

William & Mary Journal of Race, Gender, and Social Justice

Volume 6 (1999-2000)
Issue 1 *William & Mary Journal of Women and
the Law*

Article 4

October 1999

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Repository Citation

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 (1999), <https://scholarship.law.wm.edu/wmjowl/vol6/iss1/4>

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UNIQUE MENTAL HEALTH NEEDS OF HIV-INFECTED
WOMEN INMATES: WHAT SERVICES ARE REQUIRED
UNDER THE CONSTITUTION AND THE AMERICANS WITH
DISABILITIES ACT?

CONNIE M. MAYER*

I. INTRODUCTION

The Centers for Disease Control (CDC) began receiving reports about a condition eventually known as Acquired Immunodeficiency Syndrome (AIDS) in 1981.¹ By 1983, scientists had identified a new human retrovirus called HIV, or Human Immunodeficiency Virus, that was responsible for AIDS.² Since that time, the number of persons with HIV infection and AIDS has grown, and HIV/AIDS now affects nearly every country in the world.³ Between the start of the epidemic and July 1996, an estimated 27.9 million persons across the world were living with HIV infection.⁴

HIV infection has been prevalent in women from the onset of the epidemic.⁵ The CDC received the first report of a woman infected with HIV in 1981.⁶ By August of 1992, women in the United States represented 10.4% of the total epidemic.⁷ HIV is now the third leading cause of death in American women between the ages of twenty-five and forty-four.⁸ In spite of the fact that women have been infected with HIV from the very beginning of the AIDS epidemic, commentators did not focus their attention on the unique

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1. See Centers for Disease Control, *Pneumocystis Pneumonia--Los Angeles*, 30 MORBIDITY & MORTALITY WKLY. REP. 250, 251 (1981); Centers for Disease Control, *Kaposi's Sarcoma and Pneumocystis Pneumonia among Homosexual Men--New York City and California*, 30 MORBIDITY & MORTALITY WKLY. REP. 305, 305-06 (1981).

2. See JOYCE W. HOPP & ELIZABETH A. ROGERS, AIDS AND THE ALLIED HEALTH PROFESSIONS 5-6 (1989).

3. See *id.* at 2.

4. See AIDSCAP/FAMILY HEALTH INTERNATIONAL, HARVARD SCHOOL OF PUBLIC HEALTH, FINAL REPORT: THE STATUS AND TRENDS OF THE GLOBAL HIV/AIDS PANDEMIC 5 (1996).

5. See James Chin, *Current and Future Dimensions of the HIV/AIDS Pandemic in Women and Children*, 336 LANCET 221, 224 (1991).

6. See HOPP & ROGERS, *supra* note 2, at 4.

7. See Mary E. Guinan, *HIV, Heterosexual Transmission, and Women*, 268 JAMA 520, 521 (1992).

8. See Centers for Disease Control, *Update: Mortality Attributable to HIV Infection among Persons Aged 25-44 Years--United States, 1994*, 45 MORBIDITY & MORTALITY WKLY. REP. 121, 121 (1996).

needs of women living with HIV until the second decade of the epidemic.⁹ Early understanding of HIV disease progression in women was often in the context of studying some other group, such as infants, rather than targeting women as a distinct group for study.¹⁰ Many studies about women targeted only pregnant women, and researchers did not attempt to understand the disease in women, generally, until relatively recently. Despite these delays, recent studies have found that HIV-infected women do have mental health needs that are different from the needs of other groups infected with the AIDS virus.¹¹

Women with HIV infection who are incarcerated have the same mental health needs as other infected women.¹² In addition, incarcerated women are subject to other stressors related to the conditions and reality of confinement that may serve to exacerbate the mental health problems related to HIV.¹³ As a result, and given the high rate of HIV infection among women prisoners,¹⁴ the needs of HIV-infected women inmates are an enormous problem for correctional facilities.

The incidence of AIDS is fourteen times higher in our state and federal correctional facilities than in the general population.¹⁵ In some states, the number of HIV-infected inmates may be as high as 17% of the overall prison population.¹⁶ Moreover, in many systems, women inmates are infected at a much higher percentage. For example, recent statistics indicate that 20.5% of female inmates in New York are infected with HIV while only 11% of the male inmates are HIV-positive.¹⁷

To complicate the situation, prisons must understand that women inmates who are infected with HIV have mental health needs that are different from their male counterparts. The limited programs offered in men's correctional facilities are not necessarily appropriate to meet the needs of female inmates. The question, then, is whether prisons are legally required to address these mental health needs.

9. See Lorraine Sherr, *Psychosocial Aspects of Providing Care for Women with HIV Infection*, in *HIV INFECTION IN WOMEN* 107, 107 (Howard Minkoff et al. eds., 1995).

10. See *id.*

11. See *id.* at 109-14.

12. See *infra* notes 46-50 and accompanying text.

13. See *infra* notes 51-53 and accompanying text.

14. See Elizabeth Kantor, *AIDS and HIV Infection in Prisoners*, in *THE AIDS KNOWLEDGE BASE* 1.8-1, 1.8-1 (P.T. Cohen et al. eds., 2d ed. 1994).

15. See *id.*

16. See THEODORE M. HAMMETT ET AL., *NATIONAL INST. OF JUSTICE, 1992 UPDATE: HIV/AIDS IN CORRECTIONAL FACILITIES* 13-19 (1994).

17. See *id.* at 22.

This Article outlines the unique mental health needs of HIV-infected female inmates, including the types of mental health intervention shown to be effective in treating HIV-related neuropsychological disturbances. Additionally, this Article explores the type of prison mental health services that are mandated to be provided by the Eighth Amendment to the United States Constitution, which guarantees that prisoners be free from cruel and unusual punishment.¹⁸ This Article further discusses the possible impact of *Pennsylvania Department of Corrections v. Yeskey*,¹⁹ in which the Supreme Court recently held that the Americans with Disabilities Act (ADA) applies to state prison systems.²⁰ Finally, this Article discusses how prisons will likely have to respond to the mental health needs of HIV-positive female inmates in order to be in compliance with the requirements of both the ADA and the Eighth Amendment.

II. PREVALENCE OF HIV/AIDS AMONG WOMEN INMATES

During 1994, state, local, and territorial health departments reported 80,691 cases of full-blown AIDS within the general population.²¹ Although approximately 441,500 cumulative AIDS cases have been reported since 1981, it is estimated that ten times the number of persons reporting full blown AIDS are HIV-positive.²²

The incidence of AIDS is fourteen times higher in state and federal prisons than in the general United States population.²³ Prisoners are at exceptional risk for infection with HIV, in part because of the connection between drug use and imprisonment. During the late 1980's and early 1990's, eighteen states doubled or tripled their prison populations primarily because the central strategy of the United States government's "war on drugs" has been incarceration.²⁴ In its 1991 report, the National Commission on AIDS stated that:

18. See U.S. CONST. amend. VIII.

19. 524 U.S. 206 (1998).

20. See *id.* at 213.

21. See Centers for Disease Control and Prevention, *Update: Acquired Immunodeficiency Syndrome—United States, 1994*, 273 JAMA 692, 692 (1995).

22. See Mary E. Chamberland & Harold W. Jaffee, *The Epidemiology of Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus Infection*, in HIV INFECTION AND DISEASE 47, 48 (Norman Rapoza ed., 1989).

23. See *supra* note 15 and accompanying text.

24. See NATIONAL COMM'N ON AIDS, REPORT NUMBER FOUR: HIV DISEASE IN CORRECTIONAL FACILITIES 6 (1991); Kantor, *supra* note 14, at 1.8-1.

By choosing mass imprisonment as the federal and state governments' response to the use of drugs, we have created a de facto policy of incarcerating more and more individuals with HIV infection. Under the present policy, the percentage of federal prisoners who are drug offenders will rise by 1995 from 47 percent to 70 percent.²⁵

From 1985 through 1997, the number of women incarcerated increased by 265%, while the increase in the number of males incarcerated rose 148%.²⁶ The disproportionate increase in the incarceration rate for women appears to be related to minimum sentencing laws for low level drug offenders.²⁷ Nationwide, the number of women serving sentences for drug offenses accounts for more than one-half of the total growth of the female inmate population, while women incarcerated for other crimes account for only one-fifth of that increase.²⁸ In addition to being imprisoned for drug use, women are also imprisoned for sexual activity,²⁹ two of the very behaviors that also make women at risk for HIV infection.³⁰ The attempt to "criminalize" AIDS through HIV-specific criminal statutes has also added to the number of incarcerated HIV-infected women.³¹

In the nation's prisons, a recent survey conducted by the National Institute of Justice (NIJ) indicates that correctional facilities reported a cumulative total of 11,565 AIDS cases among inmates in federal, state, and select city or county correctional facilities as of March 1993.³² From 1985 through 1994, approximately 4,588 inmates died of HIV-related illnesses while in custody.³³ As of 1994, state and federal facilities housed around one million inmates, of which approximately 2.3%, or 23,000, were

25. NATIONAL COMM'N ON AIDS, *supra* note 24, at 6.

26. See DARRELL K. GILLIARD & ALLEN J. BECK, BUREAU OF JUSTICE STATISTICS, PRISON AND JAIL INMATES AT MIDYEAR 1997 4-6 (1998).

27. See TRACY L. SNELL, BUREAU OF JUSTICE STATISTICS, SURVEY OF STATE PRISON INMATES: WOMEN IN PRISON 1 (1994).

28. *See id.*

29. *See id.* at 3.

30. *See* Kantor, *supra* note 14, at 1.8-1.

31. *See, e.g.*, ARK. CODE ANN. § 5-14-123 (Michie 1997) (criminalizing the act of exposing another person to HIV); IDAHO CODE § 39-608 (1998) (criminalizing any intentional infecting of another person with HIV); MO. ANN. STAT. § 191.677 (West 1996) (criminalizing any knowing attempt to infect another person with HIV); OKLA. STAT. tit. 21, § 1192.1 (West Supp. 1999) (criminalizing any knowing conduct reasonably likely to transfer HIV to another person).

32. *See* HAMMETT ET AL., *supra* note 16, at 14.

33. *See* THEODORE M. HAMMETT ET AL., NATIONAL INST. OF JUSTICE, 1994 UPDATE: HIV/AIDS AND STDs IN CORRECTIONAL FACILITIES 4 (1995).

estimated to be HIV-positive.³⁴ Some states reported a percentage as high as 17-20% (New York) and others as low as 0-1% (Oregon).³⁵ In the New York system alone, it was estimated that approximately 6,000 of the state's 54,000 inmates were HIV-positive.³⁶

Incarcerated women are disproportionately affected by HIV as compared to incarcerated men. In fact, in 1994, aggregate rates of AIDS in state and federal prison systems for women were double the rates for men.³⁷ In New York, for example, blinded studies indicated that 20.3% of the females, as compared to only 11.5% of the male inmates, tested HIV-positive.³⁸ More recently, in Massachusetts, though women account for only 7% of the inmates who are incarcerated, they represented 20% of the HIV-positive inmates.³⁹

Additionally, women of color are disproportionately affected by HIV/AIDS. About 20% of women in the U.S. are black or Hispanic, but almost half (47%) of all female AIDS cases have occurred in these groups: 30% among blacks and 17% among Hispanics.⁴⁰ The disproportion of HIV-positive women of color in correctional facilities corresponds to the high prevalence of HIV in women of color nationwide.⁴¹ For example, in Massachusetts nearly half of all HIV-positive incarcerated women are women of color.⁴²

As demonstrated by the NIJ survey, the number of inmates suffering from HIV infection is large and growing. The number of female inmates with HIV is rising at an even greater rate.⁴³ Females have historically been under-served in correctional facilities due to their small numbers.⁴⁴ Their needs with regard to mental health services are different from male inmates and prison systems need to consider how to address these differences. For example, women more often than men may have dependent minor children for whom they are solely responsible, and immediate decisions about future care and custody of those children must be

34. See HAMMETT ET AL., *supra* note 16, at 15-26.

35. See *id.* at 22-24.

36. See *id.* at 22.

37. See *id.* at 14.

38. See *id.* at 22.

39. See Anne S. De Groot et al., *Setting the Standard for Care: HIV Risk Exposures and Clinical Manifestations of HIV in Incarcerated Massachusetts Women*, 24 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 353, 360 (1998).

40. See HAMMETT ET AL., *supra* note 16, at 13.

41. See De Groot et al., *supra* note 39, at 360-61, 381.

42. See *id.* at 358-61.

43. See *id.* at 358-59.

44. See *Casey v. Lewis*, 834 F. Supp. 1477, 1551 (D. Ariz. 1993) (stating that fewer mental health services were provided for women prisoners because there were fewer women than men in the prison system).

made. Additionally, women have many unique emotional issues surrounding reproduction, child rearing, and their roles within the family.⁴⁵

To analyze what mental health services prisons are required to provide to HIV-positive female inmates, the next section explores the common neuropsychological problems associated with HIV in women and what interventions are recommended to address those problems. These needs are exacerbated by the isolation experienced in a correctional facility. The proposed treatments, while available in the free world, are often not available behind prison walls for a variety of reasons, including cost, lack of adequate staffing, and perceived security issues. It is necessary to understand these problems in order to determine what services prisons are required to provide under the Eighth Amendment and the Americans with Disabilities Act.

III. MENTAL HEALTH NEEDS OF WOMEN LIVING WITH HIV INFECTION AND RECOMMENDED TREATMENT

Women who are HIV-positive have special mental health needs. They experience a range of psychological problems, some of which are symptoms specifically related to HIV/AIDS.⁴⁶ Women living with AIDS may experience the same psychological reactions as those experienced by other terminally ill patients—disbelief, denial, numbness, anger, depression, and suicidal ideation.⁴⁷ Yet unlike other terminal illnesses, such as cancer, a diagnosis of AIDS carries with it the stigmatization and disapproval of an entire society. This disapproval often results in social ostracism and discrimination which create additional psychological stress.⁴⁸ In addition to its effect on psychology, most patients experience some cognitive and affective changes related to HIV infection of the brain.⁴⁹ Differentiating between the effects of anxiety and depression on cognition and

45. See Sherr, *supra* note 9, at 110.

46. One study found that persons diagnosed with HIV experienced significantly higher levels of depression, anxiety, and obsessive-compulsive behavior than before their diagnosis. See Joseph Ostrow et al., *Disclosure of HIV Antibody Status: Behavioral and Mental Health Correlates*, 1 AIDS EDUC. & PREVENTION 1 (1989); see also HOPP & ROGERS, *supra* note 2, at 134-45 (discussing dementia in AIDS patients); JON MUKAND, REHABILITATION FOR PATIENTS WITH HIV DISEASE 234-38 (1991) (same); MARK WINIARSKI, AIDS-RELATED PSYCHOTHERAPY 72-85 (1991) (noting the frequency of mood disorders in HIV-infected persons).

47. See MUKAND, *supra* note 46, at 218.

48. See *id.* at 221.

49. See *id.* at 230.

the effects of neurological problems on cognition is difficult but may be crucial to proper diagnosis, intervention, and therapy.⁵⁰

HIV-positive female inmates also may have to deal with additional stigmatization and isolation within the prison setting. Though there is a trend away from the practice, some prisons continue to have segregated housing for inmates who are known to be HIV-positive.⁵¹ Inmates also are sometimes excluded from rehabilitation programs, support groups, and educational programs due to their infection.⁵² Prisoners are already cut off from familial supports as a result of incarceration. This additional isolation and lack of support systems within the prison may aggravate existing mental health problems. These mental health problems may be magnified further by the stress related to inmates' perception of lack of control over their treatment and fear of not receiving emergency care.⁵³

As described below, the mental health problems commonly experienced by women living with AIDS include dementia, depression, anxiety and panic disorders, delirium, suicidal ideation, guilt, and bereavement.⁵⁴

A. *Dementia*

The most severe neuropsychological disorder related to HIV has been termed AIDS dementia complex (ADC).⁵⁵ Though the prevalence of ADC is not completely understood, it is generally believed that approximately one-third of adults with AIDS eventually develop ADC.⁵⁶ Dementia is characterized initially by cognitive impairment causing disturbances in learning new information,

50. *See id.*

51. Mississippi's and Alabama's prison systems still maintain segregated housing and programming for HIV-positive inmates. *See HAMMETT ET AL., supra* note 16, at 59. The policies regarding segregation of HIV-positive inmates have been upheld by several courts. *See Moore v. Mabus*, 976 F.2d 268, 271 (5th Cir. 1992) (upholding Mississippi's segregation policy); *Harris v. Thigpen*, 941 F.2d 1495, 1512 (11th Cir. 1991) (upholding Alabama's segregation policy). Interestingly, courts also have upheld the decision of systems *not* to segregate HIV-positive inmates when those policies were challenged by HIV-negative inmates. *See Portee v. Tollison*, 753 F. Supp. 184, 186-87 (D.S.C. 1990), *aff'd*, 929 F.2d 694 (4th Cir. 1991).

52. *See HAMMETT ET AL., supra* note 33, at 61.

53. *See HAMMETT ET AL., supra* note 16, at 72.

54. *See HOPP & ROGERS, supra* note 2, at 134-45; MUKAND, *supra* note 46, at 218-23; WINIARSKI, *supra* note 46, at 72-85.

55. *See* Stuart A. Lipton & Howard E. Gendelman, *Dementia Associated with the Acquired Immunodeficiency Syndrome*, 332 NEW ENG. J. MED. 934, 934 (1995).

56. *See id.*

attention span, and information processing.⁵⁷ In the early stages of ADC, subtle failure in memory and concentration may occur along with an overall "slowness" in thinking.⁵⁸ Fine and gross motor skills, such as writing or walking, also may become less fluid.⁵⁹ At this stage, a person with ADC may exhibit social withdrawal, appear agitated or depressed, and experience anxiety or panic attacks.⁶⁰

As the illness progresses, a severe dementing syndrome can occur.⁶¹ The person may become incoherent or psychotic, with increased psychomotor retardation, aggressive outbursts, and inappropriate behavior.⁶² Ultimately, the demented person becomes bedridden and may suffer from severe lack of coordination and loss of bladder and bowel control.⁶³

The psychiatric manifestations that might accompany ADC are depression, irritability, panic and anxiety attacks, paranoid ideation, and suicidal tendencies.⁶⁴ Despite the overlapping similarities between HIV-related cognitive changes and those more purely "psychological" difficulties, cognitive changes due to HIV infection of the brain are not usually present to the same extent and in the same manner.⁶⁵ Psychological assessment is imperative to distinguish the diagnostic possibilities in order to plan properly the best intervention.⁶⁶

B. Depression

Though dementia is the most severe neuropsychological disorder related to HIV, patients often experience emotional trauma typified by anxiety and depression. In fact, mood disorders appear to comprise the majority of psychiatric manifestations of HIV infection.⁶⁷ Depressive reactions often lead from mild to severe behavioral manifestations such as social withdrawal, mood swings, and isolation.⁶⁸ These may feed a vicious cycle of reactions when social support is alienated, relationships are strained, and individu-

57. See IGOR GRANT & ALEX MARTIN, *NEUROPSYCHOLOGY OF HIV INFECTION* 7 (1994).

58. See MUKAND, *supra* note 46, at 231.

59. See *id.*

60. See *id.*

61. See *id.* at 232.

62. See *id.*

63. See *id.* at 231-32; GRANT & MARTIN, *supra* note 57, at 7-8.

64. See MUKAND, *supra* note 46, at 231.

65. See *id.*

66. See *id.* at 232.

67. See WINIARSKI, *supra* note 46, at 72.

68. See *id.* at 73.

als become isolated from possible avenues of benefit.⁶⁹ Obviously, women who are incarcerated are isolated from family support and cut off from many of the social services in the outside world from which they could benefit, thereby exacerbating their vulnerability to depression.

An HIV diagnosis can trigger depression related to many issues unique to women.⁷⁰ "Women are faced with the possibility of a curtailed life span, of never having children, or of never seeing their children grow up. Not having children inevitably denies them the pleasures of the mothering role, companionship, and considerable purpose and engagement in everyday life."⁷¹ Many women with AIDS "have physical manifestations that mar their self-image, such as severe weight loss, Kaposi's sarcoma lesions in visible places, or hair loss associated with various treatments."⁷²

Additionally, women who are incarcerated are cut off from traditional roles that studies have shown improve their health. The inability to fulfill these roles can lead to depression and deterioration of women's health generally. For example, considerable research has been done on the impact of employment on the physical and mental health of women.⁷³ This research shows that the "worker role" is generally rewarding for women.⁷⁴ First, employed women report better overall health and fewer symptoms of psychological distress than non-employed women.⁷⁵ Second, the relationship between the role of partner and one's physical and mental well-being is favorable to women.⁷⁶ The "partner role" is a source of identity, social support, and self-esteem.⁷⁷ Finally, the "mother role," generally defined by the presence of children at home, also has a positive impact on the physical and mental well-

69. See Sherr, *supra* note 9, at 112.

70. See *id.*

71. *Id.*

72. *Id.*

73. See Jacquie Aston & John Lavery, *The Health of Women in Paid Employment: Effects of Quality of Work Role, Social Support and Cynicism on Psychological and Physical Well-Being*, 20 WOMEN & HEALTH REV. 1, 2 (1993).

74. See *id.*

75. See *id.*; Sara Arber, *Class, Paid Employment and Family Roles: Making Sense of Structural Disadvantage, Gender and Health Status*, 32 SOC. SCI. & MED. 425, 434 (1991); Judith H. Hibbard & Clyde R. Pope, *Women's Employment, Social Support and Mortality*, 18 WOMEN & HEALTH REV. 119 (1992).

76. See Arber, *supra* note 75, at 434; Debra Froberg et al., *Multiple Roles and Women's Mental and Physical Health: What Have We Learned?*, 11 WOMEN & HEALTH REV. 79, 83-84 (1986); Ingrid Waldron & Jerry A. Jacobs, *Effects of Multiple Roles on Women's Health: Evidence from a National Longitudinal Study*, 15 WOMEN & HEALTH REV. 3, 13 (1989).

77. See Arber, *supra* note 75, at 429; Hibbard & Pope, *supra* note 75.

being of women.⁷⁸ Middle-aged women and younger women with one or two children enjoy better health than other women.⁷⁹ The fact that women inmates cannot fulfill these roles because they are incarcerated contributes to their depression in a way that is not similarly felt by their male counterparts.

Depression regarding any of the above issues may be exhibited in a number of ways: feelings of loss of worth, lack of self esteem, guilt, thoughts of suicide, inability to concentrate, poor appetite, inability to sleep properly, loss of energy, and fatigue.⁸⁰ Some studies seem to indicate that depression actually increases the progression of HIV infection.⁸¹ Other studies, however, have contradicted these results and the issue remains unresolved.⁸²

Depressive symptoms may range from an adjustment disorder with depressed mood to major depression.⁸³ The DSM-IV⁸⁴ criteria for adjustment disorder involves a maladaptive reaction to the diagnosis of HIV.⁸⁵ The reaction can result in impairment in social or occupational functioning or symptoms that exceed a "normal" reaction, such as major depression.⁸⁶ Some HIV-infected women experience major depression that should be seen as a treatable disorder rather than merely an expected response to having HIV.⁸⁷

C. Anxiety Disorders

Many women living with HIV also experience anxiety or panic disorders.⁸⁸ Anxiety disorders can range from adjustment disorders with anxious moods to panic attacks.⁸⁹ A panic attack usually is

78. See Cecile M.T. Gijbbers Van Wijk et al., *Male and Female Health Problems in General Practice: The Differential Impact of Social Position and Social Roles*, 40 SOC. SCI. & MED. 597, 607 (1995).

79. See Pamela Adelman et al., *A Casual Analysis of Employment and Health in Midlife Women*, 16 WOMEN & HEALTH REV. 5, 6-8, 15-16 (1990).

80. See Sherr, *supra* note 9, at 112-14.

81. See generally Jeffrey H. Burack et al., *Depressive Syndromes and CD4 Lymphocyte Decline among HIV-Infected Men*, 270 JAMA 2568 (1993) (finding that depressed subjects had faster rates of decline in CD4 lymphocyte counts than those who were not depressed).

82. See Constantine G. Lyketos et al., *Depressive Symptoms as Predictors of Medical Outcomes in HIV Infection*, 270 JAMA 2563, 2565 (1993).

83. See DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 317-18, 623-27 (4th ed. 1994) [hereinafter DSM-IV].

84. The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders is more commonly referred to as the DSM-IV.

85. See DSM-IV, *supra* note 83, at 623-27.

86. See *id.* at 377-78.

87. See Samuel Perry & Baruch Fishman, *Depression and HIV: How Does One Affect the Other?*, 270 JAMA 2609, 2610 (1993).

88. See WINIARSKI, *supra* note 46, at 74.

89. See *id.* at 75.

manifested by chest pain, heart palpitations, dizziness, trembling, shaking, and fear of losing control during the attack.⁹⁰ "Many of the physical symptoms of anxiety can be confused with AIDS-related symptoms that may feed the cycle of anxiety."⁹¹

Many women "with HIV infection worry about contagion, especially about the possibility of infecting those they love."⁹² Many also worry about the "incapacitating disease outcomes, particularly AIDS dementia and loss of vision or mobility."⁹³ Fear of rejection and fears relating to their inability to care for dependents are also sources of anxiety for women.⁹⁴

D. Delirium

Some AIDS patients also experience delirium caused by metabolic or toxic abnormalities.⁹⁵ Delirium is manifested by a clouded state of consciousness, difficulty sustaining attention, misinterpretations, illusions, hallucinations, increase or decrease in motor activity, or a catatonic stupor.⁹⁶ Delirium generally is not a persistent state but a temporary disturbance that may be treatable with medication.⁹⁷

E. Suicide

Partly as a result of the above described mental health needs, HIV/AIDS presents a risk factor for suicide.⁹⁸ One study indicated that the rate of suicide among New York City residents with AIDS was sixty-six times higher than that of the general population of New York residents.⁹⁹ The results of a 1988 study also demonstrated that the relative risk of suicide in California was substan-

90. See HOPP & ROGERS, *supra* note 2, at 141.

91. Sherr, *supra* note 9, at 111.

92. *Id.*

93. *Id.*

94. *See id.*

95. See HOPP & ROGERS, *supra* note 2, at 141.

96. *See id.*

97. *See id.*

98. For a discussion of the increased risk of suicide among people with HIV, see generally George R. Brown & James R. Rundell, *Suicidal Tendencies in Women with Human Immunodeficiency Virus Infection*, 146 AM. J. PSYCHIATRY 556 (1989); Richard N. Glass, *AIDS and Suicide*, 259 JAMA 1369 (1988); Peter Marzuk et al., *Increased Risk of Suicide in Persons with AIDS*, 259 JAMA 1333 (1988).

99. *See* Glass, *supra* note 98, at 1369.

tially higher for persons with AIDS than for persons without AIDS.¹⁰⁰

Several psychosocial factors have been identified as possible predictors of suicidal behavior: perceived social isolation, perception of self as a victim, and perceived lack of or unavailability of social support.¹⁰¹ These factors are almost certainly present in the prison system unless a range of mental health services, including support groups, is offered. If not, the risk of suicide for HIV-positive women inmates is certainly exacerbated.

F. Guilt

Women infected with HIV often experience guilt.¹⁰² There are many possible sources of this guilt, including "their own mode of infection, their feelings about possibly infected loved ones, . . . [and] their emotional trauma associated with their limited ability to provide care and attain a lifestyle that they may have aspired to."¹⁰³ They also feel "[guilt] about their own past behavior" and their perception of the infection as "punishment."¹⁰⁴ In addition, these feelings of guilt may be exacerbated by other mental health issues arising from HIV infection.¹⁰⁵

G. Bereavement

Bereavement is a common element of the psychological impact of HIV infection for women.¹⁰⁶ Studies have found that bereavement may manifest itself in greater sleep disturbance, greater sedative and recreational drug use, and more frequent need for and use of mental health services.¹⁰⁷ "Bereavement can be associated

100. See generally Kenneth W. Kizer et al., *AIDS and Suicide in California*, 260 JAMA 1881 (1990) (describing a study indicating that suicide rates were higher for men with AIDS than for men without AIDS).

101. See Mario Maj, *Psychiatric Aspects of HIV-1 Infection and AIDS*, 20 PSYCHOL. MED. 547, 558 (1990).

102. See Sherr, *supra* note 9, at 113.

103. *Id.* at 113-14.

104. *Id.*

105. See *id.*

106. See Brian Kelly et al., *A Comparison of the Psychosocial Aspects of AIDS and Cancer-Related Bereavement*, 26 INT'L J. PSYCHIATRY IN MED. 35, 36 (1996).

107. C.f. John L. Martin, *Psychological Consequences of AIDS-Related Bereavement among Gay Men*, 56 J. CONSULTING & CLINICAL PSYCHOL. 856, 858, 860-61 (1988) (providing the results of a study which found a direct connection between the number of bereavements and increased sleep disturbance and drug use problems); John L. Martin & Laura Dean, *Effects of AIDS-Related Bereavement and HIV-Related Illness on Psychological Distress Among Gay Men*, 61 J. CONSULTING & CLINICAL PSYCHOL. 94, 102 (1993) (reporting the manifestations

with losses that are not necessarily 'deaths.'¹⁰⁸ For example, many women mourn the loss of a shared future with their children and bear the prospect of the additional burden of knowingly leaving orphaned children.¹⁰⁹ HIV infection also may lead to the inability of women to have children,¹¹⁰ and so, as a result, "[w]omen who wanted larger families may have to mourn the loss of these additional children."¹¹¹ This naturally may lead to bereavement for those children who never were born.¹¹²

In addition, many women who already have children are concerned about losing contact with them.¹¹³ This loss of contact can happen in a variety of ways, including hospitalization, loss of custody because of the inability to care for the child, and death.¹¹⁴ These factors clearly come into play when a woman is incarcerated and physically cut off from her child.

H. Intervention and Treatment

Because many of the neuropsychological disorders associated with HIV may respond to medication and/or other interventions, the first step toward adequate treatment is "rapid and accurate diagnosis."¹¹⁵ Systems for screening, monitoring, and diagnosis are essential to the delivery of proper mental health services.¹¹⁶ Psychological assessments, including clinical interviews and cognitive, intellectual, and personality measurements, are helpful in distinguishing between neurological disorders and purely "psychological" disorders.¹¹⁷ There is an ongoing debate as to which groups of tests work best to assess cognitive changes in HIV-positive women.¹¹⁸ Researchers suggest that the development of a

of bereavement among men who lose close friends to AIDS); Richard Neugebauer et al., *Bereavement Reactions among Homosexual Men Experiencing Multiple Losses in the AIDS Epidemic*, 149 AM. J. PSYCHIATRY 1374, 1376-78 (1992) (finding that the level of depressive symptoms increased with the number of bereavements).

108. Sherr, *supra* note 9, at 112.

109. *See id.*

110. *See id.*

111. *Id.*

112. *See id.*

113. *See id.* at 113.

114. *See id.*

115. MUKAND, *supra* note 46, at 230.

116. *See id.* at 230-33.

117. *See id.* at 232-33.

118. *See, e.g.,* Nelson Butters et al., *Assessment of AIDS-Related Cognitive Changes*, 12 J. CLINICAL & EXPERIMENTAL NEUROPSYCHOL. 963, 963-78 (1990) (describing two alternative tests designed for asymptomatic persons); Samuel W. Perry, *Organic Mental Disorders Caused by HIV*, 147 AM. J. PSYCHIATRY 696, 701-04 (1990) (describing a variety of tests used

brief neuropsychological test battery is important because symptomatic HIV-positive women may tire easily.¹¹⁹ Doctors and researchers currently employ a range of assessment instruments to test for cognitive change.¹²⁰ Some, like the Mini-Mental Status Examination, take as little as fifteen minutes to administer,¹²¹ while others may take as long as seven to nine hours.¹²² Regardless of the type or length of the assessment, researchers agree that caregivers should monitor their patients continuously for changing symptoms.¹²³

Medication also can be an effective intervention as certain disorders, once properly diagnosed, respond well to drug therapy.¹²⁴ Medication can be useful in treating disturbances of mood and sleep,¹²⁵ adjustment disorders,¹²⁶ depression,¹²⁷ acute agitation,¹²⁸ and delirium.¹²⁹ Early clinical trials have demonstrated that the newly developed protease inhibitors such as Ritonair, Saquinavir, and Indinavir can provide long-term suppression of HIV infection by inhibiting the ability of the virus to replicate.¹³⁰ By inhibiting the replication of the virus, these new drugs also may work to slow or stabilize the progression of ADC.¹³¹

Behavioral modification techniques are another useful intervention. Programs teaching women skills such as relaxation training, developing strategies for coping skills, and problem-solving techniques can be effective for those suffering from anxiety and depression.¹³² Patients with certain cognitive deficiencies that may be caused by ADC need structure to limit the degree of confusion and assist them in compensating for memory loss.¹³³

to detect early mental changes in HIV-positive patients).

119. See GRANT & MARTIN, *supra* note 57, at 182.

120. See *id.* at 161-87 for general discussion of various screening instruments and use of computerized testing.

121. See MUKAND, *supra* note 46, at 232-33.

122. See Butters et al., *supra* note 118, at 965.

123. See HOPP & ROGERS, *supra* note 2, at 137.

124. See MUKAND, *supra* note 46, at 230; WINIARSKI, *supra* note 46, at 74.

125. See MUKAND, *supra* note 46, at 237; WINIARSKI, *supra* note 46, at 75-76.

126. See WINIARSKI, *supra* note 46, at 74.

127. See *id.* at 75.

128. See *id.* at 76.

129. See *id.*

130. See Emilio A. Emini & Jon H. Condra, *Biochemical Pharmacology: Protease Inhibitors*, in TEXTBOOK OF AIDS MEDICINE 848, 848-51 (Thomas C. Merigan et al. eds., 1999).

131. See *id.* It also has been shown that zidovudine (AZT) slowed the progression of ADC. See Frederick A. Schmitt et al., *Neuropsychological Outcome of Zidovudine (AZT) Treatment of Patients with AIDS and AIDS-Related Complex*, 319 NEW ENG. J. MED. 1573, 1574 (1988).

132. See WINIARSKI, *supra* note 46, at 75.

133. See *id.*

Highly structural programs that assist the patient in learning self care through routinization of activities of daily living can be extremely helpful in enhancing a patient's independence and self-esteem.¹³⁴ Behavioral techniques also can assist in treatment of dangerous behaviors associated with ADC or delirium and in pain management and stress.¹³⁵

In addition, psychotherapy and counseling can be effective tools to address nearly all the neuropsychological manifestations of AIDS and HIV infection. The two differ significantly in the amount and type of training required of those who deliver them.¹³⁶ "Psychotherapy is usually performed by doctoral-level persons, typically clinical psychologists or psychiatrists. It is intended to change problematic thoughts, feelings, and behaviors by creating new understandings and then applying them in ways that benefit the patient."¹³⁷ Counseling, on the other hand, can be performed by either paraprofessionals or professionals and typically is done by persons with degrees at the bachelor's or master's level.¹³⁸ "Counseling focuses on identifying specific current problems and delivering concrete services as well as providing structure and support."¹³⁹ Counselors identify problems that require employment, medical, or legal services and then make referrals to appropriate service providers.¹⁴⁰ Counseling emphasizes external problems rather than intrapsychic processes.¹⁴¹

Studies comparing psychotherapy with counseling have shown that patients with lower symptom levels or less severe disorders usually showed significant benefits under both treatment modalities.¹⁴² Patients with more severe forms of depression, however, did better with psychotherapy than with counseling.¹⁴³ Results of studies which examined group therapy for HIV-positive patients showed that participants in group therapy demonstrated significant reductions in psychological distress as compared with a control group that received no services.¹⁴⁴ The research illustrates that

134. See HOPP & ROGERS, *supra* note 2, at 136-37; MUKAND, *supra* note 46, at 231-34.

135. See MUKAND, *supra* note 46, at 238.

136. See George E. Woody et al., *Psychotherapy and Counseling for HIV-Positive Individuals*, in TEXTBOOK OF AIDS MEDICINE 911, *supra* note 130, at 911.

137. *Id.* at 911-12.

138. See *id.*

139. *Id.* at 912.

140. See *id.*

141. See *id.*

142. See *id.* at 913.

143. See *id.*

144. See *id.* at 914.

both counseling and psychotherapy can be helpful in reducing the emotional distress associated with HIV disease.¹⁴⁵

Specifically, psychotherapy and counseling assist patients in working through depression, fear, and grief.¹⁴⁶ Many patients with adjustment disorders respond well to cognitive psychotherapy. Suicide risk reduction can be accomplished through psychotherapy by encouraging and allowing patients to verbalize their feelings and thoughts about suicide.¹⁴⁷ Psychotherapy also can enhance and strengthen coping and problem-solving skills important to suicide reduction.¹⁴⁸

Psychotherapy groups and support groups are extremely important for women with AIDS in helping to reduce guilt and shame, decrease feelings of isolation and loneliness, and provide a forum for sharing information and experiences.¹⁴⁹ Social support is crucial to the stabilization and the psychological well-being of women living with AIDS. Lack of social support presents a formidable strain in adjusting to AIDS and coping with the psychological stress associated with HIV infection.¹⁵⁰ Effective support groups need a facilitator who is knowledgeable about AIDS, is non-judgmental, and can lead the group in sharing the knowledge and experiences of women living with AIDS.¹⁵¹

Peer support groups can be especially effective in assisting women inmates to work through their feelings of despair relating to HIV infection. They can develop a level of trust that outside counselors may not be able to achieve.¹⁵² With peer facilitators, inmates may be more able to verbalize their concerns without fear

145. *See id.*

146. *See* MUKAND, *supra* note 46, at 236.

147. *See* HOPP & ROGERS, *supra* note 2, at 139.

148. *See* MUKAND, *supra* note 46, at 237.

149. *See id.*; Sherr, *supra* note 9, at 112.

A few studies of the efficacy of these groups have been conducted. One study of HIV-positive individuals found that those who attended support groups had more social contact and lower levels of emotional distress than those who did not. Non-attenders had more avoidant coping styles and higher levels of psychological distress . . . [N]on-attenders exhibited more emotional distress regardless of how long they had known of their HIV positivity. These findings imply that self-help support groups and other support services such as volunteer "buddies" play an important role in the reduction of psychological distress associated with being HIV positive.

Woody et al., *supra* note 136, at 914 (citing the findings of Seth C. Kalichman et al., *People Living with HIV Infection Who Attend and Do Not Attend Support Groups: A Pilot Study of Needs, Characteristics, and Experiences*, 8 AIDS CARE 589 (1996)).

150. *Cf.* Woody et al., *supra* note 136, at 914 (naming social support services as the "backbone" of psychological services offered to HIV positive individuals).

151. *See* HOPP & ROGERS, *supra* note 2, at 154-55.

152. *See* HAMMETT ET AL., *supra* note 16, at 38.

of being judged or of disclosure.¹⁵³ "Provided they are carefully selected and trained, peer educators may be more credible with inmates and more likely to speak in terms relevant to and understandable to inmates."¹⁵⁴ Peer counselors also may be more aware of high risk behavior occurring within the facility and can discuss this openly with female inmates.¹⁵⁵ Moreover, peer counseling can be used at little or no cost to the system.¹⁵⁶

The Eighth Amendment of the Constitution requires that the psychosocial needs of HIV-positive women inmates must be addressed by prison systems. This has been applied to the provision of mental health services. As described below, in *Estelle v. Gamble*,¹⁵⁷ the Supreme Court established the "floor" of constitutionally adequate health services.¹⁵⁸ Additionally, the Supreme Court's ruling in *Pennsylvania Department of Corrections v. Yeskey*¹⁵⁹ makes it clear that the Americans with Disabilities Act (ADA)¹⁶⁰ is applicable in state prison systems. The next section outlines what mental health services are minimally required pursuant to the Eighth Amendment and how the ruling in *Yeskey* may impact the provision of these services.

IV. CONSTITUTIONAL REQUIREMENTS FOR PRISON MENTAL HEALTH SERVICES

Inmate challenges to inadequate psychological care are based on the Eighth Amendment to the United States Constitution, which prohibits the infliction of "cruel and unusual punishment."¹⁶¹ Originally, cases claiming violations of the Eighth Amendment involved methods of punishment that were considered barbarous.¹⁶² More recent cases, however, have extended the concept of "cruel and

153. *See id.*

154. *Id.*

155. *See id.*

156. *See* HAMMETT ET AL., *supra* note 33, at 30.

157. 429 U.S. 97 (1976).

158. *See infra* notes 164-66 and accompanying text.

159. 524 U.S. 206 (1998).

160. Americans with Disabilities Act of 1990 (ADA), Pub. L. No. 101-336, 104 Stat. 327 (1990).

161. U.S. CONST. amend. VIII.

162. *See In re Kemmler*, 136 U.S. 436, 446 (1890) (indicating that burning at the stake, crucifixion, and breaking on the wheel were cruel and unusual punishments); *Wilkerson v. Utah*, 99 U.S. 130, 135-36 (1878) (finding that punishments of torture prohibited by the Eighth Amendment included instances in which the convicted defendant was disemboweled alive, beheaded, quartered, and burned alive).

unusual punishment" to all conditions of confinement in prisons and jails.¹⁶³

In *Estelle v. Gamble*,¹⁶⁴ the Supreme Court specifically reviewed the adequacy of medical health care in prisons and found that failure to provide adequate health care could constitute cruel and unusual punishment if it rises to the level of "deliberate indifference to serious medical needs" of inmates.¹⁶⁵ *Estelle* set forth a two-prong test to establish a violation of the Eighth Amendment regarding the adequacy of medical care for physical disorders: (1) the treatment given must show deliberate indifference, and (2) the treatment must be in response to serious medical needs.¹⁶⁶

After *Estelle*, lower courts held that there was no logical distinction between the right to medical care for physical disorders and the right to mental health care for psychological or psychiatric disorders.¹⁶⁷ The Tenth Circuit applied the deliberate indifference standard to all conditions of confinement, including the right to mental health care.¹⁶⁸ As a result, it is now clearly established that the deliberate indifference standard applies to serious mental disorders, and therefore the failure to provide adequate mental health care in prisons violates the Constitution.

163. See *Wilson v. Seiter*, 501 U.S. 294, 302 (1991) (holding that court could find that prison conditions, including overcrowding and excessive noise, constituted cruel and unusual punishment if plaintiff could show culpable state of mind on the part of prison officials); see also *Gregg v. Georgia*, 428 U.S. 153, 172-73 (1976) (noting that public perception of standards of decency with respect to criminal sanctions and accordance with the basic underlying concept of the Eighth Amendment demand that the dignity of man must be considered when deciding whether a punishment is cruel and unusual); *Trop v. Dulles*, 356 U.S. 86, 101-02 (1958) (finding that punishment in the form of denationalization is cruel and unusual in that it strips the citizen of his political community and his place in organized society); *Weems v. United States*, 217 U.S. 349, 378 (1910) (noting that the Eighth Amendment may be interpreted in a manner that is "progressive, and is not fastened to the obsolete but may acquire meaning as public opinion becomes enlightened by a humane justice").

164. 429 U.S. 97 (1976).

165. *Id.* at 105.

166. See *id.* at 106.

167. See *Steele v. Shah*, 87 F.3d 1266, 1269 (11th Cir. 1996); *Riddle v. Mondragon*, 83 F.3d 1197, 1202 (10th Cir. 1996); *Doty v. County of Lassen*, 37 F.3d 540, 546 (9th Cir. 1994); *Torraco v. Maloney*, 923 F.2d 231, 234 (1st Cir. 1991); *Smith v. Jenkins*, 919 F.2d 90, 93 (8th Cir. 1990); *Partridge v. Two Unknown Police Officers of Houston*, 791 F.2d 1182, 1187 (5th Cir. 1986); *Bee v. Greaves*, 744 F.2d 1387, 1395 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214 (1985); *Wellman v. Faulkner*, 715 F.2d 269, 272 (7th Cir. 1983), *cert. denied*, 468 U.S. 1217 (1984); *Hoptowit v. Ray*, 682 F.2d 1237, 1253 (9th Cir. 1982); *Inmates of Allegheny County Jail v. Pierce*, 612 F.2d 754, 763 (3d Cir. 1979); *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977).

168. See *Ramos v. Lamm*, 639 F.2d 559, 574 (10th Cir. 1980).

A. *Deliberate Indifference*

To prevail on an Eighth Amendment claim, an inmate must prove both an objective element, that the deprivation was sufficiently serious, and a subjective element, that the defendant officials acted with a sufficiently culpable state of mind. As stated above, the state of mind giving rise to liability for an Eighth Amendment violation is "deliberate indifference."¹⁶⁹ Lower courts have argued extensively about what constitutes deliberate indifference.

In *Estelle v. Gamble*, the Court made it clear that deliberate indifference could be manifested by a prison doctor's failure to respond to a prisoner's needs, by prison personnel intentionally denying or delaying access to medical care, or by intentionally interfering with treatment once it has been prescribed.¹⁷⁰ However, accident, inadvertent failure, and negligence are not actionable under the Eighth Amendment.¹⁷¹ Even multiple claims of medical malpractice do not necessarily constitute deliberate indifference.¹⁷² Therefore, it is clear from *Estelle* and subsequent cases that the term "deliberate indifference" means more than mere negligence.

Although *Estelle* established that deliberate indifference requires a showing of more than negligence, courts also have held that an inmate need not prove that officials had the very high state of mind required in excessive force cases: a showing that official conduct was carried out with "a knowing willingness that [harm] occur."¹⁷³ In general, courts have not required this standard of

169. See *supra* text accompanying note 165.

170. See *Estelle*, 429 U.S. at 105; see also *Gill v. Mooney*, 824 F.2d 192, 196 (2d Cir. 1987) ("Prison officials are more than merely negligent if they deliberately defy the express instructions of a prisoner's doctors.").

171. See, e.g., *Wilson v. Seiter*, 501 U.S. 294, 301 (1991) (stating that mere negligence does not satisfy the "deliberate indifference" standard); *Bryan v. Endell*, 141 F.3d 1290, 1291 (8th Cir. 1998) (determining that even if treatment of inmate's broken hand was inadequate and negligent, the treatment still did not rise to the level of "deliberate indifference"); *McNeil v. Lane*, 16 F.3d 123, 124 (7th Cir. 1994) ("Obduracy and wantonness rather than inadvertence or mere negligence characterize conduct prohibited by the Eighth Amendment."); *Mandel v. Doe*, 888 F.2d 783, 787-88 (11th Cir. 1989) (noting that mere negligence or medical malpractice is not sufficient to constitute deliberate indifference); cf. *Estelle*, 429 U.S. at 105-06 (explaining that while a single act of negligence is not sufficient to support a claim of cruel and unusual punishment, if inmates could establish a pattern of negligent acts, a claim under the Eighth Amendment would be stated).

172. See, e.g., *Dulany v. Carnahan*, 132 F.3d 1234, 1245 (8th Cir. 1997) ("Multiple incidences of medical malpractice or negligence do not amount to deliberate indifference without some specific threat of harm from a related system wide deficiency.").

173. *Hudson v. McMillian*, 503 U.S. 1, 5-9 (1992). The *Hudson* Court noted that objective standards used to determine culpable state of mind are different in confinement condition claims than in excessive force claims. But see *Whitley v. Albers*, 475 U.S. 312, 319 (1986) ("It

purposeful or knowing conduct to establish the necessary *mens rea* for deliberate indifference in a prison condition case.

With deliberate indifference lying somewhere between negligence at one end of the spectrum and intentional or knowledgeable conduct at the other, most cases have identified "recklessness" or "reckless disregard" as the state of mind required to make officials liable for deliberate indifference in a prison conditions case.¹⁷⁴

Based on the concept of recklessness, earlier cases found deliberate indifference "[w]hen systematic deficiencies in staffing, facilities or procedure ma[d]e unnecessary suffering inevitable."¹⁷⁵ Deliberate indifference also was found when prison officials intentionally "prevented an inmate from receiving recommended treatment or when an inmate was denied access to medical personnel capable of evaluating the need for treatment."¹⁷⁶ Unreasonable delay in providing services when officials were aware of the need for treatment was also the basis for a finding of deliberate indifference.¹⁷⁷

Mere disagreements as to the quality and the type of health care were not found to rise to the level of "reckless disregard" and

is obduracy and wantonness not inadvertence in error or good faith, that characterize the conduct prohibited by the cruel and unusual punishment clause, whether that conduct occurs in connection with establishing conditions of confinement, supplying medical needs, or restoring official control over a tumultuous cellblock.").

174. See, e.g., *McNeil*, 16 F.3d at 124 (noting that a "total unconcern for [inmates'] welfare in the face of serious risks" is required); *LaMarca v. Turner*, 995 F.2d 1526, 1535 (11th Cir. 1993) ("In prison condition cases, 'deliberate indifference' constitutes wantonness To be deliberately indifferent, a prison official must knowingly or recklessly disregard an inmate's basic needs so that knowledge can be inferred."); *McGill v. Duckworth*, 944 F.2d 344, 348 (7th Cir. 1991) (quoting *Duckworth v. Frazen*, 780 F.2d 645, 653 (7th Cir. 1985)) (drawing distinction between the tort of recklessness and the criminal standard, which states that "recklessness" violates the Eighth Amendment only if the prison official had "actual knowledge of impending harm easily preventable, so that a conscious, culpable refusal to prevent the harm can be inferred from the defendant's failure to prevent it"); *Miltier v. Beorn*, 896 F.2d 848, 851-52 (4th Cir. 1990) ("To establish that a health care provider's actions constitute deliberate indifference to a serious medical need, the treatment must be so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness. Deliberate indifference may be demonstrated by either actual or reckless disregard.").

175. *Cody v. Hillard*, 599 F. Supp. 1025, 1055 (D.S.D. 1984), *aff'd*, 799 F.2d 447 (8th Cir. 1986) (quoting *Wellman v. Faulkner*, 715 F.2d 269, 272 (7th Cir. 1983)).

176. *Ramos v. Lamm*, 639 F.2d 559, 575 (10th Cir. 1980).

177. See, e.g., *Toombs v. Bell*, 798 F.2d 297, 298 (8th Cir. 1986) (noting delay of three weeks for treatment of gallbladder supports a claim of deliberate indifference); *Madrid v. Gomez*, 889 F. Supp. 1146, 1257 (N.D. Cal. 1995) ("[A]ccess to medical treatment cannot be substantially delayed in a systematic manner."); *Dean v. Coughlin*, 623 F. Supp. 392, 403 (S.D.N.Y. 1985) (determining that a three month delay for serious and painful dental need requires finding of deliberate indifference). But see *Murphy v. Lane*, 833 F.2d 106, 108 (7th Cir. 1987) (finding that a delay of one week for psychiatrist to evaluate a suicidal inmate on "crisis watch" did not constitute deliberate indifference).

therefore did not constitute deliberate indifference to serious medical needs.¹⁷⁸ Courts have generally held that the propriety of a certain course of treatment is not a proper subject for judicial review as long as the physician has exercised professional judgment.¹⁷⁹

With respect to psychiatric treatment, reliance on professional judgment has been addressed most clearly by the United States District Court for the District of Oregon in its supplemental opinion in *Capps v. Atiyeh*.¹⁸⁰ The *Capps* court stated that the issue of deliberate indifference is more difficult to determine with respect to mental health care than medical care. Because much is unknown about mental illness, its diagnosis and treatment remain more subjective than with physical illness.¹⁸¹ Thus, the court must distinguish between constitutionally inadequate treatment and a course of treatment upon which mental health care professionals could reasonably disagree. Citing the Supreme Court's standard for adequate care in *Youngberg v. Romeo*,¹⁸² the *Capps* court said, with respect to the type of treatment selected, that "the Constitution only requires that the courts make certain that professional judgment in fact was exercised. It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made."¹⁸³

Following the *Youngberg* decision, the *Capps* court established a fairly stringent standard that inmates must meet in order to prove deliberate indifference to serious mental health needs: "The

178. See *Abdul-Wadood v. Nathan*, 91 F.3d 1023, 1024 (7th Cir. 1996) (finding that disagreement with selection of medicine and therapy fell well short of deliberate indifference); *Randall v. Wyrick*, 642 F.2d 304, 308 (8th Cir. 1981) (holding that a prisoner's "difference in opinion over matters of expert medical judgment or a prescribed course of medical treatment" does not rise to the level of deliberate indifference); *Kontakis v. Pahlow*, 671 F. Supp. 328, 330 (D.N.J. 1987) ("A doctor's choice of a particular medical treatment cannot be the basis for a charge of cruel and unusual punishment."); *Williams v. Coughlin*, 650 F. Supp. 955, 957 (S.D.N.Y. 1987) (holding that disagreements over proper medical treatment do not rise to the level of deliberate indifference).

179. See *Sires v. Berman*, 834 F.2d 9, 15 (1st Cir. 1987) (noting that sound medical decisions are not actionable merely because there may have been disagreement over treatment); *Burns v. Head Jailer of LaSalle County Jail*, 576 F. Supp. 618, 620 (N.D. Ill. 1984) (finding that "the propriety of a certain course of medical treatment is not a proper subject for review in a civil rights action"); *Williams v. Duckworth*, 598 F. Supp. 9, 15 (N.D. Ind. 1983), *aff'd*, 749 F.2d 34 (7th Cir. 1984) ("Even if it could be argued that plaintiff's claim is grounded on a sincere disagreement with the type and quality of diagnosis and treatment received, such disagreement with treating doctors still does not rise to the level of a constitutional deprivation.").

180. 559 F. Supp. 894, 917 (D. Or. 1982).

181. See *id.* (citing *Bowring v. Godwin*, 551 F.2d 44, 48 n.3 (4th Cir. 1977)).

182. 457 U.S. 307, 321 (1982).

183. *Capps*, 559 F. Supp. at 917 (quoting *Youngberg*, 457 U.S. at 321).

inmates must, therefore, show a pattern of cases, each of which discloses, with little or no room for reasonable mental medical opinions to differ, (1) a serious mental illness (2) for which the inmate wants treatment (3) which he does not receive (4) thereby causing the inmate to suffer mental pain."¹⁸⁴ Therefore, if state officials can show that they were aware of the needs and exercised acceptable professional judgment, inmates will not be able to show that the officials recklessly disregarded their needs and so would not be able to prove deliberate indifference.

In *Weaver v. Jarvis*,¹⁸⁵ the court found that though courts were reluctant to second guess medical judgment, "in some cases the medical attention rendered may be so woefully inadequate as to amount to no treatment at all."¹⁸⁶ The court then held that deliberate indifference included "recklessness or callous neglect."¹⁸⁷ Likewise, in *Greason v. Kemp*,¹⁸⁸ the court held that providing some psychiatric care is not sufficient if the care provided is grossly inadequate.¹⁸⁹ In *Greason*, the prison psychiatrist discontinued an inmate's psychotropic medication on the basis of a visit of a few minutes, without reviewing the inmate's file or performing a mental status examination.¹⁹⁰ If the doctor had reviewed the inmate's file he would have seen that the inmate was at high risk for suicide when taken off the medication. The court held that psychiatric needs constitute serious medical needs and that the quality of psychiatric care one receives can be so substantial a deviation from accepted standards as to evidence, as in this case, a deliberate indifference to those needs even when professional judgment was exercised.¹⁹¹

Even though most courts used a standard generally equated with recklessness, courts continued to be split as to whether an objective or a subjective standard of knowledge on the part of officials was required to establish liability. Some lower courts, using the objective standard, required that the inmate show that officials disregarded a serious need about which they *knew or should have known*.¹⁹² Other courts required the inmate to

184. *Id.* at 917-18.

185. 611 F. Supp. 40 (D. Ga. 1985).

186. *Id.* at 43 (citing *Westlake v. Lucas*, 537 F.2d 857, 860 n.5 (6th Cir. 1976)).

187. *Id.* at 44.

188. 891 F.2d 829 (11th Cir. 1990).

189. *See id.* at 834.

190. *See id.* at 835.

191. *See id.*

192. *See, e.g., Wilks v. Young*, 897 F.2d 896, 898 (7th Cir. 1990) (holding that "liability may be imposed under certain circumstances in which the defendant has only objective knowledge

establish that officials had *actual* knowledge of a serious need and yet disregarded it.¹⁹³ In 1994, the Supreme Court resolved the debate by holding that:

[A] prison official cannot be found liable under the Eighth Amendment for denying an inmate humane conditions of confinement unless the official knows of and disregards an excessive risk to inmate health or safety; the official 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.¹⁹⁴

Therefore, in order to establish deliberate indifference, inmates will be required to establish that prison officials knew of the claimant's mental health need. Whether an official has knowledge of a particular need, however, is a question of fact that can be resolved in favor of the inmate if the trier of fact could conclude that the official must have known of the need from the very fact that it was so obvious.¹⁹⁵

B. *Serious Need*

A serious medical need has been defined as "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."¹⁹⁶ The test for determining whether a prisoner is entitled to treatment is medical necessity, not simply what is desirable.¹⁹⁷

With respect to mental illness, a court held that an inmate's statement that he was depressed does not require the prison official to whom the statement was made to schedule him for an appointment with a psychologist, as mere depression "hardly indicates a

of the risk of harm" provided that the risk is substantial); *Richardson v. Penfold*, 839 F.2d 392, 395 (7th Cir. 1988) (citing *Bentley v. Cady*, 761 F.2d 335, 339 (7th Cir. 1985)) ("A defendant acts recklessly when he disregards a substantial risk of danger that either is known to him or would be apparent to a reasonable person in his position").

193. See, e.g., *LaMarca v. Turner*, 995 F.2d 1526, 1535 (11th Cir. 1993) (requiring that the prison official acted "knowingly or recklessly" to infer knowledge); *Duckworth v. Franzen*, 780 F.2d 645, 653 (7th Cir. 1985) (requiring actual knowledge to infer prison official's failure to stop preventable harm).

194. *Farmer v. Brennan*, 511 U.S. 825, 837 (1994).

195. See *id.* at 843.

196. *Ramos v. Lamm*, 639 F.2d 559, 575 (10th Cir. 1980).

197. See *Bowring v. Godwin*, 551 F.2d 44, 48 (4th Cir. 1977).

'serious medical need.'¹⁹⁸ Additionally, the *Capps* court held that inmates with behavioral and emotional problems did not suffer from serious mental illness.¹⁹⁹ On the other hand, *acute* depression, paranoid schizophrenia, and nervous collapse have been identified as disorders sufficiently dramatic to amount to serious medical needs.²⁰⁰ Likewise, in *Cody v. Hillard*,²⁰¹ the court found that an inmate experiencing significant personality distress in the form of depression, to the extent that he had lost contact with reality, required treatment.²⁰²

In *Peterkin v. Jeffes*,²⁰³ the court was asked to rule on the adequacy of psychiatric care for capital inmates. The court first addressed whether death row inmates have mental health needs that amount to serious medical needs.²⁰⁴ Relying on expert testimony from mental health care professionals indicating that capital inmates have a high incidence of chronic depression, disorientation, and anxiety, the court found that those inmates have unique psychological needs.²⁰⁵ These psychological needs collectively constituted "serious needs" for Eighth Amendment purposes.²⁰⁶

At least one court has addressed the specific mental health needs of HIV-positive inmates. In *Harris v. Thigpen*,²⁰⁷ the lower court heard expert testimony which indicated that HIV-positive inmates have unique mental health needs that were not being addressed adequately by the prison system.²⁰⁸ The Court of Appeals identified as serious mental health needs "specific psychiatric disorders . . . that accompany the presence of HIV infection, such as AIDS-related dementia"²⁰⁹ The court, however, found that an inmate's need to "deal with issues of impending death, depression, despair, and stigmatization" were not serious mental health needs.²¹⁰ The court explained that "helping a terminally sick prisoner 'cope' psychologically with various aspects of a dreaded physical illness, while therapeutic, may be a more expansive view

198. *Partee v. Lane*, 528 F. Supp. 1254, 1261 (N.D. Ill. 1981).

199. *See Capps v. Atiyeh*, 559 F. Supp. 894, 920 (D. Or. 1982).

200. *See Robert E. v. Lane*, 530 F. Supp. 930, 939 (N.D. Ill. 1981).

201. 599 F. Supp. 1025 (D.S.D. 1984).

202. *See id.* at 1043.

203. 661 F. Supp. 895 (E.D. Pa. 1987).

204. *See id.* at 917.

205. *See id.* at 919.

206. *See id.*

207. 941 F.2d 1495 (11th Cir. 1991).

208. *See id.* at 1510.

209. *Id.* at 1511.

210. *Id.*

of mental health care than that contemplated by the Eighth Amendment.²¹¹ The court held that failure to address these needs did not violate the Constitution. Therefore, based on *Harris*, it appears that feelings of depression, anxiety, and despair alone will not be considered serious mental health needs.

Women living with HIV/AIDS, however, also experience *chronic* depression and anxiety that may be analogous to the depression and anxiety experienced by death row inmates. If the depression and anxiety become chronic, courts may deem them "serious needs" for purposes of Eighth Amendment analysis.

C. *Specific Treatment Issues*

Assuming that the psychological manifestations of HIV/AIDS reach the level of serious medical need, what types of services are constitutionally required? Recent cases have challenged specific treatment issues, including the adequacy of the initial procedure utilized to identify mentally disordered inmates, the adequacy of staffing, the adequacy of record keeping, the right to rehabilitative programs, and the right to participate in substance abuse programs.

1. *Screening and Classification*

Courts routinely have found that a prison must have a systematic procedure for identifying inmates with psychological problems. Prisons should have a process for screening inmates upon entry into the prison to identify those who have mental health needs.²¹² Additionally, prisons must have an ongoing system to monitor and identify problems after incarceration.²¹³ Adequately trained staff must perform the screening and classification to detect the need for mental health care.²¹⁴ Screening by a staff member untrained to detect a mental illness amounts to no screening and does not meet constitutional minima.

211. *Id.*

212. See *Cortes-Quiones v. Jimenez-Nettleship*, 842 F.2d 556, 560 (1st Cir. 1988); *Coleman v. Wilson*, 912 F. Supp. 1282, 1305 (E.D. Cal. 1995); *Madrid v. Gomez*, 889 F. Supp. 1146, 1257 (N.D. Cal. 1995); *Casey v. Lewis*, 834 F. Supp. 1477, 1550 (D. Ariz. 1993); *Balla v. Idaho State Bd. of Corrections*, 595 F. Supp. 1558, 1580 (D. Idaho 1984); *Dawson v. Kendrick*, 527 F. Supp. 1252, 1308 (S.D. W. Va. 1981); *Pugh v. Locke*, 406 F. Supp. 318, 324 (M.D. Ala. 1976), *aff'd in part and modified in part sub nom.*, *Newman v. Alabama*, 559 F. 2d 283 (5th Cir. 1977), *remanded on other grounds sub nom.*, *Alabama v. Pugh*, 438 U.S. 781 (1978).

213. See *Balla*, 595 F. Supp. at 1568.

214. See *Dawson*, 527 F. Supp. at 1273.

2. Adequate Staffing

The quality and quantity of staff available to provide psychological care is a crucial issue for prisons attempting to provide adequate mental health services to inmates with HIV or AIDS. First, prisons must have an adequate number of staff to provide inmates with genuine access to mental health professionals.²¹⁵ Second, the staff must be qualified to provide adequate care, and staff who can communicate with non-English speaking inmates must be available. Failure to provide qualified interpreters for medical/mental care encounters has been held to constitute an Eighth Amendment violation.²¹⁶ As the court stated in *Wellman v. Faulkner*:

An impenetrable language barrier between doctor and patient can readily lead to misdiagnoses and therefore unnecessary pain and suffering. This type of language problem which is uncorrected over a long period of time and as to which there is no prospect of alleviation, can contribute to unconstitutional deficiencies in medical care.²¹⁷

Depending on the size of the facility, courts have found that lack of an on-site psychiatrist can constitute deliberate indifference.²¹⁸ Furthermore, drugs cannot be a substitute for psychiatric counseling and are an unacceptable means of dealing with psychiat-

215. See *Ramos v. Lamm*, 639 F.2d 559, 578 (10th Cir. 1980) (finding that staffing shortfalls effectively deny inmates access to diagnosis and treatment); *Cody v. Hillard*, 599 F. Supp. 1025, 1059 (D.S.D. 1984) ("[T]he findings indicate the critically inadequate number of mental care staff at the SDSP."); *Balla*, 595 F. Supp. at 1577 (requiring, at a minimum, the equivalent of one full-time psychiatrist on staff); *Lightfoot v. Walker*, 486 F. Supp. 504, 524-25 (S.D. Ill. 1980) (finding that staff shortages render medical services below constitutional level).

216. See *Wellman v. Faulkner*, 715 F.2d 269, 271-72 (7th Cir. 1983), *cert. denied*, 468 U.S. 1217 (1984). But see *Franklin v. District of Columbia Dep't of Corrections*, 163 F.3d 625, 636 (D.C. Cir. 1998) (finding the prison's bilingual staff reasonable and adequate under the circumstances and no violation of prisoner's privacy when other prisoners served as translators during medical exams).

217. *Wellman*, 715 F.2d at 272.

218. See, e.g., *Wellman*, 715 F.2d at 269 (finding an on-site psychiatrist necessary to treat emergencies and to follow patients who need to be maintained on long-term psychotropic medication); *Ramos*, 639 F.2d at 577-78 (stating that due to no on-site psychiatrist, 10-25% of inmates had to wait up to five weeks before getting access to any help); *Duran v. Anaya*, 642 F. Supp. 510, 525 (D.N.M. 1986) (finding that an inmate cannot be denied access to medical personnel); *Balla*, 595 F. Supp. at 1568 (finding that inmates were often prescribed psychotropic medication in lieu of psychiatric counseling because of lack of staff).

ric disorders if they are used as the only means of addressing the disorder.²¹⁹

Although it is clear that treatment cannot be delayed due to insufficient staff,²²⁰ a survey of cases offers little in the way of a guideline for what is constitutionally mandated in terms of the ratio of staff to inmates. For example, in *Cody v. Hillard*,²²¹ the court found that a staff consisting of five full-time psychologists, seven full-time counselors, and two and one-half full-time drug and alcohol counselors was not constitutionally adequate to serve the inmates of the South Dakota Prison System when the only psychiatrist involved visited the prison one day per week and then for only about five hours on a volunteer basis.²²² On the other hand, in *Toussaint v. McCarthy*,²²³ the court found mental health services constitutionally adequate. In the *Toussaint* case, the Folsom Prison psychiatric staff consisted of two psychiatrists and one psychologist to care for an inmate population of 3,500.²²⁴ The court reached its holding despite finding that the staff was overburdened to the point that almost all treatment was devoted to emergency cases, with minimal individual treatment and no group therapy.²²⁵

In *Grubbs v. Bradley*,²²⁶ the court reviewed the mental health services provided at each of the facilities in the Tennessee Department of Corrections and found that only one of the seven facilities had on-site psychiatric care.²²⁷ Three facilities had a few counselors and one psychologist while three other facilities employed only counselors with no on-site psychiatrist or psychologist.²²⁸ Although the court determined that the services provided at each individual facility were generally inadequate, because the inmates could be transferred to a special psychiatric facility if acutely ill, the court held that the system's mental health care services were constitutionally sufficient.²²⁹

Thus, with respect to the adequacy of staffing, most courts require, at a minimum, some access to on-site psychiatric care and,

219. See *Balla*, 595 F. Supp. at 1577; *Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D. Tex. 1980).

220. See *Hoptowit v. Ray*, 682 F.2d 1237, 1253 (9th Cir. 1982); *Madrid v. Gomez*, 889 F. Supp. 1146, 1257 (N.D. Cal. 1995).

221. 599 F. Supp. 1025 (D.S.D. 1984).

222. See *id.* at 1041-42.

223. 597 F. Supp. 1388 (N.D. Cal. 1984), *aff'd in part*, 801 F.2d 1080 (9th Cir. 1986).

224. See *id.* at 1403-04.

225. See *id.*

226. 552 F. Supp. 1052 (M.D. Tenn. 1982).

227. See *id.* at 1086.

228. See *id.* at 1086, 1094, 1097, 1102, 1105, 1107.

229. See *id.* at 1130.

more generally, that staff be adequately trained to identify and assess the psychiatric needs of inmates.²³⁰ The case law fails, however, to offer a clear set of rules for what else the Constitution mandates. The above cases demonstrate that much depends on other factors, such as the overall quality of the facility and the availability of mental health services by way of transfer.²³¹

3. Record Keeping

In *Ruiz v. Estelle*,²³² the court found that maintaining adequate medical records was essential to providing acceptable medical care for inmates.²³³ The court held that "accurate, complete, and confidential records of the mental health treatment process must be maintained."²³⁴

Likewise, in *Burks v. Teasdale*,²³⁵ the court decreed that continuity of care is essential to an adequate mental health care system.²³⁶ The decentralization of records and the frequent rotation of staff created such a disorganized system that continuity of care was impossible.²³⁷ As a result, the court determined that the record keeping system contributed to the overall unacceptability of the health care provided.²³⁸ In *Coleman v. Wilson*,²³⁹ the court discovered serious deficiencies in medical record keeping.²⁴⁰ The deficiencies included "disorganized, untimely and incomplete filing of [information in the] medical records, insufficient charting, and incomplete or nonexistent treatment plans."²⁴¹ In addition, the court found that inmates were often transferred without their medical records.²⁴² The lack of accurate record keeping frustrated the continuity of care and therefore was found to be a violation of the Eighth Amendment.²⁴³

230. See *Wellman v. Faulkner*, 715 F.2d 269, 272-73 (7th Cir. 1983), *cert. denied*, 468 U.S. 1217 (1984); *Ramos v. Lamm*, 639 F.2d 559, 578 (10th Cir. 1979); *Cody v. Hillard*, 599 F. Supp. 1025, 1058 (D.S.D. 1984), *aff'd*, 799 F.2d 447 (8th Cir. 1986), *cert. denied*, 485 U.S. 906 (1988); *Balla v. Idaho State Bd. of Corrections*, 595 F. Supp. 1558, 1577 (D. Idaho 1984).

231. See *Grubbs*, 552 F. Supp. at 1052.

232. 503 F. Supp. 1265 (S.D. Tex. 1980), *aff'd in part*, 679 F.2d 1115 (5th Cir. 1982).

233. See *id.* at 1339.

234. *Id.*

235. 492 F. Supp. 650 (W.D. Mo. 1980).

236. See *id.* at 660.

237. See *id.* at 676.

238. See *id.*

239. 912 F. Supp. 1282 (E.D. Cal. 1995).

240. See *id.* at 1297.

241. *Id.* at 1314.

242. See *id.*

243. See *id.*

In other cases, courts have found record keeping systems to be unconstitutional in situations in which the information was not kept in any particular order or the information failed to include clear diagnosis and treatment plans for each inmate.²⁴⁴ Courts have held that "[t]he Eighth Amendment is implicated when 'inadequate, inaccurate and unprofessionally maintained medical records' give rise to 'the possibility for disaster stemming from a failure to properly chart' the medical care received by inmates."²⁴⁵

Therefore, courts sensibly continue to demand precise record keeping as a basic component in a constitutionally adequate health care system. Accurate records allow for the necessary continuity of care and thereby avoid the risk of needless pain and suffering.

4. *Rehabilitation Programs*

As a general rule, there is no Eighth Amendment right to rehabilitation, and thus the mere failure of a prison system to provide rehabilitative programming is not generally, standing alone, unconstitutional.²⁴⁶ The court in *Ramos v. Lamm*,²⁴⁷ however, stated that the inmate is constitutionally guaranteed a right "to be confined in an environment which does not result in . . . degeneration or . . . [threaten the inmate's] mental and physical well being."²⁴⁸ On the other hand, the court in *Grubbs* found that the only degeneration that reached constitutional proportions is "physical or mental deterioration that is so severe that it amounts to unnecessary pain and suffering."²⁴⁹ Furthermore, in *Harris v. Thigpen*,²⁵⁰ the court found that the Alabama prison system's failure to provide resources and preventative therapy necessary to delay the general psychological deterioration of inmates infected with HIV did not violate the Constitution.²⁵¹ Thus, the general rule

244. See *Cody v. Hillard*, 599 F. Supp. 1025, 1057 (D.S.D. 1984), *aff'd*, 799 F.2d 447 (8th Cir. 1986); *Dawson v. Kendrick*, 527 F. Supp. 1252, 1307-08 (S.D. W. Va. 1981).

245. *Cody*, 599 F. Supp. at 1057 (quoting *Burks v. Teasdale*, 492 F. Supp. 650, 676 (W.D. Mo. 1980)).

246. See *Bono v. Saxbe*, 620 F.2d 609, 615 (7th Cir. 1980); *Newman v. Alabama*, 559 F.2d 283, 291 (5th Cir. 1977); *Grubbs v. Bradley*, 552 F. Supp. 1052, 1123 (M.D. Tenn. 1982); see also *Lovell v. Brennan*, 566 F. Supp. 672, 689 (D. Me. 1983) (stating that courts have not recognized a constitutional right to rehabilitation for prisoners); *Robert E. v. Lane*, 530 F. Supp. 930, 938 (N.D. Ill. 1981) (declaring that, to state an Eighth Amendment claim, a prisoner must allege more than lack of access to rehabilitative programs).

247. 639 F.2d 559 (10th Cir. 1980).

248. *Id.* at 566.

249. *Grubbs*, 552 F. Supp. at 1124.

250. 941 F.2d 1495 (11th Cir. 1991).

251. See *id.* at 1506.

remains that prisoners have no constitutional right to rehabilitation.

In spite of this general rule, there are two situations in which the courts have held that the lack of rehabilitative programs does create constitutionally inadequate conditions of confinement. One such situation exists when overall conditions are so intolerable that the court finds that rehabilitation may help in overcoming some other constitutionally inadequate condition.²⁵² Though lack of rehabilitative programs, standing alone, is not sufficient to prove an Eighth Amendment violation, its absence in the face of other conditions may violate the Eighth Amendment.²⁵³ In *Dawson v. Kendrick*, the court stated that "rehabilitation is only required to the degree that the totality of the conditions of confinement are identified as causing the physical, mental, or social degeneration of the prisoners"²⁵⁴

The court observed that overall conditions at the Mercer County Jail were so bad that some form of rehabilitation was necessary:

Under the totality of conditions existent at the Mercer County Jail . . . the court believes that the undue risk of physical, mental and social degeneration of the prisoners housed there can be sufficiently deterred by the provision of opportunities for exercise to the extent previously required by this decree and the furnishing of diverse periodicals and other reading materials of sufficient quantities for the number of prisoners housed in the jail.²⁵⁵

The second situation in which lack of rehabilitation is a constitutional violation is when an inmate has been indefinitely incarcerated until he can show evidence of his rehabilitation. For example, *Ohlinger v. Watson*²⁵⁶ involved a state sodomy statute, which generally carried a maximum term of fifteen years.²⁵⁷ Yet, if the court made a finding that a defendant possessed a mental disturbance predisposing him to the commission of sex offenses, he could be given an indeterminate life sentence.²⁵⁸ Several inmates who received indeterminate life sentences under the statute

252. See *Dawson v. Kendrick*, 527 F. Supp. 1252, 1252 (S.D. W. Va. 1981).

253. See *id.*

254. *Id.* at 1315.

255. *Id.* at 1316.

256. 652 F.2d 775 (9th Cir. 1978).

257. See *id.* at 776.

258. See *id.* at 777.

challenged the mental health treatment available to them in the prison system, claiming that they had no chance to rehabilitate themselves and thereby gain their release.²⁵⁹ In analyzing what care was available, the court found only limited group therapy. The court stated that "[t]he treatment provided appellants . . . [did] not give them a reasonable opportunity to be cured or to improve their mental conditions."²⁶⁰

A more recent case dealing with a similar fact situation was *Balla v. Idaho State Board of Corrections*.²⁶¹ Like the *Ohlinger* court, the *Balla* court had to interpret what was required of the state after an inmate had been incarcerated under a special sex offenders act pursuant to which the inmate could not be released without showing evidence of rehabilitation.²⁶² The Idaho State Correctional Institution employed only two mental health care workers for more than 1100 inmates.²⁶³ The court found that because psychiatric care was virtually nonexistent and no rehabilitation programs existed, the longer sentence received by inmates incarcerated pursuant to the Sex Offenders Act was *quid pro quo* for the right to receive rehabilitative programs in order to obtain release from confinement.²⁶⁴ As a result, rehabilitation programs for those prisoners were required to meet constitutional minima.²⁶⁵

Therefore, the rule generally remains that there is no constitutional right to rehabilitative programs. However, rehabilitation programs *are* constitutionally required if it can be shown (1) that overall conditions are unconstitutional and rehabilitation programs would assist in making conditions tolerable, or (2) that rehabilitation is the specific statutory purpose of the incarceration.

5. Substance Abuse Programs

Although there is no general constitutional right to rehabilitation, the lack of substance abuse programs in a prison with an identifiable population in need of such programs may cause the system to fail to meet constitutional minima.

In *Ramos v. Lamm*,²⁶⁶ the district court found that 68% of the inmates at Colorado State Penitentiary had drug and alcohol

259. *See id.*

260. *Id.* at 780.

261. 595 F. Supp. 1558 (D. Idaho 1984).

262. *See id.* at 1578.

263. *See id.* at 1567-68.

264. *See id.* at 1578.

265. *See id.*

266. 485 F. Supp. 122 (D. Colo. 1979).

problems.²⁶⁷ Additionally, data from diagnostic tests revealed that 90% of incoming inmates had significant drug and alcohol involvement.²⁶⁸ Yet, only a few programs existed—and those that did exist involved what the court referred to as a “smidgen of prisoners.”²⁶⁹ The court found that “[d]efendants’ disregard of the need of prisoners for drug and alcohol treatment contributes to the totality of conditions which make degeneration probable and self-improvement unlikely. In fact, two thirds of Colorado inmates paroled in recent years had drug or alcohol problems when they were released.”²⁷⁰ Thus, if it can be shown that there is an identifiable population within the prison with drug and alcohol problems, prisons may be required to specifically address this problem through support groups and counseling.

6. *Privacy and Confidentiality*

One final issue that has been raised by inmates with respect to mental health services is the right to privacy and confidentiality during counseling. In *Peterkin v. Jeffes*,²⁷¹ capital inmates challenged the lack of privacy and confidentiality of communications with psychiatrists, psychologists, and counselors.²⁷² Because these inmates were on death row, mental health workers could visit them only at the door of their cell, and, for security reasons, guards had to accompany the workers.²⁷³ As a result of these cell door visits, confidential communications were revealed to administrators.²⁷⁴ Responding to the inmates’ argument that these practices eliminated privacy and undermined the value of the mental health care services, the court found that privacy and/or confidentiality were required in order to provide meaningful access to mental health treatment.²⁷⁵

7. *Summary*

Therefore, if neuropsychological disorders associated with HIV are shown to be “serious mental health needs,” prison systems will

267. *See id.* at 146.

268. *See id.*

269. *Id.* at 147.

270. *Id.*

271. 661 F. Supp. 895 (E.D. Pa. 1987).

272. *See id.* at 917.

273. *See id.* at 918.

274. *See id.*

275. *See id.* at 926.

have to provide adequate mental health services in order to address those needs. A system for screening, diagnosis, and monitoring is basic to an adequate system. There must be an appropriate number of properly trained staff to make access to mental health services meaningful. Record keeping must be accurate, complete, and confidential to ensure continuity of care. Depending on what other services are available, rehabilitative programs may be required. Finally, substance abuse programs, including support groups, are required if there is an identifiable drug and alcohol problem among inmates.

V. IMPACT OF *PENNSYLVANIA DEPARTMENT OF CORRECTIONS V. YESKEY*²⁷⁶

In addition to the constitutional parameters set forth above, state correctional facilities may have additional obligations to provide mental health care services to HIV-positive female inmates as a result of the recent Supreme Court ruling in *Pennsylvania Department of Corrections v. Yeskey*.²⁷⁷ The *Yeskey* case involved a state prison inmate who was denied admission to a prison boot camp program due to a history of hypertension.²⁷⁸ Yeskey, who was sentenced to eighteen to thirty-six months, could have been paroled in just six months had he successfully completed the boot camp program.²⁷⁹ Yeskey claimed that the denial based on his disability was a violation of the Americans with Disabilities Act (ADA).²⁸⁰ The district court found that Yeskey failed to state a claim for relief because the ADA did not apply to state prisons.²⁸¹ The Supreme Court, in a unanimous decision, held that Title II of the ADA does apply to state prison facilities.²⁸² Title II of the ADA prohibits discrimination by a public entity and provides that "[n]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs or activities of a public entity, or be subjected to discrimination by any such entity."²⁸³

The Court held that "[m]odern prisons provide inmates with many recreational 'activities,' 'medical services,' and educational

276. 524 U.S. 206 (1998).

277. *Id.*

278. *See id.* at 208.

279. *See id.* at 206.

280. *See id.* at 208.

281. *See id.*

282. *See id.* at 213.

283. 42 U.S.C. § 12132 (1994).

and vocational programs."²⁸⁴ Further, there is nothing in the statute itself that justifies distinguishing the programs and activities provided in prisons from those provided by other state entities.²⁸⁵ The Court questioned the prison officials' argument that the lack of reference to prisons in the statute's findings section was evidence that Congress did not intend for the ADA to apply to correctional facilities.²⁸⁶ According to the Court, "the fact that a statute can be applied in situations not expressly anticipated by Congress does not demonstrate ambiguity. It demonstrates breadth."²⁸⁷ Therefore, the Court found no reason to conclude that the ADA was not intended to apply to prisons.²⁸⁸

Although Title II of the ADA now clearly applies to state prisons, the Supreme Court did not address exactly how the ADA should be implemented within the prison setting. Two issues are certain to surface with respect to the application of the ADA in the prison context. First, it seems clear that women inmates infected with HIV will still have to show they have an ADA qualifying disability before they can seek the protections of the ADA. Whether HIV infection in its earliest stages is a disability for ADA purposes was clarified only partly by the Supreme Court in *Bragdon v. Abbott*,²⁸⁹ but the issue must still be decided on a case-by-case basis.²⁹⁰ Second, just as constitutional rights sometimes are limited in the prison setting based on security concerns, it should be expected that prison officials would raise similar claims regarding implementation of the statutory rights under the ADA. How a court will interpret what constitutes a "reasonable" accommodation in the prison setting and whether an inmate constitutes "a qualified individual" surely will be additional issues for litigation.

A. *Is HIV Infection a Disability under the ADA?*

To have a successful claim against a prison or other public entity under the ADA, a plaintiff must meet four criteria: the plaintiff must be found to be (1) a qualified individual, (2) with a disability, (3) who has been discriminated against by a public

284. *Yeskey*, 524 U.S. at 210.

285. *See id.*

286. *See id.* at 211-12; *see also* 42 U.S.C. § 12101(a)(3) (1994) (listing the findings of Congress of areas in which discrimination against individuals exist).

287. *Yeskey*, 524 U.S. at 212 (quoting *Sedima v. Imrex Co.*, 473 U.S. 479, 499 (1985)).

288. *See id.* at 213.

289. 524 U.S. 624 (1998).

290. *See id.* at 641-42.

entity, (4) because of her disability.²⁹¹ The ADA defines disability as follows:

the term "disability" means, with respect to an individual (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment.²⁹²

The terms "impairment," "major life activity," and "substantial limitation" are not specifically defined in the statute but have been defined in the regulations promulgated to implement the ADA.²⁹³

Department of Justice (DOJ) regulations promulgated under Title II of the ADA provide that

the phrase "physical or mental impairment" includes, but is not limited to, such contagious and noncontagious diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, HIV disease (whether symptomatic or asymptomatic), tuberculosis, drug addiction, and alcoholism.²⁹⁴

"Major life activities" are defined in the DOJ regulations as "functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."²⁹⁵ A person is "substantially limited" if she is "unable to perform a major life activity that the average person in the general population can perform," and the factors that should be considered in making this determination are "(i) [t]he nature and severity of the impairment; (ii) [t]he duration or expected duration of the impairment; and (iii) [t]he permanent or long term impact, or the expected permanent or long term impact of or resulting from the impairment."²⁹⁶

The second statutory definition of "disability" allows an individual to seek the protection of the ADA if the person can show that he or she has a record or history of an impairment that at one

291. See 42 U.S.C. § 12132 (1994).

292. 42 U.S.C. § 12102(2) (1994).

293. See 28 C.F.R. § 35.104 (1999).

294. 28 C.F.R. § 35.104(1)(B)(ii).

295. 28 C.F.R. § 36.104.

296. 29 C.F.R. § 1630.2(j)(1)(i), (ii)(2)(i) – (iii) (1998).

time substantially limited a major life activity.²⁹⁷ This provision attempts to protect people with a history of a disability, such as individuals with a history of cancer or mental illness.²⁹⁸

The third definition of disability is designed to protect individuals from the myths and fears associated with disabilities.²⁹⁹ An individual will be protected under this third definition if she has an impairment that does not substantially limit her activities, but she is treated as if she has a limitation.³⁰⁰ She also is protected if a limitation exists because of the attitudes of others toward the impairment.³⁰¹ For example, if an employer refuses to hire a person because of a facial deformity, that individual may be protected under the ADA.

Whether HIV infection is a disability for purposes of the ADA has been open to debate for some time. Between 1990, when Congress passed the ADA, and 1998, when the Supreme Court decided *Bragdon v. Abbott*,³⁰² several lower courts and two circuit courts held that HIV infection was a disability,³⁰³ while the Fourth Circuit held it was not a disability *per se*.³⁰⁴ The Supreme Court resolved the circuit split by holding in *Bragdon* that HIV infection

297. See 29 C.F.R. § 1630.2(k) (1998); see also *Doe v. Kohn, Nast & Graf*, P.C., 862 F. Supp. 1310, 1322 (E.D. Pa. 1994) (holding that a "record of impairment" means that the plaintiff has to show a history of an impairment that led directly to the facts that gave rise to the litigation).

298. See U.S. EQUAL OPPORTUNITIES COMM'N & U.S. DEPT OF JUSTICE, AMERICANS WITH DISABILITIES ACT HANDBOOK II-22 (1992).

299. See *id.* at II-23.

300. See *id.* at II-22.

301. See 28 C.F.R. § 36.104(4)(iii) (1999); 29 C.F.R. § 1630.2(l)(3).

302. 524 U.S. 624 (1998).

303. See, e.g., *Gonzales v. Garner Food Servs.*, 89 F.3d 1523, 1526 (11th Cir. 1996) (noting that ADA regulations define disability to include the HIV virus); *Gates v. Rowland*, 39 F.3d 1439, 1446 (9th Cir. 1994) (finding that a person infected with the HIV virus is an individual with a disability within the meaning of Rehabilitation Act, as well as in the ADA); *Anderson v. Gus Mayer Boston Store of Delaware*, 924 F. Supp. 763, 774-75 (E.D. Tex. 1996) (stating that AIDS and HIV are *per se* disabilities); *Sharrow v. Bailey*, 910 F. Supp. 187, 191 (M.D. Pa. 1995) ("Individuals diagnosed as HIV-positive are considered disabled for purposes of the Act, whether they are symptomatic or asymptomatic."); *Hoepfl v. Barlow*, 906 F. Supp. 317, 319 n.7 (E.D. Va. 1995) ("It is now settled law that HIV-positive individuals are 'disabled' within the meaning of the ADA."); *United States v. Morvant*, 898 F. Supp. 1157, 1161 (E.D. La. 1995) ("AIDS/HIV-positive are both disabilities under the Department of Justice regulations promulgated pursuant to the ADA."); *Doe v. Kohn, Nast & Graf*, 862 F. Supp. 1310, 1321 (E.D. Pa. 1994) ("The [HIV-positive] plaintiff has a physical or mental impairment that substantially limits one or more of his major life activities, and thus has a disability within the meaning of the Act."); *Howe v. Hull*, 873 F. Supp. 72, 78 (N.D. Ohio 1994) ("AIDS and HIV infection are both disabilities within the meaning of the ADA."); *T.E.P. v. Leavitt*, 840 F. Supp. 110, 111 (D. Utah 1993) (finding that AIDS is a physical impairment within the meaning of the ADA).

304. See *Ennis v. National Assoc. of Bus. & Educ. Radio*, 53 F.3d 55, 60 (4th Cir. 1995).

is a disability for purposes of the ADA if the plaintiff can show that it substantially limits a major life activity.³⁰⁵ In *Bragdon*, the Court found that reproduction was a major life activity and that the female plaintiff, who was in the early stages of HIV and was basically "asymptomatic," had adequately demonstrated that her HIV infection substantially limited her ability to reproduce.³⁰⁶ Therefore, women inmates of childbearing age may be able to claim the protection of the ADA based on a claim similar to that in *Bragdon*. Women who are infertile or are not of childbearing age, however, may not be helped by the decision. These women inmates will have to demonstrate that their HIV infection substantially limits some other major life activity.³⁰⁷

Although the Court in *Bragdon* did not address the other two definitions of "disability," Justice Ginsburg noted in her concurring opinion that the third prong of the definition of disability, that the individual is perceived as having a disability, may be the real basis for a finding that HIV is a *per se* disability.³⁰⁸ As discussed above, the third definition of the word "disability" is designed to protect individuals from the myths and fears associated with disabilities.³⁰⁹ Although the parties briefed the meaning of this third definition, the *Bragdon* Court did not consider its application. By neglecting the third definition, the Court did not address whether the negative treatment that people experience is, in fact, the essence of what defines a disability that triggers the protections against discrimination. For inmates who cannot make a claim that their HIV infection substantially limits their reproductive ability, this third prong of the disability definition may afford them protection under the ADA.

305. See *Bragdon*, 524 U.S. at 637-38.

306. See *id.*

307. Justice Kennedy, who wrote the majority opinion in *Bragdon*, points out that there may be many types of activities that are significantly impacted by HIV. As he stated, "had different parties brought the suit they would have maintained that an HIV infection imposes substantial limitations on other major life activities." *Id.* at 637. Justice Ginsburg, who wrote a concurring opinion, listed many activities that she found to be significantly impacted by HIV. For example, she noted that HIV "inevitably pervades life's choices: education, employment, family and financial undertakings. It affects the need for and . . . the ability to obtain health care because of the reaction of others to the impairment." *Id.* at 656 (Ginsburg, J., concurring). According to Justice Ginsburg, these problems affect the ability of one to care for oneself, one of the definitions of "major life activity." See *id.* Still, it is unclear from the opinion how far the Court will go in identifying "major life activities."

308. See *id.* at 656 (Ginsburg, J., concurring).

309. See *supra* text accompanying notes 299-301.

B. What "Reasonable Accommodations" Will Prisons Be Required to Make?

A second issue is how the ADA will be applied in the prison setting—especially with respect to the requirement that prisons provide reasonable accommodations to inmates with disabilities so that they can participate in all prison programs. The ADA defines a "qualified individual with a disability" as "an individual who, with or without reasonable modification to rules, policies, or practices . . . or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services of the participation in programs or activities."³¹⁰ Therefore, any inmate who satisfies the eligibility requirements of a prison program, with or without accommodation, should be allowed to participate in such a program.

In *Crawford v. Indiana Department of Corrections*,³¹¹ the court stated that there were several possible defenses that a prison might raise in response to an ADA complaint. Prisons may claim that no *reasonable* accommodation exists or that a requested accommodation poses an undue burden on the prison system.³¹² The court suggested that these defenses to implementation of an accommodation may be less stringent to meet in a prison, stating that "terms like 'reasonable' and 'undue' are relative to circumstances, and the circumstances of a prison are different from those of a school, an office, or a factory."³¹³

In fact, the Supreme Court made a similar conclusion in relation to a prisoner's constitutional right to marry in *Turner v. Safley*.³¹⁴ In *Turner* the Court set forth a four-part reasonableness test that weighed a prisoner's constitutional right to marry against the prison's interests in prison management.³¹⁵ The factors considered by the Court gave deference to a prison's strong interest in security.³¹⁶ Therefore, the Court acknowledged that reasonableness may depend on the circumstances and that the scope of prisoners' rights may be diminished while they are incarcerated. Because the same interests are present in the application of the ADA to prisons, it is possible that a similar conclusion may be

310. 42 U.S.C. § 12131(2) (1999).

311. 115 F.3d 481 (7th Cir. 1997).

312. *See id.* at 487.

313. *Id.*

314. 482 U.S. 78 (1987).

315. *See id.* at 84-91.

316. *See id.*

reached. While the ADA is applicable in prisons, a prison's interest in legitimate security issues may well outweigh the statutory rights of some disabled prisoners to participate in certain programs.

With respect to mental health services, the ADA generally does not create any new right to the provision of additional services. HIV-positive women inmates, however, would have to be given an opportunity to participate in any programs or services already provided by the prison. Prisons could not deny women inmates access to those programs because of their HIV infection. Therefore, if a prison chooses to offer vocational programs, educational programs, or other supportive programs, women infected with HIV could not be denied access pursuant to the ADA. Although *Yeskey* resolved an important issue by holding that the ADA applied to prisons,³¹⁷ it did not create a new cause of action for demanding mental health services not already provided by the particular prison system.

VI. RECOMMENDATIONS FOR PRISONS TREATING THE MENTAL HEALTH NEEDS OF HIV-POSITIVE WOMEN PRISONERS

The interventions outlined above, psychotherapy, counseling, and participation in self-help and support groups, are recommended treatment at all stages of HIV disease.³¹⁸ These interventions have been proven effective in decreasing the mental suffering commonly found in women who are HIV-positive.³¹⁹ Will prisons be required to provide these mental health services in order to meet constitutional standards and satisfy the requirements of the ADA given the definitions of "deliberate indifference" and "serious need" set out in *Estelle v. Gamble*?³²⁰ In order to require that a particular mental health intervention be offered, it is imperative to show that the psychological problem to be addressed constitutes a serious need.³²¹ Therefore, it is essential for HIV-positive women inmates to demonstrate that the neuropsychological problems they suffer are serious in nature and that needless suffering will occur unless each need is addressed by appropriate mental health services.

Because a proper course of treatment depends on accurate diagnosis, all prisons will be required to have a system for initially screening female inmates for HIV-related neuropsychological

317. *Pennsylvania Dep't of Corrections v. Yeskey*, 524 U.S. 206, 213 (1998).

318. *See supra* notes 115-56 and accompanying text.

319. *See id.*

320. 429 U.S. 97 (1976).

321. *See supra* notes 196-211 and accompanying text.

illnesses and for monitoring them at reasonable intervals.³²² As discussed above, psychological assessment, including interviews and testing, is critical to distinguish neurological disorders from psychological disturbances in order to provide appropriate treatment.³²³ Yet, because there is no professional consensus at this time as to which battery of tests should be used,³²⁴ the type and manner of testing will most likely be left up to the professional judgment of the prison's own mental health professionals. In any case, some basic system of initial screening and follow-up monitoring is essential to adequate care and will be required to meet constitutional minima. Furthermore, staff administering diagnostic screening should be trained adequately to identify problems that may be early signs of HIV-associated mental illness.³²⁵

Once mental health problems are diagnosed, whether the prison system is required to address them depends on the seriousness of the problem. It seems clear that AIDS dementia complex and delirium would be regarded as serious mental health needs.³²⁶ As described above, dementia is characterized by mild to severe cognitive impairment with incoherence, psychosis, and/or aggressive outbursts occurring at the later stages of the illness.³²⁷ Delirium, though a temporary disturbance, may also be characterized by incoherence and loss of contact with reality.³²⁸ Courts have held that a psychological problem in which the inmate has "lost contact with reality" was a serious mental health need that had to be addressed by the prison system.³²⁹ Additionally, courts have found that suicidal ideation is a serious mental health need.³³⁰ Therefore, it is likely that prisons will have to provide mental health services to address the needs of HIV-positive female inmates suffering from ADC and delirium and for those inmates who have been identified as suicidal. The more difficult question is whether prisons will be required to provide services to address depression and other mood disorders that are common in women with HIV infection.

322. See *supra* notes 212-14 and accompanying text.

323. See *supra* notes 115-56 and accompanying text.

324. See *supra* notes 117-22 and accompanying text.

325. See MUKAND, *supra* note 46, at 231-34 (discussing the HIV screening process).

326. See *Harris v. Thigpen*, 941 F.2d 1495, 1511 (11th Cir. 1991) (stating that a prison's failure to respond to certain psychiatric conditions which accompany HIV infection, including dementia, could be grounds for an Eighth Amendment claim).

327. See *supra* text accompanying note 62.

328. See *supra* text accompanying notes 96-97.

329. See *Cody v. Hillard*, 599 F. Supp. 1025, 1043 (D.S.D. 1984).

330. See *id.*

At least one court specifically found that "mere statements" of depression did not rise to the level of "serious medical need."³³¹ In *Peterkin v. Jeffes*, however, the Court found that depression and anxiety experienced by death row inmates did rise to the level of serious need.³³² Like death row inmates, inmates who are HIV-positive commonly experience chronic depression and anxiety.³³³

In *Harris v. Thigpen*,³³⁴ the court specifically addressed the HIV-positive inmate's need for counseling to better cope with issues of "death, depression, despair and stigmatization."³³⁵ The court rejected these psychological problems as "serious needs."³³⁶ Although the court found that the claim for services for depression was not frivolous or unsympathetic, it was beyond the basic services mandated by the Eighth Amendment.³³⁷

It is therefore critical for inmates to make a sufficient case for the seriousness of these needs. The illness must go beyond "mere depression" and rise to the level of chronic depression before the prison will have to address it. If this can be shown, then, like death row inmates, the HIV-positive inmate's needs will rise to the level of "serious mental health needs" and will be constitutionally recognized.

Assuming mood disorders are recognized as serious needs, what level of services will be mandated? As it is well established that medication can be an effective means of addressing many of the neuropsychological problems associated with HIV infection, prisons will need to have at least a part-time, on-site psychiatrist to diagnose the need, prescribe medication, and manage and monitor the inmate taking medication. Courts have held that although medication cannot be a substitute for psychotherapy, where it is necessary to relieve symptoms of mental illness the prison is required to have a psychiatrist on-site to manage the patient.³³⁸

Individual psychotherapy is also an important element of a mental health program for women who are HIV positive. Courts have held that there must be an adequate number of staff to provide meaningful access to counseling.³³⁹ Therefore, prisons will

331. See *Partee v. Lane*, 528 F. Supp. 1254, 1261 (N.D. Ill. 1981).

332. See *Peterkin v. Jeffes*, 661 F. Supp. 895, 919 (E.D. Pa. 1987).

333. See *supra* text accompanying notes 67-94.

334. 941 F.2d 1495 (11th Cir. 1991).

335. *Id.* at 1511.

336. See *id.* at 1510.

337. See *id.* at 1511.

338. See *supra* text accompanying notes 218-19.

339. See *supra* text accompanying notes 215-31.

need to provide a certain number of counselors who have been trained in HIV counseling and who are also able to identify early signs of mental disorders, including ADC.

Behavior modification is another tool that has proven helpful in treatment of women suffering from HIV-related neuro-psychological problems. Behavioral techniques range from simply structuring a patient's day and routinizing everyday tasks to establishing full programs that teach relaxation techniques and coping skills. Courts generally have held that most rehabilitation programs aimed at improving quality of life are not constitutionally mandated.³⁴⁰ To the extent this type of intervention is seen as "self-esteem building," it is likely that behavior modification programs are *not* constitutionally required. However, to the extent that these programs are effective in reducing aggressive behavior and/or behaviors leading to possible suicide, they may be required. Courts often have mandated intervention for such behaviors for the safety of the disturbed inmate as well as the safety of others.³⁴¹

The literature confirms the crucial need for support groups and peer therapy groups to address the unique feelings of isolation and social ostracism common among persons with HIV infection. If women inmates could demonstrate that there is an identifiable population of HIV-positive inmates in need of support groups to address *chronic* feelings of depression and anxiety, prisons may have to provide this service as a means to address that need. Feelings of isolation and unavailability of social support have been shown to be predictors of suicidal behavior.³⁴² If it could be demonstrated that support groups would be effective in reducing the risk of suicide, prisons may be required to provide them as well.

Currently peer counseling or support groups are offered in only 35% of the state and federal prisons.³⁴³ The ACE (AIDS Counseling and Education) program at Bedford Hills, New York, the Massachusetts Women's prison, and the Arkansas Women's prison all have provided extensive support group therapy that has been very successful for HIV-positive women inmates.³⁴⁴ Some prisons, however, have safety regulations that create obstacles to peer support groups. For example, some prisons have prohibitions against group meetings without an officer being present.³⁴⁵ This

340. See *Ramos v. Lamm*, 485 F. Supp. 122, 156 (D. Colo. 1980).

341. See *Cody v. Hillard*, 599 F. Supp. 1025, 1043 (D.S.D. 1984).

342. See *supra* notes 98-101 and accompanying text.

343. See HAMMETT ET AL., *supra* note 33, at 30.

344. See HAMMETT ET AL., *supra* note 16, at 38-39.

345. See *id.* at 72.

may have a chilling effect on the women inmates' verbalization of their feelings and may create confidentiality problems as well.³⁴⁶ Courts generally uphold regulations that are reasonably related to a safety concern.³⁴⁷ In balancing the inmate's right to mental health services and the safety concern surrounding group meetings, courts may hold that the safety concern outweighs the need for the group therapy. Yet, in a system with such a regulation, it might be possible to establish the support group with a specially trained correctional officer as the facilitator in order to satisfy both needs.³⁴⁸

Though the *Yeskey* case made it clear that the ADA applies to state prisons, the ADA only mandates equal treatment and nondiscrimination against persons with disabilities. Once a prison offers certain services or programs, the ADA would prohibit a prison system from denying access to these programs to women because of their HIV infection. The ADA, however, does not mandate that any particular programs or services be provided. To the extent that prisons offer programs, HIV infected women inmates must be reasonably accommodated so that they too can enjoy the benefits of those programs and services.

VII. CONCLUSION

As the incidence of AIDS and HIV continues to increase, prisons must create a plan to address the unique mental health challenges presented by HIV infected women inmates. Although many of the mental health needs of these women are similar to other female inmates, increasing numbers of HIV-positive women inmates who experience various stages of depression, anxiety, AIDS dementia complex, and delirium will continue to develop to an extent that prisons are not currently equipped to handle.

To meet their needs and to adhere to constitutional standards, certain elements will be required in any prison mental health program. There must be an adequate system for screening incoming women inmates to identify HIV-related neuropsychological

346. *See id.*

347. *See generally* *Turner v. Safely*, 482 U.S. 78 (1987) (limiting First Amendment rights of inmate-to-inmate correspondence by regulation reasonably related to legitimate security concerns); *Bell v. Wolfish*, 441 U.S. 520 (1979) (upholding a cell search rule in deference to security concerns); *Pell v. Procunier*, 417 U.S. 817 (1974) (restricting visitation is permissible because it is reasonably related to security). *But see generally* *Jones v. North Carolina Prisoners' Labor Union, Inc.*, 433 U.S. 119 (1977) (limiting security concerns regarding prisoners' forming of union in deference to First Amendment rights).

348. *See* HAMMETT ET AL., *supra* note 16, at 40 (describing HIV/AIDS education program established by corrections officer).

disorders. A system for monitoring inmates after entry to identify new problems or assess the progression of already identified illnesses must also be in place. An accurate record keeping system is essential to ensure continuity of care. On-site psychiatric care should be provided to assess the need for medication and to manage those patients on medication. Adequate access to individual psychotherapy also should be provided. Behavior modification programs may be constitutionally required, at least to address behavioral problems that create a safety concern. Though support groups and peer therapy groups have been shown to be crucial to the psychological well-being of women infected with HIV, unless properly characterized and supported through expert testimony, these services may not be constitutionally required. If inmates can show that there is an identifiable population of HIV infected women inmates with chronic depression or anxiety that could be most appropriately addressed by support or peer groups, courts may require this intervention. In most cases courts probably will see support groups as beyond the basic care anticipated by the Eighth Amendment prohibition on cruel and unusual punishment. The success and cost effectiveness of peer group therapy, however, should appeal to prison administrators. Peer groups are less costly to establish and maintain than traditional programs that employ outside professionals.

Regardless of the type of therapy being provided, there must be access to confidential space for such therapy. Staff responsible for screening and monitoring inmates must be adequately trained to identify and assess HIV-related mental illness and must be trained in HIV counseling and in recognizing the early signs of HIV-related neuropsychological problems.

Finally, for those women who are very ill and pose no threat to society, states should consider passing early release statutes so that critically ill women inmates can return to their homes or be placed in a long term care setting. Most prisons are not equipped to deal with a large number of HIV infected inmates who present severe, chronic, psychiatric disturbances such as dementia. Though prisons can and should provide adequate mental health services, at some point it is simply more humane to allow those who pose no threat to society to be released to a more appropriate setting for care.