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Cruel & Unusual Pathways to Crime: A Call for Gender- and Trauma-Informed Correctional Care

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**CRUEL & UNUSUAL PATHWAYS TO CRIME:
A CALL FOR GENDER- AND TRAUMA-INFORMED
CORRECTIONAL CARE**

*Emily Frances Musson**

Many female inmates have suffered trauma by way of interpersonal violence, which often precipitates mental health issues as well as criminal behavior later in life. Eighth Amendment jurisprudence dictates that they are entitled to adequate mental health treatment while incarcerated. Despite an influx of female inmates and the number of those requiring treatment, mental health programs in penal institutions have been designed to serve the needs of incarcerated men. Meanwhile, psychosocial scholarship has determined that mental health treatment needs to be informed by offenders' common experiences as women and victims of gender-based violence (gender-responsive), as well as survivors of trauma (trauma-informed) to be effective. Trauma-informed and gender-responsive mental health treatment has been proven to increase institutional security and contribute to the rehabilitative function of incarceration, reducing recidivism. The failure to reform correctional mental health care to take trauma and gender into account rises to the level of deliberate indifference to the serious medical needs of female inmates. This article further considers that a combination of inconsistent standards, procedural barriers, and institutional insolvency preclude inmates from vindicating their rights, and concludes that legislative action appropriating the necessary funding is their only hope.

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INTRODUCTION

Eighth Amendment jurisprudence supports the proposition that inmates are entitled to a certain standard of mental health treatment during their incarceration.¹ Although correctional facilities were not originally intended to serve as mental health facilities, today that is one of their main purposes.² As a result, the proportion of mentally

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¹ *Dunn v. Dunn*, 219 F. Supp. 3d 1100, 1122 (M.D. Al. 2016); *Feliciano v. Gonzalez*, 13 F. Supp. 2d 151, 208 (D.P.R. 1998); *Coleman v. Wilson*, 912 F. Supp. 1282, 1301 (E.D. Cal. 1995); *Madrid v. Gomez*, 889 F. Supp. 1146, 1255 (N.D. Cal. 1995).

² See *Human Rights at Home: Mental Illness in U.S. Prisons and Jails: Hearing Before the Subcomm. on Human Rights and the Law of the S. Comm. on the Judiciary*, 111th Cong. 68–78, 69 (2009) (statement of Michael W. Macleod-Ball, Acting Director, Joanne Lin, Legislative Counsel, of the American Civil Liberties Union) [hereinafter ACLU] (describing the deinstitutionalization of seriously mentally ill patients during the late 20th century which led to their over-incarceration because of a lack of community supports); *Human Rights at Home: Mental Illness in U.S. Prisons and Jails: Hearing Before the Subcomm. on Human Rights and the Law of the S. Comm. on the Judiciary*, 111th Cong. 214–227, 214 (2009) (statement of Human Rights Watch) [hereinafter Human Rights Watch] (“Many of the men and women who cannot get mental health treatment in the community are swept into the criminal justice system after they commit a crime.”). Prisoners are two to four times more likely to suffer from mental illness than the average person in the community. DORIS JAMES & LAUREN GLAZE, U.S. DEP’T OF JUSTICE, OFFICE OF JUSTICE PROGRAMS, BUREAU OF JUSTICE STATISTICS SPECIAL REPORT: MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1 (2006), <https://www.bjs.gov/content/pub/pdf/mhppji.pdf> [hereinafter U.S. BJS MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES REPORT 2006].

ill inmates has risen as jails and prisons have become overcrowded,³ and resources are spread increasingly thin. Meanwhile, the proportion of female inmates has increased substantially over the same time, faster than any other group.⁴ These two groups have tremendous overlap, and yet women continue to receive mental health care historically based on the needs of men.⁵ Moreover, a vast proportion of female offenders suffer from mental illness stemming from a history of trauma.⁶ Despite intervention by courts and legal advocates, policymakers continually fail to reform mental health services in a way that considers the realities of inmates' lives, particularly as they relate to gender and prior trauma. This failure constitutes a deliberate indifference to the medical needs of prisoners and encroaches upon their Eighth Amendment right to be free from cruel and unusual punishment.

³ Olga Khazan, *Most Prisoners Are Mentally Ill*, THE ATLANTIC (Apr. 7, 2015), <https://www.theatlantic.com/health/archive/2015/04/more-than-half-of-prisoners-are-mentally-ill/389682/>; Lorna Collier, *Incarceration Nation*, MONITOR ON PSYCHOL., Oct. 2014, at 56.

⁴ Matti Hautala, Note, *In the Shadow of Sandra Bland: The Importance of Mental Health Screening in U.S. Jails*, 21 TEX. J. ON C.L. & C.R. 89, 118, 121 (2015); Catherine Lewis, *Treating Incarcerated Women: Gender Matters*, 29 PSYCHIATRIC CLINICS OF N. AM. 773, 773 (2006) (citing PAIGE M. HARRISON & ALLEN J. BECK, U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, BUREAU OF JUSTICE STATISTICS: PRISONERS IN 2002 (2003); LAWRENCE A. GREENFELD & TRACY L. SNELL, U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, BUREAU OF JUSTICE STATISTICS SPECIAL REPORT: WOMEN OFFENDERS (1999); TRACY L. SNELL & DANIELLE MORTON, U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, BUREAU OF JUSTICE STATISTICS SPECIAL REPORT, SURVEY OF STATE PRISON INMATES 1991: WOMEN IN PRISON (1994)); Barbara E. Bloom et al., *Women Offenders and the Gendered Effects of Public Policy*, 21 REV. OF POL'Y RES. 1, 31 (2004).

⁵ Bloom et al., *supra* note 4, at 36, 41; Haegyung Cho, Note, *Incarcerated Women and Abuse: The Crime Connection and the Lack of Treatment in Correctional Facilities*, 14 S. CAL. REV. L. & WOMEN'S STUD. 137, 147–48 (2004); Lewis, *supra* note 4, at 773; *see generally* Barbara E. Bloom & Stephanie S. Covington, *Addressing the Mental Health Needs of Women Offenders*, in WOMEN'S MENTAL HEALTH ISSUES ACROSS THE CRIMINAL JUSTICE SYSTEM 160–176 (2009) (arguing mental health programming in women's correctional facilities should be based on their own needs); Lewis, *supra* note 4 (arguing for gender to be taken into consideration in mental health programming for women's correctional institutions).

⁶ Bloom et al., *supra* note 4, at 35.

In Part I, this Note explores Eighth Amendment jurisprudence and its application to correctional mental health services generally. It explains how unclear guidance from the Supreme Court and diverse applications and analyses by lower courts have muddled this issue further. Part II goes on to examine this application in the specific context of female inmates with common experiences of trauma and interpersonal violence. It demonstrates how the effects of trauma and gender-based violence often lead to serious medical needs, requiring appropriate attention by correctional staff. Part III proposes the implementation of validated mental health screenings and trauma- and gender-informed mental health care, and demonstrates why legislative action to that effect is necessary.

I. THE EIGHTH AMENDMENT AND MENTAL HEALTH

According to the text of the Eighth Amendment, “Excessive bail shall not be required, nor excessive fines imposed, *nor cruel and unusual punishments inflicted*.”⁷ The ambiguity of the Cruel and Unusual Punishment Clause and its application to conditions of confinement in correctional facilities has been the subject of debate for centuries.⁸ As such, developments have come in ideological waves that continue to progress with general societal norms about dignity and humanity.⁹ The Eighth Amendment has been interpreted as being primarily troubled by the idea of prisoners enduring “torture and other barbarous methods of punishment.”¹⁰ Accordingly, the Supreme Court has stated that the “dignity of man” underlies the basis of the Eighth Amendment prohibition of the

⁷ U.S. CONST. amend. VIII.

⁸ See *Trop v. Dulles*, 356 U.S. 86, 100 (1958) (citing Magna Carta (1215)).

⁹ David Heffernan, *America the Cruel and Unusual? An Analysis of the Eighth Amendment Under International Law*, 45 CATH. U.L. REV. 481, 487–95 n. 21–23 (1996) (citing *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (holding certain prison conditions unconstitutional); *State of La. ex rel. Francis v. Resweber*, 329 U.S. 459, 463 (1947) (holding “punishments inflicting wanton or unnecessary pain” unconstitutional); *Weems v. United States*, 217 U.S. 349, 397 (1910) (holding “barbaric and torturous punishments” unconstitutional)).

¹⁰ *Estelle*, 429 U.S. at 102 (citing *Gregg v. Georgia*, 428 U.S. 153, 169–173 (1976)); Lori A. Marschke, Note, *Proving Deliberate Indifference: Next to Impossible for Mentally Ill Inmates*, 39 VA. U.L. REV. 487, 500–01 (2014); Heffernan, *supra* note 9, at 488.

“unnecessary and wanton infliction of pain.”¹¹ Subsequent caselaw has illustrated that this prohibition gives rise to an affirmative duty on the part of the state to provide a certain level of physical and mental health care to its charges.¹²

A. Eighth Amendment Jurisprudence

The prohibition against cruel and unusual punishments extends to punishments which violate “broad and idealistic concepts of dignity, civilized standards, humanity, and decency.”¹³ As a result, a prisoner’s basic needs, including food and medical care, must be met in order to constitute humane conditions.¹⁴ Because the state’s custody and control prevents the inmate from satisfying her own needs,¹⁵ incarceration creates an affirmative duty for the state to

¹¹ *Gregg*, 428 U.S. at 173; *Coleman v. Schwarzenegger*, 922 F. Supp. 2d 882, 887 (E.D. Cal. 2009); *Feliciano v. Gonzalez*, 13 F. Supp. 2d 151, 204 (D.P.R. 1998); *Coleman v. Wilson*, 912 F. Supp. 1282, 1298 (E.D. Cal. 1995); *Hutchings v. Corum*, 501 F. Supp. 1276, 1280 (W.D. Mo. 1980); *Hautala*, *supra* note 4, at 107; *Marschke*, *supra* note 10, at 501 (quoting *Gregg*, 428 U.S. at 173; *Heffernan*, *supra* note 9, at 491–92; Kendra Weatherhead, Note, *Cruel but Not Unusual Punishment: The Failure to Provide Adequate Medical Treatment to Female Prisoners in the United States*, 13 HEALTH MATRIX 429, 431 (2003).

¹² *Dunn v. Dunn*, 219 F. Supp. 3d 1100, 1122 (M.D. Al. 2016); *Feliciano*, 13 F. Supp. 2d at 208; *Coleman*, 912 F. Supp. at 1301; *Madrid v. Gomez*, 889 F. Supp. 1146, 1255 (N.D. Cal. 1995).

¹³ *Feliciano*, 13 F. Supp. 2d at 205 (quoting *Estelle*, 429 U.S. at 102); *Madrid*, 889 F. Supp. at 1245; *Hutchings*, 501 F. Supp. at 1280 (quoting *Campbell v. Cauthron*, 623 F.2d 503, 505 (8th Cir. 1980)).

¹⁴ *Farmer v. Brennan*, 511 U.S. 825, 832 (1994); *Dunn*, 219 F. Supp. 3d at 1121; *Feliciano*, 13 F. Supp. 2d at 204; *Coleman*, 912 F. Supp. at 1298; Susan Herman, *Prison Litigation Reform Act: Prison Reform Litigation Acts*, 24 FED. SENT’G REP. 263, 263 (2012); *Marschke*, *supra* note 10, at 501; Joanna E. Saul, *This Game is Rigged: The Unequal Protection of our Mentally-Ill Incarcerated Women*, 5 AM. U. MOD. AM. 42, 43 (2009).

¹⁵ *Dunn*, 219 F. Supp. 3d at 1121 (citing *Estelle*, 429 U.S. at 103); *Feliciano*, 13 F. Supp. 2d at 204; *Coleman*, 912 F. Supp. at 1297–98; Herman, *supra* note 14, at 263; *Marschke*, *supra* note 10, at 502; Weatherhead, *supra* note 11, at 436 (citing *Youngberg v. Romeo*, 457 U.S. 307, 317 (1982)).

provide adequate provisions.¹⁶ The Supreme Court's holding in *Estelle v. Gamble* laid out the legal standard governing the adequacy of those provisions.¹⁷

The plaintiff in *Estelle* brought a civil suit under 42 U.S.C. Section 1983 alleging inadequate treatment of a back injury he sustained during a prison work assignment while incarcerated.¹⁸ On appeal, the United States Court of Appeals for the Fifth Circuit reversed and remanded the District Court for the Southern District of Texas's dismissal for failure to state a claim.¹⁹ On certiorari, the Supreme Court announced the applicable standard and reversed in favor of the plaintiff. Following *Estelle*, a state actor's failure to provide adequate medical care is only cognizable under 42 U.S.C. 1983 if a court finds it constitutes "deliberate indifference to serious medical needs of prisoners."²⁰ Although a course of treatment that is simply not preferred is not cruel and unusual punishment, the United States Court of Appeals for the Eleventh Circuit has held that constitutionally adequate treatment requires more than simply "some treatment."²¹ Because of the Supreme Court's failure to provide practical guidance as to the definitions of "adequate medical care," "serious medical need," and "deliberate indifference," these standards have been inconsistently applied to more recent Eighth Amendment challenges.²² As a result, the black letter law of cognizable claims of cruel and unusual punishment has developed deep cracks through which too many female offenders continue to fall.

¹⁶ See *Feliciano*, 13 F. Supp. 2d at 204; *Madrid*, 889 F. Supp. at 1245; *Herman*, *supra* note 14, at 263; *Marschke*, *supra* note 10, at 502; *Weatherhead*, *supra* note 11, at 436 (citing *Youngberg*, 457 U.S. at 317).

¹⁷ *Estelle*, 429 U.S. at 103–05.

¹⁸ *Id.* at 98.

¹⁹ *Id.*

²⁰ *Id.* at 104; *Dunn*, 219 F. Supp. 3d at 1121; *Coleman*, 912 F. Supp. at 1298; *Heffernan*, *supra* note 9, at 492; *Marschke*, *supra* note 10, at 490, 501–503; *Weatherhead*, *supra* note 11, at 436; *Ira P. Robbins, Criminal Law: Managed Health Care in Prisons as Cruel and Unusual Punishment*, 90 J. CRIM. L. & CRIMINOLOGY 195, 206 (1999).

²¹ *Dunn*, 219 F. Supp. at 1124; *Coleman v. Schwarzenegger*, 922 F. Supp. 2d 882, 887 (E.D. Cal. 2009).

²² *Marschke*, *supra* note 10, at 490; *Saul*, *supra* note 14, at 43.

B. Standards Applied to Lack of "Adequate Health Care" Claims

While the mandate for adequate health care in correctional facilities was made clear by the Court's holding in *Estelle*, the boundaries of "adequate health care" and government's legal obligation to provide it remain unclear. To that end, claims for violations of inmates' Eighth Amendment rights are largely brought in federal court pursuant to 42 U.S.C. Section 1983,²³ subject to restrictions in the Prison Litigation Reform Act.²⁴ Since the Court's decision in *Estelle v. Gamble*,²⁵ it has been settled law that the failure to provide adequate health care to prisoners could rise to the level of cruel and unusual punishment if it meets a standard of deliberate indifference to a serious medical need.²⁶ But, because there is no clear and concise definition of "serious medical need" or "deliberate indifference," application has run the gamut.²⁷ Consequently, what this often means for offenders in need of individualized mental health care is continued suffering.

²³ 42 U.S.C. § 1983 (2012); see *Farmer v. Brennan*, 511 U.S. 825, 841 (1994); *Estelle*, 429 U.S. at 97; *Union Cty. Jail Inmates v. Di Buono*, 713 F.2d 984, 986 (3d Cir. 1983); *Madrid v. Gomez*, 889 F. Supp. 1146, 1155 (N.D. Cal. 1995).

²⁴ See Prison Litigation Reform Act, 14 U.S.C. § 1997e; 18 U.S.C. § 3626 (2012).

²⁵ *Estelle*, 429 U.S. at 97 (1976).

²⁶ *Hautala*, *supra* note 4, at 107–08; *Marschke*, *supra* note 10, at 502.

²⁷ *Marschke*, *supra* note 10, at 491. See, e.g., *Peralta v. Dillard*, 744 F.3d 1076, 1081 (9th Cir. 2014) ("A medical need is serious if failure to treat it will result in 'significant injury or the unnecessary and wanton infliction of pain.'"); *Gaudreault v. Mun. of Salem, Mass.*, 923 F.2d 203, 208 (1st Cir. 1990) ("A medical need is 'serious' if it is one that has been diagnosed by a physician as mandating treatment, or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention."); *Nance v. Kelly*, 912 F.2d 605, 607 (2d Cir. 1990) ("The 'serious medical need' requirement contemplates a condition of urgency, one that may produce death, degeneration, or extreme pain."); *Monmouth Cty. Corr. Inst. Inmates v. Lanzaro*, 834 F.2d 326, 347 (3d Cir. 1987) ("[W]here denial or delay causes an inmate to suffer a life-long handicap or permanent loss, the medical need is considered serious.").

1. “Serious Medical Need”

One of the essential elements of an inmate’s Section 1983 claim for lack of adequate health care in penal institutions is a medical need that was sufficiently serious to warrant court intervention in matters historically deferred to prison personnel.²⁸ Unfortunately, the Supreme Court did not define this part of the test.²⁹ The District Court for the Eastern District of California held that “[t]he ‘routine discomfort’ that results from incarceration and which is ‘part of the penalty that criminal offenders pay for their offenses against society’ does not constitute a ‘serious medical need’.”³⁰ The court went on to apply the United States Court of Appeals for the Ninth Circuit’s standard requiring “an injury that a reasonable doctor or patient would find important and worthy of comment or treatment; the presence of a medical condition that significantly affects an individual’s daily activities; or the existence of chronic and substantial pain” to substantiate the element of a serious medical need.³¹

The term “serious medical need” was defined by the United States Court of Appeals for the First Circuit (and applied in the Eleventh Circuit) as a need previously diagnosed by a doctor as requiring professional attention, or in the alternative, one that even a reasonable lay person would be able to easily recognize the necessity of professional medical care.³² Additionally, the effect of the delay of necessary treatment can also be determinative of a serious medical need, but helpful or desirable treatments are not

²⁸ *Estelle*, 429 U.S. at 106; Marschke, *supra* note 10, at 507.

²⁹ Marschke, *supra* note 10, at 507 (citing Fred Cohen & Joel Dvoskin, *Inmates with Mental Disorders: A Guide to Law and Practice*, 16 MENTAL & PHYSICAL DISABILITY L. REP. 339, 341 (1992)).

³⁰ *Coleman v. Wilson*, 912 F. Supp. 1282, 1298 (E.D. Cal. 1995) (quoting *McGuckin v. Smith*, 974 F.2d 1050, 1059 (9th Cir. 1992)).

³¹ *Coleman*, 912 F. Supp. at 1298 (quoting *McGuckin*, 974 F.2d at 1059–60); Marschke, *supra* note 10, at 510–11.

³² *Dunn v. Dunn*, 219 F. Supp. 3d 1100, 1130 (M.D. Al. 2016); *Feliciano v. Gonzalez*, 13 F. Supp. 2d 151, 207 (D.P.R. 1998) (citing *Gaudreault v. Mun. of Salem, Mass.* 923 F.2d 203, 208 (1st Cir. 1990)); Marschke, *supra* note 10, at 507.

sufficient.³³ Specific diagnoses applied by mental health professionals are given a substantial amount of deference by the courts, and are thus, often dispositive.³⁴ As a result, “[t]he legal conclusion that a medical condition constitutes a serious medical need is intertwined with a factual determination inherently dependent on clinical findings.”³⁵ However, relying on diagnosis by a mental health professional to determine whether a serious medical need has been established is problematic.³⁶

Even qualified professionals may disagree³⁷ or may resist diagnosing an inmate if the prison does not have the resources to treat her.³⁸ Further, if either a mental health professional³⁹ or the correctional officers acting as gatekeepers distrust the inmate’s sincerity, she is less likely to be diagnosed.⁴⁰ In any case, the obviousness of the need for treatment may also be established through evidence of a physical manifestation in the form of behavior bizarre enough to alert a reasonable observer.⁴¹ This standard leaves inmates suffering from undiagnosed mental illnesses that do not manifest *bizarrely enough* without recourse.⁴²

2. “Deliberate Indifference”

If an inmate is able to sufficiently show that her medical need is serious enough to warrant judicial intervention, she must then demonstrate that correctional employees both should have been and

³³ *Feliciano*, 13 F. Supp. 2d at 208 (citing *Gaudreault*, 923 F.2d at 208); *Marschke*, *supra* note 10, at 507.

³⁴ *Marschke*, *supra* note 10, at 508–09 (citing *Cohen & Dvoskin*, *supra* note 29, at 341).

³⁵ *Coleman*, 912 F. Supp. at 1301.

³⁶ *Marschke*, *supra* note 10, at 523 (citing Fred Cohen, *Captives Right to Mental Health Care*, 17 L. & PSYCHOL. REV. 1, 19, 21 (1993)).

³⁷ *Marschke*, *supra* note 10, at 523 (citing Christy P. Johnson, *Mental Health Care Policies in Jail Systems: Suicide and the Eighth Amendment*, 35 U.C. DAVIS L. REV. 1227, 1251 (2002)).

³⁸ *Marschke*, *supra* note 10, at 520 (citing *Cohen*, *supra* note 36, at 1, 21).

³⁹ *Id.* at 521 (citing *Cohen*, *supra* note 36, at 1, 19, 21).

⁴⁰ *Id.* at 524–25.

⁴¹ *Id.* at 509 (citing *Cohen*, *supra* note 36, at 1, 19).

⁴² *Marschke*, *supra* note 10, at 510, 522–23 (citing *Johnson*, *supra* note 37, at 1227, 1251).

actually were aware of such need and were deliberately indifferent to it.⁴³ While the Court did not define “deliberate indifference,” there is some guidance indicating that “only indifference that offends developing decency standards violates the Eighth Amendment.”⁴⁴ As such, “inadvertent failures” do not constitute a violation of the Eighth Amendment,⁴⁵ but parties cannot escape liability by merely failing to verify facts that they “strongly suspect” are true.⁴⁶ And yet, there is evidence that if a prisoner was not acting bizarrely enough, they would be similarly disadvantaged in this regard. As one witness put it, “[i]f a patient did not engage in very flagrant behavior, aggressive violent behavior or suicidal behavior, they could stay in that cell for a long period of time, just nobody pays much attention.”⁴⁷ In such cases, the guards could plausibly claim it was an inadvertent oversight, negating any liability for the inmate’s suffering.

Following the Court’s holding in *Estelle*,⁴⁸ the circuits split as to whether the deliberate indifference standard should be based on subjective or objective recklessness.⁴⁹ The Supreme Court resolved this dispute in 1994.⁵⁰ The Court held (unanimously, “despite strong differences of opinion”⁵¹) in *Farmer v. Brennan* that deliberate indifference should be defined similarly to the way it is defined in

⁴³ *Casey v. Lewis*, 834 F. Supp. 1569, 1581 (D. Ariz. 1993); *Marschke*, *supra* note 10, at 511–12; *Weatherhead*, *supra* note 11, at 436.

⁴⁴ *Marschke*, *supra* note 10, at 512 (citing *Estelle v. Gamble*, 429 U.S. 97, 106 (1976)).

⁴⁵ *Estelle*, 429 U.S. at 105; *Dunn v. Dunn*, 219 F. Supp. 3d 1100, 1121 (M.D. Ala. 2016); *Hautala*, *supra* note 4, at 107.

⁴⁶ *Madrid v. Gomez*, 889 F. Supp. 1146, 1247 (N.D. Cal. 1995); *Coleman v. Wilson*, 912 F. Supp. 1282, 1316 (E.D. Cal. 1995).

⁴⁷ *Madrid*, 889 F. Supp. at 1217.

⁴⁸ *Estelle*, 429 U.S. at 97.

⁴⁹ *Marschke*, *supra* note 10, at 512 (citing Connie M. Mayer, *Unique Mental Health Needs of HIV-Infected Women Inmates: What Services Are Required Under the Constitution and the Americans with Disabilities Act?*, 6 WM. & MARY. J. WOMEN & L. 215, 236 (1999)). The Seventh Circuit applied an objective standard while the Eleventh Circuit applied a subjective one. Mayer, *supra* note 49, at 236–37 n. 192–93.

⁵⁰ *Marschke*, *supra* note 10, at 513; Mayer, *supra* note 49, at 237.

⁵¹ *Heffernan*, *supra* note 9, at 501.

criminal proceedings.⁵² This definition requires that officers were aware of an inmate's serious medical need and yet disregarded, ignored, or refused to provide the necessary treatment for it.⁵³ The Supreme Court set the standard for requisite scienter of the prison official quite high, suggesting the officer "must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference."⁵⁴ Although some were pleased with the result in *Farmer*,⁵⁵ it was unlikely to provide a realistic option for prisoners to vindicate their Eighth Amendment rights.⁵⁶ However, courts have had an easier time of finding the standard for deliberate indifference met when the serious medical needs are those of men.⁵⁷

⁵² *Farmer v. Brennan*, 511 U.S. 825, 847 (1994); Marschke, *supra* note 10, at 513, 515, 528–29; Heffernan, *supra* note 9, at 501.

⁵³ *Dunn v. Dunn*, 219 F. Supp. 3d 1100, 1125–26 (M.D. Ala. 2016); *Coleman v. Wilson*, 912 F. Supp. 1282, 1298 (E.D. Cal. 1995); *Madrid*, 889 F. Supp. at 1246; Hautala, *supra* note 4, at 107; Robbins, *supra* note 20, at 207; Weatherhead, *supra* note 11, at 437.

⁵⁴ *Farmer*, 511 U.S. at 837; *Coleman*, 912 F. Supp. at 1298; *Madrid*, 889 F. Supp. at 1246; Marschke, *supra* note 10, at 512, 515, 528–29; Robbins, *supra* note 20, at 208; Weatherhead, *supra* note 11, at 436.

⁵⁵ Heffernan, *supra* note 9, at 502 n. 108 (citing David G. Savage, *High Court Opens Door to Rape Suits by Inmates*, L.A. TIMES, June 7, 1994, at A4; Marcia Coyle, *High Court Roundup: Counsel, Jails, Taxes*, NAT'L L.J., June 1994, at A11; Joan Biskupic, *Justices Reinstate Lawsuit Filed by Raped Prisoner: Officials Held Liable Only If They Know of Risk*, WASH. POST, June 7, 1994, at A6).

⁵⁶ "The annual Harvard Law Review survey of the Supreme Court's 1993 Term was scathing in its criticism of *Farmer*. The survey argued that 'Farmer v. Brennan effectively leaves inhumane prison conditions without constitutional remedy.'" Heffernan, *supra* note 9, at 501–02 n. 109 (citing *The Supreme Court, 1993 Term: Leading Cases*, 108 HARV. L. REV. 139, 231–240 (1994)).

⁵⁷ Weatherhead, *supra* note 11, at 440 (citing *Wells v. Frazen*, 777 F.2d 1258 (7th Cir. 1985); *Bienvenu v. Beauregard Par. Police Jury*, 705 F.2d 1457 (5th Cir. 1983)).

II. PROBLEM: FEMALE PRISONERS ARE NOT RECEIVING ADEQUATE MENTAL HEALTH CARE, IN VIOLATION OF THEIR EIGHTH AMENDMENT RIGHTS

Largely dictated by male policymakers, the development of both Eighth Amendment jurisprudence and correctional mental health and rehabilitation programs have been guided by and biased towards the needs, preferences, and circumstances of male inmates.⁵⁸ In more recent years, the rate at which the number of female inmates has risen is unprecedented.⁵⁹ As a result, it has become increasingly imperative that the needs and experiences of female offenders be taken into consideration in the programming decisions made at women's correctional facilities.⁶⁰ Minimal treatment programs which fail to recognize patients' histories of trauma as well as the gendered aspect of their experiences do not rise to the level of adequate mental health care because they ignore serious medical needs.⁶¹ Meanwhile, the fact that mental health programming in correctional facilities has been molded to serve the needs of men⁶² lends itself to the argument that institutions have been deliberately indifferent to the unique needs of female offenders. As policymakers continue to ignore the evidence-based research supporting the

⁵⁸ Bloom et al., *supra* note 4, at 41; Samantha Cooney, *Jails Weren't Built for Women. Inmate Advocates Say That's a Big Problem*, TIME (July 19, 2017), <http://time.com/4864958/incarcerated-women-prison-inmates/>.

⁵⁹ Hautala, *supra* note 4, at 118, 121 (citing TODD D. MINTON & DANIELA GOLINELL, U.S. BUREAU OF JUSTICE STATISTICS, JAIL INMATES AT MIDYEAR 2013—STATISTICAL TABLES, 1 (2014), <http://www.bjs.gov/content/pub/pdf/jim13st.pdf>, <https://perma.cc/YHT8-6HMF>).

⁶⁰ See generally Bloom & Covington, *supra* note 5 (arguing that the unique needs of women need to be taken into consideration in the development of mental health programming in female correctional facilities); Lewis, *supra* note 4 (arguing for gender to be taken into consideration in mental health programming for women's correctional institutions).

⁶¹ ACLU, *supra* note 2, at 3; Shannon M. Lynch et al., *Looking Beneath the Surface: The Nature of Incarcerated Women's Experiences of Interpersonal Violence, Treatment Needs, and Mental Health*, 7 FEMINIST CRIMINOLOGY 4, 393, 394 (2012).

⁶² Bloom et al., *supra* note 4, at 36, 41 (citing JOCELYN M. POLLOCK, CRIMINAL WOMEN, at 8, 123 (1999)); Cooney, *supra* note 58.

necessity of trauma- and gender-informed mental health care, their lack of response comes to constitute further evidence of institutional deliberate indifference.⁶³

Without reliable, evidence-based standards in place, correctional facilities often fall back on gender stereotypes that influence decisions about who requires what kind of treatment.⁶⁴ As a result, particular inmates in need are often overlooked.⁶⁵ For those who receive treatment, mental health services are generally limited to a brief check in, psychiatric medication, and maybe an occasional private meeting with a clinician (albeit with limited confidentiality⁶⁶).⁶⁷ Incidentally, the goals of effective treatment include abstaining from substance abuse and criminal behavior, reconnecting with family, and becoming socially and economically independent.⁶⁸ To reach this point with patients suffering from Post-Traumatic Stress Disorder (PTSD), addiction, or depression as a result of traumatic abuse requires sustained treatment and regular visits with mental health professionals.⁶⁹ Furthermore, without trauma-informed and gender-responsive mental health treatment for

⁶³ See *Barney v. Pulsipher*, 143 F.3d 1299, 1308 (10th Cir. 1998); *Weatherhead*, *supra* note 11, at 438–439.

⁶⁴ *Saul*, *supra* note 14, at 43.

⁶⁵ *Id.* (citing PAULA M. DITTON, U.S. BUREAU OF JUSTICE STATISTICS, DEP'T OF JUSTICE, MENTAL HEALTH & TREATMENT OF INMATES AND PROBATIONERS, 3 (1999), <https://www.bjs.gov/content/pub/pdf/mhtip.pdf> [hereinafter U.S. BJS INMATE MENTAL HEALTH REPORT 1999] (reporting that of 24 percent of incarcerated women in state prisons who could identify themselves as having a mental health problem, only 67.3 percent of those women received treatment)).

⁶⁶ *Lynch et al.*, *supra* note 61, at 395. Correctional mental health professionals have urged policymakers to increase the level of confidentiality so as to foster an environment where the inmate can feel safe enough to disclose symptoms of mental illness, suicidal ideations, or traumatic memories. *Hautala*, *supra* note 4, at 121–22.

⁶⁷ *Dunn v. Dunn*, 219 F. Supp. 3d 1100, 1138 (M.D. Ala. 2016); *Madrid v. Gomez*, 889 F. Supp. 1146, 1218 (N.D. Cal. 1995); Human Rights Watch, *supra* note 2, at 214; U.S. BJS MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES REPORT 2006, *supra* note 2; *Marschke*, *supra* note 10, at 516 (citing *Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D. Tex. 1980)).

⁶⁸ Bonnie L. Green et al., *Trauma Exposure, Mental Health Functioning and Program Needs of Women in Jail*, 51 CRIME & DELINQ. 133, 135–36 (2005).

⁶⁹ *Lewis*, *supra* note 4, at 783–84.

those issues, female offenders will likely continue to suffer in a revolving door of incarceration.⁷⁰

A. Mental Health Care that Fails to Consider Past Trauma is Inadequate

Courts have held that there is “no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart.”⁷¹ Considering the prevalence of prior trauma in female inmate populations and the mental health needs that tend to arise from such histories,⁷² it follows that these realities should be factored into policymaking about mental health programming in female penal institutions. Just as the number of mentally ill inmates has risen, so too has the number of women incarcerated.⁷³ Researchers have commented that female offenders are subject to “the worst of both worlds,”⁷⁴ due to the systemic discrimination that follows them throughout their experiences in criminal justice.⁷⁵ Historically, women have comprised a minority of offenders, so their needs and issues have consistently been

⁷⁰ Andrea L. Dennis & Carol E. Jordan, *Encouraging Victims: Responding to a Recent Study of Battered Women Who Commit Crimes*, 15 NEV. L.J. 1, 17 (2014); Marie A. Failinger, *Feature, Women as Perpetrators of Crime: Lessons Unlearned: Women Offenders, the Ethics of Care, and the Promise of Restorative Justice*, 33 FORDHAM URB. L.J. 487, 496 (2006); Cho, *supra* note 5, at 147.

⁷¹ *Madrid*, 889 F. Supp. at 1255 (quoting *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977)); see *Dunn*, 219 F. Supp. 3d at 1122; *Feliciano v. Gonzalez*, 13 F. Supp. 2d 151, 208 (D.P.R. 1998); *Coleman v. Wilson*, 912 F. Supp. 1282, 1301 (E.D. Cal. 1995).

⁷² Bloom et al., *supra* note 4, at 35.

⁷³ Bloom & Covington, *supra* note 5 at 1; Bloom et al., *supra* note 4, at 31; Hautala, *supra* note 4, at 118, 121; Lewis, *supra* note 4, at 773 (citing HARRISON & BECK, *supra* note 4; GREENFELD & SNELL, *supra* note 4; SNELL & MORTON, *supra* note 4).

⁷⁴ Cho, *supra* note 5, at 157 (quoting Barbara Bloom & Meda Chesney-Lind, *Women in Prison: Vengeful Equity*, in IT’S A CRIME: WOMEN & JUSTICE 175, 189 (3d. ed., 2003)).

⁷⁵ Lisa Kanti Sangoi & Lorie Smith Goshin, *Women and Girls’ Experiences Before, During and After Incarceration: A Narrative of Gender-Based Violence, and an Analysis of the Criminal Justice Laws and Policies that Perpetuate This Narrative*, 20 UCLA WOMEN’S L.J. 137, 167–68 (2013).

neglected.⁷⁶ But as their numbers increase more rapidly, it is becoming undeniable that female offenders require services which are tailored to their particular circumstances and concerns.⁷⁷

Female inmates do not have access to programs that are truly responsive to their gendered experiences.⁷⁸ If any programs even claim to target female inmates, it is only to the extent of adding a focus on parenting to the programs provided to their male counterparts.⁷⁹ Surveys of female inmates reveal interest in rehabilitative programs, especially for stress management and problem-solving skills, which are particularly appropriate given the prevalence of poverty, mental illness, and trauma in this population.⁸⁰ These issues are only made worse as female inmates fail to receive effective treatment over time, causing additional problems for offenders upon reentry into the community and higher

⁷⁶ Sarah L. Cook et al., *Self-Reports of Traumatic Events in a Random Sample of Incarcerated Women*, 16 WOMEN & CRIM. JUST. 107, 123 (2005); see Weatherhead, *supra* note 11, at 444.

⁷⁷ Cook et al., *supra* note 76, at 123; Weatherhead, *supra* note 11, at 443. See, e.g., Lewis, *supra* note 4, at 773 (investigating the previously accepted standard of separate but equal services between male and female inmates); Cory Booker & Elizabeth Warren, *Women in Prison Deserve Dignity*, CNN (Sept. 5, 2017), <http://www.cnn.com/2017/09/05/opinions/female-prisoners-dignity-act-booker-warren-opinion/index.html> (introducing a bill for the Dignity for Women Act); Cooney, *supra* note 58 (referencing the legislation in several states backed by both Republican and Democratic lawmakers); Marisa Taylor, *A New Way to Treat Women's Mental Health in Prison*, ALJAZEERA AM. (July 31, 2015, 7:00 AM), <http://america.aljazeera.com/multimedia/2015/7/women-in-prison-find-common-ground-in-trauma.html> (describing the Beyond Violence pilot program at the Central California Women's Facility).

⁷⁸ Bloom et al., *supra* note 4, at 36, 41; Cho, *supra* note 5, at 148; Lewis, *supra* note 4, at 773.

⁷⁹ Joanne Belknap, *Access to Programs and Health Care for Incarcerated Women*, 60 FED. PROB. 34, 35 (1996); Cho, *supra* note 5, at 148; Dennis & Jordan, *supra* note 70, at 32.

⁸⁰ Green et al., *supra* note 68, at 147; see also Lewis, *supra* note 4, at 778 ("The objective of this review is to discuss epidemiological and psychiatric characteristics of incarcerated women and to explore potential roles and limitations of gender specific programming in the correctional system."); Lynch et al., *supra* note 61, at 381 ("The purpose of this study was to describe the nature of incarcerated women's [. . .] IPV [interpersonal violence] experiences, to investigate characteristics of IPV as predictors of current mental health, and to explore women's perceptions of their treatment needs.").

rates of recidivism (particularly given the dearth of support provided them at such a crucial time⁸¹).⁸² Domestic law does little to protect them, leaving them to live “on the fringes of society,” while mainstream society exhibits very little sympathy for their collective plight.⁸³ The indifference of our culture to this issue mirrors the indifference of our policymakers to the serious medical needs associated with a history of trauma for many female offenders. As evidence-based research continues to confirm the pathways to crime theory,⁸⁴ the connections between abuse, mental illness, and criminal behavior are becoming too clear to be ignored without liability.

⁸¹ Andrew S. Denney et al., *Beyond Basic Needs: Social Support and Structure for Successful Offender Reentry*, 2 J. OF QUALITATIVE CRIM. JUST. & CRIMINOLOGY 39, 41 (2014); see, e.g., DINA R. ROSE & TODD R. CLEAR, U.S. DEP’T OF HEALTH & HUM. SERVS.: OFF. OF THE ASSISTANT SEC’Y FOR PLAN. AND EVALUATION, INCARCERATION, REENTRY AND SOCIAL CAPITAL: SOCIAL NETWORKS IN THE BALANCE (2001), <https://aspe.hhs.gov/basic-report/incarceration-reentry-and-social-capital-social-networks-balance#Social> (exploring the complications involved in reentering the community and family unit with a social stigma that strains living expenses and interpersonal relationships).

⁸² See, e.g., U.S. BJS MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES REPORT 2006, *supra* note 2, at 7–8 (showing that an estimated 47 percent of State prisoners with a mental health problem were violent recidivists but only 39 percent of those without a mental health concern); *Jailing People with Mental Illness*, NAT’L ALL. ON MENTAL ILLNESS, <https://www.nami.org/Learn-More/Public-Policy/Jailing-People-with-Mental-Illness> (last visited May 7, 2018) (highlighting the impact of losing access to health care when reentering the community). See generally Collier, *supra* note 3 (discussing policy initiatives to increase effective mental health and substance abuse treatment to affect recidivism rates).

⁸³ Sangoi & Goshin, *supra* note 75, at 168.

⁸⁴ Pathways to crime theory (or feminist pathways research) “attempts to examine girls’ and women’s [. . .] histories, allowing them, when possible, ‘voice’ in order to understand the link between childhood and adult events and traumas and the likelihood of subsequent offending.” JOANNE BELKNAP, *THE INVISIBLE WOMAN* 71 (3d ed., 2007); see also Bloom & Covington, *supra* note 5, at 8–9 (describing pathways to crime theory). Such studies rely on interviews with offenders rather than longitudinal data to illuminate the social and economic patterns that tend to lead to criminal behavior and incarceration. BELKNAP, *supra* note 84, at 70–78.

1. Common Law Approaches to “Adequate Mental Health Care”

To avoid liability under Section 1983, correctional facilities must identify at-risk inmates in order to monitor, protect, and treat them.⁸⁵ *Estelle*’s adequate health care standard has been applied to mental health services in several district and circuit courts, although not uniformly.⁸⁶ This means that there is little to no clear guidance for institutions on how to provide services in a way that truly respects the Eighth Amendment rights of their charges. It is somewhat encouraging that “because the deliberate indifference standard has been applied in the mental health context, correctional institutes must have intake screening systems in place to identify mental illness among the inmate populations and they must provide adequate treatment to inmates with mental health needs.”⁸⁷ Unfortunately for female offenders, courts continue to defer to correctional authorities on the implementation of appropriate screening instruments⁸⁸ and treatment programs of mentally ill inmates,⁸⁹ despite mounting evidence of inadequate results.⁹⁰

A positive right to psychiatric treatment while incarcerated is supported by the United States Court of Appeals for the Fourth Circuit’s holding in *Bowring v. Godwin*,⁹¹ which relies on progressive interpretations of cruel and unusual punishment as well as the potential rehabilitation of inmates to productive citizens when

⁸⁵ Hautala, *supra* note 4, at 108.

⁸⁶ *See, e.g., Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D. Tex. 1980) (holding that the Texas Department of Corrections violated the Eighth Amendment when their mental health program did not meet minimal components under the *Estelle* standard). *But see, e.g., Marschke, supra* note 10, at 518 (citing *Estate of Novack ex rel. Turbin v. Cty. of Wood*, 226 F.3d 525 (7th Cir. 2000)) (describing court’s decision that found no constitutional violations when health care professional did not assess suicide risk after initial screening warranted it).

⁸⁷ Hautala, *supra* note 4, at 108.

⁸⁸ *See id.* at 111.

⁸⁹ Saul, *supra* note 14, at 42; Weatherhead, *supra* note 11, at 454.

⁹⁰ *See Estate of Novack*, 226 F.3d at 530–31.

⁹¹ *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977).

they are released.⁹² Under the *Bowring* standard, a prisoner is entitled to mental health services only if (1) the prisoner shows symptoms of a mental illness; (2) the disease is treatable; and (3) the delay or denial of care could potentially harm them.⁹³ As a result of traumatic abuse, many female offenders suffering from mental health issues show symptoms of harmful but treatable diseases.⁹⁴ There is a much higher standard for determining if a mental health need is serious, requiring a “‘significant disruption’ in an inmate’s life [which would] prevent the inmate from functioning ‘without disturbing or endangering others or himself.’”⁹⁵ The implication here is that the inmate must demonstrate that her life has been disrupted in a way that puts herself or others in danger, despite the courts’ consistent holding that “a remedy for unsafe conditions need not await a tragic event.”⁹⁶ This makes the current “crisis-driven” approach to correctional mental health services somewhat easier to understand,⁹⁷ although no less problematic.

2. Pathways to Crime

As the lives of female offenders are researched more thoroughly and more specifically, patterns of traumatic abuse, drug use, and

⁹² Egardo Rotman, *Criminal Law: Do Criminal Offenders Have a Constitutional Right to Rehabilitation?*, 77 J. CRIM. L. & CRIMINOLOGY 1023, 1049 (1987) (citing *Bowring*, 551 F.2d at 48).

⁹³ *Bowring*, 551 F.2d at 44; Hautala, *supra* note 4, at 107–08.

⁹⁴ See Bloom & Covington, *supra* note 5, at 19; Green et al., *supra* note 68, at 134, 144–145; Lynch et al., *supra* note 61, at 382; see generally Carsten Spitzer et al., *Complex Posttraumatic Stress Disorder & Child Maltreatment in Forensic Inpatients*, 17 J. OF FORENSIC PSYCHIATRY & PSYCHOL. 204 (2006) (connecting childhood trauma to diagnosable mental health issues in adulthood).

⁹⁵ Hautala, *supra* note 4, at 107–08 (citing MICHELE DEITCH, *Correctional Health Care and Special Populations—Legal Considerations and Context*, in MANAGING SPECIAL POPULATIONS IN JAILS AND PRISONS 21–29 (Stan Stojkovic ed., 2005)).

⁹⁶ *Dunn v. Dunn*, 219 F. Supp. 3d 1100, 1122 (M.D. Ala. 2016) (quoting *Helling v. McKinney*, 509 U.S. 25, 33–34 (1993)).

⁹⁷ See *Madrid v. Gomez*, 889 F. Supp. 1146, 1217–18 (N.D. Cal. 1995); Lewis, *supra* note 4, at 783. See generally *Dunn*, 219 F. Supp. 3d at 1100 (illustrating the effects of mental health services which only respond when patients are in acute crisis).

mental health issues have become increasingly apparent. As researchers focus more on these patterns, their implications for the criminal behavior of female inmates have likewise become all but indisputable.⁹⁸ More effective treatment is reliant on an understanding of the way these patterns play out in the lives of female offenders.⁹⁹ The developing scholarship on women's pathways to crime has identified factors contributing to their criminal trajectories, including: histories of traumatic violence, mental health issues related to childhood experiences, destructive relationships, substance abuse and addiction, poverty, homelessness, and social marginality.¹⁰⁰ To be effective, the psychological implications of each of these aspects of a woman's existence should be addressed in appropriate mental health treatment.

The common circumstances leading to female criminal behavior tend to be gendered in nature, especially regarding early experiences of trauma and abuse,¹⁰¹ yet policies have failed to take notice. In

⁹⁸ See generally, Bloom et al., *supra* note 4, at 39 (arguing for gender-specific mental health programming in women's correctional institutes because of common themes in their histories and needs going forward); Cory Booker & Elizabeth Warren, *Women in Prison Deserve Dignity*, CNN (Sept. 5, 2017), <http://www.cnn.com/2017/09/05/opinions/female-prisoners-dignity-act-booker-warren-opinion/index.html> (introducing a bill for the Dignity for Women Act); Cooney, *supra* note 58 (referencing the legislation in several states backed by both Republican and Democratic lawmakers); Marisa Taylor, *A New Way to Treat Women's Mental Health in Prison*, AL JAZEERA AMERICA (July 31, 2015, 7:00 AM), <http://america.aljazeera.com/multimedia/2015/7/women-in-prison-find-common-ground-in-trauma.html> (describing the Beyond Violence pilot program at the Central California Women's Facility).

⁹⁹ Melanie Randall & Lori Haskell, *Restorative Justice: Trauma-Informed Approaches to Law: Why Restorative Justice Must Understand Trauma and Psychological Coping*, 36 DALHOUSIE L.J. 501, 518–19 (2013).

¹⁰⁰ Bloom & Covington, *supra* note 5, at 8–9; Bloom et al., *supra* note 4, at 33–35, 37; Lynch et al., *supra* note 61, at 382.

¹⁰¹ See Bloom et al., *supra* note 4, at 33, 37; Cho, *supra* note 5, at 146; Green et al., *supra* note 68, at 134; Irina Alexandrovna Komarovskaya et al., *Exploring Gender Differences in Trauma Exposure & the Emergence of Symptoms of PTSD Among Incarcerated Men & Women*, 22 J. OF FORENSIC PSYCHIATRY & PSYCHOL. 395, 397 (2011), at 397; Lewis, *supra* note 4, at 775, 779; Myrna S. Raeder, *Feature, A Primer on Gender-Related Issues that Affect Female Offenders*, 20 CRIM. JUST. 4, 6 (2005); Sangoi & Goshin, *supra* note 75, at 145.

particular, the legal and social constructs in place to serve victims of domestic violence are not properly attendant to the needs of incarcerated victims.¹⁰² By the same token, gender-based violence directly increases a woman's risk of future incarceration "through the intersections of interpersonal and structural violence."¹⁰³ In fact, greater exposure to trauma has been linked to earlier criminal involvement, while earlier exposure to trauma likewise increases the ultimate chances of such criminal activity.¹⁰⁴ Studies have shown that histories of traumatic gender-based violence can be huge factors influencing a woman's involvement in prostitution, larceny, and drugs later in life.¹⁰⁵ So, if the long-lasting effects of traumatic exposure could be overcome through effective treatment, future criminal behavior would likely be avoided.

Additionally, it is not uncommon for girls to run away from home as a way to escape abuse, which often leads to the commencement of their formal delinquency.¹⁰⁶ This process has been referred to as "bootstrapping" girls with noncriminal status offenses who are subsequently labeled as juvenile delinquents.¹⁰⁷

¹⁰² Dennis & Jordan, *supra* note 70, at 24, 28; Jaime M. Yarussi, *The Violence Against Women Act: Denying Needed Resources Based on Criminal History*, 3 CRIM. L. BRIEF 29 (2008).

¹⁰³ Cho, *supra* note 5, at 144; Niki A. Miller & Lisa M. Najavits, *Creating Trauma-Informed Correctional Care: A Balance of Goals & Environment*, 3 EUR. J. OF PSYCHOTRAUMATOLOGY 17246 (2012); *see* Bloom & Covington, *supra* note 5, at 2; Carol Zlotnick, *Posttraumatic Stress Disorder (PTSD), PTSD Comorbidity, and Childhood Abuse Among Incarcerated Women*, 185 J. NERVOUS & MENTAL DISEASE 761, 761–62 (1997).

¹⁰⁴ Cho, *supra* note 5, at 144; Cook et al., *supra* note 76, at 109; Komarovskaya et al., *supra* note 101, at 397.

¹⁰⁵ Centers for Disease Control & Prevention, *Child Abuse & Neglect: Consequences* (2016), <https://www.cdc.gov/violenceprevention/childmaltreatment/consequences.html> [hereinafter CDC 2016]; Bloom et al., *supra* note 4, at 34; Cho, *supra* note 5, at 144, 146; Dennis & Jordan, *supra* note 70, at 17.

¹⁰⁶ Joan Flocks et al., *The Case for Trauma-Informed*, 12 NW. J.L. & SOC. POL'Y 1, 4 (2017); Bloom & Covington, *supra* note 5, 6, 8–9; Green et al., *supra* note 68, at 134; Cho, *supra* note 5, at 146; Sangoi & Goshin, *supra* note 75, at 145–56; Raeder, *supra* note 101, at 6.

¹⁰⁷ Sangoi & Goshin, *supra* note 75, at 147. "Feminist criminologist largely understands the juvenile justice system to be a major force in the social control of girls, reinforcing female obedience to male and familial authority. The notion that

Through the institution of policies which favor arrest, girls trying to survive the violence directed at them by virtue of being female are instead introduced to the criminal justice system.¹⁰⁸ Worse, this trend tends to continue into adulthood.¹⁰⁹ Furthermore, female offenders are often influenced through their relationships with the men in their lives. Women are eight times more likely than their male counterparts to have an opposite-gender accomplice in their criminal activity.¹¹⁰ They are also often incarcerated as a result of the coercion of their partners,¹¹¹ and broad definitions of crimes like conspiracy,¹¹² constructive possession, and aiding and abetting.¹¹³ As a result, some have argued that retributivist theories of punishments should apply less severely to female offenders who are perhaps less morally culpable for their criminal involvement.¹¹⁴

Moreover, women with histories of abuse often exhibit excessive risk taking (for instance, with regard to substance use and prostitution), increasing both the likelihood they will become

the juvenile justice system is using status and low-level criminal offenses to reinforce parental authority becomes especially problematic when considering the sexual and physical abuse perpetrated against female youth offenders.” *Id.* at 148.

¹⁰⁸ *Id.* at 148; Darrell Steffensmeier et al., *An Assessment of Recent Trends in Girls' Violence Using Diverse Longitudinal Sources: Is the Gender Gap Closing?*, 43 CRIMINOLOGY 355, 365 (2005).

¹⁰⁹ Cho, *supra* note 5, at 143; Dennis & Jordan, *supra* note 70, at 21.

¹¹⁰ Lewis, *supra* note 4, at 774.

¹¹¹ In other cases, victims commit crimes with abusers to experience part of the resulting “mutually shared power.” But even these instances of agency are motivated to please the men in their lives, often their abusers. Still, describing women in a singularly dimensional way flirts with oversimplifying their plight, “portraying them as passive victims or resistant abuse survivors only,” when the truth is they are often victims as they are choosing to commit crimes, a complex paradoxical connection. Dennis & Jordan, *supra* note 70, at 18; Failing, *supra* note 70, at 497–498.

¹¹² Sangoi & Goshin, *supra* note 75, at 150 (citing LEONORA LAPIDUS ET AL., AM. CIVIL LIBERTIES UNION, BRENNAN CENTER FOR JUSTICE & BREAK THE CHAINS, CAUGHT IN THE NET: THE IMPACT OF DRUG POLICIES ON WOMEN AND FAMILIES 11, 35–38 (2005), http://www.aclu.org/files/images/asset_upload_file431_23513.pdf).

¹¹³ Cho, *supra* note 5, at 147; Dennis & Jordan, *supra* note 70, at 17; Failing, *supra* note 70, at 496–97.

¹¹⁴ See Failing, *supra* note 70, at 491.

incarcerated and the severity of their infractions.¹¹⁵ For this reason, among others, the most common crimes for which women are convicted are drug and larceny offenses.¹¹⁶ Criminal behavior related to substance use is often used to cope with the trauma of abuse, a form of self-medication to ease the symptoms of PTSD and painful memories.¹¹⁷ Despite their often minor roles in drug distribution networks, women of color in particular have been more harshly punished in United States' war on drugs.¹¹⁸ Arguably, the introduction and abidance of strict mandatory minimum statutes tends to change the way we view women's criminal behavior, and may overshadow the traumatic experiences which often precipitate criminal behavior for women in poverty.¹¹⁹ As a result of these reforms, the discretionary judgment of the court is reduced such that the judge cannot take extenuating and mitigating circumstances (such as coercion or duress) into account in the sentencing phase.¹²⁰ Now that we have this established and growing knowledgebase on the context of and pathways to female criminal behavior, it is imperative that treatment programs and policies are so informed.¹²¹ Until that happens, the Eighth Amendment rights of female offenders will continue to be trampled upon.

¹¹⁵ See Lewis, *supra* note 4, at 778; Green et al., *supra* note 68, at 134; Sangoi & Goshin, *supra* note 75, at 145.

¹¹⁶ See Bloom et al., *supra* note 4, at 31, 34; Cho, *supra* note 5, at 147; Cook et al., *supra* note 76, at 108; Lewis, *supra* note 4, at 774; Sangoi & Goshin, *supra* note 75, at 141, 148; Weatherhead, *supra* note 11, at 430.

¹¹⁷ See Cho, *supra* note 5, at 147; Cook et al., *supra* note 76, at 108; Dennis & Jordan, *supra* note 70, at 18; Failing, *supra* note 70, at 501. Longitudinal studies have shown that addiction and substance abuse are more likely to be precipitated by abuse rather than contribute to it. See Cook et al., *supra* note 76, at 109; Green et al., *supra* note 68, at 135; Lewis, *supra* note 4, at 779; Spitzer et al., *supra* note 94, at 211.

¹¹⁸ Bloom et al., *supra* note 4, at 31, 39; Sangoi & Goshin, *supra* note 75, at 149; Weatherhead, *supra* note 11, at 433–34. “Congress has accomplished the questionable goal of filling U.S. jails and prisons with low-level drug offenders, yet the drug problem in the United States has not subsided.” Weatherhead, *supra* note 11, at 434.

¹¹⁹ See Bloom et al., *supra* note 4, at 38–39; Cho, *supra* note 5, at 140; Sangoi & Goshin, *supra* note 75, at 141, 149; Weatherhead, *supra* note 11, at 433–34.

¹²⁰ Cho, *supra* note 5, at 140; Sangoi & Goshin, *supra* note 75, at 150.

¹²¹ Bloom et al., *supra* note 4, at 45.

3. Trauma Presents Serious Medical Needs

Evidence abounds of the mental health implications of traumatic histories, particularly for those who have experienced or witnessed early or chronic physical and sexual violence.¹²² Furthermore, the suffering that results from this life trajectory supports the notion that a history of abuse or other trauma tends to produce medical needs serious enough to satisfy the legal standard.¹²³ It has been further argued that “[t]he failure of many courts to recognize a history of physical and sexual abuse as a ‘serious medical need’ among female inmates and the ‘lack of care’ in preventing the exacerbation of this condition, stand as examples of how women’s experiences can be deliberately ignored in the justice system.”¹²⁴

Whether because of earlier or increased traumatic exposure or a predisposition for emotional vulnerability, it is widely accepted that “women are more likely to develop PTSD than men.”¹²⁵ Similarly,

¹²² See Green et al., *supra* note 68, at 145; Komarovskaya et al., *supra* note 101, at 397; Spitzer et al., *supra* note 94, at 211; Zlotnick, *supra* note 103, at 763.

¹²³ Karen M. Abram et al., U.S. DEP’T OF JUSTICE, OFFICE OF JUVENILE JUSTICE & DELINQUENCY PREVENTION, PTSD, TRAUMA, AND COMORBID PSYCHIATRIC DISORDERS IN DETAINED YOUTH, JUV. JUST. BULL. 3 (June 2013), <https://www.ojjdp.gov/pubs/239603.pdf> [hereinafter DEP’T OF JUSTICE, OFFICE OF JUVENILE JUSTICE & DELINQUENCY PREVENTION BULLETIN 2013].

¹²⁴ Weatherhead, *supra* note 11, at 439.

¹²⁵ *Post-Traumatic Stress Disorder*, NAT’L INST. OF MENTAL HEALTH, <https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml> (last visited May 7, 2018) [hereinafter NIMH]; see *Intimate Partner Violence: Consequences*, CENTERS FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/consequences.html> (last updated May 7, 2018) (finding that 27 percent of women and 11 percent of men have suffered intimate partner violence); DEP’T OF JUSTICE, OFFICE OF JUVENILE JUSTICE & DELINQUENCY PREVENTION BULLETIN, *supra* note 123, at 8 (finding lifetime PTSD diagnoses among young people in the community to be significantly higher for females (10.3 percent) than for males (2.8 percent)). See also Ileana Arias, Center for Disease Control & Prevention, *The Legacy of Child Maltreatment: Long-Term Health Consequences for Women*, 13 J. OF WOMEN’S HEALTH 468, 469–71 (2004) (finding females are more likely to suffer family violence than males); Bloom et al., *supra* note 4, at 35 (finding females are more likely to suffer childhood abuse than males under correctional supervision); Komarovskaya et al., *supra* note 101, at 396–97, 401 (finding that women were more likely to report family violence than men); Lewis, *supra* note

the greater exposure to interpersonal sexual and physical violence leads to higher rates of PTSD in the incarcerated community.¹²⁶ Estimates of female inmates with a history of interpersonal violence suffering from PTSD range from 48 to 88 percent.¹²⁷ In addition to PTSD, traumatic experiences are causally linked to subsequent depression, anxiety, and suicide attempts.¹²⁸ Women with such histories may have difficulties with self-regulation, emotional self-tolerance, and expression.¹²⁹ Further, PTSD and depression often lead to self-medication using drugs and alcohol, exacerbating existing economic, social, medical, and familial burdens.¹³⁰ One study found high correlations between life stressors and mental illness, especially in women who experienced multiple traumas,

4, at 779 (illustrating how family violence begets PTSD and other mental health issues).

¹²⁶ Green et al., *supra* note 68, at 145; Sangoi & Goshin, *supra* note 75, at 143.

¹²⁷ Komarovskaya et al., *supra* note 101, at 395, 402; Lewis, *supra* note 4, at 777; Zlotnick, *supra* note 103, at 761.

¹²⁸ See CDC 2016, *supra* note 105 (connecting childhood abuse to subsequent mental health issues including depression, eating disorders, and suicidal ideation); Arias, *supra* note 125, at 471 (finding “revictimized women report[ed] higher levels of depression, anxiety, hostility, PTSD-related symptomatology”); Bloom et al., *supra* note 4, at 35 (finding one fourth of female inmates suffer from mental health issues including depression and PTSD); Cook et al., *supra* note 76, at 108 (“Traumatic experiences are related to depression and anxiety and place one at risk for posttraumatic stress disorder.”); Lynch et al., *supra* note 61, at 394 (finding incarcerated women who had suffered abuse were more likely to report “high current mental health distress in the form of PTSD, depression, and/or general psychological symptoms”); Spitzer et al., *supra* note 94, at 211 (finding that childhood trauma often leads to complex PTSD in adulthood); Zlotnick, *supra* note 103, at 763 (finding “that women prisoners with PTSD were more likely to report histories of childhood abuse as well as higher levels of affect dysregulation, dissociative experiences, and somatization than those without PTSD”).

¹²⁹ Bloom & Covington, *supra* note 5, at 17; Stephanie S. Covington & Barbara E. Bloom, *Gender-Responsive Treatment and Services in Correctional Settings*, 29 WOMEN & THERAPY 9, 12 (2006).

¹³⁰ Arias, *supra* note 125, at 470; Margaret Gatz et al., *Effectiveness of an Integrated Trauma-Informed Approach to Treating Women with Co-Occurring Disorders & Histories of Trauma: The Los Angeles Site Experience*, 35 J. OF COMMUNITY PSYCHOL. 845, 864 (2007); Green et al., *supra* note 68, at 134; Failing, *supra* note 70, at 119; Lynch et al., *supra* note 61, at 394.

leading to “concern about the lack of appropriate mental health treatment available to women in correctional treatment programs, as well [as] to the risk of recidivism associated with co-occurring mental health and substance use disorder.”¹³¹

Left untreated, PTSD can lead to severe impairment of function, become chronic, and increase costs to the inmate, the institution, and society at large.¹³² Incidentally, women who suffer from a combination of PTSD and substance abuse have more comorbid psychiatric disorders,¹³³ lower levels of function, and interpersonal relation issues than woman suffering from just one or the other.¹³⁴ No doubt, life in prison is made more difficult by mental illnesses which impede thought, reasonable response, and coping.¹³⁵ As a consequence, PTSD and comorbid disorders can be exacerbated by the conditions of the inmate’s confinement.¹³⁶ Due to the diagnosable nature of the diseases which present themselves as a result of traumatic violence in a woman’s life, and the life-altering implications should such illnesses go untreated, the notion that

¹³¹ Komarovskaya et al., *supra* note 101, at 396; Green et al., *supra* note 68, at 134–55; Zlotnick, *supra* note 103, at 762.

¹³² DEP’T OF JUSTICE, OFFICE OF JUVENILE JUSTICE & DELINQUENCY PREVENTION BULLETIN 2013, *supra* note 123, at 3; *The Effects of Trauma Do Not Have to Last a Lifetime*, AM. PSYCHOLOGICAL ASS’N (2004), <http://www.apa.org/research/action/ptsd.aspx>.

¹³³ “When two disorders or illnesses occur in the same person, simultaneously or sequentially, they are described as comorbid. Comorbidity also implies interactions between the illnesses that affect the course and prognosis of both.” NAT’L INST. ON DRUG ABUSE, COMORBIDITY: ADDICTION AND OTHER MENTAL ILLNESSES 1 (SEPT. 2010) [hereinafter NIDA], <https://www.drugabuse.gov/sites/default/files/rcomorbidity.pdf>

¹³⁴ DEP’T OF JUSTICE, OFFICE OF JUVENILE JUSTICE & DELINQUENCY PREVENTION BULLETIN 2013, *supra* note 123, at 7; Bloom & Covington, *supra* note 5, at 19; Gatz et al., *supra* note 130, at 864; Lewis, *supra* note 4, at 779.

¹³⁵ Human Rights Watch, *supra* note 2, at 216; Maggie Puniewska, *We Asked What It’s Like to Have a Mental Illness in Prison*, VICE: TONIC (May 30, 2017), https://tonic.vice.com/en_us/article/43g94d/we-asked-what-its-like-to-have-a-mental-illness-in-prison.

¹³⁶ *Coleman v. Schwarzenegger*, 922 F. Supp. 2d 882, 940 (E.D. Cal. 2009); DEP’T OF JUSTICE, OFFICE OF JUVENILE JUSTICE & DELINQUENCY PREVENTION BULLETIN 2013, *supra* note 123, at 9; Mika’il DeVeaux, *The Trauma of the Incarceration Experience*, 48 HARV. C.R.-C.L. L.R. 257, 259, 264 (2013); Marschke, *supra* note 10, at 487.

traumatic experiences are related to serious medical needs is not tenuous. Regrettably, inconsistent application of legal standards as well as procedural barriers will preclude such a judicial finding.

B. Maintaining Ineffective Treatments is Institutional Deliberate Indifference

Evidence consistently shows that the current level of mental health services provided in women's correctional facilities violates inmates' constitutional rights, demonstrating a culpable level of institutional deliberate indifference.¹³⁷ The Supreme Court has approved entity liability for unconstitutional policies or customs under section 1983,¹³⁸ extending to municipalities¹³⁹ and private corporations that provide essential government services.¹⁴⁰ This means that even if the government were to contract out the custody or mental health care of inmates, it would retain "an affirmative duty" to make certain that adequate care is provided.¹⁴¹

Institutional deliberate indifference requires either that "medical facilities were so wholly inadequate for the prison population's needs that suffering would be inevitable," or else that inmates show a "series of incidents closely related in time [which] may disclose a pattern of conduct amounting to deliberate indifference to the medical needs of prisoners."¹⁴² In either case, there is some hope in

¹³⁷ See *Estate of Novack v. County of Wood*, 226 F.3d 525, 530–31 (7th Cir. 2000).

¹³⁸ *Glisson v. Ind. Dep't of Corr.*, 849 F.3d 372, 378 (7th Cir. 2017) (citing *Monell v. N.Y.C. Dep't of Soc. Servs.*, 436 U.S. 658 (1978)).

¹³⁹ *Robbins*, *supra* note 20, at 209 (citing *Monell*, 436 U.S. at 694; *Nelson v. Prison Health Services, Inc.*, 991 F. Supp. 1452, 1464 (M.D. Fla. 1997)).

¹⁴⁰ *Glisson*, 849 F.3d at 378–79; *Robbins*, *supra* note 20, at 211.

¹⁴¹ See *Dunn v. Dunn*, 219 F. Supp. 3d 1100, 1149 (M.D. Ala. 2016) (finding liability for company contracted by the state to provide correctional medical care); *Robbins*, *supra* note 20, at 211 ("These providers can be found liable for a 1983 violation if, inter alia, the court finds that state action is present. When a corporation contracts with a state to provide medical services at a correctional facility, the obligations of the Eighth Amendment attach to the provider.").

¹⁴² *Rogers v. Evans*, 792 F.2d 1052, 1058–59 (11th Cir. 1986); *Bishop v. Stoneman*, 508 F.2d 1224, 1226 (2d Cir. 1974); *Dunn*, 219 F. Supp. 3d at 1128–1129; *Feliciano v. Gonzalez*, 13 F. Supp. 2d 151, 206 (D.P.R. 1998); *Madrid v.*

that the subjective intent on an institutional level may be inferred by the mere obviousness of the risk to inmates.¹⁴³ But this inference is categorized as a rebuttable presumption, shifting the burden to prison officials.¹⁴⁴ Therefore, by failing to implement consistent guidelines for regular screenings, the defendants can claim innocent ignorance, avoiding liability altogether.¹⁴⁵ However, this failure also ensures that mental health services remain inadequate to the point of inevitable suffering.¹⁴⁶ Without adequate individualized treatment, patients often “decompensate” quickly and require intensive psychiatric care,¹⁴⁷ or worse.¹⁴⁸

Section 1983 claims for violations of the Cruel and Unusual Punishment Clause are typically brought against prison officials,¹⁴⁹ county sheriffs,¹⁵⁰ state governors,¹⁵¹ state departments of

Gomez, 889 F. Supp. 1146, 1256 (N.D. Cal. 1995); *Hutchings v. Corum*, 501 F. Supp. 1276, 1297 (W.D. Mo. 1980).

¹⁴³ *Glisson*, 849 F.3d at 381; *Dunn*, 219 F. Supp. 3d at 1125; *Coleman v. Wilson*, 912 F. Supp. 1282, 1316 (E.D. Cal. 1995); *Madrid*, 889 F. Supp. at 1247; *Robbins*, *supra* note 20, at 210.

¹⁴⁴ *Coleman*, 912 F. Supp. at 1316 (citing *Farmer v. Brennan*, 511 U.S. 825, 843 (1994)).

¹⁴⁵ See *Marschke*, *supra* note 10, at 530.

¹⁴⁶ See, e.g., *Rogers v. Evans*, 792 F.2d 1052 (11th Cir. 1986) (inmate died by suicide following a period of screaming and crying as well as “appear[ing] lifeless, standing at her door and moving only in slow motion” while in isolation); *Bishop*, 508 F.2d at 1225 (a lack of treatment for inmate’s cirrhosis of the liver and delayed treatment leading to emergency surgery of another inmate’s gangrenous appendix); *Madrid*, 889 F. Supp. at 1255–56 (“Inmates clearly have medical needs that are genuine, frequent, and serious.”).

¹⁴⁷ *Coleman v. Schwarzenegger*, 922 F. Supp. 2d 882, 888 (E.D. Cal. 2009); *Madrid*, 889 F. Supp. at 1216–17; *Hautala*, *supra* note 4, at 126.

¹⁴⁸ In a prior proceeding, the court appointed a Special Master who found that inadequate mental health treatment contributed to nearly three quarters of the completed suicides in 2006. *Coleman*, 922 F. Supp. 2d at 941; *Feliciano*, 13 F. Supp. 2d at 199; *Hautala*, *supra* note 4, at 126.

¹⁴⁹ *Feliciano*, 13 F. Supp. 2d at 210–11; *Hutchings v. Corum*, 501 F. Supp. 1276, 1278–79 (W.D. Mo. 1980).

¹⁵⁰ *Phillips v. Sheriff of Cook Cty.*, 828 F.3d 541, 543 (7th Cir. 2016).

¹⁵¹ See, e.g., *Coleman v. Wilson*, 912 F. Supp. 1282, 1293 (E.D. Cal. 1995) (naming the Governor of California as a defendant).

correction,¹⁵² and officials therefrom.¹⁵³ Institutional liability is available even where individuals acting on behalf of the organization are not personally culpable.¹⁵⁴ While the failure of one correctional staff member to appropriately contextualize their efforts in a broader understanding of the inmates' needs and experiences could be classified as gross negligence, it does not rise to the level of deliberate indifference.¹⁵⁵ However, a correctional institution is liable where an official (municipal or corporate) custom or policy causes the harm, as opposed to the harm having been caused by individual agents acting on their own.¹⁵⁶ In order to substantiate such a claim, the custom or policy must be written down or expressly authorized,¹⁵⁷ "longstanding and widespread,"¹⁵⁸ or else directed or authorized by policy makers.¹⁵⁹ While the line between a policy to omit something and an inadvertent oversight may not always be clear,¹⁶⁰ there is a healthy line of cases standing for the proposition that a failure to regulate or a widespread practice of failing to act may itself be actionable.¹⁶¹

¹⁵² See, e.g., *Glisson v. Ind. Dep't of Corr.*, 849 F.3d 372 (7th Cir. 2017) (naming Indiana Department of Corrections as a defendant); *Dunn v. Dunn*, 219 F. Supp. 3d 1100, 1106 (M.D. Ala. 2016) (naming the Alabama Department of Corrections as a defendant).

¹⁵³ *Madrid v. Gomez*, 889 F. Supp. 1146, 1155 (N.D. Cal. 1995); *Coleman*, 912 F. Supp. at 1293.

¹⁵⁴ *Monell v. N.Y.C. Dep't of Soc. Servs.*, 436 U.S. 658, 690–92 (1978); *Glisson*, 849 F.3d at 378.

¹⁵⁵ "Without the full picture, each person might think that her decisions were an appropriate response to a problem." *Glisson*, 849 F.3d at 378, 389; *Monell*, 436 U.S. at 690–92.

¹⁵⁶ *Connick v. Thompson*, 563 U.S. 51, 51, 60 (2011); *L.A. Cty. v. Humphries*, 562 U.S. 29, 29–30 (2010); *Monell*, 436 U.S. at 694–95; *Glisson*, 849 F.3d at 379.

¹⁵⁷ See *Robbins*, *supra* note 20, at 209 (citing *Nelson v. Prison Health Servs.*, 991 F. Supp. 1452, 1465 (M.D. Fl. 1997)).

¹⁵⁸ *Id.* at 210.

¹⁵⁹ *Glisson*, 849 F.3d at 379 (citing *Vodak v. City of Chicago*, 639 F.3d 738, 747 (7th Cir. 2011)).

¹⁶⁰ *Id.* at 379–80.

¹⁶¹ See, e.g., *City of Canton v. Harris*, 489 U.S. 378, 394–95 (1989) ("Where, as here, a claim of municipal liability is predicated upon a failure to act, the requisite degree of fault must be shown by proof of a background of events and circumstances which establish that the "policy of inaction" is the functional

In light of the evidence-based treatment options which have proven effective in treating the needs of female inmates, the failure to implement them should be considered institutional deliberate indifference and thus cruel and unusual punishment.¹⁶² In addition, deliberate institutional indifference has also been substantiated through evidence that a facility “persists in a particular course of treatment in the face of resultant pain and risk of permanent injury.”¹⁶³ While mental health care that is merely “less than ideal” does not give rise to liability, the Eleventh Circuit has consistently held that, despite the provision of some mental health treatment, evidence of “a decision to take an easier but less efficacious course of treatment,” can also be dispositive on the issue of deliberate indifference.¹⁶⁴ As the District Court for the Middle District of Alabama illustrated,

[H]ealth care that is just slightly better than ‘grossly inadequate’ does not violate the Constitution when the defendant does not realize it is so subpar, [but] substantially smaller shortcomings in health care are actionably unlawful when the decision-maker understands that a particular standard of care will cause serious harm to prisoners but decides to go

equivalent of a decision by the city itself to violate the Constitution.”); *Glisson*, 849 F.3d at 381–82 (failure on the part of the Indiana prison system and its medical-care provider to implement a policy governing immediate medication needs of inmates with serious medical conditions led to the inmate’s death and was therefore actionable deliberate indifference); *Thomas v. Cook Cty. Sheriff’s Dep’t*, 604 F.3d 293, 303–05 (7th Cir. 2009) (failure of Cook County Department of Corrections and its medical-care provider to implement a policy governing immediate medication needs of inmates with serious medical conditions led to the inmate’s death and was therefore actionable deliberate indifference); *Natale v. Camden Cty. Corr. Facility*, 318 F.3d 575, 585 (3d Cir. 2003) (failure to establish a policy to administer insulin to pre-trial detainees was actionable deliberate indifference); *Brown v. Mitchell*, 308 F. Supp. 2d 682, 701–07 (4th Cir. 2004) (failure to establish a policy to administer insulin to pre-trial detainees was actionable deliberate indifference).

¹⁶² *Weatherhead*, *supra* note 11, at 444–45.

¹⁶³ *Dunn v. Dunn*, 219 F. Supp. 3d 1100, 1125–26 (M.D. Ala. 2016), (quoting *Rouse v. Plantier*, 182 F.3d 192, 197 (3d Cir. 1999)).

¹⁶⁴ *Id.* at 1126 (quoting *McElligott v. Foley*, 182 F.3d 1248, 1255 (11th Cir. 1999)).

ahead with it nonetheless, because it is easier or cheaper.¹⁶⁵

Denying female inmates access to effective treatment and rehabilitation should be considered “indifferent acceptance of the . . . deterior[ating]” effects of incarceration, coupled with mental health issues stemming from violent histories.¹⁶⁶ However, the shifting of the deliberate indifference standard to reflect systemic inadequacies is not accompanied by a shift in the requirement for subjective knowledge, requiring instead a showing of official policy or custom, as discussed above.¹⁶⁷ Even if prison staff who “[work] directly” with the inmates are subjectively “aware of the procedural misalignment of some procedures with the realities of women’s lives,” it is not common for this understanding to be reflected in formal written policies.¹⁶⁸ For instance, the District Court for the District of Puerto Rico held in *Feliciano v. Gonzalez*¹⁶⁹ that “the persistence of the problems described above go beyond deliberate indifference or reckless disregard and can be ascribed to intentional acts on the part of defendants,” relying in large part on prior court proceedings which had removed any doubt of the defendant institution’s subjective knowledge.¹⁷⁰ The court went on to reiterate, “[i]t is not a question only of mere administrative incompetence, these are willed, intended results.”¹⁷¹ However, courts often require evidence of subjective institutional knowledge beyond a reasonable doubt, either through decades of litigation,¹⁷² or correspondence and

¹⁶⁵ *Id.* at 1126–27 (citing *Ancata v. Prison Health Servs., Inc.*, 769 F.2d 700, 703–04 (11th Cir. 1985)).

¹⁶⁶ Rotman, *supra* note 92, at 1027.

¹⁶⁷ *Connick v. Thompson*, 563 U.S. 51, 60–61 (2011); *L.A. Cty. v. Humphries*, 562 U.S. 29, 29–30 (2010); *Monell v. N.Y.C. Dep’t of Soc. Servs.*, 436 U.S. 658, 694–95 (1978); *Glisson v. Ind. Dep’t of Corr.*, 849 F.3d 372, 378–79 (7th Cir. 2017).

¹⁶⁸ Bloom et al., *supra* note 4, at 45.

¹⁶⁹ *Feliciano v. Gonzalez*, 13 F. Supp. 2d 151 (D.P.R. 1998).

¹⁷⁰ *Id.* at 204.

¹⁷¹ *Id.*

¹⁷² See *Coleman v. Schwarzenegger*, 922 F. Supp. 2d 882, 898 (E.D. Cal. 2009).

official reports.¹⁷³ Unfortunately, this leaves little recourse for offenders suffering and decompensating in silence.

III. SOLUTION: TRAUMA- AND GENDER-INFORMED MENTAL HEALTH CARE AND INTAKE SCREENINGS, IMPLEMENTED THROUGH LEGISLATIVE ACTION

The only way for correctional mental health programming to truly comply with prisoners' rights is to become sensitive both to the impacts of gender and of prior violence on female offenders. Consequently, this necessitates the implementation of mental health screenings. Adequate mental health screenings must create access to effective care. Mental health care is more likely to be effective if it is informed by both the inmate's gender and her own personal history of trauma. Policy arguments abound that should lead legislative bodies to act, and yet the potential reduction in cost and recidivism that can accompany rehabilitation and increased institutional security goes ignored. For various reasons, prisoners cannot rely on swift or effective action on the part of the federal courts to redress these constitutional deprivations. Yet, the benefits of a system taking women's needs into consideration are too important to overlook any longer. These benefits impact the offenders themselves, their families, institutions, and communities, creating a compelling state interest of which state actors should take note.¹⁷⁴

A. Efficacy of Trauma- and Gender- Informed Screenings and Treatment

To cure the ills discussed above, three aspects of correctional mental health programming require reform: mental health screenings, recognition of the impacts of trauma, and sensitivity to gender issues. First, a more rigorous mental health screening should be administered by someone trained to recognize symptoms of mental illness. Those inmates exhibiting symptoms should then be provided mental health services that are both trauma-informed and

¹⁷³ Dunn v. Dunn, 219 F. Supp. 3d 1100, 1149–50 (M.D. Ala. 2016).

¹⁷⁴ Bloom et al., *supra* note 4, at 32, 45; Saul, *supra* note 14, at 42.

gender-responsive. Consequently, treatment of PTSD can be and often is complicated by comorbid psychiatric illnesses, impeding proper diagnosis and treatment decisions.¹⁷⁵ As a result, in order to integrate treatments for female inmates suffering from comorbid mental health issues, each issue must be treated concurrently rather than sequentially.¹⁷⁶ Following a validated mental health screening upon intake, if female offenders are provided care which is both gender- and trauma-informed—in a word, individualized—holistic mental health care, they are far more likely to improve or eliminate lingering mental health symptoms of earlier traumatic abuse.¹⁷⁷ Policies and programming that are both trauma-informed and gender-responsive have far reaching benefits for inmates, their families, institutions, and society generally.¹⁷⁸

1. Benefits of Mental Health Screenings

Mental health care is only constitutionally adequate when it meets the needs of the individuals who require it.¹⁷⁹ As the jurisprudence currently stands, correctional employees can ignore medical needs, avoiding liability under Section 1983 and *Estelle* by also failing to properly screen those in their charge for mental health symptoms and traumatic histories, forestalling adequate care and

¹⁷⁵ DEP'T OF JUSTICE, OFFICE OF JUVENILE JUSTICE & DELINQUENCY PREVENTION BULLETIN 2013, *supra* note 123, at 2; Lewis, *supra* note 4, at 783–84; Zlotnick, *supra* note 103, at 762.

¹⁷⁶ NIDA, *supra* note 133, at 1; Bloom & Covington, *supra* note 5, at 162; Denise A. Hien et al., *Promising Treatments for Women with Comorbid PTSD and Substance Use Disorders*, 161:8 AM. J. PSYCHIATRY 1426, 1426 (2004); Lewis, *supra* note 4, at 783–84.

¹⁷⁷ The holistic health model is a modern reconception of medical treatment that takes into consideration “the physical, emotional, psychological and spiritual aspects” of the disease. Stephanie S. Covington, *Helping Women Recover: Creating Gender-Responsive Treatment*, in THE HANDBOOK OF ADDICTION TREATMENT FOR WOMEN: THEORY AND PRACTICE (S.L.A. Straussner & S. Brown eds., 2002).

¹⁷⁸ Saul, *supra* note 14, at 42; Bloom et al., *supra* note 4, at 32.

¹⁷⁹ *Coleman v. Wilson*, 912 F. Supp. 1282, 1305, 1323 (E.D. Cal. 1995) (quoting *Balla v. Idaho State Bd. of Corr.*, 595 F. Supp. 1558, 1577 (D. Idaho 1984)); *Madrid v. Gomez*, 889 F. Supp. 1146, 1218, 1256–1257 (N.D. Cal. 1995); Hautala, *supra* note 4, at 107, 109.

trapping inmates in a “catch-22.”¹⁸⁰ Researchers have found that “[b]y tightening up and improving the quality of the mental health screening during intake, correctional systems should see a cascade of benefits and payoffs at each step of the criminal justice process following the initial pre-trial booking into a local jail.”¹⁸¹ As noted, although some inmates suffering from mental health problems may have the insight to seek out services, many others will undoubtedly “fall through the cracks of the criminal justice system” absent mental health screenings on intake,¹⁸² especially considering that extrinsic social supports are often not available to notice when inmates are decompensating or developing symptoms of mental illness.¹⁸³

Standards of several professional organizations demand mental health screening during intake, but correctional officials are free to determine which instrument to employ.¹⁸⁴ In general, intake mental health screenings in correctional facilities consist of fewer than ten yes/no questions, lasting as little as five minutes.¹⁸⁵ Although, in the worst cases, facilities ask just one or two questions related to mental health during the routine booking procedure.¹⁸⁶ The newest validated mental health screening instruments, the Correctional Mental Health Screen, are gender-specific (CMHS-M for men, CMHS-W for women), improving upon many of the issues which arose in the application of prior instruments.¹⁸⁷ The CMHS scales are most accurate, and the CMHS-W is most consistent in

¹⁸⁰ See Marschke, *supra* note 10, at 523–24.

¹⁸¹ Hautala, *supra* note 4, at 120–21.

¹⁸² Hautala, *supra* note 4, at 126; Feliciano v. Gonzalez, 13 F. Supp. 2d 151, 184 (D.P.R. 1998); Coleman, 912 F. Supp. at 1305; Madrid, 889 F. Supp. at 1218–19.

¹⁸³ Madrid, 889 F. Supp. at 1218.

¹⁸⁴ Hautala, *supra* note 4, at 111, 113–14.

¹⁸⁵ *Id.* at 112 (citing U.S. DEP’T OF JUSTICE, NAT’L INST. OF JUSTICE, MENTAL HEALTH SCREENS FOR CORRECTIONS (2007), <https://www.ncjrs.gov/pdffiles1/nij/216152.pdf>).

¹⁸⁶ *Id.* (citing SARAH KRUEGER, NAT’L ALL. ON MENTAL ILLNESS, RESPONSES OF MINNESOTA JAILS TO MENTAL ILLNESS: SURVEY OF MINNESOTA JAILS 1, 92 (Apr. 2006), <https://perma.cc/49TX-MJYA>).

¹⁸⁷ *Id.* at 117–18.

identifying mental illness in women,¹⁸⁸ has fewer false positives,¹⁸⁹ can be administered in the same five-minute timespan as traditional tests,¹⁹⁰ and can be simply scored without extensive prior training.¹⁹¹

Despite these improvements and independent benefits, a considerable number of inmates with mental illness may continue to be overlooked. Researchers have suggested that supplementing the screening instrument with a protocol for reviewing an inmate's electronic records for prior mental health treatment, if available, may bridge this gap.¹⁹² It is generally understood that introducing long, unwieldy psychodiagnostic instruments into standard intake screening procedures is prohibitively burdensome.¹⁹³ Thus, specific questions based on trends in evidence from pathways to crime research may be more effective at identifying inmates who require more extensive services.¹⁹⁴ Proper implementation of validated mental health screenings should also ease inmates' access to mental health professionals, increasing the likelihood of a court finding in their favor on the issue of a "serious medical need" should they decide (and have the resources) to bring litigation.¹⁹⁵

The harms which result from a failure to identify inmates suffering from mental health issues are undeniable,¹⁹⁶ and it is important for the distribution of appropriate services that the right questions be asked in screening. "Trauma-informed services require a paradigm shift in the way providers respond to [patients], moving from a system that asks 'what's wrong with you?' to one that asks 'what happened to you?'"¹⁹⁷ However, standard mental health

¹⁸⁸ *Id.* at 118.

¹⁸⁹ *Id.*

¹⁹⁰ *Id.*

¹⁹¹ *Id.*

¹⁹² *Id.* at 119 (citing TEX. COMM'N ON JAIL STANDARDS, MENTAL HEALTH STUDY 1 (2004), <http://www.tcjs.state.tx.us/docs/MH%20Study.pdf>).

¹⁹³ Cook et al., *supra* note 76, at 123.

¹⁹⁴ *Id.*

¹⁹⁵ Marschke, *supra* note 10, at 491, 534–35.

¹⁹⁶ *Dunn v. Dunn*, 219 F. Supp. 3d 1100, 1133–1134 (M.D. Ala. 2016); *Feliciano v. Gonzalez*, 13 F. Supp. 2d 151, 186 (D.P.R. 1998).

¹⁹⁷ Flocks et al., *supra* note 106, at 8 (citing FLA. DEP'T OF JUV. JUST., EFFECTIVE BEHAVIOR MANAGEMENT, 38–40 (2010), <http://www.djj.state.fl.us/docs/news/behavior-mgmt-pg-v3-5.pdf> (last visited May 7, 2018)).

screenings rarely include questions about past trauma, and inmates rarely volunteer such information,¹⁹⁸ perhaps in part because of the lack of confidentiality within the prison setting.¹⁹⁹ Several suggestions have been made to increase efficacy, including more detailed questions,²⁰⁰ questions which will identify victims of intimate partner violence,²⁰¹ and questions about homelessness.²⁰²

2. Benefits of Trauma-Informed Mental Health Care

When it becomes apparent from the results of the intake screening that an inmate is at risk of mental health issues, she should then be referred to a trained mental health professional for further evaluation and treatment.²⁰³ The higher prevalence of trauma in corrections than in the community suggests a need for trauma-informed mental health care in corrections provided by qualified clinical staff.²⁰⁴ Once an inmate has been identified as requiring mental health services, it is imperative that such programming be focused on, or at the very least informed by, any trauma or violence she feels led to her criminal behavior.

The goals of trauma-informed care include identifying trauma survivors in the inmate population, training staff on the impacts trauma can have and the physical manifestation of resulting psychological issues, and eliminating or modifying the institutional practices which have the potential to trigger and retraumatize

¹⁹⁸ DEP'T OF JUSTICE, OFFICE OF JUVENILE JUSTICE & DELINQUENCY PREVENTION BULLETIN 2013, *supra* note 123, at 9 (citing Kathleen T. Brady, *Posttraumatic Stress Disorder and Comorbidity: Recognizing the Many Faces of PTSD*, 58 J. OF CLINICAL PSYCHIATRY 12 (1997)).

¹⁹⁹ Lynch et al., *supra* note 61, at 395; see Miller & Najavits, *supra* note 103, at 2 ("Reporting of trauma is influenced by the culture of mistrust in prison environments. Confidentiality does not fully extend to clinical staff working in prisons.").

²⁰⁰ Komarovskaya et al., *supra* note 101, at 407.

²⁰¹ Cho, *supra* note 5, at 158–59.

²⁰² Cook et al., *supra* note 76, at 123.

²⁰³ Hautala, *supra* note 4, at 112.

²⁰⁴ Komarovskaya et al., *supra* note 101, at 407; Miller & Najavits, *supra* note 103, at 1.

incarcerated survivors.²⁰⁵ Treatments are more likely to succeed if they address past trauma and various diagnostic complications.²⁰⁶ This is because female offenders' mental illnesses may be related to their traumatic histories, which previous treatments have not addressed.²⁰⁷ Thus, there are likely to be considerable advantages to the introduction of trauma-informed mental health care in women's correctional facilities.²⁰⁸ Imperative to effective reform of correctional mental health services is consideration of the recent scholarship introducing a "lens of trauma."²⁰⁹

Despite the fact that the therapeutic connection between PTSD, comorbid mental health issues, and substance abuse is well established, these issues continue to be treated separately.²¹⁰ Moreover, treatment components often contradict one another.²¹¹ Advocates have argued that a holistic approach to such cases is required because it may not be obvious whether the substance abuse underlies the mental illness or vice versa,²¹² but concurrently

²⁰⁵ Miller & Najavits, *supra* note 103, at 1.

²⁰⁶ DEP'T OF JUSTICE, OFFICE OF JUVENILE JUSTICE & DELINQUENCY PREVENTION BULLETIN 2013, *supra* note 123, at 10; Lynch et al., *supra* note 61, at 394.

²⁰⁷ Bloom & Covington, *supra* note 5, at 17–19; Covington & Bloom, *supra* note 129, at 4.

²⁰⁸ Miller & Najavits, *supra* note 103, at 5.

²⁰⁹ DEP'T OF JUSTICE, OFFICE OF JUVENILE JUSTICE & DELINQUENCY PREVENTION BULLETIN 2013, *supra* note 123, at 9; Miller & Najavits, *supra* note 103, at 1; *see* Bloom & Covington, *supra* note 5, at 19; Randall & Haskell, *supra* note 99, at 504–05 (citing NAT'L HEALTHCARE FOR THE HOMELESS COUNCIL, DELIVERING TRAUMA-INFORMED SERVS., 14 HEALING HANDS 6 (2010) [hereinafter NHHC], <https://www.nhchc.org/wp-content/uploads/2011/09/DecHealingHandsWeb.pdf>).

²¹⁰ Bloom & Covington, *supra* note 5, at 2; Covington, *supra* note 177, at 2, 6; Lewis, *supra* note 4, at 783.

²¹¹ Bloom & Covington, *supra* note 5, at 18; Gatz et al., *supra* note 130, at 864 (citing Christine E. Grella, *Contrasting the Views of Substance Misuse & Mental Health Treatment Providers on Treating the Dually Diagnosed*, 38 SUBSTANCE USE & MISUSE, 1433–46 (2003)); *see generally* Thomas M. Kelly & Dennis C. Daley, *Integrated Treatment of Substance Use and Psychiatric Disorders*, 28 SOC. WORK PUBLIC HEALTH 388–406 (2013) (illustrating the effects of integrated treatment of comorbid disorders and the impact of contradictory treatments).

²¹² NIDA, *supra* note 133, at 3; Bloom & Covington, *supra* note 5, at 12.

treating both is more effective.²¹³ The risk of relapse associated with histories of trauma and mental illness²¹⁴ can be decimated through the introduction of trauma-informed mental health and substance abuse treatment programs.²¹⁵ Whatever the primary burden is for the individual, be it addiction, PTSD symptoms, or the symptoms of other mental illnesses, it will be treated under this approach. The holistic health model allows mental health professionals to deal with the causes of those burdens, such as learned helplessness, symptom triggers, or traumatic histories generally.²¹⁶ Survivors need to be educated on abuse, trauma, and the symptoms of PTSD.²¹⁷ Their maladjusted behaviors need to be validated as normal responses to abnormal traumatic experiences.²¹⁸ Finally, new coping skills can be imparted, such as techniques for de-escalation and self-soothing.²¹⁹

²¹³ NIDA, *supra* note 133, at 6; Cho, *supra* note 5, at 150 (asserting that the programs addressing the reasons contributing to criminal behavior and substance abuse are more likely to impede the future cycle of incarceration); Cook et al., *supra* note 76, at 123; Gatz et al., *supra* note 130, at 873–74; Green et al., *supra* note 68, at 146 (citing a study that found that women provided trauma-informed treatment saw improvement over the comparison group in their PTSD symptoms and improved use of coping skills); Lynch et al., *supra* note 61, at 396.

²¹⁴ NIDA, *supra* note 133, at 7; Bloom & Covington, *supra* note 5, at 16.

²¹⁵ Miller & Najavits, *supra* note 103, at 5; Lynch et al., *supra* note 61, at 393–94; Bloom & Covington, *supra* note 5, at 19–20.

²¹⁶ Bloom & Covington, *supra* note 5, at 13; Covington, *supra* note 177, at 2; Lynch et al., *supra* note 61, at 396; Randall & Haskell, *supra* note 99, at 525.

²¹⁷ Gatz et al., *supra* note 130, at 864 (citing Nicole D. Chaikin & Maurice F. Prout, *Treating Complex Trauma in Women Within Community Mental Health*, 74 AM. J. OF ORTHOPSYCHIATRY 160 (2004); Lisa M. Najavits, *Seeking Safety: A New Psychotherapy for Posttraumatic Stress Disorder & Substance Use Disorder*, in TRAUMA & SUBSTANCE ABUSE: CAUSES, CONSEQUENCES, & TREATMENT OF COMORBID DISORDERS 147 (Paige Ouimette & Jennifer P. Read eds., 2003); Maxine Harris & Roger D. Fallot, *Envisioning a Trauma-Informed Service System: A Vital Paradigm Shift*, in USING TRAUMA THEORY TO DESIGN SERVICE SYSTEMS 5 (Harris & Fallot eds., 2006)).

²¹⁸ *Id.*; Bloom & Covington, *supra* note 5, at 17.

²¹⁹ Bloom & Covington, *supra* note 5, at 17; Dennis & Jordan, *supra* note 70, at 32; Gatz et al., *supra* note 130, at 864.

3. Benefits of Gender-Informed Mental Health Care

The National Council on Crime & Delinquency has publicly recommended that such trauma-informed mental health care also be examined “through the lens of gender.”²²⁰ A gender-responsive system has been defined as “creating an environment . . . that reflects an understanding of the realities of women’s lives and addresses the issues of the women.”²²¹ For mental health services to be responsive to the gendered aspects of female offenders’ pathways to crime, they must expose the role of female socialization, allowing each survivor to contextualize her own individual pathways, to crime and to recovery.²²² By that token, female inmates need to confront the learned helplessness and psychological triggers which result from their particular histories of interpersonal violence.²²³ Perhaps most importantly, the method of delivery would likely be most effective if it were gender-specific, allowing female survivors the safety to speak absent a male presence.²²⁴ To the contrary, while

²²⁰ Flocks et al., *supra* note 106, at 8; see Covington & Bloom, *supra* note 129, at 10.

²²¹ Bloom et al., *supra* note 4, at 32, 42 (quoting BARBARA BLOOM & STEPHANIE COVINGTON, CENTER FOR GENDER & JUSTICE, GENDERED JUSTICE: PROGRAMMING FOR WOMEN IN CORRECTIONAL SETTINGS 1 (Nov. 2000), <http://www.centerforgenderandjustice.org/assets/files/11.pdf>).

²²² Flocks et al., *supra* note 106, at 10 (citing Lawanda Ravoira & Vanessa Patino Lydia, *Strategic Training and Technical Assistance: A Framework for Reforming the Juvenile Justice System’s Treatment of Girls and Young Women*, 20 GEO. J. ON POVERTY L. & POL’Y 297, 302–03 (2013); BARBARA BLOOM ET AL., NAT’L INST. OF CORR., U.S. DEP’T OF JUSTICE, NIC ACCESSION NO. 020418, GENDER RESPONSIVE STRATEGIES FOR WOMEN OFFENDERS: A SUMMARY OF RESEARCH, PRACTICE & GUIDING PRINCIPLES FOR WOMEN OFFENDERS 11 (2005)); Bloom & Covington, *supra* note 5, at 9; Bloom et al., *supra* note 4, at 42; Covington & Bloom, *supra* note 129, at 6.

²²³ Failing, *supra* note 70, at 136; see Komarovskaya et al., *supra* note 101, at 407; Lewis, *supra* note 4, at 784.

²²⁴ Bloom et al., *supra* note 4, at 43; Komarovskaya et al., *supra* note 101, at 407; see Failing, *supra* note 70, at 115; see generally Bloom & Covington, *supra* note 5 (arguing that the unique needs of women need to be taken into consideration in the development of mental health programming in female correctional facilities); Lewis, *supra* note 4 (arguing for gender to be taken into

gender-specific trainings prepare correctional staff to respond to a range of reactions, it may be even more effective to train officers in trauma, reactivity, comorbidity, and communication styles of both women and men concurrently.²²⁵ Explorations of the gendered differences between male and female trauma survivors and their roads to recovery “can evoke compassion, curiosity and capture the attention of male staff.”²²⁶ This universal applicability is likely to increase interest and retention for corrections officers, particularly those who are men, in addition to increasing their knowledgebase with regard to inmates’ needs.

B. Policy Arguments for Legislative Action

Considering the low likelihood of success and slow progress of prison mental health reform in the judicial forum, many arguments support the notion that it would be best achieved through legislative action. For one, treatment has been shown to have higher rates of success than surveillance and control.²²⁷ Additionally, now that pathways to crime research has revealed these patterns in the lives of female offenders, it is imperative that this knowledge be incorporated into comprehensive treatment programs for them.²²⁸ No doubt, trauma-informed and gender-responsive policies have far reaching benefits for the inmates, their families, the institution, and society at large. This magnifies the state’s compelling interest in preparing inmates for release and reentry, as the majority of offenders ultimately reenter the community.²²⁹ Mental health treatments with higher rates of success for rehabilitating inmates save lives, as well as reduce future recidivism, and increase safety

consideration in mental health programming for women’s correctional institutions).

²²⁵ Cook et al., *supra* note 76, at 123; Lewis, *supra* note 4, at 782–83; Miller & Najavits, *supra* note 103, at 4; Raeder, *supra* note 101, at 11.

²²⁶ Miller & Najavits, *supra* note 103, at 4.

²²⁷ *Id.* at 3 (citing Edward J. Latessa et al., *Beyond Correctional Quackery: Professionalism and the Possibility of Effective Treatment*, 66 FED. PROB. 43, 45 (2002); Paul Gendreau et al., *The Effects of Community Sanctions and Incarceration on Recidivism*, 12 F. FORUM ON CORRECTIONS RES. 2, 10 (2000)).

²²⁸ Bloom et al., *supra* note 4, at 36–37.

²²⁹ *See id.* at 32–33; Saul, *supra* note 14, at 42–43.

and stability both within the institution and within our communities.²³⁰ Moreover, these benefits will undoubtedly lower long-term costs for facilities and states associated with repeat incarcerations²³¹ and “crisis-driven” mental health services.²³²

Critics of gender-informed correctional care attempt to justify the differential access to services by citing the higher cost of treating fewer inmates in women’s facilities.²³³ Alternatively, judicial sentiment hints that female offenders are not entitled to gender-informed health care.²³⁴ Although it may not be the affirmative duty of the criminal justice system to heal offenders, even if they are often concurrently victims, it is instrumental in developing the norms of human behavior and determining the conditions necessary “for a just and law-abiding society in which people can expect to have their rights and freedoms respected.”²³⁵ While it is true that the federal courts do often require states to scrape their barrels for additional resources in order to comply with constitutional mandates, “true prison reform policy has to come from the political branches, not from litigation.”²³⁶ If nothing changes, the delivery of adequate mental health services to female offenders will likely continue to be hindered by prejudice against both women and inmates within the criminal justice system as well as public health systems generally.²³⁷

1. Rehabilitative Function of Correctional System

One of the major functions of incarceration is the rehabilitation of the offender, a goal undoubtedly served through the

²³⁰ Hautala, *supra* note 4, at 126; *see also* Rotman, *supra* note 92, at 1038 (describing how disciplinary measures could be reduced because “the development of trust in incarcerated human beings within a rehabilitation-oriented institution warrants a relaxing of custodial standards”).

²³¹ Hautala, *supra* note 4, at 126; Rotman, *supra* note 92, at 1038.

²³² *See* Dunn v. Dunn, 219 F. Supp. 3d 1100, 1134 (M.D. Ala. 2016); Madrid v. Gomez, 889 F. Supp. 1146, 1217–18 (N.D. Cal. 1995); Lewis, *supra* note 4, at 783.

²³³ Cho, *supra* note 5, at 148.

²³⁴ Weatherhead, *supra* note 11, at 439–40.

²³⁵ Randall & Haskell, *supra* note 99, at 533.

²³⁶ Herman, *supra* note 14, at 266.

²³⁷ Feliciano v. Gonzalez, 13 F. Supp. 2d 151, 204 (D.P.R. 1998).

implementation of gender-responsive, trauma-informed mental health care. Rehabilitation is currently viewed as a “part of governmental planning and social policy,”²³⁸ rather than a constitutional right.²³⁹ A more modern approach replaces “vindictive justice” with “social reintegration.”²⁴⁰ This is due in large part to the growth of empirical evidence demonstrating the abysmal efficacy of authoritative punishment on its own.²⁴¹ Indeed, it is the “least effective means of reducing future criminal behavior.”²⁴² To the contrary, evidence continues to show that rehabilitative measures, including proper treatment, can be effective for many inmates.²⁴³ Rehabilitation is likely to lead to a law-abiding life upon release if programming teaches prisoners new skills, or more specifically, improves the quality of their mental health.²⁴⁴ For this reason, rehabilitation for inmates suffering from or at risk of developing mental illnesses is reliant on mental health treatment.²⁴⁵

While the right to rehabilitation per se has yet to be recognized, it has been otherwise suggested that inmates have a constitutional right to be released “with an improved chance of being a useful citizen and of staying out of prison.”²⁴⁶ As it stands, offenders are far more likely to be released troubled by the same issues which led

²³⁸ Rotman, *supra* note 92, at 1036.

²³⁹ *Id.* at 1023.

²⁴⁰ *See id.* at 1027–28.

²⁴¹ Miller & Najavits, *supra* note 103, at 3 (citing Nana A. Landenberger & Mark W. Lipsey, *The Positive Effects of Cognitive-Behavioral Programs for Offenders: A Meta-Analysis of Factors Associated with Effective Treatment*, 1 J. EXPERIMENTAL CRIMINOLOGY 451 (2005); Donald A. Andrews et al., *Does Correctional Treatment Work? A Psychologically Informed Meta-Analysis*, 28 CRIMINOLOGY 369 (1990)).

²⁴² *Id.* (citing Landenberger & Lipsey, *supra* note 242; Andrews et al., *supra* note 242).

²⁴³ Rotman, *supra* note 92, at 1035 (citing Paul Gendreau & Robert Ross, *Offender Rehabilitation: The Appeal of Success*, FED. PROB. 45 (1981); ROBERT ROSS & PAUL GENDREAU, *EFFECTIVE CORRECTIONAL TREATMENT* 1 (1980)).

²⁴⁴ Rotman, *supra* note 92, at 1036.

²⁴⁵ Human Rights Watch, *supra* note 2, at 219 (citing Standard Minimum Rules for the Treatment of Prisoners, E.S.C. Res. 2076, U.N. ESCOR, 62d Sess., Supp. No. 1, UN Doc. E/5988 (1977), <http://www.ohchr.org/Documents/ProfessionalInterest/NelsonMandelaRules.pdf>).

²⁴⁶ Rotman, *supra* note 92, at 1026.

them to criminal behavior in the first place.²⁴⁷ When correctional facilities and the criminal justice system at large recognize prisoner rights, it has been found to foster for inmates a greater sense of worth and trust in both themselves and the legal system generally.²⁴⁸ This, in turn, increases the likelihood of responsible, self-controlled behavior upon release.²⁴⁹ Incarcerated trauma survivors do not suffer their life burdens in a vacuum, so treatment programs need to be shaped around the daily realities of life for female offenders.²⁵⁰ This includes taking into account the institutional culture and the relationships between staff and inmates.²⁵¹ Moreover, if rehabilitative treatment is to be effective, it needs to be trauma-informed and gender-responsive in acknowledging the impact of gender based violence on the life trajectories of female offenders.²⁵² This involves the recognition of dysfunctional reactions as behaviors adopted to survive or escape the trauma they had to endure.²⁵³

²⁴⁷ WORLD HEALTH ORG., INFORMATION SHEET: MENTAL HEALTH AND PRISONS, http://www.who.int/mental_health/policy/mh_in_prison.pdf [hereinafter WHO] (last visited May 7, 2018); Sangoi & Goshin, *supra* note 75, at 164.

²⁴⁸ JEM STEVENS, PENAL REFORM INT'L, INSTITUTIONAL CULTURE IN DETENTION: A FRAMEWORK FOR PREVENTIVE MONITORING, 12 (2d ed. 2015), http://www.apr.ch/content/files_res/thematic-paper-1_culture-in-places-of-detention-en-1.pdf; Rotman, *supra* note 92, at 1026.

²⁴⁹ WHO, *supra* note 247; Rotman, *supra* note 92, at 1026.

²⁵⁰ Miller & Najavits, *supra* note 103, at 2 (citing Karen W. Saakvitne, *Commentary on Clinical Protocol*, 20 PSYCHOANALYTIC INQUIRY 249 (2000)).

²⁵¹ Miller & Najavits, *supra* note 103, at 3; JAMES BYRNE ET AL., EXAMINING THE IMPACT OF INSTITUTIONAL CULTURE (AND CULTURE CHANGE) ON PRISON VIOLENCE AND DISORDER: A REVIEW OF THE EVIDENCE ON BOTH CAUSES AND SOLUTIONS (2005).

²⁵² See Bloom & Covington, *supra* note 5 (discussing the necessity of looking at mental health rehabilitation of female prisoners who have experienced gender violence).

²⁵³ Gatz et al., *supra* note 130, at 864 (citing Harris & Fallot, *supra* note 217).

2. Reduction of Recidivism

It is also a matter of public safety inasmuch as untreated PTSD is associated with future violent behavior.²⁵⁴ One of the major reasons rehabilitation is so strongly supported in policy arguments about correctional facilities is that it is ultimately much more likely to reduce existing recidivism than is a system of purely punitive sentences.²⁵⁵ Research has indicated that female offenders are less likely to gain social and economic independence and are more likely to recidivate if their mental health issues are not adequately addressed while they serve their sentences.²⁵⁶ It has further been argued that such treatment programs may directly reduce future involvement in criminal activity among female offenders.²⁵⁷ For instance, when formerly incarcerated women explain what factors made a difference in preventing them from being re-arrested, many have said that the “choice to end an abusive and controlling relationship with a partner and reestablish broken family relationships” was instrumental.²⁵⁸

²⁵⁴ DEP’T OF JUSTICE, OFFICE OF JUVENILE JUSTICE & DELINQUENCY PREVENTION BULLETIN 2013, *supra* note 123, at 10 (citing Christine Wekerle et al., *Childhood Maltreatment, Posttraumatic Stress Symptomatology, and Adolescent Dating Violence: Considering the Value of Adolescent Perceptions of Abuse and a Trauma Mediation Model*, 13 DEV. PSYCHOPATHOLOGY 847, 847–71 (2001); Dwain C. Fehon et al., *Correlates of Community Violence Exposure in Hospitalized Adolescents*, 42 COMPREHENSIVE PSYCHIATRY 283, 283–90 (2001); Elizabeth Cauffman et al., *Posttraumatic Stress Disorder Among Female Juvenile Offenders*, 37 J. OF THE AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY 1209, 1209–16 (1998)).

²⁵⁵ According to the National Criminal Justice Association, “[i]ncarceration alone cannot remedy recidivism; a treatment must be included in order to break the cycle, particularly when [its] costs versus incarceration are considered.” Weatherhead, *supra* note 11, at 443.

²⁵⁶ Bloom & Covington, *supra* note 5, at 4–5.

²⁵⁷ See generally Zlotnick, *supra* note 103 (discussing the prevalence of PTSD and other trauma related disorders in the female prison population, and alluding to a possible correlation between widespread issues related to childhood abuse and trauma-related disorders).

²⁵⁸ Cho, *supra* note 5, at 150 (quoting Candace Kruttschnitt & Rosemary Gartner, *Women’s Imprisonment*, 30 CRIME & JUST. 1, 54 (2003)).

Gender remains one of the most significant predictors of whether a prisoner will reoffend after release.²⁵⁹ However, when an offender with mental health issues is introduced to the criminal justice system, the resulting process has been referred to as a revolving door.²⁶⁰ Mentally ill inmates are much more likely to end up re-incarcerated than those without such psychological burdens.²⁶¹ It has been shown to be more effective in rehabilitation of female offenders for corrections and mental health personnel to work together to treat and manage inmates suffering from mental illness.²⁶² In a collaborative environment, otherwise-unmanageable inmates can be more effectively managed and treated.²⁶³ Furthermore, institutional security and control can be more easily maintained in this kind of environment.²⁶⁴ New legislation in furtherance of these benefits is therefore crucial.

3. Safety and Order in Correctional Facilities

Considering the fact that trauma-informed treatment is more likely to maintain institutional safety and security, it is unfortunate that such doctrinal elements as compassion, de-escalation, grounding, and empathy are seen as risky and ineffectual.²⁶⁵ Because prisons are not designed to care for victims, trauma-informed care can clash with the culture of correctional settings.²⁶⁶ Mental health care in correctional facilities requires the recognition of institutional obstacles, such as the fact that the penal system was not designed to provide quality mental health care, but rather was designed to control.²⁶⁷ Further, the safety of the facility and the

²⁵⁹ Cho, *supra* note 5, at 150; *see generally* Lewis, *supra* note 4, at 775 (discussing the various ways how gender implicate the criminal justice system).

²⁶⁰ Hautala, *supra* note 4, at 104.

²⁶¹ *See id.* (citing U.S. BJS MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES REPORT 2006, *supra* note 2, at 18).

²⁶² ACLU, *supra* note 2, at 77; *see* Miller & Najavits, *supra* note 103, at 1–2.

²⁶³ ACLU, *supra* note 2, at 77; WHO, *supra* note 247.

²⁶⁴ Miller & Najavits, *supra* note 103, at 1.

²⁶⁵ *Id.* at 3.

²⁶⁶ *Id.* at 1; BYRNE ET AL., *supra* note 251.

²⁶⁷ Bloom & Covington, *supra* note 5, at 11.

general public must remain priority one. Thus, mental health training and programs finding common ground with that goal are far more likely to be successful.²⁶⁸ When clinical and correctional staff are aware of their common goals, interactions with offenders can focus more easily on the maintenance of safety, the development of coping skills, and the reinforcement of gains made in treatment.²⁶⁹

As a result of inadequate facilities and programming, offenders suffering from mental health issues often act out, sometimes putting themselves and others at risk for harm.²⁷⁰ This need not be the case. As it is, these inmates often exhibit disruptive behavior, causing security issues and diverting the attention of correctional staff.²⁷¹ However, if a trauma-informed regime is implemented, all corrections personnel will learn how to reduce and de-escalate triggers and crises without using punishment techniques which are likely to retraumatize the more fragile inmates.²⁷² Research has shown that this type of approach can reduce harm to both the institution and society, as well as reduce the state's costs in security and mental health care.²⁷³

At the same time, rehabilitation efforts would ultimately fail if the institution were to mirror the abusive, maladjusted homes where female offenders frequently reside.²⁷⁴ Without trauma-informed training for corrections personnel, they are in danger of developing, “‘institutional trauma,’ becoming highly reactive and reliant on ‘management-by-crisis.’”²⁷⁵ If such a situation unfolds, prisoners

²⁶⁸ Miller & Najavits, *supra* note 103, at 2; see ACLU, *supra* note 2, at 76.

²⁶⁹ Lynch et al., *supra* note 61, at 395; Miller & Najavits, *supra* note 103, at 4.

²⁷⁰ Feliciano v. Gonzalez, 13 F. Supp. 2d 151, 178–79, 186 (D.P.R. 1998); Madrid v. Gomez, 889 F. Supp. 1146, 1215 (N.D. Cal. 1995); Rotman, *supra* note 92, at 1043.

²⁷¹ Feliciano, 13 F. Supp. 2d at 178–79, 186; WHO, *supra* note 247.

²⁷² Miller & Najavits, *supra* note 103, at 1; see Flocks et al., *supra* note 106, at 5 (citing FLA. STAT. ANN. § 985.02 (2016)).

²⁷³ See Flocks et al., *supra* note 106, at 3; see also Ross A. Thompson, *Bridging Developmental Neuroscience and the Law: Child-Caregiver Relationships*, 63 HASTINGS L.J. 1443, 1454 (2012) (as applied to pediatricians in the medical context).

²⁷⁴ Miller & Najavits, *supra* note 103, at 3; see Bloom & Covington, *supra* note 5, at 17.

²⁷⁵ Miller & Najavits, *supra* note 103, at 3.

are likely to react in a way which emulates the dysfunction they are familiar with.²⁷⁶ Ultimately, this spiral is perpetuated by the punitive measures with which the institutions are likely to respond.²⁷⁷ This risk is not limited to inexperienced officers, and can easily develop even in experienced personnel if they are not provided with necessary training.²⁷⁸ Furthermore, there is a higher risk of burnout and stress when correctional staff juggle the “constant cycling in and out of jails by individuals with mental health needs.”²⁷⁹ Generally speaking, adult victims of childhood abuse are more difficult and costly for institutions to manage.²⁸⁰ Swift legislative action is the only way to turn these trends around so as to respect the Eighth Amendment rights of these inmates.

C. Common Law Reform is Unlikely

Reform in policymaking regarding mental health services for female offenders is not likely to take place in the judicial branch due to the height of the deliberate indifference standard, the hurdles of the Prison Litigation Reform Act, and the inadequacy of institutional resources. Adequate health care standards do not account for women’s mental health needs while incarcerated, and many female inmates suffer without recourse.²⁸¹ As a result, they may need to circumvent prison authorities to request relief from the court system.²⁸² As the Supreme Court has held, “when a prison regulation or practice offends a fundamental constitutional guarantee, federal courts will discharge their duty to protect constitutional rights.”²⁸³ While it is true that consent decrees and settlements arising from Section 1983 litigation tend to increase inmate access to services,²⁸⁴

²⁷⁶ *Id.*

²⁷⁷ *Id.*

²⁷⁸ *Id.*

²⁷⁹ Hautala, *supra* note 4, at 104–05; Miller & Najavits, *supra* note 103, at 3.

²⁸⁰ Miller & Najavits, *supra* note 103, at 2.

²⁸¹ Weatherhead, *supra* note 11, at 430.

²⁸² Herman, *supra* note 14, at 263; Saul, *supra* note 14, at 42.

²⁸³ Saul, *supra* note 14, at 42 (quoting *Turner v. Safely*, 482 U.S. 78, 84 (1987)).

²⁸⁴ Cynthia L. Blitz et al., *Availability of Behavioral Health Treatment for Women in Prison*, 57 PSYCHIATRIC SERVS. 356, 360 (2006).

this proposition fails to consider the unrealistic wherewithal necessary for mentally ill inmates to navigate the requirements of the Prison Litigation Reform Act as well as the severity of conditions that are likely to convince a court of deliberate indifference to serious medical needs. Moreover, even when offenders can convince a court to order relief in their favor, the resources in correctional institutions are often insufficient to bring about necessary changes.

1. Deliberate Indifferent Standard Practically Impossible to Satisfy

Following a period of somewhat progressive advancement, federal courts pushed back on prisoner's rights, leading to the development of the deliberate indifference standard.²⁸⁵ Going forward, problems have arisen for mentally ill plaintiffs, because both the First and the Ninth Circuits' definitions of deliberate indifference are practically impossible to prove.²⁸⁶ Legal scholars have argued that "the lack of psychological expertise among prison guards makes a specific showing of awareness next to impossible[, and b]y virtue of the prison guards' deficiency, courts continually hold guards to a lesser standard in recognizing these conditions."²⁸⁷ And while the subjective knowledge requirement of the deliberate indifference standard prevents inmates' practical attempts to collect a remedy from prison officials, it also insulates institutions at large from liability.²⁸⁸ The systemic nature of such a claim requires the introduction of evidence far beyond the scope of a single inmate's experiences, and yet federal courts remain steadfast that psychological and sociological experts are not useful in answering

²⁸⁵ Marschke, *supra* note 10, at 502–03 n. 98 (quoting *Estelle v. Gamble*, 429 U.S. 97, 102–03 (1976)).

²⁸⁶ *Id.* at 489–90, 492, 529 (citing Holly Boyer, *Home Sweet Hell: An Analysis of the Eighth Amendment's 'Cruel and Unusual Punishment' Clause as Applied to Supermax Prisons*, 32 SW. U. L. REV. 317, 332–33 (2003)); Craig Haney & Mona Lynch, *Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement*, 23 N.Y.U. REV. L. & SOC. CHANGE 477, 542 (1997)).

²⁸⁷ *Id.* at 529 (quoting Boyer, *supra* note 287, at 333).

²⁸⁸ *Id.* at 518, 529 (citing Boyer, *supra* note 287, at 333).

the questions of either fact or law in such cases.²⁸⁹ Despite seeking their expert testimony, courts maintain that they do not rely on such testimony in determining legal issues.²⁹⁰

Meanwhile, the lack of mandated mental health screenings continues to harm offenders suffering from mental health issues. In general, mentally ill inmates often do not have the awareness to recognize their need for treatment and thus may not actively seek out mental health professionals.²⁹¹ And, the lack of uniform standards for mandatory mental health screenings across jurisdictions further limits access to those professionals, who alone may be able to recognize a serious need for care.²⁹² As the gatekeepers between inmates and mental health professionals, it is imperative that corrections officers be properly trained in recognizing and responding to mentally ill inmates.²⁹³ Guards escape liability based on their lack of knowledge about mental health and trauma, so inmates who need and are not provided access to adequate mental health care are left without legal recourse.²⁹⁴ In order to combat this problem, scholars have argued that the courts should abandon the subjective knowledge requirement in favor of a negligence standard.²⁹⁵

Fortunately, courts are coming to recognize the importance of trauma-informed and gender-responsive correctional care, at least in small part. For instance, the Ninth Circuit in *Jordan v. Gardner* found that searches which did not take into account the histories of interpersonal trauma and the potential for further victimization at the

²⁸⁹ *Madrid v. Gomez*, 889 F. Supp. 1146, 1156–57 (N.D. Cal. 1995); *contra* *Coleman v. Wilson*, 912 F. Supp. 1282, 1302–03 (E.D. Cal. 1995).

²⁹⁰ *Dunn v. Dunn*, 219 F. Supp. 3d 1100, 1122 (M.D. Ala. 2016); *Madrid*, 889 F. Supp. at 1156–57.

²⁹¹ *Madrid*, 889 F. Supp. at 1218; Saul, *supra* note 14, at 43 (citing U.S. BJS INMATE MENTAL HEALTH REPORT 1999, *supra* note 65 (reporting that of 24 percent of incarcerated women in state prisons who could identify themselves as having a mental health problem, only 67.3 percent of those women received treatment)).

²⁹² Marschke, *supra* note 10, at 527–8 (citing Cohen, *supra* note 36, at 19, 21).

²⁹³ *Madrid*, 889 F. Supp. at 1219; Marschke, *supra* note 10, at 524.

²⁹⁴ Marschke, *supra* note 10, at 490, 529; Weatherhead, *supra* note 11, at 438.

²⁹⁵ Marschke, *supra* note 10, at 490 n. 29.

hands of male officers constituted deliberate indifference.²⁹⁶ Similarly, it is somewhat promising to see other courts, for instance the United States Court of Appeals for the Seventh Circuit in *Torres v. Wisconsin*, beginning to recognize the unique needs of female offenders.²⁹⁷ Still, for the most part, only extreme cases of constitutional violations get the attention of federal courts,²⁹⁸ despite the claim that “a remedy for unsafe conditions need not await a tragic event.”²⁹⁹

2. Prison Litigation Reform Act

The Prison Litigation Reform Act (PLRA) impedes prisoners attempts to protect their constitutional rights, including their right to adequate mental health treatment.³⁰⁰ With the intent of ameliorating the perceived issue of frivolous “peanut butter” litigation instituted by America’s prisoners,³⁰¹ Congress passed the PLRA instituting a number of procedural barriers which are not applicable to any other group of litigants.³⁰² Three aspects of the statute, scholars have argued, severely limit inmates’ access to courts, even in cases where

²⁹⁶ *Jordan v. Gardner*, 986 F.2d 1521, 1528–29 (9th Cir. 1993); *Weatherhead*, *supra* note 11, at 437.

²⁹⁷ *Torres v. Wisconsin*, 859 F.2d 1523, 1529 (7th Cir. 1988); Cho, *supra* note 5, at 148; *Weatherhead*, *supra* note 11, at 439.

²⁹⁸ *Casey v. Lewis*, 834 F. Supp. 1477, 1552 (D. Ariz. 1993) (requiring court monitoring and periodic status reports by the institution to show compliance with court orders for accommodations for disabled inmates); *Weatherhead*, *supra* note 11, at 456–57.

²⁹⁹ *Dunn v. Dunn*, 219 F. Supp. 3d 1100, 1122 (M.D. Ala. 2016) (quoting *Helling v. McKinney*, 509 U.S. 25, 33 (1993)).

³⁰⁰ Human Rights Watch, *supra* note 2, at 225; *Weatherhead*, *supra* note 11, at 459.

³⁰¹ One of the proponents of the PLRA, Senator Bob Dole famously cited a prisoner “being served chunky peanut butter instead of the creamy variety” as an issue that would give rise to litigation if the PLRA were not signed into law. 141 CONG. REC. S14413 (daily ed. Sept. 27, 1995) (statement of Sen. Bob Dole).

³⁰² *Herman*, *supra* note 14, at 265. “The case of *Romer v. Evans*, 517 U.S. 620 (1996), held it to be unconstitutional to preclude a targeted group of unpopular people from having equal access to the lawmaking process, but the courts have not extended the reasoning of that case to prisoners kept from litigating grievances anyone else could litigate.” *Id.* at n. 14.

their claims are anything but frivolous: the requirements for (1) the exhaustion of internal grievance procedures and (2) physical injury, as well as (3) the standard for prospective relief.³⁰³

The PLRA's internal grievance exhaustion requirement creates an often impossible hurdle of rigorous compliance with technical rules and deadlines for inmates suffering from mental health issues who "may then find themselves forever barred from vindicating their rights in court."³⁰⁴ Thus, a correctional institution can effectively insulate itself from liability for the violation of inmates' constitutional rights by creating a needlessly complex and even unclear grievance system.³⁰⁵ Naturally, inmates suffering from mental health issues are likely to have an especially difficult time navigating these administrative requirements. Additionally, the PLRA's physical injury requirement bars remedies for psychological harm.³⁰⁶ The physical injury requirement has been interpreted as limiting the extent of fundamental rights by precluding prisoners from vindicating them in the courts.³⁰⁷ Even in the rare cases which make it to judicial review, the prospective relief

³⁰³ 42 U.S.C. § 1997e(a)–(e) (1996); Sangoi & Goshin, *supra* note 75, at 159–60; Raeder, *supra* note 101, at 19. Scholars have begun to call for amendment to the PLRA eliminating the physical injury requirement and the grievance procedure exhaustion requirement. Human Rights Watch, *supra* note 2, at 225; Herman, *supra* note 14, at 268.

³⁰⁴ 42 U.S.C. § 1997e(a) (1996); Human Rights Watch, *supra* note 2, at 225.

³⁰⁵ Sangoi & Goshin, *supra* note 75, at 159. For instance, in a case brought by 16 female inmates in New York claiming repeated sexual abuse by correctional staff, the merits were not even presented for the first five years of litigation, because the court was not convinced that the inmates had satisfied the grievance procedure exhaustion requirement, despite the intricacies of the grievance system and the fact that the inmates were never formally informed of them. Herman, *supra* note 14, at 265 (citing *Amador v. Andrews*, No. 03-0650, 2007 WL 4326747, *7–9 (S.D.N.Y. 2007), *vacated and remanded in part* 655 F.3d 89 (2d Cir. 2011)).

³⁰⁶ See 18 U.S.C. § 3626 (2006); Human Rights Watch, *supra* note 2, at 225; Sangoi & Goshin, *supra* note 75, at 160. The physical injury requirement has been interpreted as limiting the extent of fundamental rights by precluding prisoners from vindicating them in the courts. Herman, *supra* note 14, at 265. And this holds true if considered from the perspective of the mentally ill, traumatized female offender. *Id.*

³⁰⁷ Herman, *supra* note 14, at 265.

standard requires the remedy be as narrow as possible.³⁰⁸ This requirement forestalls the courts from holding that trauma-informed and gender-responsive mental health care is a constitutional right, because the only cases decided on the merits are extreme examples of inadequate conditions such that “narrowly drawn” relief may need to focus on more immediate needs (e.g. overcrowding or inadequate staffing).³⁰⁹

3. Inadequacy of Institutional Resources

Legislative action with appropriated funding is the only feasible option for this type of prison mental health reform, because an inadequacy of resources within institutions tend to inhibit compliance with court orders to the same effect. According to Human Rights Watch, “[w]hat is lacking in prison mental health services is not knowledge about what to do, but the resources and commitment to do it.”³¹⁰ The most common justification for discriminatory policies in female correctional facilities tends to rely on the inadequacy of available financial resources.³¹¹ In turn, insufficient funds lead to deficiencies in staffing and supplies as well,³¹² thus limiting and sometimes eliminating access to mental health services for female offenders.³¹³ Inmates need, and are entitled to, access to mental health professionals, even despite inadequate institutional resources.³¹⁴ In *Glover v. Johnson*, the

³⁰⁸ The remedy must be “the least intrusive means necessary to correct the violation of the Federal right.” 18 U.S.C. § 3626(a)(1)(A); *Coleman v. Schwarzenegger*, 922 F. Supp. 2d 882, 962 (E.D. Cal. 2009); *see generally* *Madrid v. Gomez*, 889 F. Supp. 1146, 1280 (N.D. Cal. 1995) (noting remedies must use least intrusive means).

³⁰⁹ *See generally* *Brown v. Plata*, 563 U.S. 493 (2011) (attributing medical and mental health care deficiencies to staffing inadequacies as a result of severe overcrowding and ordering release of California prisoners); *Feliciano v. Gonzalez*, 13 F. Supp. 2d 151, 160 (D.P.R. 1998) (finding meager care to be a result of inadequate staffing and training).

³¹⁰ Human Rights Watch, *supra* note 2, at 224.

³¹¹ Marschke, *supra* note 10, at 530; Saul, *supra* note 14, at 46.

³¹² *Feliciano*, 13 F. Supp. 2d at 160.

³¹³ *Coleman*, 922 F. Supp. 2d at 934; *Madrid*, 889 F. Supp. at 1218.

³¹⁴ Lynch et al., *supra* note 61, at 395 (citing HOLLY HILLS ET AL., U.S. DEP’T OF JUSTICE, NAT’L INST. OF CORR., EFFECTIVE PRISON MENTAL HEALTH

District Court for the Eastern District of Michigan even went so far as to recognize that, rather than mere parity, “per capita expenditure for female inmates will need to exceed per capita expenditure for male inmates if the former are to be afforded even a semblance of opportunity presently provided the latter.”³¹⁵ These promising holdings are ultimately overshadowed, however, by decisions holding that deference to institutional authorities requires the acceptance of limited resources as justification for discrimination against female inmates.³¹⁶ The decisions allowing the resource excuse are perplexing because it would be irrational to argue that such discrimination would be allowed in a society generally based solely on deference to financial concerns.³¹⁷ It would seem, then, that the courts’ willingness to limit a constitutional right in favor of financial considerations is due in large part to prejudice to their status either as inmates³¹⁸ or as women.

When courts do intervene in more serious cases, the most common relief ordered is the development of an official plan to remedy the constitutional deficiencies in the institution in a way which also retains deference for prison officials, with the least invasive means.³¹⁹ However, absent sufficient funding, even the

SERVICES: GUIDELINES TO EXPAND AND IMPROVE TREATMENT 1 (2004), <https://s3.amazonaws.com/static.nicic.gov/Library/018604.pdf>).

³¹⁵ *Glover v. Johnson*, 721 F. Supp. 808, 848 (E.D. Mich. 1989) *rev’d and remanded on other grounds by sub nom* *Hadix v. Johnson*, 144 F.3d 925 (6th Cir. 1998); Cho, *supra* note 5, at 157. Additionally, it is indisputable that it costs more to incarcerate mentally ill offenders because, on average, they are incarcerated longer and require additional screening, medication, supervision, and interventions. See ACLU, *supra* note 2, at 69; U.S. BJS MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES REPORT 2006, *supra* note 2, at 8–9; Hautala, *supra* note 4, at 105; Marschke, *supra* note 10, at 496–97.

³¹⁶ See Saul, *supra* note 14, at 44 (citing *Klinger v. Dep’t of Corr.*, 31 F.3d 727, 731–32 (8th Cir. 1994)).

³¹⁷ *Id.* at 47 n.113 (noting the use of gendered stereotypes concerning female correctional facilities such as referring to “Martha Stewarts federal facility [as] ‘Camp Cupcake’” and “emphasizing inmates’ pinochle games and beauty treatments”) (internal citations omitted).

³¹⁸ See *id.* at 47.

³¹⁹ *Coleman v. Wilson*, 912 F. Supp. 1282, 1304–05, 1308 (E.D. Cal. 1995) (citing *Madrid v. Gomez*, 889 F. Supp. 1146, 1280 (N.D. Cal. 1995)).

most well-developed plans for reform are unlikely to succeed.³²⁰ At this point, even facilities subject to court orders or consent decrees have trouble complying because of insufficient financial resources and staffing.³²¹ One would think policy makers would take notice of this. But, because public support for the proper treatment of inmates (as opposed to merely punishment) is even more limited than available budgetary funds, politicians have little incentive to fund or advocate for prison mental health reform.³²²

IV. CONCLUSION

The United States is the world leader in incarceration, both by total number of inmates and per capita.³²³ Yet research connecting pathways to crime, trauma, and criminal behavior has only recently begun to find application in the criminal justice context.³²⁴ Likewise, there is growing recognition that legal solutions to social ills will only become more effective and efficient as they become informed by empirical psychological evidence.³²⁵ The culmination of these political, social, and academic developments has given rise to a set of general guidelines proposing screening and diagnostic procedures, correctional training in symptoms presentment and

³²⁰ Dennis & Jordan, *supra* note 70, at 32; *see also* Hautala, *supra* note 4, at 119 (describing how the implementation of new screening measures in Texas correctional facilities requires additional resources from the Texas Commission on Jail Standards).

³²¹ *Coleman v. Schwarzenegger*, 922 F. Supp. 2d 882, 898 (E.D. Cal. 2009) (noting even after nearly twenty years of litigation and court orders, the Eighth Amendment violations in California prisons were only remedied by an order to reduce the overcrowding because it was the most immediate need); *Feliciano v. Gonzalez*, 13 F. Supp. 2d 151, 173 (D.P.R. 1998) (noting CHP, subject to court order, still didn't have enough psychiatric beds to serve all the inmates who required them).

³²² Human Rights Watch, *supra* note 2, at 215.

³²³ Human Rights Watch, *supra* note 2, at 225; DeVeaux, *supra* note 136, at 263; Herman, *supra* note 14, at 266.

³²⁴ Randall & Haskell, *supra* note 99, at 504–05 (citing NHHC, *supra* note 209).

³²⁵ *Id.* at 531.

suicide risk,³²⁶ and demanding the intervention of trained professionals if symptoms are detected.³²⁷ Such guidelines retain discretion for correctional policymakers while recognizing that limited funds and facilities may affect the ultimate policy decisions.³²⁸ Established Eighth Amendment standards require innovation in correctional mental health services based on the needs of female offenders.³²⁹ Mental health programming must be gender- and trauma-informed in order to provide services based on the needs and context of the particular institution and respect inmates' constitutional rights.³³⁰ While it is promising that local, state, and federal legislators are beginning to take note of these needs,³³¹

³²⁶ While facilities need not go so far as to train officers in the proper treatment or diagnosis of mental illness, insufficient or inappropriate training of correctional officers invites harm to inmates (and may give rise to institutional liability). *Madrid v. Gomez*, 889 F. Supp. 1146, 1258 (N.D. Cal. 1995); Hautala, *supra* note 4, at 121; Marschke, *supra* note 10, at 533–34.

³²⁷ Hautala, *supra* note 4, at 121–22; Marschke, *supra* note 10, at 491, 532.

³²⁸ Marschke, *supra* note 10, at 535 (citing *Coleman v. Wilson*, 912 F. Supp. 1282, 1301 (E.D. Cal. 1995); *Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D. Tex. 1980), *aff'd in part & rev'd in part*, 679 F.2d 1115 (5th Cir. 1982)).

³²⁹ *Booker & Warren*, *supra* note 77; *Cho*, *supra* note 5, at 158; *Cooney*, *supra* note 58; *Komarovskaya et al.*, *supra* note 101, at 404; *Taylor*, *supra* note 77.

³³⁰ Marschke, *supra* note 10, at 536.

³³¹ *See, e.g.*, Dignity for Incarcerated Women Act of 2017, S. 1524, 115th Cong. (2017) (Congressional bill proposing implementation of trauma-informed care in federal prisons); U.S. Juvenile Justice and Delinquency Prevention Reform Act, H.R. 1809, 115th Cong. (2017) (federal bill reauthorizing and improving the Juvenile Justice and Delinquency Prevention Act of 1974, in part, with a requirement of trauma-informed care for juvenile offenders); A.B. 620, 18th Gen. Assemb., Reg. Sess. (Cal. 2017) (California state bill authorizing pilot program testing the efficacy of trauma-informed programming in correctional facilities); H.B. 3904, 100th Gen. Assemb., Reg. Sess. (Ill. 2017) (Illinois bill emphasizing the importance of trauma-informed practices in women's correctional institutions); S.B. 592(5)(b), 100th Gen. Assemb., Reg. Sess. (Ill. 2017) (Illinois state bill lowering sentences on firearms possession convictions if the defendant suffers from a history of trauma); H. 3586, 190th Gen. Court, (Mass. 2017) (Massachusetts state bill “to offer trauma-informed and gender-specific approaches to diversion, programming, and re-entry and rehabilitation programs for incarcerated women”); S. 3824, 2017 Gen. Assemb., Reg. Sess. (N.Y. 2017) (New York state bill creating trauma-informed alternatives to solitary confinement); H.R. Con. Res. 33, 79th Legis. Assemb., Reg. Sess. (Or. 2017)

female inmates deserve more imminent and definitive attention on a larger scale.

(Oregon bill “[e]ncouraging state officers, agencies and employees to become informed regarding impacts of trauma and to become aware of evidence-based and evidence-informed trauma-informed care practices and interventions”); New York City, N.Y., §9-145 (2016) (effective Apr. 18, 2017) (Public law passed by the New York City city council “requiring the use of trauma-informed care in city correctional facilities”); AMANDA EDGAR ET AL., STATE OF ME. SUBSTANCE ABUSE & MENTAL HEALTH SERVS., SUBSTANCE USE, PREGNANCY, TRAUMA & INCARCERATION: A DISCUSSION OF THE COLLECTIVE IMPACTS ON FAMILIES IN MAINE 1-28, <http://www.maine.gov/dhhs/samhs/osa/help/fasddab/FASD-DAB-Conference-2015/Substance-Use-Pregnancy-Trauma-and-Incarceration.pdf> (last visited May 7, 2018) (interdisciplinary report produced by the state of Maine explaining the impact of trauma on incarcerated women).