalized person with appropriate treatment.²⁷⁷ Similarly the U.S. Circuit Court of Appeals applied this *quid pro quo* doctrine to the landmark case of *Donaldson v. O’Connor*.²⁷⁸ In exchange for taking away a person’s freedom, treatment must be provided. This constitutional right to treatment, guaranteed by the Fourteenth Amendment, was substantially weakened by the

²⁷² *Id.* at 426 (quoting *Or. Advocacy Ctr. v. Mink*, 322 F.3d 1101, 1121 (9th Cir. 2003)).

²⁷³ *Id.* at 425.

²⁷⁴ *Id.* (citation omitted).

²⁷⁵ *Id.*

²⁷⁶ See *Rouse v. Cameron*, 373 F.2d 451, 452 (D.C. Cir. 1966); *Wyatt v. Stickney*, 344 F. Supp. 373, 374 (M.D. Ala. 1972).

²⁷⁷ Morton Birnbaum, *The Right to Treatment*, 46 A.B.A. J. 499, 499 (1960).

²⁷⁸ *Donaldson v. O’Connor*, 493 F.2d 507, 522, 524 (5th Cir. 1974).

U.S. Supreme Court.²⁷⁹ In its ruling on the same case, the U.S. Supreme Court in *O'Connor v. Donaldson*, replaced the *quid pro quo* right to treatment with its “without more” doctrine: “A [s]tate cannot constitutionally confine *without more* a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.”²⁸⁰ The litigants in *In re the Detention of D.W.* were all subjected to Washington State’s involuntary treatment act (ITA) and contested their involuntary detention in an inappropriate place, an emergency department.²⁸¹ Inmates who are in need of hospitalization are, also detained involuntarily, but for reasons in criminal law, not because they are being civilly committed.

Prisoners, not just innocent citizens, however, also have a constitutional right to treatment.²⁸² Because prisoners must rely on prison staff for all of their medical needs, denial of such services causing pain and suffering, serves no penological purpose. If such denial is done with “deliberate indifference” this amounts to cruel and unusual punishment in violation of the Eighth Amendment of the U.S. Constitution.²⁸³ Jail detainees are also entitled to adequate medical care enforceable by the law and correctional litigation.²⁸⁴ Thus, the Washington Court’s recognition that those in urgent need of hospitalization have a constitutional right to hospitalization could be applied to mentally disordered jail detainees and prisoners but with the constitutional right to treatment that pertains to those two legal statuses within the criminal justice system.

SUMMARY AND CONCLUSION

That the dramatic reduction in the hospitalization of seriously mentally ill individuals has been a factor in the progressive and substantial increase in the numbers of incarcerated individuals in the United States is well known. Less well publicized is the failure of state governments to keep up with the increasing need for hospitalization within correctional systems and in some cases the withdrawal of hospital services for mentally disordered

²⁷⁹ *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

²⁸⁰ *Id.* at 576 (emphasis added).

²⁸¹ *See In re Det. of D.W.*, 332 P.3d 423, 424 (Wash. 2014).

²⁸² *Estelle v. Gamble*, 429 U.S. 97, 103–04 (1976).

²⁸³ *Id.* at 104.

²⁸⁴ *Id.*

inmates in need of this level of care. Textbooks on correctional psychiatry do not address the nature and purposes of security hospitals. Neither have courts addressed whether the community practice of administering enforced medication in a mental hospital or ward should apply as well for incarcerated persons in need of this level of treatment. As illustrated by the *Joint Report*, both mental health professionals and correctional administrators are turning a blind eye to the essential need for hospital services and proposing the “half way solution” of encouraging enforced medication within NMCFs.²⁸⁵ By appearing to obviate the need for hospitalization, this practice will further diminish the availability of hospital treatment for inmates who ought to receive this level and quality of treatment.

This unhelpful trend can be reversed, as has been demonstrated by policymakers and administrators who have in local systems increased the number of hospital beds to meet the need and/or improved the efficiency of the process of hospital transfer so as to eliminate unnecessary delay and enable timely initiation of treatment. This ought to be taking place on a larger scale with policymakers and correctional administrators as well as leaders in mental health and guardians of patient and prisoners’ right to appropriate treatment advocating for and initiating proper treatment of the most severely mentally disturbed inmates, including hospitalization where needed. Where systemic inertia does not allow ready correction of this deliberate and often institutionalized indifference towards inmates’ most critical treatment needs, those who have not lost sight of the real problem ought to turn to litigation and seek a judicial solution as occurred in the state of Washington where individuals in need of hospitalization were held in emergency rooms.²⁸⁶

²⁸⁵ See TORREY ET AL., *supra* note 5, at 105–06.

²⁸⁶ See *In re Det. of D.W.*, 332 P.3d 423, 424 (Wash. 2014).