Chapter 7: Rethinking Incarceration for People with Mental Disorders

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Learning Objectives

The following learning objectives tell you what is most important in this chapter. Use these statements as a guide to make sure you get the most out of this chapter.

1. Evaluate settings where people with mental disorders may be incarcerated, considering competing concerns and needs of the individual and the facility.
2. Discuss the use of restrictive and isolated housing for incarcerated people with mental disorders.
3. Describe the legal requirements that govern the provision of health care, including care for mental disorders, to incarcerated people.
4. Explain systems for, and barriers to, effectively assessing and treating incarcerated people with mental disorders.

Key Terms

Look for these important terms in the text in bold. Understanding these terms will help you meet the learning objectives of this chapter. You can find definitions for these terms at the end of the chapter.

- **APIC Framework**
- **Assessment**
- **Eighth Amendment**

- **Fifth Amendment**
- **Fourteenth Amendment**
- **Medication-assisted treatment (MAT)**
- **Screening**
- **Solitary Confinement**
- **Telehealth**
- **Trauma-informed (training, care or approach)**

Chapter Overview

Sedlis Dowdy, a tall, soft-spoken Black man with a diagnosis of schizophrenia, grew up poor and often hungry in Harlem. Dowdy's mother had nine other children and she, also, experienced mental illness. Despite these barriers, Dowdy obtained his GED and made it to college. He did well his first few terms, until mental illness overwhelmed him. Though violence is not common among people who are mentally ill (only 4% of violent crime is attributable to people with mental illness), Dowdy was the exception (The Council of State Governments, 2021). In 1996, Dowdy experienced auditory hallucinations and shot a stranger in a New York park (Rodriguez, 2015).

We have learned about the importance of diverting people with mental disorders away from the criminal justice system. This aligns with our understanding that people with mental disorders are at risk of being improperly criminalized due to their mental disorders, and that jail and prison can harm people with mental disorders. Diversion instead of prosecution, however, is more appropriate for people who have committed lower-level offenses, such as those connected to being unhoused or using substances.

We have also learned that the criminal justice system has mechanisms to remove more serious offenders from the criminal justice system when conviction is not appropriate due to a mental disorder. These mechanisms, including the insanity defense, are difficult to use and often unappealing. For example, Sedlis Dowdy might have pursued the insanity defense, but he says he chose not to because he was afraid of the open-ended – possibly lifetime – hospital stay that could result from a criminal commitment (Rodriguez, 2015). We will discuss criminal commitments in more detail in Chapter 9 of this text.

Ultimately, Dowdy was prosecuted and convicted, and he received a five to ten year prison sentence. For much of his time in prison, Dowdy was not on an effective medication regimen, and he was heavily impacted by his mental illness. Dowdy's behavior was uncooperative and violent. In order to control and discipline him, prison officials repeatedly placed him in solitary confinement, where he spent about nine of his prison years. In solitary, Dowdy suffered many indignities, including being fed prison "loaf:" a baked brick of mashed food that is, reportedly, disgusting and used as punishment (Rodriguez, 2015; Barclay, 2014)(figure 7.1). During his time inside, Dowdy, in anger, threw feces at guards – an offense for which he was prosecuted, adding four years to his sentence (Rodriguez, 2015).

Figure 7.1. A picture of prison veggie loaf. While nicely plated here, the food has been used as a form of punishment for incarcerated people in restrictive housing, where it is served repeatedly.

As we have learned, America's jails and prisons are full of people with mental disorders. Sedlis Dowdy is one of those people. This chapter focuses on the laws and practices, in both state and federal custodial environments, that govern and impact the experience of people like Dowdy. The criminal justice system bears obligations towards the vulnerable people who depend upon it for care while they are in custody. As you read and watch the linked videos in this chapter, consider how our system is meeting those obligations, and how we might better serve people who are incarcerated.

Chapter Overview Licenses and Attributions

Custodial Environments for People with Mental Disorders

Because so many people in our jails and prisons have mental disorders – upwards of 40% by some estimates and even higher by others – all custodial environments are places where people with mental disorders may be incarcerated. The image in figure 7.2 highlights the major components of corrections in the United States. The criminal justice system is divided into state and federal systems at the law enforcement level, where federal officials enforce federal laws and state or local officials (e.g., police, sheriffs) enforce state or local laws. State law violations are referred to local prosecuting attorneys and handled in state courts, while federal crimes are referred to federal prosecutors working in federal courts. Pre-trial detention and short terms of punishment are typically carried out within the system (state or federal) where a person is charged with a crime. If a lengthy sentence is imposed after conviction, the person will be transferred to prison in the system where they were charged.

Figure 7.2. This graphic shows the components of the U.S. incarceration system from time of arrest and incarceration to placement at a correctional facility. [Full Image Description.]

State and federal correctional facilities vary in their physical setups, policies and practices. All of this impacts the experience a person with a mental disorder will have in that custodial environment. Federal constitutional standards, discussed later in this chapter, set a "floor" for treatment of incarcerated people. These standards are met, or not, to varying degrees in different jurisdictions and facilities. Along with varying practices, jails and prison systems employ a range of terminology to describe what they do. One example is the practice of isolating an incarcerated person in a cell for most of every day. There can be great variability in how (and why) isolation is used, and the practice has different names, for example, solitary confinement, segregation, or use of restricted housing. Solitary confinement as a particular problem for people with mental disorders is discussed later in this chapter.

Note that the vast majority of people who are incarcerated in the United States are held in local jails and state prisons rather than in federal facilities (See figure 7.3 to compare these numbers). However, data are often more available from the federal system than from individual state, county, and local facilities, and that information is useful to our discussion in this text.

Incarceration in Jail

In the United States, almost two million people are currently incarcerated. As shown in the chart at figure 7.3, just over half a million of these people are held in local jails. While that is a huge number of people, that is merely the number in jail at any given moment. The people who make up that population are in constant flux; the average person will be in jail for just a few weeks before they are released or transferred (Prison Policy Initiative, n.d.). More than ten million people are booked into jails each year, eighty percent of whom are charged with low-level and non-violent misdemeanors. Only five percent of people booked into jails are charged with violent offenses (Dholakia, 2023).

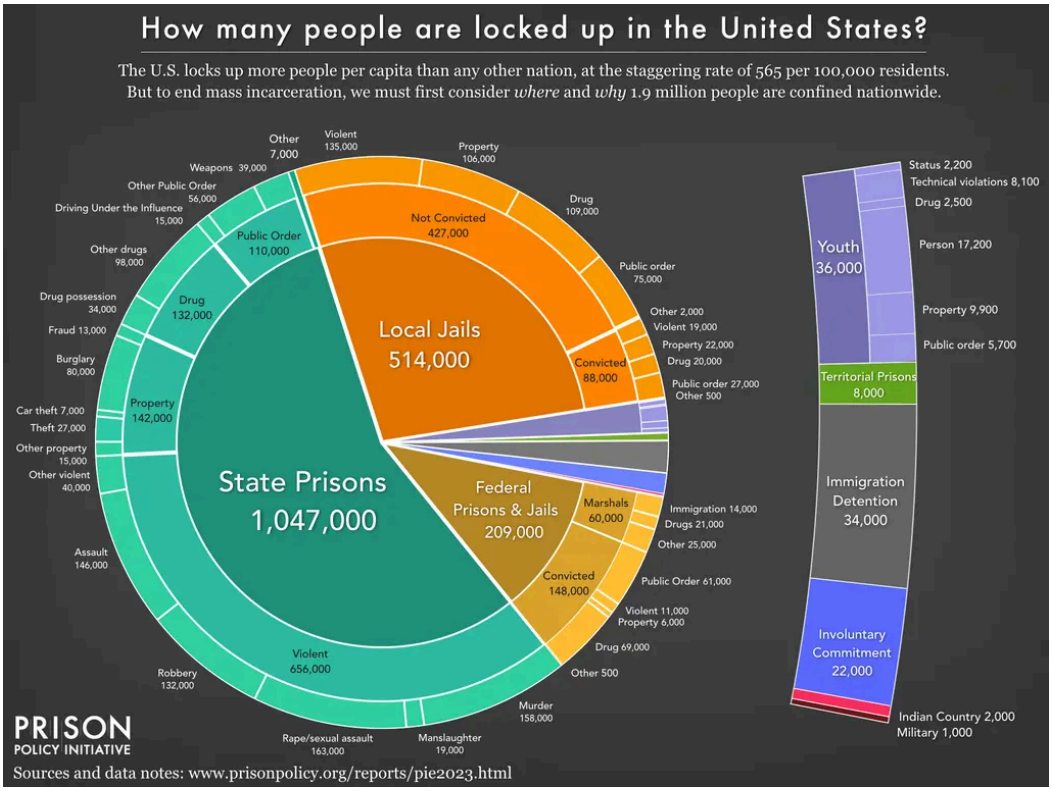

Figure 7.3. This chart illustrates the distribution of the nearly two million people incarcerated in the United States at a snapshot in time in 2023. Incarcerated people are primarily in state prisons and jails rather than in federal facilities. Notably, most jail residents have not been convicted of a crime and are awaiting resolution of nonviolent charges.

Though we often hear about people in "jails and prisons," the reality is that these are two very different placements in a number of ways. As noted, the jail population is a short-term one, and most residents are legally innocent – they have been arrested and charged with, but not convicted of, any crime. A majority of the jail population remains incarcerated due to inability to post bail pending resolution of their charges. This means that the jail population skews heavily towards people who are poor and unhoused, a demographic with high rates of mental disorders (estimated around 75%) (James & Glaze, 2006; Gutwinski, et al., 2021). In Atlanta, for example, unhoused people make up less than one-half percent of the overall population, yet they comprise 12.5% of the bookings into the city jail (Harrell & Nam-Sonenstein, 2023). About forty-four percent of people in jail have mental disorders – a higher number than in prisons (37%) – again in part because this group is less likely to make bail than people without mental disorders (National Alliance on Mental Illness [NAMI], 2023; Substance Abuse and Mental Health Services Administration [SAMHSA], 2023). People of color (especially Black and Native people) are significantly overrepresented in jails across the country. Black people are overwhelmingly more likely than white people to be sent to jail for pre-trial detention and to have an unaffordable bail set – compounding the impact of other factors like mental illness or poverty (Pew Charitable Trust, 2023; Dholakia, 2023; Sawyer, 2019).

Given the relative lack of power and visibility of most jail inhabitants, there is an enormous need for advocacy on their behalf. The Amplifying Voices of Individuals with Disabilities (AVID) Jail and AVID Prison Projects, both carried out by Disability Rights Washington, are advocacy efforts for incarcerated people who experience disabilities, primarily mental disorders. The attorneys who staffed the AVID Jail Project advocated for their clients in jails in Washington state and documented the particular struggles of people with mental disorders in jail environments (Disability Rights Washington, 2016). A number of AVID videos are linked in this

chapter to allow students to hear directly from impacted groups about their experience in custody.

Watch the videos from the AVID Jail Project at Figures 7.4 and 7.5, and consider how the speakers' mental disorders, and the jails' response (or lack of response) to their needs, shaped each person's jail experience. What changes might have re-shaped these experiences and led to different outcomes?

Siyad | AVID Jail Project

Figure 7.4. Siyad Shamo speaks from jail in King County, Washington, about his struggle with Post Traumatic Stress Disorder.

Tallon | AVID Jail Project

Figure 7.5. Tallon Satiacum, speaking from a Washington jail, has a number of mental disorders, including fetal alcohol syndrome and bipolar disorder.

If you are interested in the AVID Jail Project, consider learning more and watching additional videos at the AVID Jail Project [Website].

Incarceration in Prison

While jails are short-term facilities, prisons hold people convicted of crimes who are serving longer-term sentences. Prisons are more apt than jails to determine that a person has a mental disorder and make placement or housing decisions based on that information. In prison, programming – education, life-skills training, and substance use treatment – can be provided for people who will spend years at the facility. Additionally, time and attention can be given to preparing people for eventual reentry into the community after prison. While these things are possible in prison, there is variation in facilities' use of these opportunities.

Sedlis Dowdy, introduced at the beginning of this chapter, served fourteen years in prison before being released to a psychiatric hospital where he spent two additional years. A friend recalls her optimism when Dowdy was finally freed for the first time in sixteen years and placed into

transitional housing. However, just one day after his release, Dowdy stabbed a man. He was sentenced to eight more years in prison (Rodriguez, 2015). Watch the three-minute video at figure 7.6, where Dowdy describes and compares his experiences in jail and prison, as well as in the community. Consider how the described incarceration of people like Dowdy serves, and fails to serve, the interests of community and individual safety.

Living With Schizophrenia, in Prison and Out

Figure 7.6. A short video introduces us to Sedlis Dowdy, one of many thousands of people incarcerated in New York state with a mental disorder. Dowdy, age 42, relates and compares his experiences in jail and prison.

Prisons, like jails, do not reject applicants; rather they accept anyone placed into their custody, including people with serious, even debilitating, mental disorders. Prisons are expected and required to keep all incarcerated people safe in long-term settings — not always an easy proposition. Ideally, prisons meet this demand by housing incarcerated people in environments that balance the need for immediate safety with needs for treatment, socialization, and other resources aimed at rehabilitation. Most people who experience mental disorders in prison are housed in the same places and ways as other incarcerated people, in keeping with the appropriate goal of housing people in the least restrictive environment where they can succeed. Some incarcerated people, however, are better served in a more specialized environment despite additional restrictions that may entail.

The Oregon state prison system, for example, has a number of levels of care and housing for people with mental disorders. The highest level – called a mental health infirmary – provides the most intensive care in Oregon prisons and it is correspondingly quite restrictive. A person in this level of care would be closely supervised, which can be limiting as well as supportive. An incarcerated person with known, serious psychiatric needs might start out in the infirmary level of care, with the potential to move on when they are able to be successful at a lower level of supervision. Oregon's highest level of psychiatric care is available at only one high-security facility (figure 7.7) (Or. Admin. R. 291-048-0200 *et seq*).

Figure 7.7. A view of Oregon's highest-security facility, the Oregon State Penitentiary, from the outside. States vary in the continuum of facilities available for housing incarcerated people with higher needs.

Other Oregon prison facilities, however, offer lower and less-restrictive levels of care for people with mental disorders. At lower levels of care, people in custody may have access to ongoing support related to mental disorders, while being integrated with the general prison population. (Or. Admin. R. 291-048-0200 *et seq.*; Townsend, 2021). A wider range of placements for people at lower levels of care allows incarcerated people to receive care for mental disorders as well as access other therapeutic programs, or potentially be placed in facilities that are closer to their home communities.

Custodial Environments for People with Mental Disorders Licenses and Attributions

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Figure 7.3 How many people are locked up in the United States © The Prison Policy Initiative. All Rights Reserved, included with permission.

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Figure 7.7. Oregon State Penitentiary by Katherine H is licensed under CC BY-NC-ND 2.0.

The Problem of Solitary Confinement

As described by pulitzer-prize winning journalist Ron Powers in his book *No One Cares About Crazy People*:

> Among the most gruesome and least forgivable forms of sanctioned torture by prison [staff] is "punitive segregation," as the delicate euphemism has it. The more familiar term is "solitary confinement." Solitary confinement, even for brief periods – several days, say, with an hour's respite each day – is known to trigger hallucinations and paranoia among sane and insane prisoners alike. For people already mad, it is a quick route to deep and lasting psychosis. The human psyche is essentially social and abhors isolation; enforced separation from others thus amounts to an act of sanctioned depravity.
>
> Solitary confinement has been used as a short-duration measure in the past. In recent decades, overwhelmed wardens increasingly have turned to it in a hair-trigger way, popping prisoners into tiny, badly ventilated cells, often restricting food, water, and medications as part of the bargain.
>
> (Powers, 2017, pp. 147-48).

Solitary confinement, also called isolation or segregation, involves placement of an incarcerated person in a cell alone, with their interactions strictly limited. Solitary confinement is generally used as a form of discipline for prison rule violations, or as a method to keep the isolated person or others safe (Cornell Law School, Legal Information Institute, 2021). The reality of confinement to a very small cell for days, hours, weeks and even years is unthinkable for most people, and hard to imagine for anyone who has not had this experience. Watch the short video linked at figure 7.8 to see and hear about the experience of solitary confinement as shared by inmates at a maximum security federal prison in California.

Stories of Life in Solitary Confinement | Short Film Showcase

Figure 7.8. This video provides a brief glimpse into the lives and thoughts of inmates living in segregation, or solitary confinement, in a federal prison in California.

Solitary confinement is overused for people with mental disorders, and its ill effects are especially harmful for people with preexisting mental disorders. In addition, solitary is used disproportionately among people in other marginalized groups in criminal justice: transgender or gender non-conforming people, young people, and people of color, particularly Black and Hispanic men (Sandoval, 2023; Lantigua-Williams, 2016).

Overuse of Solitary Confinement

Use of solitary confinement has, deservedly, come under heightened scrutiny as its devastating harms are increasingly well-understood. For years, concerns have been raised from as high as the presidency that America's prisons are overusing solitary confinement, in part as a by-product of prisons' – and society's – failure to adequately treat and otherwise safely manage people with mental disorders. Despite pressure from the top, and efforts in state and federal systems to limit its use, solitary confinement in various forms is still a frequent practice in jail and prison environments (U.S. Government Accountability Office [GAO], 2024).

The presence of a mental disorder, especially one that is not adequately treated, increases the likelihood of behavioral issues that correctional staff are ill-equipped to manage – and that may prompt the use of solitary confinement. The AVID Jail and Prison Projects both have a particular focus on the problem of segregating and isolating incarcerated people with mental disorders because this is a common and exceptionally harmful occurrence (Guy, 2016). The AVID Projects share stories that give specific names and faces to the reality that solitary confinement is routinely used to manage behaviors directly related to mental disorders. Watch the short videos from the AVID Jail Project (figure 7.9) and the AVID Prison Project (figure 7.10) to hear two men share their experiences enduring solitary confinement amidst mental illness. As you watch the videos, consider: Why should prisons try to maintain people with mental disorders in less restrictive environments, and how might that be accomplished?

Ricardo | AVID Jail Project

Figure 7.9. Ricardo Rodriguez speaks from a jail in King County Washington, where he has spent six months. Rodriguez has multiple serious mental illnesses and engages in self-harm driven by hallucinations.

Five Mualimm-ak | AVID Prison Project

Figure 7.10. Five Mualimm-ak, a formerly-incarcerated prison reform advocate, shares what it was like to be in prison with a mental disorder. Mualimm-ak served a substantial amount of time in solitary confinement due to rule violations.

Harms of Solitary Confinement

Isolation in solitary confinement is known to be harmful to incarcerated people generally. There is, for example, a clear connection between time in solitary confinement and physical harm, or even death. A 2022 report indicated that while less than 10% of federal prisoners are in solitary confinement at any given time, those prisoners are at far greater risk of grave harm. Almost 40% of homicides and nearly half of suicides in custody occur among that group (Lartey & Thompson, 2024). For people with mental disorders, the risks of isolation and segregation are intensified, as solitary is likely to worsen pre-existing symptoms (Sandoval, 2023).

Consider the video linked at Figure 7.11, where a man in custody shares the lasting effects of his extended time in solitary confinement.

Daniel Perez | AVID Prison Project

Figure 7.11. Daniel Perez, a Washington State inmate with several mental health diagnoses, describes his time in prison. Perez explains that after spending many years in solitary confinement, he struggles to function – or even believe that he can function – in the typical prison environment.

If you are interested in learning more about solitary confinement among people with mental disorders in prison, and about collaborative advocacy efforts on their behalf, please consider exploring the AVID Prison Project webpage.

[feature]

SPOTLIGHT: Solitary Confinement in Federal Prisons

Figure 7.12. Examples of two unoccupied restrictive housing cells in federal facilities.

As of 2023, the federal prison system, called the Federal Bureau of Prisons, or BOP, routinely employed what it calls *restrictive housing* and what is commonly known as solitary confinement: isolating incarcerated people in cells for up to 23 hours per day (figure 7.12). People in restrictive housing are not permitted to leave their cells to attend programming or recreation, or to intermingle with others in their unit. Numerous reports, admonitions, and proposals later, BOP continues to house about 8 percent of its population (about 12,000 inmates) in these settings, including a significant number of people with serious mental disorders.

The most common form of restrictive housing in federal prisons is the Special Housing Unit, or "SHU." These units are located at most federal facilities. People can be placed in a SHU for administrative or disciplinary reasons. Administrative segregation is intended to be

"non-punitive," so that might involve a person whose behavior is not controlled or who needs protection from others. SHU cells can be double- or single-bunked. Though isolation is not as severe in a single cell, the dangers posed by a cellmate in these facilities can be substantial.

The federal system also has an entire facility, known as an Administrative Maximum Facility (ADX) that is located in Florence, Colorado. The ADX has only single cells, and it houses people who require the tightest controls and supervision. The unit has four programs, the most restrictive of which is the Control Unit, meant to house the most dangerous, violent, and disruptive incarcerated individuals, e.g. people who have assaulted or killed staff or other incarcerated people, or who have escaped from another facility.

Additional restrictive housing intended to ensure safety was, previously, located in a "Special Management Unit (SMU)" located at Thomson Penitentiary in Illinois. However, the SMU was closed in 2023 after outside reporting revealed it to be incredibly unsafe – numerous homicides and suicides occurred there over a short period. All of the incarcerated people at the Thomson unit were relocated to a SHU in another facility. It is unclear whether the BOP will reopen this or another similar unit in the future (Khalid & Shapiro, 2023). If you are interested in learning more about the grim conditions at Thomson, consider reading this article about the people who were killed there [Website].

The BOP officially allows the housing of people with mental disorders in any of its restrictive options, with some loose limitations. Every new federal prisoner is required to receive a screening, intended to identify those who may need mental health or substance abuse treatment, and if necessary, evaluation of the identified concern. People with identified needs related to a mental disorder are assigned a care "level" – from one to four – that indicates the significance of their impairment and degree of intervention required. People who are at the higher levels (levels 3 or 4) require more significant interventions, and BOP policy discourages "prolonged" placement of these people in the SHU or ADX. However, they continue to be placed there at higher rates than desired by BOP or observers. For example, more than 65,000 people at mental health levels one through four spent time in a SHU in 2022 – a number that represents an increase of a few thousand from 2018. Around 450 people with

mental health levels of three or four were held in either a SHU, SMU, or ADX in 2022, a slight increase over 2018 numbers.

Attempts to divert people with serious mental illness from restrictive housing in the federal prison system is ongoing. The BOP currently has only a few secure mental health treatment programs – which could serve as alternatives to the standard solitary confinement options – but it plans to expand that capacity.

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The Problem of Solitary Confinement Licenses and Attributions

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Figure 7.11. Daniel Perez | AVID Prison Project by Disability Rights Washington is licensed under the Standard YouTube License.

Staffing in Jails and Prisons

While Sedlis Dowdy, introduced earlier in this chapter, was the exception in committing a violent crime due to his mental disorder, the way he experienced prison as a person with a mental disorder was not so unusual. According to the National Alliance on Mental Illness, or NAMI, most people with mental illness (about three in five) do not receive treatment at all while in prison. (NAMI, n.d.). Oregon's record is better, but far from perfect. In 2023, an estimated 62% of Oregon state prisoners need mental health care, and, according to the state Department of Corrections, about 42% of Oregon inmates are actually getting the care they need (Frost, 2023).

Why is care lacking, despite the acknowledged need? The problem of staffing seems relatively mundane, but it is a central barrier to proper care in custody, and it leads to serious problems, especially for higher-needs people in custody (figure 7.13). Shortages of corrections and/or mental health staff exist for various reasons, including the rural locations of prisons, lack of competitive pay, and after-effects of the COVID-19 pandemic. The federal prison system maintains that it simply cannot find and hire enough workers to fill hundreds of vacancies at many facilities – even while the federal prison population is on the rise. Regardless of cause, shortages result in inadequate support for all incarcerated people, especially those experiencing mental disorders. Lack of adequate support creates unacceptable outcomes, including abuse and violence against incarcerated people, vast overuse of solitary confinement, and increased rates of prisoner self-harm (Lartey & Thompson, 2024).

Figure 7.13. Corrections officers speaking in the hallway of a facility. It is critical for correctional facilities to be properly staffed in order to serve large numbers of people with high needs, such as those with serious mental disorders.

Staffing problems were at the heart of a 2007 lawsuit against the Illinois Department of Corrections (DOC) brought by a man named Ashoor Rasho, who was eventually joined by 12,000 other incarcerated plaintiffs. Rasho's lawsuit challenged the Illinois DOC's pattern of punishing people like Rasho, instead of treating them for their mental disorders. Rasho had been sentenced to a few years in prison and ended up serving far more – about five times the original time he was expected to serve. This was due to behaviors in prison that were related to Rasho's mental disorders, but were handled with punishments, including decades in solitary confinement. A central issue in Rasho's lawsuit was that the prison did not have the staff to allow people who were mentally ill or suicidal out of their cells. Instead, they were locked up alone even though this was devastating to their mental health (Herman, 2019). Rasho's litigation remains ongoing as of this writing, nearly 20 years after it was first begun, but it has forced some changes. For

example, the Illinois DOC has made efforts to hire hundreds of mental health professionals and hundreds more corrections officers. It has also constructed a prison hospital, a higher level of care that serves as a critical alternative to solitary confinement for incarcerated people displaying severe symptoms of mental disorders (Strom, 2016). According to the director of the Illinois DOC: "Corrections in Illinois was a little slow to recognize we are the mental health system for Illinois. Whether we want to be or not, we are; and we have to start acting like it" (Herman, 2019).

The state of Oregon also faces staffing challenges in its prisons. Oregon is certainly not unique in facing this challenge, but it is perhaps additionally frustrating for a system that has received some notice for being progressive and reform-minded, taking steps to reduce the punitive culture in its facilities. This approach has been called the “Oregon Way,” and includes efforts to humanize incarcerated people and as well as improve prison staff well-being in the state (Wilson, 2022).

Figure 7.14. The Eastern Oregon Correctional Institution in Pendleton, Oregon maintains high expectations for its operations but struggles to adequately staff the facility.

Oregon correctional officers who endorse these institutional goals, however, are stymied by the reality of staffing shortages. A Pendleton, Oregon correctional officer interviewed in 2023 affirmed that he "likes the idea of a more humane approach to incarceration . . . [that includes] humanizing adults in custody, addressing their mental health needs and talking to them about their trauma" (Dake, 2023). These ideals feel impossible to realize, however, amidst the conditions at his workplace, the Eastern Oregon Correctional Institution (figure 7.14). Due to staffing shortages, there is only one correctional officer per 80 adults in custody. Correctional staff are expected to work extraordinarily long shifts and have mandated overtime, "so they show up for shifts having missed a kid's birthday or important anniversary" (Dake, 2023). While staff might fully embrace the idea of improving services for people in custody, significant staffing shortages make even basic required services – like ensuring time outside of cells – hard to deliver (Dake, 2023).

Staffing in Jails and Prisons Licenses and Attributions

Legal Right to Care in Custody

Given the enormous number of people with mental disorders who are confined in our nation's jails and prisons, there is a significant, complex and continuous need for support and care related to those mental disorders (figure 7.15). This section provides introductory information about the law governing incarcerated peoples' access to and control over their mental health care. Legal rulings related to care for incarcerated people outline the extent to which the government has an obligation to provide medical care, including mental health care, to incarcerated people, and whether people in prison have autonomy with respect to their mental health care.

Figure 7.15. A medical provider at work in federal prison. People who are in custody have the right to receive necessary care from the government.

Courts have decided these issues based on the Constitution, specifically the **Eighth Amendment** to the U.S. Constitution, which prohibits "cruel and unusual punishment," and the "due process"

clauses of the **Fifth Amendment** and **Fourteenth Amendments** to the U.S. Constitution, which require fair procedures and treatment when important decisions are made impacting people in the criminal justice system. The concept of *due process* is discussed more in Chapter 6 of this text. While the federal government and all states must follow the directives of the U.S. Constitution as a minimum standard, be aware that some state laws may place additional or higher demands on their own facilities.

Eighth Amendment and Deliberate Indifference

One of the most important and often-cited cases related to health care in prison is that of *Estelle v. Gamble* (1976). In November 1973, Texas inmate J.W. Gamble sustained a back injury when a hay bale fell on him while he was working his prison job. Gamble complained of excruciating pain and later developed secondary health problems related to his heart. Gamble was seen by medical personnel who provided him with some care but did not resolve his pain. When Gamble was cleared to go back to work but refused, he was punished and placed in solitary confinement. Eventually Gamble filed a lawsuit claiming that he had been subjected to "cruel and unusual punishment" in violation of the Eighth Amendment (*Estelle v. Gamble*, 1976).

The *Estelle* Court affirmed that the Eighth Amendment ban on cruel and unusual punishment prohibited "unnecessary and wanton infliction of pain" and agreed that failure to provide medical care could, in some cases, rise to a level that would violate that directive (figure 7.16). The Court clarified, however, that only *deliberate indifference* by prison officials with respect to providing medical care can be a constitutional violation. The standard of deliberate indifference, introduced in Chapter 3, is quite a difficult standard for plaintiffs to prove.

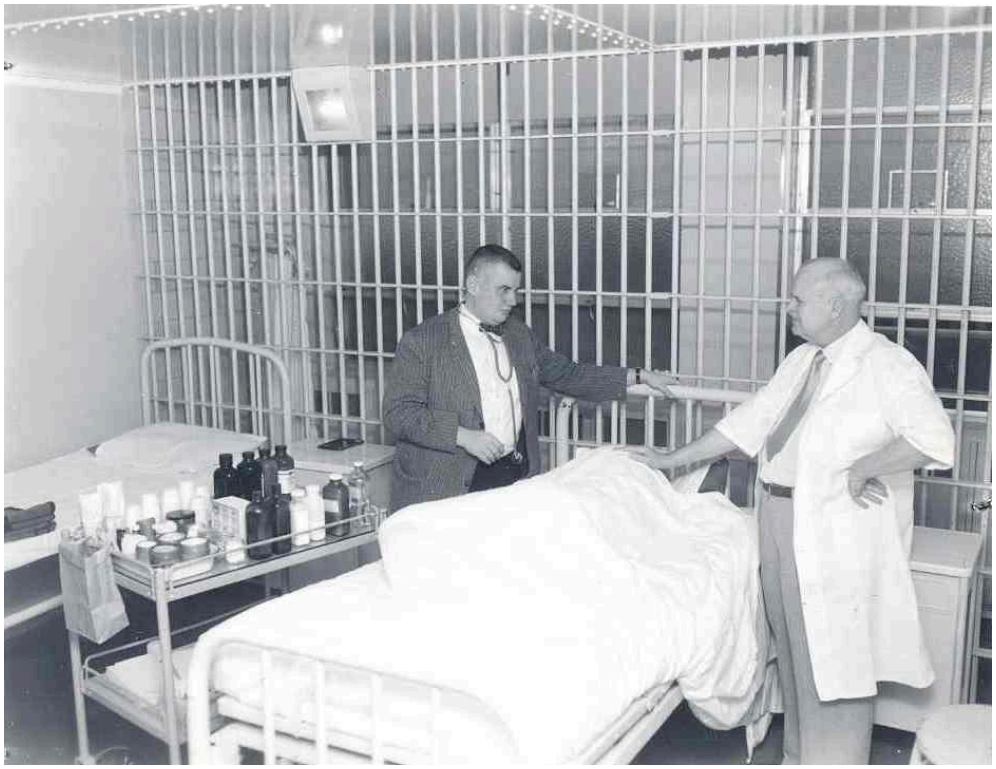

Figure 7.16. Doctors conferring over an unseen patient in a custodial setting in the 1940s in the Seattle, Washington area. Prior to *Estelle v. Gamble*, it was not legally established that failure to provide medical care violated an incarcerated person's right to be free of cruel and unusual punishment.

Proof of deliberate indifference requires a showing that an official was aware of the concerns identified, yet chose not to take action to avoid harm. Accidental failures or poor judgment by a doctor or by the prison are not considered deliberate indifference, and thus they are not violations of the Constitution: "Medical malpractice does not become a constitutional violation merely because the victim is a prisoner." (*Estelle v. Gamble*, 429 U.S. at 106.) In Gamble's case, doctors had seen Gamble repeatedly and tried to care for him. While that care was perhaps poor, it was not deliberately indifferent because it did not evidence callous disregard for Gamble's well-being. In short, Gamble lost his case.

If a person who is incarcerated believes they were not provided needed medical care, they could self-advocate or file an internal complaint, or, if certain conditions are met, they might be able to file a lawsuit – but they are unlikely to succeed in a lawsuit based on a constitutional claim. While *Estelle v. Gamble* does allow incarcerated people to sue based on failure to provide medical care, the deliberate indifference standard severely limits their ability to prevail. In order to hold a prison liable for failing to provide adequate care, an incarcerated plaintiff must be able to prove that the prison was aware of the need for care and consciously chose not to provide it.

Access to Mental Health Care

Another important case in discussions of prison care for mental disorders is *Bowring v. Godwin* (1978). While *Bowring* is not a Supreme Court case and technically governs only federal courts in certain areas, it represents the general agreement among federal courts that, like other medical care, mental health care must be provided to incarcerated people and certain denials of care may violate the Constitution (A Jailhouse Lawyer's Manual, 2020).

In the *Bowring* case, plaintiff Larry Bowring had been convicted of multiple felonies and sentenced to prison time in Virginia. When he became eligible for parole, Bowring was denied release due to, among other reasons, the symptoms of his mental disorder that were deemed likely to make him unsuccessful on parole (Hoard, 1978). Bowring sued, asserting that the prison unconstitutionally failed to provide him with care to alleviate those symptoms and allow him to be considered for release. Ultimately, the *Bowring* court applied a similar standard as in the *Estelle v. Gamble* case, holding that incarcerated people are entitled to treatment for mental disorders, within reasonable bounds (figure 7.17). The court declined to "second guess" prison medical decisions, deferring to the expertise of medical professionals, but the court did say that prisons are required to provide care according to their judgment. Generally, only necessary and not overly burdensome mental health care is required, and failure to provide proper care does not violate the Eighth Amendment to the Constitution unless, as established in *Estelle*, the jail or prison officials act with deliberate indifference (A Jailhouse Lawyer's Manual, 2020).

Figure 7.17. Prisons regularly house people with a range of mental disorders, and the Constitution requires that they are provided with a minimum level of care.

Right to Refuse Care

An important aspect of medical care, including care for mental disorders, is making choices about that care, or even refusing recommended care. The issue of whether and to what extent an incarcerated person can be forced to accept treatment for a mental disorder was addressed in the 1990 case of *Washington v. Harper*.

Walter Harper was incarcerated in a Washington state prison for many years on robbery charges. He had resided on a mental health unit for much of that time and had willingly taken medications to treat psychosis. When he stopped taking medications, however, Harper engaged in assaultive behavior that resulted in his transfer to a prison hospital setting. There, after a process involving approval of multiple doctors and a finding that he was dangerous if not medicated, Harper was given antipsychotic medication against his will.

Harper sued, claiming that his due process rights under the Fourteenth Amendment were violated when the prison forced medication on him without additional court proceedings. The Supreme

Court considered the case and ruled that the Washington prison procedures were adequate to protect Harper's rights, and that the prison could administer involuntary medication using these procedures if their action was rationally related to a legitimate prison interest, e.g. maintaining safety and order. An incarcerated person with a mental disorder can refuse medication, but that can be overruled if the prison procedures determine that the person is dangerous without the medication, and that giving the medication is in the person's best medical interests (*Washington v. Harper*, 1990).

Under the *Washington v. Harper* case, incarcerated people who are seriously impacted by mental disorders such that they may harm themselves or others when unmedicated will have a difficult time refusing medications. While the law may represent a reasonable balancing of diverse interests, the loss of autonomy for the incarcerated person can be very difficult. Forced medication can also bring other indignities, such as undesired side effects from the medication and facility hearings that violate the privacy of the incarcerated person. On the other hand, prisons have a directive to maintain safety and order, as well as to treat people who may be too impaired to act in their own self-interest.

Watch the video at figure 7.18 for a discussion of the issues at stake in forcing medication in the jail setting: the due process rights of incarcerated people; the autonomy of an unconvicted person; and the desire to protect a person from psychiatric decompensation. These issues are often explored at extremely limited hearings that may not suit the gravity of the matter from the incarcerated person's perspective.

Figure 7.18. This video explains the *Washington v. Harper* decision and its application to people incarcerated in jails specifically. As you watch, consider how you would weigh the important interests at stake in making decisions about involuntary medication administration.

Further information about the interesting topic of prisoner lawsuits is beyond the scope of this text, but if you are interested in learning more, feel free to explore materials specifically addressing this topic such as the Columbia University Jailhouse Lawyer's Manual [Website].

[feature]

SPOTLIGHT: Preventing Suicide in Jail

Among the most devastating outcomes of mental health problems are self-harm and suicide – which are significant threats to people in custody. This is especially true for certain more vulnerable groups (e.g. juveniles), but the risk spans all incarcerated populations, where suicide rates are much higher than in the general population (National Institute of Corrections, n.d.). In February of 2024 the Federal Bureau of Prisons reported on all prison deaths in the federal system during the period from 2014 to 2021. The most frequent cause of death in prison was suicide – accounting for more than half of the 344 total deaths during that period. Staffing deficiencies, inadequate assessments, and inappropriate mental health care assignments (failure to provide treatment or followup) were all identified as contributing factors to these deaths (U.S. Department of Justice, Office of the Inspector General, 2024).

In a survey of state facilities done in 2019, the Department of Justice found that about a fifth of prisons and a tenth of local jails had at least one suicide that year. Suicide accounted for a startling 30% of deaths in local jails in 2019 – representing a 13% increase from 2000 numbers (U.S. Department of Justice, Office of Justice Programs, 2021). The numbers also point to particular risks for certain groups: half of the people who died by suicide in local jails had been there for seven or fewer days, and most of them were unconvicted and awaiting court proceedings (figure 7.19). The highest rates of suicide were among inmates age 55 and older (U.S. Department of Justice, Office of Justice Programs, 2021).

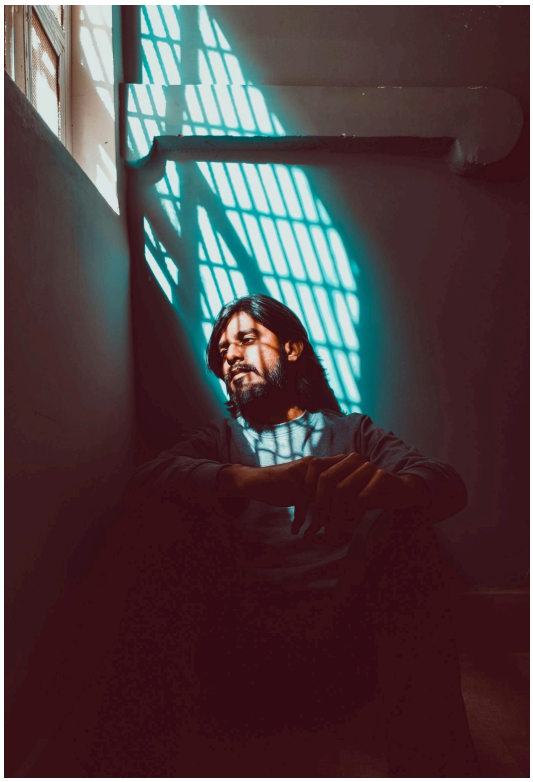

Figure 7.19. People in jail for short periods, awaiting resolution of charges, are at higher risk for suicide than people incarcerated for longer terms or people who have already been convicted and sent to prison.

How to prevent these tragic deaths? Jails and prisons can, and must, do a better job of identifying those at risk and providing necessary supervision and care. One example of a jail taking an active role in suicide prevention is the Clackamas County Jail, in Oregon. Take a look at the jail's suicide prevention resources [Website], if you are interested. The jail emphasizes recognition of the problem ("The problem is real. Know the signs.") and requests action from people in custody as well as their loved ones (contacting jail staff at a given phone number). The Clackamas county website acknowledges common barriers to taking action, including the idea that "someone else" will do something. The site also alerts readers to numerous suicide warning signs that should not be ignored (talking about death, withdrawing from friends, giving away possessions) (Clackamas County Sheriff, State of Oregon, n.d.).

For a comprehensive report on the problems of suicide and self-harm in custodial environments, including best practices for prevention, you may consider reviewing the Suicide Prevention Resource Guide: National Response Plan for Suicide Prevention in Corrections [Website] created by the National Commission on Correctional Health Care. Though this additional reading is not required, you are encouraged to be aware of this resource and the risks it seeks to prevent. As stated in the introduction to the Guide:

> Suicide is a profoundly solitary act. The response to it, however, must not be. Suicide prevention requires a coordinated, multifaceted team effort. Nowhere is that more true than in jails and prisons.
>
> Incarcerated men and women are a socially excluded population characterized by a multitude of personal and social problems and, often, mental health or substance abuse issues. Those risk factors for suicide are compounded by confinement, leaving some people feeling overwhelmed and hopeless. Tragically, too many of them die by suicide as a means of ending what feels like inescapable pain.
>
> (Barboza, et al., 2019, p.4).

[/feature]

Legal Right to Care in Custody Licenses and Attributions

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Figure 7.17. Photo by Siviwe Kapteyn is licensed under the Unsplash License.

Figure 7.19. Photo by Aaron Robinson on Unsplash

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Figure 7.18. Forced Medication Behind Bars by Rooted in Rights is licensed under the Standard YouTube License.

Ensuring Care for People with Mental Disorders in Custody

As we have established throughout this text, there are many people in custody who need care for mental disorders, and receiving that care is not only their right, but it is central to their ability to conform and succeed in custody. One of the best ways to think about caring for people in custody is to consider an objective identified throughout this text: the goal of guiding people out of more restrictive environments and into progressively less restrictive ones in ways that help them succeed (figure 7.20). Providing thoughtful and effective care for mental disorders in custody is an important aspect of this work.

Actions that support the progress of a person in custody who experiences a mental disorder can take various forms depending on the individual and their circumstances. A person may be focused on transfer from a high-security facility to a lower-security one, from restrictive behavioral health housing to the general population, or from prison to the community. Regardless of the specifics, these transitions are steps towards increasing autonomy and successfully reducing restrictions. Ensuring that incarcerated people are successful in these steps is a positive outcome for the individual as well as for the system that realizes reductions in crime and associated costs, including imprisonment (SAMHSA, 2017). This process of transitioning to release or to a less restrictive setting should start immediately when a person enters custody.

Figure 7.20. Success for a person in custody may not be direct; it likely involves stepwise progress toward less restrictive environments.

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) offers guidelines for supporting transitions of incarcerated people with mental disorders from jail or prison settings using the **APIC framework**, which includes the following actions:

- **ASSESS**: Assessing a person's needs and safety risks;
- **PLAN**: Planning for the treatment and services a person needs;
- **IDENTIFY**: Identifying suitable services and programs; and
- **COORDINATE**: Coordinating a transition plan to avoid gaps in services.

(SAMHSA, 2017).

Assessing Needs and Risks

Properly assessing the needs and risks of incarcerated people requires that facilities conduct universal **screening** as early as possible in the booking or intake process, and again as necessary, to ensure detection of mental disorders (figure 7.21). Screenings do not provide diagnostic information. Rather, they are sets of standard questions intended to flag or detect individuals who are at risk for a targeted problem, such as a mental disorder. Jurisdictions vary in how they perform screenings, depending on what resources and treatment options they have.

For example, at the Gwinnett County jail in Georgia, the jail staff screens every person for veteran status and for mental illness. At the same time, staff identify each person's needs (housing, treatment, employment, and education), and required safety precautions. Similarly, the Hancock County Justice Center in Ohio universally administers a screening instrument called the Global Appraisal of Individual Needs Short Screener (GAIN-SS) – consisting of 23 questions. The screening looks for behavioral health issues as well as propensity for criminal behavior. The screen is designed to take just a few minutes to administer and can help find people who are more likely to have a mental disorder and need further assessment (Chestnut Health Systems, n.d.).

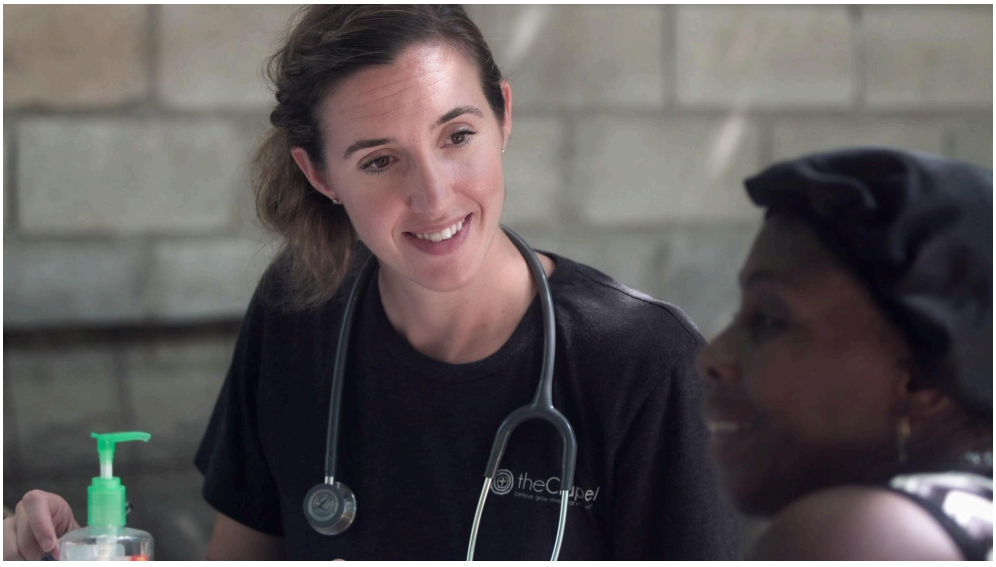

Figure 7.2. Initial screening and followup assessments of people entering custody are critical to ensure their needs are being met from the start and they are prepared to succeed in next steps.

If a screened person is flagged "positive" for concerns, the facility should follow up with a more in-depth evaluation, or **assessment**, that informs the facility about the services a person will need. In comparison to a screen, an assessment involves more in-depth questioning, administered by a behavioral health professional. Assessments examine the nature and severity of a detected mental disorder. The assessment should also gather additional information, including demographics, pathway to criminal involvement, strengths and protective factors, and the person's safety risks and needs.

At the Oregon Department of Corrections all newcomers are evaluated during a central intake process that looks for the presence of mental disorders as well as criminal risk and other needs. (Oregon Department of Corrections, n.d.-b; Oregon Department of Corrections, n.d.-a). To look for mental disorders, Oregon uses a tool called the Personality Assessment Inventory (PAI). The PAI takes around 45 minutes and requires a 4th-grade reading level to complete, so some people do need alternative means of screening (Psychological Assessment Resources, n.d.; Oregon Department of Corrections, n.d.-a). Incarcerated people with elevated PAI scores or who are identified as having recent mental health problems, who are taking psychiatric medications, or who are engaging in suicidal behaviors will receive additional evaluations, including one-on-one interviews, to determine next steps. According to the Oregon DOC, about 60 percent of incarcerated people qualify for one-on-one interviews to assess mental disorders (Oregon Department of Corrections, n.d.-a).

Planning Treatment and Services

The second step under the APIC framework is planning: using information from assessments to plan care for people in custody. A key aspect of planning is collaboration between behavioral health and criminal justice professionals to determine what level of supervision and treatment an incarcerated person needs. The planning stage also includes taking immediate steps to stabilize people so that they can engage in treatment and avoid reoffending.

As with screenings and assessments, jurisdictions can approach planning in different ways. For example, some facilities hire mental health staff, while others work with outside agencies to help them develop and provide treatment for people in custody. Increased use of **telehealth**, which can include phone or video appointments as well as electronic exchange of medical records, increases access to mental health professionals in prisons and jails. Video calls are a cost- and time-effective way to make sure corrections staff are properly advised on how to help people be more successful in custody (figure 7.22) (Police Executive Research Forum, 2018).

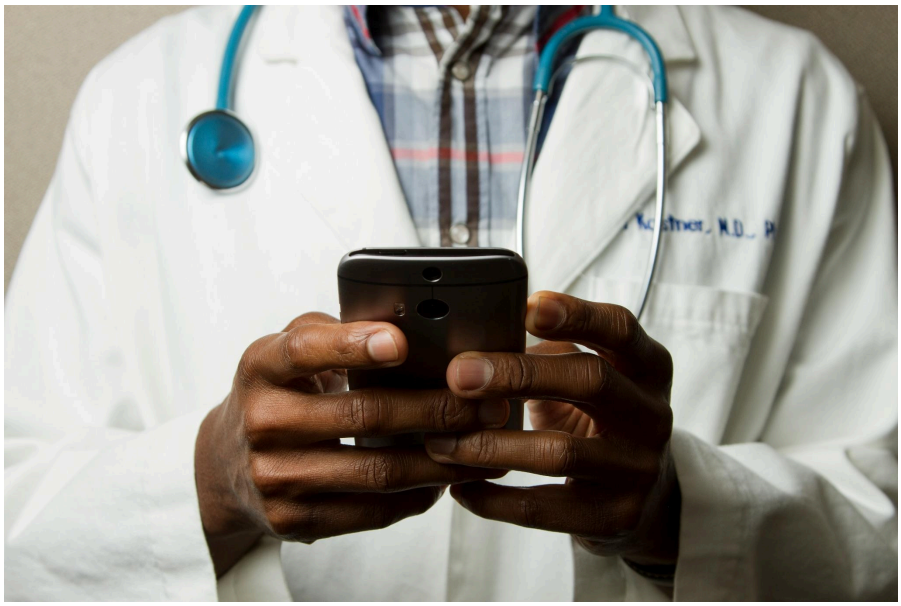

Figure 7.22. Telehealth via a phone or video call went mainstream during the COVID-19 pandemic, but it was already in use in many correctional facilities. Telehealth can help prisons and jails provide care despite shortages of mental health and other care providers in the facility or the area.

Planning may anticipate that treatment and services will be delivered in general population or in specialized housing units. Plans may include treatment with different focuses: managing medication, providing education, or supporting employment, for example. Some facilities direct people into programs with phases that allow a person to graduate from one phase to another, gaining access to additional privileges and lower levels of supervision. Planning will look very

different for a person expected to spend 72 hours in jail than it will for a person anticipating a longer prison stay.

Regardless of specifics, the priority is that jails and prisons engage in planning, and that those plans include proven-effective treatments that will help reduce a person's likelihood of reoffending. As we saw in our introductory example of Sedlis Dowdy, reoffending can and does occur within the correctional setting. Criminal reoffense, or simply problem behaviors in custody, are detrimental and can result in longer and more restrictive stays in custody (figure 7.23). Proper planning, based on proper assessment, helps ensure that a person in custody has treatment and tools to succeed.

Figure 7.23. Prompt assessment and planning for people in custody can reduce problem behaviors that give rise to additional punitive measures, a negative outcome for the individual and for the system.

Identifying Programs

The third step of the APIC framework is identification of specific programs that fulfill the plans for the incarcerated person that were developed based on assessments. Programs can be identified within a facility or elsewhere for people who are moving on to other facilities (e.g. transferring from jail to prison). For people who are leaving custody, especially those released from short stays in jail with mental disorders, identification of and direct connection with supportive programming are critical.

Lack of access to medication, housing, or food can force a person into a revolving cycle of jail admissions and releases. On the other hand, identifying a program where a person can get their needs met can disrupt that cycle – an enormous benefit to individuals and to the system. Ideally, a facility will directly connect the person with identified resources and provide a supported transition to the next service provider. This type of transition can be accomplished via a meeting, which can be virtual, or by providing the person with transportation to the new resource if it is in the community (SAMHSA, 2022b). More specifics on transfer of care to the community, and services that should be provided there post-incarceration, are discussed in Chapter 8 of this text.

Coordinating Transition Plans

Facilities recognize that no long-term treatment progress can be made if, as soon as a person moves or is transferred, their services end or drastically change. The APIC framework thus concludes with "coordination" of transition plans, which includes several elements. Coordination includes sharing information (from earlier assessments or treatment) within the criminal justice system – between facilities or with community supervision staff. When information is shared, diagnoses and medication do not need to be reestablished; needs can be met more quickly; and people in custody are relieved of some self-advocacy needs.

Coordination also includes training and education. These elements promote collaboration between criminal justice professionals and treatment or mental health professionals. Correctional personnel can be more effective and empathetic when they understand how mental disorders present (Police Executive Research Forum, 2018). Likewise, behavioral health experts benefit from better understanding of correctional issues and public safety concerns. For both sets of professionals, understanding more about what the other does can reduce mistrust and tension that interfere with the teamwork needed to produce effective outcomes (figure 7.24).

Figure 7.24. Corrections staff interacting with another person. Education about the work and struggles of others increases empathy and allows professionals to provide better, more effective service.

A variety of training approaches can be effective aspects of coordination. Crisis Intervention Teams (CIT) training, discussed in Chapter 5, can be used in the corrections environment to support officers working in tandem with mental health professionals to help people with mental disorders. If you are interested in learning more about CIT training in the corrections environment, watch Crisis Intervention Training for Corrections Officers [Streaming Video],

which describes this training approach and its outcomes. Trauma-informed training for corrections officers can also improve interactions between prison staff and incarcerated people, making the prison environment safer for everyone.

Trauma-informed, whether referring to care, training, or any approach to a problem, recognizes the impacts of trauma and how it may present in individuals. An officer's approach is adjusted so that trauma is addressed and the person involved is less likely to be re-traumatized in their interaction with the officer. Actions taken with a trauma-informed approach can include simple changes like carefully explaining what a pat-down will entail before it happens, reducing the anxiety of a person who may be expecting abuse (Stringer, 2019). Trauma-informed care as a critical element of community care after release is discussed more in Chapter 8 of this text. For an excellent resource and accessible information on trauma, consider exploring the website for Trauma Informed Oregon.

One specific and interesting example of instituting trauma-informed care in a prison setting is in Hawaii's Women's Community Correctional Center (WCCC). In contrast to a traditional correctional setting, but consistent with Native Hawaiian cultural practices, the WCCC approach was guided by belief in the transformative nature of a *pu'uhonua*, a Hawaiian term that means a protected site for healing. The WCCC initiative recognizes the significant role of trauma in most women's paths into the criminal justice system, which are often linked to childhood abuse. It also acknowledges the particular ways in which Native Hawaiian women who are incarcerated are impacted by trauma. Many women in prison are separated from their children, a circumstance that is devastating generally but has unique consequences for women in a culture that highly values family places and connections. This is in addition to historical trauma impacting Native Hawaiian women who are part of a severely oppressed larger group (Patterson, et al., 2013). Hawaii's approach includes several days of intensive trauma-informed training for staff, treatment and service practitioners, and incarcerated individuals. The training includes identifying systemic sources of trauma; recognizing the psychological, physiological, neurobiological, and social effects of trauma; and avoiding further trauma caused by practices such as seclusion and restraint. For correctional staff, the training provides knowledge and develops skills to help them reduce the trauma and trauma-related problems of incarcerated

people. For incarcerated women, the creation of the *pu'uhonua* reinforces trauma-informed principles by promoting empowerment and personal recovery, and strengthening family and community relationships (7.25).

Figure 7.25 shows programming at a women's correctional facility. It is critical for facilities to provide services that meet the needs of and are appropriate for the populations they serve.

Importantly, the coordination aspect of APIC also includes supporting people in adhering to appropriate treatment and supervision. Generally, support for adherence involves supervision with both incentives that encourage compliance and sanctions that promote safety. For example, in the Massachusetts state prison system, incarcerated people who are close to release are transferred to a lower security facility. The person is assigned to staff for review of service plans and help scheduling appointments with parole officers or treatment providers. Completing the review is a condition of discharge, providing an incentive to be sure it happens. These same staff then continue to be available to people who have been discharged from custody and can be

consulted for mentoring, crisis intervention, or referrals. Especially high risk people (e.g. very violent records, gun charges) are linked with specially trained staff who stay even more closely involved in by transporting clients to treatment appointments and supervision meetings. These connections are examples of coordination that keeps people on track.

Ensuring Care for People with Mental Disorders in Custody Licenses and Attributions

Substance Use Treatment in Custody

This chapter has discussed the importance of ensuring care for people in custody, but what does that care look like? The details of treatment that can be provided in custody are beyond the scope of this criminal justice-focused text, but treatment can and does include the psychological (counseling) and psychiatric (medication) treatments that were mentioned in Chapter 2 of this text. You have also heard a little about treatment that may occur in jails and prisons from the AVID videos embedded throughout this chapter. If you are interested in learning more about what it is like to be a mental health provider in a controlled environment, you may also hear from several of those professionals via the videos linked in Chapter 10 of this text. Additionally, feel free to take a look at this interview with a supervising psychiatrist who works in the California prison system [Website]. The interview touches on approaches to treatment within prison, as well as the challenges and satisfactions of treatment in this environment, from the perspective of a mental health provider.

One specific and important type of treatment in custody that will be briefly addressed here is treatment for substance use disorders. **Substance use treatment** can include any number of approaches that help a person manage and recover from a substance use disorder, a diagnosis discussed more in Chapter 2. Evidence-based therapies, such as cognitive behavioral therapy, can be part of treatment, as can medication-based treatments (U.S. Department of Veterans Affairs, 2024).

Availability of Substance Use Treatment in Custody

In custody, substance use disorders can be detected at the assessment stage, and treatment should be planned, identified, and coordinated – though that does not always occur. There is an enormous unmet need for substance use treatment in custody. Substance use disorders are common in U.S. jails and prisons. Though this text uses the term mental disorders broadly to include substance use disorders, many statistics do not take that approach. SAMHSA estimates that close to 60% of people in jails and prisons have substance use disorders, while rates are

closer to 10% outside of custody (SAMHSA, 2022a). Adequate screening and assessment, however, is frequently lacking. Even when problems are identified, many people do not have access to treatment in custody, and it is common that symptoms of these disorders (like other mental disorders) are worsened by incarceration (figure 7.26) (SAMHSA, 2022a).

Figure 7.26. Ideally, people who are assessed to have a need for substance use treatment are provided with that treatment in custody.

In Oregon, for example, it is estimated that two-thirds of all state prisoners (about 8000 total) have substance use disorders needing treatment. Yet, only four of Oregon's twelve prisons have intensive substance use treatment programs, so access remains very limited. For example, the Oregon State Correctional Institution outside of Salem houses 800 people, but the intensive substance use treatment program there takes only 24 participants who are close to their release date – rendering this type of treatment unavailable to most (Frost, 2023).

Recognizing the huge need, Oregon is engaged in efforts to expand substance use treatment in innovative ways. The Oregon DOC has recently created a new program that is located at the high-security Oregon State Penitentiary. This program uses prison-trained certified recovery mentors (peer mentors), alongside certified drug and alcohol counselors, to provide treatment to incarcerated people. Reportedly, the program is in high demand, and it is very meaningful to its participants, many of whom are in the facility for lengthy terms. If you are interested, watch the video at figure 7.27 to hear from some of the Oregon participants in this initiative.

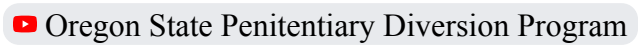

Figure 7.27. This optional nine-minute video shares the experience of several participants in Oregon's innovative peer-supported substance use treatment program that is by and for people in custody.

Medication Treatment for Substance Use Disorders

An important form of treatment for substance use disorders is medication, which can be used alone or in combination with counseling and behavioral therapies to provide a "whole-patient" approach to treatment. This type of treatment is often referred to as **Medication-Assisted Treatment**, or MAT. Medications are uniquely effective for difficult-to-treat alcohol and opioid use disorders, and sometimes these approaches are referred to in more specific terms as either *Medication for Opioid Use Disorder (MOUD)* or *Medication for Alcohol Use Disorder (MAUD)*. Both MOUD and MAUD are discussed in more detail in Chapter 8 as critical post-incarceration interventions for people in the community (figure 7.28)

Figure 7.28. A community clinic that provides medications for substance use treatment. These medications are more easily provided in the community than in custody, but they have great benefits for people in either setting.

The FDA has approved several different medications that can be safely used to treat substance use disorders. These medications relieve withdrawal symptoms and cravings that a person with a substance use disorder would otherwise experience, without the negative or euphoric effects of the substance. The medications are also safe to use for extended periods of time. Medication treatment for substance use has been shown to have significant benefits: it reduces drug use, prevents overdose events, and promotes recovery among substance users. It is also effective in reducing criminal activity and arrests, including probation revocations that result in incarceration (SAMHSA, n.d.).

Medication-Assisted Treatment (MAT) in Custody

Despite its effectiveness, the use of medications for substances has been limited in many criminal justice settings, including prisons. The reasons for this are numerous. Misunderstandings associated with the use of these medications are one barrier. Some people believe – incorrectly – that medication treatment involves "substituting one drug for another." The idea that medication functions like a drug of abuse leads to resistance to its use in the criminal justice field, even though medication treatment is a tested and proven approach with strong positive outcomes.

Misuse of medication, sometimes called diversion of medication, is another concern that limits prison (and other criminal justice program) use of these treatments. While misuse is a valid concern, criminal justice programs and facilities can limit this risk, even in the prison setting. Strategies might include use of dedicated staff for oversight; ensuring safe storage of medications; and conducting drug testing.

Costs of medication treatment are an additional concern for many correctional programs. Though long-term benefits abound, the immediate costs (of medication, staffing, training) may be prohibitive. Often, the required medications are not on correctional facilities' formularies, or lists of allowed and funded medications. In a related concern, formerly incarcerated people without insurance coverage may not be able to continue medication treatment when they are released, limiting the value of the investment during incarceration. And, setting aside affordability, many communities do not even have sufficient medication treatment providers, or ones who are able to effectively serve the justice-involved population.

Because medication treatment can be so helpful to a person in recovery from a substance use disorder, its use has been expanded across many custodial environments in recent years, despite identified barriers (Homans, et al., 2023). With these efforts, medication treatment for substance use, particularly in custodial settings, is evolving rapidly. Ask a criminal justice or mental health professional in your community: what are the current approaches to medications for substance use, or MAT, in correctional settings? What terminology is used to describe the approach? What have we learned and what changes are on the horizon?

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Figure 7.28. IMG_1607 Dispensing area for medication assisted treatment by NYS OASAS is licensed under CC BY-NC-ND 2.0.

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Figure 7.27. Oregon State Penitentiary Diversion Program by Oregon DOC is licensed under the Standard YouTube License.

Chapter Summary

- People with mental disorders are found in all parts of the criminal justice system, including jails and prisons, where they can be housed in a variety of settings from more to less restrictive.
- Segregated or isolative housing in custody, known as solitary confinement, is both overused and particularly damaging for people with mental disorders. It is also overused with other marginalized populations in custody.
- Staffing shortages in prisons and jails contribute to inadequate support for all people in custody, and particularly for people with mental disorders who may have higher support needs. Inadequate staffing can lead to use of approaches like solitary confinement to manage challenging situations.
- People in custody have a constitutional right to care, but that right is difficult to enforce, based on the law that has developed around these issues. Additionally, in order to medicate a person in custody on an involuntary basis, a facility is required to go through certain procedures. Otherwise, a person has a right to decline treatment.
- Given that jails and prisons are naturally places of transition, ensuring that people receive the care they need in custody requires systems that anticipate those transitions. One such system is the APIC framework, which suggests an approach to ensuring care that begins

with assessment and planning, and progresses to identifying services and coordinating those services.

- Care in custody can include treatment from numerous professionals in the field of mental health. One type of care that is very important for many – if not most – people in custody is substance use treatment, including medication-based treatment for substance use.

Key Term Definitions

- **APIC Framework:** A set of guidelines for ensuring people in custody receive treatment that continues and is effective across transitions. The APIC framework includes four steps: Assessment, Planning, Identifying, and Coordinating treatment.

- **Assessment:** A followup evaluation triggered by a screening that flags a potential problem or issue. An assessment is more in-depth than a screening, is performed by a mental health professional, and informs the facility about the services a person will need.

- **Eighth Amendment**: Amendment to the U.S. Constitution that prohibits cruel and unusual punishment, and regulates excessive fines and bail.

- **Fifth Amendment:** Amendment to the U.S. Constitution that creates numerous important rights. Among those rights is the right to receive "due process" of law, or fair treatment, when a person may be deprived of life, liberty, or property.

- **Fourteenth Amendment**: Amendment to the U.S. Constitution that governs the rights of citizens in the states. The due process clause of the Fourteenth Amendment is understood to guarantee fairness in proceedings in the criminal justice systems in the states, just as the Fifth Amendment due process clause requires fairness in the federal system.

- **Medication-assisted treatment (MAT)**: Use of medication, sometimes along with other therapies, to treat substance use disorders. There are several medications that target alcohol use, as well as medications that treat opioid use disorder.

- **Screening:** A standardized set of questions designed to flag people who are at risk for a targeted problem, such as a mental disorder. A screening does not provide a diagnosis or

guidance on the severity of any disorder; rather it informs that a person needs further assessment.

- **Solitary confinement**: Also called isolation or segregation, a form of incarceration where the person is isolated in a cell. Solitary confinement is generally used as a form of discipline for prison rule violations, or as a method to keep the isolated person or others safe.

- **Substance use treatment:** Treatment that helps a person manage and recover from a substance use disorder, typically including evidence-based therapies such as cognitive behavioral therapy and/or other therapeutic approaches, and increasingly including medication-based approaches..

- **Telehealth:** Provision of health care, including mental health care, via means such as phone or video appointments, as well as electronic transfer of medical data.

- **Trauma-informed (training, care or approach)**: A system or action that realizes the widespread impact of trauma; recognizes its signs and symptoms; and responds by integrating this information into policy and practice, seeking to actively resist re-traumatization.

Discussion Questions

1. What are the needs and problems associated with use of very restrictive or isolative housing for people with mental disorders in custody? What changes to our system can you imagine that could reduce the use of solitary confinement for this population?
2. How does the "deliberate indifference" standard impact a prisoner's ability to bring a lawsuit or otherwise enforce their right to care in custody? How might this legal standard impact care provided in prisons generally?
3. What are the barriers to providing substance use treatment in custody, and how can/should those barriers be addressed? Should use of medication-based treatments be expanded? Why or why not?

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