

Restore, Revert, Repeat: Examining the Decompensation Cycle and the Due Process Limitations on the Treatment of Incompetent Defendants

Though correctional facilities are one of the largest providers of mental health care in the country, the treatment provided often fails to address the needs of many mentally ill inmates. Indeed, after receiving treatment at a state mental health facility, many pretrial detainees who have been recently restored to competency revert to an incompetent state—or decompensate—upon their return to jail, at which point they must return to the state treatment facility to be restored to competency once again. This Note is the first to explore this “decompensation cycle,” highlighting the significance of the problem and demonstrating how mental health treatment provided by correctional facilities, or the lack thereof, can lead to decompensation. Ultimately, this Note argues that the decompensation cycle and inadequate mental health treatment provided to recently restored pretrial detainees violates the Due Process Clause. Therefore, courts must step in and require jails to maintain the treatment regimen recommended by the state competency treatment facility. Furthermore, this Note advocates for the use of telemedicine in correctional facilities as one way to improve treatment and end the decompensation cycle.

INTRODUCTION.....	320
I. COMPETENCY IN THE CRIMINAL JUSTICE SYSTEM: RATIONALE AND RESTORATION.....	323
A. <i>Determining a Defendant’s Competency</i>	324
B. <i>Restoring a Defendant’s Competency</i>	326
II. THE DECOMPENSATION CYCLE: RESTORING COMPETENCY ONLY TO ALLOW REVERSION UPON RETURN TO JAIL	328
A. <i>A Snapshot of the Decompensation Cycle</i>	329
B. <i>Systemic Causes of Decompensation</i>	330

III.	LEGAL CHALLENGES TO THE DECOMPENSATION CYCLE: DUE PROCESS LIMITATIONS ON PRETRIAL DETENTION AND THE PROVISION OF MENTAL HEALTH TREATMENT.....	336
A.	<i>The Constitutional Right to Be Free from Punishment</i>	336
B.	<i>The Constitutional Right to Adequate Medical Treatment</i>	343
IV.	RESTORING INCOMPETENT DETAINEES' CONSTITUTIONAL RIGHTS: A MULTI-PRONGED APPROACH TO ENSURE ADEQUATE MENTAL HEALTH TREATMENT	348
A.	<i>A Familiar Approach: Relying on Courts to Enforce Prescribed Treatment</i>	349
B.	<i>A Twenty-First Century Approach: Using Telemedicine to Enhance Mental Health Treatment in Correctional Facilities</i>	352
	CONCLUSION	355

INTRODUCTION

The number of mentally ill individuals in the criminal justice system is staggering. The current population of jail or prison inmates with a mental illness surpasses the populations of cities like Cleveland, New Orleans, and St. Louis.¹ And each year, two million people with mental illnesses are booked into jails.² Indeed, the Bureau of Justice Statistics reported that fifty-six percent of state prisoners, forty-five percent of federal prisoners, and sixty-four percent of jail inmates suffer from a mental health problem.³ As a comparison, the rate of mental

1. Matt Ford, *America's Largest Mental Health Hospital Is a Jail*, ATLANTIC (June 8, 2015), <http://www.theatlantic.com/politics/archive/2015/06/americas-largest-mental-hospital-is-a-jail/395012/> [<https://perma.cc/3ZGH-4SKJ>]. A 2003 *New York Times* article reported that two correctional facilities—the Los Angeles County Jail and Rikers Island—were the two largest psychiatric inpatient institutions. Sally Satel, *Out of the Asylum, Into the Cell*, N.Y. TIMES (Nov. 1, 2003), <http://www.nytimes.com/2003/11/01/opinion/out-of-the-asylum-into-the-cell.html?pagewanted=1> [<https://perma.cc/S7QL-ZRXD>].

2. *Jailing People with Mental Illness*, NAT'L ALLIANCE ON MENTAL ILLNESS, <http://www.nami.org/Learn-More/Public-Policy/Jailing-People-with-Mental-Illness> (last visited Oct. 26, 2017) [<https://perma.cc/N2AV-57P9>].

3. DORIS J. JAMES & LAUREN E. GLAZE, U.S. DEP'T OF JUSTICE, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1 (2006), <http://www.bjs.gov/content/pub/pdf/mhppji.pdf> [<https://perma.cc/PDU7-KVX2>]. The actual rate of mental illness in correctional facilities varies based on the definition of mental illness, the study method, and the setting. See Henry J. Steadman et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 PSYCHIATRIC SERV. 761, 764 (2009); see also B. JAYE ANNO, U.S. DEP'T OF JUSTICE, CORRECTIONAL HEALTH CARE: GUIDELINES FOR THE MANAGEMENT OF AN ADEQUATE DELIVERY SYSTEM 172 (2001), <https://static.nicic.gov/Library/017521.pdf> [<http://perma.cc/S7UW-BN47>] (explaining that the

illness in the general population is estimated to be around eighteen percent.⁴ Moreover, between seven⁵ and fifteen percent of male inmates and thirty percent of female inmates suffer from a serious mental illness,⁶ compared to just four percent of adults in the general population.⁷

The prevalence of mental illness within the criminal justice system continues to grow over time⁸ due to a variety of factors, including the deinstitutionalization of state mental health facilities, lack of community health treatment, and aggressive prosecution for drug-related offenses.⁹ As a result, the largest correctional facilities now house more mentally ill individuals than many inpatient psychiatric facilities.¹⁰ However, the mental health treatment available in correctional facilities is ineffective in addressing inmates' mental health needs.¹¹ Numerous studies have demonstrated that inadequate treatment in correctional facilities exacerbates already-existing mental

variation in the rates of mental illness in prisons is largely a result of the differing definitions of mental illness).

4. *Prevalence of Any Mental Illness (AMI) Among U.S. Adults*, NAT'L INST. MENTAL HEALTH, <https://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-us-adults.shtml> (last visited Oct. 26, 2017) [<https://perma.cc/84CZ-H2S6>].

5. Maureen C. Olley et al., *Mentally Ill Individuals in Limbo: Obstacles and Opportunities for Providing Psychiatric Services to Corrections Inmates with Mental Illness*, 27 BEHAV. SCI. & L. 811, 815 (2009); T. Howard Stone, *Therapeutic Implications of Incarceration for Persons with Severe Mental Disorders: Searching for Rational Health Policy*, 24 AM. J. CRIM. L. 283, 287 (1997).

6. Steadman et al., *supra* note 3, at 764.

7. *Serious Mental Illness (SMI) Among U.S. Adults*, NAT'L INST. MENTAL HEALTH, <https://www.nimh.nih.gov/health/statistics/prevalence/serious-mental-illness-smi-among-us-adults.shtml> (last visited Oct. 26, 2017) [<https://perma.cc/X9KU-9JUK>].

8. See AZZA ABUDAGGA ET AL., PUB. CITIZEN'S HEALTH RESEARCH GRP. & THE TREATMENT ADVOCACY CTR., INDIVIDUALS WITH SERIOUS MENTAL ILLNESSES IN COUNTY JAILS: A SURVEY OF JAIL STAFF'S PERSPECTIVES 18 (2016), <http://www.treatmentadvocacycenter.org/storage/documents/jail-survey-report-2016.pdf> [<https://perma.cc/4MZC-JE9J>] (reporting that seventy-five percent of county jails participating in the survey reported higher numbers of severely mentally ill inmates from five to ten years prior). In California, only eleven percent of the prison population was mentally ill in 1998; by 2003, it had grown to sixteen percent and was expected to reach twenty percent shortly thereafter. SpearIt, *Mental Illness in Prison: Inmate Rehabilitation and Correctional Officers in Crisis*, 14 BERKELEY J. CRIM. L. 277, 280 (2009).

9. See, e.g., Stone, *supra* note 5, at 291–98 (describing the causes of the increase in mentally ill individuals in the criminal justice system).

10. KIDEUK KIM ET AL., THE PROCESSING AND TREATMENT OF MENTALLY ILL PERSONS IN THE CRIMINAL JUSTICE SYSTEM: A SCAN OF PRACTICE AND BACKGROUND ANALYSIS 9 (2015), <https://www.urban.org/sites/default/files/publication/48981/2000173-The-Processing-and-Treatment-of-Mentally-Ill-Persons-in-the-Criminal-Justice-System.pdf> [<https://perma.cc/6DKE-JRGT>]; see also Satel, *supra* note 1 (explaining that two correctional facilities are the largest providers of inpatient psychiatric care in the country).

11. See *infra* notes 84–107 and accompanying text.

illnesses and symptoms and contributes to the emergence of new psychiatric concerns.¹²

This is particularly problematic for individuals deemed incompetent to stand trial. Legal incompetence is distinct from, and considerably narrower than, mental illness. Mental illness is defined as a “disorder[] generally characterized by dysregulation of mood, thought, and/or behavior as recognized by the . . . American Psychiatric Association.”¹³ Mentally ill individuals are legally incompetent only when they do not have the ability to either consult with their lawyer or understand the proceedings against them.¹⁴ Defendants who meet the standard of incompetency receive restoration treatment—typically at an inpatient state mental health facility—that is designed to restore their mental status so that they can both understand and participate in their own trial.¹⁵ On average, individuals are restored to competency within ninety days.¹⁶ Prior to, and after receiving competency treatment, these individuals are often detained in jail to await treatment or trial, despite the fact that they have not been found guilty of any crime.¹⁷ Due to the inadequate mental health treatment provided at jails, however, many of these recently restored pretrial detainees revert back to an incompetent or delusional state before the trial begins, a phenomenon referred to as “decompensation.”¹⁸ At this point, the defendants must go back to the treatment facility to once again be restored to competency, before returning to jail again to wait for trial, creating a cycle of decompensation that can persist for *years*. As an example, in one notorious Florida case, the defendant, Bobby Lane McGee, bounced between competency restoration treatment and jail six times, resulting in a seventeen-year delay in his trial and ultimate conviction—costing the state \$1.3 million.¹⁹

Though scholars have been unable to quantify the prevalence or severity of the decompensation cycle thus far, it is clear that McGee’s

12. See, e.g., Jamie Fellner, *A Corrections Quandary: Mental Illness and Prison Rules*, 41 HARV. C.R.-C.L.L. REV. 391, 394 (2006) (explaining that correctional facilities cannot “provide the range of services mentally ill prisoners need,” leading to deterioration).

13. *Mental Illness*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/mentalhealth/basics/mental-illness.htm> (last visited Oct. 26, 2017) [<https://perma.cc/2MHD-TGKU>].

14. See *Dusky v. United States*, 362 U.S. 402, 402 (1960) (per curiam) (describing the competency standard to proceed to trial); see also *infra* Section I.A.

15. For information on competency restoration, see *infra* Section I.B.

16. See *infra* note 57 and accompanying text.

17. See *infra* note 112 and accompanying text.

18. See *infra* notes 58–74 and accompanying text.

19. Michael Braga et al., *Definition of Insanity*, TAMPA BAY TIMES (Dec. 18, 2015), <http://www.tampabay.com/projects/2015/investigations/florida-mental-health-hospitals/competency/> [<https://perma.cc/4LH2-Y7LN>].

story is not unique. Indeed, in Florida alone, approximately two hundred pretrial detainees are sent back to the state's mental health facility within twelve months of returning to jail after restoration.²⁰ And yet, the decompensation cycle remains a relatively unexplored phenomenon within the criminal justice system and legal literature. This Note remedies that by illuminating the source and significance of the decompensation cycle, ultimately arguing that the decompensation cycle violates pretrial detainees' constitutional rights.

This Note proceeds in four parts. Part I establishes the constitutional requirements of competency, describes the competency evaluation and hearing process, and summarizes the basic components of competency restoration treatment. Part II discusses the significance of the decompensation cycle. Section A provides a snapshot of the decompensation cycle within the criminal justice system. Section B then establishes the causes of decompensation, highlighting in particular the inadequate mental health treatment provided at correctional facilities and the detrimental effects of the structure of our current institutions on mentally ill individuals. Part III explores the constitutional implications of the decompensation cycle, detailing the Supreme Court jurisprudence protecting pretrial detainees' substantive due process rights. Finally, Part IV argues that judges must order jails to continue treatment recommended by the state's competency treatment program. Further, it offers the concrete suggestion that correctional facilities rely on telemedicine to support such efforts, highlighting how these efforts can both save money and create efficiencies within the criminal justice system.

I. COMPETENCY IN THE CRIMINAL JUSTICE SYSTEM: RATIONALE AND RESTORATION

Mental illness can affect an individual's trajectory through the criminal justice system at numerous points. For instance, instead of making an arrest, police officers may choose to divert mentally ill individuals out of the criminal justice system.²¹ At trial, factfinders may determine that individuals who were mentally ill at the time of the

20. *Id.*

21. *See, e.g.,* LINDA A. TEPLIN, NAT'L INST. OF JUSTICE, KEEPING THE PEACE: POLICE DISCRETION AND MENTALLY ILL PERSONS 10–11 (2000), <https://www.ncjrs.gov/pdffiles1/jr000244c.pdf> [<https://perma.cc/DX4A-8Y5W>] (explaining how police may choose to handle a mentally ill individual creating a disturbance); Amy C. Watson et al., *Improving Police Response to Persons with Mental Illness: A Multi-Level Conceptualization of CIT*, 31 INT'L J.L. & PSYCHIATRY 359 (2008) (describing Crisis Intervention Teams as a way law enforcement diverts mentally ill individuals from jail).

crime are not guilty by reason of insanity, and thus should not be sent to prison.²² Additionally, a judge may find that an individual is not competent at the time of trial and halt the legal proceedings until the defendant is restored to competency—the focus of this Note. This Part will explain the constitutional standard of competency and the rationale for this requirement before discussing the judicial procedures for determining competency and the process for restoring competency.

A. *Determining a Defendant's Competency*

Dating back as far as the seventeenth century, English common law required that defendants be competent in order to stand trial, receive judgment, or be executed.²³ Following this tradition, courts in the United States declared early in this country's history that “[i]t is fundamental that an insane person can neither plea to an arraignment, be subjected to trial, or, after trial, receive judgment, or after judgment, [undergo] punishment.”²⁴ Most importantly, the Supreme Court determined that the U.S. Constitution requires that defendants brought to trial be competent.²⁵ This requirement serves several purposes. Primarily, it promotes accuracy and reliability in the judicial system; only a competent defendant can spot inaccuracies in the prosecution's case or share relevant and important information with his or her attorney and the court.²⁶ It also protects numerous constitutional rights, including due process, the right to effective assistance of counsel, confrontation rights, and the right to testify on one's behalf.²⁷ Finally, the competency requirement ensures the fair and just reputation of the criminal justice system.²⁸

22. Despite public perception, the insanity defense is used infrequently. Nationwide, approximately “one percent of felony defendants . . . raise the insanity defense,” and only 0.002 percent are successful in pleading the defense. Julie E. Grachek, *The Insanity Defense in the Twenty-First Century: How Recent United States Supreme Court Case Law Can Improve the System*, 81 IND. L.J. 1479, 1487–88 (2006).

23. Fatma E. Marouf, *Incompetent but Deportable: The Case for a Right to Mental Competence in Removal Proceedings*, 65 HASTINGS L.J. 929, 939 (2014); see also *Medina v. California*, 505 U.S. 437, 446 (1992) (“The rule that a criminal defendant who is incompetent should not be required to stand trial has deep roots in our common-law heritage.”); Bruce J. Winick, *Competency to Stand Trial: Developments in the Law*, in 6 PERSPECTIVES IN LAW & PSYCHOLOGY 3 (Bruce Dennis Sales ed., 1983) (tracing the incompetency doctrine to its common-law origins).

24. See, e.g., *Youtsey v. United States*, 97 F. 937, 940 (6th Cir. 1899).

25. *Dusky v. United States*, 362 U.S. 402, 402 (1960) (per curiam).

26. Marouf, *supra* note 23, at 941.

27. *Id.*; Winick, *supra* note 23, at 5–6; see also *Drope v. Missouri*, 420 U.S. 162, 172 (1975) (noting that the competency requirement is “fundamental to an adversary system of justice”).

28. Marouf, *supra* note 23, at 941.

Defendants must be competent at every point of the criminal process.²⁹ Though the issue of competency is most often raised by the defendant's attorney, a number of different parties may raise a competency concern, including the prosecutor, judge, or an outside party like a police officer or family member.³⁰ Once a party has raised the issue and the court determines that a bona fide doubt of competency related to a mental illness exists, the defendant must undergo a competency evaluation.³¹ Because it can take months to receive a competency evaluation,³² some states allow a defendant to be released from jail to await the evaluation in the community.³³ In practice, however, few defendants are released from detention at this point.³⁴

Evaluations are performed by various mental health professionals in either an inpatient setting, outpatient facility, or even in the jail itself.³⁵ The Supreme Court established the modern standard for determining competency in the 1960 case *Dusky v. United States*.³⁶ Under this standard, a defendant must have "sufficient present ability

29. Winick, *supra* note 23, at 8–9; *see also* Wojtowicz v. United States, 550 F.2d 786, 790 (2d Cir. 1977) (finding that defendants must be competent even at the sentencing proceeding).

30. Winick, *supra* note 23, at 8–9; *see also* 18 U.S.C. § 4241 (2012) (providing the different ways competency can be challenged); *Drope*, 420 U.S. at 181 (“[A] trial court must always be alert to circumstances suggesting a change that would render the accused unable to meet the standards of competence to stand trial.”); AM. BAR ASS'N, CRIMINAL JUSTICE STANDARDS ON MENTAL HEALTH 31 std. 7-4.3 (4th ed. 2016), http://www.americanbar.org/content/dam/aba/publications/criminal_justice_standards/mental_health_standards_2016.authcheckdam.pdf [https://perma.cc/6REP-PNB6] (finding that the court “has a continuing obligation, separate and apart from that of counsel . . . to raise the issue of incompetence to proceed at any time the court has a good faith doubt as to the defendant's competence”).

31. Winick, *supra* note 23, at 9. Competency evaluations are the most common forensic evaluations ordered by criminal courts. W. Neil Gowensmith, *Lookin' for Beds in All the Wrong Places: Outpatient Competency Restoration as a Promising Approach to Modern Challenges*, 22 PSYCHOL. PUB. POL'Y & L. 293, 293 (2016). Approximately fifty-five thousand evaluations are ordered each year, and this number has only grown in recent years, paralleling the increase in the number of mentally ill offenders. *Id.*; Hal Wortzel et al., *Crisis in the Treatment of Incompetence to Proceed to Trial: Harbinger of a Systemic Illness*, 35 J. AM. ACAD. PSYCHIATRY & L. 357, 357 (2007). Indeed, a study by the Washington State Department of Social and Health Services found that defense attorneys were concerned about their client's competency in ten to fifteen percent of all cases. Michael J. Finkle et al., *Competency Courts: A Creative Solution for Restoring Competency to the Competency Process*, 27 BEHAV. SCI. & L. 767, 768 (2009).

32. In one case, the court found that pretrial detainees in Arkansas were waiting up to eight months just to receive inpatient competency evaluations. *Terry ex rel. Terry v. Hill*, 232 F. Supp. 2d 934, 938 (E.D. Ark. 2002).

33. *See* Winick, *supra* note 23, at 12 (noting that some statutes allow a defendant to be released on his recognizance after an evaluation is ordered). Historically, the state mental health facilities conducted competency evaluations. However, outpatient evaluations are becoming more common over time. CHRISTOPHER SLOBOGIN ET AL., LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 1142–43 (6th ed. 2013).

34. Winick, *supra* note 23, at 12.

35. Finkle et al., *supra* note 31, at 773.

36. 362 U.S. 402 (1960) (per curiam).

to consult with his lawyer with a reasonable degree of rational understanding—and . . . a rational as well as factual understanding of the proceedings against him.”³⁷ Although the wording differs slightly, all states rely on the *Dusky* standard to determine competency under state law.³⁸ This is a relatively easy standard to satisfy, allowing a severely mentally ill defendant—even one who may be overtly psychotic—to be found competent to stand trial.³⁹

After a defendant’s competency evaluation, the judge schedules a hearing to allow forensic experts to present written reports and provide testimony, if necessary, regarding the defendant’s competency.⁴⁰ Most often, there is little debate about a defendant’s competency, and therefore both parties will agree to accept the reports and avoid a formal hearing.⁴¹ If the court deems the defendant incompetent, he or she is ordered to receive competency treatment, and all legal proceedings must halt until the defendant’s competency is restored.⁴²

B. Restoring a Defendant’s Competency

Each year, approximately ten thousand to eighteen thousand defendants are deemed incompetent to stand trial.⁴³ In 2007, incompetent defendants receiving competency treatment occupied almost four thousand psychiatric hospital beds in the country, constituting more than ten percent of state psychiatric beds.⁴⁴ Competency treatment can occur in a variety of settings, and is dependent on the specific state statute and, often, the severity of the

37. *Id.* at 402.

38. Patricia A. Zapf & Ronald Roesch, *Mental Competency Evaluations: Guidelines for Judges and Attorneys*, 37 CT. REV. 28, 28 (2000).

39. Winick, *supra* note 23, at 8. For example, an individual diagnosed with schizophrenia and suffering from severe delusions may be deemed competent if he has the current ability to consult with his lawyer and generally understands the charges against him and the consequences of a conviction.

40. *Id.* at 13–14.

41. *Id.*

42. *Id.* at 5, 14.

43. Gowensmith, *supra* note 31, at 293; *see also* Finkle et al., *supra* note 31, at 775 (finding that between eighteen and twenty percent of defendants are deemed incompetent).

44. Wortzel et al., *supra* note 31, at 357. Today, incompetent detainees have surpassed the number of civil commitments in many states. *See* Meagan Flynn, *The Revolving Door Between Jail and Mental Health Care in Harris County*, HOUS. PRESS (Apr. 11, 2016, 7:00 AM), <http://www.houstonpress.com/news/the-revolving-door-between-jail-and-mental-health-care-in-harris-county-8312008> [<https://perma.cc/9TDQ-HNMB>] (finding that the State of Texas devotes more beds in the State’s mental health facilities to competency restoration than civil commitments).

charges.⁴⁵ For example, California state law mandates that incompetent defendants who are charged with specific felonies be placed in an inpatient setting for at least 180 days.⁴⁶ Meanwhile, many state statutes still provide for automatic inpatient treatment, whereby individuals are automatically sent to the state mental health facility to receive treatment for a set period of time or until competency is restored.⁴⁷ As the number of defendants requiring competency treatment has increased, many states have attempted various reforms of their restoration programs. By 2009, thirty-five states had statutes authorizing outpatient competency restoration—allowing people to attend treatment programs during the day while remaining in the community—but only sixteen of those states actually had active outpatient programs in place.⁴⁸ And, at least seven states have attempted jail-based restoration programs.⁴⁹ However, implementation of these efforts has been spotty⁵⁰ and the majority of competency treatment still occurs primarily at state inpatient mental health facilities.⁵¹

State inpatient facilities employ highly-trained staff who operate in interdisciplinary teams to provide individualized treatment plans to each person.⁵² The facilities often staff psychiatrists, psychiatric nurses, social workers, psychologists, and therapists, as well as guards with psychiatric training.⁵³ Treatment varies depending on the needs of the patient. Generally, however, restoration involves

45. Finkle et al., *supra* note 31, at 777. For a summary of how states distinguish between felony and misdemeanor charges, see *id.* at 770.

46. CAL. PENAL CODE § 1601(a) (West 2017). Specifically, the statute states that for anyone found incompetent who is charged with

murder, mayhem, aggravated mayhem . . . or any felony involving death, great bodily injury, or an act which poses a serious threat of bodily harm to another person, outpatient status . . . shall not be available until that person has actually been confined in a state hospital or other treatment facility for 180 days or more

Id.

47. Winick, *supra* note 23, at 14.

48. Reena Kapoor, *Commentary: Jail-Based Competency Restoration*, 39 J. AM. ACAD. PSYCHIATRY & L. 311, 311 (2011).

49. *Id.*

50. *Id.*; see also Alan R. Felthous, *Enforced Medication in Jails and Prisons: The New Asylums*, 8 ALB. GOV'T L. REV. 563, 587 (2015) (“Creation of a bona fide proper hospital unit within a non-medical correctional facility is a possibility, but it would be at a considerable expense, likely defeating the hope for budgetary savings from obviating hospital transfer.”).

51. See Gowensmith, *supra* note 31, at 295 (noting that while many states have begun using outpatient competency evaluations, the competency restoration treatment is still more commonly delivered inpatient in state hospitals).

52. See *Or. Advocacy Ctr. v. Mink*, 322 F.3d 1101, 1122 (9th Cir. 2003) (describing the staffing at the state’s competency treatment facility); *Advocacy Ctr. for the Elderly & Disabled v. La. Dep’t of Health & Hosps.*, 731 F. Supp. 2d 603, 611 (E.D. La. 2010) (same).

53. *Advocacy Ctr.*, 731 F. Supp. 2d at 612.

psychiatric medication, psychotherapy and social support activities, education about the legal process, and consistent evaluation.⁵⁴ Psychotropic medications, which alter an individual's brain processes, are the most widely used and effective treatment for psychiatric conditions resulting in incompetence.⁵⁵ However, many defendants also receive group and individual psychotherapy designed to help them restore and maintain function and modify long-term patterns of maladaptive behavior.⁵⁶ On average, competence can be restored within ninety to 180 days.⁵⁷

II. THE DECOMPENSATION CYCLE: RESTORING COMPETENCY ONLY TO ALLOW REVERSION UPON RETURN TO JAIL

After competency is restored, defendants return to jail to await their trial.⁵⁸ The period immediately following their return to jail is crucial. Depending on the length of time between their return and trial, as well as a host of other factors, pretrial detainees who have recently been restored to competency are at risk of reverting to a delusional or incompetent state.⁵⁹ If this occurs, the person must go back to the competency treatment facility to be restored to competency, before returning to jail again to await trial. If the circumstances in the jail do not change while an individual undergoes a second restoration treatment, the detainee is at risk of decompensating once again, creating a cycle of decompensation and restoration.

Individuals cycling through competency and incompetency are forced to endure significant pain and suffering. Many incompetent

54. Gowensmith, *supra* note 31, at 294.

55. Winick, *supra* note 23, at 22. Psychotropic, or psychoactive, medications are chemical substances that alter one's mental processes and brain function. *Psychoactive Substances*, WORLD HEALTH ORG., http://www.who.int/substance_abuse/terminology/psychoactive_substances/en/ (last visited Oct. 27, 2017) [<https://perma.cc/JXC3-6AQU>]. These can include antipsychotic, antidepressant, and anti-anxiety medications, as well as mood stabilizers. See *Fact Sheet: Commonly Prescribed Psychotropic Medications*, NAT'L ALLIANCE ON MENTAL ILLNESS, <http://www.namihelps.org/assets/PDFs/fact-sheets/Medications/Commonly-Psyc-Medications.pdf> (last visited Oct. 27, 2017) [<https://perma.cc/5E5L-VYTG>].

56. Kapoor, *supra* note 48, at 311–12; see also *Advocacy Ctr.*, 731 F. Supp. 2d at 612 (finding that trained staff at the state hospital provide prosocial activities, including group, individual, recreational, and occupational therapy); Stone, *supra* note 5, at 305–06 (explaining that therapy is a common form of treatment at competency restoration programs).

57. Finkle et al., *supra* note 31, at 775; Gowensmith, *supra* note 31, at 294.

58. Finkle et al., *supra* note 31, at 776. Alternatively, if a court finds that a defendant is not likely to be returned to competency, he may be released. See *Jackson v. Indiana*, 406 U.S. 715, 733 (1972) (reasoning that if an incompetent detainee does not improve or if the chances are slight, then he must be released or granted a hearing for civil commitment). Individuals treated in outpatient competency restoration programs may remain in the community to await their trial.

59. For the causes of the decompensation cycle, see *infra* Section II.B.

defendants are depressed and suicidal, and may attempt to take their lives while awaiting treatment in jail.⁶⁰ Others suffer from severe and debilitating delusions and hallucinations that affect their ability to understand reality and care for themselves.⁶¹ Additionally, many individuals exhibit physical symptoms of their mental state, suffering from severe physical pain or lack of appetite, which can cause significant weight loss.⁶² This Part explores the existence and causes of the decompensation cycle, highlighting how the provision of mental health treatment in jails contributes to decompensation.

A. A Snapshot of the Decompensation Cycle

Several scholars have highlighted the decompensation cycle as a significant problem within the criminal justice system.⁶³ Yet, despite general recognition of this phenomenon and isolated reports of its prevalence, it is difficult to quantify the extent to which this cycle actually occurs each year on a national or even statewide level.⁶⁴ One analysis reported that almost twenty percent of restored detainees in two Florida counties decompensate upon returning to jail.⁶⁵ And, across the entire state of Florida, approximately two hundred detainees each year must return to competency restoration treatment after they decompensate in jail.⁶⁶

60. See *Advocacy Ctr.*, 731 F. Supp. 2d at 613 (explaining that many incompetent defendants must be placed in isolation because they are a danger to themselves); *Terry ex rel. Terry v. Hill*, 232 F. Supp. 2d 934, 939 (E.D. Ark. 2002) (noting that one incompetent class member tried to kill himself three times before being transferred for evaluation and treatment).

61. See *Advocacy Ctr.*, 731 F. Supp. 2d at 615; *Terry*, 232 F. Supp. 2d at 939–40 (describing how one incompetent detainee “came to jail believing people were controlling his mind and that he could read other people’s minds”).

62. See *Terry*, 232 F. Supp. 2d at 940.

63. See, e.g., Anna Conley, *Getting Individuals Committed to the MT State Hospital Out of County Jails*, MONT. LAW., Nov. 2013, at 10, 11 (explaining that just a few weeks in jail without proper treatment “can lead to significant suffering and deterioration”); Finkle et al., *supra* note 31, at 771 (finding “systemic problems contribute to some mentally ill defendants getting caught in a cycle of competency and subsequent decompensation”); Allison D. Redlich et al., *Is Diversion Swift? Comparing Mental Health Court and Traditional Criminal Justice Processing*, 39 CRIM. JUST. & BEHAV. 420, 421 (2012) (highlighting that as a result of poor mental health treatment in jails, many detainees with serious mental illnesses decompensate); Stone, *supra* note 5, at 285–86 (finding that a lack of adequate resources for mental health treatment contributes to decompensation).

64. Finkle et al., *supra* note 31, at 776 (noting that the authors could not locate any literature quantifying the percentage of defendants who decompensate).

65. Braga et al., *supra* note 19.

66. *Id.*

Significant anecdotal evidence also demonstrates the magnitude of this issue.⁶⁷ A Florida newspaper recently explored how the decompensation cycle delayed the state from trying and convicting one incompetent pretrial detainee for almost two decades.⁶⁸ Bobby Lane McGee confessed to killing his wife in 1998, claiming that he “was being attacked by all kinds of demons.”⁶⁹ Doctors diagnosed him with schizophrenia and bipolar disorder, and after a competency evaluation the court deemed him incompetent to stand trial.⁷⁰ Over the next seventeen years, McGee was sent to the state mental health facility for competency restoration treatment six times.⁷¹ Each time, he was treated with psychotropic medications and restored to competency, only to return to jail and decompensate after he stopped taking his medications.⁷²

Courts have also highlighted the existence of the decompensation cycle. For example, the U.S. Court of Appeals for the Ninth Circuit has explained that the longer mentally ill detainees are in jail or prison, “the greater the likelihood they will decompensate and suffer unduly.”⁷³ Similarly, in a California case, one expert noted that “inmates usually decompensate quickly and require intensive psychiatric care and/or readmission to inpatient care.”⁷⁴

B. Systemic Causes of Decompensation

Several aspects of the criminal justice system contribute to decompensation. One potential cause may be the traditional methods of control relied on by correctional facilities, particularly isolation and transfers, which can easily exacerbate a mentally ill individual's

67. *Id.* (finding that restored detainees are sent back to jail and quickly decompensate without medication); Paul A. Romer, *Courts Struggle with “Conundrum”: Officials Not Sure How to Proceed with Incompetent Defendants*, TEMPLE DAILY TELEGRAM (Sept. 9, 2009), http://www.tdtnews.com/archive/article_af035552-0763-5072-a26d-91ec619f373f.html [<https://perma.cc/566H-NK4N>] (recognizing that after an incompetent defendant is restored to competency through medications and sent back to jail, “a lot of times, they’ll decompensate when they’re [back in jail]”).

68. Braga et al., *supra* note 19.

69. *Id.*

70. *Id.*

71. *Id.*

72. *Id.*; see also Curtis Krueger, *After Years of Mental Incompetence, Bobby McGee Faces Murder Trial in Pinellas*, TAMPA BAY TIMES (May 18, 2014, 10:08 PM), <http://www.tampabay.com/news/courts/criminal/after-years-of-mental-incompetence-bobby-mcgee-faces-murder-trial-in/2180395> [<https://perma.cc/88CF-HPC8>] (explaining that the jail did not have the equipment to forcibly medicate McGee when he refused to take his medications).

73. Or. Advocacy Ctr. v. Mink, 322 F.3d 1101, 1120 (9th Cir. 2003).

74. Madrid v. Gomez, 889 F. Supp. 1146, 1216 (N.D. Cal. 1995).

symptoms.⁷⁵ Often, jail and prison staff place inmates in isolation confinement to protect either the safety of the isolated inmate or others, await the inmate's transfer, punish the inmate for violating a facility rule, or to provide for an inmate with special needs—such as mental health.⁷⁶ While isolation occurs frequently in correctional facilities,⁷⁷ mentally ill inmates—including those recently restored to competency—are disproportionately placed in isolation or security housing units compared to the general prison population.⁷⁸ A recent Department of Justice report highlighted this discrepancy, finding that twenty-six percent of prison inmates and twenty-three percent of jail inmates with a mental health disorder were placed in restrictive housing at some point during the year, compared with fourteen percent of prison inmates and twelve percent of jail inmates without a mental illness.⁷⁹

While in isolation, inmates are often placed in small cells—sometimes not even large enough to fit a bed—for up to twenty-three hours a day.⁸⁰ Mental health treatment, and medical care in general, may be limited for individuals housed in these units. Despite the well-documented need for mental health treatment among this population, jails may knowingly choose to provide fewer psychiatric services to

75. NAT'L COAL. FOR THE MENTALLY ILL IN THE CRIMINAL JUSTICE SYS., MENTAL HEALTH IN AMERICA'S PRISONS 92 (Henry J. Steadman & Joseph J. Cocozza eds., 1993); *see also In re Medley*, 134 U.S. 160, 168 (1890):

A considerable number of the prisoners fell, after even a short confinement [in isolation], into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others, still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community.;

Advocacy Ctr. for the Elderly & Disabled v. La. Dep't of Health & Hosps., 731 F. Supp. 2d 603, 612 (E.D. La. 2010) (explaining that it is problematic that inmates do not feel safe when incarcerated because "it is important for psychotic patients to feel safe in their environment"). More broadly, studies have shown that just being detained in any correctional facility can exacerbate mental illnesses. *See, e.g.*, Michael L. Perlin & Meredith R. Schriver, "You Might Have Drugs at Your Command": *Reconsidering the Forced Drugging of Incompetent Pre-trial Detainees from the Perspective of International Human Rights and Income Inequality*, 8 ALB. GOV'T L. REV. 381, 392 (2015) (finding that detention exacerbates mental health symptoms).

76. ALLEN J. BECK, U.S. DEP'T OF JUSTICE, USE OF RESTRICTIVE HOUSING IN U.S. PRISONS AND JAILS, 2011–12, at 2 (2015); *see also Mink*, 322 F.3d at 1120 (finding that detainees exhibiting troublesome behavior may be locked in a cell for twenty-two to twenty-three hours a day).

77. Approximately twenty percent of prison inmates and eighteen percent of jail inmates are placed in some form of restrictive housing each year. BECK, *supra* note 76, at 1.

78. Fellner, *supra* note 12, at 402–03 (finding that between one-quarter and one-half of all inmates in isolation are mentally ill); *see also Advocacy Ctr.*, 731 F. Supp. 2d at 612 (finding that mentally ill inmates are more likely to be subject to discipline, resulting in segregation from other inmates); *Madrid*, 889 F. Supp. at 1223 (noting that mentally ill inmates are more likely to be housed in segregated housing units due to their disruptive behavior).

79. BECK, *supra* note 76, at 6.

80. *Mink*, 322 F.3d at 1120; *Madrid*, 889 F. Supp. at 1229.

those in isolation confinement.⁸¹ Indeed, the provision of mental health treatment is often limited to conversations with staff through the cell door, medication dispersal, and infrequent consultations with a psychiatrist.⁸² Any form of therapy is generally unavailable. Recently restored pretrial detainees—many of whom may still have behavioral problems—who are sent to restrictive housing may quickly decompensate due to the lack of care. For these reasons, at least one court has found that the use of security housing units for the severely mentally ill is unreasonable, as it is like “putting an asthmatic in a place with little air to breathe.”⁸³

More commonly, it is the systemic problems with the mental health treatment available in jails and prisons that contribute to the decompensation cycle.⁸⁴ Correctional facilities must provide mental health services, but can choose the method by which care is delivered.⁸⁵ For instance, a jail may choose to provide mental health treatment through medical staff in the jail’s own hospital facility, have small psychiatric units in the jail itself, rely on private contractors to provide services, or choose any combination of these methods.⁸⁶ Currently, twenty-seven states deliver inpatient mental health care in the jail setting and forty-five provide outpatient care in jail.⁸⁷

Despite this mandate, it is well established that jails and prisons—particularly smaller, rural facilities—are inadequately suited

81. *Madrid*, 889 F. Supp. at 1223.

82. Fellner, *supra* note 12, at 404.

83. *Madrid*, 889 F. Supp. at 1265. Additionally, the American Bar Association has recommended that prisons refrain from placing inmates with serious mental illnesses in isolation. AM. BAR ASS’N, ABA STANDARDS FOR CRIMINAL JUSTICE: TREATMENT OF PRISONERS 23-2.8(a) (3d ed. 2011) https://www.americanbar.org/content/dam/aba/publications/criminal_justice_standards/Treatment_of_Prisoners.authcheckdam.pdf [https://perma.cc/5CGU-G7NU] (“No prisoner diagnosed with serious mental illness should be placed in long-term segregated housing.”).

84. See Finkle et al., *supra* note 31, at 776 (describing several deficiencies within the mental health treatment provided to detainees at jails); Stone, *supra* note 5, at 286 (finding that inadequate mental health resources lead to this decompensation cycle); see also Conley, *supra* note 63, at 10–11 (noting that pretrial detainees awaiting competency evaluations may receive no treatment while waiting to be transferred).

85. See *DeShaney v. Winnebago Cty. Dep’t of Soc. Servs.*, 489 U.S. 189, 199–200 (“[W]hen the state takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being.”); JAMES & GLAZE, *supra* note 3, at 9 (explaining that correctional facilities may choose how to provide health care services).

86. NAT’L COAL. FOR THE MENTALLY ILL IN THE CRIMINAL JUSTICE SYS., *supra* note 75, at 47.

87. KARISHMA A. CHARI ET AL., U.S. DEP’T OF HEALTH & HUMAN SERVS., NO. 96, NATIONAL SURVEY OF PRISON HEALTH CARE: SELECTED FINDINGS 5 (2016). In this survey, inpatient mental health care was defined as care requiring an overnight stay. See *id.* at 19 (asking participating prison system administrators whether they offered “inpatient mental health (overnight)” or “outpatient mental health”). Generally, inpatient treatment addresses more serious health needs, while outpatient care offers treatment for illnesses that do not require a prolonged stay at a health facility.

to manage and treat mental and psychotic disorders.⁸⁸ For instance, the Bureau of Justice Statistics found that only one in three state prisoners and one in six jail inmates with mental health problems had received mental health treatment since admission.⁸⁹ Many jails—particularly small facilities—may be unwilling or unable to provide treatment beyond medication dispersal.⁹⁰

Staffing of health personnel at correctional facilities is often inadequate, both in terms of sheer numbers and training.⁹¹ For instance, a district court in Louisiana found that one part-time psychiatrist and one psychiatry resident (“who sees patients when necessary”) were responsible for caring for more than one thousand inmates.⁹² Meanwhile, at the Louisiana state mental health facility that provided competency restoration treatment, the ratio of psychiatrists to patients was one to thirty or thirty-five.⁹³ Further, small facilities may not have *any* medical staff with psychiatric training.⁹⁴ And, often, general prison staff receive minimal mental health training and may not even be informed that a detainee has been

88. See, e.g., Fellner, *supra* note 12, at 394 (describing the inadequacies in the criminal justice system in providing mental health treatment); Redlich et al., *supra* note 63, at 421 (noting the “jail environment is . . . particularly difficult for persons with serious mental illness”). This Note acknowledges that the provision of mental health treatment in prisons and jails differs widely between facilities. Certainly, some of the inadequacies described in this Section may not be present in larger, more well-funded facilities.

89. JAMES & GLAZE, *supra* note 3, at 1. Additionally, the Department of Justice reported that twenty-seven percent of state prisoners, nineteen percent of federal prisoners, and fifteen percent of jail inmates with mental health problems used prescribed medications since admission. *Id.* at 9.

90. Finkle et al., *supra* note 31, at 776; see also Advocacy Ctr. for the Elderly & Disabled v. La. Dep’t of Health & Hosps., 731 F. Supp. 2d 603, 612 (E.D. La. 2010) (explaining that inmates have “large stretches of unoccupied and unproductive time that makes it difficult to cultivate a therapeutic environment”); JAMES & GLAZE, *supra* note 3, at 1 (finding that twenty-three percent of state prisoners, fifteen percent of federal prisoners, and seven percent of jail inmates with mental health problems received professional mental health therapy after admission); Fellner, *supra* note 12, at 394 (noting that prisoners often live without the “diversity of mental health interventions they need,” causing their symptoms to deteriorate). A recent survey found that only ten percent of county jails provide group psychotherapy. ABUDAGGA ET AL., *supra* note 8, at 42.

91. A national study of jails found that the ratio of generally trained health personnel to inmates ranged from a low of one to seventy-six to a high of one to sixteen, with a mean of one to thirty-five. ANNO, *supra* note 3, at 119. It is challenging to come up with an appropriate ratio for staffing across correctional facilities, as the ratio is dependent on the characteristics of the correctional facility, its inmates, and their health care needs. *Id.* at 124–27; see also BARBARA KRAUTH, STAFF/INMATE RATIOS: WHY IT’S SO HARD TO GET TO THE BOTTOM LINE 1 (1998) (explaining that two identical jails will have different staff-inmate ratios).

92. *Advocacy Ctr.*, 731 F. Supp. 2d at 613.

93. *Id.* at 612.

94. *Id.* at 614; Fellner, *supra* note 12, at 394 (finding mentally ill prisoners confront a paucity of qualified staff); see also Hoptowit v. Ray, 682 F.2d 1237, 1253 (9th Cir. 1982) (“Access to the medical staff has no meaning if the medical staff is not competent to deal with the prisoners’ problems.”).

deemed incompetent.⁹⁵ This lack of training not only presents concerns with identifying mental health issues (and recognizing decompensation), but also with the provision of treatment.⁹⁶ More generally, low staffing can also lead to treatment models that focus solely on crisis prevention, whereby staff can only address those with the most pressing, and likely disruptive, symptoms.⁹⁷

Moreover, many correctional facilities do not consistently or reliably give inmates medications prescribed by the competency restoration facility.⁹⁸ Given that psychotropic medications are the most common and effective method of treatment provided to restore defendants to competency,⁹⁹ the inadequate provision of psychotropic medications to recently restored defendants, even if only for a short period of time, can easily trigger decompensation.¹⁰⁰

There are many reasons why medication may not be appropriately dispensed. Staffing levels and training significantly affect the provision of medication to inmates. At facilities with fewer staff members, the nurses are often overworked and thus may not have time to ensure inmates actually take their medication.¹⁰¹ Relatedly,

95. See *Advocacy Ctr.*, 731 F. Supp. 2d at 613 (finding guards in parish jails receive minimal mental health training); Fellner, *supra* note 12, at 396 (reporting that most facilities “do not provide correctional officers with more than minimal mental health training”); Meredith Karasch, *Where Involuntary Commitment, Civil Liberties, and the Right to Mental Health Care Collide: An Overview of California’s Mental Illness System*, 54 HASTINGS L.J. 493, 521 (2003) (“The bizarre behavior that mentally ill people display is often met with a lack of understanding and violence by guards and inmates.”); SpearIt, *supra* note 8, at 281 (finding prison staff often are not trained to recognize “genuine mental illness”). In contrast, a recent survey of county jails found that seventy-two percent reported providing formal training on handling mentally ill inmates. However, for the majority of these jails, this training constituted only two to three percent of their overall training. ABUDAGGA ET AL., *supra* note 8, at 28, 30.

96. See SpearIt, *supra* note 8, at 281–82 (explaining that the lack of mental health training precludes guards from recognizing serious mental illnesses). One particular concern in the provision of treatment is the potential detrimental side effects caused by psychotropic medications.

97. See *Madrid v. Gomez*, 889 F. Supp. 1146, 1217–18 (N.D. Cal. 1995) (noting that the staffing levels led to care directed at inmates experiencing “disruptive, bizarre or aberrant behavior, making suicidal statements or gestures, or experiencing a personal family crisis”).

98. See *id.* at 1224 (explaining how the prison did not provide an inmate’s prescribed medication for five months upon his admission, and then stopped giving it later “for no reason apparent in the record,” causing the inmate to deteriorate to a violent state); Finkle et al., *supra* note 31, at 776 (“Adherence to psychiatric medications is a documented problem. Because of the side-effects of medication, stigma among other prisoners, or a lack of insight into his or her condition, a defendant may begin to refuse medications while incarcerated, and decompensate further.” (internal citations omitted)); SpearIt, *supra* note 8, at 286 (“[M]any prisoners are left with inappropriate types or amounts of psychotropic medication that further impairs their ability to function.”); *supra* note 89 and accompanying text.

99. Finkle et al., *supra* note 31, at 777.

100. Brenda C. Desmond & Paul J. Lenz, *Mental Health Courts: An Effective Way for Treating Offenders with Serious Mental Illness*, 34 MENTAL & PHYSICAL DISABILITY L. REP. 525, 526 (2010).

101. *Advocacy Ctr. for the Elderly & Disabled v. La. Dep’t of Health & Hosps.*, 731 F. Supp. 2d 603, 612 (E.D. La. 2010).

some prisons may not even have a system to ensure inmates *receive* their medication.¹⁰² For instance, in California, a study found that poor prison policy left many prisoners with inappropriate types or amounts of psychotropic medication that further impaired their ability to function.¹⁰³ Alternatively, the prison administration may decide to withhold medication due to cost or a general dislike of psychotropic medications. In Wisconsin, for example, a task force found that a county jail's health provider actually had a policy against providing psychotropic medications—what he called “feel good” drugs—to inmates.¹⁰⁴ And, a Washington state investigation revealed that, due to rising drug costs, one county jail was charging defendants for psychiatric medications.¹⁰⁵

Finally, mentally ill individuals themselves often refuse to take medication upon returning to jail.¹⁰⁶ There are numerous reasons why an individual may refuse medications, including potential side effects, stigma among the other prisoners, or a lack of awareness about the severity or presence of a mental health condition.¹⁰⁷ Though jails may legally force inmates to take medication,¹⁰⁸ many lack the resources to do so.

Given these deficiencies, it is clear that the longer the time between the restoration of competency and a defendant's trial, the greater the risk that he or she will decompensate.¹⁰⁹ Once a detainee decompensates, however, competency treatment is often not quickly forthcoming. Given a lack of funding for mental health treatment, pretrial detainees often face long waiting periods to receive competency treatment.¹¹⁰ In California, for example, approximately three-hundred

102. A recent study of county jails found that only forty-two percent provide pharmacy services. ABUDAGGA ET AL., *supra* note 8, at 38.

103. SpearIt, *supra* note 8, at 286 (finding that drug treatment is often interrupted when prisoners are transferred between prisons or are under lockdown).

104. Desmond & Lenz, *supra* note 100, at 526.

105. Finkle et al., *supra* note 31, at 776; see ABUDAGGA ET AL., *supra* note 8, at 40 (finding that the “cost of medications to treat the mental illnesses has increased substantially” (quoting jail survey response)).

106. Finkle et al., *supra* note 31, at 776.

107. *Id.*

108. See *infra* notes 210–212 and accompanying text.

109. See Finkle et al., *supra* note 31, at 771, 776; see also Trueblood v. Wash. State Dep't of Soc. & Health Servs., 101 F. Supp. 3d 1010, 1022 (W.D. Wash. 2015):

Each additional day of incarceration causes further deterioration of class members' mental health, increases the risks of suicide and of victimization by other inmates, and causes illness to become more habitual and harder to cure, resulting in longer restoration periods or in the inability to ever restore that person to competency.

110. See Michael J. Churgin, *The Transfer of Inmates to Mental Health Facilities: Developments in the Law*, in 6 MENTALLY DISORDERED OFFENDERS: PERSPECTIVES FROM LAW AND SOCIAL SCIENCE

pretrial detainees are waiting to receive competency treatment each month¹¹¹ and, in some states, pretrial detainees are forced to wait in jail for up to a year before being transferred to the state treatment facility.¹¹² Therefore, recently decompensated detainees may further deteriorate as they wait in jail for treatment, despite the fact that they have not been proven guilty of committing a crime.

III. LEGAL CHALLENGES TO THE DECOMPENSATION CYCLE: DUE PROCESS LIMITATIONS ON PRETRIAL DETENTION AND THE PROVISION OF MENTAL HEALTH TREATMENT

Leaving incompetent detainees to suffer through periods of decompensation and endure long periods of incarceration before a finding of guilt not only raises serious ethical concerns, but also implicates many individual rights protected by the Constitution. This Part will explain how the current provision of mental health treatment in jails and the decompensation cycle violates the Due Process Clause, both by infringing on a pretrial detainee's liberty interests in restorative treatment and freedom from incarceration and by violating a detainee's basic right to adequate medical treatment.

A. The Constitutional Right to Be Free from Punishment

As a “‘general rule’ of substantive due process, . . . the government may not detain a person prior to a judgment of guilt in a criminal trial.”¹¹³ Nevertheless, the Supreme Court has permitted pretrial detention under the Due Process Clause of the Fifth and Fourteenth Amendments when the government's regulatory interest outweighs the individual's liberty interest, and has specifically permitted the detention of individuals deemed incompetent to stand trial.¹¹⁴ Nevertheless, the Supreme Court jurisprudence on the

207, 227 (Bruce Dennis Sales ed., 1983) (finding jails “usually are dependent on financially-strapped local governments for their funding” and therefore rarely receive funding for comprehensive mental health treatment); *see also* Terry *ex rel.* Terry v. Hill, 232 F. Supp. 2d 934, 936–37 (E.D. Ark. 2002) (explaining that while the state hospital is licensed for 315 beds, it only has 186 due to funding, space, and personnel shortages).

111. Patrick S. Pemberton, *Mentally Ill Defendants Languish in Jail from Lack of Hospital Space*, TRIBUNE (Jan. 4, 2014, 7:46 PM), <http://www.sanluisobispo.com/news/local/investigations/article39465075.html> [<https://perma.cc/T9TC-MWLA>].

112. Terry, 232 F. Supp. 2d at 938. Numerous courts have found these waiting periods to violate a pretrial detainee's due process rights. *See infra* Section III.A.

113. United States v. Salerno, 481 U.S. 739, 749 (1987).

114. See Jackson v. Indiana, 406 U.S. 715, 731–39 (1972) (finding it constitutional to detain a mentally incompetent defendant prior to trial); Greenwood v. United States, 350 U.S. 366, 375

substantive due process rights of pretrial detainees and civil committees has clearly established that pretrial detainees deemed incompetent to stand trial retain significant liberty interests under the Due Process Clause.

In *Jackson v. Indiana*—perhaps the most seminal case establishing the substantive due process rights of incompetent pretrial detainees—the Supreme Court determined that “due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed.”¹¹⁵ Given that the purpose for which incompetent individuals are detained is restoration, an individual detained solely due to incompetency “cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future.”¹¹⁶ If a defendant cannot be returned to competency—as appeared to be the case for the defendant in *Jackson*¹¹⁷—then the state must either institute civil commitment proceedings or release the individual.¹¹⁸

Further, under the Due Process Clause, correctional facilities cannot subject pretrial detainees to restrictions and conditions of confinement that constitute punishment.¹¹⁹ Jails may impose conditions or restrictions that are “reasonably related to a legitimate governmental objective,” such as assuring presence at trial, maintaining security, and ensuring discipline.¹²⁰ However, arbitrary and purposeless restrictions or conditions amount to punishment, and therefore cannot be imposed upon pretrial detainees.¹²¹

To determine the constitutionally mandated conditions of confinement, courts must balance the individual’s liberty interest with the state’s asserted purpose for confinement.¹²² To conduct this balance

(1956) (same); see also *Salerno*, 481 U.S. at 748–49 (listing the cases in which the Court has found the state may detain an individual prior to any conviction).

115. 406 U.S. at 738.

116. *Id.*

117. A trial court ordered Jackson to be detained in a state mental health facility until he became “sane,” despite expert testimony that he could never be restored to competency. *Id.* at 718–19.

118. *Id.* at 738. In practice, however, many individuals remain in competency treatment for years. See Andrew R. Kaufman et al., *Forty Years After Jackson v. Indiana: State Compliance with “Reasonable Period of Time” Ruling*, 40 J. AM. ACAD. PSYCHIATRY & L. 261, 262–64 (2012) (discussing various studies that showed states are not complying with *Jackson*).

119. *Bell v. Wolfish*, 441 U.S. 520, 536–37 (1979).

120. *Id.* at 539–40.

121. *Id.* at 539.

122. See *Youngberg v. Romeo*, 457 U.S. 307, 320–21 (1982) (asserting that the proper constitutional inquiry balances the liberty interests of the individual with any relevant state

and minimize “interference by the federal judiciary with the internal operations of these institutions,” courts must give deference to professional judgment.¹²³ Essentially, “liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment.”¹²⁴ For example, in *Youngberg v. Romeo*, the Supreme Court found that civil committees retain liberty interests in safety, freedom from restraint, and minimally adequate training sufficient to ensure the protection of these interests.¹²⁵ Rather than dictating what that training might look like, the Court stated only that states must provide training “as an appropriate professional would consider reasonable” to fulfill the individual’s liberty interests.¹²⁶

Through the line of cases beginning with *Jackson*, the Supreme Court has established that if a facility has imposed restrictions and conditions that are not reasonably related to a legitimate government interest and the reason for which an individual was detained, then the conditions constitute punishment and violate the detainee’s liberty interest under the Due Process Clause. Lower courts have relied on these decisions to protect the substantive due process rights of incompetent pretrial detainees. Recently, the U.S. District Court for the Western District of Washington described the interests at stake and the balance courts conduct when considering delays in competency evaluation and treatment under the *Jackson* line of cases, noting:

[T]he gravity of the harms suffered by the class members during prolonged incarceration . . . directly conflict with [pretrial detainees’] rights to freedom from incarceration and to the competency services which form the basis of their detention, and . . . with the State’s interests in swiftly bringing those accused of crimes to trial and in restoring incompetent criminal defendants to competency so as to try them.¹²⁷

In other words, the continued incarceration of incompetent detainees—without proper treatment for their mental illnesses—did not further the state’s interest in their restoration and, ultimately, their conviction. Relying on similar reasoning, several courts have found that

interests, such as “the State’s asserted reasons for restraining individual liberty” through confinement).

123. *Id.* at 322.

124. *Id.* at 323.

125. *Id.* at 318, 322–24. The Court defined minimally adequate training as training that “may be reasonable in light of respondent’s liberty interests in safety and freedom from unreasonable restraints.” *Id.* at 322.

126. *Id.* at 324.

127. *Trueblood v. Wash. State Dep’t of Soc. & Health Servs.*, 101 F. Supp. 3d 1010, 1022 (W.D. Wash. 2015).

significant delays in receiving competency treatment, resulting in prolonged pretrial detention, violate the Due Process Clause.¹²⁸

For example, in *Oregon Advocacy Center v. Mink*, the plaintiffs-appellees claimed that delays in admitting pretrial detainees to competency treatment violated the Due Process Clause.¹²⁹ Pretrial detainees were waiting in jail to be transferred to the state facility for “two, three, or even five months” due to limited state funding.¹³⁰ In addition to recognizing a broad liberty interest in freedom from restraint, the court asserted that incompetent pretrial detainees also have a liberty interest in restorative treatment.¹³¹ On the other side of the balance, the court found that the delays failed to serve the state’s interest in restoring competency and bringing these individuals to trial.¹³² Therefore, relying on the framework established in *Jackson* and *Youngberg*, the Ninth Circuit held that the delays violated a detainee’s due process rights because the “nature and duration of their incarceration [bore] no reasonable relation to the evaluative and restorative purposes”¹³³ Consequently, the court ordered the state to admit incompetent detainees within seven days, explaining that the state could not rely on a “lack of funds, staff, or facilities” to justify its failure to provide the necessary treatment in a timely manner.¹³⁴

Similarly, in *Advocacy Center for the Elderly and Disabled v. Louisiana Department of Health and Hospitals*, the plaintiffs argued that both the delays before being transferred to the state’s competency program and the mental health treatment they received in jail were unrelated to the state’s purpose in restoring their competency, amounting to punishment.¹³⁵ After examining the jail’s mental health treatment program, the court determined that the care provided at the jail was inadequate because it did not meet the professional standard

128. However, at least one state court has denied a plaintiff’s facial challenge under its state constitution for delays in treatment caused by a statute that required all incompetent defendants to be treated at the state mental health facility. See *Lakey v. Taylor*, 435 S.W.3d 309, 313, 321–22 (Tex. Ct. App. 2014). The court reasoned that because some incompetent individuals are also detained based on their danger to others, the State had a compelling and legitimate interest in detaining the defendant aside from restoration, making the delays justifiable and constitutional. *Id.*

129. 322 F.3d 1101, 1105 (9th Cir. 2003).

130. *Id.* at 1106. Alternatively, the State allowed defendants to be sent home under supervision if commitment was not required. *Id.* at 1115.

131. *Id.* at 1121.

132. *Id.*

133. *Id.* at 1122.

134. *Id.* at 1121, 1123 (quoting *Ohlinger v. Watson*, 652 F.2d 775, 779 (9th Cir. 1980)). Following this trial, Oregon significantly increased the state hospital’s capacity to manage the increasing number of competency treatment detainees. Gowensmith, *supra* note 31, at 294.

135. 731 F. Supp. 2d 603, 607 (E.D. La. 2010).

of care provided at the state forensic facility or other competency programs.¹³⁶ Specifically, the jail was understaffed, did not provide adequate psychiatric services, and could not ensure pretrial detainees took their medications.¹³⁷ Further, the court noted that the circumstances failed the “*Youngberg* inquiry” because detainees faced long delays and inadequate treatment, directly in contradiction with the recommendation by a court and a “panel of mental health professionals.”¹³⁸ Therefore, the delays and inadequate treatment amounted to punishment and were not reasonably related to the state’s asserted interest in ultimately bringing the individuals to trial.¹³⁹ As a result, the court held that the extended delays in jail violated pretrial detainees’ substantive due process rights and ordered the jails to transfer individuals to the state facility within twenty-one days.¹⁴⁰

Some scholars have interpreted the *Jackson* line of cases through *Seling v. Young*¹⁴¹ more broadly, arguing that these cases demonstrate that state facilities have an affirmative obligation to provide treatment to protect and enhance a detainee’s liberty interests.¹⁴² In the civil commitment context, courts have been willing to recognize such an affirmative obligation. For instance, some courts have suggested that the Due Process Clause requires treatment that provides “a realistic opportunity to be cured or improve the mental condition for which they were confined.”¹⁴³ And, in *Seling*, the Supreme Court acknowledged that civil committees may challenge a lack of

136. *Id.* at 611–15.

137. *Id.* at 612–15.

138. *Id.* at 609–10, 623.

139. *Id.* at 623–24.

140. *Id.* at 611, 627. In a similar case from the Eastern District of Arkansas, the court came to a similar conclusion based primarily on *Bell*, reasoning that

the delay in transferring court ordered pretrial detainees to the [state facility] for evaluation or treatment, amounts to punishment of the detainees. The lack of inpatient mental health treatment, combined with the prolonged wait in confinement, transgresses the constitution. The lengthy and indefinite periods of incarceration, without any legal adjudication of the crime charged, caused by the lack of space at [the state facility], is not related to any legitimate goal, is purposeless and cannot be constitutionally inflicted upon the members of the class.

Terry *ex rel.* Terry v. Hill, 232 F. Supp. 2d 934, 943–44 (E.D. Ark. 2002) (relying on *Bell v. Wolfish*, 441 U.S. 520, 538–39 (1979)).

141. 531 U.S. 250 (2001).

142. See, e.g., Eric S. Janus & Wayne A. Logan, *Substantive Due Process and the Involuntary Confinement of Sexually Violent Predators*, 35 CONN. L. REV. 319, 344, 358 (2003); see also *Youngberg v. Romeo*, 457 U.S. 307, 319 (1982) (“[R]espondent’s liberty interests require the State to provide minimally adequate or reasonable training to ensure safety and freedom from undue restraint.”).

143. *Sharp v. Weston*, 233 F.3d 1166, 1172 (9th Cir. 2000).

proper treatment based on their substantive due process rights.¹⁴⁴ The plaintiff in that case challenged a Washington statute that provided for the civil commitment of sexually violent offenders, claiming that it violated the Double Jeopardy Clause and *ex post facto* guarantees, as well as his substantive due process rights.¹⁴⁵ Because the Ninth Circuit did not consider the due process challenge, the Supreme Court's holding was limited: as-applied, the act did not violate the Double Jeopardy Clause or *ex post facto* guarantees.¹⁴⁶ Nevertheless, citing *Jackson*, the Court emphasized in dicta that if no mental health treatment is provided, there may be a substantive due process violation because the failure to provide adequate treatment would not be reasonably related to the statute's purpose to incapacitate and treat these individuals.¹⁴⁷

Thus, the Supreme Court jurisprudence in the *Jackson* line of cases has significant implications for the rights of incompetent pretrial detainees stuck in the decompensation cycle. As demonstrated in *Mink* and *Advocacy Center*, lower courts have applied the Supreme Court's balancing test to weigh the state's interest in detaining incompetent individuals to bring them to trial with the individual's interest in freedom from incarceration and restorative treatment.¹⁴⁸ Like detainees waiting for competency treatment, individuals who return to jail after being restored to competency continue to have an interest in freedom from incarceration, and arguably also retain their interest in restorative treatment and in maintaining a competent mental state. Nevertheless, many pretrial detainees return to jail only to receive inadequate treatment, forcing them to be detained for a longer period of time.¹⁴⁹ Importantly, this treatment is often in direct contradiction with the treatment prescribed and recommended by the competency facility, failing the *Youngberg* inquiry.¹⁵⁰ Therefore, providing inadequate mental health treatment in jail to recently restored detainees may violate their substantive due process rights: it does not

144. 531 U.S. at 265.

145. *Id.* at 253–56.

146. *Id.* at 263.

147. *Id.* at 265 (citing *Jackson v. Indiana*, 406 U.S. 715, 738 (1972)); see also *Janus & Logan*, *supra* note 142, at 335–36 (finding that the Court in *Seling v. Young* “was at pains to emphasize that other potential claims, in particular substantive due process, were not implicated” because the statute was designed to incapacitate and treat).

148. See *supra* notes 129–140 and accompanying text.

149. See *supra* Part II.

150. See *Advocacy Ctr. for the Elderly & Disabled v. La. Dep't of Health & Hosps.*, 731 F. Supp. 2d 603, 610, 623 (E.D. La. 2010) (finding delays in treatment failed the *Youngberg* inquiry because they were in direct contradiction with the opinion of mental health professionals and the court); *supra* notes 98–100 and accompanying text (explaining that many detainees do not receive prescribed medication).

bear a “reasonable relation” to either freedom from incarceration or the maintenance of competency necessary to bring them to trial, nor does it comply with a professional’s judgment.¹⁵¹ This potential violation is only magnified by the fact that once a detainee does decompensate, he or she may be forced to wait in jail to return to competency treatment, raising additional due process concerns.¹⁵²

Additionally, the *Jackson* line of cases suggests a potential durational limit stemming from the Due Process Clause.¹⁵³ In *Jackson*, the Court explicitly stated that the duration of confinement must be related to the state’s purpose, and held that states could not hold an individual longer than is necessary to determine if he or she will be restored to competency.¹⁵⁴ Similarly, in *Bell v. Wolfish*, the Court stated that “hardship over an extended period of time might raise serious questions under the Due Process Clause.”¹⁵⁵ *Mink* and *Advocacy Center* provide further support for this notion, highlighting that an extended period of time in jail unrelated to the rehabilitative purpose of the detention may violate the Due Process Clause.¹⁵⁶ Tracking these cases, Professors Janus and Logan suggest that “[c]onfinement that is [otherwise] non-punitive . . . can become punitive if its duration is excessive.”¹⁵⁷ Such a durational limitation would provide another potential due process concern when, under the decompensation cycle, detainees bounce between jail and the competency treatment facility for a significant period of time.

Finally, if cases like *Youngberg* and *Seling* establish an affirmative obligation to provide treatment for individuals who are civilly committed, it stands to reason that this obligation extends to

151. See *Youngberg v. Romeo*, 457 U.S. 307, 323 (1982) (noting there is a presumption of validity if the treatment follows a professional judgment); *Jackson*, 406 U.S. at 738 (holding that due process requires a reasonable relation between the purpose and the nature of confinement); cf. *Or. Advocacy Ctr. v. Mink*, 322 F.3d 1101, 1122 (9th Cir. 2003) (holding that delays in transferring incompetent detainees violated the detainees’ due process rights); *Advocacy Ctr.*, 731 F. Supp. 2d at 621 (finding “the continued imprisonment of the Incompetent Detainees in parish jails” violated the Due Process Clause because it did not relate to the nature of commitment).

152. See *supra* notes 112, 129–140 and accompanying text (detailing the due process concerns triggered by extended imprisonment of detainees awaiting treatment).

153. See Janus & Logan, *supra* note 142, at 355 (explaining that the *Jackson* line of cases demonstrates that “confinement that is durationally out of proportion to the state’s non-punitive purpose” constitutes punishment).

154. 406 U.S. at 738.

155. 441 U.S. 520, 542 (1979).

156. *Mink*, 322 F.3d at 1122; *Advocacy Ctr.*, 731 F. Supp. 2d at 621.

157. Janus & Logan, *supra* note 142, at 353. It is important to note, however, that incompetent detainees held for other reasons—such as danger to the community—may not be subject to durational limits, as there are other reasons for their continued detention. *Id.* at 355.

incompetent detainees.¹⁵⁸ In *Youngberg*, the Court held that the state must provide minimally adequate training in order to protect the liberty interests of civilly committed individuals.¹⁵⁹ Like civil commitment, the purpose of detaining incompetent individuals is, at least in part, to provide treatment.¹⁶⁰ Incompetent individuals, however, also retain a liberty interest in freedom from incarceration. Therefore, the state has an affirmative obligation to not only provide treatment but also to protect the individual's interest in freedom from incarceration and ensure he or she maintains competency while detained in jail awaiting trial.¹⁶¹

B. The Constitutional Right to Adequate Medical Treatment

In addition to the right to be free from punishment before being found guilty, the Constitution also provides pretrial detainees and inmates with other basic rights. Most relevant here, jails and prisons have an obligation to provide medical care for prisoners and inmates under the Eighth Amendment's protection against cruel and unusual punishment.¹⁶² Though pretrial detainees are not covered under the Eighth Amendment, the Due Process Clause protection against punishment provides similar rights to pretrial detainees.¹⁶³ Accordingly, many courts have found that pretrial detainees maintain the same right to adequate medical treatment, and thus follow the standard under the Eighth Amendment to evaluate the detainee's constitutional claim.¹⁶⁴ Some courts have gone even further, suggesting

158. See *Seling v. Young*, 531 U.S. 250, 265 (2001) (noting that the petitioner may still have a substantive due process claim because the purpose of the statute permitting commitment is to incapacitate and treat); *Youngberg v. Romeo*, 457 U.S. 307, 319 (1982) (recognizing the State's duty to provide "minimally adequate . . . training" to protect the respondent's liberty interest); *Janus & Logan*, *supra* note 142, at 344 (suggesting *Youngberg* establishes an affirmative duty to provide treatment).

159. *Youngberg*, 457 U.S. at 319.

160. See *Seling*, 531 U.S. at 265 (explaining that the purpose of civil commitment is incapacitation and treatment). Additionally, like civil committees, some may be detained due to judgments that they present a danger to the community.

161. Cf. *Youngberg*, 457 U.S. at 319 (requiring the state to provide minimally adequate training to civilly committed individuals); *Sharp v. Weston*, 233 F.3d 1166, 1172 (9th Cir. 2000) (recognizing that due process requires facilities to provide individuals with the opportunity to be cured).

162. *Estelle v. Gamble*, 429 U.S. 97, 103–04 (1976). Under either the Eighth Amendment or the Due Process Clause, the right to medical care is not extensive. For example, prisoners do not have a choice in the professional who treats them, the treatment location, or the treatment program model.

163. *Bell v. Wolfish*, 441 U.S. 520, 535 (1979); NAT'L COAL. FOR THE MENTALLY ILL IN THE CRIMINAL JUSTICE SYS., *supra* note 75, at 27.

164. See, e.g., *Weyant v. Okst*, 101 F.3d 845, 856 (2d Cir. 1996):

that “the protections provided pretrial detainees by the Fourteenth Amendment in some instances exceed those provided convicted prisoners by the Eighth Amendment,” because pretrial detainees have not been convicted and thus cannot be subjected to punishment.¹⁶⁵

Treatment, however, is only mandated for serious medical needs.¹⁶⁶ And, failure to provide treatment only rises to a constitutional violation when it constitutes deliberate indifference, as set forth in *Estelle v. Gamble*.¹⁶⁷ As explained by the Supreme Court, deliberate indifference only constitutes the “unnecessary and wanton infliction of pain,” which can occur when prison staff—either medical staff or guards—disregard medical needs or intentionally interfere with prescribed treatment.¹⁶⁸ Though negligence or an “inadvertent failure to provide adequate medical care” does not constitute deliberate indifference, a consistent pattern of negligence may rise to a constitutional violation.¹⁶⁹ Under this test, the defendant bears the burden of proving both that he or she had a serious medical need and that there was deliberate indifference on behalf of prison officials in regards to this medical need.¹⁷⁰ A medical need is serious if it has been diagnosed by a physician as mandating treatment or is so obvious that a layperson could recognize the need for medical attention.¹⁷¹

[W]hile the Supreme Court has not precisely limned the duties of a custodial official under the Due Process Clause to provide needed medical treatment to a pretrial detainee, it is plain that an unconvicted detainee’s rights are at least as great as those of a convicted prisoner. Thus, the official custodian . . . may be found liable for violating the detainee’s due process rights if the official denied treatment needed to remedy a serious medical condition and did so because of his deliberate indifference to that need. (citations omitted);

Hampton v. Holmesburg Prison Officials, 546 F.2d 1077, 1079–80 (3d Cir. 1976) (“It would be anomalous to afford a pretrial detainee less constitutional protection than one who has been convicted.”); *see also* *City of Revere v. Mass. Gen. Hosp.*, 463 U.S. 239, 244 (1983) (“[T]he due process rights of a [pretrial detainee] are at least as great as the Eighth Amendment protections available to a convicted prisoner.”).

165. *Gibson v. Cty. of Washoe*, 290 F.3d 1175, 1188 n.9 (9th Cir. 2002).

166. NAT’L COAL. FOR THE MENTALLY ILL IN THE CRIMINAL JUSTICE SYS., *supra* note 75, at 25; *see also* *McGee v. Adams*, 721 F.3d 474, 480 (7th Cir. 2013) (identifying a serious medical need as a requirement for a constitutional violation).

167. 429 U.S. at 104–05.

168. *Id.* at 104 (quoting *Gregg v. Georgia*, 428 U.S. 153, 173 (1976)).

169. *Id.* at 105; *Todaro v. Ward*, 565 F.2d 48, 52 (2d Cir. 1977) (“[W]hile a single instance of medical care denied or delayed, viewed in isolation, may appear to be the product of mere negligence, repeated examples of such treatment bespeak a deliberate indifference by prison authorities . . .”).

170. *E.g., McGee*, 721 F.3d at 480; *Brown v. Strain*, 663 F.3d 245, 249 (5th Cir. 2011); *Inmates of Allegheny Cty. Jail v. Pierce*, 612 F.2d 754, 762 (3d Cir. 1979).

171. *Greeno v. Daley*, 414 F.3d 645, 653 (7th Cir. 2005).

Defendants may choose to challenge either the way in which treatment was provided or the lack of treatment altogether.¹⁷²

Though the Supreme Court has not explicitly extended this mandate to the provision of mental health care, “every court which has spoken to the issue has equated the two.”¹⁷³ Therefore, a judge must determine whether “inmates with serious mental or emotional illnesses or disturbances are provided reasonable access to medical personnel qualified to diagnose and treat such illnesses or disturbances.”¹⁷⁴

Successfully challenging a facility’s mental health treatment, however, may be especially difficult, as disagreements over the proper treatment or allegations of mere negligence do not constitute deliberate indifference.¹⁷⁵ For example, in *Bellotto v. County of Orange*, the Second Circuit rejected a detainee’s claim that inadequate monitoring by health staff—which led to missed medication dosages and resulted in hallucinations, an anxiety attack, and a suicide threat—constituted deliberate indifference.¹⁷⁶ Rather, the court found that the plaintiff was alert and frequently received attention from the mental health medical staff, including medication adjustment and group therapy.¹⁷⁷ Moreover, the court emphasized that he did not suffer pain or physical harm as a result of these alleged deficiencies, suggesting that the inadequate treatment must make an appreciable difference in the inmate’s mental health status.¹⁷⁸

Despite the difficulties plaintiffs face in bringing an Eighth Amendment challenge, courts have outlined several ways in which an inmate can prove deliberate indifference. For instance, correctional facilities cannot “prevent an inmate from receiving recommended treatment for serious medical needs or deny access to a physician capable of evaluating the need for such treatment.”¹⁷⁹

172. See NAT’L COAL. FOR THE MENTALLY ILL IN THE CRIMINAL JUSTICE SYS., *supra* note 75, at 35 (“[D]eliberate indifference . . . may apply to how treatment was provided or to a failure to provide treatment when it was mandated.”).

173. *Id.* at 29; see, e.g., *Doty v. Cty. of Lassen*, 37 F.3d 540, 546 (9th Cir. 1994) (“[W]e now hold that the requirements for mental health care are the same as those for physical health care needs.”); *Pierce*, 612 F.2d at 763 (reasoning that psychiatric care for pretrial detainees should be held to the same standards as the provision of medical treatment for physical illnesses); *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977) (finding “no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart”).

174. *Pierce*, 612 F.2d at 763.

175. See, e.g., *Bellotto v. Cty. of Orange*, 248 F. App’x 232, 237–38 (2d Cir. 2007) (rejecting a due process challenge to the adequacy of medical treatment).

176. *Id.*

177. *Id.* at 237.

178. *Id.*

179. *Pierce*, 612 F.2d at 762.

Alternatively, “[s]ystemic deficiencies in staffing which effectively deny inmates access to qualified medical personnel for diagnosis and treatment of serious health problems” may constitute deliberate indifference.¹⁸⁰ For example, in *Inmates of Allegheny County Jail v. Pierce*, the district court held that the jail’s treatment amounted to deliberate indifference of the inmates’ serious mental health needs.¹⁸¹ In particular, the court found that the medical staffing levels were inadequate: the jail did not employ a psychiatric social worker or a psychiatrist, but instead had only one part-time physician who spent three hours a day at the jail seeing both medical and psychiatric patients.¹⁸² As a result of these deficiencies, the medical staff insufficiently monitored inmates’ medication, despite it being prescribed by either the jail doctor or outside providers.¹⁸³ Though the court recognized the limitations of jails as care providers, it noted that jails must at least be organized and sufficiently staffed to address emergencies, make referrals, and provide adequate care to inmates.¹⁸⁴

Finally, intentionally interfering with prescribed medications may constitute deliberate indifference.¹⁸⁵ In *Purkey v. Green*, the Tenth Circuit found that the prison doctor’s discontinuance of a medication prescribed by another physician—the denial of which caused the inmate to suffer persistent pain—was sufficient to state a cause of action for deliberate indifference at an early stage of litigation.¹⁸⁶

The care, or lack thereof, provided at many correctional facilities likely involves more isolated incidents of negligence, and thus would not rise to a system-wide level of deliberate indifference. Nevertheless, jails in which pretrial detainees regularly decompensate may be found deliberately indifferent. The Wisconsin jail that refused to provide psychotropic medications to all inmates clearly goes beyond mere negligence.¹⁸⁷ Similarly, a court could find that jails that knowingly

180. *Id.*; see also *Todaro v. Ward*, 565 F.2d 48, 52–53 (2d Cir. 1977) (finding that systematic deficiencies in staffing required court intervention); *Newman v. Alabama*, 349 F. Supp. 278, 281 (M.D. Ala. 1972) (finding the prison violated the Constitution because it was “grossly understaffed,” resulting in the poor administration of medical treatment and the intentional denial of medicine), *aff’d*, 503 F.2d 1320 (5th Cir. 1974). If the systemic deficiencies in staffing are severe enough, a court may find that the exercise of informed judgment may be precluded. *Pierce*, 612 F.2d at 763.

181. 487 F. Supp. 638, 643 (W.D. Pa. 1980).

182. *Id.* at 642.

183. *Id.* (“Nurses disburse medications to those inmates who show up at the office. . . . Naturally, many inmates do not appear routinely for medication.”).

184. *Id.* at 643.

185. *Purkey v. Green*, 28 F. App’x 736, 743 (10th Cir. 2001).

186. *Id.*

187. See *Desmond & Lenz*, *supra* note 100, at 526 (describing the jail’s health care provider’s policy of denying psychotropic drugs to inmates).

place incompetent detainees in isolation, providing little to no mental health treatment,¹⁸⁸ are intentionally interfering with prescribed treatment and thus are deliberately indifferent.¹⁸⁹

Moreover, the lack of adequate medical staff trained in mental health may constitute a violation of a detainee's due process rights if it results in the inadequate provision of treatment. For example, as discussed above, some Louisiana jails only staff one part-time psychiatrist and a psychiatry resident, similar to the staffing structure in *Pierce*.¹⁹⁰ Given the rise in mental health problems in prisons and jails, an improperly trained staff may be insufficient to meet the jail's obligation to its inmates.¹⁹¹ Indeed, in many of the cases, experts concluded that pretrial detainees found incompetent were consistently not getting the care they needed.¹⁹² As in *Pierce*, then, insufficient staffing that causes the inadequate provision of mental health treatment may rise to the level of deliberate indifference.¹⁹³

For incompetent individuals, the right to adequate medical treatment under the Due Process Clause provides less protection than the right to be free from punishment. While the *Jackson* line of cases suggests that jails have an affirmative obligation to provide restorative treatment, the right to adequate medical treatment only requires jails to provide treatment sufficient to treat and manage the individual's underlying mental illness. Nevertheless, this protection creates an important constitutional obligation to continue an individual's treatment—at a minimum providing prescribed psychotropic medications—helping to ensure he or she remains competent.

188. See *supra* note 83 and accompanying text (discussing the American Bar Association's recommendation to keep inmates with serious mental illnesses out of isolated units).

189. See *Purkey*, 28 F. App'x at 743 (finding the jail was deliberately indifferent when it intentionally interfered with prescribed treatment); see also *Langley v. Coughlin*, 715 F. Supp. 522, 536 (S.D.N.Y. 1989) (“[C]ourts have repeatedly noted that while one isolated failure to treat, without more, is ordinarily not actionable, it may in fact rise to the level of a constitutional violation if the surrounding circumstances suggest a degree of deliberateness, rather than inadvertence, in the failure to render meaningful treatment.”), *appeal dismissed*, 888 F.2d 252 (2d Cir. 1989).

190. *Advocacy Ctr. for the Elderly & Disabled v. La. Dep't of Health & Hosps.*, 731 F. Supp. 2d 603, 613 (E.D. La. 2010) (noting that a prison with more than one thousand inmates had one part-time psychiatrist and one resident on medical staff).

191. See *supra* notes 1–8 and accompanying text (discussing rates of mental illness in the prison population).

192. *E.g.*, *Terry ex rel. Terry v. Hill*, 232 F. Supp. 2d 934, 940 (E.D. Ark. 2002) (citing expert testimony that lack of treatment may have worsened incompetent detainee's mental illness).

193. *Inmates of Allegheny Cty. Jail v. Peirce*, 487 F. Supp. 638, 643 (W.D. Pa. 1980).

IV. RESTORING INCOMPETENT DETAINEES' CONSTITUTIONAL RIGHTS: A MULTI-PRONGED APPROACH TO ENSURE ADEQUATE MENTAL HEALTH TREATMENT

In addition to the due process concerns, the cost of the decompensation cycle and the systemic inefficiencies it creates further highlight the need to end this cycle. Depending on the severity of the mental illness and the inadequacy of the jail's mental health treatment, a pretrial detainee's trial may be delayed for years in order to finally restore the defendant's competency in time for trial. The cost of competency treatment ranges from \$400 to over \$800 per day.¹⁹⁴ Based on the average time of ninety days to restore competency, one course of treatment costs approximately \$30,000 to \$100,000 per defendant.¹⁹⁵

If pretrial detainees decompensate several times, the cost of competency treatment alone can easily reach several hundred thousand dollars. Indeed, as discussed above, one detainee in Florida waited in confinement for seventeen years before he was eventually convicted and after he cost the state \$1.3 million.¹⁹⁶ Given the increase in the number of incompetent defendants, the overall annual cost to states for treatment is significant and continuing to grow. California now spends \$170 million per year for competency treatment.¹⁹⁷ And in Florida, the state spends one-fifth of its budget on mental health and competency treatment programs.¹⁹⁸

Furthermore, every time a pretrial detainee may be incompetent, the issue of his competency must be raised during pretrial proceedings, resulting in a competency evaluation and sometimes a

194. See *Terry*, 232 F. Supp. 2d at 937 (finding that competency treatment in Arkansas costs four hundred dollars per day); Kapoor, *supra* note 48, at 311 (finding competency treatment costs in Texas, Wisconsin, and Connecticut to be \$401 per day, \$667 to \$833 per day, and \$834 per day, respectively).

195. See Kapoor, *supra* note 48, at 311 (finding Texas spent \$401 per day for competency treatment, averaging \$35,659 per defendant). Additionally, a Florida newspaper compared the costs of mental health treatment at the state facility and jail, finding that it cost \$110,000 a year to treat someone at the state mental health facility, compared to \$17,338 to "house an inmate in a Florida prison." Krueger, *supra* note 72.

196. Braga et al., *supra* note 19.

197. Mac Taylor, *An Alternative Approach: Treating the Incompetent to Stand Trial*, CAL. LEGIS. ANALYST'S OFF. 3, 8 (2012), <http://www.lao.ca.gov/reports/2012/hlth/ist/incompetent-stand-trial-010312.pdf> [<https://perma.cc/7DXU-QLHP>].

198. Braga et al., *supra* note 19. Pretrial detainees in this decompensation cycle also cost more simply because they are in jail for longer. On top of the regular costs of detaining individuals in jail, numerous studies have found that the cost to house a mentally ill inmate is significantly higher due to their substantial needs and higher rates of misconduct. See, e.g., HEALTH MGMT. ASSOCS., IMPACT OF PROPOSED BUDGET CUTS TO COMMUNITY-BASED MENTAL HEALTH SERVICES 3, 9–10 (2011) (finding that the cost of housing a mentally ill inmate is three times the cost of housing other inmates).

hearing involving both parties, the judge, and experts.¹⁹⁹ This consumes limited court resources, including both time and money. Over time, delays in trial may make it more difficult for the prosecutor to convict the accused due to changes in the prosecution staff, the unavailability of witnesses, and stale evidence.²⁰⁰ And yet despite the potential to save scarce resources, correctional facilities that allow detainees to decompensate currently face no negative consequences. Therefore, these institutions are not incentivized to change their behavior to improve mental health treatment.

In this day and age, when psychiatric treatments can effectively reduce symptoms, failure to adequately care for inmates with mental illnesses and maintain their competency is inexcusable.²⁰¹ More importantly, given the due process protections owed to incompetent pretrial detainees, jails simply cannot continue providing inadequate treatment or standing by as detainees decompensate. As such, this Part proposes a multi-pronged approach, relying on both the courts and new technology, to protect the constitutional rights of incompetent pretrial detainees and prevent decompensation.

A. A Familiar Approach: Relying on Courts to Enforce Prescribed Treatment

More state funding on mental health—including prevention, jail and prison treatment, and competency restoration programs—could solve many of the issues facing incompetent detainees in the criminal justice system today. Unfortunately, given the current political reticence regarding state spending, particularly for issues like mental health and suspected criminals, this is unlikely to happen in the near future.

Some states and courts have tried unsuccessfully to address the decompensation cycle. For example, the state of Florida “work[ed] out a deal” to allow Bobby Lane McGee to stay at the state mental hospital until his court date, at which point he was given an injection of medication that would last for several months, sufficient to complete his trial.²⁰² Similarly, commentators have pointed out that “[i]n some cases, the court may order that the person remain at [the state facility] while awaiting trial, to ensure that he does not again become

199. See *supra* notes 30–33 and accompanying text.

200. See *Barker v. Wingo*, 407 U.S. 514, 521 (1972) (explaining that, due to the potential unavailability of witnesses, delays “may work to the accused’s advantage”).

201. Stone, *supra* note 5, at 299–300.

202. Braga et al., *supra* note 19.

incompetent due to possible disruptions in treatment.”²⁰³ Though keeping recently restored detainees at the competency treatment facility satisfies the state’s interest in bringing the person to trial on an individual basis, it does not solve the problem on a large scale. In practice, this solution is expensive and involves high opportunity costs to other incompetent detainees who remain in jail awaiting treatment, potentially causing further delays in treatment.

Instead, in order to protect pretrial detainees’ constitutional rights and comply with the Due Process Clause, judges and courts must require jails to maintain the treatment recommended by the competency treatment facility. Jails are not health care providers and should not be required to provide the exact same standard of care provided at state mental health facilities. However, the Due Process Clause requires that correctional facilities provide at least adequate treatment for serious mental health needs and avoid conditions that constitute punishment.²⁰⁴ Accordingly, at a minimum, courts should require correctional facilities to maintain and monitor the detainee’s medications prescribed at the state mental health facility, ensuring that the majority of defendants remain competent for trial. This is consistent with the American Bar Association’s Criminal Justice Mental Health Standards, which recommend that

If a defendant found incompetent to proceed is treated with medication in an inpatient facility, becomes competent, and returns to jail or to the community to await further legal proceedings, the court should order as a condition of the defendant’s return that the receiving facility or local treatment facility continue such treatment as the inpatient facility may recommend to maintain the defendant’s competence.²⁰⁵

Medication is the most common and effective form of treatment provided by state mental health facilities to restore detainees to competency.²⁰⁶ Numerous studies have discussed the benefits and

203. JUSTICE POLICY INST., WHEN TREATMENT IS PUNISHMENT: THE EFFECTS OF MARYLAND’S INCOMPETENCY TO STAND TRIAL POLICIES AND PRACTICES 24 (2011), http://www.justicepolicy.org/uploads/justicepolicy/documents/when_treatment_is_punishment-full_report.pdf [<https://perma.cc/UM3C-7A8Z>].

204. See *supra* Section III.A; see also *Madrid v. Gomez*, 889 F. Supp. 1146, 1258 (N.D. Cal. 1995) (“[S]ome constitutional minima are specific to mental health care. Psychotropic or behavior-altering medication should only be administered with appropriate supervision and periodic evaluation.”), *rev’d on other grounds*, 190 F.3d 990 (9th Cir. 1999).

205. AM. BAR ASS’N, *supra* note 30, std. 7-4.11(e). Additionally, after finding that the provision of medications was such an issue after competency treatment, a Washington State report noted that “[t]here is support for the limited use of involuntary treatment for defendants who return to jail after competency restoration treatment in state hospital, in order to ensure the defendant remains competent for trial.” Finkle et al., *supra* note 31, at 777.

206. See Brief of Am. Psychiatric Ass’n and Am. Acad. of Psychiatry and the Law as Amici Curiae in Support of Neither Party and Supporting Affirmance at *12, *United States v. Loughner*, No. 11-10339, 2011 WL 3672689 (9th Cir. July 12, 2011):

effectiveness of such medication.²⁰⁷ These medications often address symptoms that lead to a diagnosis of incompetency, including hallucinations, delusions, and psychosis.²⁰⁸ Moreover, appropriately dispensing prescribed psychotropic medication is one of the easiest ways to maintain competency and requires relatively little of jails. Such an order would not require medical staff with specialized training in psychiatric care, or ask the jail to provide other treatments, like therapy, to its detainees.

In some cases, detainees may refuse to take medication, leading to decompensation.²⁰⁹ In this circumstance, the court's order should require forced medication upon recently restored pretrial detainees. Though various commentators have argued against involuntary medication, either due to the potential side effects of psychotropic medication or in the absence of a judicial hearing,²¹⁰ the Supreme Court has clearly held that "[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."²¹¹ Subsequently, the Supreme Court permitted involuntary medication of pretrial detainees, outlining the circumstances in which incompetent defendants may be forcibly medicated against their will in

Antipsychotic medications are an accepted and often irreplaceable treatment for acute psychotic illnesses, as most firmly established for schizophrenia, because the benefits of antipsychotic medications, compared to any other available means of treatment, outweigh their acknowledged side effects. Although psychosocial interventions are helpful in the long-term management of schizophrenia, they lack proven efficacy for controlling acute psychotic symptoms.;

Winick, *supra* note 23, at 22 (explaining that medication is the most effective treatment for incompetent defendants, but that it requires ongoing use to ensure competency); *see also supra* note 55 and accompanying text (explaining that medication is the most common form of treatment).

207. *See, e.g.,* Stone, *supra* note 5, at 304–05 (finding that seventy percent of patients with schizophrenia experience clear improvement from use of antipsychotic drugs, and seventy to eighty percent of patients with depression or mood disorders improve with use of antidepressant drugs).

208. *See id.* at 305 (noting that antipsychotic drugs can be used to address symptoms like psychomotor excitement, hallucinations, delusions, mania, and organic psychosis).

209. *See supra* notes 106–107 and accompanying text; *see also* Robert D. Miller et al., *The Impact of the Right to Refuse Treatment in a Forensic Patient Population: Six-Month Review*, 17 BULL. AM. ACAD. PSYCHIATRY & L. 107, 110–11 (1989) (finding that twenty-nine percent of patients already taking psychotropic medications and seventy-five percent of newly admitted patients refused medication after being told of a right to refuse treatment).

210. This is a very controversial topic in the academic literature. However, it is beyond the scope of this Note to further explore the involuntary medication debate. For an argument that involuntary medication without a judicial hearing may violate the Due Process Clause, *see* Patricia E. Sindel, *Fourteenth Amendment: The Right to Refuse Antipsychotic Drugs Masked by Prison Bars*, 81 J. CRIM. L. & CRIMINOLOGY 952, 967–79 (1991).

211. *Washington v. Harper*, 494 U.S. 210, 227 (1990).

Sell v. United States.²¹² Even more importantly, this requirement ultimately benefits individuals who vacillate between competence and incompetence, allowing them to avoid the significant pain and suffering that accompanies the decompensation cycle.

Such an order may also require prisons and jails to spend more money to hire additional staff to ensure the proper provision of medications and to fund treatment review committees, which are often required to forcibly medicate inmates.²¹³ However, reducing the prevalence of the decompensation cycle will lead to significant cost savings over time that can be used to support a more robust staff.²¹⁴ And more importantly, given the potential constitutional violations at stake, a state may not deprive pretrial detainees of their substantive due process rights due to limited resources.²¹⁵

B. A Twenty-First Century Approach: Using Telemedicine to Enhance Mental Health Treatment in Correctional Facilities

Though maintaining the treatment prescribed by the state mental health facility will serve to lessen the chance of decompensation, some detainees may still begin to decompensate upon their return due to the conditions of jail. Without specially trained psychiatric staff, the decompensation may go unnoticed by jail staff. Therefore, to further reduce the risk of decompensation and to help facilities provide sufficient care, states should consider using new and emerging technology to provide “telemedicine” to recently restored pretrial

212. 539 U.S. 166 (2003). Specifically, the Supreme Court held:

First, a court must find that *important* governmental interests are at stake. . . . Second, the court must conclude that involuntary medication will *significantly further* those concomitant state interests. . . . [and] that administration of the drugs is substantially unlikely to have side effects that will interfere significantly with the defendant’s ability to assist counsel. . . . Third, the court must conclude that involuntary medication is *necessary* to further those interests. . . . Fourth . . . the court must conclude that the administration of the drugs is *medically appropriate, i.e.*, in the patient’s best medical interest in light of his medical condition.

Id. at 180–81. The *Sell* decision provides a potential exception that may apply to defendants deemed incompetent to stand trial. *See id.* at 182–83 (noting that courts applying the *Sell* test should determine if the drugs are necessary to a governmental interest, including “whether medication is permissible to render a defendant competent”). For a discussion about how this exception may apply to defendants deemed incompetent, see Christopher Slobogin, *Sell’s Conundrums: The Right of Incompetent Defendants to Refuse Anti-Psychotic Medication*, WASH. U. L. REV. 1523, 1532–35 (2012).

213. Although beyond the scope of this Note, changing the composition and structure of treatment review committees to be more efficient could also serve to prevent decompensation for detainees who refuse to take their medication.

214. *See supra* notes 194–200 and accompanying text.

215. *See supra* note 134 and accompanying text.

detainees who have returned to jail. Telemedicine allows medical personnel to rely on the use of satellite technology, video conferencing, and data transfer through smartphones and computers to connect doctors and patients who are located outside of the same setting.²¹⁶ In recent years, telemedicine has emerged as a tool to provide high-quality psychiatric care.²¹⁷ As noted by one article, “[t]elemedicine has the potential to improve quality of care by allowing clinicians in one ‘control center’ to monitor, consult and even care for . . . patients in multiple locations.”²¹⁸

Telemedicine has emerged as a possible solution to the underfunding of prison and jail medical facilities and the severe health needs of many inmates. Recent statistics suggest that at least thirty states already use telemedicine to address at least one health specialty in jails or prisons.²¹⁹ And in twenty-eight of these states, telemedicine was most commonly used to provide psychiatric services not available at the correctional facility.²²⁰ In Texas, for example, the University of Texas Medical Branch and Texas Tech provide telemedicine and telepsychiatry to roughly 130,000 inmates each year.²²¹

The Bureau of Prisons began testing the use of telemedicine in its facilities in 1996.²²² A study of its implementation found that telemedicine successfully replaced the use of local consulting physicians, who would visit the prison on a scheduled basis to provide treatment.²²³ The prisons relying on this technology reported higher satisfaction with the quality of care provided by the telemedicine specialists than the consulting psychiatrists who previously provided care.²²⁴ In two of the four facilities studied, the use of telemedicine increased the number of psychiatric encounters per month.²²⁵

216. Pauline W. Chen, *Are Doctors Ready for Virtual Visits?*, N.Y. TIMES (Jan. 7, 2010), <http://www.nytimes.com/2010/01/07/health/07chen.html> [https://perma.cc/E644-XMBY].

217. See Kristine Crane, *Telepsychiatry: The New Frontier in Mental Health*, U.S. NEWS (Jan. 15, 2015, 10:36 AM), <http://health.usnews.com/health-news/patient-advice/articles/2015/01/15/telepsychiatry-the-new-frontier-in-mental-health> [https://perma.cc/A4GG-UVY9] (explaining the use and expansion of telemedicine in providing psychiatric care).

218. Chen, *supra* note 216.

219. CHARI ET AL., *supra* note 87, at 8.

220. *Id.*

221. Stacie Deslich et al., *Telepsychiatry in the 21st Century: Transforming Healthcare with Technology*, PERSP. HEALTH INFO. MGMT., Summer 2013, at 1, 8.

222. ABT ASSOCS. INC., U.S. DEP'T OF JUSTICE, NCJ 175040, TELEMEDICINE CAN REDUCE CORRECTIONAL HEALTH CARE COSTS: AN EVALUATION OF A PRISON TELEMEDICINE NETWORK 2 (1999).

223. *Id.* at 15.

224. *Id.*

225. *Id.* Similarly, a study of the use of telemedicine for Georgia state prisoners found that inmates might be more willing to seek psychiatric care through telemedicine because of the lack of interpersonal intimacy compared to in-person meetings. Deslich et al., *supra* note 221, at 8.

Moreover, the prisons reported that the use of telemedicine psychiatrists was advantageous because they “were available by telephone as needed to revise medication orders . . . [and] had better medication management skills than did local psychiatrists.”²²⁶ The prisons using telemedicine also saw a reduction in violent acts, which many attributed to the improved psychiatric care.²²⁷ Finally, the use of telemedicine reduced spending, as it no longer required the transfer of prisoners to outside medical facilities.²²⁸ A separate study of the use of telemedicine in ten rural prisons in Arizona found that it saved the state more than one million dollars due to decreases in transportation costs, paperwork, and person-hours dealing with grievances.²²⁹

Thus, the use of telemedicine could allow specialized health care personnel at the state mental health facility to monitor pretrial detainees who have returned to jail to await trial. As evidenced by the Bureau of Prisons study, telemedicine can improve the mental health of inmates at a low cost to the state.²³⁰ Indeed, in one study, videoconferencing was found to be equally effective in assessing schizophrenics as in-person interviews by the same staff.²³¹ Further, the psychiatrists at the state mental health facility could easily ensure the detainee is receiving his medications properly and “revise medication orders” as necessary after speaking with the detainee.²³²

Though the use of telemedicine for psychiatry is already underway, many participating states have reported that their facilities relied on telemedicine primarily to reduce travel to rural or geographically remote facilities.²³³ Therefore, states would need to “scale up” this technology in order to meet the needs of detainees at every correctional facility. However, costs associated with implementing such a system may not be high, as the cost of

226. ABT ASSOCS. INC., *supra* note 222, at 29.

227. *Id.* at 30. In prisons and jails, the use of telemedicine can also reduce the security risks inherent in transferring prisoners to treatment outside of the facility. *Id.* at 2.

228. *Id.* at 16–19 (finding that telemedicine saved approximately \$27,500 by preventing transfers to external specialists, and \$59,000 in avoiding costly air transfers).

229. Deslich et al., *supra* note 221, at 8.

230. *See* ABT ASSOCS. INC., *supra* note 222, at 22–26 (describing the costs and savings in implementing telemedicine in correctional facilities).

231. ANNO ET AL., *supra* note 3, at 175. However, this study noted that the videoconferencing must be at high bandwidth to be effective, as lower-bandwidth conferencing did not allow providers to notice nonverbal cues. *Id.*; *see also* Deslich et al., *supra* note 221, at 5 (finding that “[l]atency, poor image quality, and other possible quality problems experienced over IP networks can hamper or prevent proper diagnosis”).

232. *See* ABT ASSOCS. INC., *supra* note 222, at 29 (describing the ways in which off-site psychiatrists manage medication).

233. CHARI ET AL., *supra* note 87, at 6.

telemedicine technology continues to drop.²³⁴ Nevertheless, prisons and jails relying on telemedicine would still need to address questions of patient safety, security, and confidentiality.²³⁵

Certainly, an order to maintain treatment recommended by the state mental health facility, supported by telemedicine, would not address all the issues facing incompetent pretrial detainees. The environment of the facility could still prove detrimental to a pretrial detainee's fragile mental health state.²³⁶ And correctional institutions should still take steps to train both prison and jail medical staff, as well as guards, about the signs and symptoms of mental illnesses to allow for better awareness and treatment within the facility itself. However, the adequate provision of medication and monitoring by psychiatry staff from the state competency treatment facility through telemedicine could go a long way in addressing the faults of our current system that create a recurring cycle of decompensation.

CONCLUSION

The increase in both mentally ill and incompetent defendants has stretched the capacity of prisons, jails, and state mental health facilities to serve these individuals. The prevalence of mentally ill individuals within the criminal justice system suggests that there is a substantial need for improved mental health treatment. However, due to insufficient state funding and inadequate mental health treatment in jails, many pretrial detainees deemed incompetent cycle through the treatment system, bouncing between states of competency and incompetency. Such a decompensation cycle not only wastes scarce fiscal resources and creates inefficiencies, it also raises significant substantive due process concerns—affecting an individual's right to

234. See, e.g., ABT ASSOCS. INC., *supra* note 222, at 4 (noting that even during the short implementation period when the study was conducted, the cost of telemedicine technology had continued to decrease significantly). A 2004 report suggested that the cost of implementing telemedicine in a prison ranged between \$50,000 and \$75,000. CHAD KINSELLA, COUNCIL OF STATE GOV'TS, CORRECTIONS HEALTH CARE COSTS 18 (2004). However, a recent article suggests that a “standard telemedicine unit—including a small audio console, a camera that can zoom in and out, and a monitor—costs less than \$2,000.” Michelle Ollove, *State Prisons Turn to Telemedicine to Improve Health and Save Money*, PEW CHARITABLE TRUST: STATELINE (Jan. 21, 2016), <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/01/21/state-prisons-turn-to-telemedicine-to-improve> [<https://perma.cc/T8JU-NLCV>]. Furthermore, some facilities have already begun using televisits for nonhealth-related reasons, including family visits. See, e.g., Joe Mauceri, *Televisiting Lets Kids Talk to Incarcerated Parents Without Going to Prison*, PIX 11 (Aug. 3, 2017, 4:44 PM), <http://pix11.com/2017/08/03/televisiting-lets-kids-talk-to-incarcerated-parents-without-going-to-prison/> [<https://perma.cc/C3SG-795X>].

235. Deslich et al., *supra* note 221, at 6–7 (describing some of the implementation challenges involving confidentiality, patient security, and safety).

236. See *supra* notes 75–83 and accompanying text.

adequate medical treatment and liberty interests in freedom from incarceration and restorative treatment. Furthermore, it causes individuals to experience significant pain and suffering, even leading to suicide. To end this cycle, judges must order jails to provide sufficient mental health treatment to maintain the treatment prescribed by the state mental health facility. States should also consider other efforts to support the continued health of these detainees, including the use of telemedicine, which offers promising outcomes for psychiatric care. These efforts will help to ensure that individuals who are still presumed innocent do not suffer at the hands of our criminal justice system.

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