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Medicate and Segregate: How Due Process Fails to Protect Mentally Ill Inmates From Medically Inappropriate Confinement and Restraint

by Peter J. Teravskis*

INTRODUCTION

Prior to the invention of modern psychiatric medications, confinement, restraint, and segregation were the primary modalities used in the treatment of serious mental illness.¹ The discovery of antipsychotic medications was one of the driving forces leading to the civil rights movement known as deinstitutionalization where state mental hospitals were shuttered in favor of community treatment of the mentally ill.² In reality, deinstitutionalization is better understood as transinstitutionalization where mentally ill individuals have not been transferred to outpatient treatment but into the penal system where they are (par-

* Peter J. Teravskis, 2021. J.D. Candidate, University of Minnesota Law School; M.D. Candidate, University of Minnesota Medical School; B.S., Neuroscience, Physiology, University of Minnesota College of Biological Sciences. In loving memory of Grant J. Hendrickson, June 20, 1967–August 24, 2020, “I don’t care what you believe as long as you believe it for yourself.”

1. See Kim J. Masters, *Physical Restraint: A Historical Review and Current Practice*, 47 *PSYCHIATRIC ANNALS* 52, 52 (2017) (stating that physical restraint was the primary means by which society “manage[d] . . . psychiatric patients”).

2. See, e.g., Daniel Yohanna, *Deinstitutionalization of People With Mental Illness: Causes and Consequences*, 15 *AMA J. ETHICS* 886, 886–87 (2013) (discussing three factors leading to the policy of deinstitutionalization in the 1950s).

adoxically) confined, restrained, and segregated from the community.³ Put bluntly, the prison system has become the point-of-care for many Americans with severe mental illness.⁴

Unfortunately, a study of the New Jersey Department of Corrections' involuntary antipsychotic administration program revealed that, in at least one jurisdiction, inmates with mental illnesses in need of treatment are not only separated from the community by imprisonment but can be separated from the general prison population via an unwritten rule of automatic medical segregation.⁵ This finding underscores the fact that the Due

3. Cf. Bernard E. Harcourt, *From the Asylum to the Prison: Rethinking the Incarceration Revolution*, 84 TEX. L. REV. 1751, 1755–56 figs.1 & 2 (2006) (reporting a rise in the previously stable prison rate following, temporally, the fall in mental hospital population from the mid-1950s through the 1970s, and showing a statistically significant autocorrelation between homicide and institutionalization rates since 1928); Yohanna, *supra* note 2, at 888 (asking, “[w]hy are so many people with severe mental illness placed inappropriately in our jails and prisons?”).

4. See, e.g., H. Richard Lamb & Linda E. Weinberger, *The Shift of Psychiatric Inpatient Care From Hospitals to Jails and Prisons*, 33 J. AM. ACAD. PSYCHIATRY L. 529, 529 (2005) (“For many [persons with severe mental illness], their psychiatric inpatient care is now provided in jails and prisons.”). The National Institute of Mental Health defines “serious mental illness” as “as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.” *Mental Illness*, NAT’L INST. OF MENTAL HEALTH, <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml> (last updated Jan. 2021). This definition is broad and functionally based. See *id.* (“The burden of mental illnesses is particularly concentrated among those who experience *disability* due to [serious mental illness].” (emphases added)). It encompasses manifestations of myriad diseases including major depression, schizophrenia, and bipolar disorder. *What is Mental Illness?*, AM. PSYCHIATRIC ASS’N, <https://www.psychiatry.org/patients-families/what-is-mental-illness> (last updated Aug. 2018). However, in the context of compulsory medication, antipsychotic agents (also called neuroleptic or psychotropic agents) are a commonly utilized modality and are the focus of most relevant law. Cf. KONRAD FRANCO ET AL., HOW MANY INCARCERATED INDIVIDUALS RECEIVED PSYCHOTROPIC MEDICATION IN CALIFORNIA JAILS: 2012–2017 1 (2018), https://calhps.com/reports/PolicyBrief_PsychotropicMedications_CalHPS.pdf (discussing a rapid increase in the use of antipsychotic drugs among other psychotropic medications in the California jail system).

5. See Anasuya Salem et al., *Nonemergency Involuntary Antipsychotic Medication in Prison: Effects on Prison Inpatient Days and Disciplinary Charges*, 43 J. AM. ACAD. PSYCHIATRY L. 159, 163 (2015) (“The unstated practice in the [New Jersey Department of Corrections] has been to move inmates onto a prison inpatient unit upon commencement of involuntary medication and to err on keeping the patients there for the security of both the inmates and others.”). A companion article by Henry S. Levine & Bruce C. Gage describes the policy thus: “the tendency in the system studied . . . is to keep [inmates] on an

Process Clause of the Fourteenth Amendment, at present, has not been extended to curtail the anachronistic practice of confining, restraining, and segregating inmates with mental illness in need of treatment.

This Note proceeds in four parts. Part I examines the history of confinement, restraint, and segregation of the mentally ill and charts the invention of antipsychotic medications and their use in modern psychiatric practice. Part II explores the paradox of transinstitutionalization and the custom of medically segregating inmates in need of psychiatric treatment. Part III describes the due process protections afforded to mentally ill individuals both in the community and in the penal system. Part IV explains how existing due process requirements fail to protect inmates from involuntary medical segregation simply because they are mentally ill and in need of treatment. Finally, I propose that courts should view medical segregation as it was viewed historically: as a treatment modality. Accordingly, the same due process protections which shield inmates from medically unnecessary and capricious involuntary medication, should insulate them from medically unnecessary and automatic confinement and restraint.

I. HISTORICAL AND MODERN PSYCHIATRIC PRACTICE

A. HISTORY OF PSYCHIATRIC CONFINEMENT, RESTRAINT, AND SEGREGATION

Prior to the discovery of pharmaceutical agents for the treatment of mental illness, physical restraint was the primary means by which society “manage[d] . . . psychiatric patients.”⁶ Eighteenth century law justified the practice based on a “*quid pro quo* principle.”⁷ “Permission to restrain these people was granted under the assumption that it would be of benefit to them

inpatient unit during the entire duration of t[he involuntary antipsychotic] protocol, regardless of whether there is behavioral improvement.” Henry S. Levine & Bruce C. Gage, *Commentary: Involuntary Antipsychotics in Prison—Extending Harper, Contracting Care?*, 43 J. Am. Acad. Psychiatry L. 165, 169 (2015). They hypothesized that this effect may affect the disciplinary charges accrued by inmates, thus making any finding of a reduction of violence “less generalizable” to the non-prison community. *Id.*

6. Masters, *supra* note 1, at 52.

7. *Id.*

and that the restraint would lead to an improvement or cessation in their unruly behavior.”⁸ This practice was largely unchallenged until the mid-twentieth century when civil rights objections began to be leveled against physical restraint as a medical practice.⁹ Concurrently, the earliest forms of psychopharmacotherapy (a triad of neurologically active compounds: morphine, potassium bromide, and chloral hydrate) were discovered.¹⁰ These agents allowed for “day and night-time sedation . . . [and] the replacement of physical restraint by pharmacological means in behavior control.”¹¹ While additional sedative agents were added to the pharmacopeia during the first half of the twentieth century¹² including, notably, antihistamines,¹³ in the United States, physical restraint remained the predominant modality for controlling the behavior of psychiatric patients.¹⁴

This state of affairs was disrupted by the synthesis of chlorpromazine (branded Thorazine) in 1951¹⁵ and the deinstitutionalization movement.¹⁶ Chlorpromazine quickly accrued a wealth of evidence suggesting its beneficial effects: unlike prior agents, chlorpromazine was not merely a sedative agent but affected the clinical course of psychosis.¹⁷ The success of chlorpromazine in the treatment of psychosis led to a dramatic reduction in the

8. *Id.* at 52–53.

9. *See id.* at 52 (“It became increasingly obvious through the years that such practices were violations of patients’ civil rights.”).

10. *See* Thomas A. Ban, *Pharmacotherapy of Mental Illness—A Historical Analysis*, 25 PROGRESS NEURO-PSYCHOPHARMACOLOGICAL & BIOLOGICAL PSYCHIATRY 709, 710–11 (2001) (discussing the discovery and use of these early drugs).

11. *Id.* at 711.

12. *See id.* at 712–13 (discussing the implications of chlorpromazine and five other early antipsychotic drugs to treatment regimens in the early twentieth century).

13. *See id.* at 712 (“The origin of chlorpromazine was in the synthesis of the phenothiazine structure in 1883, and in research with antihistamin[es] . . .”).

14. *See* Masters, *supra* note 1 and accompanying text.

15. *See* Thomas A. Ban, *Fifty Years Chlorpromazine: A Historical Perspective*, 3 NEUROPSYCHIATRIC DISEASE AND TREATMENT 495, 495 (2007) (describing the discovery of chlorpromazine); Jeffrey A. Lieberman, *Disease Modifying Effects of Antipsychotic Drugs in Schizophrenia: A Clinical and Neurobiological Perspective*, 17 WORLD PSYCHIATRY 163, 163 (2018) (describing the discovery of chlorpromazine).

16. *See* Yohanna, *supra* note 2 and accompanying text.

17. *See, e.g.,* Lieberman, *supra* note 15, at 163–64 (describing early indications that antipsychotic medications alter the disease course of schizophrenia).

physical restraint of psychiatric patients in the United States.¹⁸ The development of an animal model to screen novel compounds for chlorpromazine-like effects with reduced drowsiness led to the invention of a new class of psychopharmaceutical agents: the phenothiazines.¹⁹ Phenothiazines were thought to be primarily active via inhibition of serotonin-mediated neurotransmission in the brain.²⁰ In the early 1970s, scientific interest shifted to the effects of antipsychotics on dopamine receptors.²¹ This “dopamine hypothesis of schizophrenia” remains the predominant neuropsychological explanation of schizophrenia to this day.²²

B. MODERN TRENDS IN PSYCHIATRY

In treating serious mental illness, modern psychiatric practice focuses on the use of pharmacological agents that alter the

18. Cf. Henry Brill & Robert E. Patton, *Analysis of 1955–1956 Population Fall in New York State Mental Hospitals in First Year of Large-Scale Use of Tranquilizing Drugs*, 114 AM. J. PSYCHIATRY 509, 510 fig.1 (1957) (illustrating an inverse correlation between the rise of “patients receiving tranquilizing drugs” and the fall in “[s]omatic therapy and restraint-seclusion”).

19. See Holly Moore, *The Role of Rodent Models in The Discovery of New Treatments for Schizophrenia: Updating Our Strategy*, 36 SCHIZOPHRENIA BULL. 1066, 1067 (2010) (recounting the move from “serendipit[ous]” discovery to systematic animal model-based discovery of antipsychotics in the 1950s).

20. See Borisz Varga et al., *Possible Biological and Clinical Applications of Phenothiazines*, 37 ANTICANCER RES. 5983, 5986 (2017) (“For phenothiazine antipsychotics, the inhibition of serotonin receptors results in anxiolytic and antidepressant activity . . .”). See generally Ban, *supra* note 10, at 714 (describing the discovery of the neurotransmitter “serotonin” and the early drugs that influenced serotonergic neurotransmission).

21. See generally Alan A. Baumeister & Jennifer L. Francis, *Historical Development of the Dopamine Hypothesis of Schizophrenia*, 11 J. HIST. NEUROSCIENCES 265 (2002) (discussing the history of the shift from the serotonin hypothesis of schizophrenia, first proposed in 1954, to the dopamine hypothesis).

22. See *id.* (“The hypothesis that an overactivity of dopamine systems in the brain is a central aspect of the pathogenesis of schizophrenia is one of the earliest, most enduring, and *most influential of the modern neurochemical theories* of mental disorders.” (emphasis added)); cf. Ralph Brisch et al., *The Role of Dopamine in Schizophrenia from a Neurobiological and Evolutionary Perspective: Old Fashioned, but Still in Vogue*, FRONTIERS IN PSYCHIATRY, May 19, 2014, at 1 (discussing the continued focus on the role of hyperactive dopamine receptors in the development of schizophrenic symptoms). *But cf.*, ERIC KANDEL, THE DISORDERED MIND: WHAT UNUSUAL BRAINS TELL US ABOUT OURSELVES 90–94 (2018) (discussing the role of dopamine in early biological treatments of schizophrenia but noting that newer antipsychotic medications have implicated the involvement of “serotonergic and histaminergic pathways” as well).

“balance” of neurotransmitters in the brain.²³ Antipsychotic drugs are the predominant treatment modality used. Presently, antipsychotic drugs are divided into two broad categories defined by the mechanism of action, side effect profile, and date of development. First generation antipsychotics (FGAs), like chlorpromazine, inhibit dopamine, histamine, and acetylcholine receptors to “varying degrees;” their dopamine receptor inhibition is strongly associated with extrapyramidal symptom (EPS) side effects.²⁴ By contrast, second generation antipsychotics (SGAs)—also called atypical antipsychotics—were developed in the 1980s and inhibit both dopamine and serotonin receptors in the brain.²⁵ SGAs carry a reduced but non-zero risk of EPS side effects; however, many are associated with metabolic side effects including diabetes and obesity.²⁶ FGAs are further divided into two classes based upon the strength of their dopaminergic inhibition: weak FGAs, like chlorpromazine, and strong FGAs, like haloperidol.²⁷ A series of large studies demonstrated that some SGAs were equal if not superior to FGAs in the treatment of schizophrenia.²⁸ Further, physicians largely prefer prescribing SGAs over FGAs.²⁹

23. See KANDEL, *supra* note 22, at 73 (noting how in the 1990s, researchers like Aaron Beck discovered how to use psychopharmacological agents to “restore the balance of chemicals in the brain”). *But see* Ronald W. Pies, *Debunking the Two Chemical Imbalance Myths, Again*, PSYCHIATRIC TIMES, Aug. 1, 2019, at 9 (arguing that the “chemical imbalance theory” was never actually a credible theory in psychiatry).

24. See AGENCY FOR HEALTH CARE RESEARCH & QUALITY, FIRST-GENERATION VERSUS SECOND-GENERATION ANTIPSYCHOTICS IN ADULTS: COMPARATIVE EFFECTIVENESS 1 (2013), https://www.ncbi.nlm.nih.gov/books/NBK142851/pdf/Bookshelf_NBK142851.pdf (comparing first- and second-generation antipsychotic medication classes; FGAs blockade of the “dopamine type 2” receptor is thought to be responsible for EPS side effects).

25. See Keith Willner et al., *Atypical Antipsychotic Agents*, in STATPEARLS (2020) (listing the active targets of SGAs).

26. See *id.* (listing, generally, the metabolic effects of SGA); see also John Muench & Ann M. Hammer, *Adverse Effects of Antipsychotic Medications*, 81 AM. FAM. PHYSICIAN 617, 617–19; tbl.3 (2010) (summarizing the adverse effects of FGAs and SGAs).

27. See Muench & Hammer, *supra* note 26 (comparing FGAs that weakly or strongly bind dopamine receptors).

28. See generally John M. Davis et al., *A Meta-Analysis of the Efficacy of Second-Generation Antipsychotics*, 60 ARCHIVES GEN. PSYCHIATRY 553, 559 (2003) (“Some SGAs . . . are significantly more efficacious than FGAs, whereas others are not proven to be so.”).

29. See, e.g., Maxine D. Fisher, *Antipsychotic Patterns of Use in Patients with Schizophrenia: Polypharmacy Versus Monotherapy*, 14 BMC PSYCHIATRY

Neither treatment with FGAs nor SGAs is without risk. EPS side effects include dyskinesia (often tardive dyskinesia—abnormal, involuntary movement), Parkinsonism (cogwheel-like rigidity), akinesia (loss of voluntary movement), akathisia (restlessness), and neuroleptic malignant syndrome (a life-threatening condition characterized by fever, tremors, muscle cramps, unstable blood pressure, and altered mental status including delirium and coma).³⁰ Many EPS side effects may persist after cessation of antipsychotic treatment.³¹ FGAs and SGAs may also cause a heart arrhythmia called QT prolongation which can predispose patients to a life-threatening ventricular arrhythmia called torsades de pointes.³² Many SGA are associated with an increased risk of metabolic disorders including obesity, derangement of blood cholesterol levels, and diabetes mellitus.³³ Additionally, clozapine, an early SGA recommended as a second- or third-line treatment for drug-resistant schizophrenia, has been associated with a very rare but life-threatening side effect called agranulocytosis, wherein certain white blood cells necessary to fight off foreign pathogens are dramatically reduced.³⁴ An inmate's interest in avoiding these life threatening, functional, and aesthetic side effects has been recognized by the Supreme Court.³⁵

Multiple FGAs and SGAs are available in both oral and injectable formulations which have short half-lives, as well as long-acting-injectable—also called “depot”—formulations which

tbl.2 (2014) (showing 86.6% of patients studied on monotherapy were taking an SGA compared to only 13.4% taking an FGA; of patients taking more than one antipsychotic medication, only 26.5% of regimens included an FGA; the remainder were combinations of SGAs).

30. See Muench & Hammer, *supra* note 26, at 618–21 (discussing the EPS side effects of SGAs and FGAs). Different EPS side effect profiles are observed in different FGAs and SGAs. See *id.* at 619, tbl.3 (illustrating the prevalence of side effects for FGAs and SGAs).

31. Cf. Stanley N. Caroff et al., *Movement Disorders Induced by Antipsychotic Drugs: Implications of the CATIE Schizophrenia Trial*, 29 NEUROLOGIC CLINICS 127, 128–29 (2011) (noting that dystonia, a common EPS side effect of antipsychotic medications, may actually worsen after the cessation of antipsychotic agents).

32. See Muench & Hammer, *supra* note 26, at 620.

33. See *id.* at 621.

34. See *id.* at 620.

35. See *Washington v. Harper*, 494 U.S. 210, 229 (1990) (“While the therapeutic benefits of antipsychotic drugs are well documented, it is also true that the drugs can have serious, even fatal, side effects.”).

can be effective for weeks, rather than hours.³⁶ When initially developed, depot antipsychotics were not commonly prescribed.³⁷ This stemmed from the belief that they posed an increased risk of prolonged side effects and their action cannot be rapidly stopped if side effects develop.³⁸ More recent studies show that this is not the case; depot medications are as safe and as effective as oral, short acting formulations.³⁹ Depot medications offer the additional benefit of ensuring patient compliance without daily observation.⁴⁰ For this reason, treatment advocacy organizations have recently begun to promote their use as an alternative to inpatient civil commitment.⁴¹

II. THE PARADOX OF DEINSTITUTIONALIZATION AND MEDICAL SEGREGATION IN PRISON

Compared to medical reforms in continental Europe, the United States was late to abandon Freudian, neurostructural,

36. See Sofia Brissos et al., *The Role of Long-Acting Injectable Antipsychotics in Schizophrenia: A Critical Appraisal*, 4 THERAPEUTIC ADVANCES IN PSYCHOPHARMACOLOGY 198, 200 tbl.1 (2014) (listing the biologically active half-lives of various oral and depot antipsychotics).

37. See *id.* at 198 (“[T]he concept of [long-acting injectable antipsychotics] for schizophrenia was not initially received warmly by the medical profession for fears of increased side effects, lack of efficacy, and the fact this was seen as an attempt by psychiatrists to impose a treatment upon patients without due regard to their feelings or rights . . .”).

38. See Mary V. Seeman, *Drawbacks of Long-Acting Intramuscular Antipsychotic Injections*, 1 J CLINICAL & PRACTICAL NURSING 12, 16 (2017) (“[O]nce the drug is in the muscle and side effects develop, they can remain unalleviated for a very long time.”); *cf.*, *e.g.*, Brissos et al., *supra* note 36, at 198 (stating depot antipsychotics were “not initially received warmly by the medical profession for fears of increased side effects”); C. Besenius et al., *Health Professionals’ Attitudes to Depot Injection Antipsychotic Medication: A Systematic Review*, 17 J. PSYCHIATRIC & MENTAL HEALTH NURSING 452, 453, 458 (2010) (finding many physicians believe depot antipsychotics have a greater risk of more numerous and more severe side effects than equivalent oral antipsychotic formulations).

39. See *generally* Brissos et al., *supra* note 36, at 202 (“Severe side effects . . . may occur; nevertheless, there [sic] are rare and there seems to be no increased risk for EPS liability . . .”).

40. *Cf. id.* at 202 (“[I]f a patient suffers a relapse, despite receiving regular [depot injection] treatment, it is then clear that compliance is not the reason . . .”).

41. See, *e.g.*, THE AM. PSYCHIATRIC ASS’N, PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH SCHIZOPHRENIA 118 (2020) (recommending long-acting injectable formulations for outpatient commitment); TREATMENT ADVOCACY CENTER, WHAT CAN YOU DO IF SOMEONE WITH A SERIOUS MENTAL ILLNESS REFUSES TREATMENT? 4 (2014) (noting and suggesting depot medications for use in community civil commitment).

and restraint-based methods of treating mental illness.⁴² The shift to modern pharmacological treatment practices was ultimately spurred on by a civil rights movement known as deinstitutionalization. However, deinstitutionalization did not live up to its name: it may have been a primary driver of the transinstitutionalization of the mentally ill from the asylum to the prison where they can be further confined, restrained, and segregated in inpatient medical units.

A. DEINSTITUTIONALIZATION OR TRANSINSTITUTIONALIZATION?

In the early 1950s, a confluence of political, legal, and social factors led to a seismic shift in the organization and funding of mental health service infrastructure in the United States.⁴³ Chief among these was a newfound public awareness of the abysmal conditions found within state asylums and mental hospitals conjoined with a spreading skepticism of the efficacy and humaneness of midcentury psychiatric practices.⁴⁴ These factors culminated in a policy movement in the 1960s and 1970s known as deinstitutionalization, wherein laws and norms came to disfavor the involuntary commitment of mentally ill individuals in mental hospitals or asylums, resulting in a decades-long process

42. See Masters, *supra* note 1, at 53.

43. See, e.g., Lamb & Weinberger, *supra* note 4, at 529 (noting “structural changes that have been made in the mental health system—namely, a radical reduction in long-term, intermediate, and short-term psychiatric inpatient treatment under mental health’s jurisdiction”).

44. See Enric J. Novella, *Theoretical Accounts on Deinstitutionalization and the Reform of Mental Health Services: A Critical Review*, 11 MED. HEALTH CARE & PHIL. 303, 312 (2008) (noting the importance of public perception of “maltreat[ment]” in asylums as well as “a radical questioning of their therapeutic value” in the early deinstitutionalization movement). Concern over the inhumane practices in state mental hospitals coincided with the close of the “Freudian Enlightenment” which “competed with somatic therapies—shock, insulin, and psychosurgery” as well as behavioral science and psychopharmacology in the 1950s. Milton Greenblatt, *Deinstitutionalization and Reinstitutionalization of the Mentally Ill*, in HOMELESSNESS: A NATIONAL PERSPECTIVE 48 (1992). On the whole, the somatic practices which entailed institutionalization in state mental hospitals was no longer required given the outpatient treatment success of novel antipsychotic “tranquilizing” agents such as chlorpromazine. Cf., e.g., Brill & Patton, *supra* note 18, at 510 fig.1 (illustrating an inverse correlation between the rise of “patients receiving tranquilizing drugs” and the fall in “[s]omatic therapy and restraint-seclusion”).

of emptying state mental hospitals.⁴⁵ Between 1955 and 1994, the population of patients in state mental hospitals had decreased from 558,239 to 71,619 despite population growth over that time period.⁴⁶ In the 1990s, state funding for state mental hospitals was diverted into community health programs, resulting in a wave of hospital closures in addition to a reduction in beds.⁴⁷ Ultimately, before the start of the twenty-first century, ninety-five percent of state mental hospital beds had been eliminated.⁴⁸

Despite the libertarian promise of deinstitutionalization, community infrastructure outside of state mental hospitals proved inadequate to the task of providing homes, medical care, and other social services to the formerly committed.⁴⁹ A large portion of deinstitutionalized persons were released to the

45. See, e.g., ANNE E. PARSONS, FROM ASYLUM TO PRISON: DEINSTITUTIONALIZATION AND THE RISE OF MASS INCARCERATION AFTER 1945 3 (2018) (attributing deinstitutionalization—defined as “the downsizing and closure of state-run mental hospitals”—starting in the 1950s and rapidly accreting in the 1960s and 1970s, to “[c]ommunity-based approaches in psychiatry, legal challenges to commitment laws, and activism around patients’ rights”).

46. See E. FULLER TORREY, OUT OF THE SHADOWS: CONFRONTING AMERICA’S MENTAL ILLNESS CRISIS app.1 (1997) (summarizing the decrease in open state mental hospital beds during the five decades of deinstitutionalization from the 1950s to the mid-1990s); cf. William H. Fisher et al., *The Changing Role of the State Psychiatric Hospital*, 28 HEALTH AFF. 676, 678 (2009) (noting a decline of seventy percent of state hospital beds between 1972 and 1990; however, this was not due to the closure of hospitals).

47. Fisher et al., *supra* note 46, at 677–79.

48. *Id.* at 676 (“[Deinstitutionalization] efforts led to a 95 percent reduction in the country’s state hospital population.”).

49. See, e.g., Nancy K. Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31 EMORY L.J. 375, 376 (1982) (“The reason deinstitutionalization has failed is simple: adequate community facilities have not been created.”).

streets,⁵⁰ likely contributing to a growing population of individuals with serious mental illness who were also homeless.⁵¹ Individuals with serious mental illness are disproportionately affected by homelessness.⁵² There is also an inverse correlation between available state mental hospital beds and the population of homeless individuals with mental illness.⁵³ Adding insult to injury, the seeds of mass incarceration were planted in the early

50. See *id.* at 387 (“Many patients, whether they have gone to nursing homes, halfway houses, welfare hotels, or to the streets, are abused and neglected in their new ‘homes’ just as they were in the public hospitals from whence they came.”); see also H. Richard Lamb, *Deinstitutionalization and the Homeless Mentally Ill*, 35 HOSP. & COMMUNITY. PSYCHIATRY 899, 899 (1984) (discussing the connection between deinstitutionalization and homelessness in the United States and comparing to Israel, where homelessness “of the chronically mentally ill is not a significant problem” and where “deinstitutionalization has barely begun”).

51. But see Peter Winkler et al. *Deinstitutionalised Patients, Homelessness and Imprisonment: Systematic Review*, 208 BRIT. J. PSYCHIATRY 421, 421 (2016) (“Since deinstitutionalization began, arguments that psychiatric reforms have led to former patients entering prisons and becoming homeless have been prolifically published in the professional literature, as well as in newspapers. As a rule, these arguments have been based on either ecological studies or—more often—personal observations or judgements.” (endnotes omitted)). Observational studies have supported the claim, but have also yielded “contradictory findings.” *Id.* However, social science studies conducted during deinstitutionalization in the United States have been criticized due to political pressure to “emphasize individual and cultural rather than structural aspects of poverty.” Marian Moser Jones, *Creating a Science of Homelessness During the Reagan Era*, 92 MILBANK Q. 139, 140 (2015).

52. See Hunter L. McQuiston et al. *Challenges for Psychiatry in Serving Homeless People With Psychiatric Disorders*, 54 PSYCHIATRIC SERVS. 669, 669 (2003) (“[R]eliable studies describing psychiatric illness showed reasonably consistently that one-third to one-half of homeless people had severe psychiatric disorders, such as major mood disorder (19 percent to 30 percent) and schizophrenia (11 percent to 17 percent).”); *cf.*, e.g., 2 CLAUDIA D. SOLARI ET AL., THE 2013 ANNUAL HOMELESS ASSESSMENT REPORT (AHAR) TO CONGRESS 7-7 (2014) (finding 30.3% of adults living in permanent supportive housing self-reported suffering from a disabling mental health issue). Compare these numbers to the estimated 4.5% of U.S. adults, generally, with serious mental illness. See *Mental Illness*, NAT’L INST. OF MENTAL HEALTH, <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml> (last updated Mar. 2021) (“In 2019, there were an estimated 13.1 million adults aged 18 or older in the United States with [serious mental illness]. This number represented 5.2% of all U.S. adults.”).

53. Fred E. Markowitz, *Psychiatric Hospital Capacity, Homelessness, And Crime and Arrest Rates*, 44 CRIMINOLOGY 45, 62 (2006) (“[T]he results indicate a moderate link between public hospital capacity and homelessness at the city level that is not conditioned by private psychiatric beds, general hospital psychiatric beds or community-based expenditures.”).

1970s, at the height of deinstitutionalization.⁵⁴ These and other broad sociological changes led, in part, to a substantial rise in the number of individuals with serious mental illness who received their psychiatric care in various inappropriate care settings such as emergency departments or jails and prisons.⁵⁵ Some scholars have abandoned the term “deinstitutionalization” entirely, preferring the term “transinstitutionalization” to refer to the movement of persons with mental illness from state mental hospitals into the penal system.⁵⁶ However, observational studies of the relationship between homelessness, incarceration, and deinstitutionalization have yielded mixed results.⁵⁷

Estimates of the number of United States prison inmates with serious mental illness vary dramatically.⁵⁸ A commonly relied upon study places the number in the range of sixteen to twenty-four percent of the prison population.⁵⁹ The most recent

54. PARSONS, *supra* note 45, at 3 (“Mental health centers in prisons and jails grew at the very same moment that involuntary confinement in mental hospitals declined. Today, this new system of mass incarceration disproportionately affects people with psychiatric disabilities.”).

55. Yohanna, *supra* note 2, at 889 (“Emergency rooms are crowded with the acutely ill patients with long psychiatric histories but no plausible dispositions.”) Further, in the absence of functioning state hospitals to act as “entry points to the mental health system . . . most people with severe mental illness . . . otherwise will wind up in jail or prison.” *Id.*

56. See, e.g., PARSONS, *supra* note 45, at 3 (“Some people have explained this phenomenon as a transinstitutionalization rather than a deinstitutionalization.”).

57. Cf. Winkler et al., *supra* note 51, at 421–23 (summarizing the results of ecological studies of the relationship between homelessness and deinstitutionalization and reporting the results of a systematic review of twenty-three empirical cohort and research articles into the relationship between deinstitutionalization, homelessness, and incarceration where the authors found no meaningful correlation).

58. Cf. Seth J. Prins, *The Prevalence of Mental Illnesses in U.S. State Prisons: A Systematic Review*, 65 PSYCHIATRIC SERVS. 862, 866 (2014) (“[T]he wide variation in prevalence found among even the more robust studies reviewed here warrants caution against generalizations from any single study.”).

59. See, e.g., Lamb & Weinberger, *supra* note 4, at 529 (“The latest methodologically sound estimates of the number of persons in jails and prisons diagnosed with major depression, schizophrenia, and other psychotic disorders, and bipolar disorder yielded percentages that ranged from 16 to 24 percent.”) (footnote omitted) (citing 1 NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE, THE HEALTH STATUS OF SOON-TO-BE-RELEASED INMATES 22–25 (2002)). A more recent survey conducted by the Bureau of Justice Statistics looked at self-reported “experiences that met the threshold for serious psychological distress . . . in the 30 days prior to a survey,” finding that number to be fourteen

Department of Justice estimate of the total “incarcerated population” was 2,162,400.⁶⁰ If prior estimates remained constant, between 346,000 and 519,000 people with mental illness are incarcerated. There is a broad consensus that individuals with serious mental illness are overrepresented in forensic populations.⁶¹ The explanation for the overrepresentation of people with mental illness in jails and prisons is likely multifactorial and remains elusive.⁶² While an obvious explanation, studying the relationship between mental illness and the likelihood of committing crime is difficult to assess as a matter of criminological inquiry given confounding variables such as vagrancy laws, which disproportionately affect persons with serious mental illness who are without homes,⁶³ as well as poor data reporting at the state-level. As a result, studies of index crime measures,⁶⁴

and twenty-six percent in federal prison and jail respectively. JENNIFER BRONSON & MARCUS BERZOFKY, BUREAU OF JUSTICE STATISTICS, NCJ 250612 INDICATORS OF MENTAL HEALTH PROBLEMS REPORTED BY PRISONERS AND JAIL INMATES, 2011–12 1 (2017). It is important to view this second statistic with caution as it does not require a medical diagnosis of mental illness to qualify and is based on self-reporting alone. *Cf. id.* at 2 (describing, briefly, the methodology).

60. DANIELLE KAEBLE & MARY COWHIG, BUREAU OF JUSTICE STATISTICS, NCJ 251211, CORRECTIONAL POPULATIONS IN THE UNITED STATES, 2016 1–2 tab.1 (2018) (estimating the total “incarcerated population” as of December 31, 2016).

61. *See, e.g.*, Seth J. Prins, *Does Transinstitutionalization Explain the Overrepresentation of People With Serious Mental Illnesses in the Criminal Justice System?*, 47 COMMUNITY MENTAL HEALTH J. 716, 717 (2011) (“Though researchers disagree about the transinstitutionalization hypothesis and potential solutions to the problem, there is broad consensus that people with [severe mental illness] are overrepresented in the criminal justice system and that correctional facilities are not ideal treatment settings.”).

62. *Cf. id.*, at 716–17 (describing a lack of agreement as to the “policy trends” that have resulted in high numbers of individuals with serious mental illness in prison, as well as noting that “*involvement* in the criminal justice system . . . is more accurately described as *entrenchment*,” pointing to longer incarceration and reduced likelihood to become and remain parolees).

63. *Cf.* Chris Herring et al., *Pervasive Penalty: How the Criminalization of Poverty Perpetuates Homelessness*, 67 SOC. PROBS. 131, 138–40 tbl.1 (2019) (analyzing the impact of criminalization policies such as vagrancy laws on perpetuating homelessness, specifically providing subgroup analysis of mentally disabled individuals). *But cf.* James D. Livingston, *Contact Between Police and People With Mental Disorders: A Review of Rates*, 67 PSYCHIATRIC SERVS. 850, 852 (2016) (finding that the rate of police encounters for people with mental disorders are “in line with rates in the United States” (endnote omitted)).

64. *Cf.* NATHAN JAMES & LOGAN RISHARD, CONG. RESEARCH SERV., HOW CRIME IN THE UNITED STATES IS MEASURED 42 tab.1 (2018) (listing index of offenses measured by the United States government).

such as the rate of violent crime or assault, are often used to assess involvement with the criminal justice system between populations of people with mental illness and the general population.⁶⁵

At the height of deinstitutionalization, the prevailing academic view was that people with mental illness are no more or less likely to be violent than the population at large.⁶⁶ However, more extensive studies have revealed a more complex relationship implicating serious mental illness—especially when comorbid with drug abuse—in increased rates of violent crime.⁶⁷ Notably, this effect is diminished by treatment.⁶⁸ Nonetheless, serious mental illness is a much stronger predictor of being the

65. Cf., e.g., Patricia A. Brennan et al., *Major Mental Disorders and Criminal Violence in a Danish Birth Cohort*, 57 ARCHIVE GEN. PSYCHIATRY 494, 495 (2000) (describing why a Danish index of felony-level crimes was used in the study).

66. See Heather Stuart, *Violence and Mental Illness: An Overview*, 2 WORLD PSYCHIATRY 121, 122 (2003) (“Prior to 1980, the dominant view was that the mentally ill were no more, and often less likely to be violent.”).

67. See, e.g., Seena Fazel et al., *Schizophrenia, Substance Abuse, and Violent Crime*, 301 JAMA 2016, 2021 (2009) (“[T]he association between schizophrenia and violent crime is minimal unless the patient is also diagnosed as having substance abuse comorbidity.”). But see Seena Fazel et al., *Bipolar Disorder and Violent Crime*, 67 ARCHIVE GEN. PSYCHIATRY 931, 935 (2010) (“[T]here was an increased risk for violent crime among individuals with bipolar disorder. Most of the excess violent crime was associated with substance abuse comorbidity.”) Note that the association between bipolar disorder and violent crime was confounded by a parallel finding that showed an increase in violent crime amongst sibling controls. *Id.* at 936.

68. See, e.g., Jeffrey W. Swanson et al., *Comparison of Antipsychotic Medication Effects on Reducing Violence in People With Schizophrenia*, 193 BRIT. J. PSYCHIATRY 37, 39 (2008) (“[P]atients assigned to perphenazine showed a greater reduction in violence risk—from 19% at baseline to 7% at follow-up—when compared with patients assigned to quetiapine, whose risk of violence declined from 15% to 14% over the same period. Perphenazine did not differ from olanzapine, risperidone or ziprasidone.”); John E. Kraus & Brian B. Sheitman, *Clozapine Reduces Violent Behavior in Heterogeneous Diagnostic Groups*, 17 J. NEUROPSYCHIATRY & CLINICAL NEUROSCIENCES 36, 41 (2005) (“[C]lozapine was effective in markedly decreasing the number of violent episodes in persistently violent patients, regardless of the underlying psychiatric diagnosis and even in the absence of psychotic symptoms.”). See generally *Mental Illness and Violence*, HARV. HEALTH PUB. (Jan. 2011), https://www.health.harvard.edu/newsletter_article/mental-illness-and-violence (“The research suggests that adequate treatment of mental illness and substance abuse may help reduce rates of violence.”).

victim of violent crime than being the victimizer.⁶⁹ Further, mentally ill inmates report being physically victimized at increased rates in prison compared to non-mentally ill inmates.⁷⁰ Transinstitutionalization, it seems, has led to the reemergence of confinement and restraint in the treatment of inmates with mental illness—perhaps harming their mental health rather than healing. Regrettably, the process of confining, restraining, and segregating those with serious mental illness does not cease its operation at the prison gate.

B. AUTOMATIC MEDICAL SEGREGATION OF INMATES RECEIVING INVOLUNTARY MEDICATION

Until recently, there had been no empirical evidence as to the effectiveness of forced antipsychotic medication in prison.⁷¹ Neither benefits to maintaining order in prisons nor the medical benefit of the practice has been comprehensively assayed.⁷² A 2015 study of the New Jersey Department of Corrections' nonemergency involuntary antipsychotic medication policy⁷³ was the first attempt to quantify these considerations.⁷⁴ The study compared "in patient days" and "disciplinary charges" for

69. See Linda A. Teplin et al., *Crime Victimization in Adults With Severe Mental Illness*, 62 ARCHIVE GEN. PSYCHIATRY 911, 916 tbl.3 (2005) (finding individuals with serious mental illness had a four-fold increase in self-reported violent crime victimization over control).

70. See Cynthia L. Blitz et al., *Physical Victimization in Prison: The Role of Mental Illness*, 31 INT'L J.L. & PSYCHIATRY 385, 391 (2008) (finding male and female inmates with mental disorders to be 1.6 and 1.7 times more likely to be victimized by another inmate); see also Kayla G. Jachimowski, *The Relationship Between Mentally Disordered Inmates, Victimization, and Violence*, 57 J. OFFENDER REHABILITATION 47, 56, 58 (2018) (finding a statistical increase in victimization of mentally ill inmates compared to control, including in all subgroups by reported diagnosis except for the "anxiety" subgroup).

71. See Salem et al., *supra* note 5, at 160 ("[T]here has been no published study of involuntary medication of mentally ill inmates.").

72. *Id.*; cf. Max Blau, *Marketing Psychiatric Drugs to Jailers and Judges*, THE ATLANTIC (Dec. 31, 2019), <https://www.theatlantic.com/politics/archive/2019/12/pharmaceutical-companies-are-marketing-drugs-jailers/604264/> (noting pharmaceutical companies efforts to lobby prison officials and judges to use certain psychotropic medications with "scant evidence of . . . effectiveness compared to competing treatments . . .").

73. See generally Salem et al., *supra* note 5.

74. See *id.* at 160 (noting the New Jersey Department of Corrections (NJ DOC) "policy follows the *Harper* standard in the provision of administrative review" and noting the requirement that "the prisoner's liberty interests must be balanced against the state's "legitimate penological interests" in maintaining safety." (citing *Washington v. Harper*, 494 U.S. 210, 224 (1990))).

inmates before and during a nonemergency involuntary antipsychotic medication protocol.⁷⁵ Psychiatrist Dr. Anasuya Salem and colleagues found that there was no significant difference in inpatient treatment days before or during the involuntary medication protocol.⁷⁶ However, three measures of disciplinary charges showed significant reductions during the protocol.⁷⁷

Interestingly, Salem and colleagues note that their results may not be attributable to the use of antipsychotic medication due to an “unstated practice . . . to move inmates onto a prison inpatient unit upon commencement of involuntary medication and to err on keeping the patients there for the security of both the inmates and others.”⁷⁸ The authors note that “[i]nmates enjoy the relative security and enhanced programming and attention offered on the inpatient units” and that inmates “occasionally feign symptoms to secure placement on an inpatient unit and avoid release from the same.”⁷⁹ A companion article to the Salem study amplifies, “[w]hen inmates are placed on an involuntary medication protocol, the tendency in the system studied, the New Jersey state prisons, is to keep them on an inpatient unit during the entire duration of that protocol, regardless of whether there is behavioral improvement.”⁸⁰ While both articles suggest that the practice is harmless,⁸¹ automatic, near-universal medical segregation may implicate liberty interests. The extent to which medical segregation during involuntary treatment is justified and what legal remedies aggrieved inmates may possess must be addressed.

Because prisons in the United States are primarily controlled under state laws and regulations, it is difficult to determine how medical segregation is used throughout the country. An initial survey attempted to categorize medical and mental

75. *Id.* at 161. The study could not be randomized or placebo-controlled because NJ DOC policy prohibits experimentation on prisoners. *Id.* at 160.

76. *Id.* at 162 tbl.1 (displaying inpatient days weighted by time recorded before and during the protocol).

77. *Id.* (displaying weighted “mean number of inmates with charges,” “mean instances of charges per inmate,” and “average number of charges per inmate”).

78. *Id.* at 163.

79. *Id.*

80. Levine & Gage, *supra* note 5, at 169.

81. *See id.* (“The practice of keeping involuntary patients on prison hospital wards for the duration of their involuntary administrative order appears to be a humane and justifiable practice.”).

health facilities available in state prisons;⁸² however, it did not study the conditions and types of restrictions deployed in medically segregated wards. In fact, there has been no systematic effort to assess what medical segregation entails in various state prisons. This is further complicated by the potpourri of terminology used to describe medical segregation in state and federal laws and regulations.⁸³ Also, as Salem and colleagues point out, the degree to which medical segregation is used in the treatment of mental illness is unlikely to be captured in a survey of the laws and regulations governing prison segregation because it is controlled by unwritten and unstated policies and practices.⁸⁴

Under New Jersey regulations, medical segregation is considered separate from punitive segregation (i.e., solitary confinement). Narrative accounts of New Jersey's medical segregation program show that segregated inmates have many of the same liberties as inmates in the general population.⁸⁵ This is in stark contrast to solitary confinement, where most liberties are sharply curtailed.⁸⁶ However, this is not the case in all state prison systems. In other states, medical and punitive segregation units are distinct in name only, and medically segregated

82. See E. FULLER TORREY ET AL., *THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN PRISONS AND JAILS: A STATE SURVEY* 106 (2014) [hereinafter JOINT REPORT].

83. Various states use terms like “segregated housing,” “punitive segregation,” “disciplinary segregation,” and “administrative segregation” to refer to all levels of increased security, including intermediate and high security segregation practices. See generally Jody Sundt, *The Effect of Administrative Segregation on Prison Order and Organizational Culture*, in *RESTRICTIVE HOUSING IN THE U.S.: ISSUES, CHALLENGES, AND FUTURE DIRECTIONS* 297, 298 (2016) (available at <https://www.ncjrs.gov/pdffiles1/nij/250323.pdf>) (classifying prison restriction by function).

84. See generally Salem et al., *supra* note 5 and accompanying text.

85. BUREAU OF JUSTICE ASSISTANCE, *PREA AUDIT REPORT 3* (2018) [hereinafter *PREA AUDIT REPORT*] (“Medium custody: Each housing unit is separated by fence. Inmates have little interaction with inmates from other housing units. Beds are located on eight to ten wings in each unit. They are double bunked with separation between four bed areas. One aisle way provides access to all the beds. They are fed in the unit and recreation is located outside the unit within the fence. Common bathrooms with a sink, toilet and shower are located at the front of each wing. These bathrooms provide security and privacy.”).

86. See *id.* (describing how different levels of custody offer different liberties).

inmates are functionally kept in solitary confinement.⁸⁷ It is not known whether these states also regularly place inmates receiving compulsory medication in solitary-confinement-like medical segregation. If mentally ill inmates on forced medication protocols are kept in medical solitary confinement, it creates a bevy of medical and ethical problems: the American Psychiatric Association strongly recommends against the solitary confinement of inmates with mental illness.⁸⁸ However, it is an open question whether there are any legal protections for inmates in medical segregation.

For the purposes of this Note, medical segregation can be separated into three categories. First, medical segregation can mirror the New Jersey system where there is an *intermediate level of additional security* and segregated inmates maintain most of the same freedoms afforded to the general population—just in a separate location within the prison.⁸⁹ Second, medical segregation may be equivalent to *punitive segregation or solitary confinement* where all but the barest freedoms are restricted.⁹⁰ Third, *off-site segregation*, where the prison lacks facilities to care for mentally ill inmates and must transfer them to mental hospitals or community hospitals.⁹¹ Due to security concerns, inmates are often shackled and may be under constant one-on-one

87. See, e.g., Melinda Tasca & Jillian Turanovic, *Examining Race and Gender Disparities in Restrictive Housing Placement*, NAT'L CRIM. JUST. REFERENCE SERV., Sept. 2018, at 3 (describing “mental health segregation” as part of a class of segregation including disciplinary segregation wherein inmates with mental illness are placed in “maximum security housing units”).

88. See AM. PSYCHOL. ASS'N, POSITION STATEMENT ON SEGREGATION OF PRISONERS WITH MENTAL ILLNESS (dec. 2012) (“Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates.”).

89. See PREA AUDIT REPORT, *supra* note 85 and accompanying text (describing the audit findings of a New Jersey correctional facility).

90. See Sundt, *supra* note 83 and accompanying text (discussing why prisons have classification systems and how those systems affect inmates).

91. See PEW CHARITABLE TRUSTS, STATE PRISONS AND THE DELIVERY OF HOSPITAL CARE: HOW STATES SET UP AND FINANCE OFF-SITE CARE FOR INCARCERATED INDIVIDUALS 2 (2018), <https://www.pewtrusts.org/en/research-and-analysis/reports/2018/07/19/state-prisons-and-the-delivery-of-hospital-care> [hereinafter PEW STUDY] (“[A]ll states rely on hospitals for some specialist consultations, diagnostic tests, surgery, and other services.”); *cf.* Joint Report, *supra* note 82, at 43 (describing the need for Georgia jails to use local hospital beds for the treatment and housing of mentally ill detainees). However, this practice does not guarantee superior care or continuity of care. See Steven Ross Johnson, *Prison Health Systems Need Better Integration Into the Community*, MODERN

surveillance during stays at the community hospital.⁹² Their social interactions are dramatically curtailed and other privileges cease.⁹³ Each of these varieties of medical segregation may be subject to a separate due process analysis. However, current due process law is limited in scope and applicability, meaning most mentally ill inmates are without protections from medically inappropriate confinement, restraint, and segregation within the prison.

The proper role for the government in compelling the medication of individuals with mental illness both inside and outside of the prison system also continues to inspire rancorous debate.⁹⁴ It is, however, generally accepted that the level of mental health care provided to inmates suffering from serious mental illness in prison does not meet community standards of care.⁹⁵ Further,

HEALTHCARE (Oct. 11, 2018, 1:00 AM), <https://www.modernhealthcare.com/article/20181011/NEWS/181019963/prison-health-systems-need-better-integration-into-the-community> (discussing a report that found that “many states are struggling to adhere to their mandate to provide an adequate level of care for prisoners”).

92. See PEW STUDY, *supra* note 91, at 11–12 (describing methods of transport and security for prisoners receiving treatment at community hospitals). This practice is predominately governed by the Eighth Amendment, *Estelle v. Gamble*, 429 U.S. 97 (1976), and is outside the scope of this Note.

93. *Cf.*, e.g., PEW STUDY, *supra* note 91, at 11 (describing specialized “hardened” hospital floors, staffed by doctors and nurses but guarded by corrections officials, compared with “a single room guarded by two officers round-the-clock”).

94. See, e.g., Damon Tweedy, *The Heated Battle Over When to Commit a Patient Involuntarily to Psychiatric Care*, WASH. POST (Oct. 21, 2016), http://wapo.st/2ePw3TU?tid=ss_mail (noting the interrelationship between the debate over civil commitment and the criminal justice system’s ability to care for people with mental illness); Haley Sweetland Edwards, *Should Mentally Ill People Be Forced Into Treatment?*, TIME (Feb. 20, 2015), <https://time.com/3716426/mental-illness-treatment-cost/> (framing the debate from a budgetary perspective); see also Jacob Kurlander, *Pro/Con: Outpatient Commitment for the Severely Mentally Ill*, 5 VIRTUAL MENTOR 324, 324–25 (2003) (summarizing recently published arguments for and against the practice of outpatient commitment); Alan R. Felthous, *The Treatment of Persons with Mental Illness in Prisons and Jails: An Untimely Report*, PSYCHIATRIC TIMES (Aug. 13, 2014) <https://www.psychiatrictimes.com/forensic-psychiatry/treatment-persons-mental-illness-prisons-and-jails-untimely-report> (dissenting against suggestions that increased mental health services in prisons will alleviate concerns over mental illness and its treatment in prisons and jails).

95. See, e.g., JOINT REPORT, *supra* note 82, at 106 (recommending that state laws must be altered in order to provide appropriate mental health treatment

events associated with living in a penitentiary pose additional risks to the mental well-being of inmates with and without serious mental illness.⁹⁶ In fact, the practice of prolonged, punitive segregation of inmates with serious mental illness has been condemned by the American Psychiatric Association.⁹⁷ This professional society's policy change represents a final abandonment of the physical-restraint-as-treatment model of psychiatric care in favor of pharmacological intervention in the treatment of mental illness. For this reason, it is all the more surprising that medical segregation is a "go to" component of treatment protocols in some jurisdictions for inmates with mental illness.⁹⁸ Inmates do, however, retain some recognized liberty interests and associated due

in prisons and jails); Jennifer M. Reingle Gonzales & Nadine M. Connell, *Mental Health of Prisoners: Identifying Barriers to Mental Health Treatment and Medication Continuity*, 104 AM. J. PUB. HEALTH 2328, 2331 tbl.1 (2014) (listing categories of multimodal or holistic care, finding a reduction in services available to mentally ill inmates); cf. Anasseril E. Daniel, *Care of the Mentally Ill in Prisons: Challenges and Solutions*, 35 J. AM. ACAD. PSYCHIATRY & L. 406 (2007) (asking, "Shouldn't standards of care of psychiatric disorders be respected in the correctional setting as they are in other community provider settings?"). *But cf.* Maureen C. Olley et al., *Mentally Ill Individuals in Limbo: Obstacles and Opportunities for Providing Psychiatric Services to Corrections Inmates with Mental Illness*, 27 BEHAVIORAL SCI. & L. 811, 830 (2009) ("Although there are innumerable challenges to providing expedient and appropriate mental health services to inmates experiencing mental health problems, *the opportunity that is presented* when an individual with mental health needs is in correctional custody also should not be overlooked." (emphasis added)).

96. See Reingle Gonzales & Connell, *supra* note 95, at 2329 ("[C]rowded living quarters, lack of privacy, increased risk of victimization, and solitary confinement within the institution have been identified as strong correlates for self-harm and adaptation challenges for those with mental health conditions in prison settings." (footnotes omitted)). Notably, the deleterious effects of solitary or segregation and "supermax" housing have been studied extensively. See, e.g., Jeffery L. Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, 38 J. AM. ACAD. PSYCHIATRY L. 104, 105 (2010) ("Mental health professionals are often unable to mitigate fully the harm associated with isolation."); Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax" Confinement*, 49 CRIME & DELINQUENCY 124, 130 (2003) ("Evidence of the[] negative psychological effects comes from personal accounts, descriptive studies, and systematic research on solitary and supermax-type confinement . . .").

97. AM. PSYCHIATRIC ASS'N, POSITION STATEMENT ON SEGREGATION OF PRISONERS WITH MENTAL ILLNESS (2017), <http://nrca.org/storage/documents/apa-statement-on-segregation-of-prisoners-with-mental-illness.pdf> ("Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates.").

98. Salem et al., *supra* note 5 at 163.

process protections which limit the State's authority to administer involuntary treatments.

III. DUE PROCESS PROTECTIONS FOR THE MENTALLY ILL INSIDE AND OUTSIDE OF PRISON

Because of the history of confinement, restraint, and segregation of those with serious mental illness, the Supreme Court has developed a body of due process protections specific to this population. When considering legal protections for the mentally ill, a key distinction must be drawn between patients in the community and inmates in prison. However, the general formula for due process protection hangs on the balance between legitimate state interests and personal liberty interests. This interplay is illustrated by comparing government regulation of the behavior of mentally ill people in the community (where personal liberty interests are the strongest) and in prison (where the governmental interest is the strongest).

A. THE RIGHT TO REFUSE TREATMENT

The animating principle of modern American medical ethics is the principle of patient autonomy.⁹⁹ The legal correlate to this principle of professional ethics is the right to refuse treatment as elaborated in *Cruzan v. Director*.¹⁰⁰ In *Cruzan*, the Supreme Court held that due process operates, “to repose judgment on [medical decisions implicating life or death] with . . . the patient herself.”¹⁰¹ The *Cruzan* decision is widely understood to acknowledge a patient's right to refuse medical care.¹⁰² However,

99. See Barbara Chubak, *Clinical Responsibility in the Age of Patient Autonomy*, 11 *AMA J. ETHICS* 567, 567 (2009) (“In the United States, th[e] international patients' rights] movement placed, and continues to place, a particular emphasis on individual choice Out of these ideas, the principle of respect for autonomy was born, and, since then, the influence of this single principle . . . has eclipsed that of the other principles”); see also Am. Med. Ass'n, *Opinions on Consent, Communication & Decision Making*, in *AMA CODE OF MEDICAL ETHICS: OPINIONS ON CONSENT* § 2.1.2 (2019), <https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-2.pdf> (“Respect for patient autonomy is central to professional ethics”).

100. 497 U.S. 261 (1990).

101. *Id.* at 286.

102. See *id.* at 279 (“[F]or purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.”); *id.* at 287 (O'Connor, J., concurring) (“I agree that a protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions”); see also

the right to refuse medical care is not absolute; the *Cruzan* court noted that a patient's, or her surrogate's, right to refuse life sustaining treatment must be balanced against state interests.¹⁰³ Accordingly, courts have consistently upheld disease control laws which force the involuntary testing and treatment of communicable diseases in the community where state interests in compelling treatment are strong.¹⁰⁴ State interests in compelling medical treatment of physical ailments in prison extend to cover a broader range of medical interventions.¹⁰⁵ However, psychotropic medications have unique characteristics which militate in favor of patient autonomy and counterbalance similarly unique state interests in involuntary administration.

B. LEGAL PROTECTIONS IN THE COMMUNITY

To begin, understanding the legal test for involuntary treatment of people with mental illness in the community—where liberty interests are at their acme—is crucial. Court precedent in

Vacco v. Quill, 521 U.S. 793, 796 (1997) (“*Everyone*, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment . . .” (emphasis in original)); cf. JANET L. DOLGIN & LOIS L. SHEPHERD, *BIOETHICS AND THE LAW* 459 (4th ed. 2019) (asking whether *Cruzan* should be read “as upholding a constitutional ‘right to die’ or *merely* a ‘right to refuse treatment?’” (emphasis added)).

103. See *Cruzan*, 497 U.S. at 280–84 (finding Missouri’s interests to be heightened where a patient lacks capacity to make medical decisions).

104. See, e.g., *S. Bay United Pentecostal Church v. Newsom*, 590 U.S. ___ (2020) (Roberts, C.J., concurring) (“Our Constitution principally entrusts ‘[t]he safety and the health of the people’ to the politically accountable officials of the States ‘to guard and protect.’” (quoting *Jacobson v. Massachusetts*, 197 U.S. 11, 38 (1905) (upholding a conviction and fine imposed to compel small pox vaccination))); *Reynolds v. McNichols*, 488 F.2d 1378, 1383 (10th Cir. 1973) (approving an ordinance “authorizing limited detention in jail without bond for the purpose of examination and treatment for a venereal disease of one reasonably suspected of having a venereal disease . . .”). But see *Roman Catholic Diocese of Brooklyn v. Cuomo*, 590 U.S. ___ (2021) (Gorsuch, J., concurring) (“*Jacobson* hardly supports cutting the Constitution loose during a pandemic.”).

105. For example, forced suturing of an inmate’s open wound was not found to violate due process protections. *Davis v. Agosto*, 89 Fed. Appx. 523, 528 (6th Cir. 2004). Similarly, compelled injection of medically recommended insulin for the treatment of diabetes was constitutionally permissible. *State ex rel. Schuetzle v. Vogel*, 537 N.W.2d 358, 364 (N.D. 1995). Additionally, tuberculosis screening and treatment over the objection of an inmate has consistently been permitted. See, e.g., *Parks v. McCoy*, 35 Fed. Appx. 239, 241 (7th Cir. 2002); *McCormick v. Stalder*, 105 F.3d 1059, 1062 (5th Cir. 1997); *Dunn v. Zenk*, No. 1:07-CV-2007-RLV, 2007 U.S. Dist. LEXIS 73891, at *9 (N.D. Ga. Oct. 1, 2007).

this area largely centers around the practice of civil commitment. Involuntary confinement of mentally ill individuals—as a method of treatment—historically derives from the police power of the states to regulate matters of health and safety amongst their civilian population; this was balanced with the principle of *parens patriae*, or “the government’s obligation to provide for the incapacitated.”¹⁰⁶

Early American psychiatric practice dictated that physicians and monied family members had largely unchecked authority to involuntarily commit persons with mental illness; a practice that was codified in the mid-1800s.¹⁰⁷ At this time, court involvement in involuntary commitment was limited to indigent populations.¹⁰⁸ Later in the nineteenth century, states began to enact legislation providing civil rights protections for mentally ill persons, often requiring a jury trial finding of insanity prior to, and judicial review after, involuntary commitment.¹⁰⁹ These reforms culminated in a slew of early twentieth century state laws requiring two physicians to testify as to the need for commitment.¹¹⁰ Despite these procedural reforms, from the eighteenth to early twentieth century the legal criteria for involuntary commitment remained unchanged: “the person was mentally ill and in need of treatment.”¹¹¹

Substantive change in civil commitment standards arrived in the 1970s, at which time “every state” had “constricted its substantive standard for commitment to *dangerousness* to self or

106. See Megan Testa & Sara G. West, *Civil Commitment in the United States*, 7 PSYCHIATRY (EDGEMONT) 30, 32 (2010) (describing an 1860s case in which a court allowed for the involuntary hospitalization of a woman on the principle of the state’s authority acting in *parens patriae*). Interestingly, the *parens patriae* authority sounds in beneficence, a pillar of medical ethics. *Cf.* T. L. Beauchamp, *Methods and Principles in Biomedical Ethics*, 29 J. MED. ETHICS 269, 269, 271 (2003) (framing beneficence and *parens patriae* in the context of practical medical ethics).

107. See Testa & West, *supra* note 106, at 32 (“[I]t was quite possible for families to purchase the confinement of unwanted relatives.”).

108. *Cf. id.* (“Prior to the inception of American asylums, people with mental illness were relegated to prisons and shelters for the poor.”).

109. See *id.* at 32–33 (describing statutory changes requiring a trial for civil commitment).

110. See *id.*

111. See AMA, *Code of Medical Ethics Opinion 2.1.2*, <https://www.ama-assn.org/delivering-care/ethics/decisions-adult-patients-who-lack-capacity> (last visited Feb. 2, 2020).

others.”¹¹² The Supreme Court entered the affray in the 1972 case of *Jackson v. Indiana*.¹¹³ Acknowledging the states’ “broad power to commit persons found to be mentally ill,”¹¹⁴ the Court held, “due process requires that the nature and duration of commitment must bear some reasonable relation to the purpose for which the individual is committed.”¹¹⁵ To involuntarily commit an adult, the state must show not only that they have a mental illness but also that they are a danger to themselves or others.¹¹⁶ This must be shown by “the ‘clear and convincing’ standard” which “is required to meet due process guarantees.”¹¹⁷ Individuals who are legally civilly committed maintain a due process right to be free from unnecessary confinement or unnecessary personal restraint.¹¹⁸

112. Testa & West, *supra* note 106, at 33 (emphasis added).

113. 406 U.S. 715, 717, 740 (ruling on a case of indefinite pretrial commitment of an individual with organic mental illness accused of two robberies under Indiana state law).

114. *Id.* at 736.

115. *Id.* at 738 (analogizing the practice of civil commitment to the confinement of convicted criminals for the purposes of due process protections); *see id.* at 726–27.

116. *See O’Connor v. Donaldson*, 422 U.S. 563, 575 (1975) (“A finding of ‘mental illness’ alone cannot justify a State’s locking a person up against his will and keeping him indefinitely in simple custodial confinement. Assuming that that term can be given a reasonably precise content and that the ‘mentally ill’ can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.”).

117. *Addington v. Texas*, 441 U.S. 418, 433 (1979). In *Addington*, the civil commitment proceeding did not emerge from pretrial commitment in a criminal action, but instead from appellant’s mother’s “petition for . . . indefinite commitment.” *Id.* at 420. In cases where the individual with mental illness is a minor, the Court has found that due processes does not require an adversarial hearing for parent-initiated petitions; rather, with parental consent, the decision of a trained psychiatrist is sufficient to “render psychiatric judgements.” *Parham v. J.R.*, 442 U.S. 584, 607 (1979) (quoting *In re Roger S.*, 569 P.2d 1286, 1299 (Cal. 1977) (Clark, J., dissenting)).

118. *See, e.g., Youngberg v. Romeo*, 457 U.S. 307, 316, 319, 320 (1982) (holding that civilly committed individuals have due process rights to safe conditions and “freedom from bodily restraint,” but that these rights are bounded by the “necessary . . . balance” between “the liberty of the individual’ and ‘the demands of an organized society.” (quoting *Poe v. Ullman*, 367 U.S. 497, 542 (1961))). This accords with the Court’s findings of the state’s interest in controlling medical decision making over the right of a non-committed patient to make decisions about his or her own care, as discussed in notes 102–105 and accompanying texts.

C. LEGAL PROTECTIONS DURING PRETRIAL DETENTION AND IN PRISON

The Supreme Court has never defined the boundaries of a civilly committed person's right to refuse treatment.¹¹⁹ However, the Court has delineated substantive and procedural due process rights in the contexts of pretrial commitment and prison. In the landmark case *Washington v. Harper*, the Supreme Court laid down the substantive and procedural due process boundaries for involuntary antipsychotic treatment of convicted inmates.¹²⁰ To determine "reasonableness," any prison regulation (here, establishing a procedure for involuntary treatment of mentally ill inmates) must first be premised on a "valid, rational connection" . . . [with] the legitimate governmental interest put forward to justify it."¹²¹ Further, *Harper* requires a decisionmaker to "consider 'the impact accommodation of the asserted constitutional right will have on guards and other inmates, and on the allocation of prison resources generally.'"¹²² Finally, a decisionmaker

119. *Cf. Mills v. Rogers*, 457 U.S. 291, 305 (1982) ("[I]t would be inappropriate for us to attempt to weigh or even to identify relevant liberty interests that might be derived directly from the Constitution, independently of [Massachusetts] state law."). In *Mills*, the operative question was "whether an involuntarily committed mental patient has a constitutional right to refuse treatment with antipsychotic drugs." *Id.* at 298–99 (footnote omitted). Subsequently, the Supreme Judicial Court of Massachusetts ruled that while involuntary commitment itself is not sufficient to overcome a patient's right to refuse antipsychotic medication, where a judge has ruled a patient incompetent, a court may act in substituted judgment on behalf of the patient in accepting the treatment plan. *Rogers v. Comm'r of Dep't of Mental Health*, 458 N.E.2d 308, 318 (Mass. 1983) (discussing how a judge should determine whether to "approve a substituted judgment treatment plan"). This rule is cited as the seminal ruling regarding the right of involuntarily committed patients to refuse treatment. *See, e.g.*, Hal S. Wortzel, *The Right to Refuse Treatment*, 23 PSYCHIATRIC TIMES (Dec. 1, 2006), <https://www.psychiatristimes.com/right-refuse-treatment/> (situating the *Rogers* case within current legal doctrines surrounding patients' right to refuse treatment generally).

120. 494 U.S. 210, 233–36 (1990).

121. *Id.* at 224 (quoting *Turner v. Safley*, 482 U.S. 78, 89 (1987)).

122. *Id.* at 225 (quoting *Turner*, 482 U.S. at 90). Ruling on the statutory requirements of Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12131 *et seq.*, the Supreme Court held that states must:

provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.

must consider “the absence of ready alternatives [a]s evidence of the reasonableness of a prison regulation.”¹²³

Applying these principles, the *Harper* court found that involuntary antipsychotic administration in prison does not require a “judicial decisionmaker.”¹²⁴ Instead, absent “institutional biases [that] affect[] or alter[] the decision to medicate respondent against his will,” an administrative hearing panel composed of individuals who are not “involved in the inmate’s current treatment or diagnosis” meets procedural due process requirements.¹²⁵ The Court balanced the liberty interest of an inmate in refusing treatment with the “legitimacy and the importance of the governmental interest.”¹²⁶ Substantively, the involuntary antipsychotic medication must be “medically appropriate”¹²⁷ and its administration, in accordance with prison

Olmstead v. L.C., 527 U.S. 581, 607 (1999). The court “confined” its review to statutory grounds, failing to reach the question of whether the Due Process Clause of the Fourteenth Amendment similarly required outpatient commitment where reasonable. *Id.* at 588. Contemporary critics of *Olmstead* contend that it fails to require states to establish community-based treatment programs and is therefore insufficiently protective of patient rights under the ADA. *See, e.g.*, Paul S. Appelbaum, *Least Restrictive Alternative Revisited: Olmstead’s Uncertain Mandate for Community-Based Care*, 50 PSYCHIATRIC SERVS. 1271, 1272 (1999) (“Whatever else it may accomplish, the decision in *Olmstead* . . . is unlikely to precipitate the widespread creation of community-based services for persons with mental disabilities.”). Similar considerations also plague the application of the ADA in prisons. *Cf., e.g.*, *Edison v. Douberly*, 604 F.3d 1307, 1310 (11th Cir. 2010) (*reh’g denied*) (finding privately owned prisons are not covered under Title II of the ADA). *But see* Letter from Thomas E. Perez, Ass’t Att’y Gen., U.S. Dep’t of Justice Civil Rights Div. & David J. Hickton, U.S. Att’y, U.S. Att’y’s Office, W.D. Pa., to Hon. Tom Corbett, Pa. Governor (May 31, 2013), https://www.justice.gov/sites/default/files/crt/legacy/2013/06/03/cresson_findings_5-31-13.pdf) (concluding that a prison’s use of prolonged isolation of mentally ill inmates without appropriate medical treatment in the setting of a “flawed” review process violated Title II of the ADA).

123. *Harper*, 494 U.S. at 225 (quoting *Turner*, 482 U.S. at 90–91) (internal quotation marks omitted). This does not place a requirement on prison officials to “shoot down every conceivable alternative method of accommodating the claimant’s constitutional complaint.” *Id.*

124. *Id.* at 228, 233.

125. *Id.* at 233.

126. *Id.* at 225. The Court opined that “[t]here are few cases in which the State’s interest in combating the danger posed by a person to both himself and others is greater than in a prison environment, which, ‘by definition,’ is made up of persons with ‘a demonstrated proclivity for antisocial criminal, and often violent, conduct.’” *Id.* (quoting *Hudson v. Palmer*, 468 U.S. 517, 526 (1984)).

127. *Id.* at 222 n.8 (“That an inmate is mentally ill and dangerous is a necessary condition to medication, but not a sufficient condition; before the hearing

policy, must be “reasonably related to legitimate penological interests.”¹²⁸ In practice, due process is satisfied if “the inmate is dangerous to himself or others and the treatment is in the inmate’s medical interest.”¹²⁹

In *Riggins v. Nevada*, the Supreme Court addressed involuntary medication the context of pretrial detention.¹³⁰ The Court held that the government “certainly would have satisfied due process if the prosecution had demonstrated, and the District Court had found, that treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of [the defendant’s] own safety or the safety of others.”¹³¹ Importantly, the *Riggins* court took issue with “the District Court allow[ing] administration of [an antipsychotic] to continue without making any determination of the need for this course or any findings about reasonable alternatives.”¹³² The *Riggins* case is unique insofar as the defendant was later adjudged competent (even in the absence of medication) to stand trial. By contrast, *Sell v. United States* involved an incompetent defendant, and asked whether involuntary antipsychotic medication could be used to restore his competency for trial.¹³³ Expanding *Harper* and *Riggins*, the Court held that:

the Constitution permits the Government involuntarily to administer antipsychotic drugs to a mentally ill defendant facing serious criminal charges in order to render that defendant competent to stand trial, but only if the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the fairness of the trial, and,

committee determines whether these requirements are met, the inmate’s treating physician must first make the decision that medication is appropriate.”).

128. *Id.* at 223 (quoting *Turner v. Safley*, 482 U.S. 78, 89 (1987)) (internal quotation marks omitted).

129. *Id.* at 227.

130. 504 U.S. 127 (1992).

131. *Id.* at 136 (citing *Harper*, 494 U.S. at 225–26).

132. *Id.* The Court was also frustrated by the manner in which the district court conducted itself. *Id.* at 137 (noting “the court’s laconic order denying *Riggins*’ motion” and failure to “acknowledge the defendant’s liberty interest in freedom from unwanted antipsychotic drugs.”).

133. *Sell v. United States*, 539 U.S. 166, 178 (2003) (evaluating whether “forced administration of antipsychotic drugs to render [an individual] competent to stand trial unconstitutionally deprive[s] him of his ‘liberty’ to reject medical treatment”).

taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests.¹³⁴

Each step in the *Sell* analysis requires a balance between the state interest in advancing a criminal trial against a defendant and a defendant's interest in avoiding unwanted medication.¹³⁵ In both *Riggins* and *Sell* the Court was interested in restoration of competency as a sole justification for involuntary antipsychotic administration and the potential prejudicial effect treatment would have at trial.¹³⁶ Each case suggests that the "dangerousness" prong of *Harper* represents an independent rationale for involuntary antipsychotic administration which does not require the additional analysis laid out in *Sell*.¹³⁷ The Court, however, has never reached the question of whether medication can be forcibly administered to a legally *competent* or *incompetent* defendant or inmate who maintains the mental *capacity* to make decisions about his or her health care. However, the *Sell* court, in dicta, suggested that civil mechanisms prescribed by state law should guide courts' decisions regarding the imposition of substituted judgment when capacity is at issue.¹³⁸

134. *Id.* at 179. Ultimately, the Court found in favor of defendant on the basis that the record was not developed with regard to whether side effects of antipsychotic treatment (namely drowsiness) might negatively impact his demeanor at trial. *Id.* at 185–86 ("We cannot tell whether the side effects of antipsychotic medication were likely to undermine the fairness of a trial in *Sell*'s case."). Further, the lower courts failed to contemplate whether involuntary medication would lengthen the amount of time *Sell* would spend in a mental health facility, militating against the government's interest in adjudging him guilty to serve punishment by lengthening his pretrial detention. *Id.* at 186 ("[T]he lower courts did not consider that *Sell* has already been confined at the Medical Center for a long period of time, and that his refusal to take antipsychotic drugs might result in further lengthy confinement.").

135. *See generally id.* at 180–81 (listing, in detail, the four elements the government must prove, and factors that affect the government's interests).

136. *See id.* at 186 (noting the potential interference with the "fairness" of a subsequent trial); *Riggins*, 504 U.S. at 138 ("[W]e have no basis for saying that the substantial probability of trial prejudice in this case was justified.").

137. *See, e.g., Sell*, 539 U.S. at 178 ("[T]he 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." (quoting *Washington v. Harper*, 494 U.S. 210, 227 (1990)) (internal quotation marks omitted)).

138. *See Sell*, 539 U.S. at 182 ("Every State provides avenues through which, for example, a doctor or institution can seek appointment of a guardian with the power to make a decision authorizing medication—when in the best interests of a patient who lacks the mental competence to make such a decision." (citation omitted)).

Despite imprisonment, inmates retain due process protections for some other liberty interests.¹³⁹ In *Hewitt v. Helms*, the Supreme Court ruled that Pennsylvania inmates had a statutorily-created liberty interest in remaining in the general population.¹⁴⁰ However, subsequently, in *Sandin v. Conner*, the Court abandoned the test used in *Hewitt* without overruling it.¹⁴¹ While state statutes can create liberty interests for inmates, “these interests will be generally limited to freedom from restraint . . . while not exceeding the sentence in such an unexpected manner as to give rise to protection by the Due Process Clause of its own force.”¹⁴² In practice, the *Sandin* ruling does not completely immunize administrative segregation decisions made by prison officials from constitutional claims of due process

139. *Cf. Hewitt v. Helms*, 459 U.S. 460, 467 (1983) (“We have repeatedly said both that prison officials have broad administrative and discretionary authority over the institutions they manage and that lawfully incarcerated persons *retain only a narrow range of protected liberty interests*.” (emphasis added)); *cf. also, e.g., McKune v. Lile*, 536 U.S. 24, 36 (2017) (“The privilege against self-incrimination does not terminate at the jailhouse door, but the fact of a valid conviction and the ensuing restrictions on liberty are essential to the Fifth Amendment analysis.”).

140. *See Hewitt*, 459 U.S. at 470–71 (“[W]e conclude in the light of the Pennsylvania statutes and regulations here in question . . . that respondent did acquire a protected liberty interest in remaining in the general prison population.”).

141. *See Sandin v. Conner*, 515 U.S. 472, 483 n.5 (1995) (“Such abandonment of *Hewitt*’s methodology does not technically require us to overrule any holding of this Court.”).

142. *Id.* at 484; *see also Wilkinson v. Austin*, 545 U.S. 209, 223–24 (2005) (finding the Due Process Clause was implicated when an inmate was transferred to a Supermax facility where “almost all human contact is prohibited, even to the point that conversation is not permitted from cell to cell; the light, though it may be dimmed, is on for 24 hours; exercise is for 1 hour per day, but only in a small indoor room” and the term of confinement is indefinite with only annual review); *Meachum v. Fano*, 427 U.S. 215, 228 (1976) (“Whatever expectation the prisoner may have in remaining at a particular prison so long as he behaves himself, it is too ephemeral and insubstantial to trigger procedural due process protections as long as prison officials have discretion to transfer him for whatever reason or for no reason at all.”). *But see Wolff v. McDonnell*, 418 U.S. 539, 557 (1974) (“[T]he State having created the right to good time and itself recognizing that its deprivation is a sanction authorized for major misconduct, the prisoner’s interest has real substance and is sufficiently embraced within Fourteenth Amendment ‘liberty’ to entitle him to those minimum procedures appropriate under the circumstances and required by the Due Process Clause to insure [sic] that the state-created right is not arbitrarily abrogated.”).

violation.¹⁴³ Even without an asserted statutory right, due process protections are triggered by “transfer to a mental hospital for involuntary psychiatric treatment” due to “the stigmatizing consequences . . . [and] mandatory behavior modification as a treatment.”¹⁴⁴

IV. MEDICAL SEGREGATION AS A TREATMENT MODALITY

A. APPLYING EXISTING LAW TO MEDICAL SEGREGATION IN PRISON

As described above, medical segregation can be divided into three broad categories: off-site medical segregation, medical segregation in solitary-confinement-like conditions, and medical segregation in “intermediate security” housing. Each of these conditions may implicate a different legal test to determine whether they “exceed[] the sentence in . . . an unexpected manner” and are therefore entitled to due process protections under the Fourteenth Amendment.¹⁴⁵ Courts have considered different factors when applying due process protections to supermax confinement¹⁴⁶ or long-term punitive segregation without review,¹⁴⁷ revocation of “good time credit” resulting in a longer prison

143. See, e.g., *Marion v. Columbia Corr. Inst.*, 559 F.3d 693, 694 (7th Cir. 2009) (“[W]e hold that the 240 days of segregation in this case was sufficiently long to implicate a cognizable liberty interest if the conditions of confinement during that period were sufficiently severe.”); cf., e.g., *Sealey v. Giltner*, 197 F.3d 578, 587 n.7 (2d Cir. 1999) (“[I]f conditions were of sufficient harshness that confinement for 365 days constituted atypicality, an official who held a hearing for a prisoner already confined in such conditions for 364 days would normally have to accord procedural due process before continuing the confinement beyond an aggregate interval of 365 days.”).

144. *Vitek v. Jones*, 445 U.S. 480, 494 (1980).

145. See *supra* Part III.C.

146. *Wilkinson v. Austin*, 545 U.S. 209, 223–24 (2005).

147. See *Marion*, 559 F.3d at 697 (“The Supreme Court’s decisions in *Sandin* and *Wilkinson* establish that disciplinary segregation can trigger due process protections depending on the duration and conditions of segregation.”); cf., e.g., *Townsend v. Fuchs*, 522 F.3d 765, 772 (7th Cir. 2008) (“[B]ecause Townsend’s placement in [temporary lock-up] neither was indefinite, nor affected his parole eligibility, nothing in *Wilkinson* requires us to reconsider our established position that inmates have no liberty interest in avoiding placement in discretionary segregation.”).

term,¹⁴⁸ transfer to a mental hospital,¹⁴⁹ and involuntary anti-psychotic administration.¹⁵⁰ All have been held to implicate liberty interests; however, none of these due process analyses are adequate to capture the particular harms of medical segregation to the liberty interests of mentally ill inmates.

1. Comparing Medical Segregation to Solitary Confinement

To compare medical segregation to solitary confinement the practice must be situated on a continuum between the circumstances of *Sandin v. Conner* and the circumstances of *Marion v. Columbia Correctional Institute*.¹⁵¹ In *Sandin*, respondent inmate was sentenced to thirty days of disciplinary segregation; in *Marion*, appellant inmate was sentenced to 240 days of segregation.¹⁵² In both cases, the inmates were not allowed to proffer witnesses to testify that the alleged disciplinary infraction did not occur.¹⁵³

In *Sandin*, the Supreme Court only considered the short duration of disciplinary segregation when it determined that the “nature of the deprivation” was contained “within the expected parameters of the sentence imposed by a court of law.”¹⁵⁴ In *Marion*, however, the Seventh Circuit looked beyond the mere duration of confinement to the “conditions of the segregation” specifically asking whether “the conditions of segregation were significantly harsher than those in the normal prison environment.”¹⁵⁵ Conditions that violate that liberty interest, the Seventh Circuit opined, include “more restrictive prison conditions if those conditions result in an ‘atypical and significant hardship’

148. *Meachum v. Fano*, 427 U.S. 215, 228 (1976).

149. *Vitek*, 445 U.S. at 494.

150. *Washington v. Harper*, 494 U.S. 210, 213 (1990).

151. *See generally* *Sealy v. Giltner*, 197 F.3d 578 (2d Cir. 1999) (looking at this continuum to determine whether due process was implicated).

152. *Compare* *Sandin v. Conner*, 515 U.S. 472, 475–76 (1995) (describing the alleged violation of liberty interest), *with* *Marion v. Columbia Corr. Inst.*, 559 F.3d 693, 695 (7th Cir. 2009) (construing *Sandin* and describing the duration of disciplinary segregation).

153. *See Sandin*, 515 U.S. at 475; *Marion*, 559 F.3d at 695.

154. *Sandin*, 515 U.S. at 481, 485–86.

155. *Marion*, 559 F.3d at 698 (quoting *Bryan v. Duckworth*, 88 F.3d 431, 433 (1996)) (internal quotation marks omitted). Note that the Seventh Circuit only examines conditions if confinement extends beyond six months. *Id.*

when compared to ‘the ordinary incidents of prison life.’¹⁵⁶ A similar test has been adopted by multiple circuits.¹⁵⁷ The Supreme Court has also looked to conditions beyond the mere duration of confinement when considering supermax detention and mental hospital transfers.¹⁵⁸

The New Jersey practice of automatic, near-universal medical segregation does not implicate the Fourteenth Amendment’s due process protections under punitive segregation case law. First, the policy is *discretionary*, rather than punitive.¹⁵⁹ In some jurisdictions non-punitive prison housing decisions are not subject to due process analysis.¹⁶⁰ Second, the *duration* of the involuntary antipsychotic protocol are relatively short¹⁶¹ and would not trigger due process protections in most jurisdictions.¹⁶²

156. *Townsend v. Fuchs*, 522 F.3d 765, 768 (7th Cir. 2008) (quoting *Sandin*, 515 U.S. at 484–86).

157. *See Harden-Bey v. Rutter*, 524 F.3d 789, 793 (6th Cir. 2008) (“[M]ost (if not all) of our sister circuits have considered the nature of the more-restrictive confinement *and* its duration in determining whether it imposes an ‘atypical and significant hardship.’”); *see also, e.g.*, *Wilkerson v. Goodwin*, 774 F.3d 845, 855 (5th Cir. 2014) (examining the restrictiveness of conditions); *Brown v. Pa. Dep’t of Corr.*, 290 Fed. Appx. 463, 465 (3d Cir. 2008) (noting that “[r]outine transfer” can require due process protections if the conditions pose unique hardship) (citing *Sandin*, 515 U.S. at 484); *Trujillo v. Williams*, 465 F.3d 1210, 1225 (10th Cir. 2006) (requiring trial courts to examine “whether . . . confinement was atypical and significant when compared to conditions imposed on other prisoners”). The Fifth Circuit wrote a detailed account of how its sister circuit courts use “conditions” in determining Fourteenth Amendment due process rights in the context of administrative segregation. *See Wilkerson*, 774 F.3d at 854–55 (“Courts have considered different baselines when determining what conditions are ‘atypical’ in a particular case.”).

158. *Wilkinson v. Austin*, 545 U.S. 209, 223–24 (2005) (analyzing factors affecting due process in a supermax prison transfer challenge); *Vitek v. Jones*, 445 U.S. 480, 494 (1980) (considering factors relevant to due process in the case of transfer from prison to a state mental hospital).

159. *See Salem et al.*, *supra* note 5, at 163; *cf.* NATASHA A. FROST & CARLOS E. MONTEIRO, ADMINISTRATIVE SEGREGATION IN U.S. PRISONS 5, 8 (2016) (comparing administrative segregation, which is discretionary, with punitive segregation which is not).

160. *See, e.g., Townsend*, 522 F.3d at 772 (citing *Holly v. Woolfolk*, 415 F.3d 678, 680 (7th Cir. 2005)) (“[B]eing placed in segregation is too trivial an incremental deprivation of a convicted prisoner’s liberty to trigger the duty of due process”).

161. *Salem et al.*, *supra* note 5, at 161 (describing the NJ DOC involuntary treatment protocol durations: 30 days, then 180 days between due process review and approval).

162. *See Marion v. Columbia Corr. Inst.*, 559 F.3d 693, 698 (7th Cir. 2009) (noting that “six months of segregation is ‘not such an extreme term’ and, standing alone, would not trigger due process rights”).

Third, the *conditions* described by Salem and colleagues do not implicate due process protections.¹⁶³ Finally, New Jersey's unwritten policy does not create a liberty interest in remaining free from medical segregation that would give rise to a claim under *Hewitt*.¹⁶⁴

In some penitentiary systems, however, medical segregation is little more than glorified solitary confinement.¹⁶⁵ In those jurisdictions inmates may have a colorable claim that medical segregation exceeds the expected parameters of an ordinary prison sentence. However, appellate courts have construed *Sandin* and *Wilkinson v. Austin*¹⁶⁶ narrowly and the precedent developed around solitary confinement is a poor fit in the context of medical segregation.¹⁶⁷ Using punitive segregation case law will be unavailing for most inmates seeking Fourteenth Amendment protections from capricious involuntary medical segregation. Perhaps due process protection from institutionalization in an off-site mental hospital provides protection from on-site medical segregation.

2. On-Site Medical Segregation and Stigmatization

In *Vitek v. Jones*, the Supreme Court recognized that transfer to a mental hospital from prison carried attendant “stigmatizing consequences” that inmates possess a liberty interest in

163. See Salem et al., *supra* note 5, at 163 (“There is no external pressure, as there is in a community hospital that is subject to an insurance company’s review, to discharge patients from the NJ DOC’s prison inpatient units. Inmates enjoy the relative security and enhanced programming and attention offered on the inpatient units. Indeed inmates, both mentally ill and not, occasionally feign symptoms to secure placement on an inpatient unit and avoid release from the same.”).

164. See *supra* notes 139–42 and accompanying text.

165. Cf., e.g., Alex Hundert, *Down in a Hole*, BRIARPATCH (Mar. 22, 2013), <https://briarpatchmagazine.com/articles/view/down-in-a-hole> (“‘They push you till you snap,’ a man imprisoned in these circumstances told me. Days later, the prison equivalent of a riot squad rushed his cell. Dressed in full storm trooper gear, they dragged him off to a separate section of the unit – medical segregation – and threw him into ‘the rubber room.’”); Maya Srikrishnan, *Documents Allege Serious Medical Neglect Inside Otay Mesa Detention Center*, KPBS (Aug. 15, 2019), <https://www.kpbs.org/news/2019/aug/15/documents-allege-serious-medical-neglect-inside-ot/> (comparing medical segregation in immigration detention centers to solitary confinement).

166. 545 U.S. 209 (2005).

167. E.g., *Holly v. Woolfolk*, 415 F.3d 678, 680 (7th Cir. 2005) (finding that nonpunitive segregation is “too trivial” to implicate due process rights).

remaining free from.¹⁶⁸ Could the same be true for on- or off-site medical segregation? Inmates labeled as mentally ill receive less attention from prison staff and guards,¹⁶⁹ potentially leading to an increased danger of suicide, self-harm, or harm to others.¹⁷⁰ Further, inmates who carry the stigma of mental illness “are often ostracized by other inmates.”¹⁷¹ Real and perceived ostracization negatively influence mental health outcomes¹⁷² and are linked to antisocial and aggressive behavior.¹⁷³ However, inmates and other plaintiffs have had mixed success convincing courts to extend *Vitek*’s “stigmatization” interest into other circumstances inside and outside the prison.¹⁷⁴

168. 445 U.S. 480, 494 (1980). The *Vitek* Court continued, “A criminal conviction and sentence of imprisonment extinguish an individual’s right to freedom from confinement for the term of his sentence, but they do not authorize the State to classify him as mentally ill and to subject him to involuntary psychiatric treatment without affording him additional due process protections.” *Id.* at 493–94.

169. *Cf.* Elizabeth Ford, *Why We Shouldn’t Stigmatize Mentally Ill Prisoners*, TIME (May 17, 2017), <https://time.com/4782404/prison-mental-health-stigma-suicide> (“Very few officers or health staff wanted to work in them.”).

170. *See id.* (attributing the death of a schizophrenic inmate in a Rikers Island mental health unit to stigmatization and inattention from guards and staff); Dean Aufderheide, *Toward a Public Safety/Public Health Model*, HEALTHAFFAIRS (Apr. 1, 2014), <https://www.healthaffairs.org/doi/10.1377/hblog20140401.038180/full/> (describing the effects of stigma on some mentally ill inmates). For instance, “[s]ome become overly passive, withdrawn and dependent during incarceration; others may become agitated, episodically violent, or engage in non-suicidal self-injurious behaviors.” *Id.* “[I]nmates with mental illness [are] often punished for their symptoms. As a result, the report noted, prisoners with mental illness often have extensive disciplinary histories.” *Id.* (citing HUMAN RIGHTS WATCH, ILL EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS (2009)).

171. Aufderheide, *supra* note 170.

172. *Cf., e.g.,* Eric D. Wesselmann et al., *Does Perceived Ostracism Contribute to Mental Health Concerns Among Veterans Who Have Been Deployed*, 13 PLOS ONE 8 (2018) (noting preliminary empirical evidence that perceived ostracism is linked with frequently occurring psychological problems in combat veterans).

173. *See, e.g.,* Beth Azar, *Singled Out*, 40 MONITOR PSYCH. 36, 38–40 (2009) (noting that antisocial and aggressive behaviors may stem from ostracism). *Cf., e.g.,* Wesselmann et al., *supra* note 172, at 6 (finding that perceived ostracism correlated with PTSD symptomatology and symptoms of anxiety).

174. *See* *Coleman v. Dretke*, 395 F.3d 216, 223–24 (2004) (finding that the stigmatizing effect of labeling an inmate a sex offender, despite no conviction with a sex offense to be “materially indistinguishable from *Vitek*”); *see also* *Foucha v. Louisiana*, 504 U.S. 71, 114 (1992) (Kennedy, J., dissenting) (“Stigmatization (our concern in *Vitek*) is simply not a relevant consideration where insanity acquittees are involved.”); *Jones v. United States*, 463 U.S. 354, 367

A large portion of penitentiaries lack inpatient wards for inmates with mental illnesses and must transfer inmates to community hospitals or state mental hospitals to provide the type of inpatient care available in the New Jersey prison system studied by Salem and colleagues.¹⁷⁵ Medical segregation in these penitentiaries involves taking inmates off-site to a mental hospital or equivalent. While not a “*transfer* to a mental hospital” per se, this is precisely the *type* of practice that *Vitek* found implicated the Fourteenth Amendment.¹⁷⁶ In contrast, when inmates receiving involuntary antipsychotic medication are kept in on-site inpatient wards, the *Vitek* argument is weaker because due process protections *do not* extend to “state action taken ‘within the sentence imposed.’”¹⁷⁷ Despite this, *Vitek* insists that transfer to a hospital or civil commitment-like setting may fall outside of the imposed sentence because of the stigmatization associated with the hospitalization itself.¹⁷⁸ However, unlike *Vitek*, off-site medical segregation in a community hospital is not an indefinite transfer and has a putative end date: when the involuntary treatment protocol expires.¹⁷⁹ Courts of appeal have been reluctant to find Fourteenth Amendment protections apply without an element of indefiniteness.¹⁸⁰ Ergo, the *Vitek* analysis also offers little protection to medically segregated, mentally ill inmates.

n.16 (1983) (“A criminal defendant who successfully raises the insanity defense necessarily is stigmatized by the verdict itself, and thus the commitment causes little additional harm in this respect”).

175. KARISHMA A. CHARI ET AL., NATIONAL SURVEY OF PRISON HEALTH CARE: SELECTED FINDINGS 5 (2016) (“Of the 45 participating states, 44 delivered outpatient mental health care exclusively on-site. In 27 states, inpatient mental health care was delivered exclusively on-site. Three states delivered inpatient mental health care exclusively off-site.”).

176. *Vitek v. Jones*, 445 U.S. 480, 496 (1980) (emphasis added). Namely, “classify[ing a prisoner] as mentally ill.” *Id.* at 493–94.

177. *Sandin v. Conner*, 515 U.S. 472, 480 (1995) (quoting *Hewitt v. Helms*, 459 U.S. 460, 478 (1983)).

178. *Vitek*, 445 U.S. at 494.

179. *Contra Townsend v. Fuchs*, 522 F.3d 765, 772 (7th Cir. 2008) (making indefiniteness and punitive-nature the requisite standard to trigger due process rights in the context of administrative segregation).

180. *Id.*; *cf. also* *Marion v. Columbia Corr. Inst.*, 559 F.3d 693, 694 (7th Cir. 2009) (finding 240 days of disciplinary segregation was sufficient to create a cognizable liberty interest under the Fourteenth Amendment).

If due process protections are to extend to all forms of arbitrary medical segregation, courts must look back into history, and recognize that just like involuntary pharmacotherapy (protected under *Harper*), confinement, segregation, and restraint are also anachronistic forms of treatment justified by clinical rationales. Therefore, medical segregation should trigger the same due process protections as involuntary medication.

B. REIMAGINING MEDICAL SEGREGATION AS A TREATMENT UNDER *HARPER*

If medical segregation is framed as a type of medical treatment, due process protections exist even if the duration and conditions of segregation are only nominally different from the expected parameters of an ordinary prison sentence and no statutorily created liberty interest exists. *Washington v. Harper* held that inmates have a liberty interest in avoiding involuntary treatment and defined the due process required to protect that interest.¹⁸¹ While the right to refuse treatment is colloquially viewed as the right to decline or discontinue medical *interventions*, patients in the community retain the right to remove themselves from the medical care setting entirely in most circumstances.¹⁸² Indeed, physicians who restrain patients or compel them to stay in a medical care facility without other legal justification can be subject to tort actions in false imprisonment.¹⁸³ The rationale supporting nonemergency involuntary

181. *Washington v. Harper*, 494 U.S. 210, 227 (1990) (“[T]he 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.”); see also *Vitek*, 445 U.S. at 493–94 (“A criminal conviction . . . do[es] not authorize the State to classify [a prisoner] as mentally ill and to subject him to involuntary psychiatric treatment without affording him additional due process protections.”).

182. So called “discharges against medical advice.” See generally David J. Alfandre, “*I’m Going Home*”: *Discharges Against Medical Advice*, 84 MAYO CLINIC PROC. 255 (2009).

183. See, e.g., Arthur H. Coleman, *False Imprisonment of a Patient*, 55 J. NAT’L MED. ASS’N 85, 85 (1963) (summarizing the seminal case *Maben v. Rankin*, 358 P.2d 681 (1961)).

antipsychotic treatment is explicitly tied to medical appropriateness as a matter of regulatory policy¹⁸⁴ and as a matter of constitutional law.¹⁸⁵ Reading *Harper*, *Riggins*, and *Sell* together, medical appropriateness is a threshold question for an involuntary treatment due process hearing in the setting of both pretrial detention and postconviction incarceration.¹⁸⁶

The constitutional interest in maintaining voluntary bodily integrity is not implicated by involuntary medical segregation. Nevertheless, involuntary medical segregation can be conceptualized as a form of medical treatment. Segregation has profound implications for clinical outcomes in the treatment of mental illness—both positive and negative¹⁸⁷—and plays a role in the prevention and early detection of important side effects.¹⁸⁸ As such, the practice should be treated with the same level of due process scrutiny as the actual antipsychotic treatment itself. The Con-

184. See, e.g., Salem et al., *supra* note 5, at 160 (“[NJ DOC policy provides that m]erely disruptive inmates may not be involuntarily medicated.”); cf. Andy Mannix, *At Urging of Minneapolis Police, Hennepin EMS Workers Subdued Dozens with a Powerful Sedative*, STARTRIBUNE (June 15, 2018), <https://www.startribune.com/at-urging-of-police-hennepin-emts-subdued-dozens-with-powerful-sedative/485607381/> (describing a draft change in Minneapolis police policy forbidding non-medical use of sedative drugs at the urging of law enforcement).

185. See *Harper*, 494 U.S. at 222 n.8 (“That an inmate is mentally ill and dangerous is a necessary condition to medication, but not a sufficient condition; before the hearing committee determines whether these requirements are met, the inmate’s treating physician must first make the decision that medication is appropriate.”).

186. *Id.*; *Sell v. United States*, 539 U.S. 166, 179 (2003) (“[T]he Constitution permits the Government involuntarily to administer antipsychotic drugs to a mentally ill defendant facing serious criminal charges in order to render that defendant competent to stand trial, but only if the treatment is medically appropriate”); *Riggins v. Nevada*, 504 U.S. 127, 135 (1992) (“Nevada certainly would have satisfied due process if the prosecution had demonstrated . . . that treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of Riggins’ own safety or the safety of others.”).

187. For example, the ability to monitor for potentially irreversible side effects of medication may be facilitated by close monitoring, thus attenuating the risk of treatment. Cf. *supra* notes 28–29 and accompanying text. Alternatively, however, mental health outcomes are poorer if a mentally ill individual is confined or restrained. Cf. AM. PSYCHIATRIC ASS’N, *supra* note 97. Also consider the abandonment of the practice of confining and restraining psychiatric patients in the late twentieth century because these were not effective *treatment modalities*. See generally discussion *supra* Part I.A.

188. See *supra* notes 28–29 and accompanying text.

stitution does not protect an inmate's liberty interest in remaining in the general population in the context of *explicitly punitive* administrative segregation.¹⁸⁹ However, it is another question entirely whether involuntary segregation for *explicitly medical* purposes escapes due process considerations.

Harper, *Riggins*, and *Sell* hold that the state must show treatment is medically necessary before asking whether there is a penological interest in involuntary treatment. If medical segregation is considered part of the treatment protocol and subjected to the *Harper* analysis, it is unlikely to be medically justified in most cases. Professional societies and advocacy groups argue involuntary inpatient *commitment* is more beneficial than treatment in *prison*, and involuntary *outpatient* commitment is more favorable than *inpatient* treatment.¹⁹⁰ These values are natural extensions of the historical trend away from confinement, isolation, and restraint in the treatment of psychiatric illness.¹⁹¹ Simply put, *restraint and confinement* are no longer considered appropriate medical modalities for the treatment of mental illness.¹⁹² This principle is acknowledged in state regulation prohibiting nonemergency antipsychotic administration in cases of belligerent, mentally ill inmates with no other medical indication.¹⁹³ Similarly, the use of neuroleptic medication for exclusively penological interests has been roundly criticized.¹⁹⁴ Even when some degree of confinement is medically necessary and legally warranted, it is understood that necessary medical confinement should not be punitive.¹⁹⁵

Because segregation has profound effects on medical outcomes, the government should be required to show that involuntary medical segregation serves a medical purpose, just like involuntary pharmaceutical treatment. If considered a form of treatment, inmates with mental illnesses are entitled to substantive and procedural due process protections prior to medical segregation. Additionally—while the balance between personal

189. *Hewitt v. Helms*, 459 U.S. 460 (1983) (*overruled in part by Sandin v. Conner*, 515 U.S. 472, 482 (1995)) (finding a statutory liberty interest in remaining in the general population).

190. *See supra* note 69 and accompanying text.

191. *See* discussion *supra* Parts I.B. & II.A.

192. *Id.*

193. *See* Salem et al., *supra* note 5, at 163.

194. *See supra* note 182 and accompanying text.

195. *Cf. AM, PSYCHIATRIC ASS'N*, *supra* note 97.

liberty interests and legitimate governmental interests is tipped in favor of the government in a penal setting—the absence of *any* due process protections against unnecessary medical segregation, confinement, or restraint in the prison system is out of alignment with the due process requirements for involuntary commitment to mental hospitals in the community.¹⁹⁶ The *Harper* analysis can be easily adapted to fill this role.

First, *Harper* already incorporates, as a preliminary matter, the requirement that treatment is medically necessary. Applying this prong to medical segregation *as a treatment* simply requires a preliminary showing from a treating psychiatrist that segregation is medically appropriate and is in the particular inmate's medical interest.¹⁹⁷ This has the benefit of preventing the removal of medically stable but mentally ill patients housed in the general population into a foreign, confined environment where psychological decompensation may occur. Second, the government must show a legitimate penological interest. While the *Harper* court indicated that being imprisoned essentially guaranteed a finding of legitimate penological interest,¹⁹⁸ the analysis provides a greater level of protection when pharmaceutical administration and medical segregation are reconceptualized as separate treatment modalities. When *Harper's* second prong is applied to medical segregation, the government must show that involuntary pharmaceutical treatment and segregation together further its penological interest more than pharmaceutical treatment alone. In many cases the argument that long term medical segregation is necessary due to inmate dangerousness will be

196. *Cf. Jackson v. Indiana*, 406 U.S. 715, 738 (“[D]ue process requires that the nature and duration of commitment must bear some reasonable relation to the purpose for which the individual is committed.”). In the community setting, this standard includes showing both a legitimate medical reason for commitment and a legitimate governmental interest, namely, the dangerousness standard that was universally adopted by the states by the 1970s. *See O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975) (noting that “‘mental illness’ alone cannot justify” confinement); *see also supra* Part III.B (discussing reforms to include a dangerousness standard for civil commitment).

197. Notably, *Riggins v. Nevada* stands for the proposition that involuntary medical treatment must be particularized to the individual, disease, and circumstances. 504 U.S. 127, 136 (1992) (demanding, in the pretrial setting, that a court must make a “determination of the need for *this* course [Mellaril] or . . . reasonable alternatives” (emphasis added)).

198. *Washington v. Harper*, 494 U.S. 210, 225–26 (1990) (“[T]he State’s interest in decreasing the danger to others necessarily encompasses an interest in providing him with medical treatment for his illness.”).

unavailing for the government¹⁹⁹ because individuals with serious mental illness who are *medicated* (not confined, restrained, or segregated) are no more dangerous than individuals without mental illness.²⁰⁰ In fact, segregation, confinement, and restraint may be counterproductive as these conditions have been shown to lead to increased antisocial and aggressive behaviors in mentally ill populations.²⁰¹

Further, evidence showing depot antipsychotics are as safe as short-acting oral antipsychotics makes meeting this standard more difficult.²⁰² When treating with oral medications, compliance must be verified by regular observation or blood work. One method of ensuring compliance is placing an inmate in inpatient medical segregation. Depot medications, on the other hand, last for weeks—obviating the need to medically segregate inmates to monitor for medication compliance. Similarly, the need to monitor for side effects is another medical justification for inpatient medical segregation. However, because rapid adjustments of dosage are precluded by depot medication, the need to titrate antipsychotic dosing under close supervision carries little weight as a justification for long-term medical segregation. In this sense, depot medications are a “ready alternative” to medical segregation.²⁰³ This does not mean that there can never be a medical justification for segregation of mentally ill inmates. Past medical history and poor or unpredictable responses to antipsychotic medication may necessitate closer monitoring of an inmate’s mental and physical status. Additionally, a mentally decompensated patient who threatens self-harm or harm to others may require closer monitoring. Alternatively, the increased risk of victimization among populations of inmates with mental illness may require segregation for protection of that inmate. The benefit of treating medical segregation as a separate treatment modality under *Harper* ensures that medical segregation is not a “go-to” measure used by prison officials to control the behavior

199. *Contra id.*

200. *Cf. supra* notes 67–68 and accompanying text.

201. *Cf. Aufderheide, supra* note 170.

202. *See supra* note 39 and accompanying text.

203. *Harper*, 494 U.S. at 224. However, *Harper*—relying on *Turner v. Safley*—also notes that allocation of prison resources must be considered when determining the constitutional validity of an involuntary treatment program. Accordingly, states may argue that they lack the resources to provide depot medications to inmates who wish to avoid prolonged medical segregation, thus overcoming this argument.

of mentally ill inmates. Rather, the government must articulate a particularized medical need for segregation.

Requiring the government to overcome a due process hurdle is critical to ensuring that inmates are not capriciously subjected to the anachronistic and defunct practice of confinement and restraint that typified psychiatric practice prior to the development of antipsychotic drugs. The *Harper* analysis is a pragmatic solution; it recognizes that there are some instances where a particular inmate may have an individual medical need for which segregation from the general population is appropriate. At the least, applying *Harper* would compel the government to articulate its medical and penological need for segregating, confining, or restraining a mentally ill inmate. Substantively, requiring that segregation be medically necessary for the individual inmate will ensure that prison officials cannot simply recite “magic words” to segregate all mentally ill inmates receiving antipsychotic treatment. Put another way, “[t]hat an inmate is mentally ill and dangerous is a necessary condition to” medically segregate, “but not a sufficient condition; before the hearing committee determines whether these requirements are met, the inmate’s treating physician must first make the decision that” medical segregation is appropriate.²⁰⁴

CONCLUSION

While involuntary medical segregation of inmates with mental illness may be necessary in some situations, New Jersey’s unwritten policy of automatic, near-universal medical segregation of inmates subjected to involuntary antipsychotic administration sweeps far too broadly. Just as the development of FGA agents obviated the need to restrain people with mental illness as a form of treatment, long-acting depot medications render involuntary medical segregation of mentally ill inmates largely redundant from a medical and penological standpoint. New Jersey’s unchecked policy of automatic medical segregation

204. *Id.* at 222 n.8. Note also that *Harper*-protocols are not indefinite and require periodic review. *See, e.g.*, Salem et al., *supra* note 5, at 160 (describing how protocol extensions are granted under New Jersey’s *Harper*-compliant involuntary antipsychotic administration procedure). At each renewal hearing for a *Harper* protocol, the State would be required to prove that segregation *remains* medically necessary. If there were an instance where extremely long medical confinement was approved, due process analysis under the *Sell* and *Wilkinson* would likely be triggered.

illustrates a defect in due process jurisprudence. Reconceptualizing medical segregation as a mode of treatment cures this defect by providing due process protections for an already acknowledged liberty interest in avoiding unwanted medical treatment under *Washington v. Harper*.

New Jersey's medical segregation housing units are largely indistinguishable from general population housing; however, this is not the case in many other state prison systems. In some states, medical segregation is little more than glorified solitary confinement. As societal norms and psychiatric practice have evolved to disfavor confinement, restraint, and segregation as methods for controlling the behavior of people with mental illness, efforts at reform have paradoxically led to a different form of restraint: imprisonment and medical segregation. The degree of confinement, restraint, and segregation faced by inmates with mental illness in various jurisdictions has not been systematically studied and remains shrouded in the unwritten policies of departments of corrections throughout the nation. Applying the due process protections promulgated by *Harper* to the practice of involuntary medical segregation for mental illness represents a modest step towards aligning the medical treatment of mentally ill inmates with modern psychiatric practice and the intended objectives of the deinstitutionalization movement.