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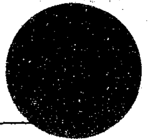

U.S. Department of Justice National Institute of Corrections

Legal Issues and the Mentally Disordered Prisoner

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LEGAL ISSUES AND THE MENTALLY DISORDERED PRISONER

By

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National Institute of Corrections

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FOREWORD

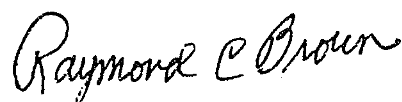
The number of mentally disordered offenders incarcerated in federal, state, and local correctional facilities presents a very real challenge to correctional officials.

Deinstitutionalization of mental health patients and stringent legal requirements for commitment to mental health facilities are generally perceived to have contributed to an increasing number of mentally disordered individuals being convicted of criminal offenses and sentenced to correctional facilities. Additionally, some studies indicate that stressful, overcrowded prison environments, offering few opportunities for productive activity, exacerbate mental disorders found in inmates.

In 1985, the National Institute of Corrections published a Sourcebook on the Mentally Disordered Prisoner, prepared by the New York State Department of Correctional Services under NIC funding. That document provided a national overview of issues related to correctional management of mentally disordered prisoners, including a comprehensive section on pertinent caselaw. Caselaw continues to evolve in the area of mental health services and can have a profound effect on the delivery of those services in correctional facilities.

Due to the popularity of the Sourcebook and the need for updated information on the legal aspects of working with mentally disordered inmates, the Institute arranged with the original author of the legal section of the Sourcebook to update the information in this area. This document, therefore, is a revised, expanded and updated discussion of "Legal Issues and the Mentally Disordered Prisoner."

It is our hope that this document will be of assistance to professionals and their colleagues in the area of correctional mental health services.



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I thank them all but, as usual, the author takes all the blame or credit for the ultimate product.

LEGAL ISSUES AND THE MENTALLY DISORDERED INMATE

I. INTRODUCTION AND OVERVIEW

A. Introduction: The Boundaries of the Problem

This work is concerned with legal issues and the mentally disordered prison inmate. This seemingly straightforward, boundary-setting sentence, like the topic itself, is pregnant with definitional and conceptual problems which we should address, if not fully resolve, at the outset.

First, what is and is not a legal issue is in itself a complex and important question. Issues resolved in court are not the only ones which qualify as legal issues. That type of traditional legal problem has an important historical quality to it, but many of the most troublesome legal problems are future-oriented. For example, this work demonstrates clearly that prison inmates have a constitutional right to treatment, at least for serious mental illness.[1] This establishes the basic legal right but now we have the problem of how far in the refinement of this right does the issue maintain its legal identity? At what point are the unfolding issues more accurately described as policy, clinical, or administrative issues?[2]

The answers to these questions, of course, have a major impact on judicial power and institutional-professional autonomy. While it may be difficult to draw a bright line separating legal from non-legal issues, I will establish some reasonably clear answers in specific areas, including the right to treatment.

The term mentally disordered encompasses any form of mental illness whether it be a type of neurosis or psychosis or whether it is viewed as organic or functional in origin.[3] I will make the appropriate note in the text where it seems important to make these distinctions.

Mentally retarded inmates will be referred to as such and the reader should not generally consider them included in the term mentally disordered. There are obvious differences between the mentally ill and the mentally retarded[4] as to the origin and nature of the condition and the appropriate treatment or habilitation program.

Even more fundamental than the semantic or definitional problems, however, is the conclusion reached here that the constitutional right to treatment noted earlier arises from a medical model of disease or injury and treatment and probably does <u>not</u> include inmates who are only mentally retarded. This is <u>not</u> to argue that the mentally retarded inmate is without a constitutional basis for claims of right, but only that the analysis and constitutional source is different than for the mentally ill.

The reader should be alerted early to the critical distinction between a constitutional claim or right and what may be desirable or good

practice. In dealing with such matters as Eighth Amendment claims of cruel and unusual punishment, due process claims to certain procedural safeguards, First Amendment claims to preserve one's thinking and expressive powers or to resist certain treatments as violative of religious beliefs, and right to privacy claims said to be located in penumbras emanating from specific sections of the Constitution, we encounter claims to legally required minima.

The claim to a constitutional right is the loftiest claim known to our legal system, but judicial acceptance of the claim is often in its most diluted form. For example, a constitutional right to treatment might be fashioned as a right to the most thorough diagnosis and the most skillful treatment available for the particular condition. Mentally retarded inmates might be entitled to such habilitative efforts as will maximize their human potential. On the other hand, such rights could be constructed to require only that some medical or professional judgment be brought to bear to identify and then to provide minimally acceptable care in order to avoid death or needless suffering.

As the text will make clear, the constitutional right to treatment is much closer to the second construction than the first. The more important point here is that constitutional minima in this (or any other) area must not be confused with desirable governmental policy, desirable professional practices or standards, or desirable penal practices or standards.[5]

Although this work shall include numerous references to claims of federal constitutional rights, it must be established at the outset that the source of inmate claims and rights also may be located in the various state constitutions, statutes, administrative regulations or directives, and perhaps long-followed practices.[6]

Thus, federal constitutional rights should be seen as the highest claim to minimal rights, with other sources of federal and state law representing an additional and considerable body of specific "do's" and "don'ts" and rights and remedies. Within the broad outline of constitutional requirements there are many acceptable variations on the same theme. Those variations are the stuff of local policy and practice and, as often as possible, this study will attempt to distinguish minimal mandates from allowable and perhaps desirable policy and practice.

Our central concern is with the person who is convicted of a crime, sentenced to prison for that crime, and subsequently is identified as mentally disordered or mentally retarded. We shall refer more than occasionally to the pretrial detainees' and the unconvicted persons' special claims to care, but this population is not central to this work.[7]

I will also have occasion to refer to civilly committed patients and residents but almost always by way of analogy or in contrast with prisoners. Problems of consent to various forms of psychiatric intervention represent one area where it is especially useful to refer to legal developments regarding the civilly committed.

One of the most interesting points of contrast between the prisoner and the civilly committed is that the prison inmate's claim to care is not based on a "treat me or release me" type of argument: that is, the right to liberty versus the right to some needed care or service. The prison inmate presumably is lawfully deprived of liberty and his claims to services or treatment must be fashioned within that narrow framework. While I do not propose to deal in detail with the treacherous ground of right to treatment claims by the civilly committed, the contrast is stark.

Whatever the rationale or legal source relied upon, ultimately a civil patient's legal claim to treatment faces outward from the institution:

> Treat me or release me.
>
> I'm here without benefit of full criminal procedures and without the moral opprobrium of having committed a crime. Therefore you cannot punish me, and if you fail to treat me, you are punishing me and this place is a prison, whatever you may choose to call it.
>
> I'm here because you (or the court) said I needed treatment. You, therefore, owe me treatment and if you will not or cannot deliver, then you must let me go.[8]

There is no ready analogue for prison inmates' claims to psychiatric or psychological care. Their presence in prison does not rest on any explicit or implicit diagnosis or on promises of restorative care or rehabilitation; there is no procedural quid pro quo argument available; there is no "treat or release" argument reasonably available; and it is axiomatic in our constitutional system that a lawful conviction of a crime empowers the state to impose punishment, although not cruelly or unusually.[9]

Persons who are profoundly mentally retarded and institutionalized occupy a sort of middle ground between the prison inmate and the civilly committed. Although a state is not constitutionally bound to provide services for the mentally retarded, once a service is provided, a set of rights and reciprocal obligations arise. In Youngberg v. Romeo,[10] a decision to which I will return, the Court dealt with a profoundly retarded, institutionalized adult whose representatives conceded that no amount of training could make possible his release.

In this case, the Court's first decision involving the substantive rights of involuntarily committed, mentally retarded persons, it was determined that such persons -- along with convicted prisoners -- possess a constitutionally protected liberty interest in personal safety and freedom from undue restraint.[11] Justice Powell, for the Court, concluded that those "liberty interests require the state to provide

minimally adequate or reasonable training to ensure safety and freedom from undue restraint."[12]

Thus a rather grudging and narrow right to minimal training was established in Youngberg and this right is in no way related to a claim -- or even the possibility -- of preparation for release from confinement. In reaching this result, the Court made reference to the rights of convicted criminals -- rights that include freedom from unsafe conditions and from undue bodily restraint -- and concluded that if such rights survive penal confinement they must also survive civil confinement.[13]

The pretrial detainee and the civilly committed have been placed at the outer edges of this work's central concern: the mentally disordered or retarded prison inmate. This focus eliminates, or gives secondary importance to, other special categories of accused or convicted offenders, including those found incompetent to be tried and under treatment in a mental hospital; those persons acquitted by reason of insanity; persons found guilty but mentally ill; and various abnormal offenders dealt with as sexual psychopaths, sociopaths, or defective delinquents.

While this focus reduces the number of arguably relevant categories, it does not seriously reduce the number of people. A recent study concluded that, "more prisoners serving active sentences are admitted to mental hospitals each year than the combined number of persons hospitalized after having been adjudicated incompetent to stand trial, found not guilty by reason of insanity, or adjudged mentally disordered sex offenders."[14] This study found that 10,895 prisoners were admitted to health facilities in 1978, and that on any given day in that year 5,158 inmates resided in mental health facilities.[15]

We must view these numbers as quite conservative if we wish to use them as a measure of the real incidence of mental disorder among prison inmates. There clearly are many inmates who are disturbed and who, for a variety of reasons, are not transferred to a mental hospital. At this juncture, however, it is not important to have a completely accurate picture of the incidence of mental disorder or mental retardation among prison inmates. The point here is that despite the exclusions and the limitations, our central concern focuses on a large number of prisoners, a number that exceeds by far all persons in the other related categories.

In addition to time and space factors there are a number of substantive reasons for the focus of this work. For example, the current trend clearly is toward repeal and abandonment of sexual psychopath and defective delinquency laws and programs.[16] On the other hand, the deceptively reformist verdict of guilty but mentally ill (G.B.M.I.), which was enacted first in Michigan in 1975, has since gained acceptance in twelve other jurisdictions.[17]

Although G.B.M.I. procedures vary from state to state, typically the judge must impose a criminal sentence. The defendant is then examined to determine suitability for treatment, and, if treatment seems called for, the defendant is hospitalized subject to imprisonment to complete the remainder of the criminal sentence. In Illinois, a jurisdiction vesting vast discretion under its G.B.M.I. law in correction officials, some 60 defendants found guilty but mentally ill were all confined at Menard Correctional Facility where, it is reported, they receive the same type of treatment afforded all other inmates.[18]

This novel verdict of G.B.M.I. thus far does not involve significant numbers of inmates. Since the verdict does not exculpate the defendant and the defendant constitutionally may be punished, inmates in this category are not in a very different legal position than other inmates claiming a right to treatment. The only significant difference occurs under a statute, such as the one Michigan has adopted, which requires that "the defendant ... shall undergo further evaluation and be given such treatment as is psychiatrically indicated."[19]

This language may be -- and in Michigan has been -- read as creating a statutory right to treatment.[20] In Illinois, on the other hand, the Department of Corrections is given the discretion to "provide such ... treatment for the defendant as it determines necessary."[21] Since the Illinois approach has resulted in no special treatment for such inmates, it makes the verdict a fairly meaningless ritual.

Persons incompetent to be tried or acquitted by reason of insanity may present the criminal justice system with difficult problems. Such problems, however, are not typically manifested in the prison setting. Insanity acquittees and incompetents are found in mental hospitals[22] awaiting either restoration to competence[23] or remission of their mental illness and a finding of nondangerousness.[24]

A recent empirical study sheds some light on the factors which go into prosecutorial decisions to utilize the mental health or criminal justice system when presented with an accused possibly eligible for either system. Ellen Hochstedler looked at 379 cases of defendants identified as mentally disordered by a mental health screening unit within a prosecutor's office.[25] Her data show that the court used its criminal authority in a significant number of cases to mandate a treatment only disposition. Criminal justice officials tended to view misdemeanants with a verified history of mental health problems as inappropriate for criminal sanctions.[26] Thus, only the felons who are arguably mentally disordered are likely to be brought into the conviction-imprisonment process and then serve as the human subjects of the present work.

In concluding this aspect of the introductory section, I would like to offer a few observations which took shape as I studied the literature, talked with corrections and mental health personnel, and observed some

treatment programs. First, front-line personnel, whether they are in security or treatment, almost all agree that the number of seriously mentally disordered inmates in prison has increased dramatically in the last few years. They offer two explanations for this perceived change: overcrowding increases tension in prison and causes more mental illness than previously existed;[27] and the increasingly narrow criteria for civil commitment of the mentally ill and the general policy of deinstitutionalization have resulted in higher rates of conviction and imprisonment of persons who earlier would have entered the mental health system.[28]

For the moment we will treat this perception of increase and the explanations put forward as having perceptual, although not necessarily empirical, validity. As a widely held belief, these notions take on their own reality; deviant behavior is filtered though these beliefs and explanations and solutions are framed accordingly.

Commentators and courts offer wildly differing numbers and percentages of the mentally disordered and mentally retarded inmates in particular facilities or systems.[29] My impression is that this is one of those areas where the available solutions dictate the nature of the problem.

To illustrate that point in a highly exaggerated fashion, I would suggest that a system which is oriented toward seeing certain inmate behavior as "crazy" -- for example, eating one's own feces or forcefully banging one's head against the cell wall -- and which has "clinical" space to deal with such inmates will react with a therapeutic-type response. The very same behavior in a security-conscious facility, which has little or no space available for any type of therapy, may easily be viewed as evidence of the basic "badness" of the inmate.

With diagnostic categories and labels of mental illness ambiguous under the best circumstances, it is conceivable that what is viewed as "mad" or "bad" will be colored as much by available solutions as by relatively objective diagnostic factors. This point is central since neither the courts nor the legislature can perform diagnostic or clinical services. Each might insist on treatment for the disturbed inmate, there may even be funds provided for certain services, but ultimately it will be corrections and clinical personnel who perform as gatekeepers. Unlike family or police officers on the outside, correction personnel cannot ignore the individual or his behavior. They must and will respond, although how they do so is not certain.

It is possible to reject, or seriously question, my formulation that the available solutions importantly influence the nature of the problems and still accept the proposition that those who control prison security and clinical services ultimately determine the major dimensions of the problem. Indeed, even the most casual observations will reveal the tension between security and treatment staff in virtually any prison

setting where they coexist. Clinical personnel will complain about having disciplinary problems foisted on them, and security staff will be angry or bewildered at how quickly some inmates believed to be "out of it" are returned from a treatment unit or a mental hospital. In New York, this is known as "bus therapy."

Finally, it is my impression that correction and clinical personnel know and understand precious little relevant law, and much of what is "known" is misunderstood. That, by itself, is not surprising. What was surprising, if only slightly, is that whenever the law -- typically an appellate decision, not legislation -- was misunderstood, it was *always* in the direction of appearing to be more burdensome than it was and calling for more substantive and procedural adjustments than it actually did.

On the other hand, one does not find the same sense of urgency, or even panic, engendered by such police-oriented decisions as *Miranda v. Arizona*,[30] *Mapp v Ohio*,[31] or even *Wolff v. McDonnell*[32] and its minimal procedural requirements for prison disciplinary proceedings. There is, however, a real hunger to know what is and is not required by the law, and I hope this work will contribute to the satisfaction of that hunger.[33]

B. Overview

This section is a general summary of the detailed information which begins in Chapter III: The Right to Treatment. Chapter II: The Prison Inmate's Legal Identity, may be described as having an identity of its own. That is, it may be read as a general legal foundation for the chapters which follow, it may be read alone as a summary of "prisoners' rights," or it may be passed over entirely. I believe that the material on mental disorder and treatment may be absorbed without reading Chapter II but I also believe that reading it would enhance understanding.

Where Section A, *supra*, hopes to capture your interest and establish the boundaries for this work, this section is more like an executive summary. As such, the reader is taken over the general territory of this work and given sufficient detail to illustrate the particular topic. Subsequent chapters provide additional detail, extended analysis and extended quotations from original sources.

A prison or jail administrator, for example, who reads this section should have a reasonably complete overview of the law and the mentally disordered inmate. We might describe the approach in this section as a map of the United States limited to state boundaries and interstate highways. What follows in subsequent chapters is a rather detailed network of major and minor highways along with explanatory "legends."

* * * * * * * *

Having custody of another person invariably creates a legal duty to care for that person, although the nature of the custody determines the particular care required. And one wonders how it could be otherwise in a civilized society which adheres to a rule of law. Custody is sufficiently complete that prisoners must depend on their keepers for food, water, clothing, and medical care. There are very few shopping opportunities and very few private clinicians available for prison housecalls.

Phrased somewhat differently, the most fundamental obligation of a prison system -- indeed, of any system which confines persons -- is to maintain the life and health of those in its charge. This obligation of basic care now clearly includes the physical and psychological dimensions of the person and has moved from the exclusive domain of private (or tort) law to include the public domain of constitutional law. That is, we are in an era where an inmate's right to basic decency and protection as well as medical and psychological care has moved from private legal actions to constitutionally based legal actions.

At the outset, a major distinction must be established as to the type of care owed an inmate. When the law insists, as it does, that an inmate be provided with basic shelter, food, water, clothing and insulation from inmate predators the objective is to preserve health and life. All inmates are entitled to the minimal conditions necessary to sustain life and the avoidance of needless suffering.

This duty -- the preservation of life and health -- resembles the duty to provide medical and psychological care but it is also quite different. Prison officials, for example, are duty bound to prevent an inmate known to be a predator from inflicting harm on prospective victims. The duty to the victim is not to provide relief from a physical or psychological malady, it is to prevent the infliction of harm. Keeping inmates warm, clothed and fed are similarly protective.

The Right To Care

The duty to provide medical or psychological care arises at the point where an inmate is known to be ill or injured. When that condition is a recognizable and serious psychiatric disorder, the Eighth Amendment's ban on cruel and unusual punishment kicks in and the basic coverage of this work begins. As we shall see, the duty to provide medical or psychological care is not merely preventive but includes an obligation to relieve pain, prolong life, and stabilize -- if not cure -- the malady.

The Eighth Amendment's proscription of cruel and unusual punishment has been interpreted to require that state and federal prison officials must avoid deliberate indifference to the serious medical and psychological needs of inmates.[34] This less-than-demanding duty places the constitutional obligation of care a notch below the general standards of reasonableness for determining medical malpractice. What must be

stressed, however, is that while constitutional minima may be met, state officials may still be liable civilly for what is the equivalent of malpractice in the omission or provision of medical or psychological care. In other words, meeting minimal federal requirements is no guarantee that officials responsible for medical and psychiatric care may not be liable under state law. Since existing state law varies greatly on standards of liability it is incumbant on correctional officials to ascertain the law of their jurisdiction.

The essence of the Eighth Amendment is an obligation of government to avoid the needless infliction of pain and suffering. Courts well understand that prisons are not likely to be models of comfort or free from damaging stress and conflict. They may view some psychological stress and possible deterioration as an inherent part of imprisonment and thus beyond the realm of legal protection. Whatever the cause, however, there exists the legal duty to identify and treat inmates with serious mental disorders.

There are two critical phrases in the statement of the legal obligation of care owed a mentally disordered inmate: "deliberate indifference" and "serious medical needs." Unfortunately, there is no single, authoritative definition for either phrase but it is possible to distill a good understanding from a number of leading decisions.

Deliberate Indifference

"Deliberate indifference" requires more than poor judgment and less than intentional acts or omissions calculated to cause suffering. An excellent rule of thumb is that deliberate indifference to the needs of inmates exists when action is not taken in the face of a strong likelihood that failure to provide appropriate care would result in harm to the inmates.

Deliberate indifference may exist in a facility with excellent mental health resources but where an individual inmate is inexplicably denied access to needed care or where a prescribed course of treatment is ignored by officials. Deliberate indifference also may be made out where an entire facility, or perhaps all of the facilities in the jurisdiction, are so lacking in mental health resources that minimal care cannot be provided.

"Serious Needs"

What is or is not a serious medical/psychological need suffers from the same lack of precision as the deliberate indifference standard. And, again, we must try to reach some understanding of this important concept through a distillation of leading decisions. The test for seriousness begins with clinical (or medical) necessity and not simply what may be desirable. Because the constitutional basis for the right to treatment is in the Eighth Amendment's ban against cruel and unusual punishment,

courts tend to equate seriousness with the needless infliction or prolongation of pain or suffering. Clearly, then, such minor ailments as mild anxiety, depression or headaches are not within the judicial concern for seriousness.

On the other hand, a debilitating depression where an inmate is virtually immobilized and is not attendant to even basic hygienic needs, would likely qualify. In the wake of a major law suit, the Michigan Department of Corrections adopted a definition which may commend itself to other jurisdictions and which clearly meets legal criteria:

> Serious mental illness (or severe mental disorder) means a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.
>
> A serious/severe mental state or condition (1) is manifested by substantial discomfort, pain, and/or disability that cannot be legitimately ignored by appropriate clinical staff, (2) requires a mental health assessment, diagnostic evaluation, treatment planning and disposition planning; and (3) is generally associated with (a) the inability to attend to and effectively perform the usual/necessary activities of daily living, (b) extreme impairment of coping skills, rendering the patient exceptionally vulnerable to unintentional or intentional victimization and possible mismanagement and/or (c) behaviors that are dangerous to self or others.
>
> Serious mental illness/severe mental disorder includes psychiatric conditions/states that span the entire diagnostic spectrum of DSM-III and is not limited to specific diagnosis.[35]

Duty to Diagnose

However minimal the constitutional duty of treatment, important ancillary (or supportive) rights and duties also are created. The right to treatment, at least for serious disorders, would be meaningless without an additional duty to provide diagnosis, and this duty to diagnose sweeps more broadly than the underlying right to care. More inmates necessarily must be examined than treated unless one makes the absurd assumption that all inmates eligible for diagnosis somehow are also seriously psychotic.

There is no doubt that all prison systems must have some classification or diagnostic system. This is a duty owed the healthy

inmate, who has a right not to be "infected" or injured, let us say, by a violent, psychotic inmate. The seriously disturbed inmate, in turn, has a right to be identified as such so that the needless continuation of pain and suffering -- and that increasingly includes preventable deterioration -- is avoided.

A number of federal courts have insisted that prisons deficient in classification or diagnostic systems prepare plans to learn about the inmates' skills, background, or psychological difficulties. They have ordered large scale and expensive epidemiological studies and have insisted that mental health specialists be involved in this process and that certain standardized tests be used.

Every prison system must have in place a regular screening and evaluation process, adequately staffed with qualified personnel, where the information and conclusions developed are used and periodically reviewed. Any system that can be evaluated on the factors just noted and pass need not worry about a successful legal challenge.

However, the cases reveal that the more glaringly deficient the classification-diagnostic system, the more sweeping the judicially mandated relief. Indeed, where a system seems utterly primitive in treatment and classification resources, judges seem more likely to mandate diagnostic information more clearly related to rehabilitation than the more restrictive right to treatment.

Thus, a glaringly deficient prison system invites some federal judges to require programs and penal objectives they would not likely impose if the particular claim (rehabilitation, for instance) was made in isolation or if the overall prison conditions were minimally acceptable. The point is: the greater the deficiency, the more extensive the likely relief.

Records

The basic right to treatment for serious disorders has spawned not only a right to diagnosis-classification but also a right to the maintenance of minimally adequate clinical records. Records are necessary for continuity of care, for review of the efficacy of care, future diagnosis, and certainly to respond to questions raised about the legal obligation to provide care. Courts that have decided challenges to a facility's record keeping have looked for a written plan for future treatment, how well the files are organized, notations as to physical and mental examinations, medical history and, certainly, medication records.

Where a clinician's notes are lucid and reasonably comprehensive and the course of future treatment clear the judicial demands likely will be met. Clearly, if any administrator has doubts about the medical records system the time to have a professional evaluation is now and not with lawyers pressing the matter.

Curiously, courts are divided on whether access by fellow inmates to such records is legally permissible. As a matter of policy, one would likely condemn the practice on the grounds of privacy and the potential for corrupt usage.

Components of a Treatment Program

It is very difficult, although not impossible, to predict what is constitutionally acceptable for inmate mental health care, diagnosis, and records. Six components, as articulated first in the *Ruiz* decision involving the Texas Department of Corrections, provide a very useful guide to a solution:

> First, there must be a *systematic program for screening and evaluating inmates* in order to identify those who require mental health treatment;
>
> Second, as was underscored in other cases, *treatment must entail more than segregation and close supervision of the inmate patients*;
>
> Third, treatment requires the *participation of trained mental health professionals*, who must be employed in sufficient numbers to identify and treat in an individualized manner those treatable inmates suffering from serious mental disorders;
>
> Fourth, *accurate, complete, and confidential records* of the mental health treatment process must be maintained;
>
> Fifth, *prescription and administration of behavior-altering medications in dangerous amounts, by dangerous methods, or without appropriate supervision and periodic evaluations, is an unacceptable method of treatment*;
>
> Sixth, *a basic program for the identification, treatment, and supervision of inmates with suicidal tendencies is a necessary component* of any mental health treatment program.

I have established that inmates have a constitutional right to treatment for their serious medical and mental disorders and that there are two initial factors which figure prominently in the legal acceptability of prison mental health services: diagnosis and classification, and adequate records. Of course, a third factor is implicit in all of this and that is how courts are likely to evaluate the adequacy of treatment.

Evaluation of Treatment

There are essentially two ways to evaluate the adequacy of treatment: the objective and the subjective approach. An objective approach focuses on such empirical items as inmate-staff ratios, available beds, the

number of clinician-patient contacts, and so on. A subjective approach is primarily evaluative. It asks about the quality of the services provided or uses terms resembling those noted above from the Texas case.

Courts seem to prefer the objective approach, probably because it is easier to work with; standards are available; and expert witnesses can speak to needed numbers of personnel, clinician-inmate contacts, beds, and so on.

A final word on treatment and how the term is used in the ensuing chapters of this document. Treatment in this context most often refers to efforts to provide short-term relief from acute psychic distress. Treatment in the sense of forward-looking, future-oriented improvement in, say, coping and social skills is not the type of treatment referred to here.

Substance Abusers

The question of whether, and if so how, to treat substance abusers often arises in the prison and jail setting. Indeed, we should pose the fundamental question here early and attempt to answer it squarely: Do prison inmates have a constitutional right to treatment for their alcoholism or drug addiction? Although there are some caveats to my answer, the basic answer is no.

This is not a question that asks whether it would be good policy to treat such persons or whether it would be humane, effective, and so on. The question is asked only in terms of legal obligation and the answer is -- no. The key to disentangling this answer is whether or not courts characterize alcoholism or drug addiction as serious medical needs and the courts generally say they are not.

In rejecting a claim for alcohol treatment programs at New Jersey's Rahway Prison the federal judge indicated that not every illness or injury is "serious." He appeared to leave room for a claim that some substance abusers were seriously ill but, like many of his judicial colleagues, he ultimately viewed the claim as one for rehabilitation.[36]

There simply is no constitutional right to rehabilitation. If alcoholism and drug addiction are viewed as a kind of status or condition, as opposed to disease, then the claim is "read" as one to rehabilitation and it is lost. It should also be said that in a number of court cases a trial judge will order or the parties may enter into a consent agreement for a substance abuse program.

A prison system may be found so deficient that the judge requires things that are viewed as desireable and the government sees no point in challenging the requirement. The same factors may explain consent decrees that sweep more broadly than constitutional minima. Thus, there are examples of judicially-mandated substance abuse programs but they

result from unusual aspects of the litigation and not from strict adherence to legal norms.

Isolation

Returning now to some specific problems encountered by jails and prisons in dealing with their mentally disturbed inmates, we note that the use of isolation often creates legal entanglements. No case has been found which totally forbids isolation, even though some experts find its use, especially with suicidal inmates, counterproductive. The inmate's mental condition is -- and should be -- a crucial factor in determining whether the overall conditions of isolation are cruel and unusual.

Prison officials must be especially judicious in their use of isolation (or other forms of temporary restraint) and be certain to follow local rules closely on such items as duration, authorization, and monitoring.

Pretrial Detainees

Thus far, the primary focus in this summary has been on mentally disordered prisoners with occasional reference to pretrial detainees. Pretrial detainees have at least the same right to diagnosis, adequate records, and treatment as persons convicted of crime. Indeed, in the hierarchy of legal rights retained by those in some form of confinement, convicted prisoners occupy the lowest rung. It is safe to assume that the unconvicted detainee possesses whatever rights the convicted possess, and is entitled to at least the same level of care.

The source of the right to care for pretrial detainees is not the Eighth Amendment, but the Due Process Clause of the Fourteenth Amendment. The distinction creates some interesting constitutional issues, but for present purposes the bottom line is the nature, rather than the specific source, of the right. To repeat the point made earlier: detainees are entitled to at least the same level of care as the convicted.

Pretrial detainees clearly present a different package of mental health problems than convicted prisoners. Their stay is relatively brief; alcohol and drug abuse problems abound; suicide is more prevalent; incompetence for trial may be an issue; and the initial shock of jailing is itself traumatic for many. Suffice it to say that the right to care is there; it is at least as demanding as the "deliberate indifference" standard which applies to the convicted; and, jails simply must have ready access to diagnostic and treatment resources and personnel.

Suicide

Suicide, of course, is not a problem that is confined to jails although about four times as many suicides occur in jails as in prison. The risk of suicide is sufficiently greater in the jail setting that

every jailor must immediately confront that phenomenon as a problem of appropriate care, surveillance, and custody. In reviewing law suits which result from custodial suicide, the following questions emerge:

1. Did the facility have the basic capacity to respond to the problem?
2. How many staff were in place and how were they trained?
3. Is the structure of the facility itself a contributory factor?
4. How well did staff respond to the threat posed, for example, by a highly intoxicated or highly agitated detainee?
5. How closely was the person monitored?
6. Exactly what steps, in compliance with what suicide protocols, were taken to prevent the suicide?
7. Were clinical personnel involved and, if not, why not and, if so, when and how?

The above questions are not exhaustive but they are highly representative. Jails confine a highly diverse population and often receive people who are in extreme, albeit temporary, conditions. It is incumbent on jailors to initially screen and provide humane and protective care for the potential suicide. This, of course, is crisis intervention in its most basic form and not a commitment of resources to long-term care.

The Mentally Retarded

The mentally retarded inmate presents a special package of problems which may confound correctional administrators. Mental health professionals believe that the plight of the retarded inmate is even worse than that of the mentally ill inmate. Retarded inmates are vulnerable and too often are victimized and manipulated by fellow inmates.

At the outset, there is a serious question concerning just how a retarded person goes through the criminal justice system and ends up in prison. Persons who are severely retarded are likely to be incompetent to be tried or enter a plea since they may not understand the criminal charges or be able to assist counsel. Therefore, an inmate who is functionally impaired to the point where a conviction is improper should not be in prison. But they are.

One recent study estimates that about two percent of our prison population is retarded. On the other hand, some courts have found 10 to 15 percent of the prison population to be retarded. Persons who are severely or profoundly retarded simply should not be in prison and if they are, there is a failure somewhere along the way in the system. Only the mild to moderately retarded should ever be found in prison.

With problems ranging from exploitation to the serving of longer terms, no one seems to deny the plight of this group of people. Do the mentally retarded have a constitutional right to treatment in prison?

Unfortunately, the answer is no. Do the mentally retarded have any special claims to help while imprisoned? The answer is a guarded yes, grounded on a due process claim to physical safety and freedom from undue restraints.

The above concepts are more fully developed in Chapter III and it is enough to say here that the right to treatment in prison exists within a disease or illness model. However mental retardation is classified, it is not a disease and inmates do not become retarded in prison. Their learning or developmental disability may contribute to problems of adjustment in prison but that, of course, is different than acquiring a condition in prison.

The mentally retarded are prime candidates for diversion from prison and, once in prison, for programs designed to enhance social and educational skills, to allow the person to maximize his human potential. The claim to positive help, however, as opposed to special protective concerns, is not of the same legal stature as that of the seriously mentally ill inmate.

Transfers for Treatment

While all prisons and jails must provide basic treatment at least for the seriously disordered inmate, the choice as to the type of treatment and where it is provided raises few, if any, legal questions. Discretion clearly exists as to the mix of on-site and off-site medical and psychological services. However, when a prisoner appears to need care in a mental hospital and a transfer is contemplated, then the Supreme Court's decision in *Vitek v. Jones* applies.

A *Vitek*-like situation arises when a decision is made that a particular prison does not have the treatment resources or security appropriate to a mentally disordered inmate. Correctional officials seek a transfer to a mental hospital and the inmate seeks to resist. This creates an adversary situation and one in which the inmate has important rights.

Quite simply, *Vitek* decided that the combination of additional stigma, a drastic alteration in the conditions of confinement, and being subjected to a mandatory behavior-modification program created a protected liberty interest traceable to the Fourteenth Amendment Due Process Clause.

The following minimal due process safeguards are now constitutionally required by *Vitek* before such a transfer:

1. Written notice to the prisoner that a transfer to a mental hospital is being considered.
2. A hearing, sufficiently after the notice to permit the prisoner to prepare, at which disclosure to the prisoner is made of the

evidence being relied on for the transfer and at which an opportunity to be heard in person and to present documentary evidence is given.

3. An opportunity at the hearing to present testimony of witnesses by the defense and to confront and cross-examine witnesses called by the state, except upon a finding, not arbitrarily made, of good cause for not permitting such presentation, confrontation, or cross-examination.
4. An independent decision-maker who need not come from outside the prison or hospital administration.
5. A written statement by the fact-finder as to the evidence relied on and the reasons for transferring the inmate.
6. Availability of "qualified and independent assistance," furnished by the state, if the inmate is financially unable to furnish his own.
7. Effective and timely notice of all the foregoing rights.

There are a number of interesting questions surrounding _Vitek_ which are raised and discussed in Chapter IV. Perhaps the most basic question relates to whether _Vitek_-mandated procedures apply where the transfer is to a treatment facility administratively within the prison system. The answer suggested here is that when a finding of mental illness is a predicate for admission to a treatment facility, then the physical location or administrative responsibility should be irrelevant to _Vitek_'s applicability.

Indeed, as more and more mental health services are provided by corrections -- a clear movement since _Vitek_ was decided -- such a result is necessary to give meaning to the procedural safeguards the Court sought to provide.

The Treatment Relationship

The treatment relationship in the institutional setting presents recurring and profound legal questions regarding confidentiality and privilege, the duty to disclose when a clinician learns about a particular kind of danger, and the problems of consent to treatment. The need for confidentiality and privilege, as a matter of law and professional ethics, rests on the individual's expectations of privacy and nondisclosure and recognition that the need for information in order to provide needed treatment generally outweighs even compelling demands for disclosure. Where the relationship with the inmate is for diagnosis-evaluation-classification (or something similar), then the full impact of privilege and confidentiality does not apply.

The mental health professional in a prison or mental hospital setting is well advised to disclose his or her agency to the individual before proceeding, disclose the purpose of the meeting, indicate the uses to which the information will or may be put, and indicate a willingness to answer questions as concretely as possible concerning the risks of disclosure.

The really difficult problems for the clinician are to balance the generally applicable principle of confidentiality in a treatment relationship with the countervailing demands of security: the security of specific individuals who may be in jeopardy and the general security of the institution.

Every jurisdiction should adopt a clear set of rules as to when confidentiality is inapplicable. One solution is to require mental health personnel to report to correctional personnel when they identify an inmate as:

a) suicidal,
b) homicidal,
c) presenting a reasonably clear danger of injury to self or to others either by virtue of conduct or oral statements,
d) presenting a reasonably clear danger of escape or the creation of internal disorder or riot,
e) receiving psychotropic medication,
f) requiring movement to a special unit for observation, evaluation, or treatment of acute episodes, or
g) requiring transfer to a treatment facility outside the prison or jail.

When a mental health professional has reason to believe that a patient presents a danger of violence to persons who are readily identifiable, a duty arises to use reasonable care to protect the intended victim. This often is referred to as a _Tarasoff_ problem and the safest response would be for the clinician to alert appropriate security personnel and allow them to implement needed security.

Consent

On the question of the need to obtain consent for various types of treatment, there is a general formula which may be useful in developing an answer: the more intrusive the treatment, the more likely the risk of permanent side effects, and the more experimental the procedure, the more likely the need to obtain consent.

Where informed consent is required, then the legal minima include a competent adult, the absence of duress or coercion, the disclosure of information on risks, and the likely consequences of not accepting the proferred care.

Inmates and detainees have gained considerable ground in the effort to require consent either to various forms of psychotherapy or drug therapy. Drugs that are intended to cause paralysis or vomiting as a part of a behavioral modification program have been characterized as cruel punishment unless there is consent.

The Constitution does not forbid "cruel treatment," only cruel punishment. Occasionally there will be a threshold argument concerning whether this or that is punishment or treatment. However, characterizing an intervention as treatment does not wholly insulate it from legal challenge. If a due process "liberty" interest or a First Amendment interest in religious freedom or expression is implicated, then a constitutional barrier to the intended treatment may be found.

The Future

Looking to the future, it would appear that the conservative tone established by the current Supreme Court will prevail for the foreseeable future. Among other things, this means that an inmate's basic constitutional right to minimal physical and psychological care is not likely to be enriched or expanded. It also means continued deference to mental health professionals as to what is or is not appropriate diagnosis and care. And it surely seems unlikely that more in the way of inmate consent to care will be required.

The basic legal framework for a mentally disordered inmate's claim to care and services has been established and is not likely to be undone. However, it is also not likely that the Supreme Court will further refine those rights, although the more liberal and activist federal district courts may continue to expand and enrich prisoners' rights. The substance and the direction of care for the mentally disordered and mentally retarded inmate and detainee likely will be determined by state and federal officials and by professionals seeking to expand and improve prison and jail care.

Those readers interested in a more detailed analysis may now turn to the chapters which follow where we examine in some detail the law, the definitions, and conclusions we have presented here. In the chapter which follows, a general overview of the prisoner's legal identity is presented.

FOOTNOTES CHAPTER I

[1] See generally Estelle v. Gamble, 429 U.S. 97 (1976).

[2] There are, of course, other troublesome "jurisdictional" questions that arise independent of the establishment of a predicate, or basic, legal right. For the view that the judiciary has exceeded its proper role and capacity in dealing with social and clinical problems of the type discussed in this work, see D. Horowitz, The Courts and Social Policy (1977).

[3] "Mentally disordered offender" is a term often used as an umbrella term to include those found incompetent to be tried, found not guilty by reason of insanity, found to be in a special offender category such as "sex psychopath" or "defective delinquent," or those transferred from a prison to a mental health facility. See Hartstone, Steadman, & Monahan, Vitek and Beyond: The Empirical Context of Prison-to-Hospital Transfers, 45 Law & Contemp. Prob's, Summer 1982, at 125, 126 n.5, (hereinafter Vitek and Beyond).

See Chapter III, Sec. A, 2 for an extended discussion of "serious medical needs."

[4] The term treatment typically is used for illness; rehabilitation is used with reference to "normal" prisoners or persons otherwise under correctional supervision; and the term habilitation is applied to programs for the mentally retarded.

[5] The word desirable, as an unflinching normative term, does not present itself free from ambiguity and reasonable debate. In contrasting minimum requirements with desirable practices, what is clear is that desirable will always exceed the minimum on whatever scale is used.

[6] See Meisel, The Rights of the Mentally Ill Under State Constitutions, 45 Law & Contemp. Prob's, Summer 1982, at 7, 9, for the view that state constitutional and statutory grounds may be more fruitful for development of patient's rights than federal grounds in view of the Supreme Court's unwillingness to go very far or fast in this area.

See Connecticut Board of Pardons v. Dumschat, 452 U.S. 458 (1981) which gravely impairs the thought that practices long engaged in create liberty interests.

[7] The American Medical Association has issued a series of useful pamphlets dealing with the medical and psychiatric needs of prisoners and detainees in jail. See, e.g., The Recognition of Jail Inmates with Mental Illness, Their Special Problems and Needs for Care (undated monograph) and P. Isele, Health Care in Jails: Inmate's Medical Records & Jail Inmates Right to Refuse Medical Treatment (undated monograph).

Write: A.M.A., 535 N. Dearborn St., Chicago, IL 60610 for more information on these and other related publications.

[8]See A. Stone, Mental Health and Law: A System in Transition, Ch. 5 (N.I.M.H., 1975). For the total rejection of these claims made on behalf of confined juvenile offenders, see Santana v. Collazo, 714 F.2d 1172 (1st Cir. 1983), cert. denied, 466 U.S. 974 (1984).

[9]See Bell v. Wolfish, 441 U.S. 520 (1979) where the Court made it clear that a pretrial detainee may not be punished at all but a person duly convicted of crime is clearly eligible for punishment so long as it is not cruel or unusual.

[10]457 U.S. 307 (1982).

[11]Liberty interests are individual rights traceable to the word "liberty" contained in the Due Process Clause of the Fourteenth Amendment to the United States Constitution. It is by no means an inmate's right to freedom from restraint.

[12]Youngberg v. Romeo, 457 U.S. at 319.

[13]Id. at 316.

[14]Vitek and Beyond, supra note 3, at 135, (emphasis in original) referring to the full study in Monahan, Hartstone, Davis & Robbins, Mentally Disordered Offenders: A National Survey of Patients and Facilities, 6 L. & Hum. Behav. 31 (1982).

[15]See supra note 3, at 126.

[16]Dix, Special Dispositional Alternatives for Abnormal Offenders in Mentally Disordered Offenders 136-57 (J. Monahan & H. Steadman, eds. 1983).

[17]See Craig & Kissell, The Mentally Ill Offender: Punishment or Treat-Treatment, 11 State Legis Report 3 (Nat'al Conf. of State Legis's, Aug. 1987).

[18]Plaut, Punishment Versus Treatment of the Guilty But Mentally Ill, 74 J. Crim. L. & Crim. 428, 436 (1983). The "law reform" in Illinois was not accompanied by any appropriation for treatment resources.

[19]Mich. Comp. Laws Sec. 768.36 (1976).

[20]See People v. McLeod, 407 Mich. 632, 288 N.W.2d 909 (1980).

[21]Ill. Rev. Stat. Ch. 38 Sec. 1005-2-6(b) (1981).

[22]This was not always the case. Early laws, including New York State's, mandating that insanity acquittees be hospitalized, often were ignored, and prisons were used for secure confinement. See Mentally Ill Offenders and The Criminal Justice System: Issues in Forensic Services 17 (N. Beran & B. Toomey, eds. 1979).

[23]Under Jackson v. Indiana, 406 U.S. 715 (1972) persons found to be incompetent to be tried can no longer be hospitalized indefinitely. The state is obligated to demonstrate some progress, after a reasonable period of time (six months may be the outside limit), toward the goal of "triability." See A. Stone, Mental Health And Law: A System In Transition Ch. 12 (1975).

[24]In Jones v. United States, 463 U.S. 354 (1983) the Court decided that an insanity acquittee who successfully invokes the defense may be automatically committed to a mental hospital, may be detained there for a longer period than the maximum term of imprisonment available on conviction, and that it is constitutionally acceptable at a post-commitment hearing to require the acquitted person to prove he or she is no longer mentally ill or dangerous by a preponderance of the evidence.

The most troublesome aspects of this five-to-four decision are the Court's casual acceptance of the propositions that a conviction of a crime (here, attempted petty larceny) allows an inference to be drawn that the defendant was and remains dangerous and, second, that a finding of insanity allows a conclusion that the underlying mental illness continues post-verdict, thus obviating the need for a civil commitment hearing.

See generally Note, Commitment Following an Insanity Acquittal, 94 Harv. L. Rev. 605 (1981) for a pre-Jones summary of various post-acquittal laws.

For an interesting study of offenders who are formally designated as mentally disordered see S. Halleck, The Mentally Disordered Offender (U.S. Dept. of Health and Human Services, 1986).

[25]Hochstedler, Criminal Prosecution of the Mentally Disordered, 20 Law & Society Rev. 279 (1986).

[26]Id. at 291.

[27]"Studies examining [overcrowding] have varied in design but all have found a positive relationship between overcrowding and illness of communicable diseases, including tuberculosis, with elevated rates of illness complaints and with higher rates of psychiatric commitments." T. Thornberry, et al., Overcrowding in American Prisons: Policy Implications of Double-Bunking Single Cells XI (Univ. of Georgia; July, 1982) (hereinafter Thornberry).

[28]This perception is thinly supported but widely held. The 1983 NIC program reports that, "during recent National Institute of Corrections Advisory Board meetings, the increase in the number of mentally ill and retarded inmates was identified as a major concern of practitioners." National Institute of Corrections. NIC Annual Program Plan for Fiscal Year 1983, 15 (Washington, D.C.: July, 1982). See also Hardy, Dealing With the Mentally and Emotionally Disturbed, 46 Corrections Today 16, 17 (1984).

[28] (continued)

Although there is little data on point, Steadman's work in New York State found that the percentage of inmates statewide with prior mental hospitalizations decreased from 13.4 percent in 1968 to 9.5 percent in 1978. In contrast, the percentage of patients admitted to state mental hospitals with prior arrests increased from 38.2 percent to 51.8 percent. Steadman, From Bedlam to Bastille? The Confinement of the Mentally Ill in U.S. Prisons (presented at the Annual Meeting, American Sociological Association, Aug. 1981, Toronto, Canada.).

See also Dix, Major Current Issues Concerning Civil Commitment Criteria, 45 Law & Contemp. Prob's 137, 154-159 (1982) for an analysis of other studies dealing with the involvement of the mentally ill in the criminal justice system.

Jean Harris, in assessing the numerous problems female inmates face in New York's Bedford Hills prison, writes, "Were I to be asked to choose, I would put mental illness at the top of the list." J. Harris, They Always Call Us Ladies 70 (1988). Ms. Harris also wonders whether "we are not reaching the point where treatment, however expensive, will be less expensive than the cost of neglect." Id. at 75.

[29] The trial judge in an important case challenging overcrowding at Ohio's Lucasville prison determined that 75 to 80 percent of the inmates were mentally disordered. Quoted in P.J. Cooper, Hard Judicial Choices: Federal District Court Judges and State and Local Officials 253 (Oxford U. Press, 1988).

[30] 384 U.S. 436 (1966).

[31] 367 U.S. 643 (1961).

[32] 418 U.S. 539 (1974).

[33] An excellent reference work for virtually all legal problems associated with the mentally disabled and the law is S. Brakel, J. Parry & B. Weiner, The Mentally Disabled and the Law (A.B.F., 3d ed. 1985).

[34] This Section does not document all specific statements such as the one to which this footnote is attached. The reader will find citations to the cases noted here and complete documentation in the succeeding chapters.

[35] This definition appears in the "Comprehensive Mental Health Plan" of June 6, 1986, submitted to Judge Enselen in USA v. Michigan, No. G84-63CA (W.D. Mich.). The Plan's pages are not numbered, thus making more precise citation impossible.

The first paragraph of the definition is drawn from ABA Criminal Justice Mental Health Standards, Standard 7-10.1(b).

[36] Pace v. Fauver, 479 F. Supp. 456 (D.N.J. 1979), aff'd, 649 F.2d 860 (3d Cir. 1981).

II. THE PRISON INMATE'S LEGAL IDENTITY

A prison inmate exists generally in a world of constricted legal rights. A broad understanding of that world should serve to further our grasp of a prison inmate's rights and obligations in the area of mental disorder. Thus, this Chapter is a broad introduction to the law of prisoners' rights and, at the same time, a legal framework for the detailed material in the subsequent Chapters.

It is clear beyond argument that upon conviction and sentence of imprisonment a radical change occurs in the legal status of a person. The Thirteenth Amendment to the United States Constitution reads, in part, "Neither slavery nor involuntary servitude, except as a punishment for crime whereof the party shall have been duly convicted, shall exist within the United States...." The duly convicted prisoner, then, may be punished, and also expect that many freedoms enjoyed as a free person have been relinquished.[1] Indeed the Supreme Court has stated, "[p]rison brutality ... is 'part of the total punishment to which the individual is being subjected for his crime and, as such, is a proper subject for Eighth Amendment scrutiny.'"[2]

While persons convicted of crime may be punished subject to the limitations of the Eighth Amendment, pretrial detainees may not be punished at all, a right traceable to the Due Process Clause of the Fourteenth Amendment. We shall also see that the convicted inmate's claim to psychiatric or psychological care also is rooted in the Eighth Amendment, while the pretrial detainee must fashion his claims under due process.[3]

A. Basic Rights

Lawful conviction of a crime and imprisonment, although working a radical change in the legal identity of the inmate, do not strip the person of all rights. Indeed, this was never the case although some earlier observers concluded that prisoners simply have no rights.[4]

From earliest times prisoners had a right to the minimal conditions necessary for human survival. Nothing fancy here, just the right to such food, clothing, shelter, and medical care as was necessary to sustain life. The right to the minimal conditions for human survival may accurately be viewed as the irreducible minimum for prisoners' rights.[5]

An inmate's right to a non-life threatening environment goes beyond the provisions of life's necessities. Prison officials are under a general duty to protect inmates from other inmates and from themselves.[6] In a recent decision involving the suicide of a jail inmate, Connecticut claimed that in the absence of a clear holding that there is a constitutional right to be protected from suicide, the claim should be dismissed.[7] The district court held that, "protecting inmates from themselves [is] an aspect of the broader constitutional duty to provide medical care for inmates."[8]

In many -- perhaps most -- instances, the duty to protect inmates would be unrelated to a medical or psychiatric issue. However, in cases of the sort mentioned above, two normally independent duties -- to protect and to provide medical or psychiatric care -- converge.

There are some other general statements or principles which will aid in the further development of this topic. Given the lack of certainty as to what specific rights are lost or retained on conviction and imprisonment, one aid to understanding is to try to identify the competing positions and to select the one which most nearly points in the correct direction.[9]

One position is the frequently cited view announced in Coffin v. Reichard,[10] that a prisoner retains all the rights of an ordinary citizen except those expressly or by necessary implication taken by law. The Coffin opinion does not further explicate the matter and is open to the criticism of "glittering generality." However, there is a "rights are preferred" position inherent in this formulation, and while this will not of itself resolve any specific problem, it could provide direction for decision-making.[11]

Diametrically opposed to the Coffin position is one that views the prisoner as wholly without rights except those expressly conferred by law or necessarily implied. Again, no particular issue can be resolved by this formula, but it is clear that fewer rights will be afforded the inmate under this formulation.

Neither of these statements, even in their generality, is completely descriptive of an agreed upon approach to the legal status of prisoners. The second, more grudging, formula does, however, come close to describing the approach to prisoner's claims now employed by the Supreme Court.[12]

Lower federal courts appear to be more generous toward prisoners than the Supreme Court and have been especially responsive to inmate claims regarding overall prison or jail conditions. In Rhodes v. Chapman,[13] Justice Brennan, in dissent, points out that there were over 8,000 pending cases filed by inmates challenging prison conditions and that individual prisons or entire prison systems in at least 24 states have been declared unconstitutional.

One authoritative work states, "[i]n summary, prisoner status lies in the gray area between slaves and citizens."[14] Three general principles descriptive of prisoners' claims support their "slave-citizen" dichotomy. First, prisoners do not forfeit all constitutional rights. Second, the rights retained are not necessarily or generally coextensive with those enjoyed by free persons. Third, prisoners' rights are tempered by the fact of confinement and the needs of the administration, including order, security, and discipline.[15]

These principles appear to be accurate as far as they go, but, with all deference, it is possible to go quite a bit further. The Supreme

Court appears to have passionately reembraced the older doctrine of judicial "hands-off."[16] That is, the Court favors a situation of minimal and nominal judicial involvement in the internal affairs of prisons. This view may be discerned in the large number of losses for inmate claims which reached the Court, and thus the discouragement of further suits in that area of law; in the excessive deference to correctional expertise, real or imagined;[17] and in the former Chief Justice's repeated public pronouncements of the need to cleanse the federal courts of prison litigation.[18]

1. Prisoners' Rights Versus Prison Security

Prison security is perhaps the most frequently cited rationale for denying inmates' claims. While security concerns are authentic and compelling, it does appear that the Court too easily accepts such claims. For example, in Jones v. North Carolina Prisoners' Union[19] the inmates claimed a First Amendment right to organize as a Prisoners' Labor Union and to pursue such goals as improved working conditions, to work for change in prison policies, and to serve as a conduit for prisoners' grievances. Needless to say, prison officials viewed the union as a threat and took steps to effectively ban it.

The prisoners actually won broad relief in the lower court, which found that there was not a scintilla of evidence that the union had been used to disrupt the prisons. The lower court was also unable to perceive how soliciting union membership would disrupt prison order and discipline.[20]

In reversing the lower court, the Supreme Court took a completely different approach to the claims surrounding security. Prison officials had testified that the presence, perhaps even the objectives, of a prisoners' labor union would be detrimental to order and security in the prisons. Such testimony could only have been impressionistic and speculative since there had been no experience in North Carolina, or anywhere else, with similar inmate organizations. Justice Rehnquist, writing for the majority, stated, "[i]t is enough to say that they [prison officials] have not been conclusively shown to be wrong in this view. The interest in preserving order and authority in the prisons is self-evident."[21]

This quotation illustrates how the allocation of the burden of proof determines the outcome when neither side has a factual advantage. The inmates could not possibly show conclusively that prison officials were wrong in their views about a possible threat to prison security. If prison officials had been required to substantiate their impressions concerning security -- as they were in the lower court -- then the inmates would have prevailed.

Jones is a powerful illustration of judicial deference to claims of threats to prison security, and it is by no means the only case that might be cited.[22] We will encounter security claims made on behalf of

corrections repeatedly throughout this work. In dealing with behavioral problems associated with the mentally disordered inmate, we must grapple with maintenance-of-order claims on the one hand and issues of inmate accountability and treatment on the other hand.

The specific legal claims and rights of prisoners may be arranged into different categories. First, a significant number of important legal rights possessed by the unconvicted which are entirely lost to prisoners: freedom from punishment, the right to move about freely, freedom of association, and the right to cohabit with one's mate. Second, some rights possessed by free persons are retained by inmates but in a diluted version. Inmates have some First Amendment rights, especially in the area of religious beliefs and practices, that resemble the same rights possessed by free persons. But an inmate's First Amendment right to freedom of expression is subject to inspection and censorship that would be unthinkable in the free world. As Jones made clear, inmate claims to freedom of association carry virtually no weight.

2. Reasonableness Test

In two recent Supreme Court decisions, prisoners' already attenuated First Amendment rights were further reduced. In addition, Turner v. Safley[23] and O'Lone v. Shabazz[24] appear to have brought virtually all inmate constitutional claims not involving the rights of nonprisoners within the so-called reasonableness test; that is, rules are considered valid if reasonably related to legitimate penological interests. As a consequence it is now even easier for prison officials to legally justify a broad array of prison regulations.

Turner involved a challenge against two Missouri prison regulations; one relating to inmate marriages, the other relating to inmate-to-inmate correspondence. O'Lone dealt with New Jersey prison policies which resulted in Muslim inmates' inability to attend a weekly congregational service known as Jumu'ah, a service viewed as central to the observance of the Muslim faith.

The correspondence issue in Turner and the religious service issue in O'Lone are plainly grounded in the First Amendment. The Missouri marriage rule was characterized by the Court as a fundamental right that does accompany an inmate to prison.[25] Since Turner applied the same analysis to inmate-inmate correspondence and marriage, we may safely assume that the Court did not view any one of these rights as weightier than the other.

The Court's decision in Turner to uphold the inmate-to-inmate correspondence ban, sets the tone for the other matters. Subject to a couple of narrow exceptions, Missouri inmates could correspond with other inmates only when prison personnel deemed it in the best interest of the parties involved.[26] According to the trial court, the practice was that inmates simply did not write non-family inmates.[27]

The most critical point in resolving any First Amendment claim is to decide first on the standard to be used in reaching a decision. In finding the Turner mail ban unconstitutional both lower federal courts applied a strict scrutiny/least intrusive standard. That is, these courts read an earlier Supreme Court decision, Procunier v. Martinez[28] as supporting the proposition that the correspondence restriction could be justified only if it furthered an important or substantial governmental interest unrelated to suppression of expression and the limitation was no greater than necessary to protect that interest.[29]

Justice O'Connor, writing for a slim five to four majority, rejected the lower court's reliance on Procunier and stated: "When a prison regulation impinges on inmates' constitutional rights, the regulation is valid if it is reasonably related to legitimate penological interests."[30] This standard of review known as the reasonableness test is obviously less demanding on government than the strict scrutiny/least intrusive means test rejected by the Court.

Two points bear emphasis: under the reasonableness test as adopted in Turner the governmental interest need only be legitimate (as opposed to important or substantial) and the regulation need only be reasonably related to that legitimate interest (as opposed to the least intrusive means available).

Turning to the actual decision in Turner, we can demonstrate how the competing tests produce quite different outcomes. The inmates claimed -- and the lower courts accepted -- that the monitoring of inmate correspondence was sufficient to satisfy the prison's undoubtedly valid security interests. A majority of the Court, however, found that monitoring was an unduly burdensome alternative not required by the Constitution; that it would tax limited prison resources and still not be wholly effective. Thus, a total prohibition of all correspondence with a limited class of persons (other Missouri prisoners) was upheld as reasonable.[31]

The Missouri marriage rule also at issue in Turner prohibited inmates from marrying inmates or civilians unless the prison superintendent found "compelling reasons" for allowing the marriage.[32] Generally, only pregnancy or the birth of a child were considered to be "compelling reasons."[33] After determining that marriage is a fundamental constitutional right which inmates do not fully surrender, the Court next determined that the Missouri rule swept too broadly for rehabilitative purposes and was an exaggerated response to valid security objectives.[34]

Although the Missouri marriage rule was found constitutionally infirm, the majority made it very clear that a rule requiring a finding of a threat to security or to public safety would be constitutionally satisfactory.[35] A moments reflection reveals just how undemanding that would be especially in light of the Court's almost total deference to prison officials' conclusions about security interests.

Although much more could be written about Turner, for our purposes enough has been articulated. The primary points I wish to make may be summarized as follows: until Turner (and O'Lone) there was good reason to believe that even for prisoners there was a hierarchy of constitutional rights and that hierarchy would importantly include First Amendment rights to expression. Therefore, when a prison rule or practice impinged on such a lofty right, courts were mandated to look very closely at the objective sought and to decide whether less drastic means were available to achieve that objective.[36] In other words, they were to employ the strict scrutiny test.

The Court very plainly intended to substitute the easily complied with reasonableness test for strict scrutiny and thereby lend instant constitutional credibility to a number of restrictive rules and practices. The policy of deference to prison officials and the purging of the federal courts of a number of inmate legal claims has now received additional impetus.

In O'Lone, Chief Justice Rehnquist employed an interesting analysis to reach the result. Muslim inmates at Leesburg State Prison challenged policies which resulted in their inability to attend a religious service every Friday afternoon. The service -- known as Jumu'ah -- was accepted by the Court as central to the faith and no question was raised as to the legitimacy of the religion or the sincerity of the inmate claimants.

Muslim inmates who were given a work assignment outside the prison's main buildings were required to spend all day outside and were thereby effectively precluded from attending the religious service. The inmates asked to be placed on inside work details or to be given substitute weekend tasks. These alternatives were rejected by prison officials based on an assertion of scarce prison personnel.

Prison officials also raised the ubiquitous security factor and the Chief Justice found a logical connection between security and the prohibition against return to the prison.[37] We should note that the Chief Justice used the word logical whereas in Turner Justice O'Connor had used reasonable. But the most interesting maneuver in O'Lone relates to the issue of alternative means of exercising the claimed right. As indicated earlier,[38] the critical factor here is how the absence or presence of alternatives is analyzed. In this case, there was no alternative offered to Jumu'ah and one would think this would strengthen the inmate claim. However, the Chief Justice found that the availability of a number of other avenues for religious observance created reasonable alternatives.[39] In other words, the larger one defines the universe of alternatives, the easier it is to uphold as reasonable the total denial of one aspect of the area.

O'Lone and Turner together represent a serious dilution of inmate claims to free expression and the free exercise of religion, both encompassed by the First Amendment. The possible extent to which this

development will have direct or indirect effects on the constitutional obligation to provide medical and psychological care to inmates must remain speculative at this early date.

At first blush, I would not expect any significant impact on medical and psychiatric claims. The Court appears reluctant to dilute these inmates' rights beyond the "deliberate indifference" standard.[40]

When we broach other areas of prisoners' rights, however, the Court is not so reluctant. In Whitley v. Albers,[41] for example, the Court had the problem of determining what standard governs an inmate's claim that prison officials subjected him to cruel and unusual punishment by shooting him during their attempt to quell a prison uprising. While adopting a standard emphasizing force which is used maliciously and sadistically to cause harm for the prison uprising situation, Justice O'Connor also wrote:

> The deliberate indifference standard articulated in Estelle was appropriate in the context presented in that case because the State's responsibility to attend to the medical needs of prisoners does not ordinarily clash with other equally important governmental responsibilities. Consequently, 'deliberate indifference to a prisoner's serious illness or injury' can typically be established or disproved without the necessity of balancing competing institutional concerns for the safety of prison staff or other inmates.[42]

Inmates have a right to be free of cruel and unusual punishment, a right which now may be reserved exclusively for convicted prisoners.[43] Persons who are civilly confined -- the mentally ill or retarded, for example -- are protected from cruelty but that protection is expressed as a liberty interest traceable to the Due Process Clause or as a form of impermissibly intrusive treatment also safeguarded by the Fourteenth Amendment.

B. Right of Access to Courts

One of the most fundamental rights possessed by inmates is the right of access to the courts.[44] In Johnson v. Avery the Court struck down a state prison regulation which allowed inmates to be punished for assisting other inmates in the preparation of habeas corpus applications and other legal documents.[45] Johnson was decided in the context of a prison which provided inmates with no apparent alternatives to the so-called jailhouse lawyers.[46]

Johnson should be understood as an analogue to the injunction that "thou shalt not discriminate." It is a constitutional ruling which only goes so far as to require that prison officials not prevent or erect

barriers to access to the courts. The decision stops short of requiring "affirmative action." In Bounds v. Smith the Court decided that a prisoner's right of access to the courts required either an adequate law library or assistance from persons trained in the law, although not necessarily lawyers.[47] Bounds, then, added "affirmative action" to the right of access to the courts.[48]

Once again, as in the area of treatment, the establishment of a predicate right -- here, access to the courts -- spawns important ancillary rights. If there is a right to seek redress of grievances through the courts, then inmates must have paper, writing implements, envelopes, stamps, and so on. And courts have so decided.[49] Does an inmate require a typewriter? Probably not unless a particular court will accept only typed documents.

The rationale, or policy, behind the establishment of a right of access to the courts is plain enough. The walls which keep prisoners in, keep the community out. Prisons cannot be allowed to function as hermetically sealed places of confinement subject to no outside scrutiny or challenge. Prisoners are not so legally naked as to be without access to legal redress. Prisoners may seek access to the courts because of a legal matter that preceded their confinement (a contract dispute or a tort action, for example); they may wish to challenge their conviction or confinement; they may seek to challenge and alter the conditions of confinement; or they may wish to bring a tort action arising from a claim of intentional or negligent injury related to a breach of duty of care on the part of the defendant.

1. Tort Actions

In Estelle v. Gamble[50] the Supreme Court denied relief to a Texas inmate who claimed that he received inadequate diagnosis and treatment for a back injury and thus had been subjected to cruel and unusual punishment. The Court did say of the inmate's claim that, "[a]t most it is medical malpractice, and as such the proper forum is the state court under the Texas Tort Claims Act."[51]

As one authoritative work puts it, "[t]ort remedies may be critically important to the prisoner who sustains an injury in prison."[52] This is not the appropriate occasion to review tort remedies available to inmates. Suffice it to say that prisoners generally have a right to seek damages for injuries they claim have been intentionally or negligently inflicted upon them.

Tort actions may be brought in state courts and in the federal courts. State prisoners favor the use of federal courts and a variety of damage suits are brought under the Federal Civil Rights Act.[53] Apart from problems of proof and access to counsel, the major hurdle to success in such suits is the doctrine of immunity.

Prison officials have a qualified immunity when sued under 18 U.S.C., Sec. 1983.[54] In Cleavinger v. Saxner[55] federal prisoners gained a modest victory when a divided Court refused to extend absolute immunity to members of a prison discipline committee. Justice Blackmun reasoned that unlike judges, committee members are not truly independent. As employees of the prison system they are under obvious pressure to favor their colleagues and the procedural safeguards afforded inmates are rather nominal.[56]

Finding that qualified immunity was appropriate in this situation, the Court did offer balm by noting, "[a]ll the committee members need to do is follow the clear and simple constitutional requirements of Wolff v. McDonnell, and "they then should have no reason to fear substantial harassment and liability."[57]

In practical effect, qualified immunity means that the law controlling the matter complained about was known and clearly established and that the violation was malicious. As a matter of practical consequence, this means that winning damages will be rare and inmate law suits must look more to injunctive remedies.

Although prison officials remain open to suits for money damages under Sec. 1983, recent Supreme Court decisions have severely limited the acts or omissions which might create liability. In Daniels v. Williams an inmate at a city jail slipped and fell on a pillow negligently left on the stairs by a deputy.[58] The inmate claimed that his resultant injuries deprived him of his constitutionally protected liberty interest in freedom from bodily injury.[59] The Court rejected the claim and announced that injuries inflicted by governmental negligence are not encompassed by the Constitution.[60]

Negligence involves a lack of due care on the part of the person who causes the injury subject to the complaint. In Daniels, the Court indicated that the intentional infliction of harm by prison officials would likely suffice in a Sec. 1983 claim but found no occasion to decide whether recklessness or gross negligence could trigger the protections of due process.[61]

In a case decided the same day as Daniels, the Court dealt with a similar problem but on facts that were sufficiently different to attract three dissenters. Davidson v. Cannon involved a New Jersey prison inmate who sought damages for serious injuries inflicted on him by a fellow inmate.[62] Davidson had been threatened by another inmate and he sent a note reporting the threats to the assistant superintendent. This official read the note and passed it along to a corrections sergeant. The sergeant forgot about the note and a day or two later -- no on-duty staff having been properly advised -- the threat was made good and Davidson was seriously injured.

The Court reiterated its position from Daniels and found that mere negligence was not a basis for a Sec. 1983 claim. There is an obvious

difference between a slip and fall due to the careless placement of a pillow and the failure to take some action -- if only to alert on-duty personnel -- in the face of an apparently authentic threat. Justice Blackmun's dissenting opinion captures that difference:

> [W]here the State renders a person vulnerable and strips him of his ability to defend himself, an injury that results from a state official's negligence in performing his duty is peculiarly related to the governmental function. *** The deliberate decision not to protect Davidson from a known threat was directly related to the often violent life of prisoners. And protecting inmates from attack is central to one of the State's primary missions in running a prison -- the maintenance of internal security.[63]

What is even more compelling about Davidson is that New Jersey law provides that neither a public entity nor a public employee is liable for any injury caused by a prisoner to another prisoner.[64] Thus, an inmate in Davidson's position either has a federal claim for damages or his injuries go uncompensated.

It is likely that Daniels and Davidson will lead to one of two different avenues of approach by inmate litigants. Where the state courts are open (unlike New Jersey), and especially if negligence will suffice as a basis for recovery, we may expect more actions for damages to be brought in state courts. Where the state courts are not open or not particularly friendly to inmate claims then on facts such as Davidson it will be relatively easy to plead the case as involving "deliberate indifference" or "gross negligence."[65]

Plainly, if prison officials know that some powerful and violent inmate has threatened to dismember a weak and passive inmate and officials place the two in the same cell, the resulting violence approximates the intentional infliction of harm. Presumably this hypothetical case would remain within the coverage of a Sec. 1983 suit. Injured inmates and their counsel will therefore increasingly attempt to array the facts and construct their legal theory to resemble the above type of problem. Proving the claim, of course, is another matter.

C. Right to Privacy

Does a prison inmate retain any legal rights to privacy? The very asking of the question may strike some readers as frivolous. The answer to the question may be no, but the inquiry is not frivolous. Indeed, in a recent decision, the Oregon Supreme Court relied on privacy concepts to decide a case brought by male inmates of the Oregon State Penitentiary who sought to enjoin the assignment of female guards from duties which involved frisking them.[66]

The lower court decided the case on the theory that male prisoners have a federal constitutional right of privacy against searches by female guards involving the genital and anal areas. The State Supreme Court upheld the injunction, as modified, and while the court appeared to agree that inmates possessed a federal constitutional right to privacy, it was of the view that the state constitution provided a more solid legal footing. Art. I, Sec. 13 of the Oregon Constitution guarantees that no person arrested or confined in jail shall be treated with unnecessary rigor. This guarantee was treated as the functional equivalent of privacy.

This rather unusual decision should not be taken as representative of the treatment given inmate claims to privacy. The Fourth Amendment, which provides protection from illegal searches and seizures, and which is applied with special vigor to searches conducted in a person's home, is virtually nonexistent in prison. Cell searches, body searches, including strip and body cavity searches, and intensive surveillance, with or without any specific reason or probable cause are regular occurrences in prison. These activities also are at the core of the privacy protections afforded by the Fourth Amendment.

The overwhelming weight of legal authority simply refuses to apply the Fourth Amendment, or apply it favorably, to prison inmates. In Bell v. Wolfish[67] the Supreme Court was asked to determine a broad array of claims brought by pretrial detainees housed at the Federal Metropolitan Correctional Center located in New York City. Concerning the challenge to routine strip and body cavity searches, Justice Rehnquist wrote:

> Admittedly, this practice instinctively gives us the most pause. However, assuming for present purposes that inmates, both convicted prisoners and pretrial detainees, retain some Fourth Amendment rights upon commitment to a corrections facility, we nonetheless conclude that these searches do not violate that Amendment. The Fourth Amendment prohibits only unreasonable searches, and under the circumstances, we do not believe that these searches are unreasonable.[68]

We should note that Justice Rehnquist did not bind himself or the Court to the acceptance of any Fourth Amendment safeguards in jail or prison. The Justice simply accepted that position in stipulative (or *arguendo*) fashion.[69] More important, however, is the allowance of the most intrusive of searches -- the body cavity inspection -- on pretrial detainees and without regard to articulable facts suggesting a security problem. One might safely infer then that searches conducted in prison are inherently reasonable, according to the Rehnquist view.

In general, prisoners have no expectation of privacy as to their place or possessions. An inmate's body, at least for the most highly intrusive searches, may be subject to nominal safeguards. Prison officials may have to show at least reasonable suspicion to justify, for example, a body cavity probe for drugs.[70]

The prisoner's body, his few possessions, and his "home" are subject to surveillance and inspection with no anterior safeguards (in the form of a requirement of cause or a warrant) and with no realistic opportunity for subsequent challenge.[71]

An inmate may, however, have significant protections in the area of custodial interrogation[72] or when incriminating statements are deliberately elicited after the right to have an attorney has become operative. For example, when an informer, planted in a jail cell, manages to elicit damaging statements later used to help convict the duped inmate, a violation of the Sixth Amendment right to the effective assistance of counsel may be found.[73] This is not a recognition of an inmate's right to privacy. Rather, it is the continuation of an extensive set of pretrial safeguards designed to protect an accused's privilege against self-incrimination and right to counsel.

D. Rights in Disciplinary Proceedings, Transfers, and Administrative Segregation

The maintenance of order and security and the utilization of prison disciplinary proceedings go hand-in-glove. Do prison inmates have any procedural or substantive legal rights when accused of a violation of prison rules? Suppose a prisoner is simply transferred from one prison to another, as opposed to being placed in solitary confinement, and the underlying motivation for such transfer is punitive? Does a prisoner entering the prison system have any rights during the classification-diagnostic process?

These problems may seem quite different from each other, and indeed the Supreme Court has given answers which are at variance. However, the issues involved here are quite similar and provide important background for understanding the Court's decision in Vitek v. Jones,[74] which involves the transfer of a prison inmate to either a mental hospital or mental health facility.

The most significant decision involving prison discipline is Wolff v. McDonnell.[75] A more recent decision, Hewitt v. Helms,[76] promises to be a close second to Wolff, but the decision is too new to be entirely certain of its impact.

Wolff involved a challenge to the procedures used in Nebraska state prisons for the imposition of disciplinary sanctions[77] as a result of flagrant or serious misconduct. Nebraska's position was that the procedure for imposing prison discipline is a matter of policy, which raises no constitutional issue. A majority of even this highly conservative Supreme Court strenuously objected to that argument, stating:

> If the position implies that prisoners in state institutions are wholly without the protections of the Constitution and the Due Process Clause,

> it is plainly untenable. Lawful imprisonment necessarily makes unavailable many rights and privileges of the ordinary citizen, a 'retraction justified by the considerations underlying our penal system.' But though his rights may be diminished by the needs and exigencies of the institutional environment, a prisoner is not wholly stripped of constitutional protections when he is imprisoned for crime. There is no iron curtain drawn between the Constitution and the prisons of this country.[78]

Whatever procedural rights inmates would be afforded at disciplinary proceedings are located in the Due Process Clause of the Fourteenth Amendment. However, before the procedural safeguards of due process may be unraveled and put to work, constitutional analysis requires that there first be identified a constitutionally recognized and protected interest. In other words, it is not enough to claim some loss, even a serious loss. The loss, or harm, complained of either must be an interest located within the flexible boundaries of life, liberty, or property as stated in the Fourteenth Amendment, or be an interest created by the state.[79]

No state is required either to create a good-time credit system or to then decide that such credits may be forfeited for major infractions of the rules. However, Nebraska having done so, the prisoner's liberty interest -- a state created interest -- has real substance and is embraced within the procedural safeguards of the Fourteenth Amendment. At a minimum this is to assure that the right is not arbitrarily abolished.

Once it is decided that due process applies, as the Court did in Wolff, the second task is to determine what process is due. The fact that this task remains tells us that the procedural safeguards required by due process are not invariable. Indeed, the importance, or weight, assigned to the right and the setting in which the right is operative are the major factors in reaching this decision.[80]

At the core of procedural due process is the requirement of some kind of hearing before an impartial tribunal.[81] In Wolff, the Court held that inmates facing serious disciplinary charges are entitled to written notice of the claimed violation at least twenty-four hours in advance of the hearing. In addition, the fact-finders must provide a written statement of the evidence relied on and reasons for the disciplinary action.[82] These are the only unconditional procedural rights in disciplinary proceedings extended to inmates.

The Court determined that inmates also have certain conditional rights, including the right to call witnesses or present documentary evidence when permitting them to do so will not be unduly hazardous to institutional safety or correctional goals.[83] Illiterate inmates or inmates facing

complex charges have a right to seek aid from a fellow inmate or, if this is forbidden, to seek help from staff or a sufficiently competent inmate designated by staff.[84]

The Court rather casually rejected the inmate's claim that the hearing tribunal composed entirely of correction officials was not sufficiently impartial to satisfy due process.[85] Apparently the only constitutional basis for preclusion is whether or not a decision-maker was actually involved in the incident or in bringing the charge.

Confrontation and cross-examination were found to present grave hazards to institutional interests. Allowing an inmate to hear the evidence against him and to examine his accusers, said the Court, creates the potential for havoc and for making these proceedings unmanageable and longer than need be.[86]

If we take a step away from the details of Wolff, we may note that the Supreme Court recognized a liberty interest in an inmate's good-time credits and in the avoidance of solitary confinement, and those liberty interests required a rather undemanding procedural format before they may be taken away. Prison officials remain in charge of the investigating, charging, adjudicating, and sentencing phases of these disciplinary proceedings.

We must emphasize that these modest requirements exist only because the Supreme Court found substantive value -- expressed as a liberty interest -- in the retention of good time and the avoidance of solitary confinement. Clearly Wolff does not reallocate any important power between prison officials and inmates. At best it creates some paperwork requirements (the notice and reasons) and requires the assignment of some personnel to the hearing tribunal. If the Court had decided, for example, that due process required that inmates had a right to full representation before the tribunal, there is a real possibility that the appearance and reality of impartiality might have been obtained.[87]

Eleven years after the decision in Wolff the Court answered two of the many procedural issues it left unresolved. In Ponte v. Real[88] the question was whether the Due Process Clause requires that prison officials provide some reason for the denial of an inmate's conditional right to call witnesses at a disciplinary hearing.

The Court answered in the affirmative:

> We think the answer to that question is that prison officials may be required to explain, in a limited manner, the reason why witnesses were not allowed to testify, but that they may do so either by making the explanation a part of the 'administrative record' in the disciplinary proceeding, or by presenting testimony in court

> if the deprivation of a 'liberty' interest is challenged because of that claimed defect in the hearing. In other words, the prison officials may choose to explain this at the hearing, or they may choose to explain it 'later.' Explaining the decision at the hearing will of course not immunize prison officials from a subsequent court challenge to their decision, but so long as the reasons are logically related to preventing undue hazards to 'institutional safety or correctional goals,' the explanation should meet the Due Process requirements as outlined in Wolff.[89]

Thus, the conditional right of an inmate to call witnesses at a disciplinary hearing when denied does require a stated reason but the reason need not be in writing nor be contemporaneous with the denial.[90]

Superintendent v. Hill raised the question of the evidentiary requirement constitutionally necessary to support a prison disciplinary proceeding, at least where a loss of good time is involved.[91] The choices available to the Court ranged from the criminal law's "proof beyond a reasonable doubt" to a "some evidence" or "unreasonable and arbitrary" rule.

The Court opted for the feather weight requirement of "some evidence."[92] What this appears to mean is that if there is virtually any evidence at all in the record to support the conclusion, and despite what might be stronger yet countervailing evidence, a disciplinary tribunal's decision is constitutionally acceptable.[93] Clearly, the Court is not bent on strengthening the prisoner's legal identity in the context of disciplinary proceedings.

Is there a functional difference between being removed from general population and placed in solitary confinement and being transferred from a medium or minimum security prison to a maximum security prison? The answer, it seems, depends on what aspects of the alterations in confinement one chooses to highlight.

If the analysis focuses on the nature and extent of the loss both may be termed serious and, if anything, a prison-to-prison transfer may be more of a loss than a hospital transfer, with the newly arrived inmate possibly far from friends and family, in physical jeopardy from other inmates until "turf" claims are settled, separated from lawyers and advisors, and so on.

In Meachum v. Fano[94] and Montanye v. Haymes,[95] the Supreme Court dealt with the inter-prison transfer question and handed the inmates a damaging defeat. Justice White made it clear that not every grievous loss visited upon a person by the state entitles that person to procedural due process. Changes in the conditions of confinement which do not otherwise violate the Constitution are not within the ambit of constitutional protection.

The Court made it clear that the rights protected in Wolff were rights created by the state. Here, neither Massachusetts nor New York created any right -- a hope, perhaps, but no right -- to remain in any particular prison. Transfers occur for a variety of reasons and, especially in New York, occur on a frequent basis. The Court was unable to locate any state-created rights and was unwilling to create a federal right deserving of procedural due process safeguards.

Whether a transfer is for punitive, administrative, security, or program purposes, there are no constitutionally required procedural rights, not even to a hearing. Should a state elect to condition a transfer on the occurrence of a specific event -- for example, proof of misconduct -- then due process would likely apply.

E. Rights in Classification Decisions

All correctional systems have some form of a classification system. Classification decisions, of course, have a major impact on the immediate security status of the inmate and the longer-term question of parole. Classification decisions rely heavily on factual data (as well as professional judgment and intuition); data that may be wrong, incomplete, or in need of clarification.[96] Although the Supreme Court seems not to have spoken directly to the issue, Meachum's reasoning and dicta in Moody v. Daggett[97] strongly suggest that the Court recognizes no inmate legal rights in the ordinary classification process.

In Meachum the Court stated:

> [G]iven a valid conviction, the criminal defendant has been constitutionally deprived of his liberty to the extent that the State may confine him and subject him to the rules of its prison system so long as the conditions of confinement do not otherwise violate the Constitution. The Constitution does not require that the state have more than one prison for convicted felons; nor does it guarantee that the convicted prisoner will be placed in any particular prison, if, as is likely, the State has more than one correctional institution. The initial decision to assign the convict to a particular institution is not subject to audit under the Due Process Clause, although the degree of confinement in one prison may be quite different from that in another. The conviction has sufficiently extinguished the defendant's liberty interest to empower the State to confine him in *any* of its prisons.[98]

The Court was even more explicit, although in dicta, in Moody, stating:

> [N]o due process protections [are] required upon the discretionary transfer of state prisoners to a substantially less agreeable prison, even where that transfer visit[s] a 'grievous loss' upon the inmate. The same is true of prisoner classification and eligibility for rehabilitative programs in the federal system.[99]

Whatever the practical importance of the classification decision, it is reasonably clear that the Court is not likely to decide that inmates have a right of access and input into the decision. However, not all legal questions surrounding classification are thereby laid to rest. As we shall develop in detail later an inmate's constitutional right to medical and psychological care necessarily mandates that a failure to identify serious physical or mental problems constitutes a cruel and unusual punishment. Where, for example, such failure results in confining aggressive psychotics with passive and physically vulnerable inmates, resultant attacks may well be violations of the Eighth Amendment.[100]

In our previous discussion of Wolff and prison disciplinary proceedings, the matters at stake for the inmate were clearly loss of good time credits and, less clearly, confinement to disciplinary segregation.[101] Hewitt v. Helms[102] confronted the Court with the extended use of administrative segregation without observance of the Wolff procedural requirements. How a majority of the Court resolved the questions presented and how the four dissenting Justices approached the questions and would have resolved them is representative of the present debate on the legal rights of inmates.

Justice Rehnquist, for a divided Court, determined that the Pennsylvania regulations on point provided Helms with a protected liberty interest in continuing to reside in the general prison population.[103] The Commonwealth went beyond the adoption of simple procedural guidelines, and adopted rules which liberally use "will," "shall," and "must," language of an unmistakably mandatory character, governing the specific occurrences when administrative segregation may be imposed.

Following the two-stage analysis used in Wolff, Justice Rehnquist grudgingly recognized that the inmate did have a liberty interest in remaining in the general population. Since a majority of the Court believes that not all rights are created equal, he then had to decide the significance of the right in order to determine what process was due. Not surprisingly, the majority decided that the inmate's right was weak and the prison official's concerns rather strong.

Justice Rehnquist then stated:

> We think an informal, nonadversary evidentiary review sufficient both for the decision that an

> inmate represents a security threat and the decision to confine an inmate to administrative segregation pending completion of an investigation into misconduct charges against him. An inmate must merely receive some notice of the charges against him and an opportunity to present his views to the prison official charged with deciding whether to transfer him to administrative segregation. Ordinarily a written statement by the inmate will accomplish this purpose, although prison administrators may find it more useful to permit oral presentations in cases where they believe a written statement would be ineffective. So long as this occurs, and the decisionmaker reviews the charges and then-available evidence against the prisoner, the Due Process Clause is satisfied. This informal procedure permits a reasonably accurate assessment of probable cause to believe that misconduct occurred, and the 'value [of additional 'formalities and safeguards'] would be too slight to justify holding, as a matter of constitutional principle' that they must be adopted.[104]

This procedure, of course, is even less than the nominal requirements of Wolff. Helms apparently had an opportunity to present his views to the committee sometime during his extended confinement, and that was enough to satisfy this highly diluted version of due process.

The dissenters see things rather differently than the present Chief Justice Rehnquist. Justice Stevens established that the conditions in disciplinary and administrative segregation were identical, that the charges against Helms following a prison riot never were substantiated, and that this inmate spent over seven weeks in isolation prior to any hearing.[105]

The dissent goes on to disagree fundamentally with the approach of the majority:

> [The Court's] analysis attaches no significance either to the character of the conditions of confinement or to actual administrative practices in the institution. Moreover, the Court seems to assume that after his conviction a prisoner has, in essence, no liberty save that created, in writing, by the State which imprisons him. Under this view a prisoner crosses into limbo when he enters into penal confinement. He might have some minimal freedoms if the State chooses to

> bestow them; but such freedom as he has today may be taken away tomorrow ....The source of the liberty recognized in Wolff is not state law, nor even the Constitution itself.[106]

The differences here are striking. Three Justices do not view Wolff as resting on a state created liberty interest and are more receptive to the recognition of inmate rights as an aspect of liberty within the meaning of the Due Process Clause. Justice Stevens adheres to his earlier views from Wolff that an inmate has a protected right to pursue his limited rehabilitative goals or, at a minimum, to maintain whatever attributes of dignity are associated with his status in a tightly controlled society.[107]

He recognizes that the state can change an inmate's status abruptly and adversely, but if the change is sufficiently grievous -- now using pre-Meachum language -- then due process must be afforded to safeguard against arbitrariness.[108] The grievousness of any prisoner's claim, according to the dissenters, is a relative matter requiring a comparison of the habitual treatment afforded the general population with the disparate treatment imposed on an individual inmate.

This approach concedes that the relative toughness of a prison, or an entire prison system, is a matter of local policy and subject only to Eighth Amendment limitations. The written rules of the system, which determine the matter for the majority, are relevant to the dissenters, but they would require due process safeguards even in their absence when a transfer to administrative custody is the functional equivalent of punitive isolation.[109]

The decisions involving discipline, transfer, classification, and administrative segregation highlight, among other things, a major jurisprudential debate occurring within the Supreme Court. Prison inmates who seek some form of ceremony, some type of procedural due process, must first show that they possess a liberty (or property) interest. A majority of the Court subscribes to the view that the liberty interests are created either by the state or, less often, are an unspecified part of the Due Process Clause itself.

The Court requires that a liberty or property interest, as opposed to state-inflicted harm, be found before it will determine that any process is due. One critic of the Court's approach puts it this way:

> Until recently, the general outlines of the law of procedural due process were pretty clear and uncontroversial. The phrase 'life, liberty, or property' was read as a unit and given an openended, functional interpretation, which meant that the government couldn't seriously hurt you without due process of law. What process was

'due' varied, naturally enough, with context, in particular with how seriously you were being hurt and what procedures would be useful and feasible under the circumstances. But if you were seriously hurt by the state you were entitled to due process. Over the past few years, however, the Court has changed all that, holding that hence forth, before it can be determined that you are entitled to 'due process' at all, and thus necessarily before it can be decided what process is 'due,' you must show that you have been deprived of what amounts to a 'liberty interest' or perhaps a 'property interest.' What has ensued has been a disaster, in both practical and theoretical terms. Not only has the number of occasions on which one is entitled to any procedural protection at all been steadily constricted, but the Court has made itself look quite silly in the process -- drawing distinctions it is flattering to call attenuated and engaging in ill-disguised premature judgments on the merits of the case before it. (It turns out, you see, that whether it's a property interest is a function of whether you're entitled to it, which means the Court has to decide whether you get a hearing on the question whether you're entitled to it.) The line of decisions has been subjected to widespread scholarly condemnation, which suggests that sometime within the next thirty years we may be rid of it.[110]

It should be clear that when the source of a liberty or property interest is state law, then the law may be changed and have the effect of dissipating the protective procedural rights. For example, if Wolff does indeed rest on Nebraska law, then Nebraska need only abolish good-time credits.

On the other hand, where written laws and regulations for the governance of prison life are favored, there is the paradox that the more that is written, the greater the chance that rights (liberty interests) have been created. Justice Rehnquist, however, in Hewitt v. Helms stated:

> Except to the extent that our summary affirmance in Wright v. Enomoto may be to the contrary, we have never held that statutes and regulations governing daily operation of a prison system conferred any liberty interest in and of themselves.[111]

The distinction Justice Rehnquist draws seems to be between rules that directly relate to the maintenance of institutional order or

security as opposed to liberty or to the duration of confinement is, to parole and good-time credits. Where it is a question of rules governing the day-to-day operation of a prison, he suggests that administrative discretion should prevail.

F. Summary

This Chapter provides a broad framework for understanding the law of prisoners' rights. Much of that law is derived from the United States Constitution and pronounced by the Supreme Court. Therefore much of our discussion necessarily focuses on the development and status of federal constitutional rights.

This Chapter is representative, but hardly exhaustive, of the entire body of prisoners' legal rights and responsibilities. For example, the Supreme Court has condemned racial discrimination in prisons,[112] and dealt with questions involving limitations on visits.[113] Other important matters, including access to literature and problems of media access and coverage, are merely noted in passing.

My hope was to present enough law that the reader might understand somewhat the less-than-clear picture of the inmate as a legal entity. Among the more important points to take from this Chapter are:

1. The Supreme Court now repeatedly decides cases against the inmate position and has adopted a non-activist (or "hands-off") approach to prisons. Recent decisions on use of force, inmate privacy, and procedural requirements incident to disciplinary matters all serve to reinforce this proposition.
2. The Court has repeatedly deferred to the real or presumed expertise of prison officials. Inmates need a powerful case to overcome the opinions of correctional authorities and their concerns about order and security.
3. There may not be any hierarchy of constitutional rights held by inmates. After Turner and O'Lone reasonableness may be the exclusive test for prison regulations.
4. Earlier thinking by correction officials to the effect that "no rules are good rules" may now be tempered by Chief Justice Rehnquist's views on "housekeeping" procedural rules that do not necessarily create liberty interests.
5. An observation not previously expressed in the text is that correctional authorities may not always see that at times their interests coincide with the legal claims put forward by inmates. For example, if the corrections establishment "loses" a general conditions-overcrowding case then the "loss" means fewer inmates, more programs, more personnel (typically professionals or specialists), and less tension.
6. As a lead into the next Chapter, we shall there see that courts do not show as much deference to prison officials on questions of medical and psychiatric care. Typically, there is no valid security interest to balance against an inmate's claim to treatment.

FOOTNOTES CHAPTER II

[1]See Price v. Johnson, 334 U.S. 266, 285 (1948).

[2]Ingraham v. Wright, 430 U.S. 651, 669 (1977), quoting Ingraham v. Wright, 525 F.2d 909, 915 (5th Cir. 1976).

[3]See Bell v. Wolfish, 441 U.S. 520, 535 n.16 (1979). Whether or not this doctrinal difference make a difference in the detail of what care actually is required is not at all clear. My best speculation is that there is no practical difference.

[4]See, e.g., Ruffin v. Commonwealth, 62 Va. (21 Gratt.) 790 (1871).

[5]H. Kerper and J. Kerper, Legal Rights of the Convicted 285 (1974). The Court clearly has endorsed the statement in the text, but the more disturbing problem may be the extent to which the Eighth Amendment is interpreted to require more.

[6]See B. Knight & S. Early, Jr., Prisoners' Rights in America, Ch. 8 (1986). Also see, Hudson v. Palmer, 104 S.Ct. 3194, 3200 (1984) "([Prisons] are under an obligation to take reasonable measures to guarantee the safety of the inmates themselves").

[7]Guglielmoni v. Alexander, 583 F. Supp. 821, 826 (D. Conn. 1984). The decedent had attempted suicide at least twice before succeeding.

[8]Id. at 827.

[9]In New York State Association for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752 (E.D. N.Y. 1973) (popularly known as the "Willowbrook Case"). Judge Judd, after denying the existence of a constitutional right to treatment or habilitation for these profoundly retarded residents, determined that such residents had at least the same rights as prison inmates. At bottom, this was determined to be a tolerable living environment, including protection from assaults by fellow inmates or by staff.

[10]142 F.2d 443, 445 (6th Cir. 1944), cert. denied, 325 U.S. 887 (1945).

[11]One author has challenged the widely held view that prisoners necessarily lose rights by virtue of imprisonment itself. The necessity doctrine, he argues, is not as sweeping nor as categorical as one might first suppose. Putting aside political and empirical grounds, there is no reason in theory why the differences in social and material conditions between the inside and outside worlds cannot be diminished to the point where inmate rights, while confined, are not necessarily lost.

[11] (continued)
See Gochnaver, Necessity and Prisoners' Rights, 10 N. Eng. on Crim. & Civil Confinement 276 (1984).

[12] Meachum v. Fano, 427 U.S. 215 (1976) is a good example of this dichotomy. Justice White, writing for a majority in denying inmates a constitutional right to procedural safeguards prior to a "punitive transfer," takes the view that not all grievous losses suffered by inmates are constitutionally protected; the state, with impunity, may imprison an inmate in any prison it maintains, regardless of varying degrees of security; and, in general, a state may confine and subject to its rules a convicted person so long as the conditions of confinement do not otherwise violate the Constitution.

Justice Stevens, in dissent, argued "that even the inmate retains an unalienable interest in liberty -at the very minimum the right to be treated with dignity -which the Constitution may never ignore." This posture allowed Justice Stevens, and two other Justices, to conclude that despite the content of state law a prisoner whose transfer results in a grievous loss is entitled to some due process safeguards. Id. at 234 (Stevens, J., dissenting).

[13] 452 U.S. 337 (1981). Thornberry, et al. uncovered litigation concerning overcrowding in 37 states, the District of Columbia, Puerto Rico, and the Virgin Islands. See supra Thornberry, Chapter I, note 27.

See also Smolla, Prison Overcrowding and the Courts: A Roadmap for the 1980's, 1984 U. Ill. L. Rev. 389 for a study of post-Rhodes litigation showing a surprising number of inmate victories.

[14] J. Gobert and N. Cohen, Rights of Prisoners 13 (1981).

[15] Id. at 12, 13.

[16] The "hands-off" doctrine is not so much a doctrine as a description of judicial reluctance to accept and decide prison cases.

[17] See, e.g., Houchins v. KQED, Inc., 438 U.S. 1 (1978).

[18] Annual Report on the State of the Judiciary (transcript), by Chief Justice Warren E. Burger, 69 A.B.A.J. 442 (1983).

[19] 433 U.S. 119 (1977).

[20] Id. at 123, 124.

[21] Id. at 132.

[22] See, e.g., Procunier v. Martinez, 416 U.S. 396, 413-14 (1974).

[23]107 S.Ct. 2254 (1987).

[24]107 S.Ct. 2400 (1987).

[25]Safely, 107 S.Ct. at 2265. Such a right will usually be traced to the Due Process Clause and characterized as substantive due process in contrast to the procedural due process (e.g. notice, hearings, burden of proof, etc.) we normally associate with that clause.

The right to marry also might be grounded in the First Amendment as an aspect of the "free exercise clause." The Court did not further expand on the constitutional basis for its view of marriage as a fundamental right.

[26]The exceptions allowed inmates to correspond with other inmates who also were relatives and to correspond over legal matters. See Safely, 107 S.Ct. at 2263-64.

[27]Safely v. Turner, 586 F. Supp. 589, 591 (W.D.Mo. 1984).

[28]416 U.S. 396 (1974).

[29]Safely v. Turner, 777 F.2d 1307, 1310 (8th Cir. 1985).

[30]Safely, 107 S.Ct. at 2261.

[31]Id. at 2264. The Court did elaborate on the analytical framework to be used in measuring "reasonableness." A four-prong test was announced:

(1) Is there a valid, rational connection between the prison regulation and the government's legitimate interest?

(2) Are there alternative means open to the inmate to exercise that right?

(3) What impact will accomodation of the asserted right have on other inmates and prison personnel?

(4) The absence of ready alternatives will be taken as evidence of reasonableness. Id. at 2261-62.

Given the limited purposes of this section of this work, a detailed analysis of the above criteria is not warranted. There are, however, deep-rooted problems immediately apparent. For example, if the first point simply means a logical connection between the end (security) and the means, then—as Justice Stevens argues in a separate opinion—imaginative wardens and deferential courts will nearly always find that connection.

On "alternative means," the crucial problem relates to what is an alternative. In Turner, there were no alternatives to writing to other Missouri inmates but not all correspondence was cut off. In O'Lone, we shall see that this point is even more dramatic.

The fourth point is quite puzzling in that it appears to be a statement of "least drastic alternatives" analysis, but Justice

[31] (continued)
O'Connor indicates that it is meant only as an aspect of the overall reasonableness analysis and not meant to be determinative.

[32] Safely, 107 S.Ct. at 2265. Justice O'Connor added a cryptic note that the "strict scrutiny" standard of review might apply if the interest of nonprisoners was directly involved in the decision. That issue was not reached since the regulation fell under the less demanding reasonableness test.

[33] Id.

[34] Id. at 2266-67.

[35] Id. The Court cited with approval the federal prison rules which take the position described in the text. See 28 CFR Sec. 551.10 (1986).

[36] The above is simply another way of phrasing the strict scrutiny test. It must be emphasized that the discussion in the text does not relate First Amendment rights of non-inmates, namely publishers, free world correspondents. There is good reason to believe that the Martinez test survives for non-prisoners. See, e.g., Abbot v. Meese, 824 F.2d 1166 (D.C. Cir. 1987), cert. granted, 108 S.Ct. 1572 (1988).

[37] O'Lone v. Shabazz, 107 S.Ct. 2400 (1987).

[38] See supra note 31.

[39] O'Lone, 107 S.Ct. at 2406.

[40] Discussed in detail at Chapter III, A.1

[41] 475 U.S. 312 (1986).

[42] Id. at 320 (citation omitted).

[43] Ingraham v. Wright, 430 U.S. 651 (1977) held that public school students who are subjected to corporal punishment are not protected by the Eighth Amendment's prohibition against cruel and unusual punishment. See also Bell v. Wolfish, 441 U.S. 520 (1979).

[44] See Ex parte Hull, 312 U.S. 546 (1941).

[45] 393 U.S. 483 (1969).

[46] Discussed in Wolff v. McDonnell, 418 U.S. 539, 577-80 (1974). The Court extended the Johnson v. Avery rationale to civil rights actions.

[47] 430 U.S. 817 (1977).

[48]A correction system which opts for providing access to adequate law libraries also may be required to provide assistance to those inmates not able to comprehend legal material. In Hooks v. Wainwright, 536 F. Supp. 1330 (M.D. Fla. 1982) a federal district found that given the high rate of illiteracy among Florida's inmates, it would be dishonest to conclude that meaningful access to the courts would be provided only with law libraries. This federal court ruling required some access to attorneys in addition to the availability of libraries.

The district court's decision was reversed at 775 F.2d 1433 (11th Cir. 1985), cert. denied, 479 U.S. 913 (1986).

[49]See O'Bryan v. County of Saginaw, Mich., 437 F. Supp. 582 (E.D. Mich. 1977).

[50]429 U.S. 97 (1976).

[51]Id. at 107.

[52]J. Gobert & N. Cohen, Rights of Prisoners 63 (1981).

[53]See 42 U.S.C. Sec. 1983. See also the excellent article by Turner, When Prisoners Sue: A Study of Prisoner Section 1983 Suits in the Federal Courts, 92 Harv. L. Rev. 610 (1979).

[54]Procunier v. Navarette. 434 U.S. 555 (1978). See also Ward v. Johnson, 690 F.2d 1098 (4th Cir. 1982) extending judicial-type immunity to prison officials when serving on a disciplinary tribunal.

[55]474 U.S. 193 (1985).

[56]Id. at 203-04.

[57]Id. at 207 (citation omitted).

[58]474 U.S. 327 (1986), aff'd., 474 U.S. 327 (1986). There were several concurring opinions in this case.

[59]Recall that it is necessary to ground a Sec. 1983 claim either in the Constitution or federal law. Without an available federal statute, the inmate sought to shoe-horn his claim into the Due Process Clause.

[60]Daniels v. Williams, 474 U.S. at 328.

[61]Id. at 334.

Id. at 344.

[63]Id. at 355 (Blackmun, J., dissenting) (citations ommitted).

[64] N.J. Stat. Ann. Sec. 59:5-2(b)(4).

[65] In a case involving a fight in the District of Columbia Jail, an injured inmate received a $75,000 jury verdict. On appeal, the reviewing court held that the "deliberate indifference" standard -- as opposed to "wanton and malicious" was properly invoked. Morgan v. District of Columbia, No. 85-5331, 85-5709, slip op. (D.C. Cir. July 21, 1987).

[66] Sterling v. Cupp, 290 Ore. 611, 625 P.2d 123 (1981).

[67] 441 U.S. 520 (1979)

[68] Id. at 558 (citations omitted).

[69] See also Lanza v. New York, 370 U.S. 139 (1962) for dicta supportive of the inapplicability of the Fourth Amendment to prison cells.

[70] See Cohen & King, Drug Testing and Corrections, 23 Crim. L. Bull. 151 (1987) for a review of the Fourth Amendment and drug testing of inmates, visitors, and employees.

[71] More recently, Hudson v. Palmer, 468 U.S. 517 (1984) and Block v. Rutherford, 468 U.S. 576 (1984), made it absolutely clear that inmates simply have no Fourth Amendment rights in connection with their possessions or their cell.

In Griffin v. Wisconsin, 107 S.Ct. 3164 (1987), the Court went so far as to uphold a warrantless search on less than probable cause of a probationer's home. The product of the search--a weapon--was used to support a new conviction and not simply a revocation where more relaxed procedures generally apply.

There is an interesting question concerning an inmate's claim to privacy surrounding the content of his medical records when such records are maintained by fellow inmates. See Ruiz v. Estelle, 503 F. Supp. 1265, 1323 (S.D. Texas 1980), mot. to stay granted in part and denied in part, 650 F.2d 555 (5th Cir. 1981), aff'd in part and reversed in part, 679 F.2d 1115 (5th Cir. 1982), opinion amended in part and vacated in part, and rehearing denied, 688 F.2d 266 (5th Cir. 1982), cert. denied, 460 U.S. 1042. See also Ruiz v. Estelle, 553 F. Supp. 567 (S.D. Texas, 1982) on the award of attorney fees.

[72] Custodial interrogation, of course, is the essential condition for the application of Miranda rights.

[73] This is exactly what was found in United States v. Henry, 447 U.S. 264 (1980).

[74] 445 U.S. 480 (1980).

[75]418 U.S. 539 (1974).

[76]459 U.S. 460 (1983).

[77]Loss of good-time credits was clearly at issue, with confinement in a disciplinary cell less obviously at issue. Wolff procedures are now generally understood to apply to charges of "serious misconduct." Serious misconduct, in turn, is determined by the nature of the sanction. In New York, "keeplock" is now considered a sufficiently onerous sanction to trigger Wolff-like procedures and keeplock is simply confinement in one's own cell even for a day. See Powell v. Ward, 487 F. Supp. 917 (S.D. N.Y. 1980).

[78]Wolff, 418 U.S. at 555-56 (citation omitted).

[79]This analytical approach is of relatively recent origin. In the very recent past, where government activity caused a serious or grievous harm, it was assumed that due process applied, leaving only the question of what process was due. See, e.g., Bell v. Burson, 402 U.S. 535 (1971).

[80]See J. Nowak, R. Rotunda & J. Young, Constitutional Law 449 (1978).

[81]Wolff, 418 U.S. at 557

[82]Id. at 563.

[83]Id. at 566.

[84]Id. at 570.

[85]Id. at 570-71.

[86]Id. at 567.

[87]For an excellent overview of the Wolff issues, see Babcock, Due Process in Prison Disciplinary Proceedings, 22 Bost. C.L. Rev. 1009 (1981).

[88]471 U.S. 491 (1985).

[89]Id. at 497.

[90]In New York, for example, the denial must be supported with a written contemporaneous reason.

Curiously, the Court's decision to allow reasons to be given in a subsequent law suit seems contrary to its general policy of discouraging inmate litigation.

[91]472 U.S. 445 (1985).

[92]Id. at 457.

[93] See People ex rel. Vega v. Smith, 66 N.Y.2d 130 (1985) for an elaboration of what evidence suffices under New York's self-imposed, more stringent "substantial evidence" rule.

[94]427 U.S. 215 (1976).

[95]427 U.S. 236 (1976), cert. denied, 431 U.S. 967 (1977).

[96]See S. Kranz, Model Rules and Regulations on Prisoners' Rights and Responsibilities 96-100 (1973).

[97]429 U.S. 78 (1976).

[98]427 U.S. at 224 (emphasis in original).

[99]429 U.S. 78, 88 n.9 (1976) (emphasis added).

[100]Cf., Withers v. Levine, 449 F. Supp. 473 (D. Md. 1978), aff'd, 615 F.2d 158 (4th Cir. 1980), cert. denied, 449 U.S. 849 (1980) involving the homosexual assault of an inmate by his cellmate when the cell assignment was made without regard to known or available information on point.

[101]In McKinnon v. Patterson, 568 F.2d 930 (2d Cir. 1977), cert. denied, 434 U.S. 1087 (1978), it was decided that Wolff applied to "substantial deprivations," which include all forms of punitive segregation ranging from "keeplock" to special housing units to "drycells." See also Wright v. Enomoto, 462 F. Supp. 397 (N.D. Cal. 1976), aff'd, 434 U.S. 1052 (1978).

[102]459 U.S. 460 (1983).

[103]Id. at 471.

[104]Id. at 476.

[105]Id. at 480-81.

[106]Id. at 482-83.

[107]Id. at 484.

[108]Id.

[109]Id. at 488.

[110] J. Ely, Democracy and Distrust: A Theory of Judicial Review 19 (1980).

[111] 459 U.S. at 469.

[112] Lee v. Washington, 390 U.S. 333 (1968).

[113] See Pell v. Procunier, 417 U.S. 817 (1974).

III. THE RIGHT TO TREATMENT

A. Treatment: In General

This Chapter is central to an overall coverage of the legal rights of the mentally disordered offender. Consequently, it details the many issues encompassed by treatment and uses extended quotations from legal material. The quoted material provides specific facts and details of judicial decrees and orders to help the reader assess the legal health of individual prisons or prison systems.

The key to this Chapter is, of course, whether or not a prison inmate has a legal right to treatment.[1] Statements made earlier in this work should leave no doubt that Estelle v. Gamble[2] established that prisoners have an Eighth Amendment right to treatment for physical ailments and subsequent federal court decisions, Bowring v. Godwin[3] being an important example, find no reason to distinguish physical illnesses from mental illnesses on the question of required care.

J.W. Gamble, while an inmate in the Texas prison system, was injured while performing a prison work assignment. He complained of back pains because a heavy bale of cotton fell on him. Gamble was seen by doctors and medical assistants, examined, and given some medication. His complaint was not that his medical needs were wholly ignored. Rather he complained that he received inadequate or inappropriate care, that some medical orders were not observed, and that his subsequent punishment -- in effect, for malingering -- was illegal.

The Court was asked to find that Texas's inadequate medical care violated the Eighth Amendment. The Court refused to so hold on these facts, but it did decide that the deliberate indifference to the serious medical needs of prisoners constitutes unnecessary and wanton infliction of pain. This is true whether the indifference is manifested by doctors in their response to the prisoner's needs or by prison guards intentionally denying or delaying access to medical care.[4]

Elaborating on this constitutional obligation to provide medical care, Justice Marshall explained the meaning of deliberate indifference:

> an inadvertant failure to provide adequate medical care cannot be said to constitute 'an unnecessary and wanton infliction of pain' or to be 'repugnant to the conscience of mankind.' Thus, a complaint that a physician has been negligent in diagnosing or treating a medical condition does not state a valid claim of medical mistreatment under the Eighth Amendment. Medical malpractice does not become a constitutional violation merely because the victim is a prisoner. In order to state a cognizable claim, a prisoner must allege acts or

> omissions sufficiently harmful to evidence deliberate indifference to serious medical needs. It is only such indifference that can offend 'evolving standards of decency' in violation of the Eighth Amendment.[5]

While Estelle clearly establishes the inmate's constitutional right to medical care along with the "deliberate indifference" standard as the legal duty, it leaves several key questions unanswered. It is unclear what the Court meant by "serious medical needs," whether mental disorders were included, and what specific acts or omissions would meet the deliberate indifference standard.[6]

In Bowring v. Godwin a federal court of appeals confidently asserted that "we see no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart."[7] The court went on to state:

> We therefore hold that Bowring (or any other prison inmate) is entitled to psychological or psychiatric treatment if a physician or other health care provider, exercising ordinary skill and care at the time of observation, concludes with reasonable medical certainty (1) that the prisoner's symptoms evidence a serious disease or injury; (2) that such disease or injury is curable or may be substantially alleviated; and (3) that the potential for harm to the prisoner by reason of delay or the denial of care would be substantial.[8]

Bowring arose in a somewhat unusual fashion. The inmate argued that he had been denied parole by the Virginia Parole Board, in part, because a psychological evaluation indicated he might not successfully complete a parole period. Bowring, not surprisingly, then argued that if that was the reason for denial of parole, then the state must provide him with psychological diagnosis and treatment so that ultimately he might qualify for parole.

The court did not decide that inmates have a right to rehabilitation -- a claim consistently rejected by the judiciary when raised in isolation -- although it did express the belief that failure to attend to an inmate's psychological illness thwarts the purported goal of rehabilitation and jeopardizes an inmate's ability to assimilate into society.[9]

The case was remanded for a hearing to determine if the inmate was suffering from a qualified mental illness. At the hearing the trial judge found that the inmate did not suffer from such an illness. The Virginia Parole Board has since been advised not to use psychological impairment as a reason to deny parole.[10]

1. "Deliberate Indifference" Standard

Since the decisions in Estelle and Bowring many courts have grappled with the precise meaning of "deliberate indifference."[11] Estelle itself marked out the general territory: deliberate indifference requires something more than poor judgment, inadvertance or failure to follow the acceptable norms for practice in a particular geographic area. On the other hand, deliberate indifference is not coextensive with the intentional inflication of needless pain and suffering.

In Guglielmoni v. Alexander,[12] in the context of a suit for damages based on the suicide of the plaintiff-mother's son, the court wrote:

> The 'deliberate indifference' standard implicitly requires assessment of states of mind in order to determine the constitutional adequacy of inmate medical care. Isolated negligence or malpractice is insufficient to state an Estelle claim. Deliberate indifference exists when action is not taken in the face of a 'strong likelihood, rather than a mere possibility,' that failure to provide care would result in harm to the prisoner.[13]

Guglielmoni elaborated on a problem faced earlier in the Second Circuit: the relationship between a single incident of denied, delayed or improper care and a series of such incidents closely related in time.[14] Today there is little doubt that a single dramatic incident as well as a series of less dramatic, but cumulatively painful, incidents may meet the "deliberate indifference" standard.

Wellman v. Faulkner,[15] involving the Indiana State Prison at Michigan City, recites an increasingly popular litany for understanding "deliberate indifference":

> As a practical matter, 'deliberate indifference' can be evidenced by 'repeated examples of negligent acts which disclose a pattern of conduct by the prison medical staff' or it can be demonstrated by 'proving there are such systemic and gross deficiencies in staffing, facilities, equipment, or procedures that the inmate population is effectively denied access to adequate medical care.'[16]

In dealing with a successful challenge to the South Dakota prison system, a federal district court judge went a step beyond the quotation from Faulkner, adding: "A court need not wait 'until an inmate bleeds to death' or until institutional health care deficiencies reach catastrophic proportions in order to exercise its declaratory or injunctive powers to cure an otherwise inadequate health care system."[17]

The metaphors employed in the South Dakota case are illustrative of a very difficult problem. The "deliberate indifference" standard is not intended to serve as a springboard for basic reform or as a straightforward basis for importing community medical standards into the prison world. On the other hand, courts do not -- and should not -- wait until a system is littered with physical and psychological wrecks before finding deliberate indifference.

By now it should be clear that deliberate indifference is a legal standard of care based on constitutional norms. As such it is not easily disconnected from specific fact situations. While those fact situations are developed later in this work,[18] one fact pattern will be mentioned here to illustrate the point.

A successful challenge to the Occoquan facilities of the Lorton Correctional Complex included a sweeping challenge to medical and psychiatric care.[19] Judge Green noted that:

> The Court makes special note of the poor medical services at Occoquan because of the added burden that the overcrowding places on these already inadequate services, in addition to defendants' cavalier attitude about this unsatisfactory and life threatening state of affairs. While the Court is careful to rely on model correctional standards only insofar as they provide guidance, it is noteworthy, though not surprising, that defendants' medical experts concurred in most instances with plaintiffs' experts in concluding that the state of medical services at Occoquan is quite poor.
>
> The Court detects an attitude on defendants' part that the medical needs of their inmates are of little concern. The evidence is plentiful: haphazard record keeping; unlicensed dispensation of prescription medicines; insufficient availability of sick call; insufficient medical staff; confused management; a chronic shortage of dental and psychiatric staff; and a barely functioning emergency care system. The suffering that these deficiencies cause is needless, results in purposeless infliction of pain with no conceivable penological justification, and violates plaintiffs' eighth amendment rights.[20]

The factors noted by Judge Green are an important part of the overall framework within which either individual or systemic claims of deliberate indifference are decided. In order to succeed, an Estelle claim must demonstrate a shocking level of care or lack thereof in the individual

case; or the most outrageously primitive overall system (or more accurately, non-system). In the Occoquan decision the wholly deficient health care system was found to exist within a prison system that in nearly all respects violated the Eighth Amendment.

That situation, of course, represents the worst of all worlds for the inmates. Where a prison system is found generally deficient in a general conditions lawsuit -- as in the Occoquan decision -- then even a marginally acceptable health care system is likely to be swept over the edge into the pool of constitutional unacceptability.

2. "Serious Medical Needs" Standard

Writing in 1986 about civil commitment, one author stated, "there has been remarkably little consideration given to the kind and degree of illness that should be required before one is committed."[21] Where civil commitment law is essentially legislative in character, prisoners' mental health law is essentially judicially created. The courts, although possibly for different reasons, have been almost as reticent as the legislatures in addressing the threshhold question of what is a serious medical or psychiatric need.[22] Even where the courts have spoken, substantial uncertainty remains.

In Ramos v. Lamm, the court provided more of a description than a definition in stating that:

> A medical need is serious if it is 'one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention.'[23]

The initial reference to a physician's diagnosis simply transfers the actual decision-making process, while the reference to that which is "obvious" merely evades the problem.[24] In partial defense of the court, it should be noted that Ramos dealt with the Colorado State Penitentiary which housed 1350 inmates at the time. Experts estimated that 5 to 10 percent of those inmates were seriously ill and another 10 to 25 percent needed treatment.[25] At the time of trial, the regular mental health staff consisted of three civilians and two inmates, all five occupied more with clerical than with clinical work.[26] Given the expert testimony on the number of seriously ill inmates and the stark testimony on the absence of clinical assistance, then perhaps the unconstitutionality was so clear that no precise definition was needed.

What is or is not a serious illness is likely to be slugged out in the battle of experts at trial.[27] The trial court will utilize the term serious as a line-drawing norm and then require the experts to maintain a position on either side of the line.

Courts also properly focus on the functional aspect of the Estelle formulation: the unnecessary and wanton infliction of pain.[28] It is true that pain is a consequence of illness and can be known either through self-reporting or inference. Whatever the abstract merits of including pain in the formulation of "serious medical needs," Estelle has placed it there and it is a critical part of every administrator's and every court's consideration of when clinical services are required.

Beyond the basic line-drawing and the emphasis on pain, courts frequently state that the test is medical necessity and not simply what is desirable.[29] An inmate's statement that he was depressed was held not to require that the prison official to whom the statement was made schedule him for an appointment with a psychologist. Mere depression, said the court, is not a serious medical need.[30] In yet another case, the court held that inmates with behavioral and emotional problems did not suffer from serious mental illness.[31]

On the other hand, acute depression, paranoid schizophrenia and nervous collapse have been identified as disorders sufficiently dramatic and painful to qualify as serious medical needs.[32] After stating that psychiatric intervention clearly is necessary where an inmate is contemplating suicide or displays psychiatric symptoms to such a degree that he presents a risk of harm to himself or others, the court stated: "An inmate experiencing significant personality distress in the form of depression or psychotic symptoms to the degree that he has lost contact with reality not only requires but is amenable to psychiatric intervention and treatment."[33]

The few authors who have addressed the definitional problem have not been able to advance the matter much beyond the typically descriptive efforts of the courts. One ambitious writer lists five categories of medical needs which he believes qualify for care under the Eighth Amendment:

> (1) highly contagious or dangerous conditions or illnesses which a state statute clearly mandates that prison officials treat,
>
> (2) injuries which are both severe and obvious,
>
> (3) professionally diagnosed mental or physical illnesses or injuries which are either curable or relievable, and threaten substantial harm when left untreated,
>
> (4) chronic disabilities and afflictions, and
>
> (5) conditions or illnesses which result in serious injury when requests for their treatment are denied.[34]

The same author suggests that the prisoner least likely to have an illness which is constitutionally acceptable as "serious" is a prisoner with a temporary, latent illness that goes undiagnosed and will not result in any significant lasting injury if left untreated.[35] By failing to focus on the pain component of Estelle, the author has not closely adhered to the Estelle mandate.

Based on my own observations and discussions, it does appear that the inmate whose mental illness is characterized by passivity and withdrawal is the one who may most often be overlooked. This illness may indeed be a severe psychosis which causes much pain and suffering and yet the equally ill inmate who is aggressive and acting out is likely to be viewed as more "eligible" for care. Returning to a point made at the outset of this Chapter, the law of the mentally ill prisoner is essentially judicially made. The courts, in turn, remain strongly influenced by the opinions of mental health care professionals in determining whether an inmate has a "serious" need. In trying to describe what is "serious mental illness" for constitutional purposes, I have found myself using an analogy: prisoners with the psychiatric equivalent of a compound fracture of the leg where even a layman would insist on the need for care. "Broken psyches" and broken legs require care.

Other writers construct a somewhat different description, arguing that only "blatant, abnormal behavior" qualifies for constitutionally mandated care.[36]

Whatever else is meant by a serious mental illness or disorder, it is clear that the Court in Estelle meant to eliminate the minor ailments and the mild depressions and anxieties many of us experience. The focus is on pain, and most clearly on such factors as agitation, manifest psychopathology (hallucinations or delusions), deep depression, personal neatness, social interaction, and disorientation.

Even with the apparent "broken psyche" or "blatantly, abnormal behavior," we face a dilemma exacerbated by the prison milieu. Take a hypothetical male prisoner who is observed hoarding his own feces, talking to himself, asking to wear lipstick for the first time, and so on. Obviously, this is strange behavior but is it a manifestation of mental illness? Is this inmate challenging the system in his own way? Is he a "wise guy" looking for a transfer?

At a minimum, this is the type of behavior that calls for a professional diagnosis. It should not be assumed that this inmate is "mad" or "bad." And there could be no obvious challenge to a diagnosis of serious mental illness -- especially if the history was supportive -- and the prescription of treatment. By the same token, a contrary diagnosis would not be a priori unreasonable.

In dealing with an incarcerated child molester diagnosed as a pedophiliac who was claiming deliberate indifference to his serious medical needs, the Fifth Circuit stated:

> The complaint must allege enough facts of prior psychiatric illness or treatment, of expert medical opinion, or of behavior clearly evincing some psychiatric ill to create a reasonable ground to believe that psychiatric treatment is necessary for his continued health and well-being. Woodall's allegations meet this initial burden. He has alleged prior hospitalization and treatment, a medical diagnosis and prescribed manner of treatment, and confirmation by the Parish Prison's staff psychiatrist. With this [sic] kind of allegations, the district court should not have dismissed Woodall's complaint...."[37]

When the heat of the courtroom battle has cooled and the experts have returned to their respective corners, an interesting new encounter often begins. If the inmate's successful legal attack was focused on the mental health care system -- as opposed to an individual complaint of inadequate care or a deliberately indifferent omission -- the trial judge is likely to request the parties to prepare a mental health service plan. Such a plan must include reasonable estimates of the target population -- the seriously mentally ill -- as well as a service delivery plan and schedule. Obviously the target population cannot be estimated without some working definition of "seriously mentally ill."

The State of Michigan has been involved in protracted litigation over general conditions in its prisons.[38] One of the more perplexing areas of the litigation has been the issue of improving mental health services to the over 20,000 inmates in that system. The Michigan Department of Corrections has adopted the following definition of serious mental illness:

> Serious mental illness (or severe mental disorder) means a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.
>
> A serious/severe mental state or condition (1) is manifested by substantial discomfort, pain, and/or disability that cannot be legitimately ignored by appropriate clinical staff, (2) requires a mental health assessment, diagnostic evaluation, treatment planning and disposition planning; and (3) is generally associated with

> (a) the inability to attend to and effectively perform the usual/necessary activities of daily living, (b) extreme impairment of coping skills, rendering the patient exceptionally vulnerable to unintentional or intentional victimization and possible mismanagement and/or (c) behaviors that are dangerous to self or others.
>
> Serious mental illness/severe mental disorder includes psychiatric conditions/states that span the entire diagnostic spectrum of DSM-III and is not limited to specific diagnosis.[39]

The proponents of this definition note that it is drawn from the American Psychiatric Association's, DSM-III as modified by language from the Michigan Mental Health Code. Further, they note that the diagnosis is only one factor in a treatment decision. Other factors would include the severity of the symptomatology, the inmate's mental state, and the availability of external resources.

It is not my intent to wholly endorse the above definition. It does, however, represent one of the more comprehensive and manageable definitions yet encountered and for those who must continue to deal with the issues in this book, it is at least an excellent point of departure.

Before moving on to a discussion of classification issues, it is appropriate to deal with a few thoughts and items about epidemiological studies used to determine the number of seriously mentally ill prisoners. As Henry Steadman and his colleagues recently noted, "'In the United States there is a paucity of empirical studies on the occurence of mental disorders in prisons.' In the seven years since James and his colleagues wrote this, little has changed in the amount of available research, while prison populations have burgeoned and cries for mental health services for inmate populations have become rampant."[40]

The Michigan litigation referred to earlier resulted in an order that the Department of Corrections prepare an epidemiological study. The University of Michigan's School of Public Health collaborated with Michigan State University's Department of Psychiatry to produce what they termed, "the most comprehensive and methodologically sophisticated psychiatric epidemiologic study ever conducted on a prison population."[41]

Overall, the study concluded that 19.7 percent of the prison population were severely impaired; 47.5 percent were moderately impaired; and only 32.8 percent had minimal or no impairment.[42]

A study of New York's prison inmates found that 8 percent have severe mental disabilities and another 16 percent have significant mental disabilities.[43] Inmates placed in the "severe" category scored the

equivalent of the average long stay patient in New York State mental hospitals. Those in the "significant" category obviously are not so impaired but their psychiatric and functional disabilities were said to call for periodic mental health services. Thus, at least 22 percent of New York's inmates would appear to meet the Estelle criteria.[44]

It is evident from the above discussion that the term serious mental disease or illness is not clearly or consistently defined by the courts, correction agencies or researchers. This is not a disabling problem if we keep in mind the fact that different definitions may be used depending on one's objective. That is, in planning for mental health services and arguing for a given level of funding, agencies may take a broad view of illnesses calling for treatment. Courts may rest content with a descriptive or metaphorical approach, depending on counsel and experts to provide specificity. Researchers may be more concerned with diagnostic accuracy than with Estelle's constitutional criteria.

One thing seems certain: in jurisdictions where the question remains open or unresolved, a definition of serious mental illness (along the lines of the Michigan approach) should be adopted by statute or regulation. In addition, a corrections department that cannot give a good answer to the question "How many seriously mentally ill prisoners do you have?" is inviting a court to mandate an answer.

B. Classification Requirements

Upon entering a prison, every inmate undergoes some kind of "sorting out," or classification, process, ranging from highly sophisticated, multi-factor screening to rather uncomplicated prison assignments based on the instant crime, age of the inmate, and prior record.[45] As was discussed in Chapter Two, the Supreme Court has made it clear that prison inmates have no constitutionally based procedural rights in the reception-classification process. On the other hand, an inmate's undoubted right to a non-life-threatening environment and to treatment for at least serious mental disorders does create some obligations and rights.[46]

This topic will be approached first by considering the major cases finding prison classification systems constitutionally deficient. Next, we will examine the cases upholding the challenged system and conclude with an overview of the area.

Ruiz v. Estelle,[47] a landmark overall prison conditions case, is also one the more significant judicial decisions on classification. Judge Justice found that nearly all of the conditions and practices of the Texas Department of Corrections (TDC) were constitutionally defective. He described the TDC classification system as follows:

> A variety of tests are administered to incoming inmates to determine intelligence, educational achievement, and psychological stability.

> Nonetheless, these tests have not been adequate to screen or diagnose mentally disturbed inmates. The Minnesota Multi-phasic Personality Inventory (MMPI) is the sole test administered to measure personality abnormalities; however, it cannot be understood by persons with less than a sixth grade reading ability, and it is therefore, useless in evaluating the large number of TDC inmates who read at lower levels. Other tests are administered which measure general employment aptitudes and educational achievement levels, but they are not designed for use by persons whose dominant language is other than English. It follows that those inmates who primarily speak Spanish cannot be effectively tested. Further more, Dr. Jose Garcia, Chief of Mental Health Services at TDC, testified that all of the tests were culturally and racially biased.[48]

To make matters worse for Texas, a member of the TDC Classification Committee admitted that the Committee did not consider MMPI test results because only a handful of their personnel knew how to analyze them. As a consequence the results were merely "filed."[49]

The court determined that in order to meet basic minimum standards for mental health treatment, among other things, "[t]here must be a systematic program for screening and evaluating inmates in order to identify those who require mental health treatment."[50]

<u>Pugh v. Locke</u>[51] involved a major challenge to the constitutionally vulnerable Alabama prison system. The classification system -- or more accurately, the lack thereof -- was described as follows:

> There is no working classification system in the Alabama penal system....Although classification personnel throughout the state prisons have been attempting to implement a wholly new classification process established in January, 1975, understaffing and overcrowding have produced a total breakdown of that process....Prison officials do not dispute the evidence that most inmates are assigned to the various institutions, to particular dormitories, and to work assignments almost entirely on the basis of available space. Consequently the appreciable percentage of inmates suffering from some mental disorder is unidentified, and the mentally disturbed are dispersed throughout the prison population without receiving treatment.[52]

The court then ordered the state to prepare a classification plan for all inmates incarcerated in the Alabama penal system:

> 2. The plan to be submitted to the Court shall include:
>
> (a) due consideration to the age; offense; prior criminal record; vocational; educational and work needs; and physical and mental health care requirements of each inmate;
>
> (b) methods of identifying aged, infirm, and psychologically disturbed or mentally retarded inmates who require transfer to a more appropriate facility, or who require special treatment within the institution; and
>
> (c) methods of identifying those inmates for whom transfer to a pre-release, work-release, or other community-based facility would be appropriate.
>
> 3. The classification of each inmate shall be reviewed at least annually.[53]

Barnes v. Government of Virgin Islands[54] involved a constitutional challenge to the archaic prison system of the Virgin Islands. Calling the classification system a "glaring deficiency," the court found that the lack of pertinent data about the inmate made it impossible to develop a rational penal program.[55]

To remedy the situation, the court ordered that:

> A mental status examination should be given as part of the intake and classification procedure. If at that time or any time subsequent thereto, the psychiatrist believes that proper mental health care cannot be provided for the inmate at the facility, the inmate shall be transferred to an institution which is adequate to deal with his problems.[56]

The Puerto Rican prison system was the subject of a devastating legal attack in Feliciano v. Barcelo.[57] In condemning the prison system, the court was urgently concerned with the unknown, but believed to be large, number of psychotic inmates. It attributed much of the blame for this chaos on an inadequate screening or classification system in which guards, who had no training in the area, carried out what evaluations there were.[58]

In addition to finding many aspects of the Puerto Pican prison system unconstitutional, the district judge entered a detailed order concerning classification.[59]

Laaman v. Helgemoe involved yet another constitutional challenge to overall prison conditions, this time aimed at the New Hampshire State Prison (NHSP).[60] At NHSP, a new inmate passes through "quarantine," a 14-day period during which he is supposed to undergo, among other things, an initial classification interview, a complete psychological evaluation, and a social work-up. Although most of the inmates who testified before the court had been visited and interviewed by personnel from the Mental Health Division, only three had actually been tested. Only one had actually seen the psychiatrist.[61] The only way mentally ill inmates could receive treatment at NHSP was to apply to, be screened and then accepted by the treatment unit. The court thought that the difficulty in gaining access to appropriate mental health care presented one of the most distressing aspects of NHSP.[62] To remedy this situation, the court entered an even more detailed order than was entered in the decision involving Puerto Rico.[63]

In Palmigiano v. Garrahy, prisoners and pretrial detainees challenged conditions at the Rhode Island Adult Correctional Institutions (ACI).[64] After a recitation of problems caused by a deficient classification system, which parallels the problems described in the previous cases, this court took a somewhat different approach.

Chief Judge Pettine found it clear that prison officials had never given heed to the authoritative expressions of the Rhode Island legislature as embodied in two statutes. The first expresses the policy that "efforts to rehabilitate and restore criminal offenders as law-abiding and productive members of society are essential to the reduction of crime."[65] The second requires prison officials "to furnish the means as shall be best designed to effect ... rehabilitation;"[66] a requirement that they failed to fulfill.

It was also determined that the classification system failed to comply with yet another statute requiring that each inmate be evaluated as to his proper security status and for such medical or rehabilitative care as may be proper.[67] Parenthetically, we may note that the heavy reliance on state law is unusual in a federal decision.

Nine years after the first decision in Palmigiano, Judge Pettine, by now Senior District Judge, lamented, "[i]t is discouraging to find that virtually the same conditions still exist nine years later."[68] The judge severely criticized the lack of mental health protocols, suicide prevention practices, and the tracking of psychotic patients, and concluded that "there is no smoothly functioning health delivery system."[69]

Showing remarkable restraint given the nine year hiatus, the judge merely ordered the state to develop a compliance plan within sixty days.[70]

A recent case involving the District of Columbia's Lorton Correctional Complex emphasized the importance of classification and screening from the dual aspects of security and services.[71] Judge Green wrote:

> Classification of inmates is essential for prison security. One critical function of classification is the efficient identification of violent, aggressive inmates and those in need of psychiatric care so they can be separated from the rest of the population....Mental health screening of all inmates should be performed by a trained mental health professional and appropriate psychological tests administered in order to identify those in need of psychological care. The experts agreed that the screening process conducted at the D.C. Jail [the point of entry to the Lorton Complex] is not successful in identifying all those suffering with serious mental disturbances. This is not surprising given that no formal mental health screening performed by trained mental health professionals is conducted there. At the same time, in place at Occoquan is only an informal system for screening inmates for psychological problems. The system, or lack thereof, is entirely inadequate.[72]

These cases make it abundantly clear that many federal courts are willing to scrutinize prison classification systems and to accept challenges to the most glaringly deficient. The more lacking the system, the more detailed the corrective solution likely to be judicially imposed on the system.

We should also note the facility with which some judges go beyond the strict confines of classification and, on occasion, order programs that more nearly resemble rehabilitative efforts than classification systems.

The detail provided in this Section is important, but the reader should not overlook the fact that the legal issues involved here are inmates' constitutional right to treatment for serious mental disorders and the concomitant need for some reasonably accurate, regularized way of spotting mental disorders as inmates enter the prison system.

Not all prison systems challenged on classification fared as badly as those just described. Where a regular screening and evaluation process is in place, adequately staffed with presumably qualified personnel, and where the information and conclusions are in fact used and then periodically reviewed, the courts are not likely to impose additional requirements.

Hendrix v. Faulkner[73] considered and rejected a constitutional challenge to the Indiana State Prison. The court described the acceptable conditions and practices as follows:

> Screening and assessment is first done at the RDC [Reception and Diagnostic Center] when inmates are first admitted to the Department of Correction. Psychological evaluations, histories and physical evaluations are performed on each inmate and compiled in a report. The packets randomly inspected had surprisingly thorough psychological or psychiatric reports. Some packets had both. Once an inmate arrives at the I.S.P., the Director of Classification reviews these reports and notifies the psychologist and counselors of past or present mental problems. Dr. DeBerry also receives a copy of the RDC report for his review. Mental health problems that surface during incarceration are observed and reported by all types of staff, other inmates, or the inmate himself. This screening and referral system was quite adequate.[74]

In Johnson v. Levine[75] the Maryland House of Corrections was found to be unconstitutionally overcrowded but classification procedures were upheld. The classification system was briefly described as follows:

> Classification activities and offices are located in a building which adjoins the South Wing. The classification staff includes two supervisors, fourteen counselors and two full-time psychologists. These figures result in an average caseload per counselor of 120.[76]

In conclusion, there is little doubt that a prison system's initial diagnostic-classification system implicates an inmate's right to treatment for serious mental and physical disorders as well as the right of all inmates to a non-life-threatening environment.[77] There must be acceptable tests and other evaluative devices that are racially unbiased and effective given the characteristics of the inmate population. Where psychologists or psychiatrists are involved in the classification process, as opposed to wholly untrained, unqualified personnel, courts are more inclined to validate the system.

A disorganized system that cannot show consistent development, use, and review of classification information and conclusions is vulnerable to legal challenge. It also appears that utilization of dormitory housing and having a mixed population raises judicial demands concerning adequate classification and screening.

C. Treatment: In Detail

Having established that inmates have a constitutional right to treatment which, in turn, creates an ancillary right to some form of initial (and subsequent) classification/diagnosis, we turn now to a detailed review of treatment as considered in the leading cases on point. Before undertaking that exercise, however, a cautionary word concerning treatment is in order.

1. Definition

There are fundamental conceptual, definitional, and empirical questions about treatment that rarely are addressed by the courts. For example, is there treatment if there simply is some regular exchange between a person labelled client or patient and another person labelled mental health professional? Is there treatment in the absence of one or both of these persons? Is treatment descriptive of the process or is it the end product? If it is more process than end -- and that seems generally acceptable -- then what are the aims of treatment? Cure? Relief of suffering? Amelioration?

If it is agreed that treatment is a process of intervention within a model which emphasizes healing-relief of suffering or pain, and that the presence of a mental health professional implies, but does not guarantee, treatment, then further questions arise. In the legal context, do we assess the availability and efficacy of treatment by a qualitative or by a quantitative approach?

Rouse v. Cameron, the landmark right-to-treatment case, although involving an insanity acquittee, fashioned a three-factor, qualitative approach to the treatment question:

(1) whether the hospital (we might substitute prison) has made a bonafide effort to cure or improve the patient.
(2) whether the treatment given the patient was adequate in the light of present knowledge.
(3) whether an individual treatment plan was established initially and updated periodically thereafter.[78]

Another landmark case, Wyatt v. Stickney,[79] sought to avoid the subjectivity of Rouse by employing the objective standards approach. These standards, often expressed in terms of staff-patient (or staff-inmate) ratios, seek to guarantee access to adequate levels of humane and professional care.[80]

Neither the subjective nor the objective approach fastens on "cure" as the sole objective of treatment and neither approach articulates a preference for a particular modality of treatment. Perhaps the reader has noted the ease with which this text has moved from the basic question of what is treatment to the question of assessing the adequacy of

treatment within the legal context of a right to treatment. That type of unannounced transition characterizes a very common approach used by the courts as well. The independent questions of what is treatment, is the questioned treatment adequate, and what is the treatment modality too often are dealt with as though they were a single question.

We should be grateful that courts do not express binding preferences for one type of treatment over another.[81] However, courts do, and in my judgment should, express skepticism when presented with certain fact situations: where a simple regimen of room or ward confinement is described as milieu-therapy; when housekeeping chores become work-therapy; and when a kick in the pants is termed physical-therapy. I strongly suggest that readers beware of the hyphen and adopt a healthy skepticism about the manipulative potential of clinically-oriented terms.

As the ensuing material unfolds it will become clear that courts favor an objective approach in measuring the adequacy of treatment. It will also become painfully evident that as deficient as the available treatment programs are for the mentally ill, the mentally retarded inmate is almost totally ignored. When this problem is recognized it seems to be simply submerged in the judicial orders issued to improve various state facilities.

Finally, the reader should try to distinguish the type of treatment rights spawned by Estelle from the earlier, more expansive type of treatment claims that equated treatment with efforts to achieve personal growth, a satisfactory life, happiness, and so on.[82] Legally mandated treatment is usually aimed at short-term relief from acute psychic distress, distress which can find a ready diagnostic category in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders III.

The expansive version of treatment is forward looking and includes what some refer to as cultivation of functioning.[83] On the other hand, treatment, as in right to treatment, may be narrowly limited to a serious mental disorder and much less oriented to the future. Indeed, whereas expansive treatment focuses on the person -- and at times seems indistinguishable from rehabilitation in concept -- treatment as used here often focuses on a provocative incident which raises immediate questions about the inmate's mental health. The correctional response may be as concerned with "curing" the incident as with "curing" the inmate.

Before turning to a review and analysis of the leading cases, a final introductory question must be addressed: When does a mentally ill inmate's right to treatment end? Does it end when the absence of "deliberate indifference" may be shown? When the immediate pain and suffering is diminished or is in remission? When the inmate is deemed able to function in general population? When the clinician believes that the inmate will not further benefit from the available therapy?

If the inmate's right to care ends at the point when the prison has met its minimal constitutional obligation, then the right to continued care will, indeed, terminate early. Preparing an inmate for return to general population appears to be the most frequently adopted, although unarticulated, goal. In truth, this treatment objective masks more problems than it solves. On the affirmative side, it does give treatment staff an operational objective: they believe they can visualize what it takes to simply survive in the pressure-packed world of the prison. On the other hand, it poses the ethical dilemma of ending care before substantial progress is made; of the attendant risk that, in many cases, the marginally adjusted inmate will quickly deteriorate in general population, even if seen on an out-patient basis.

As case after case makes clear, treatment staff range from being seriously limited in numbers to being virtually nonexistent. Understaffing clearly forces staff to engage in triage-like decisions. This, again, creates often unbearable ethical dilemmas.

There are five problem situations that frequently occur and which must be faced by health care professionals:[84]

> (1) The health care professional can give adequate care to a few inmates but clearly not to all who are in need in the prison.
>
> (2) The professional can do adequate evaluation, diagnosis, and prescription but the prison does not have an adequate follow-up system.
>
> (3) The professional believes that a disciplinary measure taken in the name of security is likely to be injurious to the inmates' physical or mental health.
>
> (4) The professional is asked to use seeming therapeutic methods or procedures, in a way that is inconsistent with their curative or ameliorative purpose, in order to advance institutional goals.
>
> (5) The professional believes that good progress is being made by a particular inmate, and with continued care long-lasting relief seems likely, yet the pressure to treat others requires disengaging from the inmate.[85]

2. <u>Cases Granting Relief</u>

Turning now to a review of the leading cases on treatment, we begin with Judge Justice's assessment of the Texas Department of Corrections, where it was found that:

> 'Treatment' there consists almost exclusively of the administration of medications, usually psychotropic drugs, to establish control over disturbed inmates. Other options, such as counseling, group therapy, individual psychotherapy, or assignment to constructive, therapeutic activities are rarely, if ever, available on the units. Essentially, an inmate with a mental disorder is ignored by unit officers until his condition becomes serious. When this occurs, he is medicated excessively. If his condition becomes acute, he is deposited at TDC's Treatment Center, a facility exclusively for inmates with mental disorders. Located at the Huntsville Unit, the Treatment Center has only limited professional staffing, and inmates who are sent there are the recipients of little more than medication and what amounts to warehousing.[86]

At the prison-unit level, it was found that the part-time psychiatrists:

> have little time to supervise the psychologists technically under their superintendence or to provide treatment to the inmates with mental disorders. Instead, their primary activities consist of approving and renewing prescriptions of psychotropic medications for these inmates.[87]

Psychologists were found to provide the bulk of the treatment at the TDC units. The usual result of a psychological interview was the prescription of psychotropic medication for the inmate or the relegation of the inmate to administrative segregation, hospital lock-up, or solitary confinement. No facilities for more sophisticated treatment existed on the units.[88]

Inmates diagnosed as schizophrenic or as having an acute psychosis spent long periods of time (as long as five months) in segregation without receiving treatment or seeing a member of the psychiatric staff. Inmates displaying suicidal tendencies were either ignored or punished (TDC officials felt that these inmates were attempting to manipulate the system).[89]

Parenthetically, problems connected with manipulation or malingering are deeply rooted and widespread. Interviews I conducted with uniformed prison staff and clinical personnel reveal that no small part of the tension between them consists of security personnel believing that some inmates "fake it" and manipulate gullible treaters and treaters, gullible or not, believing that security staff foist behavioral problems on them regardless of actual mental illness.[90]

Returning to Ruiz, Judge Justice moved from TDC's generally inadequate care for the mentally disordered inmate to an evaluation of the Treatment Center which housed the most seriously disturbed inmates. The Center was described as an overcrowded warehouse virtually identical to administrative segregation, with very strict confinement and virtually no treatment the rule. Security staff were plentiful, while mental health professionals were hardly in evidence. Psychotropic medication and unadorned confinement constituted TDC's inadequate response to inmates' serious mental disorders.[91] Finding the level of mental health care in TDC to be constitutionally inadequate, the court held:

> treatment must entail more than segregation and close supervision of the inmate patients[92].... [and the]...prescription and administration of behavior-altering medications in dangerous amounts, by dangerous methods, or without appropriate supervision and periodic evaluation is an unacceptable method of treatment.[93]

The court went on to find that:

> a basic program for the identification, treatment, and supervision of inmates with suicidal tendencies is a necessary component of any mental health treatment program.[94]

Judge Justice's six components for a minimally adequate mental health treatment program may serve as the basic outline to assess the legal adequacy of any prison system's mental health services:

> First, there must be a systematic program for screening and evaluating inmates in order to identify those who require mental health treatment....Second, as was underscored in both Newman and Bowring, treatment must entail more than segregation and close supervision of the inmate patients....Third, treatment requires the participation of trained mental health professionals, who must be employed in sufficient numbers to identify and treat in an individualized manner those treatable inmates suffering from serious mental disorders....Fourth, accurate, complete, and confidential records of the mental health treatment process must be maintained. Fifth, prescription and administration of behavior-altering medications in dangerous amounts, by dangerous methods, or without appropriate supervision and periodic evaluations, is an unacceptable method of treatment. Sixth, a

> basic program for the identification, treatment, and supervision of inmates with suicidal tendencies is a necessary component of any mental health treatment program....TDC's mental health care program falls short of minimal adequacy in terms of each of these components and is, therefore, in violation of the eighth amendment.[95]

In Finney v. Hutto the court found that mental health care for mentally or emotionally ill prisoners in the Arkansas system consisted of nothing more than the administration of drugs or, for violent inmates, transfer to the state hospital for a temporary hold.[96] A form of group therapy had recently been introduced by corrections, and while the court viewed this favorably, it did not accept this minimal effort as a total substitute for the unavailable, conventional methods of psychotherapy.[97]

The challenge to the Maryland House of Corrections in Johnson v. Levine[98] resulted in a finding that the overall mental health care was constitutionally acceptable except for the Special Confinement Area (SCA). Inmates judged to have "psychological or psychiatric" problems were housed there in conditions found elsewhere only in punitive segregation. One more difference, moreover, was that disciplinary confinement tended to be of relatively short duration while SCA confinement lasted an average of six to eight months and, for some, even longer.[99]

This case combines the absence of treatment -- mentally ill inmates are warehoused -- with uncivilized overall conditions, resulting in the failure of SCA to meet minimum constitutional standards. The court forced the remedy issue by requiring that the actively psychotic inmates be transfered to a mental hospital, threatening to join any recalcitrant agencies as defendants and by using segregation for those inmates who were acting and found not to be mentally ill.[100]

Newman v. Alabama involved a similar situation, a combination of no treatment and dubious isolation practices and conditions.[101]

> Severe, and sometimes dangerous, psychotics are regularly placed in the general population. If they become violent, they are removed to lockup cells which are not equipped with restraints or padding and where they are unattended. While some do obtain interviews with qualified medical personnel and a few are eventually transferred for treatment to a state mental hospital, the large majority of mentally disturbed prisoners receive no treatment whatsoever. It is tautological that such care is constitutionally inadequate.[102]

Living conditions for mentally disordered prisoners in the Puerto Rican prison system appear to have closely resembled the Maryland House of Correction and the Alabama system.[103] Psychiatric treatment, or rather the lack of it, was described as disgraceful. Psychotics were confined in dungeons or isolation cells known as "calabozos," where they received no treatment. Others who were mentally ill were generally kept in their own dormitory ward and also received no treatment. Even at the Bayamon prison, which did have a psychiatric unit, the inmates were merely confined and otherwise neglected. A few inmates received treatment only because one of them tampered with the records and ordered medication.[104] The court held that the above conditions violated the inmates' constitutional rights.[105]

The problems of adequate treatment were a little more sophisticated in the New Hampshire prison system. A semblance of mental health care existed. Indeed, the decision even related a debate concerning the amount of time to be spent on diagnosis and on treatment, and a discussion of manageable caseloads.[106] What was actually available, however, was constitutionally deficient.

> In the face of the professed orientation of the program and the severe understaffing, it is not surprising that plaintiffs' experts found mental health treatment at NHSP basically nonexistent. The program is reactive and crisis oriented, and, while there is some diagnostic work done, there is little or no capacity to follow through with treatment. There are no therapy groups run by the mental health unit. Less than 20% of the inmate population is seen at all, and most of those are counseled only irregularly. Defendants themselves recognize that they do not have the facilities, staff or expertise to deal with seriously disturbed persons.[107]

The court did not order any specific type of care, but did order that the NHSP establish procedures to identify those inmates who require mental health care within the institution and make arrangements to implement the provision of such care.[108]

The Menard Correctional Center in Illinois succumbed to a broad-based attack on its health care delivery system.[109] The court did not detail what would constitute an adequate number of health care professionals, but it plainly found the following conditions and available resources inadequate:

- Inmates were not properly assessed.
- Potential suicides were not given professional care.
- No clinical psychologist was employed for on-going therapy.
- No psychiatrist was employed for psychotherapy.

- Record keeping was inadequate.
- Of 18 employees available for counseling, eight had no formal training. The counselors' duties were primarily administrative and the ratio of counselor to convict was 1:155, well above the 1:100 ratio recommended in trial testimony. Consequently little, if any, actual counseling occurred.
- Psychotropic medication was overprescribed and inadequately monitored. Of 80,000 doses of medication dispensed, 50 percent was psychotropic medication.
- Delays were routine in transferring those in need of psychiatric care.
- Psychiatric care was available for only 15 hours per week.[110]

In Hoptowit v. Ray the Ninth Circuit upheld the district court's finding that health care was inadequate at the Washington State Penitentiary.[111] The penitentiary lacked basic psychiatric services and had deficiencies in staff and programs.

The Court of Appeals, however, did reject the trial judge's reliance on the standards promulgated by the American Medical Association and the American Public Health Association as constitutional minima. Following a recurring pattern in resolving this question, the court stated that, "[a] higher standard may be desirable but that responsibility is properly left to the executive and legislative branches. The remedy of the court could go no farther than to bring the medical services up to the constitutional minima."[112]

In Cody v. Hillard[113] inmates successfully challenged almost every aspect of the South Dakota State Penitentiary. Of the 538 inmates at the time of suit, 20 to 25 percent were estimated to be psychotic.[114] A volunteer psychiatrist visited the prison once a week for about five hours which he devoted primarily to parole board work-ups.[115]

The prison employed one full-time psychologist, who spent most of his time on testing, seven full-time counselors and the equivalent of two and one half full-time drug and alcohol counselors. In its decision the court emphasized the need for an adequate counseling staff:

> Adequate counseling staff reduces the number of instances in which individuals in the general population deteriorate both physically and mentally, thus reducing the number of inmates who must be referred to a mental hospital for psychiatric treatment. Adequate counseling services aid in the treatment and prevention of mental health problems among the inmate population by enabling qualified personnel to intervene at an early stage in the diagnosis, care and treatment of these problems. Adequate counseling services also assist, for example, in the continued monitoring of inmates who have

> returned to the general population after having been removed from the general population for psychiatric treatment. At present, the counseling staff at the SDSP does not have time to adequately perform psychotherapy or psychological treatment on inmates.[116]

This court's emphasis on the need for mental health services to alleviate mental deterioration is interesting and important. Where a court emphasizes this concern as a constitutional duty -- and many do not -- it creates a predicate for earlier intervention and a broader base for mandated services.[117]

To further highlight the systemic failure of this prison, the court discussed the case of one inmate whose sentencing judge urged that psychiatric care be given. This inmate met with the volunteer psychiatrist for, at most, twelve minutes and during his entire prison stay received no other psychiatric or psychological attention.[118] The court also found instances where inmates interfered with other inmates' treatment plans and, in at least one case, the result was suicide.[119]

In devising a mandated plan for South Dakota the Cody decision went into considerably more detail than most other decisions:

* * * *

> b. There are three levels of care which are essential in providing an adequate system of psychiatric and psychological care. Absent such a system, the probability is strong that inmates requiring psychiatric and psychological treatment will not be cared for adequately and will experience unnecessary mental and/or physical deterioration in the general inmate population.
>
> c. The first necessary level of care consists of in-patient hospitalization care to treat acutely psychotic individuals, individuals experiencing suicidal tendencies, and those other individuals most significantly impaired by psychiatric illness.
>
> d. The second necessary level of care consists of intermediate care and treatment for those individuals who have been stabilized by medication and supportive psychotherapy but who cannot return immediately to the general inmate population. This level of care is designed to provide a transition for inmates coming from an inpatient psychiatric hospital environment back

into the general inmate population. An intermediate level care facility would provide the inmates an environment less intensive than the first level psychiatric hospital, but more supportive than that provided by the general population facility. An intermediate level care facility requires appropriate nursing staff, support staff, and psychiatric and psychological staff.

e. The third necessary level of care consists of out-patient care for inmate-patients who have received psychiatric treatment and who have returned to the general population so that these inmates can have prescribed medications monitored and can receive supportive group or individual psychotherapy as indicated.

f. The mental health needs of inmates at the SDSP require that the SDSP maintain an acute (first level) care and an intermediate (second level) care facility equipped with approximately twenty to twenty-five beds. Of these number, approximately eight to ten beds would be devoted to psychiatric care -- requiring twenty-four hour nursing coverage and adequate support staff. The remaining beds would be devoted to intermediate care.

g. Staffing for this facility would require a full-time psychiatrist, two full-time psychologists, approximately six full-time equivalent nurses in order to provide twenty-four hour coverage, at least four full-time equivalent counselors or psychiatric social workers to provide support to the psychiatric and psychology staff, and the necessary correctional staff to provide twenty-four hour security over the facility.

h. The mental health needs of inmates at the SDSP also require that the SDSP provide outpatient (third level) care.

i. In addition to the staff necessary to provide acute and intermediate care, adequate outpatient care would require approximately two days per week of on-site psychiatric coverage, a full-time psychologist whose work is devoted exclusively to the treatment component of mental health care,

> and increased counseling staff. The full-time psychologist position would be in addition to the present full-time psychologist who performs primarily administrative functions involving the evaluation and assessment of newly admitted inmates. While it is preferable that every counselor have a master's degree, a counselor holding a bachelor's degree accompanied by sufficient experience and appropriate supervision is acceptable.[120]

The three levels of care approach mandated in Cody is rapidly becoming the model for prison mental health services. It is within the range of legally acceptable options for long-term, acute or chronic patient care to be provided "off campus." So long as emergency care exists within the facility (or at a moment's call), then prison systems presumably continue to have the right to choose the preferred place for care.[121]

Earlier, in Finney v. Mabry a federal court took a similar approach but also insisted on a separate facility for the most severely disturbed:

> [P]rovision of a separate facility and treatment for the most severely mentally disturbed is constitutionally required. Persons who are severely sick simply cannot be held in custody unless they are provided with necessary medical services. Mental health treatment is clearly a necessary medical service in certain cases. Many inmates who have mental and emotional problems, and need temporary or 'outpatient' type of treatment or counseling by psychiatrists or other mental health personnel, may, of course, remain in the general population; but there must be some manner of dealing with them while in the population....However, in addition, there must be a permanent, separate facility so that those people who are most severely mentally disturbed may be removed, for their own protection and for the safety of others, from the correctional environment of the general population and provided with the treatment and services they need.[122]

In Duran v. Anaya, Federal District Judge Burciga was confronted with the New Mexico prison system which is still recovering from the 1980 prison riot considered "the bloodiest in the history of American corrections."[123] This case is confounded by a political struggle within the state which came to a head for our purposes when the legislature actually reduced the budget for prison medical and mental health care.[124]

The proposed budget would have eliminated 36 percent of the psychologists and mental health support personnel thus causing even greater harm to mentally ill prisoners in the form of added mental and emotional stress. The reductions would have impacted greatly on both outpatient, intermediate and acute treatment.[125]

In a word, the court adopted the views of the then Secretary of the New Mexico Corrections Department, the reductions, he said, "will devastate our ... mental health system."[126]

In responding favorably to the plaintiff's request for an injunction prohibiting staff reductions and to require that vacant mental health positions be filled, the court stated:

> As a result of the reductions projected to occur on July 1, 1986, defendants will be unable to meet their constitutional obligation to provide a level of medical care that is reasonably designed to meet the routine and emergency health care needs of prisoners. This will be true with respect to medical care, dental care and psychiatric care. By implementing drastic reductions in the number of medical and mental health professionals available to treat prisoners, defendants will deny prisoners access to medical personnel capable of evaluating the need for treatment and providing necessary medical care. By reducing the level of security staffing below the minimal safety level recommended by the Court's expert consultant on security staffing, and below the level found by the Special Master and approved as necessary by the Court without objection from either party, defendants are significantly increasing the risk of violence and assaults and thus are evidencing deliberate indifference to the legitimate safety needs of prisoners.
>
> It is apparent that the medical and psychiatric needs of prisoners that will go unmet if proposed staffing reductions are implemented are serious ones. Unnecessary deaths, physical trauma, suicides and self-mutilation are virtually inevitable. Both plaintiffs' and defendants' experts have testified that the impact of the proposed staffing reductions will make the delivery of satisfactory routine and emergency medical care impossible. As a result, prisoners will endure an unnecessary level of pain and suffering and will be the victims of irreparable physical and mental injury. In summary, the

proposed staffing reductions in the medical and mental health areas reflect deliberate indifference to serious medical needs of prisoners in the four institutions under the Court's jurisdiction in this cause. Estelle v. Gamble, 429 U.S. 97 (1976).

The evidence before the Court makes it abundantly clear that the Secretary of Corrections has attempted to persuade both the New Mexico Legislature and the Governor of New Mexico (the latter being a defendant in this action) to make sufficient funds available to avoid the dangerous and life threatening reductions in medical, mental health and security staff that are imminent. These efforts thus far have been to no avail. Nonetheless, defendants' constitutional obligations may not be avoided for lack of financing. Moreover, this Court's exercise of its equitable powers is not limited by the fact that needed equitable remedies implicate state funds.

Turning to the criteria that must be met for the issuance of a preliminary injunction, the Court finds that there is a substantial likelihood that plaintiffs eventually will prevail on the merits in upcoming hearings on plaintiffs' contempt motion and the parties' cross motions for modification insofar as those motions relate to medical, mental health and security staffing. There is no evidence before the Court that staffing reductions of the magnitude contemplated in the medical and mental health areas will permit the maintenance of minimal constitutional standards in these areas. Indeed, the Court's expert, plaintiffs' expert, defendants' expert and the New Mexico Secretary of Corrections all have testified to the contrary. Particularly in view of the steady increase in the penal population that will occur in New Mexico's incarcerated population, deficiencies outlined in earlier reports of the Special Master and in testimony before the Court in connection with the pending motion for preliminary injunction no doubt will be exacerbated. Likewise, the consistent evidence before the Court is that the level of psychiatric care being provided at this time, particularly to prisoners in need of acute care, is unacceptable by any conceivable measure or standard. All expert testimony is in agreement that the

magnitude of mental health staffing reductions
contemplated will eliminate essential mental
health services.[127]

It should be emphasized that the Duran case involved a previously "settled" dispute about the unconstitutional level of mental health services and a mutually acceptable way to remedy the deficiencies. The court was dragged into the matter when there was an attempt to veto the consent decree with the "power of the purse."

Consent decrees can be modified -- although with great difficulty[128] -- but that was not the strategy employed by New Mexico. Where a consent decree is unmodified, then the law of the case is derived from the terms of the decree. These face-offs between state legislatures and federal judges are wrenching exercises of judicial authority and federal constitutional supremacy versus state power.

With the horrors of the 1980 prison riot still relatively fresh, and with the prospect of an increasing number of violently mentally ill prisoners going untreated, Judge Burciga had little choice except to act as he did.[129]

Wellman v. Faulkner[130] is an interesting and useful decision involving yet another successful inmate challenge to medical and psychiatric care, this time against the Indiana State Prison at Michigan City. In finding that there was deliberate indifference to serious medical needs, the reviewing court cited the fact that two physicians at the prison were recent immigrants from Vietnam who could not communicate with their patients. It also found that the position of staff psychiatrist had gone unfilled for two years, leaving no one qualified to evaluate suicidal or homicidal candidates or to monitor patients on psychotropic medication.

Before remanding the case for further orders concerning specific relief, the court made the interesting observation that, "the policy of deferring to the judgment of prison officials in matters of prison discipline and security does not usually apply in the context of medical care to the same degree as in other contexts."[131]

This point is interesting in several respects. First, in Youngberg v. Romeo, the Supreme Court held that a profoundly retarded resident of a state school had a due process right to minimally adequate training in order to maximize his right to be free of harm and minimize undue restraint.[132] In evaluating what training was reasonable, the Court stated that courts should show deference to the judgment exercised by a qualified professional.[133]

Youngberg v. Romeo, then, raised the possibility that courts might defer to the opinions of experts who find that the state's mental health system, or design for care in an individual case, is appropriate and

adequate.[134] In other words, the argument is that prison officials who are security experts should receive deference in their areas of expertise and prison employees who provide health care should receive deference in their area of expertise.

I do not believe that this is what the Court had in mind in the Youngberg decision. Under the present state of the law, where an inmate is given medical or psychiatric care and the inmate either disagrees with the treatment methodology or argues that good medical or psychiatric care would have provided him with more or different treatment, the inmate is very likely to lose.[135]

Second, in reiterating the "deliberate indifference" standard as appropriate for prison medical care issues in Whitley v. Albers[136] the Court showed no inclination to further facilitate a prison system's defense of arguably unconstitutional mental health care systems. Indeed, the Court has maintained its position that where lifesaving and pain reducing care are at issue then it is not necessary to weigh competing concerns about security.

In sum, the Wellman court's position of less deference to prison officials in matters of physical and mental health is well taken. While it is not a position often made explicit by other courts, one would hope that if confronted with this proposition, most courts would accept it.

a. Interference with Treatment

Deliberate indifference may be manifested in a variety of ways: by treatment staff in their reaction to a prisoner's needs; by staff needlessly denying or delaying access to help; by resources wholly inadequate to meet basic needs; and by interfering with care previously prescribed. When an inmate establishes that a prison representative has intentionally interfered with treatment already prescribed, he will almost certainly prevail. The only substantial question remaining would be the nature and extent of the relief.

Jones v. Evans,[137] while not a mental illness case, is almost a textbook classic on how to plead and prove a case of "interference." Jones had undergone back surgery and wore a prescribed back brace before he entered the Georgia Prison System. On entry an officer took away the brace and allegedly stated, "the doctor...isn't running this place."[138]

Jones was given a substitute brace, which he claimed was inadequate, and was provided with heat and whirlpool treatments subsequent to completing work that was proscribed by his physician.[139]

Federal District Judge Hall provided the following analysis for the resolution of a defendant's motion for a directed verdict:

> In cases alleging a denial of care, or
> inadequate, negligently provided care, such as

Estelle, assessment of deliberate indifference weighs equally with assessment of the plaintiff's serious medical needs. A defendant in such cases may show a lack of deliberate indifference by establishing he was generally attentive to the prisoner's needs. By contrast, in cases alleging interference with prescribed care, a defendant has a more difficult task in showing the absence of deliberate indifference. First, in some sense, a non-medical, prison employee's refusal to follow a doctor's instructions regarding a prisoner's care can almost never be characterized as other than deliberate and indifferent. Second, one episode of gross misconduct is not excused by general attentiveness to a prisoner's medical needs. Where a prisoner, as in this case, alleges that a guard disregarded written instructions and interfered with prescribed care, a question of gross misconduct is raised.

A guard's interference with prescribed care does not establish a _per se_ case of unnecessary and wanton infliction of pain violative of the Eighth Amendment. A plaintiff prisoner must still show that the interference was unjustified, and that serious medical needs were affected. Moreover, where a plaintiff makes a mixed allegation that interference with prescribed care marked the start of a course of inadequate treatment, _Estelle_ leaves the door open to an argument by personnel not involved with the interference with prescribed care, that the extent and timing of care given subsequent to isolated incidents of interference can establish that those personnel were not indifferent to the prisoner's serious needs.

Nonetheless, in the context of a defendant's motion for summary judgment in a case alleging interference with prescribed care, or episodes of gross misconduct, a showing of general attentiveness, is not sufficient to establish an absence of deliberate indifference in the conduct complained of. Assuming, for purposes of the summary judgment motion that the alleged interference occurred, a court's primary attention must be on the second element of the _Estelle_ test, the seriousness of the plaintiff's medical needs. In such cases, whether interference with prescribed medical care rises to the level of cruel and

> unusual punishment depends upon the degree of pain or harm suffered by the prisoner as a result of the interference with prescribed care, the adequacy of alternative care if and when it begins, and whether the interference with care is an isolated event or one incident in a pattern.
>
> Instead of addressing the issue of the plaintiff's serious medical needs during the period he was without his back brace and offering evidence on the factors listed above, the defendants treated this case as directly analogous to Estelle, and simply sought to show that the prison system was generally attentive to the plaintiff's needs. To this end, the defendants attempted to demonstrate that the plaintiff made numerous visits to the prison infirmary, and that along with other care, he received motrin and other drugs, was on a program of whirlpool and heat treatments throughout his two year incarceration, and eventually received a new back brace. As discussed, this approach is inadequate.
>
> In order to counter the plaintiff's allegations in a case such as this, the defendants must demonstrate in their affidavits that even assuming misconduct for which they were responsible led to interference with prescribed care, the misconduct was not gross. In other words, the defendants must show that the interference with prescribed care was not only a temporary aberration in a pattern of attentive care, but also that it was de minimis. To make this showing, the defendants, in line with the second prong of the Estelle test, must give evidence that the plaintiff's medical needs were not serious, given the duration of the interference with prescribed care.[140]

Thus, Jones v. Evans establishes very clearly that prison officials should not lightly disregard an inmate's previously prescribed treatment. What is especially interesting here is that it is no defense to show other occasions where care was provided if the omission complained of caused pain and the underlying condition was serious. Of course, if there is an intervening medical or psychiatric diagnosis then we do not face an interference question. Rather, we now have a new diagnosis and treatment which may face an independent test of constitutional acceptability.

b. Delaying or Denying Access to Treatment

In addition to the willful interference problem, denying or impeding access to medical and psychiatric services is looked upon with disfavor by the courts. In Balla v. Idaho State Board of Corrections the federal district court was sharply critical of Idaho's access procedures.[141] Idaho inmates were required to file a written request for medical services which would, in turn, initiate medical staff review. The court was skeptical about this procedure and the attendant practices and stated, "[a] system which does not respond to written requests for medical attention cannot possibly be construed as affording access to nor being responsive to complaints about the health care system."[142]

The court found a combination of inadequate staff, poor training, insufficient hours, and absence of written procedures amounted to considerable evidence of deliberate indifference.[143]

Every decision discussed thus far in this section has come from the federal courts. Under Art. III of the Constitution the federal judicial power extends, among other things, to cases arising under the Constitution. The Supreme Court, of course, is the final, but not the exclusive, arbiter of constitutional rights and duties.

c. State Cases

The West Virginia Supreme Court recently reviewed a comprehensive consent decree and determined that the state was not in compliance. Crain v. Bordenkircher[144] is unusual if only for the fact that it involves a state court enforcing a comprehensive decree which involves violations of inmates' federal constitutional rights.

The court noted that:

> Despite the Department's efforts to improve the quality of health care, the fact remains that there is no plan for a full-time physician to organize and oversee the health care services; inadequate plans to care for the mentally ill, retarded, and segregated inmates; no plan to improve medical facilities; no plan to improve the receiving and screening system; continued reliance on untrained inmates to perform medical procedures; and inadequate plans to provide proper dental care.
>
> Most of these deficiencies can be corrected without an inordinate economic burden on the State. We, therefore, hold that health care at WVP, even assuming full implementation of the Compliance Plan as approved, constitutes

> deliberate indifference to the serious medical needs of the prisoners, and we order the Department to submit a revised plan ... that, at a minimum, includes: (1) the hiring of a full-time physician to organize and oversee all health care at WVP; (2) the elimination of the reliance on untrained inmate staff to perform medical procedures; (3) a detailed protocol for receiving and screening inmates on a regular basis; (4) a detailed plan for providing adequate dental care; (5) a plan for at least minimal treatment for the mentally ill and retarded inmates; (6) a plan to improve health care to segregated inmates; (7) a plan to correct defiencies in the medical facilities; and (8) the retention of the plans already approved.[145]

This compliance mandate is unusual, as noted earlier, only in that it came from a state court. What is unusual is some earlier case law upon which Crain v. Bodenkircher rests. In Cooper v. Gwinn, the West Virginia Supreme Court held:

> In summary, we hold that inherent in the republican form of government established by our State Constitution is a concept of due process which insures that the people receive the benefit of legislative enactments. The Legislature has provided that rehabilitation is the primary purpose of confinement in state prisons, and has specified that programs of classification, education and treatment must be implemented in furtherance of that policy. The Department of Corrections is the government agency responsible for implementing the policy specified by the Legislature. It has not fulfilled its policy mandate and the petitioners have no other adequate remedy to enforce their rights.[146]

In effect, this court raised a legislatively enacted objective of confinement -- rehabilitation -- to the level of a State created constitutional right. From there, the court was able to endorse the A.C.A. Standards as the norms to be followed in restructuring the 120 year old, crowded and crumbling West Virginia Penitentiary. It is extraordinary for any court to find a constitutional right to rehabilitation, and how this court did it -- reasoning from a republican form of government -- is absolutely unique.[147]

The various standards -- including the A.C.A. Standards relied on in Crain -- which compete for attention in this area are uniformly regarded as relevant and admissible on the problem of establishing treatment

norms. However, courts recognize that there is a wide gulf between the ideal or preferred and constitutional minima. This is not to say that the state cannot -- or ought not -- agree to provide more than the minima.

In Hoptowit v. Ray, the court said flatly, "[i]t was error for the district judge to constitutionalize the standards of the American Medical Association and the American Public Health Association."[148]

Thus, a review of the leading decisions where relief was granted produces a pattern of either no mental health care[149] or patently inadequate care coupled with brutal conditions of confinement as the most compelling factors for the courts. As we might expect, the more diagnostic and clinical services available, the less likely it is for a court to find a violation of the inmates' rights or the rights of others. It also is clear that when a system is found to be unconstitutional, the courts are prone to order far more detailed relief than might be expected in light of the minimally demanding Estelle v. Gamble standard of "deliberate indifference."

3. Cases Upholding Available Care

Turning now to decisions upholding available care, we first note that the Indiana State Prison (ISP) was found to provide adequate levels of on-site and off-site psychological care for that prison's mentally disordered inmates.[150] According to the chief psychologist, he personally saw about 150 inmates per month and spent 80 percent of his time counseling. He testified that there were group therapy sessions for sex offenders and inmates with special adjustment problems.

A grant provided therapeutic services for inmates on self-lockup, and an outside consultant conducted a stress and relaxation therapy group two days a week. In addition, psychotherapy groups were run by a consulting psychiatrist.[151] Mentally ill inmates were transferred to Westville Correctional Institution, which had a program consisting of psychotropic drugs, group and individual therapy, milieu therapy, and recreational therapy.[152]

Although the troubling theme of desirable (not attained) versus constitutional (easily attained) runs through this extensive opinion, ultimately the existing level of mental health care was upheld. The availability and use of an acceptable off-site treatment facility may well have tipped the balance in favor of the state.

The cases do not reflect a strong judicial preference for on-site or off-site services, although some of the decisions divide the analysis along those lines. And there is good reason for doing so. Suppose that a hypothetical jurisdiction -- one not yet encountered -- decides that all psychological or psychiatric services will be provided away from the site of the prison. A question would then arise concerning the emergency case, the inmate with a sudden, acute, and perhaps life-threatening

episode. There should be no doubt that such an inmate has a right to immediate, and perhaps life-sustaining care and that right almost certainly calls for some kind of on-site care.[153]

In Grubb v. Bradley inmates successfully challenged many of the conditions in 12 of Tennessee's penal institutions but the court upheld the provision of mental health care.[154] It was determined that while on-site care was not extensive most inmates suffering with serious mental disorders were identified and transferred to the DeBerry Correctional Institute for Special Needs Offenders, a maximum care facility housing about 275 inmates.[155]

The full-time mental health staff at DeBerry consisted of two clinical psychologists, two psychological examiners, six psychiatric social workers, five counselors, and one nurse clinician. Another 90 hours of professional services were obtained from outside professionals.[156]

Although the court lamented the paucity of on-site care and believed that there was room for improvement, it felt constrained to find that the care provided met minimum constitutional standards; in other words the "deliberate indifference" standard had not been breached.

The plaintiffs in Canterino v. Bland, involving inmates at the Kentucky Correctional Institute for Women (KCIW), won a significant overall victory in court by demonstrating unconstitutional disparities between the male and female prisons on such matters as overall restrictions; vocational, educational, and job opportunities; and the general allocation of resources and benefits. The inmates did not, however, prevail on their claim concerning inadequate medical and psychological care.[157]

A report prepared by the Kentucky Department of Education had earlier concluded that out of 189 female inmates, 144 should be classified as "emotionally disturbed" for the purpose of planning the vocational education program.[158] A consulting physician testified that depression and anxiety were major problems and that he prescribed psychotropic medication for 33 to 50 percent of the female population.[159] Other treatment at KCIW consisted of a visit once a week by a mental health team from a newly opened Psychiatric Center, psychiatric evaluations for parole purposes by a consultant, some counseling by a psychologist and the chaplain, and a self-help program called rational behavior counseling.[160] Although the court indicated a concern about the seriousness and extent of the psychological problems and the rather minimal care provided at KCIW, it nonetheless held that constitutional minima were obtained.[161]

In Toussaint v. McCarthy,[162] California's Folsom Prison escaped a constitutional challenge, but just barely. Plaintiffs were able to show isolated instances of neglect but, on the whole, the district court was

upheld in its determination that Folsom provides almost all of the strictly necessary treatment on a timely basis.[163]

The reviewing court clarified the difference between a good system and a constitutionally acceptable one:

> In sum, Folsom's health care conditions fall below medical standards. The fact that a given condition might constitute medical malpractice, however, does not necessarily mean that the condition constitutes cruel and unusual punishment....It is only deliberate indifference to serious medical needs that can offend 'evolving standards of decency' in violation of the eighth amendment. However, the district court's failure to render specific factual findings regarding the level of reliance on unqualified personnel requires a remand for entry of such findings.[164]

Ferola v. Moran[165] is an interesting example of how a system which is not in compliance with an order entered nine years previously on mental health care can successfully defend an individual complainant's suit for money damages. Ferola involves the Adult Correctional Institutions of Rhode Island which has been under the supervision of a court appointed Master since 1977.[166]

The 25 year old inmate who filed suit had repeatedly manifested bizarre and aberrant behavior: he injured himself some sixty times and set fire to his cell; he saw a prison psychiatrist about once a week for a couple of years; and he took prescribed drugs. A finding was made that the doctor did all that was possible for Ferola's anti-social personality.[167] In short, "Ferola was not ignored however; in fact, there was almost solicitous concern for him."[168]

The foregoing review and analysis of the leading decisions on adequate treatment for mentally disordered inmates highlights several distinct conclusions. First, the constitutional minimum -- the deliberate indifference standard -- is relatively easy to meet. The cases echo the theme of generally unsatisfactory, yet constitutionally acceptable, levels of care: care that is below professional standards but constitutionally acceptable. Second, with a minimally-demanding standard for assessing mental health services, many jurisdictions either failed the federal constitutional test or, less frequently, a state law test. Reliance on psychotropic drugs alone; simple confinement or group therapy alone; reacting only to crisis believed to stem from mental disorders; heavy reliance on untrained or nonprofessional personnel; interference with previously prescribed care; and creating unreasonable obstacles for access to care all appear to be critical factors in a finding of unconstitutionality.

Finally, each jurisdiction has a number of options available in formulating a mental health care policy. The distribution of on-site and off-site care; the proportion of various mental health professionals employed; the reliance on various types of recognized treatment all are important examples of -- shall we say -- local option. <u>No jurisdiction has the option to do nothing</u>!

Available data would have us believe that the number of mentally disordered inmates in any given system varies greatly. One suspects that the variance is more a result of research methods and individual perceptions than objective diagnoses or testing. It would be interesting for a court to be confronted by a claim of "no mental health care" to which the answer was "no mentally disturbed inmates." One envisions a subsequent battle of experts with one side finding all "bad guys" and the other finding only "mad guys." And who would be correct?

D. Specific Legal Issues

1. Isolation and Mental Disability

After studying the supposedly therapeutic effects of solitary confinement in American prisons in the 1800s Charles Dickens wrote:

> I believe it, in its effects, to be cruel and wrong. In its intention, I am well convinced that it is kind, humane, and meant for reformation; but I am persuaded that those who devised this system of Prison Discipline, and those benevolent gentlemen who carry it into execution, do not know what it is that they are doing. I believe that very few men are capable of estimating the immense amount of torture and agony which this dreadful punishment ... inflicts upon the sufferers ... I hold this slow and daily tampering with the mysteries of the brain, to be immeasurably worse than any torture of the body ....[169]

In <u>Crain v. Bordenkircher</u> which involved the wholesale condemnation of the West Virginia Penitentiary, a cryptic footnote reads:

> Mr. Lane [Director of the Illinois Department of Corrections and an expert witness here] was particularly upset over what he observed in what was termed the psychiatric ward of the infirmary area which had to be entered by unlocking a door off a hallway. It contained a toilet area and a dark cell from which somebody stuck his hand out. Mr. Lane, who said that without a flashlight he could not see in the cell, asked if there was a toilet in the cell and the person inside said no.[170]

Isolation, of course, remains a part of prison life, and here we take a close look at the various forms and competing objectives involved in the isolation of mentally disordered inmates. Previously, I discussed the use of isolation in such jurisdictions as Puerto Rico, Texas, and Alabama but within the context of whether classification or treatment needs were being met.

The cases make it clear that isolation, even prolonged isolation, of adult prisoners, by itself generally raises no constitutional problems.[171] Legal problems do arise concerning the procedures used, especially for disciplinary isolation; where the conditions of isolation involve the wanton infliction of pain; and where the conditions deny basic human needs or are grossly disproportionate to the crime warranting the imprisonment.[172] On the other hand, where confinement is extraordinarily long[173] or where isolation might cause psychiatric deterioration, courts have been extremely reluctant to interfere.[174]

Is there a legal argument to be made that the isolation of a mentally disordered inmate is unconstitutional *per se* or that the inmate's disorder should be viewed as an important variable in determining what may be unduly harsh or damaging? The question seems to presuppose that isolation is damaging, in a way that exceeds the pain that many of us feel in being denied even minimal human interaction. Professor Hans Toch's study of prison inmates leads him to conclude that, whatever the law may be, isolation for some inmates may indeed have a devastating effect.[175] Suicidal inmates, for example, can be pushed over the brink if isolated. Pathologically fearful inmates can regress into a panic reaction that is psychologically devastating. According to Toch, paranoid-schizophrenics often have a counterproductive reaction to isolation.[176]

At least one other authority has found that the isolation of some inmates may actually produce positive results.[177] Inmates may use the break in routine to improve themselves. Thus from the clinical perspective there is no certain connection between isolation and psychological reactions.[178] At a minimum, results seem linked with prior psychological strengths or weaknesses.

It seems reasonably well established that isolation is not unconstitutional *per se*, although it may be exceedingly poor policy to isolate at least certain mentally disordered inmates. The mental condition of the inmate -- like the age of a juvenile who is incarcerated -- becomes a factor in the constitutional formula, along with duration and the overall conditions of confinement. It was recently decided that while juveniles could be kept in isolation, their non-criminal status and youth were important factors in assessing the validity of the nature and duration of such isolation.[179] In addition to the questions of law and effectiveness, health providers face serious ethical questions.

Two commentators go so far as to state:

> Medical practitioner involvement in the isolation and restraint of juveniles for nonmedical purposes, for example, violates every fundamental tenet of ethical medicine.... The United Nations Principles of Medical Ethics, for example, specifically condemns the active or passive participation of health personnel in any cruel, inhumane, or degrading treatment or punishment of inmates.[180]

A prison inmate, of course, has been convicted of a crime and may be punished. The inmate's mental condition, however, is a factor in the amount of pain which may be inflicted. Where isolation has been found to violate an inmate's Eighth Amendment rights, the surrounding conditions have been sufficiently brutal or uncivilized that it becomes difficult to assess the specific weight accorded a mental disorder.

a. Disciplinary Proceedings and Competency

Thus far, I have addressed -- and only in preliminary fashion -- the isolation itself. Serious questions are now being raised in judicial proceedings challenging both the legality of conducting a disciplinary proceeding when an inmate may be unable to defend himself and the general unavailability of mental disability as a defense.[181]

The essence of the initial challenge is to argue that there is a federally grounded due process right to a fair hearing in prison disciplinary proceedings.[182] At a minimum, the argument goes, the accused inmate has a right to participate in the hearing and offer defenses and matters in explanation or mitigation. Unless the inmate is able to understand the charges and to aid in the defense, then it is fundamentally unfair to conduct a disciplinary proceeding.[183]

Competency is a synonym for "triability," whereas the proposed mental disability defense (actually a form of insanity defense) is a synonym for responsibility. If an inmate is sufficiently mentally ill at the time of the alleged infraction and thus lacks the capacity to know or appreciate either the nature or consequences of his conduct or that this conduct was wrong then, it is argued, the inmate cannot be punished. To punish such an inmate, it is claimed, constitutes cruel and unusual punishment.

To summarize, these legal claims seek either to delay a disciplinary proceeding until the inmate is competent or to deny the right to impose punishment on the inmate who is irresponsible as a result of mental disease.

In a case challenging New York State's handling of these issues, the inmates' legal complaint makes several allegations. One inmate with a

long history of suicidal behavior and with severe psychosis was disciplined for striking an officer who attempted to remove the inmate from his cell. Another inmate was disciplined for threatening suicide shortly after being returned to prison from a mental hospital. He continued to threaten suicide and eventually did mutilate himself several times. Disciplinary action continued between stays at a mental hospital. One of the more shocking allegations involves a 24 year old transsexual who attempted suicide four times at the jail while awaiting transfer to a prison. While imprisoned, the inmate continued to attempt suicide and also attempted to remove his penis and testicles, finally succeeding in removing a testicle by making an incision with a part of a ballpoint pen. This inmate faced serious disciplinary charges as a result of this conduct.[184]

Concededly, the cases just mentioned are extreme. However, whether or not the inmates' charges are fully substantiated, they do represent the type of case that calls for a decision on competency and responsibility. Although the law is unsettled in this area, we might agree in principle that it is unfair to try someone incapable of presenting a defense and it is unfair as well as cruel to punish someone for conduct which they could not appreciate or control.

The consequences of recognizing competency and responsibility in a prison disciplinary proceeding are not as threatening as might first appear. That is, there is no loss or even impairment of custody. Whether incompetent or irresponsible the inmate would be placed in a treatment environment and there subjected to the control deemed necessary. There will be the marginal cases, and there will be those who "fake it." The answer to these problems must be that the possibility of abuse ought not to dominate the search for acceptable general principles.

Every jurisdiction should formulate a policy on these questions and, in addition, create mechanisms whereby marginally competent inmates in disciplinary proceedings are afforded even more assistance at the hearing than would be afforded the normal inmate.[185] Special attention should be given to the mentally retarded inmate whose disability will likely have more of an effect on competence to be tried than on responsibility for the alleged infraction.

b. Conditions of Confinement

At this point we shall examine some of the leading decisions on the conditions of confinement in the isolation which may result from a disciplinary proceeding. McCray v. Burrell, involving the Maryland Penitentiary, raises many questions about isolation as well as the interaction between punishment and treatment.[186] McCray initially asked to be removed from his cell on the grounds that it was unsanitary. The warden issued an order that the inmate's law books be provided to him in his new cell but there was some delay and a disturbance ensued.

An officer had McCray placed in Isolated Confinement (IC), which further enraged the inmate. The officer now viewed the behavior as evidence of mental instability and directed McCray be placed in IC without clothing or bedding. The cell was described as:

> quite long and narrow with a high ceiling. The walls, ceiling and floor were all concrete and there was a one-foot high concrete slab, six to eight feet long and three feet wide, which was McCray's bed. Although, initially, McCray was furnished no blankets or other bedding, during the night a prison guard gave him a mattress. McCray testified that it was so cold that he tore open the mattress, which was old and deteriorated, and dug a channel down in the cotton so that he could sleep nestled in the mattress. Subsequently, McCray was disciplined for destroying the mattress.
>
> The cell contained a toilet and a sink. The record does not show whether the cell had a window, but evidence was offered that there was a lightbulb recessed in the rear wall. The cell had two doors -- the inner one composed of bars, and the outer one made of solid wood but not closed. McCray was given no materials with which to clean himself or the cell, and he was fed in plastic cups. He was deprived of reading and writing materials.
>
> The next morning Sergeant Smith returned to check on McCray and found that he had defecated into a cup and smeared feces over himself and the cell wall. Accordingly Smith decided not to return him to his former cell. Instead, he had McCray bathed and the cell scrubbed, and then returned McCray to I.C. cell No. 5 for another twenty-four hours. It was not until that time that Smith caused notice to be given to a psychologist or psychiatrist in accordance with the applicable written administrative directive which had become effective August 10, 1970. The directive stated that 'an inmate who is displaying mentally disturbed behavior may be placed in an isolation cell for the inmate's own safety, or that of the inmate population, until the psychologist/psychiatrist is notified ...' and directed that the '<u>psychologist/psychiatrist should be contacted immediately after the confinement of the inmate, and the inmate should</u>

be evaluated within a twenty-four (24 hour period.' By its terms, the directive permitted the placing of inmates displaying mentally disturbed behavior in a punitive or isolation cell when the institution lacks a mental observation cell and a psychologist or a psychiatrist approves the lodging of such an inmate in an isolation cell.

> The next day, November 22, McCray according to Smith, 'started acting [sic] alright.' He was then returned to his regular cell on the third tier. We infer that McCray's clothes were not returned to him until this time. The record on appeal does not show that he was ever evaluated by a psychologist or a psychiatrist.[187]

On or about January 1, 1972, McCray again was removed to another cell, where a fire soon broke out. Captain Burrell, not unreasonably according to the court, concluded that McCray set the fire and placed the inmate in a mental observation (MO) cell. Again, the inmate was denied clothing, a mattress, and any bedding.[188]

> The M.O. cell in which McCray was placed was described by Captain Burrell as a bare cell. The windows were covered with sheet metal, but the cell had an electric light. The cell had concrete walls, a concrete ceiling, and a tile floor. There was no sink, and the only sanitary facility was an 'oriental toilet' -- a hole in the floor, six to eight inches across, covered by a removable metal grate which was encrusted with the excrement of previous occupants. The 'toilet' flushed automatically once every three to five minutes. McCray was not permitted to bathe, shave or have or use articles of personal hygiene, including toilet paper. He was not afforded reading or writing materials. He claimed that during the forty-six hours he spent in this confinement 'it was impossible to sleep ... I stood up most of that [first] night, the floor was cold.'[189]

The district court found that the inmate's confinement in these cells was intended not as punishment but for mental observation and as a precaution against self-inflicted harm. The court of appeals, however, disagreed and found that, while these confinements were not intended as punishment, they amounted to punishment in violation of inmate McCray's Eighth Amendment rights.[190]

The court reasoned that McCray's isolation occurred within a prison context and was, in whole or part, a reaction to his misdeeds. Characterizing this reaction as punishment, the court determined that the Eighth Amendment was applicable, and went on to decide whether cruel and unusual punishment had been inflicted.[191]

The court determined that two separate violations had occurred. First, when the initial protective measures were taken, a clinician should have been contacted immediately and an evaluation performed within 24 hours. The administrative directive calling for this procedure was held to be the constitutional minimum as well. Thus the discomforts and suffering during the period of unwarranted delay in seeking professional diagnosis and help was found to be a cruel and unusual punishment.[192] Second, the conditions of confinement in the MO cell per se fell short of the current standards of decency of present-day society. Indeed, it is probably of no legal consequence that the inmate may have been mentally disordered. The previously described conditions in the MO cell are not constitutionally acceptable for any inmate.

This, of course, is an extreme case, but it does invite some generalizations. Here a written directive to seek professional advice and care is treated as a constitutional obligation.[193] Where prison officials defend a practice by saying it is treatment and not punishment, that argument triggers the obligation to seek further help. If officials characterize this type of practice as punishment, then they face the demands of meeting civilized standards of decency and a compelling Eighth Amendment claim.

In an interesting Pennsylvania case involving broad-based challenges to conditions in the prisons, Judge Lord wrote, "[i]t is clear that [solitary] confinement is not per se violative of the Eighth Amendment."[194]

After upholding the isolation cells at three other prisons, he reviewed the Huntingdon Correctional Institution and found certain isolation cells intolerable.

> The maximum security area at Huntingdon contains 144 cells. The psychiatric quarters consist of seventeen cells. Three of these cells are known as the 'Glass Cage' and provide the focus of the Huntingdon inmates' constitutional attack. We conclude that use of the Glass Cage constitutes treatment so inhumane and degrading as to amount to cruel and unusual punishment. Its continued use cannot be tolerated.
>
> The Glass Cage is enclosed by glass walls and a locked steel door. The cells measure approximately nine feet deep by eight feet wide

> by nine feet high. There is no furniture, no window, and no inside lighting. Cells are equipped with a toilet and sink and are supposed to include a mattress, two sheets, a pillow, and blankets. We saw none of these items during our visits, but the cells were not in use at that time. Outside lighting is totally inadequate for reading. In addition, despite use of a large fan, ventilation is insufficient. The cells are unclean and an unpleasant odor pervades.
>
> Our conclusion that the cells in the Glass Cage cannot remain in use is based in large part on our two visits to the institution. On each occasion we were genuinely shocked by dark, dirty, and totally isolated conditions we observed. We agree with plaintiffs that the continued existence of the Glass Cage constitutes a serious threat to the physical and mental well-being of every resident who is confined there, and thus we conclude that confinement in such conditions could serve no legitimate penological purpose.[195]

Judge Lord's reference to psychiatric cases seems almost casual and clearly is not central to his finding the Glass Cage as unconstitutional. Laaman v. Helgemoe, however, provides a much more direct reference to the special needs and problems of the mentally disordered inmate and the use of isolation.[196] The isolation cells in New Hampshire are described as having "the potential of devastating psychic, emotional, and physical damage."[197]

Judge Bownes wrote further that:

> The experts concurred that the use of isolation for disturbed inmates violates all modern treatment practice and is potentially destructive and physically dangerous. Disturbed persons need at a minimum, to be observed and not to feel isolated and abandoned. Isolation is counterproductive in terms of treatment ....[198]

In a very recent ruling concerning isolation, the First Circuit confronted the question:

> whether very extended, indefinite segregated confinement in a facility that provides satisfactory shelter, clothing, food, exercise, sanitation, lighting, heat, bedding, medical and psychiatric attention, and personal safety, but

> virtually no communication or association with fellow inmates, which confinement results in some degree of depression, constitutes such cruel and unusual treatment, violative of the Eighth and Fourteenth Amendments, that prison authorities can be required to provide several hours' daily interaction with other inmates.[199]

The court concluded that such isolation was not unconstitutional and stated:

> We do not suggest that the district court's prescription of several hours of inmate contact a day is a mere 'amenity', to use the language of Newman. It might very well be helpful therapy. But to accept plaintiff's proposition that there is a constitutional right to preventive therapy where psychological deterioration threatens, notwithstanding that the physical conditions of confinement clearly meet or exceed minimal standards, would make the Eighth Amendment a guarantor of a prison inmate's prior mental health. Such a view, however civilized, would go measurably beyond what today would generally be deemed 'cruel and unusual.'
>
> We conclude that the confinement which has taken place in this case has not been wanton, unnecessary, or disproportionate and that there has been no 'deliberate indifference' to the mental health needs of plaintiff.[200]

In arriving at its decision, the court relied heavily on the landmark case of Newman v. Alabama,[201] and from it extracted this grim but probably accurate quotation:

> The mental, physical, and emotional status of individuals, whether in or out of custody do deteriorate and there is no power on earth to prevent it .... We decline to enter this uncharted bog. If the State furnishes its prisoners with reasonably adequate food, clothing, shelter, sanitation, medical care, and personal safety, so as to avoid the imposition of cruel and unusual punishment, that ends its obligations under the Amendment Eight. The Constitution does not require that prisoners, as individuals or as a group, be provided with any and every amenity which some person may think is needed to avoid mental, physical, and emotional deterioration.[202]

In Ferola v. Moran[203] the inmate was awarded damages for the suffering he endured when his cell became the equivalent of an isolation unit. He lost his claim that he did not receive adequate psychiatric care while imprisoned in Rhode Island. Ferola was diagnosed as having an anti-social personality as defined in DSM-III. He was seen by a psychiatrist at least once a week for approximately two years. Treatment, however, did not reduce the self-injurious and anti-social behavior.

In 1980, Ferola severely cut himself and was taken to the hospital where the wound was sutured. On his return to prison Ferola said he was going to injure himself again because he wanted to be in the prison hospital. At this point the prison psychiatrist had a dilemma and his record entry is most interesting:

> 'He has been superficially slashing his wrists and beating his head against wall. So far, his self-inflicted injuries have not been such that he has had to be placed in the Dispensary for medical or surgical reasons. He may very well harm himself sufficiently to receive such placement. Can this be prevented?
>
> 1. Were I to place him in observation he still could harm himself and would if his placement were not satisfactory to him. Therefore, to place him in the rear room now would be to consent to being manipulated with no reasonable end in sight.
>
> 2. Should I load him up with Thorazine, whether in BCU (Behavioral Correctional Unit) or in Dispensary? This kind of pharmaceutical behavior control is acceptable to totalitarians but is repugnant to our culture and ethical values. There is no psychiatric ground present at this time for an invasive pharmaceutical intervention.
>
> 3. Should he be restrained physically in order to reduce the likelihood of serious selfinjury? This non-invasive procedure impinges less immediately on his integrity and exposes him less to personal degradation, although it appears more brutal. Physical restraint would seem to be the response of choice, however short of ideal it may be.
>
> 4. Must he be placed in the Dispensary to be restrained? No! Physical restraint, whether short lived or more prolonged, is a proper

> custodial activity. Custodial authorities, for a variety of reasons, do not like to be involved in more prolonged physical restraint. While I can sympathize with them, I can not agree that dislike for an acceptable procedure is a sufficient reason to shift the burden to the medical staff under the arbitrary and false rubric that the inmate is 'crazy and belongs in the rear room.' Consequently, in response to Erickson's call, I advised him to follow custodial procedure, assuring him that Ferola is not a psychiatric patient.'[204]

The doctor's record entry reveals a thoughtful process akin to the "least intrusive alternative" approach adopted by some courts faced with similar problems. The doctor rejected use of the psychiatric observation room (the "rear room") and the use of restraint in a treatment setting. Ferola was diagnosed as anti-social and untreatable and more a disciplinary problem than a medical problem.

Ferola's own cell became, in effect, the isolation unit when it was stripped bare and Ferola shackled and handcuffed in a supine position. For 20 hours he was shackled to his bed and for fourteen consecutive hours he was spread-eagled.[205]

Judge Pettine first noted that prior cases

> establish that, while there is no <u>per se</u> constitutional prohibition on the use of restraints such as shackles, chains, handcuffs and the like, courts must review with great care the circumstances surrounding their use in a particular instance to determine whether the strictures of the Eighth Amendment have been satisfied. These cases are, of course, only particular applications of the general rule that no measure instituted by prison officials, whether it be denominated 'punishment,' 'control,' 'treatment,' or otherwise, may inflict wanton and unnecessary pain. And in these cases, as is generally true in Eighth Amendment analysis, the individual circumstances surrounding a challenged measure, including its duration and the objective sought to be served, weigh heavily.[206]

Relying both on Rhode Island prison regulations forbidding restraints which cause physical pain or discomfort and Eighth Amendment principles, Judge Pettine found:

1. The absence of medical monitoring, control or supervision during the shackling created health risks.

2. The spread-eagling and tightness of the restraints caused pain which should have been mitigated.

3. Denial of access to a toilet for at least fourteen consecutive hours worked great and gratuitous suffering.[207]

The plaintiff was awarded one thousand dollars compensatory damages and Judge Pettine granted equitable relief in the form of imposing on Rhode Island the Federal Prison System's rules on restraint.[208]

Ferola is not an isolation case in the sense that the inmate was placed in restrictive prison housing used exclusively for segregation purposes. The inmate's cell became a functional isolation unit and the practices encountered here are too often encountered in special housing units. Great care should be used in restraining the unruly inmate and, very clearly, medical supervision and the infliction of minimal pain are legal prerequisites.

In Inmates of Occoquan v. Barry, the court dealt with the prison's use of a unit used for disciplinary and punitive segregation as a holding area for mentally ill prisoners awaiting transfer to a mental hospital.[209] The court found that this confinement was inappropriate and aggravated the inmates' mental condition.

While it is not clear what specific relief was granted -- the court ultimately placed population limits on the prison -- it appears that confinement in this unit for over 24 hours was proscribed.[210]

The final isolation issue concerns prisoners facing the death penalty. Such prisoners always are confined in a form of isolation. These inmates obviously have at least the same rights to medical and psychiatric care as other inmates. The interesting question is whether their status as condemned and their pro forma isolation combine to create a special set of needs.

In Peterkin v. Jeffes the district court judge stated: "Since I find that the capital inmates' collective medical needs are serious, I only consider whether the system of care evinces a deliberate indifference to their medical needs."[211] The court upheld the prison system's provision of psychiatric and counseling services while seemingly accepting as self-evident that condemned inmates had an Eighth Amendment right to such care.[212]

To conclude this Section, it should be emphasized that the critical legal aspects of isolation and the mentally disordered inmate relate, first, to the provision of the basic conditions necessary for simple survival and, next, to the duration of confinement and the special needs of the mentally disordered inmate. Where clinical judgment so dictates, the use of temporary isolation along with regular observation to deal with an acting-out inmate is not likely to create any legal problems. Prison officials have a duty to preserve life and limb, and limited use of isolation may indeed be more humane and effective than longer use of body restraints or the reliance on psychotropic drugs.

2. Records

While visiting with the head of psychiatric services at a southern state's prison facilities, I casually asked about the medical recordkeeping system. The doctor moved things about his desk, seeming to search for something. Looking relieved, he found a paper restaurant placemat and on the back he located some record entries dealing with mentally ill prisoners.

The right to receive, and the obligation to provide, treatment creates important ancillary duties. The preparation and maintenance of adequate medical records often is judicially recognized as an integral part of providing constitutionally acceptable medical care. In Ruiz v. Estelle Judge Justice clearly articulated the purposes of proper medical records:

> legal documentation of treatment; audits of the quality of treatment; providing an indication of the needs of treatment of the institution; a record of major illnesses; and a record of treatment that can be followed by a doctor who is unfamiliar with the patient.[213]

In Ruiz records that consisted merely of the inmate's complaint and documentation of prescribed medication were found to be inadequate. The records at corrections facilities failed to include the physician's diagnosis, test results, entries indicating the care actually provided, and admission and discharge summaries.[214]

Furthermore, inmates frequently made or transcribed the records and many inmates had access to them. The court held that inmate involvement contributed to the inaccuracy of the records and also represented an invasion of privacy.[215]

The essence of the ruling is that "accurate, complete, and confidential records of the mental health treatment process must be maintained."[216] Obviously, utilization of such informal methods as the back -- or even the front -- of a placemat is inherently unacceptable by every criteria used to measure the legal adequacy of mental health records.

In a very important decision involving consent to psychotropic medication, Bee v. Greaves,[217] the ambiguity of the attending psychiatrist's records formed an important backdrop for the decision. The plaintiff, a detainee of the Salt Lake County Jail, was forcibly medicated intramuscularly and then required to continue the unwanted medication (Thorazine) orally for several weeks under the threat of forcible injection. The record notation in question read simply: "give repeat." At the doctor's deposition he stated that this meant he would allow one more intramuscular injection if there was a refusal to accept oral medication. Any further injections, said the doctor, would call for additional medical instructions.[218]

The court, however, concluded that the jail staff clearly interpreted this notation to mean that the doctor authorized them to medicate the detainee against his will any time he refused oral medication. This led to the further critical finding that all subsequent medications over roughly a three week period were taken under the continuing threat of force.[219] The point was critical to the plaintiff's victory in this case.

In Hendrix v. Faulkner[220] the court reviewed testimony indicating chaotic and disorganized medical record-keeping, but ultimately found that this situation did not create a constitutional violation. Testimony indicated that although records were sometimes incomplete, records of intake screening were adequate, and the physician's notes were intelligible and contained sufficient information to indicate to a reviewer the manner and approach to treatment.[221] The major flaw in the record keeping system was the absence of a suspense file which would trigger information on the need for follow-up visits. Most inmates were left to their own devices to request a follow-up visit through the normal sick call procedure. The court concluded that these problems were not in the nature of a constitutional violation and accepted testimony indicating that the medical records procedure was being reevaluated.[222]

As an important aspect of the minimal care available in the Virgin Islands, the district court's order states:

> Complete and accurate medical records should be maintained under the physician in charge. Whenever an inmate is involved in a situation with another inmate or staff member which requires medical attention, a complete record of his physical condition shall be made at the time.[223]

In Burks v. Teasdale the court found that the Missouri prison's record-keeping system contributed to the overall unacceptability of the medical care provided.[224] This court emphasized the constitutional necessity of continuity of care, an objective which was impaired by the frequent rotation of clinicians, decentralized records, and the general disorganization which prevailed.[225]

Surprisingly, the court did not find anything constitutionally objectionable about the use of inmates in the medical records department. Even if there is doubt about the connection between inmate access and quality of care, the potential for blackmail and other abuse is so great as to be an independent basis for denying access to such records.[226]

The Burks decision, to the contrary, held:

> This Court finds that while the use of inmates in the medical records department may be in many respects an undesirable practice, the evidence does not support a finding that a deliberate indifference to the serious medical needs of the inmates has resulted thereby. It was the opinion of one of plaintiffs' experts that for confidentiality purposes, inmates should not have access to the medical records. Defendants indicated that they have not experienced any problems with the use of inmates in the medical record department. In the absence of any showing of how the use of inmates for these clerical tasks has adversely affected the prisoner patients, the use of inmates in the medical records department is not proscribed on constitutional grounds.[227]

Record-keeping in the New Hampshire penal system fared no better than in Missouri. In Laaman v. Helgemoe[228] medical records were found to be deficient because no basis for medical care was noted; there were no written plans for future treatment; at times physicians used only an order sheet; and the records were disorganized.[229] Of 370 records submitted to the court for study, 75 percent contained no notation of a physical examination and 86 percent contained no medical history. Only 9 percent contained complete records, including a physical examination and a mental health diagnosis. Failure to document and record these matters, certainly including mental health diagnosis, was held to create a grave risk to the inmates because it prevented continuity of care inside and outside the prison.[230]

The court found the record-keeping inadequate and ordered that:

> Complete and accurate records documenting all medical examinations, medical findings, and medical treatment maintained pursuant to standards established by the American Medical Association, under the supervision of the physician in charge.[231]

Review of the South Dakota State Penitentiary's medical records revealed similar glaring deficiencies. In Cody v. Hillard, the court stated:

> The 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. Dawson v. Kendrick, 527 F. Supp. 1252, 1306-07 (S.D.W.Va. 1981) (quoting Burks v. Teasdale, 492 F. Supp. at 676). In Burks, 492 F. Supp. at 676, the court recognized 'the critical importance of adequate and accurate medical records in any attempt to provide a continuity of medical care.' It held that 'inadequate, inaccurate and unprofessionally maintained medical records' constituted a 'grave risk of unnecessary pain and suffering' in violation of the eighth amendment. Id. at 676, 678. Similarly, in Lightfoot v. Walker, 486 F. Supp. at 517, 724-25, the court found that inmate medical records were 'disorganized and failed to meet minimal standards' and that the recording system was not properly coordinated to ensure that all medical information and test results were entered in an inmate's file within a reasonable time. The court held that these deficiencies contributed to an unconstitutional health care system, and it ordered prison officials to develop and maintain '[c]omplete and accurate records documenting all medical examinations, medical findings and medical treatment...pursuant to accepted professional standards.' Id. at 527.
>
> Applying these principles to the instant case, the court concludes that the inadequate organization of medical records and files at the SDP constituted a deficiency in the health care system.[232]

In conclusion, the cases indicate that constitutionally acceptable physical and mental health care is highly dependent on adequate records. Mere disorganization and occasionally incomplete record-keeping will not violate constitutional minima, although the precepts of professionally acceptable care may dictate otherwise. Where the course of treatment is apparent and the clinician's notes intelligible, then minimum standards may be met. Where the records do not trigger an automatic follow-up, the practice may be dubious although not legally censorable.

The objectives to be achieved through proper record-keeping are well stated in Ruiz[233] and Cody, and those objectives should serve as a guide for those concerned with reviewing their practices and for those facing a challenge. At a minimum, documentation of diagnosis and the

record of treatment allowing the assessment and continuity of care seem to be the most basic considerations.

3. Substance Abuse Programs

In Marshall v. United States[234] the Supreme Court considered a challenge to the Narcotic Addict Rehabilitation Act of 1966[235] insofar as the Act excluded from discretionary rehabilitative commitment, in lieu of penal confinement, addicts with two or more prior felony convictions. Possibly the most persuasive argument for the excluded class of inmates was that the statutory classification had little or no relevance to the purpose for which it was made, and that the two felony exclusion rule would irrationally exclude some addicts most in need of, and most likely to profit from, treatment.

The Supreme Court agreed with the court of appeals that there was no fundamental right to rehabilitation from drug addiction at public expense after conviction of a crime and that there was no suspect classification in the statutory scheme.[236] This meant that the Act had to pass only a rationality test and the majority thought it rational for Congress to exclude those with two prior felonies on the grounds that they might be more disruptive and less amenable to treatment.[237]

Marshall stands as a major barrier, then, to any constitutional claims brought by narcotic addicts or alcoholics to rehabilitative care after conviction and confinement. It is appropriate to pause here and ask why a drug addict or an alcoholic does not have at least the same constitutional claim to treatment extended to the mentally disordered?

In Robinson v. California the Supreme Court determined that it was cruel and unusual punishment to convict and criminally punish a person for the status of narcotic addiction.[238] Counsel for the state conceded that narcotic addiction was an illness, citing Linder v. United States to support this view.[239]

Five years later, in Powell v. Texas, the Court dealt with the question of whether it was constitutionally permissible to punish a chronic alcoholic for being drunk in a public place.[240] The Justices apparently saw the potentially explosive implications of the expansion of the disease concept and elected to halt the logical push outward from Robinson. A plurality of the Court refused to concede that alcoholism was a disease and distinguished Robinson on the basis that in Powell there was conduct (being drunk in public) whereas in Robinson there was none.[241]

This is not the occasion for any detailed analysis of these decisions. Robinson and Powell may be read as deciding that it is unconstitutional to punish a person for having a disease -- at least where the state concedes the existence of a disease -- but it is permissible to punish a person who has a disease for criminal conduct.

Robinson does seem to turn on the Court's acceptance of narcotic addiction as a disease, while Powell is more cautious in characterizing alcoholism as a disease.[242]

However these complex decisions ultimately are read, the problems they deal with arise in the shadowy world of criminal responsibility. The concept of disease surely is not clarified. Thus, while Robinson and Powell cannot be ignored in this work, neither are they central, especially since the Estelle v. Gamble standard for medical care requires a serious disorder and, at least for some, there remains room to debate alcoholism and addiction on the seriousness scale.[243]

Substance abuse problems appear to abound among prisoners. A study of inmates admitted to the North Carolina prison system between March and May of 1983 revealed that half of the sample were (or had been) alcohol abusers and 19 percent were dependent on drugs.[244] The data, and general impressions, support the view that alcohol and drug abuse are important factors in the criminal behavior of a very high percentage of inmates.[245]

When directly confronted with a constitutional claim to treatment for problems of substance abuse, courts consistently reject it. On the other hand, there are many instances where drug and alcohol treatment programs are ordered (or agreed upon) when these problems are presented in the larger framework of an overall failure to provide adequate medical or psychological care. Thus the legal obligation to provide substance abuse programs seems highly dependent on how the claim is presented.

Pace v. Faver presented the district court directly with the question "whether failure to provide treatment for alcoholic prisoners constitutes cruel and unusual punishment, in violation of the Eighth Amendment...."[246] The court recognized the constitutional obligation of government to provide medical care to those it confines and, correctly, pointed out that any alleged failures were measured by the less-than-demanding standard of deliberate indifference. The court went on to state:

> Nor may it be assumed that every debilitation or addiction cognizable as medically-related requires that the government establish a treatment facility or program in order not to violate a prisoner's Eighth Amendment rights. Rather, in order to state a sufficient Eighth Amendment claim a plaintiff must show such deliberate indifference on the part of prison officials to his serious medical needs as to offend evolving standards of decency. As the Third Circuit has stated, 'not every injury or illness evokes the constitutional protection -- only those that are 'serious' have that effect.' A 'serious' medical need may fairly be regarded

> as one that has been diagnosed by a physician as requiring treatment or one that is so obvious that a lay person would easily recognize the necessity for a doctor's attention.
>
> The Court does not regard plaintiffs' desire to establish and operate an alcoholic rehabilitation program within Rahway State Prison as a serious medical need for purposes of Eighth Amendment and Sec. 1983 analysis. As the Supreme Court has stated in the context of drug addiction, 'there is no 'fundamental right' to rehabilitation ...at public expense after conviction of a crime.' [citing Marshall v. United States]...[T]his Circuit has held that there is no constitutional right to methadone or to the establishment in prisons of methadone maintenance facilities for the treatment of drug addiction, although under certain emergent circumstances failure to provide a prisoner with methadone treatment may constitute an Eighth Amendment violation.
>
> The Court takes judicial notice that alcohol and narcotics abuse is a serious problem in the United States. Moreover, the Court recognizes that in deciding whether the Eighth Amendment requires that State prison and health officials allow the establishment of rehabilitation programs, that Amendment 'must draw its meaning from the evolving standards of decency that mark the progress of a maturing society.' However, whatever may be our hopes for the standards of the future, the Court cannot at this time hold that failure or refusal to provide opportunities to establish and operate alcoholism rehabilitation facilities in state prisons rises to the magnitude of cruel and unusual punishment.[247]

The Pace court did not anguish about the complexities of the disease concept and quietly slipped in references to rehabilitation vis a vis treatment, thus making it easier to deny the inmate claim. As was noted, claims to rehabilitation generally lose while claims to treatment for serious diseases may win.

Norris v. Frame confronted the Third Circuit with a pretrial detainee who was denied access to a methadone maintenance program he was participating in at the time of his arrest and subsequent detention.[248] Finding that a detainee's legal status exceeded that of a convict, the court concluded that Norris had made out a claim to an interference with

a protected liberty interest in the continuation of his drug treatment program. On remand, the state was invited to show whether a countervailing security interest could be shown to outweigh the detainee's interest in the continuation of his treatment.[249]

In Palmigiano v. Garrahy the court found a variety of conditions at the Rhode Island Adult Correctional Institutions (ACI) to be below constitutional minima.[250] Among its findings, the court linked the prison system's failure to identify drug users as a contributing factor in the increased drug traffic, increased risk of suicide, and overall deterioration in the prison.[251]

The chief physician at ACI testified that between 70 and 80 percent of inmates enter as drug abusers and remain drug abusers while confined. The court found no written or unwritten protocols or policies despite the powerful dimensions of the problem.[252]

The court ordered that:

> 8. (a) Defendants shall within thirty days from the entry of this order establish a program for the treatment of inmates physiologically addicted to drugs or alcohol that does not require withdrawal by means of an abrupt denial or 'cold turkey' approach.
>
> (b) Defendants shall within three months from the entry of this order establish a program for the treatment of drug abuse that is in compliance with the minimum standards of the American Public Health Association, the United States Public Health Service, and the Department of Health, State of Rhode Island.
>
> (c) Defendants shall within thirty days from the entry of this order place the responsibility for the treatment of drug abuse under a physician able and willing to treat prison addicts.[253]

In Palmigiano the trial judge was far more willing than his fellow judges to deal with drug and alcohol abuse as medical problems requiring a treatment response. There is no extended analysis of the disease concept, and those searching for doctrinal purity would insist on a more vigorous analysis of "serious disease" and the "deliberate indifference" standard. This court, when shown a problem of crippling dimensions with an insidious effect on prison life, elected to press the constitutional treatment button.[254]

In conclusion, it seems plain enough that substance abuse problems are rife in our prisons and jails and that the cases on point are inconsistent and often poorly reasoned in dealing with this problem as "disease," or if seen as a disease, in recognizing that it is sufficiently serious to evoke constitutional protection. Although the constitutional mandate may be murky or lacking, programs for substance abusers are among the most common in our prison systems.

4. Rehabilitation

In more than a few cases, issues involving treatment and rehabilitation are confounded and dealt with in overlapping fashion.[255] Rehabilitation:

> refers to the process of restoring the individual to behaviors and values which fall within the social definition of what is acceptable. Socially acceptable behaviors and values are by definition not 'illegal.' Thus, it is assumed in the rehabilitative process that the individual formerly held socially acceptable values with appropriate behavior and temporarily laid it [sic] aside.[256]

The supposed differences between treatment -- to which there now is a clear but narrow constitutional right -- and rehabilitation -- to which there is no clear right -- may be more formal than real. In our context we view treatment as a mental health response to a disease process, while we see rehabilitation as a forward looking response to inadequate or improper socialization. Thus, in addition to the distinctions noted earlier, another difference between treatment and rehabilitation may be in the causal assumptions about the individuals' problem.[257]

A further difference relates to professional and occupational claims over the particular territory. Mental health professionals, with psychiatrists and psychologists as the elite, provide treatment services. Efforts at rehabilitation certainly may, but need not, include mental health professionals. Indeed, what constitutes rehabilitative activity is so amorphous, and the claims to success so dubious, that rehabilitation founders at its conceptual and empirical core.[258]

Ohlinger v. Watson, a fascinating decision that will be discussed at some length, contains the following sentence: "Lack of funds, staff or facilities cannot justify the State's failure to provide appellants *with that treatment necessary for rehabilitation*."[259]

The italicized phrase should be digested slowly -- treatment-for-rehabilitation. Does this indicate some unpublicized marriage of the two concepts? Is it just loose usage and perhaps attributable to the context of the case? Is this an example of the conceptual dilemma posed by treatment and rehabilitation?

Ohlinger, in fact, is a special case. It involves a situation where the inmates had been convicted under a sodomy statute carrying a maximum term of 15 years but were confined under indeterminate life sentences on a finding that they possessed a mental disturbance predisposing them to the commission of sex offenses.[260]

In analyzing what ultimately is recognized as a statutory right to treatment, the court stated:

> Having chosen to incarcerate appellants on the basis of their mental illness, the State has determined that it no longer has an interest in punishing appellants, but rather in attempting to rehabilitate them.
>
> The rehabilitative rationale is not only desirable, but it is constitutionally required. Robinson v. California, strongly suggests that the State may not justify appellants' extended sentence on the basis of mental illness without affording appropriate treatment. The Supreme Court of California has so interpreted Robinson. Indeed the State concedes that appellants are constitutionally entitled to treatment. The disagreement between the parties is solely over the level of treatment which is constitutionally required.
>
> The district court held that '[a]ll that is required is that [appellants] be provided a reasonable level of treatment based upon a reasonable cost and time basis.' We do not agree.
>
> Constitutionally adequate treatment is not that which must be provided to the general prison population, but that which must be provided to those committed for mental incapacity.[261]

The opinion in Ohlinger uses the terms rehabilitation and treatment interchangeably. This appears to be more careless than considered. For example, in reviewing the appellants' individual needs the court emphasized the inadequacy of the limited group therapy available and held: "The treatment provided appellants, therefore does not give them a reasonable opportunity to be cured or to improve their mental conditions."[262]

Ohlinger considered the relevance of Bowring v. Godwin[263] but found it inapplicable precisely because Bowring involved inmates confined for their offenses, while the instant decision involved inmates confined, at least in part, because of their mental condition. In the Bowring situation, then, an "ordinary" inmate would have no constitutionally

recognized claim to rehabilitation or treatment, treatment being reserved for those with serious mental disorders. In the Ohlinger situation the special findings and extended term of confinement create a hybrid constitutional and statutory claim to psychiatric care.[264]

Despite the implications of Ohlinger, the widely followed general rule is that there is no constitutional right to rehabilitation, rehabilitation being the operative term applied to claims for affirmative programs by ordinary inmates or even those with problems of substance abuse. Rehabilitation, in the sense of efforts to socialize or resocialize inmates where a disease model is not imposed, does slip into some decisions and does so in various ways.[265]

Some courts will assess the general unavailability of rehabilitative programs as an aspect of a broader claim that the overall conditions of a prison or jail are unconstitutional. Another approach is to view the unavailability of rehabilitative programs either as a factor militating against self-help and reform or as contributing to the emotional deterioration of inmates.[266]

Justice Stevens, alone among his Supreme Court colleagues, has yet another view of rehabilitation in prison. In dealing with the problem of whether procedural due process should apply to interprison transfers, Justice Stevens, in dissent writes:

> Imprisonment is intended to accomplish more than the temporary removal of the offender from society in order to prevent him from committing like offenses during the period of his incarceration. While custody denies the inmate the opportunity to offend, it also gives him an opportunity to improve himself and to acquire skills and habits that will help him to particpate in an open society after his release. Within the prison community, if my basic hypothesis is correct, he has a protected right to pursue his limited rehabilitative goals, or at the minimum, to maintain whatever attributes of dignity are associated with his status in a tightly controlled society. It is unquestionably within the power of the State to change that status, abruptly and adversely; but if the change is sufficiently grievous, it may not be imposed arbitarily. In such case due process must be afforded.[267]

More recently, in Rhodes v. Chapman the Court refused to equate prison overcrowding with cruel and unusual punishment.[268] Diminished job and education opportunities due to overcrowding were found not to violate the Eighth Amendment, even when viewed as "desirable aids to rehabilitation."[269]

The right to avoid degeneration is explicitly recognized by some courts.[270] In Battle v. Anderson the Tenth Circuit said: "while an inmate does not have a federal constitutional right to rehabilitation, he is entitled to be confined in an environment which does not result in his degeneration or which threatens his mental and physical well-being."[271]

The nature of this emergent duty to prevent degeneration was synthesized by the court in Laaman v. Helgemoe.[272] The court said the conditions of incarceration should not threaten the inmates' sanity or mental well-being, should not be contrary to the inmates' efforts to rehabilitate themselves, and should not increase the probability of the inmates' future incarceration.[273]

The Laaman court included the scarcity of rehabilitation, recreation, and skills training as part of its balance sheet demonstrating that prison life in New Hampshire causes prisoners to degenerate and lose whatever social conscience and skills they may have had.[274] In its expansive order, the court required vocational training programs, meaningful access to services and programs that are offered, and also mandated certain programs with an emphasis on pre-release inmates.[275]

In Pugh v. Locke[276] the Alabama prisons were subjected to very much the same analysis as the New Hampshire prisons. Conditions in those prisons were found to be generally deficient, with failure to provide rehabilitation opportunities listed among the system's many liabilities. Among other things, the court ordered that inmates be provided with the opportunity to participate in job and educational programs.[277]

Canterino v. Wilson is a somewhat unusual decision resting on equal protection grounds when comparing the programs available to female inmates with those available to men. Equal protection analysis does not lead to the creation of rights.[278] Rather, the problem is the fairness or rationality with which desirable items -- here rehabilitative programs -- are distributed and the rationale used to support the challenged misallocation.

Where gender is the basis for unequal distribution, "The State must show that the disparate treatment of females is substantially related to an important government objective."[279] Judge Johnstone found that equal protection was violated in the unequal distribution of resources and in the more onerous conditions imposed in the exercise of privileges. The assumption underlying the gender-based disparities appeared to be the innate inferiority of women, a proposition that was rejected out of hand.[280]

Thus it should be kept in mind that while a system may not be legally obliged to provide rehabilitative opportunities, when it does, gender-based (and obviously, racially-based) discrimination will likely violate the Equal Protection Clause of the Fourteenth Amendment.

To conclude this topic, it may appear odd to analyze inmate claims to rehabilitation at a time when sentencing policy is so strongly committed

to just desserts and punishment. Our concern with rehabilitation, however, is not directly related to judicial sentencing goals. It is with the conceptual and factual overlap between rehabilitation and treatment and with the minimal obligations of constitutionally mandated care imposed on our penal systems.

This is an area where it is relatively easy to identify and state the general rules: yes, there is a limited right to treatment; no, there is no general right to rehabilitation.

If one digs a bit, however, one uncovers a line of decisions that consider the lack of rehabilitative opportunities as a factor in the overall assessment of conditions in prison. Where the overall conditions in a prison, or prison system, are so primitive as to contribute importantly to inmates' mental or physical debilitation then a finding of an Eighth Amendment violation will likely result in an order where no practical distinctions may be drawn between treatment and rehabilitation. Again, however, this is a far cry from an affirmative duty to provide opportunities for self-improvement.

Finally, although unadorned claims to rehabilitation are rejected when urged straightforwardly as demands for substance abuse programs, such programs do slip into judicial orders and consent decrees when the problems in a given prison are massive and the necessary relief encompassing.

5. Suicide

The decision to deal separately with suicide is based on a single premise: suicide is the most extreme manifestation of personal despair and breakdown and it is also a statistically significant problem. Just under 50 percent of all jail deaths are suicides.[281] Only about 10 percent of all prison deaths are suicides and, indeed, in terms of actual numbers, prison suicides are only about a quarter of the jail suicides.[282]

Professor Hans Toch, perhaps the most prominent scholar of prison violence, describes the social-psychological dimension of inmate self-injury:

> Contrary to stereotypes, most inmate self-injuries reflect concrete and intense personal breakdowns. Most frequently, these are crises of self-doubt, hopelessness, fear, or abandonment. There are also psychotic crises -- problems of self-management, tension, delusions, or panic. At best, self-directed violence mirrors helplessness, and involves coping problems with no perceived solution. Crises vary with type of population. They are more prevalent among youths

than among older inmates, and among white and Latin inmates. Prisons feature different crises than jails; married inmates, for instance, feel more vulnerable in jail, while single inmates suffer more heavily in prison. Ethnic, sex, and age groups differ in their special vulnerabilities. Latin inmates, for example, are often acutely upset if they feel abandoned by relatives; women have problems with loneliness, or with the management of their feelings.

Prisons as living environments cannot control the stresses they may tend to produce. Different inmates react to different aspects of their imprisonment as particularly stressful. While some men are susceptible to the press of isolation, others react to crowding, conflict, coldness, or the aggressive challenges of peers.

Whatever the shape of a man's crisis, the institution has no truck with it when the inmate reacts with self-inflicted violence. The yard's measure of esteem is manliness. Self-injury means despair, and despair is unmanly. The inmate-in-crisis must deny his problems to survive. Others must deny them too. If problems are recognized, the inmate is stigmatized. If they are not recognized, he is abandoned.[283]

Legally, however, the potential suicide cannot be abandoned. Collins v. Schoonfield is representative in holding that a jail is constitutionally required to provide access to medical care, treatment, and adequate suicide prevention measures.[284]

Among the more serious mistakes in dealing with suicidal inmates is the reflexive use of isolation, and, still worse, unsupervised or non-professionally supervised isolation. In Lightfoot v. Walker the district court determined that Menard, Illinois prison officials frequently placed potential suicides in "control cells" without informing the administrator of the medical unit.[285] Also, these suicidal inmates were cared for randomly by technicians and not professional clinicians.[286] In its decree the court ordered, among other things, that:

> Defendants shall provide an adequate number of mental health professionals to diagnose, treat and care for those prisoners who have mental health problems, inmates requiring evaluation shall be promptly referred to this staff; suicidal inmates shall be referred on an emergency basis and kept under observation in suitable conditions.[287]

Ruiz v. Estelle squarely determined that minimally adequate health care requires "a basic program for the identification, treatment, and supervision of inmates with suicidal tendencies ...."[288] Judge Justice condemned the practice of ignoring or punishing inmates who attempted suicide, something which frequently occurred in Texas.

The recent decision in Guglielmoni v. Alexander[289] contains one of the most comprehensive analyses of the legal issues relevant to suicide prevention and liability for failure to prevent suicide. This was a federal civil rights action for damages brought by the mother of a prisoner serving a one year prison term for the crime of "threatening." Three months after beginning his sentence the son was found hanging by a shoelace from a light fixture in his cell. He was basically unharmed this time and was placed in isolation.[290] A doctor who had given the inmate psychiatric treatment over a period of years saw him the same day as the incident and concluded that the act was essentially a manipulative gesture designed to bring about a transfer.[291]

Two months later the inmate was seen with torn bedsheets around his neck which he appeared to be tying to his cell bars. He was stopped and again placed in isolation. Shortly thereafter he was seen by the same doctor who reached the same conclusions as to "manipulative behavior."

Four days later the inmate was found dead, hanging from a light fixture in his cell, a shoelace around his neck.[292]

The State offered two primary arguments for their motion to dismiss the claim without a trial. First, they argued that there is no constitutional right to be protected from suicide. Second, they claimed that there was no genuine issue as to the adequacy of the care actually provided; that mere negligence, as opposed to "deliberate indifference," is not a basis for liability.[293]

The argument around the first point seems to be that a self-inflicted injury is not an act which is attributable to the State. Conversely, if the State injures someone then the act and potential responsibility are attributable to the State.

The fatal flaw in this argument is, of course, that legal liability may rest on affirmative harm-producing conduct as well as a culpable omission; which is the failure to act when there is a duty to do so. The federal district court dismissed this defense argument stating:

> This argument is without merit. Just as the eighth amendment reaches psychiatric care as a component or aspect of medical care, so too is protecting inmates from themselves as an aspect of the broader constitutional duty to provide medical care for inmates. Defendants' research failed to uncover a recent case facing this question and [not] (sic) flatly rejecting the proposition for which defendants contend....[294]

In answering the claim regarding the adequacy of care, the judge noted that courts ordinarily will not "second guess" treatment or diagnosis. While it is true that the federal judiciary has moved increasingly toward a "hands off" attitude concerning much of prison administration, less deference is shown prison officials in matters of medical care.[295] The court decided that material issues of fact remained for subsequent decision.

In Guglielmoni the court appeared to treat two issues as one, or at least seemed to confuse the issues. Prison officials had two independent duties in this case: the first was to provide constitutionally acceptable medical care for whatever serious mental illness one might diagnose in the wake of the suicide attempts. The other was an independent duty to protect the suicidal inmate from himself regardless of the reasons for the suicidal behavior.

On the latter duty the critical issues include the extent and frequency of observations, the availability of items which might be used in committing suicide (e.g., the source of the shoelaces), the furnishings and physical setup of the cell, the existence and observance of a suicide protocol,[296] and similar matters. Compliance with the duty to provide psychiatric care would, of course, be measured by those items previously developed in this work -- adequate diagnosis, records, and access to at least minimally adequate care. In this case, if the doctor is proven right at trial -- that the inmate was not psychotic and that the diagnosis of manipulative behavior was reasonable -- the State would argue that no medical care was required.[297]

In Cody v. Hillard, Federal District Judge Porter put the matter succinctly, "[p]sychiatric intervention is clearly necessary in those instances where an inmate is contemplating suicide or where he exhibits psychiatric symptoms in such a degree that the inmate presents a risk of harm to himself or to others."[298] The point is that jailors simply must view suicide attempts with alarm and take action which is medically and protectively sound. There is too much at risk in the loss of human life and the civil suits which invariably follow.

A recent, and quite sophisticated, set of jail standards identifies suicide prevention as one of its four primary service goals.[299] Staff training is to include suicide prevention and there is a plan to train inmates to function as "suicide prevention aides," with a duty to react to suicide warning signals.[300] The standards also urge cooperation between the Departments of Health and Correction, especially in sharing relevant mental health information.[301]

We may thus view the threat of suicide either as a "serious illness" which invokes the Estelle v. Gamble standard of care or as an aspect of the common law duty imposed on keepers to protect the lives of the kept. As the overcrowding problem spills into the jails, the suicide prevention issue will become even more important.[302] Prison and jail personnel,

at a minimum, must know the signals of a potential suicide and have a medically sound, ready response to the problem.

6. Pretrial Detainees

Virtually everything discussed thus far concerning legal issues and the mentally disordered offender applies to convicted prisoners as well as pretrial detainees. Bell v. Wolfish[303] laid to rest a judicial trend to recognize more rights in the detainee than the convicted. Prior to Wolfish some courts determined that detainees retained the rights of unincarcerated individuals and could be deprived of their liberty only to the extent the deprivation inhered in confinement itself or was justified by compelling necessity.[304]

Justice Rehnquist, writing for the court in Wolfish, found no constitutional basis for the compelling necessity standard, granting only that detainees may not be punished.

> Not every disability imposed during pretrial detention amounts to 'punishment' in the constitutional sense, however. Once the Government has exercised its conceded authority to detain a person pending trial, it obviously is entitled to employ devices that are calculated to effectuate this detention. Traditionally, this has meant confinement in a facility which, no matter how modern or how antiquated, results in restricting the movement of a detainee in a manner in which he would not be restricted if he simply were free to walk the streets pending trial. Whether it be called a jail, a prison, or custodial center, the purpose of the facility is to detain. Loss of freedom of choice and privacy are inherent incidents of confinement in such a facility. And the fact that such detention interferes with the detainee's understandable desire to live as comfortably as possible and with as little restraint as possible during confinement does not convert the conditions or restrictions of detention into 'punishment.'[305]

Pretrial detainees, then, have a due process right not to be punished, while convicted inmates have an Eighth Amendment right not to be punished in a cruel and unusual manner. As we have seen, a convicted inmate's claim to medical and psychological care is grounded in the Eighth Amendment, while a detainee's similar claim is grounded in the Due Process Clause. Although the constitutional source of the right clearly is different, is there a difference in the nature and level of care required?

A recent decision of the Fifth Circuit Court of Appeals deals directly with our problem, holding:

> Estelle v. Gamble applied its standard of medical care to prisoners who had actually been convicted. The holding was based on a convicted prisoner's Eighth Amendment right to be free from cruel and unusual punishment. A pretrial detainee, however, has a Fourteenth Amendment Due Process right to be free from punishment altogether. Bell v. Wolfish held that in determining whether a particular condition accompanying pretrial detention amounts to a denial of due process, the court must decide whether the condition is imposed for the purpose of punishment or whether it is but an incident of some other legitimate governmental purpose. If a particular condition of pretrial detention is reasonably related to a legitimate governmental objective, it does not, without more, amount to punishment. '[I]f a restriction or condition is not reasonably related to a legitimate goal -- *if it is arbitrary* or purposeless -- a court permissibly may infer that the purpose of the governmental action is punishment that may not constitutionally be inflicted upon detainees *qua* detainees.'
>
> As we noted in our earlier opinion: Pretrial detainees are often entitled to greater protection than convicted persons. See Bell v. Wolfish; Jones v. Diamond, 5 Cir. 1981, 636 F.2d 1364, 1368 ('The due process clause accords pretrial detainees rights not enjoyed by convicted inmates.') Although '[t]he standard by which to measure the medical attention that must be afforded pretrial detainees has never been spelled out,' Jones v. Diamond, 636 F.2d at 1378, both this Circuit and other circuits have held that pretrial detainees are entitled to at least the level of medical care set forth in Estelle. The Fourth Circuit has explicitly used an Eighth Amendment standard to assess a pretrial detainee's allegations of inadequate medical care.[306]

In City of Revere v. Mass. General Hospital,[307] the Supreme Court was confronted with the question of who should absorb the cost of medical care administered to a detainee who was shot and wounded by police during his arrest. In deciding that the allocation of costs is a matter of State law, the Court held,

> The Due Process Clause, however, does require the responsible government or governmental agency to provide medical care to persons, such as Kivlin,

> who have been injured while being apprehended by the police. In fact, the due process rights of a person in Kivlin's situation are at least as great as the Eighth Amendment protections available to a convicted prisoner. See Bell v. Wolfish. We need not define, in this case, Revere's due process obligation to pretrial detainees or to other persons in its care who require medical attention. Whatever the standard may be, Revere fulfilled its constitutional obligation by seeing that Kivlin was taken promptly to a hospital that provided the treatment necessary for his injury. And as long as the governmental entity ensures that the medical care needed is in fact provided, the Constitutution does not dictate how the cost of that care should be allocated as between the entity and the provider of the care.[308]

A reading of the cases, then, reveals that a pretrial detainee is entitled to at least the same rights due the convicted prisoner, if not greater rights. The nature of the facility, the duration of the stay, special problems of suicide and substance abuse, and similar matters suggest that jails may need different approaches and programs. The principle of minimally adequate care clearly applies, including screening and classification, records, careful and restricted use of isolation, suicide prevention, and emergency care.[309]

In Dawson v. Kendrick the district court used the Wolfish standard to uphold restrictions of detainees where such restrictions helped ensure the inmates' presence at trial or aided in the effective management of the facility.[310] The Mercer County Jail did not have routine psychological testing. Prisoners with mental or emotional problems were sent into the general population; there was no detoxification program; and there were no arrangements for psychiatric or psychological assistance.[311] Needless to say this litany of "not availables," along with generally poor conditions, was found to be inadequate.[312]

In a number of detainee cases, courts will recognize the due process source of the claimed right but test the constitutional adequacy of conditions according to the Estelle "deliberate indifference" standard. For example, on remand a district court found "as a matter of fact that the care of the mentally ill in the Allegheny County Jail is woefully inadequate ... to the extent of 'deliberate indifference.'"[313] The jail had no mechanism for screening new admittees, no observation or diagnostic area for new inmates, no segregation of seriously disturbed inmates, and no monitoring of medication. Also it was found that one-quarter to one-third of the 450 to 500 detainees were seriously mentally ill and there was no staff psychiatrist, psychologist, or psychiatric social worker to deal with them.[314] In its decree the

court ordered the jail to establish procedures to care for these inmates, to transfer them to other institutions when necessary, and to adopt a means of monitoring the dispensing and handling of medication.[315]

Decisions rendered prior to 1979, when Bell v. Wolfish was decided, generally must be read closely to determine if the court was applying a type of strict necessity test on behalf of detainees. This is especially so on such questions as double-bunking, reading material, strip searches, and the like. There is less of a problem with medical and psychological needs. No one seriously speaks of the need to closely examine inmate claims to be free of infectious diseases, to be free of inmate violence and to be protected from one's own self-destructive violence.

The case law is replete with decisions concerned with initial screening and reception. For example, in Campbell v. McGruder the court found there was no staff psychiatrist at the jail and that the jail was not equipped to house, care for, or treat psychiatric patients.[316] The Court of Appeals substantially upheld the lower court's order and spoke clearly to the jail's reception process:

> 'In the event an inmate displays unusual behavior suggestive of possible mental illness, such behavior shall be immediately reported to the medical staff. The inmate will be seen by a psychiatrist within twenty-four (24) hours. If the inmate is found to be mentally ill, he will be transferred within forty-eight (48) hours of such finding to a hospital having appropriate facilities for the care and treatment of the mentally ill.'[317]

In Jones v. Wittenburg the inmate challenged the conditions of the Lucas County Jail.[318] Mental health care was among the challenged conditions and found lacking by the court because of the absence of a psychiatrist. The court said that, although various needs of inmates with special needs were being met "psychiatric services are needed in order to meet the special needs of inmates suffering from psychological and psychiatric maladies."[319]

Alberti v. Sheriff of Harris County, Texas involved a successful challenge to jail conditions.[320] The court ordered an immediate screening program to detect psychological and psychiatric problems.[321] In addition, the jail officials were ordered to find a new location to house mentally ill and mentally disturbed inmates.[322]

The situation in Houston apparently had not materially improved 11 years later. Parents of a detainee who committed suicide in the municipal jail successfully brought a suit for damages.[323] The gist of the claim was that the defendants deliberately adopted a policy of indifference to the medical needs of detained persons and, as a consequence, failed to render aid to their son who clearly displayed suicidal tendencies.[324]

While the boy was being arrested, his father told the police that he had previously suffered a nervous breakdown and when their attention was directed to medical bracelets he wore, the police suggested that a letter from the boy's psychiatrist would likely result in his release.[325]

The boy became very agitated on the trip to the jail. He banged his head on the police car divider. On arriving at the station the officers told no one of the aberrant behavior. The young man was placed in solitary confinement and three hours later he hanged himself with a pair of socks tied around the upper bars of his cell.[326]

In reviewing the adequacy of the complaint, the Fifth Circuit found that the claim rested squarely on the jail's systematic lack of adequate care for detainees, including: failure to be alert to the risk of suicide; the absence of a written policy or procedure manual; no sharing of the personnel records of the jail's clinic; inadequate staffing; no regular cell-checking procedures; failure of personnel to alert to the decedent's behavior; and failure to adequately train staff.[327]

Readers should view the above paragraph as a useful checklist of the minimum requirements that every jail must meet.

Yet another dramatic case involving a detainee's suicide exposes further dimensions of the jailor's duties.[328] The decedent was a passenger in a car involved in an accident. Highly intoxicated at the time, the young man was arrested at the scene on a disorderly conduct charge.[329]

The decedent's parents offered proof that a deputy hit their son and dragged him to the booking area. He was dragged and repeatedly struck on the way to a cell where he was stripped naked. This cell was without a mattress, pillow or blanket. The decedent began to yell and, in reaction, officers dragged him to an isolation cell where he continued to scream and beat his head on the bars. He cried for a doctor. Several hours after the arrest, the young man was found dead as a result of hanging himself with bedsheets.[330]

The first important defense was that the plaintiff's assertion of overcrowded and undermanned conditions at the jail was not relevant. This the court easily dismissed, finding that the conditions complained of might easily contribute to an utter disregard of the detainee's right to care and to freedom from harm.[331] Again, this is a clear warning to local government that when overcrowding contributes to conditions which effectively deny care and safety to those in its charge, the consequences in terms of liability can be compelling.

Strandell is interesting also because the court found that,

> The Illinois County Jail Standards provide that detainees shall be assigned to suitable quarters,

> that emotionally disturbed detainees shall be kept under constant supervision, and that 'suspected disturbed' detainees shall be immediately examined by a physician. Ill. Admin. Reg. ch. IV and VII (7/11/80). The Court concludes that the mandatory language of these regulations creates a protected liberty interest in an expectation of certain minimal standards and treatment. The Court further finds that plaintiffs' complaint sufficiently alleges a deprivation of that liberty interest in violation of the fourteenth amendment.[332]

In conclusion, then, an analysis of numerous decisions fails to disclose any sharp functional distinction between pretrial detainees and convicts on the factors considered relevant where medical or psychological services are challenged. More often than not, the courts utilize the standards developed under the Eighth Amendment as the standards by which to decide the due process right.[333]

For all practical purposes, and subject to the special problems noted earlier, the rights of detainees and sentenced inmates in the area of psychiatric care appear to be the same.

Detainees should be separated from convicted prisoners.[334] They must be classified in a reasonable fashion and be provided with access to mental health professionals. Some cases make it clear that, "It would be an unfortunate precedent that would allow prison officials to examine a detainee or prisoner once and to rely henceforth on the results of that examination."[335] Thus, post-examination or post-classification behavior or an opinion from an outside doctor may well call for a different custodial or treatment response. The risk of suicide and the problems of detoxification seem inherently greater in jails than in prisons. Thus, while the principle of the right to care remains constant, the required response naturally will vary with the facility and the nature of the problem.

7. <u>Mentally Retarded Offenders</u>

No one seems to deny the plight of the mentally retarded inmate. Numerous mental health professionals, when interviewed, agreed that, as bad as it is in most prisons for the mentally ill, it is always worse for the retarded inmate. Questions about programs prompted an empty smile -- there are none.

Miles Santamour and Bernadette West offer an accurate description of the problems of the mentally retarded inmate:

1. In prison, the retarded offender is slower to adjust to routine, has more difficulty in learning regulations, and accumulates more rule infractions, which, in turn, affect housing, parole, and other related matters.

2. Retarded inmates rarely take part in rehabilitation programs because of their desire to mask their deficiencies.

3. They often are the brunt of practical jokes and sexual harassment.

4. Such inmates are more often denied parole, serving on the average two or three years longer than other prisoners for the same offense.[336]

In addition to being manipulated and victimized by the general population, a recent study suggests that mentally retarded inmates are disproportionately placed into menial jobs and are more likely to be the recipient of more disciplinary action than the general population.[337]

There does seem to be more agreement about the definition of mental retardation than that of mental illness. The American Association on Mental Deficiency (AAMD) promulgates the following definition: "Mental retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period."[338]

As is well known intellectual functioning is quantified and the upper boundary of mental retardation is set at an IQ level of 70. However, to be classified as mentally retarded, the intellectual deficit must be accompanied by

> significant limitations in an individual's effectiveness in meeting the standards of maturation, learning, personal independence, and/or social responsibility that are expected for his or her age level and cultural group, as determined by clinical assessment and, usually, standardized scales.[339]

There is general agreement that mental retardation manifests itself at an early age. Indeed, an arbitrary cutoff age of eighteen has been established.[340] Mentally retarded people are classified as mild, moderate, severe, and profound. Mildly retarded people make up perhaps 89 percent of all those so classified, having IQ scores in the 50 to 55 range.[341]

It is very difficult to know just how many mentally retarded persons are in our prisons. A recent study estimates that about two percent of our prison population is retarded. At the time of the Denkowsky study there were 7,600 inmates regarded as retarded out of a national prison population of 378,400.[342]

Initially, there is a problem concerning why so many mentally retarded inmates avoid the various "kick-outs" and avenues of diversion that exist in the criminal justice system.[343] It is possible that the marginally retarded, comprising the mild and moderate categories previously noted, simply may escape detection.[344] However, it is difficult to imagine how persons in the low moderate range, and certainly

in the severe and profound range, are found competent to stand trial or to enter a guilty plea.

In 1984 the author did an evaluation of the mental health and mental retardation services offered in the South Carolina prison system. One of the most impressive features of this system was the Developmentally Disabled Unit (known as the Stephens Unit). The unit contained 32 residential beds and could serve an additional 15 inmates on a non-residential basis.

While precise figures were not available, some of the inmates tested in the IQ range of 40, and virtually every inmate had previously been through the State's Department of Mental Retardation. A fair number had been convicted of assault committed while institutionalized and the conviction served, in effect, as a way to transfer these residents from a school to a prison.

I observed one inmate wearing a leather cap to cover his open skull; he had no hands and was severely facially disfigured. He was obviously below mild retardation. How might such a person receive a fair trial or enter a competent guilty plea? How could the mandated defense attorney fail to raise competence and how could a judge impose a criminal sentence under these circumstances?[345]

I detected no venality in all of this. My impression is that it was understood that programs available in the prison were better than those available elsewhere. Lawyers, judges and expert witnesses understood that and used the criminal conviction as a device by which to help, not hurt. The great majority of these inmates had never worked. In prison they were taught to wash cars, perform janitorial duties and farm labor. In addition, inmates learned basic life skills -- cooking, using the telephone, dressing and so on.

The terrible irony is that with very limited bed space and staff only the most retarded inmates received services. The humane, but dubious, use of the prison as a "community resource" effectively prevented other retarded inmates -- the most educable -- from receiving services.

Penal administrators indicated that their most common management problem with the retarded inmate is that they require almost constant and individualized staff attention, which badly strains already thin resources.[346]

We turn now to the mentally retarded person as an inmate and begin the legal inquiry.

A person does not suddenly become retarded in prison, although it is generally agreed that a person may, indeed, become mentally ill in prison. Thus, at the outset there is encountered a group of prospective inmates who are prime candidates for diversion; for placement in

appropriate settings with the requisite level of security and adequate programming. Until such placement efforts are made, we must confront the reality of perhaps two percent of the prison population classified as mentally retarded. Does the mentally retarded inmate have a constitutional right to treatment (or habilitation), and if so, what is the source of such a right?[347]

The question is an interesting one and the answer is not entirely clear. Estelle v. Gamble most certainly is the constitutional basis of an inmate's minimal claims to treatment for a serious mental disorder.[348] The Estelle analysis, and subsequent judicial extension from physical to mental disorders, does not cleanly include those who are only mentally retarded. The American Psychiatric Association recently argued that:

> [t]he word 'habilitation'... is commonly used to refer to programs for the mentally retarded because mental retardation is ... a learning disability and training impairment rather than an illness .... [T]he principal focus of habilitation is upon training and development of needed skills.[349]

Thus, by keeping mental retardation out of the sickness model, the retarded inmate's claims to help, whatever such help is called, seems also outside the scope of the Estelle rule. That, however, is not the end of the matter.

In Youngberg v. Romeo the Supreme Court for the first time considered the substantive rights of involuntarily committed mentally retarded persons under the Eighth Amendment to the Constitution.[350] Romeo, a profoundly retarded adult, did not challenge the legitimacy of his initial commitment or seek release. He claimed that the defendants unduly restrained him for prolonged periods of time and that he was entitled to damages for their failure to provide him with appropriate treatment or programs for his mental retardation.[351]

In analyzing Romeo's claims, and then fashioning an extraordinarily narrow ground for relief, Justice Powell, for the Court, looked to the rights of prison inmates as the handiest analogue from which to establish Romeo's rights. That is, persons convicted of crimes and sentenced to prison have the weakest claims to any substantive rights, but if a prisoner should possess a legal right then, the argument goes, surely those who are unconvicted, yet confined, possess at least the same right.

The Court recognized that the right to personal security is an historic liberty interest, protected by due process, and not extinguished even by penal confinement.[352] Also, freedom from undue bodily restraint was recognized as a fundamental liberty interest which also survives criminal conviction and incarceration.[353]

Justice Powell, for the Court, agreed

> that Romeo is entitled to such minimally adequate care, or training, as may be needed to protect his liberty interests in safety and freedom from unreasonable restraint. What is reasonable is determined by the judgment exercised by qualified professionals. Indeed, so long as such judgment is exercised, constitutional minima have been met.[354]

Exactly what all this means for the mentally retarded citizen in civil confinement is hardly clear.[355] To the extent that this narrow right to training equates with treatment/habilitation it need not be of a type or intensity aimed at achieving the resident's ultimate freedom or even maximizing whatever life-skill potential the individual has. The training is required only to minimize the use of physical restraints and to maximize freedom from physical jeopardy. And those who prescribe the training are protected so long as they exercised judgment -- not necessarily good judgment -- simply judgment.

Justice Powell also stated, "[p]ersons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish."[356] Thus the question arises whether Youngberg indirectly creates any rights for mentally retarded prisoners? The answer, it would seem, is yes. The practical consequence, it would seem, is very little.

The mentally retarded inmate's claim to "help" cannot easily be derived from a disease model nor may it comfortably rest on a "preparation for release"-type argument. The latter argument was not dealt with in Youngberg, and it has a sufficient ring of rehabilitation to face speedy rejection unless encompassed by other glaringly deficient conditions in a given penal system. Although there is a high percentage of retarded offenders in prison -- three times the number of the general population -- the vast majority of such inmates are only mildly retarded.[357]

Should a person as profoundly retarded as Romeo appear at the prison gates (an I.Q. of between 8 and 10, who cannot talk or exercise basic self-care skills), then there would have been an earlier profound miscarriage of justice. The most elemental concepts of criminal responsibility, and certainly competence to be tried, would have been violated.

It should again be noted that, unlike mental illness, no one suggests that imprisonment may cause retardation. Clearly already minimal skills may deteriorate, vulnerability may be increased, but prison does not cause retardation.

Mentally retarded inmates' special claim to help is derived from their due process rights to physical safety and freedom from undue

restraint. This, of course, is far from an obligation to assist the inmate in the mastery of basic social and cognitive skills as part of a systematic, individualized plan.[358]

The Ruiz decision, once again, sets the tone for judicial consideration of the mentally retarded inmate.[359] Judge Justice found that between 10 and 15 percent of TDC inmates were retarded and that they were distributed throughout the TDC system.[360] The Judge echoed Santamour and West concerning the retarded inmates' special problems and added that:

> 1. They are abnormally prone to injury, [sic] many of which are job-related.
> 2. They are decidedly disadvantaged when appearing before a Disciplinary Committee and this raises basic problems of fairness and the special need for assistance.[361]

Judge Justice did not hesitate to find a constitutional basis for the lack of special care afforded mentally retarded inmates. He stated:

> The evidence shows that TDC has failed to meet its constitutional obligation to provide minimally adequate conditions of incarceration for mentally retarded inmates. Their special habilitation needs are practically unrecognized by TDC officials, and they are subjected to a living environment which they cannot understand and in which they cannot succeed. Moreover, prison officials have done little to protect these mentally handicapped inmates from the type of abuse and physical harm which they suffer at the hands of other prisoners. Their conduct is judged by the same standards applicable to prisoners of average mental ability, and they are frequently punished for actions, the import of which they do not comprehend.[362]

The Judge's constitutional rationale is located in the Eighth Amendment and his view that:

> Those whose needs are more specialized or complex than the average inmate's may not be denied their eighth amendment rights to adequate living conditions, protections from physical harm, and medical treatment by being forced to fit into a mold constructed for persons of average intelligence and physical mobility.[363]

Obviously there is some confusion and some inconsistency here. It is one thing to find living conditions constituting cruel and unusual punishment, based, in part, on the special characteristics of the

confined individuals. Indeed, that conclusion was important earlier in this work in analyzing the use of isolation cells for the mentally disordered inmate.[364] It is another thing, however, to find that an absence of habilitation efforts is a constitutional deficiency and then order programs that are designed to do more than safeguard personal security.

The desirability of habilitation is not the issue here. The issue is whether Ruiz requires habilitation as a primary constitutional right -- and thus exceeds the Youngberg mandate for the civilly confined -- or whether a lack of habilitation efforts and programs, along with other conditions contributing to endangerment, culminate in an Eighth Amendment violation?

In fashioning relief, the objective of ameliorating dangerous conditions inherently requires fewer resources and less effort than the objective of affirmative advancement for the threatened inmate. Implementation of Ruiz by the TDC now includes special education programs, occupational therapy, and coping skills development. Inmates are now uniformly tested and screened, and, if retarded, are placed in an Intellectually Impaired Offender Program and housed in special units.[365] Thus, while Judge Justice's constitutional analysis may be less than clear, the implementation phase in Texas appears to encompass elements of both habilitation and personal security.

In Kendrick v. Bland another federal district court ordered the creation of a basic training course for correctional officers designed to develop skills in identifying and reacting to mentally ill and mentally retarded inmates.[366] That type of an order, whether designed to prevent harm or identify habilitation needs, has much to commend it. Indeed, it may profitably be viewed as an aspect of the more encompassing task of classification. The need for a regular and adequate system of classification is not limited to possible mental or physical illnesses.

A retarded inmate who may be particularly vulnerable, or violent, must be identified and dealt with. This may be limited to protective measures or, if legally mandated, may include habilitation efforts. In either case there is a legal duty at least to use standard testing procedures.

Earlier, it was noted that the creation and maintenance of adequate records was a vital component of the basic right to treatment.[367] Records are necessary to preserve test data, diagnosis, treatment and rehabilitation plans and activities, and to preserve the continuity of such efforts. Adequate records for the retarded inmate, whether to ensure habilitation or safety, would seem to be as legally and professionally desirable as for the mentally ill inmate.

The mentally retarded inmate is more than occasionally recognized by courts as having special needs and requiring special attention.[368]

Judicial concerns have centered on classification systems -- on adequate testing -- to identify these vulnerable inmates. Programs or habilitation activities are more likely to be mandated when part of an overall order to improve prison conditions in general, and medical care in particular.

In concluding this topic, it seems appropriate to again shift the focus from the mentally retarded inmate to the mentally retarded accused. One must be concerned about the relatively large number of inmates believed to be mentally retarded and wonder how they came to be in prison. Are mentally retarded offenders entitled to special exemption or at least special consideration on the threshold issue of criminal responsibility?

Professor Richard C. Allen points out:

> Historically, society has pursued three alternative courses with the mentally retarded offender: we have ignored his limitations and special needs; or we have sought to tailor traditional criminal law processes to fit them; we have grouped him with psychopaths, sociopaths, and sex deviates in a kind of conventicle of the outcast and hopeless.[369]

Allen's proposal suggests the creation of an Exceptional Offenders' Court, modeled on the Juvenile Court, and he appears to have proposed it without the caution dictated by the contemporary state of juvenile justice or defective delinquency-type laws. The point, however, is that now the mentally retarded are not given special doctrinal attention in the criminal law.[370] And it is not clear that the retarded, especially the marginally retarded, would profit from such doctrinal attention. The risk, of course, is to further stereotype, discriminate, and remove incentives for the exercise of individual responsibility.

Persons who are severely retarded are not proper subjects for prosecution or imprisonment, nor are they found in great numbers in prison.[371] Our concern is with the disproportionately high percentage of moderately retarded inmates who are processed through the criminal justice system and find themselves in prison.

As a matter of law, sensible practice, and common decency, these are people who require special care and attention.

FOOTNOTES - CHAPTER III

[1]This question, as alluded to earlier, includes the similar right of pretrial detainees and the claim to habilitation made by mentally retarded inmates. Specific attention is given to the mentally retarded at <u>infra</u> Section L.

[2]429 U.S. 97 (1976).

[3]551 F.2d 44 (4th Cir. 1977).

[4]<u>Estelle v. Gamble</u>, 429 U.S. at 104-05.

[5]<u>Id</u>. at 105-06. Justice Marshall stated that the various courts of appeal were in essential agreement with this standard.

On remand, the Fifth Circuit concluded that no claim was stated against supervisors for the doctor's actions. <u>Gamble v. Estelle</u>, 554 F.2d 653 (5th Cir. 1977).

Despite a broadly shared fear of malpractice litigation, psychiatrists actually are quite safe. Indeed, it is reported that, "[n]o reported decision by an American court has been found that deals with a psychiatrist's liability for purely verbal therapy." Horan & Milligan, Recent Developments in Psychiatric Malpractice, 1 <u>Behav. Sci's & The Law</u> No. 1, 1983, at 23, 27.

[6]Justice Marshall's examples of constitutional abuse are fairly gross: refusing to administer a prescribed pain killer during surgery; choosing to throw away an ear and stitching the stump instead of attempting to reattach it; and administering penicillin knowing of the inmate's allergy and then refusing to treat the allergic reaction.

[7]551 F.2d at 47. No post-<u>Estelle</u> decision to the contrary has been found.

[8]<u>Id</u>. <u>See also</u> <u>Cody v. Hillard</u>, 599 F. Supp. 1025, 1058 (D.S.D. 1984), <u>aff'd</u>, 799 F.2d 447 (8th Cir. 1986), <u>cert</u>. <u>denied</u>, 108 S.Ct. 1078 (1988) fully supportive of <u>Bowring</u>.

[9]551 F.2d at 48, n.2. This approach does depend on accepting rehabilitation and rejecting punishment as objectives of imprisonment. Rehabilitation is viewed as one possible goal and, at times, considered to be an objective that an inmate has a right to pursue although not necessarily with aid from the state. <u>See</u> <u>infra</u> Section D, 4 for further discussion of rehabilitation.

[10]Letter to Fred Cohen from Donald C. Gehring, Aug. 25, 1983, Deputy Attorney General, Commonwealth of Virginia.

[11]The deliberate indifference standard for adult prison inmates' claims to medical and psychiatric care is not open to serious doubt as to its continued vitality. See supra Chapter II, for a discussion of Whitley v. Albers.

[12]583 F. Supp. 821 (D. Conn. 1984) (citations omitted).

[13]Id. at 826 (citations omitted).

[14]Todaro v. Ward, 565 F.2d 48 (2d Cir. 1977).

[15]715 F.2d 269 (7th Cir. 1983), cert. denied, 468 U.S. 1217 (1984). As will be developed infra, denial of access to needed care is one of the more successful claims made by inmates.

[16]Id. at 272.

[17]Cody v. Hillard, 599 F. Supp. 1025, 1055 (D. S.D. 1984), aff'd, 799 F.2d 447 (8th Cir. 1986), cert. denied, 108 S.Ct. 1078 (1988).

[18]See infra Section A, 1.

[19]Inmates of Occoquan v. Barry, 650 F. Supp. 619 (D.D.C. 1986), vacated, 844 F.2d 828 (D.C. Cir. 1988).

[20]650 F. Supp. at 633 (citations omitted).

[21]Mills, Civil Commitment of the Mentally Ill: An Overview, Annals, March 1986, at 28, 33.

[22]Judges may well feel a sense of institutional constraint or a sense of institutional incompetence in this murky area.

[23]639 F.2d 559, 575 (10th Cir. 1980) (citation omitted), cert. denied, 450 U.S. 1041 (1981). Another court used the Ramos formulation in dealing with an inmate's claim of deliberate indifference to his acne.

> The Court is unaware of any decision that has found acne to be a serious medical need or the failure to treat the condition a constitutional violation. Nevertheless, it must be acknowledged that such a skin disease can be painful and extensive, and that the Court has before it sufficient evidence concerning the scope or severity of the Plaintiff's acne infection to determine whether it was so serious that even a lay person would have seen the necessity of a doctor's attention. Whether the plaintiff's acne

represented a 'serious medical need' is a question of fact that must be addressed at trial. If the plaintiff can prove that the need was serious, he will also bear the burden of showing that the defendant was deliberately indifferent. In this regard, it might be relevant that the defendant Andrews allegedly refused to allow the plaintiff to receive treatment from his wife for his skin condition, and that defendant Andrews prescribed the allegedly inadequate remedy of hot soap and water. On this latter issue, it also should be borne in mind that '[a]lthough [a] plaintiff has been provided aspirin, this may not constitute adequate medical care. If, 'deliberate indifference caused an easier and less efficacious treatment' to be provided, the defendants have violated the plaintiff's Eighth Amendment rights by failing to provide adequate medical care.' Ancata v. Prison Health Services, Inc. 769 F.2d 700, 704 (11th Cir. 1985), quoting West v. Keve, 571 F.2d 158, 162 (3d Cir. 1978) (citations omitted). Downs v. Andrews, slip op. (S.D. Ga., Dec. 30, 1986).

[24]The "obvious" reference is a somewhat unusual use of a tort doctrine known as res ipsa loquitur or "the thing speaks for itself." If, for example, a surgeon sews up a patient leaving an instrument or a sponge inside, then we may say that the need for expert testimony is obviated since the negligent act "speaks for itself."

[25]639 F.2d at 575, 577. Other experts testified to a great gulf between psychiatric needs and available services.

[26]Id. at 578. A psychiatrist visited once every two months.

[27]Judges are not alone with the definitional dilemma. In one of the best and most comprehensive articles on health care for incarcerated juveniles, not a word is spent on what is or is not serious. See Costello & Jameson, "Legal and Ethical Duties of Health Care Professionals to Incarcerated Children," 8 J. of Legal Med. 191 (1987).

[28]See, e.g., Cody v. Hillard, 599 F. Supp. 1025, 1055, (D.S.D. 1984), aff'd, 799 F.2d 447 (8th Cir. 1986), cert. denied, 108 S.Ct. 1078 (1988).

[29]Bowring v. Godwin, 551 F.2d 44, 47 (4th Cir. 1977).

[30]Partee v. Lane, 528 F. Supp. 1254, 1261 (N.D. Ill. 1981). Depression, of course, may be mild or debilitatingly severe. One can only conclude that the court was speaking to mild depression and equating that with discomfort rather than pain.

[31]Capps v. Atiyah, 559 F. Supp. 894, 920 (D. Ore. 1983).

[32]Robert E. v. Lane, 530 F. Supp. 930, 939 (N.D. Ill. (1981).

[33]Cody v. Hillard, 599 F. Supp. 1025, 1043 (D.S.D. 1984), aff'd 799 F.2d 447 (8th Cir. 1986), cert. denied, 108 S.Ct. 1078 (1988).

In considering the "serious" problem outside the mental health area, one court held that a toothache and a cut were not serious medical needs, Tyler v. Rapone, 603 F. Supp. 268, 272 (E.D. Pa. 1985); another held that reasonable minds could differ as to whether injuries which caused bleeding from the nose, mouth and back of the head created a serious medical need, Lewis v. Cooper, 771 F.2d 334, 337 (7th Cir. 1985).

[34]Comment, State Prisoners' Rights to Medical Treatment: Merely Elusive or Wholly Illusory, 8 Black L. J. 427, 441 (1983).

[35]Id.

[36]Brenner & Gallanti, Prisoners' Rights to Psychiatric Care, 21 Idaho L. Rev. 29-30 (1985). These writers realize that this standard qualifies relatively few inmates for mandated care.

[37]Woodall v. Foti, 648 F.2d 268, 273 (5th Cir. 1981).

It should be stressed that the court of appeals tended to view this claim, at least in part, as a failure to continue previously prescribed treatment. When that claim is made and proved, then the inmate claimant invariably establishes deliberate indifference.

[38]The primary case is USA v. Michigan, No. G84-63CA (W.D. Mich.), which is before the Honorable Richard A. Enselen, an exceptionally able federal district court judge.

[39]This definition appears in the "Comprehensive Mental Health Plan" of June 6, 1986, submitted to Judge Enselen in the matter cited at n. 38. The Plan's pages are not numbered, thus making more precise citation impossible.

The first paragraph of the definition in the text is drawn from ABA Criminal Justice Mental Health Standards, Standard 7-10.1(b).

[40]Steadman, et al., The Prevalence of Mental Disability Among State Prison Inmates: A Statewide Survey, (In press, Hospital & Community Psychiatry, October 1987) (hereinafter Steadman, et al.).

[41]The Prevalence of Mental Disorder in Michigan Prisons: A Final Report submitted to the Michigan Department of Corrections 15 (July 2, 1987) (hereafter referred to as "Michigan Prevalence Report"). (The document is on file with the Michigan Department of Corrections, Stevens T. Mason Bldg., Lansing, MI 48909.)

[42]Michigan Prevalence Report, supra note 39, at 20. The previously noted definition appears to have been the basis for the study.

[43]Steadman, et al., supra note 20, at 11.

[44]An earlier study found that among 246 Oklahoma prisoners, 10 percent were acutely or severely disturbed and 35 percent required some mental health treatment. James et al., Psychiatric Morbidity In Prison, 11 Hospital & Community Psychiatry 674 (1980).

[45]See, e.g., Nat'l Adv'y Comm'n on Criminal Standards and Goals Standards Sec's. 6.1, 6.2 emphasizing classification based on risk and program factors.

Some prison assignments are made simply on the basis of the availability of space.

[46]There is little doubt that a prison system which repeatedly exposes inmates to contagious diseases through failure to detect and treat the diseased person would be open to tort liability and cruel and unusual punishment charges. The duty to detect and isolate, if not cure, is owed the exposed, nondiseased inmate at least as clearly as the duty of care is owed the ill inmate.

There are analogous issues in the risk of exposure to violence that may be involved in the failure to identify the mentally ill and violent inmate.

[47]Ruiz v. Estelle, 503 F. Supp. 1265, 1323 (S.D. Texas, 1980), mot. to stay granted in part and denied in part, 650 F.2d 555 (5th Cir. 1981), aff'd in part and reversed in part, 679 F.2d 1115 (5th Cir. 1982), opinion amended in part and vacated in part, and rehearing denied, 688 F.2d 266 (5th Cir. 1982), cert. denied, 460 U.S. 1042 (1983). See also Ruiz v. Estelle, 553 F. Supp. 567 (S.D. Texas, 1982) on the award of attorney fees.

For an excellent discussion of the litigation in Texas see S.J. Martin & S. Ekland-Olson, Texas Prisons: The Walls Came Tumbling Down (1987).

[48]503 F. Supp. at 1332 (footnote omitted).

[49]Id. at 1333. Inadequate training or education is a recurrent problem throughout this area. Subsequently we shall note how low levels of training contribute to the legal deficiency of various prisons and prison systems.

[50]Id. at 1339.

[51]406 F. Supp. 318 (M.D. Alabama, 1976), aff'd in part and modified in part sub nom. Newman v. Alabama, 559 F.2d 283, (5th Cir. 1977) rev'd in part sub nom. Alabama v. Pugh, 438 U.S. 781 (1978), cert. denied sub nom. Newman v. Alabama, 438 U.S. 915 (1978).

[52]Id. at 324. The Court had found Newman v. Alabama, 349 F. Supp. 278 (M.D. Alabama, 1972), aff'd in part, 503 F.2d 1320 (5th Cir. 1974), cert. denied, 421 U.S. 948 (1975) that approximately 10 percent of the inmates in the Alabama penal system were psychotic and that 60 percent were sufficiently disturbed to require treatment.

[53]406 F. Supp. at 333. On appeal the order was modified only slightly, placing primary responsibility for the classification system on the Board of Corrections. Newman v. Alabama, 559 F.2d 283, 290 (5th Cir. 1977), rev'd in part sub nom. Alabama v. Pugh, 438 U.S. 781 (1978), cert. denied sub nom. Newman v. Alabama, 438 U.S. 915..

[54]415 F. Supp. 1218 (D. Virg. Islands, 1976).

[55]Id. at 1229.

[56]Id. at 1235. Note that in this case a psychiatrist is specified as a part of the classification system. In Hines v. Anderson, 439 F. Supp. 12, 17 (D. Minn. 1977) a consent decree was entered and, with regard to classification, it was ordered that "a psychological test and/or examination as determined by a certified psychologist shall be administered to each inmate who enters the Minnesota State Prison."

[57]497 F. Supp. 14 (D.P.R. 1979).

[58]Id. at 29.

[59]

> "ORDERED, that from the commencement of the screening of all incoming inmates, each inmate shall be screened medically and psychologically within one week from the date of his entry into the custody of the Administration of Correction of the Commonwealth of Puerto Rico; and it is further
>
> ORDERED, that among the persons to be employed by the medical director shall be one in charge of the psychiatric care for emotionally and mentally disturbed inmates; and it is further
>
> ORDERED, that the psychiatrist in charge employed by the medical director shall forthwith

establish procedures for the psychiatric screening of all incoming inmates into the facilities operated by the Administration of Correction; and it is further

ORDERED, that those incoming inmates who require hospital treatment in a psychiatric institution shall be transferred thereto and that those incoming inmates who require intensive psychiatric treatment shall have such treatment provided as is necessary; and it is further

ORDERED, that the psychiatric screening of all incoming inmates shall commence within one week from the appointment of the psychiatrist in charge, whose appointment shall be made within one week of the appointment of the medical director; and it is further

ORDERED, that within two months from the date of this Order the medical director shall cause the entire existing population in the custody of the Administration of Correction to be screened with a complete physical examination and psychiatric examination for the detection of any chronic disorder or any communicable disease; and it is further

ORDERED, that the screening of the entire population of the facilities operated by the Administration of Correction shall be completed within three months of the date it is commenced;..."Id. at 40.

[60] 437 F. Supp. 269 (D.N.H. 1977).

[61] Id. at 283.

[62] Id. at 290.

[63]

VIII. Mental Health Care

1. Defendants shall immediately establish, by means of psychiatric and psychological testing and interviews, the actual mental health care needs of the prison population. Defendants shall file with plaintiffs and this court, within six months, the results of said testing, and shall, at the same time, submit a plan as to how to satisfy the needs established by the study. Defendants shall immediately hire a psychiatrist or Ph.D. psychologist and sufficiently qualified support staff to conduct said survey.

2. Defendants shall establish an ongoing procedure to identify those prisoners who, by reason of psychological disturbance or mental retardation, require care in facilities designed for such persons. Such persons shall be transferred as soon as the necessary arrangements can be made.

3. Defendants shall establish ongoing procedures, including, but not limited to, a psychiatric interview during the quarantine period to identify those prisoners who require mental health care within the institution and shall make arrangements for the implementation of the provision of such care.

4. The mental health care unit shall be administered by a psychiatrist or Ph.D. psychologist in coordination with the Chief of Medical Services.

IX. Classification

1. Defendants shall establish within ninety days of this order a classification system which shall include:

a. Due consideration to the age; offense; prior criminal record; vocational, educational and work needs; and physical and mental health care requirements of each prisoner;

b. Methods of identifying aged, infirm, and psychologically handicapped or physically disabled prisoners who require transfer to a more appropriate facility, or who require special treatment within the institution;

c. Educational, vocational, rehabilitative, training, religious, recreational and work programs specifically designed to meet the needs of the classification system;

d. Methods of identifying those prisoners for whom pre-release, work release or school release are appropriate;

2. All persons currently incarcerated at the NHSP shall be classified pursuant to the classification plan mandated by this order within six months. The classification of each prisoner shall be reviewed every six months thereafter.

3. Quarantine status for the purpose of admission, orientation and classification shall not exceed fourteen days, and, while in such status, each prisoner shall receive adequate exercise, recreation, food, health and hygiene services.

4. Defendants shall establish reasonable entrance requirements and rational objective criteria for selecting prisoners to participate in work, vocational training or educational or recreational programs; such criteria may be a part of the general classification system;

5. Defendants shall hire an outside expert in classification to aid in the planning of and the implementation of a classification system. Id. at 328-329.

The text includes material from the order which obviously goes beyond the mentally disordered inmate. Inclusion of references to the aged, infirm, and physically disabled is to illustrate the commonality of legal concerns for "special needs" categories of inmate.

[64] 443 F. Supp. 956 (D.R.I. 1977), remanded on issue of deadlines, 599 F.2d 17 (1st Cir. 1979).

[65] R.I.G.L. Sec. 42-56-1 (Supp. 1976).

[66] 443 F. Supp. at 980. R.I.G.L. Sec. 42-56-19 (Supp. 1976).

[67] See R.I.G.L. Sec. 42-56-29 (Supp. 1976). As the Supreme Court becomes more conservative in the creation of federal liberty interests, we may expect to see more reliance on state constitutional and statutory law.

The complete order includes program mandates that are not limited to classification matters and which look suspiciously like rehabilitation-type activities without a clear label to that effect. Note, however, that the program mandates are included to "implement the classification process." The point is that some courts, while denying a right to rehabilitation, actually grant it within the context of an order in the form of implementing another right. The link between classification and "help," however named is not inescapable, but it is close. 443 F. Supp. at 987-88.

[68] Palmigiano v. Garrahy, 639 F. Supp. 244, 249 (D.R.I. 1986).

[69] Id. at 254.

[70] Id. at 259.

[71] Inmates of Occoquan v. Barry, 650 F. Supp. 619 (D.D. Cir. 1986), vacated, 844 F.2d 828 (D.C. Cir. 1988).

[72]Id. at 623, 630 (citations omitted). Judge Green also emphasized the special need for adequate classification in a prison system relying on dormitory housing and where the inmate population is mixed.

[73]525 F. Supp. 435 (N.D. Ind. 1981), aff'd in part vacated in part sub nom. Wellman v. Faulkner, 715 F.2d 269 (7th Cir. 1983), cert. denied, 468 U.S. 1217 (1984).

[74]Id. at 493. Interestingly, the court did find that the overcrowding in the prison system violated the Eighth Amendment and a reduction was ordered.

[75]450 F. Supp. 648 (D. Md. 1978), aff'd, 588 F.2d 1378 (4th Cir. 1978). Parole and release procedures also were upheld.

[76]Id. at 652.

[77]Nathan Glazer, who is generally critical of activist courts, especially in their creation and implementation of rights for those who are incarcerated, incorrectly writes, "one would think that a classification system for prisoners is a matter of prison policy ... rather than a matter of right." N. Glazer, The Judiciary and Social Policy in the Judiciary In a Democratic Society 67, 73 (L. Theberge, ed. 1979).

[78]373 F.2d 451 (D.C. Cir. 1966).

[79]325 F. Supp. 781 (M.D. Ala. 1971).

[80]See Hoffman & Dunn, Guaranteeing the Right to Treatment in Psychiatrists and the Legal Process: Diagnosis and Debate 298 (R. Bonnie, ed. 1977).

[81]One distinguished lawyer-psychologist examined hundreds of "outcome" studies, of differing methodological vigor, which have examined various therapies. The overall conclusions, he states, are remarkable: all therapies conducted under all types of conditions seem to offer a greater chance of improvement in short-term emotional feelings than spontaneous remissions. With the exception of success with behaviorally oriented therapies for certain phobias and habituations, no one dynamic therapy seems more successful than any other. Morse, Failed Explanations and Criminal Responsibility: Experts and the Unconscious, 68 Va. L. Rev. 971, 1000-01 (1982).

[82]See Joint Comm'n on Mental Illness and Health, Action for Mental Health, Ch. II (1963).

[83]In a seminal article, Professor Lewis Swartz described cultivation of functioning as the pursuit of value goals, in therapy, beyond the prolongation of life and the avoidance of pain. The latter goals are quite consistent with the _Estelle_ constitutional minima for treatment. _See_ L. Swartz, "Mental Disease": The Groundwork for Legal Analysis and Legislative Action, 111 _U. Pa. L. Rev._ 389 (1963).

[84]Most of these problems are drawn from an excellent article, Costello & Jameson, "Legal and Ethical Duties of Health Care Professionals to Incarcerated Children", 8 _J. of Legal Med._ 191, 202-07 (1987).

Naturally, the questions have been modified to reflect this work's concern with incarcerated adults.

[85]The answer to problem (4) is the easiest: no medication or isolation, for example, ever should be "prescribed" in the name of care when the real objective is to cause pain. Costello & Jameson, _supra_ note 84, at 207 mention a doctor in a juvenile facility who injected juveniles with vitamin B in solution for the express purpose of causing pain, as a disciplinary measure.

The other problems are far more difficult and require the prison mental health professional to first resolve a very difficult role question: to what extent shall he or she act as an advocate for the inmate's needs? The advocate's role will create sufficient conflict with security staff that one would not be surprised that the advocate's tenure is of short duration.

[86]_Ruiz v. Estelle_, 503 F. Supp. 1265, 1332 (S.D. Tex. 1980), _aff'd in part_, 679 F.2d 1115 (5th Cir. 1982), _cert. denied_, 460 U.S. 1042 (1983).

[87]_Id_. at 1333.

[88]_Id_. at 1333-34.

[89]_Id_. at 1334. That, of course, is precisely what TDC officials believed about Mr. Gamble and his back pains.

[90]Interview with Ken Adams, doctoral student at S.U.N.Y. at Albany, Graduate School of Criminal Justice, Aug. 10, 1983, Albany, N.Y. Mr. Adams recently completed his doctoral thesis on prison decision-making and the mentally disordered inmate.

The "price" for receiving mental health care may include harsh isolation, sharing cell space with highly undesirable inmates, being placed in physical jeopardy, and so on.

[91]503 F. Supp. at 1334-36. These pages are rich in detail and should be consulted by those needing such detail.

[92]Id. at 1339.

[93]Id.

[94]Id.

[95]Id. The six criteria in the text may serve as the basic outline assessing the legal adequacy of any prison system's mental health program.

[96]410 F. Supp. 251, 259 (E.D. Ark. 1976), aff'd, 548 F.2d 740 (8th Cir. 1977), aff'd, 437 U.S. 678 (1978).

[97]Id. at 260.

[98]450 F. Supp. 648 (D. Md. 1978), aff'd, 588 F.2d 1378 (4th Cir. 1978).

[99]Id. at 657. It is difficult to resist the comparison between indefinite confinement of the mentally ill and determinate confinement for criminal offenders.

[100]Id. at 657-658. (citations omitted)

[101]349 F. Supp. 278 (M.D. Ala. 1972), aff'd in part, 503 F.2d 1320 (5th Cir. 1974), cert. denied, 421 U.S. 948 (1975).

[102]Id. at 284 (footnote omitted). The court pointed out, in Footnote 5, that "[t]he inadequacy of the treatment available at the mental hospitals within the state was the subject of this Court's opinion in Wyatt v. Stickney, 325 F. Supp. 781 (1971), and subsequent orders in that case, 344 F. Supp. 373, 344 F. Supp. 387 (1972)." Id. at n.5.

[103]Feliciano v. Barcelo, 497 F. Supp. 14 (D.P.R. 1979).

[104]Id. at 30.

[105]Id. at 34. See Santana v. Collazo, 714 F.2d 1172 (1st Cir. 1983), cert. denied, 466 U.S. 974 (1984) where conditions at a Puerto Rico industrial school and juvenile camp are reviewed, with special attention given to isolation units. The court took the view that acceptable conditions for the isolation of adults and juveniles inherently are different and that adults could be constitutionally subjected to a generally harsher environment than juveniles.

[106]Laaman v. Helgemoe, 437 F. Supp. 269 (D.N.H. 1977).

[107] *Id.* at 290.

[108] *Id.* at 328.

[109] *Lightfoot v. Walker*, 486 F. Supp. 504 (S.D. Ill. 1980).

[110] *Id.* at 521-22.

[111] 682 F.2d 1237 (9th Cir. 1982).

[112] *Id.* at 1253. *See* the various standards reproduced in the text at Appendix A.

[113] 599 F. Supp. 1025 (D.S.D. 1984), *aff'd*, 799 F.2d 447 (8th Cir. 1986), *cert. denied*, 108 S.Ct. 1078 (1988).

[114] *Id.* at 1042.

[115] *Id.*

[116] *Id.*

[117] Earlier, it was noted that the *Cody* decision called for services before an inmate bleeds to death or the facility reaches catastrophic proportions.

[118] 599 F. Supp. at 1043. A sentencing judge's recommendation as to psychiatric care normally is not binding on correctional authorities. The recommendation, however, was used in the *Cody* decision to compound the system's failure to deliver care.

[119] *Id.*

[120] *Id.* at 1043-44.

[121] *See* Wardlaw, Models for the Custody of Mentally Disordered Offenders, 6 *International J. of Law and Psychiatry* 159, 164-65 (1983) for an analysis of six competing models for inmate mental health services. The author favors a mix of prison psychiatric units, including at least one that is secure, along with links to regional forensic centers. *Id.* at 166.

[122] 534 F. Supp. 1026, 1037 (E.D.Ark. 1982). Discussed in Brenner & Galanti, Prisoners' Rights to Psychiatric Care, 21 *Idaho L. Rev.* 1, 26 (1985).

[123] 642 F. Supp. 510, 527 (D.N.M. 1986).

[124]The Corrections Department's Director of Administrative Services testified that the budget was cast as a punitive response to the consent decree entered in the case and as a way to make it virtually impossible for the Department to comply. 642 F. Supp. at 527 n.2.

[125]642 F. Supp. at 519.

[126]Id. at 521. The court made detailed findings of fact as to the system's inadequacies which need not be fully repeated here.

[127]Id. at 525-26 (citations omitted).

[128]See United States v. Swift & Co., 286 U.S. 106 (1932), where the Court required a showing of a change in conditions so substantial as to constitute a clear showing of a grievous wrong should the original terms be enforced.

[129]In Palmigiano v. Garrahy, 639 F. Supp. 244 (D.R.I. 1986), Rhode Island was not in compliance with medical and mental health care mandates nine years after the initial judgment. The judge gave the State 60 days to prepare an acceptable compliance plan.

[130]715 F.2d 269 (7th Cir. 1983), cert. denied, 468 U.S. 1217 (1984).

[131]Id. at 272.

[132]457 U.S. 307 (1982). Youngberg is discussed more fully supra Chapter I, Section A.

[133]Id. at 322-23.

[134]In many cases there is no expert available for such testimony.

[135]See, e.g., Ferola v. Moran, 622 F. Supp. 814 (D.R.I. 1985) on inmate's disagreement with therapeutic regimen.

[136]474 U.S. 312 (1986). See supra Chapter II for additional discussion of this case.

[137]544 F. Supp. 769 (N.D.Ga. 1982).

[138]Id. at 772.

[139]Id. at 774.

[140]Id. at 775-76 (citations omitted). The extended quote is provided in the belief that it is an exceptionally accurate and complete guide to the preparation and defense of this type of case. One need only substitute medication for the brace and a psychosis for the back problem.

[141] 595 F. Supp. 1558 (D.Idaho 1984).

[142] _Id._ at 1567.

[143] _Id._ at 1568. The court ordered the preparation of an "access" plan within 90 days.

[144] 342 S.E.2d 422 (W.Va. 1986).

[145] _Id._ at 434.

[146] 298 S.E.2d 781, 795 (W.Va. 1981).

[147] _See infra_ Sec. D, 4 for a discussion of the Supreme Court's view that there is no federal constitutional right to rehabilitation.

[148] 682 F.2d 1237, 1253 (9th Cir. 1982).

[149] _See also Williams v. Edwards_, 547 F.2d 1206, 1218 (5th Cir. 1977) finding that the medical care at the Louisiana State Penitentiary at Angola was constitutionally deficient, with mentally ill inmates supervised by officers with no training, and no notes or medical records on the in-patient psychiatric population.

[150] _Hendrix v. Faulkner_, 525 F. Supp. 435 (N.D. Ind. 1981), _aff'd in part, vacated and remanded on the issue of costs_; 715 F.2d 277 (7th Cir. 1983), _cert. denied_, 468 U.S. 1217 (1984).

[151] _Id._ at 495-96.

[152] _Id._ at 504. It is not clear what is meant by milieu and recreational therapy but simple lock-up and use of the yard have been known to receive the "hyphen approach" as in the recreation-therapy.

[153] _Cf._, _Schmidt v. Wingo_, 499 F.2d 70, 75-76 (6th Cir. 1974).

[154] 552 F. Supp. 1052, 1130 (M.D. Tenn. 1982).

[155] _Id._ at 1130.

[156] _Id._

[157] 546 F. Supp. 174 (W.D. Ky. 1982).

[158] _Id._ at 200 n.22.

[159] _Id._ at 200.

[160]Id.

[161]Id. at 215.

[162]801 F.2d at 1080 (9th Cir. 1986), cert. denied, 107 S.Ct. 2462 (1987).

[163]Id. at 1111.

[164]Id. at 1113 (citations omitted).

[165]622 F. Supp. 814 (D.R.I. 1985).

[166]See Palmigiano v. Garrahy, 639 F. Supp. 244 (D.R.I. 1986) where Judge Pettine, who is also the judge in Ferola, finds the state out of compliance with the nine year old order.

[167]622 F. Supp. at 816.

[168]Id. at 817. Ferola was successful on his claim relating to physical abuse as a result of being shackled to his bed for 20 hours where he was denied use of toilet facilities for 14 hours. He was awarded $1000.00 in damages.

[169]C. Dickens, American Notes and Pictures From Italy 86 (1903).

[170]342 S.E.2d 422, 427 n.5 (W.Va. 1986).

[171]Cf., LaReau v. MacDougall, 473 F.2d 974, 978 (2d Cir. 1972), cert. denied, 414 U.S. 878 (1973) (threatening an inmate's sanity and severing his contacts with reality by a lengthy confinement in a "strip cell" violates the eighth amendment). See cases cited in Benjamin & Lux, Constitutional and Psychological Implications of the Use of Solitary Confinement: Experience at the Maine State Prison, 9 Clearinghouse Rev. 83, 86-88 (1975).

[172]See Rhodes v. Chapman, 452 U.S. 337, 347 (1981). The procedural issues suggested in the text are not addressed here.

[173]Sostre v. McGinnis, 442 F.2d 178 (2d Cir. 1971), cert. denied, 404 U.S. 1049 (1972).

[174]Jackson v. Meachum, 699 F.2d 578, 581-83 (1st Cir. 1983). In Huto v. Finney, 437 U.S. 678, 686-87 (1978) the Court indicated that the duration of confinement in a filthy, overcrowded isolation cell might be determinative on the question of unconstitutional cruelty.

[174] (continued)

There is some irony in the reluctance in that some of the earliest affirmative rulings for inmates involved conditions in solitary confinement. See Wright v. McMann, 387 F.2d 519 (2d Cir. 1967), aff'd in part and modified in part and rev'd in part, 460 F.2d 126 (2d Cir. 1972), cert. denied, 409 U.S. 885 (1972); E.J. Jordon v. Fitzharris, 257 F. Supp. 674 (N.D. Cal. 1966).

[175] See generally H. Toch, Men in Crisis: Human Breakdown in Prison (1975).

[176] Interview with Hans Toch, Jan. 21, 1984, Albany, NY. Professor Toch argues strongly for the availability of intermediate care-type facilities in prisons, space that is between isolation and general population.

[177] P. Suedfeld, Restricted Environmental Stimulation: Research and Clinical Applications (1980).

[178] Professor Toch's findings do strongly argue for a shift in certain practices that may, in fact, be based on folklore. Isolation of suicidal inmates is a clear example of a well- intentioned practice that generally is counterproductive.

[179] Santana v. Collazo, 714 F.2d 1172 (1st. Cir. 1983), cert. denied, 466 U.S. 974 (1984).

[180] Costello & Jameson, Legal and Ethical Duties of Health Care Professionals to Incarcerated Children, 8 J. of Legal Med. 191, 248-49 (1978).

[181] In Anderson v. Coughlin, No. 86 Civ. 8879 (S.D.N.Y., filed November 17, 1986) (references in the text are drawn from the pleadings in the case and not from any judicial decision). Prisoner Legal Services of New York raised both those issues in a law suit seeking declaratory and injunctive relief.

[182] See Wolff v. McDonnell 418 U.S. 539 (1974) and cases discussed supra Chapter II.

[183] In a criminal trial, if a defendant is found incompetent to be tried the government can -- and most often does -- commit the accused for treatment. Thus, in the prison setting, a decision to delay a hearing would be, in effect, also a decision to seek treatment. See Jackson v. Indiana, 406 U.S. 715 (1972).

[184] These accounts are taken from Anderson v. Coughlin, supra note 179.

[185]For example, a lay advocate could be used, or even counsel, instead of a prison employee. Rules governing triability and responsibility can be kept simple and workable. There is no requirement of expert testimony.

The examples mentioned earlier in the text represent inmates with a record of hospitalizations and bizarre and destructive behavior, and where there is enough evidence available to reach an informed opinion.

Again, it makes a good deal of sense for jurisdictions to formulate their own rules and policy instead of simply awaiting judicial intervention.

[186]516 F.2d 357 (4th Cir. 1975), *cert. dismissed*, 426 U.S. 471 (1976).

[187]*Id.* at 365-66 (emphasis added).

[188]*Id.* at 366.

[189]*Id.* at 367.

[190]*Id.*

[191]*Id.*

[192]*Id.* at 369.

[193]This aspect of the decision clearly needs to be reconsidered in light of *Helms v. Hewitt*, 459 U.S. 460 (1983).

[194]*Imprisoned Citizens' Union v. Shapp*, 451 F. Supp. 893, 896 (E.D. Pa. 1978). Most of the issues had been settled by consent decree.

[195]*Id.* at 898.

[196]437 F. Supp. 269 (D.N.H. 1977).

[197]*Id.* at 280.

[198]*Id.* Prison officials agreed that psychiatric inmates should be transferred to the state mental hospital because of the lack of proper staff at the prison.

[199]*Jackson v. Meachum*, 699 F.2d 578, 581 (1st Cir. 1983). The inmate had been diagnosed as suicidal.

[200]*Id.* at 583-84.

[201]559 F.2d 283 (5th Cir. 1977), *rev'd in part sub nom. Alabama v. Pugh*, 438 U.S. 781, *cert. denied*, 438 U.S. 915 (1978).

[202] Jackson v. Meachum, 699 F.2d at 582-83 citing to 559 F.2d at 291.

[203] 622 F. Supp. 814, 820 (D.R.I. 1985).

[204] Id. 622 F. Supp. at 818-19.

[205] Id. at 818.

[206] Id. at 820-21 (emphasis in original). The judge rejected the state's claim that a single isolated incident of mistreatment cannot amount to cruel and unusual punishment. Indeed, he said it had no support in law or logic.

[207] Id. at 822.

[208] Id. at 824. Judge Pettine indicated that the plaintiff-inmate, in a telephone conversation, amended the complaint to include declaratory and injunctive relief.

[209] 650 F. Supp. 619, 630 (D.D.C. 1986).

[210] Id. at 630.

[211] 661 F. Supp. 895 (E.D.Pa. 1987), aff'd in part and vacated in part, 855 F.2d 1021 (3rd Cir. 1988).

[212] See also Groseclose v. Dutton, 829 F.2d 581, 583 (6th Cir. 1987) (discussing Grubbs v. Bradley, 552 F. Supp. 1052 (M.D. Tenn. 1984) and issues relating to the confinement and treatment of death row inmates).

[213] 503 F. Supp. 1265, 1323 (S.D. Tex. 1980), aff'd in part, 679 F.2d 1115 (5th Cir. 1982), cert. denied, 460 U.S. 1042 (1983).

[214] Id. at 1323.

[215] Id.

[216] Id. at 1339.

[217] 744 F.2d 1387 (9th Cir. 1984), cert. denied, 469 U.S. 1214 (1985).

[218] Id. at 1390, n.2.

[219] Id.

[220] 525 F. Supp. 435 (N.D. Ind. 1981), aff'd in part and vacated in part sub nom. Wellman v. Faulkner, 715 F.2d 269, cert. denied, 468 U.S. 1217 (1984).

[221] Id. at 504.

[222] Id. at 504, 520

[223] Barnes v. Government of Virgin Islands, 415 F. Supp. 1218, 1235 (D. Virgin Islands 1976).

[224] 492 F. Supp. 650 (W.D. Mo. 1980).

[225] Id. at 676.

[226] In Cody v. Hillard, 599 F. Supp. 1025, 1036 (D.S.D. 1984), aff'd, 799 F.2d 447 (8th Cir. 1986), cert. denied, 108 S.Ct. 1078 (1988) the court stated simply, "[i]t is inappropriate for inmate workers to have any sort of access to the medical records of other inmates."

[227] 492 F. Supp. at 681. A more recent decision came to the same debatable conclusion, Toussant v. McCarthy, 801 F.2d 1080, 1112 (9th Cir. 1986), cert. denied, 107 S.Ct. 2462 (1987).

[228] 437 F. Supp. 269 (D.N.H. 1977).

[229] Id. at 287.

[230] Id.

[231] Id. at 327.

[232] 599 F. Supp. 1025, 1057-1058 (D.S.D. 1984), aff'd, 799 F.2d 447 (8th Cir. 1986), cert. denied, 108 S.Ct. 1078 (1988. See also Inmates of Occoquan v. Barry, 650 F. Supp. 619, 630 (D.C. Cir. 1986), vacated, 844 F.2d 828 (D.C. Cir. 1988) for a similar holding.

[233] 503 F. Supp. 1265 (S.D. Tex. 1980), aff'd in part, 679 F.2d 1115 (5th Cir. 1982), cert. denied, 460 U.S. 1438 (1983).

[234] 414 U.S. 417 (1974).

[235] 18 U.S.C. Sec's. 4251-4255.

[236] 414 U.S. at 421-22.

[237] Id. at 428-29.

[238] 370 U.S. 660 (1962).

[239] Id. at 667, n.8 (citing Linder v. United States, 268 U.S. 5 (1925), which recognized addicts as diseased for the purpose of receiving treatment).

[240] 392 U.S. 514 (1968).

[241] Id. at 532.

[242] Even the latter statement needs some clarification. Justice White, in concurring and providing the swing vote, stated that, "the alcoholic is like a person with smallpox, who could be convicted for being on the street but not for being ill, or, like the epileptic, who could be punished for driving a car but not for his disease." 392 U.S. at 550. Justice White upheld the conviction based on the state of the record and not an express or tacit rejection of alcoholism as a disease.

In Traynor v. Turnage, 108 S.Ct. 1372 (1988) the Court dealt with the question of whether certain types of alcoholism could be treated as "willful misconduct" which thereby meant that certain alcoholic veterans would not be able to claim educational benefits. The case did not directly decide whether alcoholism is a disease and, indeed, Justice White wrote, "This litigation does not require the Court to decide whether alcoholism is a disease whose course its victims cannot control." Id. at 1383.

For an interesting analysis of the above case see Neal, Is Alcoholism a Disease?, Feb. 1988, A.B.A.J., at 58.

[243] See C. Winick, The Alcohol Offender Ch. 15 & The Drug Offender Ch 16 in Psychology of Crime and Criminal Justice (H. Toch, ed. 1979).

On the manipulative uses of the language of disease and care, see M. Edelman, Political Language: Words That Succeed and Policies That Fail (1977). See also T. Szasz, Ceremonial Chemistry Ch 1 (1985).

[244] Paper delivered by James J. Collins & William E. Schlenger at the American Society of Criminology Meeting, Denver, CO, Nov. 9-13 (1983).

See also James, Gregory & Jones, Psychiatric Morbidity in Prisons, 31 Hosp. & Comm'y Psych'y 674 (1980); Hare, Diagnosis on Antisocial Personality Disorder in Two Prison Populations, 140 Amer. J. of Psych. 887 (1983).

[245] One court took judicial notice of the magnitude of the problem, terming it serious, Pace v. Fauver, 479 F. Supp. 456, 459 (D.N.J. 1979), aff'd, 649 F.2d 860 (3d Cir. 1981).

[246] Id. at 458. The court also dealt with a similar claim based on state law.

[247] Id. at 458-59 (citations omitted).

[248] 585 F.2d 1183 (3d Cir. 1978).

[249]Id. at 1189. Note that the court did not decide there was a right to the establishment of a drug treatment program or of access to methadone. The key is the claim to the continuation of a treatment regimen.

[250]443 F. Supp. 956 (D.R.I. 1977).

[251]Id. at 972.

[252]Id.

[253]Id. at 989.

[254]The same is true in Barnes v. Government of Virgin Islands where it was ordered that:

> Arrangements shall be made to introduce an alcohol and drug rehabilitation program. Otherwise, inmates who are in need of such treatment, in the opinion of the psychiatrist, shall be transferred to an appropriate institution. 415 F. Supp. 1218, 1235 (D. Virgin Islands 1976).

In Alberti v. Sheriff of Harris County, Texas, a challenge to jail conditions, the court ordered that a medical screening program be designed to include detection of alcohol and drug problems. In addition, the court ordered the creation of a program where afflicted inmates would be housed in a separate treament unit. 406 F. Supp. 649, 667 (S.D. Tex. 1975).

The court decided that the totality of the conditions at Harris County's Jail were unconstitutional. The more serious problems were inmates with substance abuse histories that were not properly cared for or treated. Testimony indicated that failure to properly care for these inmates contributed to overall medical and security problems. Id. at 658.

[255]It is also the case that mentally retarded inmates may present claims to habilitation adding further semantic and conceptual complexity to the area.

[256]M.B. Santamour & B. West, Retardation and Criminal Justice: A Training Manual for Criminal Justice Personnel 25 (Pres's Committee on Mental Retardation, 1979).

Various approaches to, and definitions of, treatment are discussed, supra Chapter III, D, 7.

Two authorities suggest that rehabilitation is simply the wrong word since most inmates arrive at prison without ever having acquired

[256] (continued)
educational, vocational, or social skills adequate for success in the free world. See DeWolfe & DeWolfe, Impact of Prison Conditions on the Mental Health of Inmates, 1979 S. Ill. Univ. L. J. 497, 521 (1979).

[257] See supra Chapter III, D, 7 for an earlier discussion. The concepts of rehabilitation and treatment as cultivation of functioning have much in common.

[258] See Martinson, California Research at the Crossroads in R. Martinson, T. Palmer & S. Adams, Rehabilitation, Recidivism, and Research 63 (N.C.C.D. 1976). See generally M. Edelman, Political Language: Words That Succeed and Policies That Fail (1977).

[259] 652 F.2d 775, 779 (9th Cir. 1980) (emphasis added).

[260] Id. at 777.

[261] Id. at 777-78 (citations and footnote omitted). The California case referred to is: People v. Feagley, 14 Cal.3d 338, 359, 535 P.2d 373, 386, (1975) where the court stated it is settled that:

> A person committed as a mentally disordered sex offender is not confined for the criminal offense but because of his status as a mentally disordered sex offender.
>
> [I]nvoluntary confinement for the 'status' of having a mental or physical illness or disorder constitutes a violation of the cruel and unusual punishment clauses of both the state and federal Constitutions ... unless it is accompanied by adequate treatment.

[262] 652 F.2d at 780.

[263] 551 F.2d 44 (4th Cir. 1977).

[264] For an excellent analysis of abnormal offenders and special sentencing options, see Dix, Special Dispositional Alternatives for Abnormal Offenders: Developments in the Law in Mentally Disordered Offenders: Perspectives From Law and Social Science 133 (J. Monahan & H. Steadman, eds. 1983).

[265] See Grubbs v. Bradley, 552 F. Supp. 1052, 1123 (M.D. Tenn. 1982) holding squarely that there is no federal constitutional right to rehabilitation.

[266]One article put it this way:

> Under the current case law of most jurisdictions, prisons have no constitutional duty to provide rehabilitative programs designed to prevent the inevitable 'mental, physical, and emotional deterioration' of inmates which is part of the general human condition. Prisons must, however, avoid unconstitutional conditions which would produce such deterioration or which prevent inmates from pursuing self-rehabilitation. In other words, only where the failure to provide rehabilitation services is found to be part of an overall prison situation which 'militate[s] against reform and rehabilitation' is such failure of constitutional proportions. DeWolfe & DeWolfe, Impact of Prison Conditions on Mental Health of Inmates, 1979 S. Ill. Univ. L. J. 497, 522.

[267]Meachum v. Fano, 427 U.S. 215, 234 (1976) (Stevens, J., dissenting). Again, it should be emphasized that even this limited version of rehabilitation rights is exotic. The rather cursory rejection of a right to rehabilitation in Marshall v. United States, 414 U.S. 417 (1974) is much more representative of judicial thinking.

Justice Steven's position seems aligned with the "militating against self-help and reform" position noted in the text.

Holt v. Sarver, a landmark prison case, is often cited for the following proposition:

> Given an otherwise unexceptional penal institution, the Court is not willing to hold that confinement in it is unconstitutional simply because the institution does not operate a school, or provide vocational training, or other rehabilitative facilities and services which many institutions now offer.
>
> That, however is not quite the end of the matter. The absence of an affirmative program of training and rehabilitation may have constitutional significance where in the absence of such a program conditions and practices exist which actually militate against reform and rehabilitation. 309 F. Supp. 362, 379 (E.D. Ark. 1970), aff'd, 442 F.2d 304 (8th Cir. 1971). See also McCray v. Sullivan, 509 F.2d 1332, 1335 (5th Cir. 1975); Newman v. Alabama, 559 F.2d 283, 291 (5th Cir. 1977) and Madyun v. Thompson, 657 F.2d 868, 874 (7th Cir. 1981).

[268]452 U.S. 337 (1981).

[269]Id. at 348. There is also rhetoric about the Constitution not mandating comfortable prisons. Rehabilitation and comfort clearly need not be viewed as synonymous, but the philosophy of rejection of minimal comfort is consistent with the rejection of minimal rehabilitation.

[270]Concerning the English system, Margaret Brazier writes:

> Although no English court has determined the issue, I would suggest that those authorities owe to each prisoner a duty not only to take reasonable steps to preserve him in good physical health but also as far as is practicable to ensure that he does not sink into such a state of anxiety, depression, or emotional stress that it becomes likely that he will inflict injuries upon himself.

Brazier, Prison Doctors and Their Involuntary Patients, 1982 Public Law 282, 286.

[271]564 F.2d 388, 403 (10th Cir. 1977).

[272]437 F. Supp. 269 (D.N.H. 1977).

[273]Id. at 316. See also James v. Wallace, 564 F.2d 97 (5th Cir. 1977).

[274]437 F. Supp at. 325.

[275]Id. at 329-30.

[276]406 F. Supp. 318 (M.D. Ala. 1976), aff'd in part and mod. 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).

[277]Id. at 330, 335. See also Barnes v. Government of Virgin Islands, 415 F. Supp. 1218 (D. Virgin Islands 1976) for a similar view on rehabilitative programs and the duty to avoid (or reduce) inmate degeneration.

[278]546 F. Supp. 174 (W.D. Ky. 1982).

[279]Id. at 211.

[280]Id. at 207.

[281]The latest data is for 1977 and it shows 297 suicides out of a total of 611 deaths. The southern jails were the clear leader in suicides. Source Book for Criminal Justice Statistics, 1982, 528.

The administrator of Menard Psychiatric Center, a part of the Illinois Department of Corrections, reports that 40 percent of their admissions involve suicidal behavior. Hardy, Dealing With the Mentally and Emotionally Disturbed, 44 Corrections Today 16, 18 (1984).

[282]Source Book for Criminal Justice Statistics: 1982. In 1980, there were 727 total deaths in prisons with 80 (only 1 female) deaths by suicide.

One study concluded that there are twice as many deaths in prison by suicide as would be expected in terms of the general population. S. Sylvester, J. Reed & D. Nelson, Prison Homicide 73 (1977).

[283]H. Toch, Peacekeeping: Police, Prisons, and Violence, 61-62 (1976).

[284]344 F. Supp. 257 (D. Md. 1972). There is a general, common law rule that jailers owe a duty of ordinary care to persons in their custody. Restatement of Torts 2d., Sec. 314A.

There are limits on discretion. For example, Delgado v. Cady, 576 F. Supp. 1446 (E.D.Wisc. 1983) held that coerced double celling of suicidal inmates is unconstitutional.

[285]486 F. Supp. 504, 521 (S.D. Ill. 1980).

[286]Id. at 521.

[287]Id. at 527.

[288]503 F. Supp. 1265, 1339 (S.D. Tex. 1980), aff'd in part, 679 F.2d 1115 (5th Cir. 1982), cert. denied, 460 U.S. 1042 (1983). See also Gioia v. State, 22 A.D.2d 181, 254 N.Y.S.2d 384 (1964) recognizing a duty to prevent suicide when a suicidal tendency is, or should have been, noted.

[289]583 F. Supp. 821 (D.Conn. 1984).

[290]Id. at 824.

[291]Id. at 825. The doctor prescribed unspecified medication.

[292]Id.

[293]Id. at 826-27.

[294] Id. at 827. Judge Dorsey actually is incorrect to describe the duty to provide medical care as broader than the duty to protect inmates. As the present work makes abundantly clear, medical and psychiatric care is constitutionally owed only to the seriously ill. All inmates are owed a duty of protection. The conceptual error, however, does not affect the validity of his point.
Accord, Matje v. Leis, 571 F. Supp. 918 (S.D. Ohio, 1983).

[295] Guglielmoni v. Alexander, 583 F. Supp. at 827.

[296] In Palmigiano v. Garrahy, 639 F. Supp. 244, 254 (D.R.I. 1986) the judge "found serious deficiencies in the administration of the one existing [mental health] protocol -- the red tag or suicide protocol."
See also Kanayuvak v. Northslope Borough, 677 P.2d 893 (Alaska, 1984) where an intoxicated woman in "protective confinement" killed herself and the authorities were deemed to be on notice as to "high risk" since they knew she had just been divorced, had recently lost two sons, and was intoxicated.

[297] The fact that the inmate did indeed kill himself obviously impairs the diagnosis but it does not by itself destroy it. Even holding doctors to a "beyond a reasonable doubt standard" leaves room for perhaps a 15 percent margin of error.

[298] 599 F. Supp. 1025, 1043 (D.S.D. 1984), aff'd, 799 F.2d 447 (8th Cir. 1986), cert. denied, 108 S.Ct. 1078 (1988). See also Rogers v. Evans, 792 F.2d 1052 (11th Cir. 1986) for an interesting review of the suicide liability issues discussed in the text.

[299] New York City, Board of Correction, Draft Minimum Standards for the Delivery of Mental Health Services in N.Y.C. Correctional Facilities, Sec. 1.1 (b) (Oct. 1982).

[300] Id. at Sec. 2.4.

[301] Id. at Sec. 7.4 (b).

[302] The New York Times reported that there were 6.2 million jailings in 1982 and that of the 100 largest jails, 49 were over rated capacity. New York Times 1, A24 (Nov. 23, 1983).

[303] 441 U.S. 520 (1979).

[304] See, e.g., Brenneman v. Madigan, 343 F. Supp. 128, 142 (N.D.Cal. 1972).

[305] 441 U.S. at 531-535.

[306] Partridge v. Two Unknown Police Officers of the City of Houston, 791 F.2d 1182, 1186 (5th Cir. 1986) (citations omitted).

[307] 463 U.S. 239 (1983).

[308] Id. at 244-245 (citations omitted). Plainly, this statement by the Court places the detainee's right to medical care in the Due Process Clause and indicates, in agreement with the text, that a detainee's rights are at least as great as the convicted.

[309] See Jones v. Diamond, 636 F.2d 1364 (5th Cir. 1981), overruled, International Woodworkers of America, AFL-CIO and its Local No. 5-376 v. Champion Intern. Corp., 790 F.2d 1174 (5th Cir. 1986).

For a valuable study on current practices in jail mental health law see H.J. Steadman, D.W. McCarty & J.P. Morrissey, Developing Jail Mental Health Services: Practice and Principles (U.S. Department of Health & Human Services, 1986).

[310] 527 F. Supp. 1252 (S.D. W.Va. 1981).

[311] Id. at 1273.

[312] See Lareau v. Manson, 651 F.2d 96 (2d Cir. 1981) for a discussion of due process and Eighth Amendment standards.

[313] Inmates of Allegheny County Jail v. Peirce, 487 F. Supp. 638, 642-43 (W.D. Pa. 1980).

[314] Id. at 641.

[315] Id. at 644.

[316] 580 F.2d 521, 549 (D.C. Cir. 1978).

[317] Id. at 548-49. The order was amended for additional flexibility on the 48-hour time limit.

[318] 509 F. Supp. 653 (N.D. Ohio 1980).

[319] Id. at 687.

[320] 406 F. Supp. 649 (S.D. Tex. 1975).

[321] Id. at 677.

[322] Id.

[323]Partridge v. Two Unknown Police Officers of Houston, 791 F.2d 1182 (5th Cir. 1986).

[324]Id. at 1183.

[325]Id. at 1184.

[326]Id. Police also were unaware that the boy had attempted suicide during an earlier confinement. Those records were four doors away from the booking desk.

[327]Partridge v. Two Unknown Police Officers of Houston, 791 F.2d at 1184-85. The matter was remanded, one of the crucial issues being whether the alleged indifference was a custom or policy of the municipality. See Monell v. Department of Social Services, 436 U.S. 658 (1978).

[328]Strandell v. Jackson County, Ill., 634 F. Supp. 824 (S.D.Ill. 1986).

[329]Id. at 824.

[330]Id. at 827. It must be emphasized that the government moved to dismiss the complaint and the facts noted in the text are merely the bare allegations of the plaintiff parents.

[331]Id. at 828. See Matzker v. Herr, 748 F.2d 1142 (7th Cir. 1984); Madden v. City of Meriden, 602 F. Supp. 1160 (D.Conn. 1985); and Soto v. City of Sacramento, 567 F. Supp. 662 (E.D.Cal. 1983).

[332]634 F. Supp. at 829. Although this aspect of the ruling might seem to encourage jail and prison officials to avoid written regulations, that is not necessarily true. We note how often courts fault defendants for failure to have written regulations and policies. Avoiding mandatory language is another matter, however.

[333]There is some attention given to distinguishing housing minima for detainees from that of convicts. In Lareau v. Manson, 651 F.2d 96, 108-09 (2d Cir. 1981) the court argued that sentenced inmates could be subjected to marginally passable living conditions for a longer period of time than pretrial detainees.

[334]Palmigiano v. Garrahy, 443 F. Supp. 956, 971 (D.R.I. 1977), remanded on the issue of deadlines, 599 F.2d 17 (1st Cir. 1979).

[335]Downs v. Martin, slip op. (C.D.S.D. Ga. 1986).

[336]M.B. Santamour & B. West, Retardation and Criminal Justice: A Training Manual for Criminal Justice Personnel 14 (President's Committee on Mental Retardation, 1979).

[337]Denkowski & Denkowski, The Mentally Retarded Offender in the State Prison System: Identification, Prevalence, Adjustment, and Rehabilitation, 12 Crim. Justice & Behav. 55, 62-63 (1985).

[338]AAMD, Classification in Mental Retardation 1 (H. Grossman ed. 1983).

[339]Id. at 11. Most prison systems use 69 or 70 IQ as their cut-off point for classification of an inmate as retarded.

[340]Ellis & Luckasson, Mentally Retarded Criminal Dependants, 53 Geo. Wash. L. Rev. 414, 422 (1985). This is an excellent article to consult for an analysis of the impact of the ABA Criminal Justice Mental Health Standards (1984) on the retarded offender.

[341]Ellis & Luckasson, at 423.

[342]Denkowski & Denkowski, supra note 335, at 66. Today, there would likely be over 10,000 inmates classified as mentally retarded. The two percent estimate actually is three below the estimate for mentally retarded persons in the general population.

[343]By 'kick-outs' I refer to such mechanisms as grand jury refusal to indict; discretionary non-enforcement or refusal to prosecute; and determinations of incompetence to stand trial. By diversion I simply mean placement in programs in lieu of prosecution, conviction, or confinement.

[344]See Allen, The Retarded Offender: Unrecognized in Court and Untreated in Prison, 32 Fed. Probation 22 (September 1968).

[345]The ABA Mental Health Standards, Sec. 7-4.1(b) (1984) sets out the test for competence to stand trial and recognizes retardation as an appropriate basis for such a finding. Among the major problems here is whether a retarded person ever will gain sufficient competence to be tried.

[346]B. Rowan, "Corrections" in The Mentally Retarded Citizen and the Law 650, 661 (M. Kindred ed. Pres's Committee on Mental Retardation, 1976).

[347]I.Q. scores of 69 or below on a standardized test is the generally acceptable measure for identifying the mentally retarded. Research suggests that about 9 percent of the offender population is retarded. See B. Rowan & T. Courtless, The Mentally Retarded Offender (N.I.M.H. 1967).

[348]See supra Chapter III, A. See also Morse, A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered, 70 Cal. L. Rev. 54 (1982) for an insightful discussion of the assumptions and consequences of viewing "craziness" as indicating incompetence, lack of control, or treatability.

[349]Brief of the American Psychiatric Association as Amicus Curiae at 4, n.1, quoted in Youngberg v. Romeo, 457 U.S. 307, 309 n.1 (1982).

[350]457 U.S. at 309 (1982).

[351]Id. at 311. Treatment was used synonymously with habilitation.

[352]Id. at 315.

[353]Id.

[354]Id. at 322. The Court expanded on the definition of professional decision-maker as follows:

> By professional decision-maker, we mean a person competent, whether by education, training or experience, to make the particular decision at issue. Long term treatment decisions normally should be made by persons with degrees in medicine or nursing, or with appropriate training in areas such as psychology, physical therapy, or the care and training of the retarded. Of course, day-to-day decisions regarding care -- including decisions that must be made without delay -- necessarily will be made in many instances by employees without formal training but who are subject to the supervision of qualified persons. Id. at 322, n.30.

[355]See, e.g., the several interpretations discussed in Rennie v. Klein, 720 F.2d 266 (3d Cir. 1983). See also Wexler, Seclusion and Restraint: Lessons From Law, Psychiatry and Psychology, 5 Int'l J. of Law & Psych'y 285 (1982) which emphasizes the vast discretion ceded professionals in the use of restraints.

[356]Youngberg v. Romeo, 457 U.S. at 321-22. The Justice cites Estelle v. Gamble, 429 U.S. 97 (1976) to support this proposition.

[357]M. Santamour & B. West, supra note 254, at 9. Indeed, the point seems to be that the vast majority clearly are educable.

[358]Appendix A, containing the survey of various standards in this area, reveals that the mentally ill and the retarded offender are, more often than not, joined for purposes of establishing a right to appropriate care.

[359]Ruiz v. Estelle, 503 F. Supp. 1265 (S.D. Tex. 1980), aff'd in part, 679 F.2d 1115 (5th Cir. 1982), cert. denied, 460 U.S. 1042 (1983).

[360]Id. at 1344.

[361]Id.

[362]Id. at 1346.

[363]Id. at 1345.

[364]See supra Section D, 1.

[365]Interview with James Shaddock, former Chief Psychologist, Texas Dept. of Corrections; Jan. 9, 1984.

[366]541 F. Supp. 21, 48 (W.D. Ken. 1981).

[367]See supra Section D, 2.

[368]Newman v. Alabama, 349 F. Supp. 278, 284 (M.D. Ala. 1972), aff'd in part, 503 F.2d 1320 (5th Cir. 1974), cert. denied, 421 U.S. 948 (1975) is one of the earliest decisions to order the identification of mentally retarded inmates and require transfer from prison when necessary. Laaman v. Helgemoe, 437 F. Supp. 269, 328 (D.N.H. 1977) is in accord.

[369]R. Allen, Reaction comment to S. Fox, The Criminal Reform Movement in The Mentally Retarded Citizen and the Law 627, 645 (Pres's Committee on Mental Retardation, M. Kindred ed. 1976).

[370]Jackson v. Indiana, 406 U.S. 715 (1972) deals with important questions of competency to be tried and concerns itself with the plight of a severely disabled accused. Competence -- the ability to aid counsel and grasp the essence of the charges -- is not limited to mental retardation.

[371]Interviews and informal discussion with numerous clinicians affiliated with dozens of prison systems confirms this view. Inmates with I.Q.s ranging from the 50s on up represent the great majority of the retarded or learning disabled persons found in prisons.

IV. TRANSFER OF INMATES FOR TREATMENT

The choice of where to provide an inmate with needed treatment, like the selection of a preferred treatment modality, raises few, if any, legal issues. Policy questions, yes! Robert Levinson describes prisons as the system that cannot say no.[1] He notes that individuals with "mixed" diagnoses are persona non grata in all settings. Prisoner A, he writes, may be "crazy" in prison and "sane" in the state hospital. A mental health facility in a Department of Mental Hygiene may have regulations or priorities that make it nearly impossible to accept an inmate for treatment.[2]

How the inmate is moved from place to place for such treatment does create some significant legal issues. In 1980 the Supreme Court decided Vitek v. Jones,[3] which now governs the procedural requirements applicable to transfers from prisons to mental treatment facilities. Not surprisingly, Vitek leaves open a good many important questions while answering others. In order to grasp the significance and the ambiguity of Vitek, it will be useful to briefly discuss earlier decisions on transfer and related issues and then return to Vitek itself.

A. Procedural Claims

The 1966 case of Baxstrom v. Herold[4] is the earliest Supreme Court decision which is most related to Vitek, yet it is easily distinguishable. Baxstrom was convicted of assault and sentenced to a New York prison. When he was nearing the end of his relatively short sentence, a petition was filed in the local Surrogate's Court stating that Baxstrom's prison term was about to expire, that he remained mentally ill, and requesting civil commitment to Dannemora State Hospital.

Baxstrom appeared alone in the judge's chambers and was allowed to ask a few questions prior to his commitment. The Supreme Court determined that Baxstrom was denied equal protection of the laws in not having the opportunity for jury review available to all other civil committees in New York and, as a separate violation, in being confined in a facility housing the "dangerously mentally ill" without the judicial determination of dangerousness required for all others so confined.[5]

It should be emphasized that since this decision is based on equal protection grounds, its analytical basis is strictly comparative and the case does not create independent rights. That is, Baxstrom does not decide there is a constitutional right to a jury prior to commitment or that there is a constitutional right to a determination of dangerousness. It does hold that where a jurisdiction elects to provide the right to a jury in a civil commitment proceeding, and designates a facility for housing those found to be dangerous, then whether a person is nearing the end of a prison term is not relevant to the availability of a jury trial or a finding of dangerousness. The state cannot base post-sentence confinement on a person's criminal sentence. Chief Justice Warren wrote:

> Where the State has provided for a judicial proceeding to determine the dangerous propensities of all others civilly committed to an institution of the Department of Correction, it may not deny this right to a person...solely on the ground that he was nearing the expiration of a prison term. *** A person with a past criminal record is presently entitled to a hearing on the question whether he is dangerously mentally ill so long as he is not in prison at the time civil commitment proceedings are instituted. Given this distinction, all semblance of rationality of the classification, purportedly based upon criminal propensities, disappears.[6]

In a somewhat generous reading of Baxstrom, the Second Circuit Court of Appeals extended the decision to cover the New York prison inmates being transferred to a mental hospital during the term of their criminal sentence.[7] Baxstrom, it should be recalled, importantly turned on the state acquiring a basis other than the criminal sentence for the post-sentence confinement of the person.

Schuster, shortly after charging prison officials with corruption, was transferred to a mental hospital where he remained for many years. Consistent with the de facto policy in many jurisdictions, he was never seriously reviewed for parole during his confinement in a corrections-administered mental health facility.[8]

The Second Circuit concluded that prison inmates had an equal protection right to be committed by substantially the same procedures as those available to free persons subjected to an involuntary commitment proceeding. Judge Kaufman's analysis tracked Baxstrom in determining that the procedures used for commitment are not dependent on the place where the alleged mentally ill persons happen to be. According to Judge Kaufman, being on the street or in prison is not determinative of procedural fairness in civil commitment. That is not the approach, however, taken more recently, and more authoritatively, by the Court in Vitek.

Baxstrom involved a prison-to-mental hospital transfer, whereas Meachum v. Fano,[9] a 1976 decision, involved an inter-prison transfer. Meachum, however, is an important part of the overall procedural framework needed to fully grasp Vitek, especially some of the open questions. In Meachum the question before the Court was straightforward: does the Due Process Clause of the Fourteenth Amendment entitle a state prisoner to a hearing when transferred to a prison with less favorable conditions, absent a state law conditioning such a transfer on proof of misconduct or the occurrence of other events?[10]

The Court found that a prisoner has no right to any form of due process and in so holding surprised a number of lawyers. Why? Just two

years earlier the Supreme Court determined that where a state prisoner was faced with disciplinary charges that might result in a loss of good-time credits or in a form of solitary confinement, the prisoner was entitled to advance, written notice prior to a hearing before an impartial tribunal and a written statement of reasons for an adverse decision.[11]

The pre-Meachum thinking was that a prison-to-prison transfer, and especially a punitive transfer, which rather clearly was the situation in Meachum was not functionally distinct from a general population-to-isolation, intra-prison transfer. Indeed, if anything, moving from a minimum or medium security prison and being some distance from family and friends, losing a job, and facing strange, new fellow inmates probably is a more grievous loss than certain forms of disciplinary confinement.[12]

No matter. In Meachum the Court decided that any rights that an inmate had to resist transfer (or discipline) were rights created by the state. So long as the state did not condition a transfer on the occurrence of some event -- for example, a rule infraction -- then no procedures were required since no protected rights were at stake. Not every loss, even a grievous loss, equates with a constitutionally protected right. The more discretion invested in corrections officials, then, the fewer procedural claims available to inmates.

Returning to Vitek, the question to ask at the outset is whether Nebraska created a liberty interest which it might later withdraw or is the Constitution itself the source of any such liberty interest? The statute at issue in Vitek reads as follows:

> When a physician designated by the Director of Correctional Services finds that a person committed to the department suffers from a physical disease or defect, or when a physician or psychologist designated by the director finds that a person committed to the department suffers from a mental disease or defect, the chief executive officer may order such person to be segregated from other persons in the facility. If the physician or psychologist is of the opinion that the person cannot be given proper treatment in that facility, the director may arrange for his transfer for examination, study, and treatment at any medical-correctional facility, or to another institution in the Department of Public Institutions where proper treatment is available. A person who is so transferred shall remain subject to the jurisdiction and custody of the Department of Correctional Services and shall be returned to the department when, prior to the expiration of

> his sentence, treatment in such facility is no longer necessary.[13]

Justice White agreed with the lower courts that this statute created a liberty interest in the inmates.

> Section 83-180(1) provides that if a designated physician finds that a prisoner 'suffers from a mental disease or defect' that 'cannot be given proper treatment' in prison, the Director of Correctional Services may transfer a prisoner to a mental hospital. The District Court also found that in practice prisoners are transferred to a mental hospital only if it is determined that they suffer from a mental disease or defect that cannot adequately be treated within the penal complex. This 'objective expectation, firmly fixed in state law and official Penal Complex practice,' that a prisoner would not be transferred unless he suffered from a mental disease or defect that would not be adequately treated in the prison, gave Jones a liberty interest that entitled him to the benefits of appropriate procedures in connection with determining the conditions that warranted his transfer to a mental hospital. Under our cases, this conclusion of the District Court is unexceptional.[14]

At the risk of being redundant, I must stress that if this liberty interest -- this objective expectation concerning transfer -- is based solely on state law, then that interest is as permanent as the legislature's desires. A majority vote and the stroke of a pen ends it. The Court, however, went further, holding:

> None of our decisions holds that conviction for a crime entitles a State not only to confine the convicted person but also to determine that he has a mental illness and to subject him involuntarily to institutional care in a mental hospital. Such consequences visited on the prisoner are qualitatively different from the punishment characteristically suffered by a person convicted of crime. Our cases recognize as much and reflect an understanding that involuntary commitment to a mental hospital is not within the range of conditions of confinement to which a prison sentence subjects an individual....

> A criminal conviction and sentence of imprisonment extinguish an individual's right to freedom from confinement for the term of his sentence, but they do not authorize the State to classify him as mentally ill and to subject him to involuntary psychiatric treatment without affording him additional due process protections.
>
> In light of the findings made by the District Court, Jones' involuntary transfer to the Lincoln Regional Center pursuant to Sec. 83-180, for the purpose of psychiatric treatment, implicated a liberty interest protected by the Due Process Clause. Many of the restrictions on the prisoner's freedom of action at the Lincoln Regional Center by themselves might not constitute the deprivation of a liberty interest retained by a prisoner.***But here, the stigmatizing consequences of a transfer to a mental hospital for involuntary psychiatric treatment, coupled with the subjection of the prisoner to mandatory behavior modification as a treatment for mental illness, constitute the kind of deprivation of liberty that requires procedural protections.[15]

Thus, regardless of state law, the combination of stigma, a drastic alteration in the conditions of confinement, and being subjected to mandatory behavior modification programs combined to create a liberty interest traceable to the Fourteenth Amendment Due Process Clause. This, of course, is not to say that a prison-to-mental hospital transfer cannot be done, only that certain minimal procedural safeguards apply.

The following minimal safeguards now must precede such a transfer:

1. Written notice to the prisoner that a transfer to a mental hospital is being considered.
2. A hearing, sufficiently after the notice to permit the prisoner to prepare, at which disclosure to the prisoner is made of the evidence being relied on for the transfer and at which the prisoner receives an opportunity to be heard in person and to present documentary evidence.
3. An opportunity at the hearing for the defense to present testimony of witnesses and to confront and cross-examine witnesses called by the State, except upon a finding, not arbitrarily made, of good cause for not permitting such presentation, confrontation, or cross-examination.
4. An independent decision-maker ("This person need not come from outside the prison or hospital administration").
5. A written statement by the decision-maker as to the evidence relied on and the reasons for transferring the inmate.

6. Availability of "qualified and independent assistance," furnished by the State, if the inmate is financially unable to furnish his own.
7. Effective and timely notice of all the foregoing rights.[16]

Unlike the Second Circuit's analysis in Schuster, the Supreme Court did not rely on equal protection and it did not procedurally equate prisoner transfers with free person commitments. Professor Michael Churgin correctly points out that the Court opted for a parole-revocation model, requiring far less than a "full blown" trial but considerably more than a disciplinary hearing.[17]

Churgin considers an administrative hearing procedure constitutionally permissible, but he believes it may be wiser to rely on the regular civil commitment processes.[18] This approach makes available the entire range of statutory commitments, from emergency[19] to voluntary, from short to longer terms. The American Bar Association Standards create yet another option entitled "court ordered transfer." If an inmate seeks admission, but the mental health or retardation facility rejects the application, then a petition for a court-ordered transfer may be filed, with the adverse parties being the inmate and institution of choice.[20]

B. Specific Issues

What are some of the important questions concerning transfer that are not answered by Vitek?

1. Does Vitek apply to mental health facilities operated by corrections or is it limited to outside mental health facilities? In a multi-prison state, would Vitek apply to a transfer from a prison without mental health facilities to one with such facilities? Would it apply to an intra-prison transfer to a treatment unit?[21]
2. What criteria and what evidentiary standards must (or should) apply?
3. Does Vitek impose any durational limits short of the criminal sentence? If Vitek procedures equate with civil commitment procedures (and standards), then may the inmate be confined beyond the prison term?
4. May the transferred inmate be denied good time credits or consideration, if eligible, for parole?
5. What is the legal status of the transferred inmate while in the treatment facility? Is he or she a prisoner in a hospital or a patient in a hospital?

1. Facilities

The Court provides no clear answer on what facilities are covered, although the opinion makes numerous references to a mental hospital. However, if Vitek is read as limited to mental-health-operated hospitals,

such a limitation would seem inconsistent with the Court's rationale and have little actual impact.[22] The Court's concern in Vitek was with involuntary psychiatric care and the compounding effect of adding the label mental illness to that of convict. Where such treatment is attempted, and which agency is responsible for the facility or service, seem irrelevant.

The results of recently undertaken research led the authors to conclude "that if Vitek is not applied to prison-operated mental health facilities, its impact will be severely limited."[23] Conducting a study of psychiatric transfers in six states, the authors discovered that five of the six states transferred nearly all (86 percent) of their mentally disordered inmates to mental health facilities within corrections; three of these states had changed to this pattern since 1978; and the mental health facilities in corrections were not drastically different from their mental-health-operated counterparts.[24] Thus, Vitek should be read as applicable to prison-to-mental-hospital transfers as well as prison-to-prison-hospital transfers.

A very interesting recent decision involving the North Carolina prison system dealt with this and other related questions. In Baugh v. Woodard[25] the court began its analysis of the problem by stating that "we do not distinguish, for the purpose of compliance with Vitek, inpatient mental treatment hospital facilities whether operated by the prison system, as in the case here, or by another state agency as in Vitek."[26]

The basic issue for decision in Baugh involved the timing and the place of the hearing required by Vitek. Putting to one side transfers based on an emergency, the reviewing court disagreed with the district court and held that due process does not require a hearing on the propriety of an inmate's involuntary mental health transfer prior to the inmate's physical transfer from the unit where he is currently housed. So long as the requisite hearing is held promptly after the physical transfer and before admission and treatment begins, then due process is satisfied.[27]

Very plainly, the court's purpose in this decision is not to impede either emergency transfers for short-term care of the acutely ill or transfer for diagnostic or observational purposes. Baugh seems to be a workable solution to these problems and to be within the letter and spirit of Vitek.

Suppose that an inmate is serving time in a prison which has what in New York is termed a satellite unit, a psychiatric unit used for outpatient type services, diagnostic procedures, and short-term, acute care. Should transfer into such a unit trigger a Vitek problem? Is this more like an administrative transfer, which may be virtually free of procedural demands?[28] The answer is not very clear.

The critical factors appear to be the probability of stigma, a drastic change in confinement,[29] and enforced treatment. On balance, Vitek seems applicable where the admission is not diagnostic and treatment of the acute case exceeds a brief -- for example, 10 day -- stay.

2. Criteria for Transfer

What criteria and evidentiary standards are applicable to a Vitek transfer? The answer to this question also is unresolved by Vitek. Where an equal protection analysis has been employed and inmates dealt with like any one else, the answer is clear. The criteria and procedures are the same. This is true, for example, as a result of legislation in New York State.[30]

In light of Vitek's silence on criteria, analysis should begin with the already impaired legal status of the inmate. The choice here is not liberty versus confinement. Since liberty has already been taken, the question is the place and the objectives of confinement. Arguments in support of a rigorous dangerousness standard for civil commitment lack the same force when applied in the prison context. Some courts find that the traditional "need of care and treatment" standard is unconstitutionally overbroad and vague in light of O'Connor v. Donaldson.[31] On the other hand, Professor Churgin argues:

> Once a proper procedure is utilized and the individual inmate is found to be both mentally ill and in need of some treatment, any other requirement might be superfluous. The Supreme Court hinted as much in Vitek by repeated references to the determination required by the Nebraska statute, a finding of mental illness and a benefit in being transferred to the mental health facility.[32]

The Court did not address the burden of proof required in a Vitek-mandated hearing. In this situation the primary concern is the risk-of-error problem. Addington v. Texas[33] determined that civil commitment proceedings required the state to prove committability by proof that is at least clear and convincing. On the other hand, the Court deferred to medical judgment and a presumed identity of interest when parents sought to commit their children.[34]

The handiest analogue here appears to be the Addington standard of "clear and convincing." The Court's basic premise in Addington is the inmate's individual interest in avoiding arbitrary classifications as mentally ill. The risk of error in a Vitek situation appears sufficiently substantial to warrant substantial evidentiary safeguards against error.[35]

3. Durational Limits

Vitek itself, rather clearly, imposes no durational limits on the confinement of the transferred inmate. Statutes also are of little assistance here. Thus, how long an inmate remains in a mental health facility is a question of policy or clinical judgment so long as the confinement does not exceed the term of the criminal sentence.

If civil commitment procedures are used and the state gains authority to hold indefinitely, then, in the absence of any countervailing State law, the transferee could be held beyond the term of the sentence. In New York, for example, the director of a hospital to which an inmate may be committed may apply for a new commitment at the expiration of the prison sentence.[36] The general rule seems to be that the maximum duration of an inmate's hospitalization is linked to the length of the prison term.

Another durational issue that seems not to have been litigated but which arises with some regularity in practice relates to the expiration of time between the transfer/commitment hearing and the actual transfer. If the mental health facility has no bed space, or simply engages in delaying tactics, then one has to ask when does the determination of mental illness and commitability become stale? Three weeks? Two months? Six months? Again, there is no clear answer but the applicable principles seem clear:

1. The determination of a present condition and a treatment need that is not inherently stable, such as mental illness, does have inherent limits.
2. The longer the delay between the determination and the requisite action -- transfer and care -- the more dubious the continued validity of the earlier determination.

4. Good Time Credits and Parole Eligibility

With regard to good-time credits and parole eligibility, the ABA Standards are more clear and more to the point than the limited amount of recent case law. The standards read:

> (a) A prisoner in a mental health or mental retardation facility is entitled to earn good time credits on the same terms as offenders in adult correctional facilities.
> (b) A prisoner in a mental health or mental retardation facility should be eligible for parole release consideration on the same terms as offenders in adult correctional facilties.
> (c) If otherwise qualified for parole, a prisoner should not be denied parole solely because the prisoner had or is receiving

treatment or habilitation in a mental health retardation facility.

(d) If otherwise qualified for parole, a prisoner who would benefit from outpatient treatment or habilitation should not be denied parole for that reason.[37]

With few exceptions, the courts which dealt with the good time credit issue have determined that prisoners may and do lose the opportunity to earn good-time credits after a determination of mental illness ("insanity" in the older cases) and some form of hospitalization. In Bush v. Ciccone, for example, the court dealt with federal law and determined that good-time credits are suspended for prisoners found "insane" by a Board of Examiners.[38]

Bush relied on Urban v. Settle which found that a prisoner:

> who has been removed to a hospital for defective delinquents under 18 U.S.C.A. Sec. 4241 is not entitled to have further good conduct accruals made or become operative for conditional release purposes until, in the judgment of the superintendent of the hospital, he has become restored to sanity or health. If, in the judgment of the superintendent, he does not become so restored, he is entitled to be kept in the hospital, under Sec. 4241, until his maximum sentence is served. He cannot, in this situation, ordinarily seek his release from the hospital until one or the other of these two contingencies has occurred.
>
> Within the power of Congress to control the care and treatment of all federal prisoners, it necessarily may set up such appropriate administrative machinery for dealing with this problem as it sees fit, without leaving the way open to a prisoner to have the judgment of the officials to whom that responsibility has been entrusted subjected to judicial examination, except as some right otherwise of a prisoner may be violated.[39]

Sawyer v. Sigler[40] is an important case which runs contrary to most other decisions. Nebraska apparently denied statutory good-time credits to prisoners found to be physically unable to work. This was viewed as forcing prisoners to choose between constitutionally required medical care and statutory good time. The judge concluded:

> I am compelled to declare that the policy of denying statutory good time to persons physically

unable to perform work, when that physical inability does not result from misconduct on the part of the prisoner, is contrary to the equal protection clause of the Fourteenth Amendment of the Constitution of the United States and to enjoin the enforcement of the policy to that extent.

Meritorious good time, as opposed to 'statutory good time' stands on a different footing. The granting of meritorious good time is permissive under the statute, rather than mandatory. There is nothing in the evidence to indicate a deliberate or purposeful discrimination against the petitioners with respect to meritorious good time. Indeed, there is no evidence as to what the practice is in awarding meritorious good time to persons who are not physically infirm. The mandatory nature of the statute with respect to meritorious good time sets no standard, so evidence of actual practice must provide guidelines and no such evidence was here presented. The burden in that respect being upon the petitioners, I hold that they have not carried their burden of showing impermissible discrimination in the granting of meritorious good time.[41]

If we may interpolate this approach to mental disability -- and it is difficult to imagine why not -- then in a system where good time accrues either for good behavior or employment, an inmate undergoing mental treatment should not be deprived of the opportunity to earn such credits.[42]

There is, of course, no right to good time credits in the sense that a State must adopt such a system of rewards and sentence reduction. However, where good time laws exist, inmates cannot be prevented from earning credits on irrational or discriminatory grounds. That is the essence of the reasoning in _Sawyer v. Sigler_,[43] which seems eminently sound in general and as applied to mentally disordered inmates undergoing treatment.

It will be recalled that _Bowring v. Godwin_[44] is one of the earliest decisions to clearly apply the _Estelle v. Gamble_ right to medical care to psychiatric and psychological treatment. In _Bowring_ a parole board denied release on parole, at least in part, due to the inmate's mental condition, which was judged to be sufficiently impaired to make success on parole problematic. The reason for the denial then became the basis for a limited right to treatment.[45]

This encounter between mental disorder and parole resembles, but is distinguishable from, the issue of denial of parole during the course of treatment. In Sites v. McKenzie, the only decision found directly on point, the court dealt with a 76-year-old inmate who had been incarcerated for 45 years either in the West Virginia Penitentiary or Weston State Hospital. Although the inmate was first eligible for parole in 1941, his first parole interview was "slightly" delayed and not granted until 1970.[46]

A West Virginia regulation provided:

> Prisoners confined in mental institutions for observation and psychiatric treatment will not be interviewed by the Parole Board until it has received a complete report from the institution showing that there has been a recovery from the mental illness or disturbance.[47]

The judge reasoned that this regulation had the effect of creating an irrebutable presumption of dangerousness or at least unfitness for release into society. From there the decision confounds the problem of release from civil commitment with the problem of consideration for release on parole.

The ruling itself, however, is mercifully clear.

> Accordingly, to grant parole hearings to prisoners not confined in mental institutions and to deny parole consideration to the Plaintiff because he was in Weston State Hospital was unequal and unfair.
>
> Thus, it is clear that this regulation is unconstitutional because it denies prisoners in mental institutions the equal protection of the law.[48]

Presumably what the court meant was that whether this inmate was properly or improperly in a mental hospital, that alone should not be an absolute bar to parole consideration. No case law is cited for this unique holding, and no effort was made to articulate the equal protection analysis being employed. However, since there is no right to parole,[49] we may infer that the court used a form of the rational basis test[50] and compared one group of prisoners (in prison) with another group of prisoners (in a mental treatment facility).

The question that should have been articulated, then, is whether there is a reasonable relationship between confinement in a mental hospital and parole ineligiblity. In effect, Sites found that there is not. There seems to be no barrier to a parole board taking into account an inmate's

mental condition -- whether the inmate remains in prison or is in a treatment facility. However, a bar to release based on hospitalization *per se* is indeed suspect in light of equal protection analysis and the result in *Sites*.[51]

5. Rights Subsequent to Transfer

To conclude this Chapter we turn to an infrequently litigated but potentially serious question: after a prisoner has been transferred to a mental health facility, does he acquire any substantive or procedural rights to resist return to prison?

The great weight of the case law is that neither substantive nor procedural rights are acquired by the inmate-patient. *Burchett v. Bower*[52] appears to be the only case to the contrary. Here the district court finessed the question of a federally based right to treatment by determining that Arizona state law invested this inmate-patient with a right to treatment.[53]

Once the right to treatment was resolved, the court could then determine that as a "right" or "benefit," termination could not occur without some type of hearing prior to retransfer. The court did not decide whether an administrative hearing with judicial review or only judicial review would meet constitutional standards.[54]

In Re Hurt[55] occupies a sort of middle ground on retransfer. A prisoner challenged his transfer from St. Elizabeth's Hospital to Lorton Correctional Complex. Although this prisoner had a judicial hearing on retransfer, he claimed that it did not meet due process standards.

Hurt's claim was that the interest at stake in such a hearing was the right to treatment, a right long recognized in the District of Columbia. The court agreed that Hurt had the right to treatment but did not agree that was the issue.

> The record makes plain the fact that appellant would continue to receive treatment in the form of daily dosages of Thorazine while at the Lorton Correctional Complex, and that he would be under the care of mental health professionls at that facility. What is therefore actually at stake is only the locus of treatment.
>
> With the question before us thus presented, we cannot accept appellant's contention that the opportunity for a hearing which he was afforded was any less than he is entitled to under the Constitution or the pertinent statute.[56]

Because Hurt already had been transferred and retransferred twice, the appellate court viewed the court-ordered hearing actually held as

appropriate to these special circumstances but more than required by the Constitution or by statute. A Vitek hearing was deemed unnecessary in these circumstances. Specifically reserved was the question presented where a prisoner transferred to a mental hospital for treatment is then returned to the prison population without further care or treatment.[57]

More typical of judicial handling of this matter is the pre-Vitek decision in Cruz v. Ward.[58] New York prisoners challenged their administrative transfers from Matteawan State Hospital to prison as violative of their due process rights. Although New York State provided elaborate procedures for the prison-to-hospital transfer, no hearing procedures were required or provided on retransfer.[59]

Over the strong dissent of Judge Kaufman, the court decided that there was no indication that these were punitive transfers.[60] In rejecting the claim to due process procedures the court suggested that for these uniquely medical judgments, hearings, a statement of reasons, and counsel might do more harm than good. Also rejected was a request that guidelines be adopted and observed.[61]

The dissent found that these challenged transfers often were punitive and that the record disclosed an almost sadistic propensity to shuttle unruly inmates from Matteawan to stripped cells in the prison system.[62]

Ultimately, the substantive problem in this area is whether an inmate is receiving at least the minimal right to treatment afforded by the Constitution or the perhaps more expansive right provided by State law. As stated earlier, there is no cognizable right in the inmate as to the place of care, only a right to minimal care. Indeed, even where State law expresses a policy for care in the least restrictive environment, this may not be viewed as a constitutionally protected right to remain in a mental health care facility and resist return to jail.[63]

The conservative approach here is to argue that a hearing is required prior to transfer to a mental hospital because of the additional stigma and possibility of enforced treatment. On return from the hospital, the inmate is not further disadvantaged or additionally stigmatized. Whatever right to treatment he or she had remains intact.

A less conservative view would stress the possibility for abuse, as did Judge Kaufman in Cruz. The argument for a hearing would be to provide some opportunity to challenge clinical or medical judgment and to determine whether statutory criteria were met. However that may be, the weight of authority does not support a mandatory hearing, although as a matter of policy some opportunity for retransfer challenges may be the better part of wisdom.

FOOTNOTES - CHAPTER IV

[1]Levinson, The System That Cannot Say No, Amer. Psychologist July 1984, at 811.

[2]Id.

[3]445 U.S. 480 (1980).

[4]383 U.S. 107 (1966).

[5]Id. at 110.

[6]Id. at 114-15. For interesting follow-up data on this decision see Hunt & Wiley, Operation Baxstrom After One Year, 129 Amer. J. Psych. 974 (1968); and Steadman & Keveles, The Community Adjustment and Criminal Activity of the Baxstrom Patients: 1966-1970, 129 Amer. J. Psych. 304 (1972).

[7]United States ex rel. Schuster v. Herold, 410 F.2d 1071 (2d Cir. 1969), cert. denied, 396 U.S. 847 (1969).

[8]Id. at 1081.

[9]427 U.S. 215 (1976). See also Montanye v. Haymes, 427 U.S. 236 (1976), cert. denied, 431 U.S. 967 (1977).

[10]427 U.S. at 216.

[11]Wolff v. McDonnell, 418 U.S. 539 (1974).

[12]In New York State, Wolff procedures are applicable for "keep-lock," which is simply being confined to your own cell and temporarily taken out of the normal prison routine. See Powell v. Ward, 487 F. Supp. 917 (S.D. N.Y. 1980), cert. denied, 454 U.S. 832 (1981).

[13]Neb. Rev. Stat. Sec. 83-180 (1).

[14]Vitek v. Jones, 445 U.S. at 489-90.

[15]Id. at 493-94.

[16]Churgin, The Transfer of Inmates to Mental Health Facilities in Mentally Disordered Offenders 207, 218-19 (J. Monahan & Steadman, H. eds. 1983).

See Ellis & Luckasson, Mentally Retarded Defendants, 53 Geo. Wash. L. Rev. 414, 483-84 (1985) for a discussion of the law and policy of transfering the mentally retarded inmate.

[17]Churgin, _supra_ note 16, at 221.

[18]_Id._ at 221-22. Wiser because prisoners do not often have in place a decision-making body resembling a parole board.

[19]In New York State, the most seriously ill inmates are transferred to Central New York State Psychiatric Center at Marcy. Many of those transfers are done on an emergency basis, thus obviating any pretransfer court procedures. The average stay for this population of 180 inmate-patients is about 70 days.

[20]A.B.A., Criminal Justice Mental Health Standards 7-10.4 (1984).

[21]_See_ _Okumoto v. Lattin_, 649 F. Supp. 55 (D. Nev. 1986) for a discussion, but no resolution, of this matter.

[22]_See_ Churgin, _supra_ note 16, at 226.

[23]Hartstone, Steadman & Monahan, _Vitek_ and Beyond: The Empirical Context of Prison-to-Hospital Transfers, 45 _Law & Contemp'y Prob's_ 125, 130 (1982)

[24]_Id._ at 130-31.

[25]808 F.2d 333 (4th Cir. 1987).

[26]_Id._ at 335, n.2.

[27]_Id._ at 836-37.

[28]In _Hewitt v. Helms_, 459 U.S. 460 (1983) the Court found that Pennsylvania created a liberty interest in the avoidance of prolonged and unilaterally imposed administrative segregation. So long as an inmate receives some notice of the charges under review and is given an opportunity to respond, then due process is satisfied.

The recently decided _Pennhurst State School v. Halderman_, 465 U.S. 89 (1984) held that a federal court cannot order injunctive relief against state officials on the sole basis of state law. _Hewitt v. Helms_ did not concern injunctive relief, but the implications of _Halderman_ may be far reaching.

[29]Satellite units often have very secure cells, and inmates have been confined in such isolation and security for over three months.

[30]_See_ N.Y. Correct. Law Sec. 402 (1) (McKinney Supp. 1983-84).

[31]422 U.S. 563 (1975). _See, e.g._, _Commonwealth ex rel. Finken v. Roop_, 234 Pa. Super. 155, 339 A.2d 764 (1975), _cert. denied_, 424 U.S. 960

[31] (continued)
(1976). In Kolender v. Lawson, 461 U.S. 352, 357 (1983) Justice O'Conner indicated that vagueness doctrine focuses on arbitrary enforcement rather than on notice to the persons arguably affected. This approach, of course, strengthens vagueness claims in this area.

[32] Churgin, supra note 16, at 228. This clearly seems correct. Another author argues that the state should show dangerousness. Gottlieb, Vitek v. Jones: Transfer of Prisoners to Mental Institutions, 8 Am. J. L. & Med. 175, 206 (1982).

[33] 441 U.S. 418 (1979).

[34] Parham v. J.R., 442 U.S. 584 (1979). The Court also found that social welfare agencies may be presumed to act in the best interests of their wards when they move for admission to a psychiatric hospital.

[35] 441 U.S. 418 (1979). In Jones v. United States, 463 U.S. 354 (1983) the Court refused to apply Addington standards to commitment following a not guilty by reason of insanity verdict. Professor David Wexler critically reviews Addington in D. Wexler, Mental Health Law: Major Issues 59-68 (1981).

[36] N.Y. Correct. Law Sec. 404 (1) (McKinney Supp. 1983-84).

[37] A.B.A., Criminal Justice Mental Health Standards, 7-10.10 (1984). See also 2 Mental Disability Law Rptr. 669-70 (1978).

[38] 325 F. Supp. 699 (W.D. Mo. 1971). 18 U.S.C Sec. 4241 reads in part as follows:

> A board of examiners for each Federal penal and correctional institution ... shall examine any inmate of the institution alleged to be insane or of unsound mind or otherwise defective and report their findings and the facts on which they are based to the Attorney General.
>
> The Attorney General, upon receiving such report, may direct the warden or superintendent or other official having custody of the prisoner to cause such prisoner to be removed to the United States hospital for defective delinquents or to any other institution authorized by law to receive insane persons charged with or convicted of offenses against the United States, there to be kept until in the judgment of the superintendent of said hospital, the prisoner shall be restored

[38] (continued)
to sanity or health or until the maximum sentence without reduction for good time or commutation of sentence, shall have been served.

[39] 298 F.2d 592, 593 (8th Cir. 1962).

[40] 320 F. Supp. 690 (D. Neb. 1970), aff'd, 445 F.2d 818 (8th Cir. 1971).

[41] Id. at 699.

[42] It should be clear that this discussion centers on the opportunity to earn such credits and not on the problem of forfeiting credits already accrued. See Wolff v. McDonnell, 418 U.S. 539 (1974), Preiser v. Rodriguez, 411 U.S. 475 (1973) (a prisoner's challenge to the loss of good time is within the core of a habeas corpus challenge).

[43] 520 F. Supp. 690 (D. Neb. 1970), aff'd, 445 F.2d 818 (8th Cir. 1971).

[44] 551 F.2d 44 (4th Cir. 1977).

[45] Id. at 46. By implication, the treatment was to be aimed at "parole readiness."

[46] 423 F. Supp. 1190, 1192 (N.D. W.Va. 1976).

[47] Id. at 1194.

[48] Id. at 1194-95.

[49] Greenholtz v. Inmates of the Nebraska Penal & Correctional Complex, 442 U.S. 1 (1979).

[50] See, e.g., Dandridge v. Williams, 397 U.S. 471 (1970).

[51] Where parole boards do not have to give reasons for their decisions or otherwise be held accountable for a pattern of practice, the real problem will not be a written law or regulation. It will, of course, be the practice. In New York State an earlier reluctance to parole inmates from the Central New York State Psychiatric Facility in Marcy has softened somewhat in recent months and over 20 paroles have occurred from the hospital in recent months.

[52] 355 F. Supp. 1278 (D. Ariz. 1973).

[53] Id. at 1281.

[54] Id. at 1282.

[55]437 A.2d 590 (D.C. Cir. 1981).

[56]Id. at 593. The statutory provision relevant to returning a prisoner to the custody of the Department of Corrections reads as follows:

> When any person confined in a hospital for the mentally ill while serving sentence shall be restored to mental health within the opinion of the superintendent of the hospital, the superintendent shall certify such fact to the Director of the Department of Corrections of the District of Columbia and such certification shall be sufficient to deliver such person to such Director according to his request. [D.C. Code 1973, Sec. 24-303(b)].

[57]Id. See Bailey v. Noot, 324 N.W.2d 164 (Minn. 1982) for a discussion of statutory authority to transfer a patient committed to a security hospital to a prison. Authority was denied.

[58]558 F.2d 658 (2d Cir. 1977), cert. denied, 434 U.S. 1018 (1978).

[59]Id. at 662.

[60]Id.

[61]Id.

[62]Id. at 663, 665.

[63]Santori v. Fong, 484 F. Supp. 1029 (E.D.Pa. 1980), holding no right to a hearing for a pretrial detainee on the retransfer decision.

V. THE TREATMENT RELATIONSHIP

A. Confidentiality and Privilege

Questions concerning confidentiality and privilege, of when information gained by a mental health professional from an inmate-patient/client may or must be shared, are among the most frequently asked and most difficult to clearly answer. The prison or secure mental hospital setting creates the often conflicting demands on the mental health specialist that give rise to much of the difficulty. There are questions of "split agency" -- for example, court ordered evaluation, jail, or prison screening -- and there are questions of confusion of agency.[1] There are also questions related to duties owed identifiable others who may be in danger from an inmate-patient[2] and questions related to the general security and order of the facility.

I will analyze these complex issues, and more, in this Chapter. However, let me propose at the outset a general solution to a great many -- but certainly not all -- of these problems. The need for confidentiality and privilege, as a matter of law and professional ethics, rests on the individual's expectations of privacy and nondisclosure. It recognizes that the need for information to provide needed treatment generally outweighs even compelling demands for disclosure.[3] Where the interaction with the inmate is for diagnosis, evaluation, or classification (or something similar), the full impact of privilege and confidentiality does not apply.

The mental health professional in a prison or mental hospital setting is well advised to disclose his or her agency to the individual before proceeding, disclose the purpose of the meeting, indicate the uses to which the information will or may be put, and indicate a willingness to answer questions as clearly as possible concerning the risks of disclosure.[4]

The principle of confidentiality of information obtained in the course of treatment is applicable in the prison or jail setting. Although disclosure of the type recommended above is most appropriate when the inmate-clinician contact is not for treatment, it may also apply during the course of treatment where certain categories of information, to be discussed shortly, are likely to be disclosed.[5]

The common law did not recognize the doctor-patient privilege, and not until 1828 did New York pass the first statute granting doctors the right to refuse to testify.[6] The late-arriving and narrowly expressed medical doctor-patient privilege has now been generally extended to psychotherapists and other mental health professionals.[7]

In the federal courts, Rule 501 of the Federal Rules of Evidence is applicable and provides:

RULE 501-GENERAL RULE

Except as otherwise required by the Constitution of the United States or provided by Act of Congress or in rules prescribed by the Supreme Court pursuant to statutory authority, the privilege of a witness, person, government, State, or political subdivision thereof shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience. However, in civil actions and proceedings, with respect to an element of a claim or defense as to which State law supplies the rule of decision, the privilege of a witness, person, government, State or political subdivision thereof shall be determined in accordance with State law.

This general rule, deferring to the privilege laws in the various states, should be contrasted with the highly specific rule that had been proposed and was rejected:

PSYCHOTHERAPIST-PATIENT PRIVILEGE

(1) Definitions.

(1) A 'patient' is a person who consults or is examined or interviewed by a psychotherapist.

(2) A 'psychotherapist' is (A) a person authorized to practice medicine in any state or nation, or reasonably believed by the patient so to be, while engaged in the diagnosis or treatment of a mental or emotional condition, including drug addiction, or (B) a person licensed or certified as a psychologist under the laws of any state or nation, while similarly engaged.

(3) A communication is 'confidential' if not intended to be disclosed to third persons other than those present to further the interest of the patient in the consultation, examination, or interview, or persons reasonably necessary for the transmission of the communication, or persons who are participating in the diagnosis and treatment under the direction of the psychotherapist, including members of the patient's family.

(b) General rule of privilege.

A patient has a privilege to refuse to disclose and to prevent any other person from

disclosing confidential communications, made for the purposes of diagnosis or treatment of his mental or emotional condition, including drug addiction, among himself, his psychotherapist, or persons who are participating in the diagnosis or treatment under the direction of the psychotherapist, including members of the patient's family.

(c) Who may claim the privilege. The privilege may be claimed by the patient, by his guardian or conservator, or by the personal representative of a deceased patient. The person who was the psychotherapist may claim the privilege but only on behalf of the patient. His authority so to do is presumed in the absence of evidence to the contrary.

(d) Exceptions.

(1) Proceedings for hospitalization. There is no privilege under this rule for communications relevant to an issue in proceedings to hospitalize the patient for mental illness, if the psychotherapist in the course of diagnosis or treatment has determined that the patient is in need of hospitalization.

(2) Examination by order of judge. If the judge orders an examination of the mental or emotional condition of the patient, communications made in the course thereof are not privileged under this rule with respect to the particular purpose for which the examination is ordered unless the judge orders otherwise.

(3) Condition an element of claim or defense. There is no privilege under this rule as to communications relevant to an issue of the mental or emotional condition of the patient in any proceeding in which he relies upon the condition as an element of his claim or defense, or, after the patient's death, in any proceeding in which any party relies upon the condition as an element of his claim or defense.[8]

Recognizing that privilege and confidentiality generally apply in institutional settings, and that these privacy safeguards are most clearly implicated during a treatment relationship, author Christine Boyle points out:

It is suggested that there is a basic conflict here between the authoritative or controlling

> aspect of imprisonment, represented, in a very general way, by the custodial and administrative staff, and the need to rehabilitate, which is largely seen as the responsibility of the professional personnel. Because of this conflict, organization problems are bound to arise in an institution which must perform custodial as well as rehabilitative functions, since confidentiality may be seen as vital to the latter, but dysfunctional to the former.[9]

The difficult problem for the clinician, then, is to balance the generally applicable principle of confidentiality in a treatment relationship with the countervailing demands of security: the security of specific individuals who may be in jeopardy and the general security of the institution.

Legally safeguarded expectations of privacy in jail or prison are virtually nonexistent. In the context of freedom from unreasonable searches and seizures, claims that an inmate's cell is "home" and thus subject to some protections simply are not recognized.[10] Parenthetically, the attorney-client relationship is vital to detainees and inmates, and there is little choice as to where to meet with counsel. Clearly the attorney-client privilege, and the necessity for privacy, attaches during attorney-client contacts in the facility.

In Peterkin v. Jeffes,[11] inmates under sentence of death in Pennsylvania complained generally about their conditions of confinement. One rather unusual claim was that inmates felt constrained to reveal their innermost feelings or the more than occasional thoughts of suicide that sweep over persons on death row. The inmates, for good reason, feared disclosure.

The Commonwealth's psychiatrists testified that they would disclose confidences, even if such disclosure engenders mistrust, but only under circumstances that create necessity and are in accord with standard psychiatric practice:

> Thus, Dr. Wawrose testified that he would disclose confidentially revealed plans to escape, intentions to injure, and possession of contraband, even though revealed to him in confidence. He would not disclose, however, confidentially revealed sexual or emotional problems. Moreover, even though the Commonwealth's policy of reacting sternly to an inmate ostensibly contemplating suicide may deter inmates from discussing suicidal inclinations, both sides agree that the overriding concern for the welfare of the inmate necessitates this practice.[12]

Every jurisdiction should adopt a clear set of rules as to when confidentiality is inapplicable. I suggest that mental health personnel be required to report to correctional personnel when an inmate is identified as:

a) suicidal;
b) homicidal;
c) presenting a reasonably clear danger of injury to self or to others either by virtue of conduct or oral statements;
d) presenting a reasonably clear risk of escape or the creation of internal disorder or riot;
e) receiving psychotropic medication;
f) requiring movement to a special unit for observation, evaluation or treatment of acute episodes; or
g) requiring transfer to a treatment facility outside the prison or jail.[13]

Not according confidentiality to these various categories serves various purposes. The duty to preserve the life and health of inmates underpins the need to breach apparent confidences to prevent suicide, homicide, or self-inflicted harm and harm to others. Riot or escape from prison are crimes and, as a general proposition, no privilege attaches to discussions of future criminality.[14] Given the alterations in behavior that occur as a result of psychotropic medication, it is in the inmate's best interests that correction staff be informed of their use. Finally, if there is a need for intra- or inter-institutional transfer, then it is perfectly obvious that correction staff must know and likely assist.

The Tarasoff situation alluded to earlier calls for some elaboration. In Tarasoff, a mental health outpatient carried out his intention to kill his former fiance, having previously confided his plan to his therapist. The decedent's parents sued for damages and the Supreme Court of California held that a psychotherapist owes a duty of reasonable care to identifiable third parties endangered by the therapist's patient.

The court held:

> When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.[15]

Professor David Wexler raises the question of just how the therapist may discharge the duty to warn, suggesting that alerting the intended victim would be the standardized safe response.[16] In a prison or jail the standardized safe response would seem to call for alerting the appropriate security personnel and allowing them to take steps to protect the intended victim.

A Tarasoff situation does not arise unless there is an identifiable victim. If a patient (or client) during treatment talks generally about murderous thoughts or hostility against authority, then clearly this is not a Tarasoff situation because there is no enforceable duty to an identifiable victim. Here, it seems, the world of professional ethics and individual judgment prevails.

A recent study of psychiatrists, psychologists and social workers in the eight largest metropolitan areas of the country disclosed widespread awareness of Tarasoff and a substantial increase in willingness to warn potential victims.[17] As of 1980, according to the study, there was a widespread endorsement of the Tarasoff obligation to protect potential victims as a personal and professional norm.[18]

To the extent that these findings suggest that an important tort decision in one state has found its place in the professional norms of mental health workers, then we may expect those norms to infiltrate the prison world. Indeed, with the dangers generally intensified and with a diminished world of identifiable victims, Tarasoff norms are more compelling in prison.[19]

One authority would solve the ethical question of disclosure when Tarasoff is not involved by treating such disclosures as generally confidential to the extent that the "public" is not imperiled. She states:

> Actually this ...is not discrepant with the American Psychological Association's Ethical Standards of Psychologists. Principle 6, Section a (1972:3), which reads as follows: 'Such information is not communicated to others unless certain important conditions are met: (a) information received in confidence is revealed only after most careful deliberation and when there is clear and imminent danger to an individual or to society, and then only to appropriate professional workers or public authorities.'[20]

On the practical level, students of this problem indicate that, with the exception of the probability of harm to the clinician or others, the decisions to be made are far from clear-cut. Quijano and Logsdon put it this way:

> It seems to be the general practice among correctional psychologists to inform their inmate clients -- and the inmates must understand -- that aside from plans to escape and/or harm themselves or others, the principle of confidentiality holds. Even in these two cases, the issue is not clear-cut. Special care must be exercised not to report just any talk about escape or violence to the security authorities. Only those threats whose probability of actual execution is reasonably high should be reported, and the only basis for that decision is historical data and the psychologist's best judgment. Unnecessary reports may harm not only the inmate client in question but also the correctional psychologist's credibility to both the inmate clientele and the administration. It is obvious that in the implementation of the principle of confidentiality many decisions will be 'judgment calls', and prudence (whatever that means to the psychologist) is the guide.[21]

Another observer admonishes the prison counselor or therapist to consider:

1. The role conflict in seeking to balance the therapeutic needs of the patient with the security and stability of the institution.
2. Inherent problems in accurately predicting dangerousness.
3. The impact of a breach of confidentiality on the relationship with the inmate.[22]

Thus, where there is no identifiable, intended victim and the therapist encounters "threats in the air," so to speak, there is no easy answer. Confidentiality in the treatment relationship should be the norm, with therapists ultimately having to exercise their best judgment on the seriousness of the general threat. Therapists who reflexively reveal their patient's every threatening word surely compromise themselves professionally and likely undermine their ability to help inmates.

B. Consent to Treatment

The basic principle of the law concerning how treatment decisions should be made is most clearly embodied in the doctrine of informed consent.[23] We begin with a general norm of the sanctity of the body of a competent adult. This, in turn, implies autonomy in decision-making by the individual whose body -- or life or health -- is at stake.

The patient has autonomy and the healer has information and expertise. Informed consent strives for some equilibrium between these two, so the

patient can apply his personal value system to the alternatives presented.[24] This approach -- let us call it the traditional model -- applies most comfortably to physical medicine outside the area of psychological treatment.

A right to refuse treatment where mental disorder is at issue raises the question of the competency of the individual to make the decision or, at times, even to absorb the proferred information. When the individual is in penal confinement, the matter is even more complicated given, on the one hand, a conceivably legitimate constitutional right to treatment and, on the other hand, the inherent coercion of the institutional setting.

Al Bronstein, one of the country's foremost litigators on behalf of prisoners, is quoted as saying, "'You cannot create [a prison] institution in which informed consent without coercion is feasible.'"[25] If informed consent, then, is to be a legal requirement for the more intrusive types of treatment -- for example, electric convulsion therapy or psychotropic medications -- Mr. Bronstein's approach rules out the treatment.[26]

Prisons and jails do create what I will term situational coercion. Situational coercion arises when the characteristics inherent in the particular environment impinge on free choice. If coercion is defined as efforts intended to influence another by severe and credible threats which appear to be irresistible, then the prison-jail environment clearly must be factored into the coercion calculation. This environment of distrust places a heavy burden on the person seeking consent.

Although situational coercion creates hurdles, it does not create barriers. As a matter of policy and law this seems an eminently reasonable approach because it allows for informed consent and possibly valuable treatment while it accomodates obvious environmental pressures.

In one rather early federal case, a prisoner confined in Leavenworth complained that prison clinicians authorized the injection of psychotropic medicine over his general and religious objections.[27] The inmate had been diagnosed as paranoid schizophrenic and exhibited hostile and destructive behavior (self-mutilation, destruction of a prison cell, unprovoked fights with other inmates, and so on). The medication was authorized on the basis of a clinical judgment that the inmate posed a substantial threat to his own safety and to the safety of other inmates.

The essence of the court's reasoning in rejecting the inmate's claim is that the prison officials are under a duty to provide medical care for an inmate's serious medical needs and the inmate's disagreement with the nature or type of care provided presents no legally recognized claim.[28] Thus the right to care is converted into a duty to accept it with no intermediate concerns expressed about competency and consent.[29]

If this decision had been factually characterized as presenting an emergency situation, with forced medication as the clinically preferred choice to achieve temporary control, then other issues would arise. That, however, is not the case, and the rule which emerges is that where clinical judgment is brought to bear on the choice of treatment, a combination of the need to control penal institutions and to provide care for the seriously disordered inmate allows for the forcible administration of psychotropic medication.

An inmate's right to care, however, should not be so easily converted to a duty of uninformed and unquestioning obligation to accept care. Let us assume that there are two competing purposes that might be served by the doctrine of informed consent: protection from potential harm and/or respect for personal autonomy.[30] Prolonged injection of psychotropic medication over an inmate's -- or inmate-patient's -- objection actually violates both purposes.

Even those who generally favor the use of psychotropic medication for in-patients are careful to point out the side effects:

> The anticholingergic effects include dry mouth, blurred vision, constipation, and urinary retention, each of which can be variably disturbing. Some patients find visual blurring particularly disturbing; others are more distressed by alteration in bowel irregularity.
>
> The autonomic side effects include postural hypotension, leading to dizziness on abrupt rising to a standing posture.
>
> The extrapyramidal side effects are often the most subjectively disturbing. These include dystonias and dyskinesias (spasms and abnormalities of movement); alathisia (motor restlessness, occasionally experienced as discomfort without a movement component); akinesia or stiffness; or tremor and incoordination. When these movement disturbances affect eye muscles, tongue or pharnyx musculature, they can be especially upsetting, as the eyes may roll upward, and speech and swallowing may be interfered with.
>
> * * * * * * * *
>
> Tardive dyskinesia (TD). This side effect is the most problematic for the psychiatric profession and is the one most seized upon by legal and other opponents of pharmacotherapy. The term refers to lasting (tardive) effects of

> medication that may involve movement disorders (dyskinesias) of face and tongue musculature, as well as muscles of the extremities. Fear of, or the appearance of, this effect may lead to medication refusal, although patients are not often conscious of the existence of the abnormal movements.
>
> This relatively recently discovered deleterious effect of antipsychotic medication use poses several problems. First, in terms of diagnosis, a careful reading of Kraeplin's observations of schizophrenics, in the century before phenothiazines were first synthesized, reveals descriptions of movement disorders appearing in late life and strikingly resembling TD. Second, concerning prevention, this affect appears at times to occur even following relatively brief exposure to medication at low doses. Third, treatment response for TD has been variable but generally poor; at present, research in treating TD, though extremely active, is at an embryonic stage.
>
> Given the current irreplaceable importance of medications in the treatment of major illness and in facilitating the return of patients to the community, tardive dyskinesia must be viewed as a risk to be carefully weighed against the benefits, as with all treatments.[31]

Accepting all of the above as accurate, and accepting further the potential benefits of such medication, when it comes to weighing the risk, the authors suggest that the inmate-patient should be involved and consent generally required.[32]

Whether informed consent is required (or desirable) for treatment of a mentally disordered inmate should not turn on whether the proposed treatment will be administered in a prison or a mental health facility. The identity of the agency administering the treatment facility would seem equally irrelevant. The objectives of autonomy and protection from harm simply are not related to the place of care or administrative arrangements.

Does the inmate's legal status dilute his claims to autonomy or protection from harm to the point where consent to treatment either is not generally required but rather is applied in some diluted form? Where does the person convicted of crime fit on the chart where the two extreme positions are: (a) that a clinician always knows best and acts in the best interests of the individual, and (b) that a person, no matter how

disturbed, always has the right to resist therapy? Do the same considerations apply to all forms of psychiatric care?

It may be recalled that in Vitek v. Jones the Supreme Court imposed procedural due process on prison-to-mental-hospital transfers because the requisite finding of mental illness is qualitatively different from conviction and punishment for crime and because the transferee was subject to a mandatory behavior modification program.[33]

In Vitek, although the challenge was not to the enforced participation in any particular treatment program, the Court does seem to unquestioningly accept enforced treatment. The due process requirements are imposed to reduce the risk of error in fact finding and to provide an adjudicative format for those inmates seeking to resist the move, and thus the treatment. Vitek, then, far from determines any of the questions posed above, but it suggests a judicial acceptance of some types of enforced treatment. And depending on the treatment, such a position is not remarkable.[34]

Dr. Alan Stone indicates that:

> It would be possible to rank various psychiatric treatments according to criteria of severity, such as the gravity and duration of intended effects and likely side-effects, the extent to which a reneging patient can avoid these effects, and the sheer physical intrusiveness of the therapy. Presumably, as one moved from the more to the less severe treatments, the patient's consent would be less consequential.[35]

At a minimum, informed consent requires a competent adult, the absence of duress or coercion (i.e., voluntariness), and the disclosure of information on risks, alternatives, and the likely consequences of refusing the proffered care.[36] The mere listing of such factors should not serve to camouflage inherent difficulties in each factor and the lively debate surrounding this area.

For example, by what standards shall we measure competency? Typically an inmate's or patient's competence is questioned primarily when his treatment decision varies from that of the clinician's.[37] The circularity of this approach is apparent, but its utilization, especially in the institutional setting, may be unavoidable.

Some will argue that informed consent, and especially the notion of voluntariness, is an illusion in an institutional setting.[38] Voluntariness, however, seems to be more of a problem with research on prisoners than it is with traditional treatment techniques. One important study concluded "that more detailed disclosures and no therapeutic privileges should be the rule in the experimental setting."[39]

The possibility of secondary gain from participation in prison experiments -- money, better living conditions, early release -- all contribute to problems of voluntariness that are not likely to be present in a treatment situation. Indeed, the inmates themselves may "fake it" in order to obtain what is seen as the benefits of being labeled mentally ill. For mentally disturbed prisoners, the key element in consent would seem to be the richness of the information concerning risks, alternatives, and possible consequences.

One critical point requires absolute clarity: neither the impaired legal status of the prisoner nor the loss of liberty inherently associated with confinement reaches into the inmate's physical or psychic interior. Obviously, imprisonment per se will have a profound physical and emotional impact on inmates. What I mean, however, is that the inmate's physical and psychic autonomy is not sufficiently breached so that the basic legal norm of autonomy mentioned earlier is vitiated.

While rarely explicit, the more recent judicial decisions involving prisoners do draw a line between the exterior and the interior of a person. Although the line is rudimentary and may appear to be obvious, it is, nonetheless, useful. Where official activity requires penetration of the body, whether that penetration is to help or hurt and whether it is by scalpel, needle or pill, the inmate's legal and human autonomy makes informed consent the norm.[40]

Professor Norvall Morris directly faced the issue of inmate consent and did so in the context of a debate on highly experimental and dangerous treatments. Morris states:

> I adhere to the view that it is possible to protect the inmate's freedom to consent or not; that we must be highly skeptical of consent in captivity, particularly to any risky and not well-established procedures; but there seems little value in arbitarily excluding all prisoners from any treatment, experimental or not. Like free citizens they may consent, under precisely circumscribed conditions to any medical, psychological, psychiatric, and neurosurgical interventions which are professionally indicated; their protection must be more adequate than that surrounding the free citizen's consent, since they are more vulnerable. It is better directly to confront the potentialities of abuse of power over prisoners than to rely on the temporary exclusion of prisoners from "experimental" programs.[41]

Many judicial decisions in this area, and especially the more recent ones, are supportive of Professor Morris' views, often without being as

direct or thoughtful. In the relatively early case of Haynes v. Harris,[42] a federal prisoner, confined at the Medical Center in Springfield, Missouri, unsuccessfully challenged his forced medical care. He claimed that he was being subjected to corporal punishment, which was outside the scope of permissible punishment, and that as a citizen he had a right to decide for himself whether to receive treatment.

The court summarily rejected both claims, without any analysis of the nature of the challenged treatment or the possible need for the inmate's consent. In an institution designed for treatment, the court assumed that the complaint here was really about the enforcement of rules and regulations, an area deemed the exclusive perogative of administrative authorities.[43]

In the later case of Ramsey v. Ciccone,[44] a similar approach resulted in a similar ruling. The prisoner did not raise the issue of consent, but the court found that:

> Having custody of the prisoner's body and control of the prisoner's access to medical treatment, the prison authorities have a duty to provide needed medical attention....Even though the treatment is unusually painful, or causes unusual mental suffering, it may be administered to a prisoner without his consent if it is recognized as appropriate by recognized medical authority or authorities.[45]

In Peek v. Ciccone[46] a federal prisoner also confined at Springfield challenged his forced medication. After refusing to take a tranquilizer ordered by a physician, the prisoner was forcibly given an injection of thorazine by prison guards. The court held that the prisoner did not have a valid Eighth Amendment claim because: "[t]he officers of the Medical Center [subordinates of the Attorney General] were not attempting to punish or harm the petitioner by forcibly administering under medical direction the intramuscular injection...."[47]

The court gave weight to the following factors in reaching its decision: 1) the prisoner was given a chance to take the drug orally and refused; 2) the prison guard had received sufficient training at the medical center to administer an intramuscular injection; and 3) although the thorazine did cause the prisoner to become dizzy and faint on occasion, the drug is non-narcotic and not habit forming.[48]

In Smith v. Baker[49] a prisoner confined in the Missouri State Penitentiary claimed that his federal rights were violated when he was injected with prolixin against his will and against his religious beliefs. The Court dismissed the Eighth Amendment claim of improper or inadequate medical care by following the decision in Ramsey v. Ciccone. Surprisingly, the court casually dismissed the First Amendment claim by

simply stating "it is well established that medical care which is administered over the objections of a prisoner does not constitute the denial of any federal right."[50]

Clearly these early decisions left prisoners with very little voice in the medical or psychiatric care they received. It should be noted, however, that the cases all are from the Federal District Court of the Western District of Missouri and the Eighth Circuit Court of Appeal. The reason for this is the United States Medical Center for Federal Prisoners is located in Missouri. Thus, little diversity of opinion to be found or to be expected.[51]

Mackey v. Procunier involved a challenge to a behavior modification-type program experimentally used at the California Medical Facility at Vacaville.[52] The protesting inmate conceded that he had consented to ECT but not to the drug succinylcholine (for example, Anectine). The inmate (one of 64 involved) had described the drug as a "breath-stopping and paralyzing 'fright drug.'"[53]

This program caught the eye of writer Jessica Mitford, who states:

> According to Dr. Arthur Nugent, chief psychiatrist at Vacaville and an enthusiast for the drug, it induces 'sensations of suffocation and drowning.' The subject experiences feelings of deep horror and terror, 'as though he were on the brink of death.' While he is in this condition a therapist scolds him for his misdeeds and tells him to shape up or expect more of the same. Candidates for Anectine treatment were selected for a range of offenses: 'frequent fights, verbal threatening, deviant sexual behavior, stealing, unresponsiveness to the group therapy programs.' Dr. Nugent told the San Francisco Chronicle, 'Even the toughest inmates have come to fear and hate the drug. I don't blame them, I wouldn't have one treatment myself for the world.' Declaring he was anxious to continue the experiment, he added, 'I'm at a loss as to why everybody's upset over this.'[54]

Although the district court below dismissed the complaint, the court of appeals held that "[p]roof of such matters could, in our judgment, raise constitutional questions respecting cruel and unusual punishment or impermissible tinkering with the mental process."[55]

Clonce v. Richardson involved a challenge to the Special Treatment and Rehabilitative Training (START) behavior modification proposed for federal prisoners at the Springfield facility. The program was designed for highly aggressive and destructive inmates whose behavior was sought

to be altered by a type of token economy.[56] As Professor David Wexler describes it:

> The inmate plaintiffs contended that the deprivations which they were involuntarily required to endure at the first level of the program (such as visitation rights, exercise opportunities, and reading materials) amounted to a constitutional violation. In response, the government argued that it was necessary, at the initial stage, to deprive the inmates of those rights so that those items and events might be used as reinforcers. Moreover, the government continued, the fact that the inmates deemed the denial of rights significant enough to challenge actually established the psychological effectiveness of those reinforcers as behavioral motivators. Note that the government's argument comes close to creating a legal Catch 22: If you complain of the denial of certain rights, you are not entitled to them; you are entitled only to those rights the denial of which you do not challenge!
>
> While the lawsuit was pending, the Bureau of Prisons decided to terminate the START program, though the Bureau's director testified that such 'positive-reinforcement' approaches would in all likelihood be employed in future correctional efforts. Because of the START termination, however, the federal court found the suit to be moot, except with respect to certain procedural aspects, and accordingly did not address the merits of the deprivation issue.[57]

Souder v. McGuire involved a former inmate at Pennsylvania's Farview State Hospital for the criminally insane who claimed that a violation of his constitutional rights occurred when he and other inmates were forcibly treated with psychotropic drugs.[58] The court denied a motion to dismiss, stating that the administration of drugs that have a painful or frightening effect can amount to cruel and unusual punishment.[59]

One of the most decisive of the earlier cases in this area, Knecht v. Gillman, involved the Iowa State Medical Facility (ISMF), to which an Iowa prisoner could be transferred for diagnosis, evaluation, and treatment.[60] Inmates challenged the forcible injection of apomorphine, a drug that caused vomiting for 15 minutes to an hour and also caused a temporary increase in blood pressure. The drug was used as an aversive stimulus when inmates were caught swearing, lying, or getting up late. These rule infractions were reported to a nurse, who would administer the injection in a room containing only a water closet.

The court refused to accept as final the characterization of this program as treatment and thus insulate it from scrutiny under the Eighth Amendment. The court concluded that:

> [w]hether it is called 'aversive stimuli' or punishment, the act of forcing someone to vomit for a fifteen minute period for committing some minor breach of the rules can only be regarded as cruel and unusual unless the treatment is being administered to a patient who knowingly and intelligently has consented to it.... The use of this unproven drug for this purpose on an involuntary basis, is, in our opinion, cruel and unusual punishment prohibited by the eighth amendment.[61]

To remedy the situation at ISMF, the court ordered that before apomorphine treatments can be used the following conditions must be met:

1. a written consent must be obtained with the patient being fully informed of the nature, purpose, risks, and effects of treatment;
2. the consent is revocable at any time, even orally; and
3. each injection must be authorized by a physician.[62]

Knecht is important in several respects. First, aversive therapy is not insulated from the strictures of cruel and unusual punishment. The simple expedient of labeling an intervention as treatment will not prevent a court from engaging in a type of functional analysis to arrive at an independent judgment concerning the accuracy of the label. So long as the courts are reluctant to apply the concept of cruel and unusual punishment to treatment, the intellectual task is to analyze the complained about activity on a treatment v. punishment scale. The second point is that consent is the essential element of this treatment program; and it must be informed and is revocable.

Thus, the treatment community must be on notice that while many of these earlier judicial decisions are rather permissive and deferential to clinical judgments as to proper treatment, in instances where the direct effects of treatment are physically or emotionally painful, at a minimum, informed consent is the norm.[63]

The well-known Kaimowitz[64] case represents the outer limits of intrusive therapy and consent issues. A three-judge trial court held that as a matter of law involuntarily confined patients cannot give consent to experimental psychosurgery. The court reasoned that institutionalization created a type of impaired competency, that confinement itself dramatically affected voluntariness, and that the risks, known and unknown, of psychosurgery made it impossible to impart an adequate information base.[65]

Of the several important, more recent decisions dealing with the constitutional right of involuntarily committed mental patients to refuse antipsychotics, the decision in Rennie v. Klein ranks among the more important.[66] The suit originally was filed in 1977, after Rennie's twelfth hospitalization. The initial evidentiary hearing took about a year, and the case has gone as far as the Supreme Court,[67] which remanded the case for reconsideration in light of Youngberg v. Romeo.[68]

On the remand, the Third Circuit Court of Appeals held:

> that antipsychotic drugs may be constitutionally administered to an involuntarily committed mentally ill patient whenever, in the exercise of professional judgment, such an action is deemed necessary to prevent the patient from endangering himself or others. Once that determination is made, professional judgment must also be exercised in the resulting decision to administer medication.[69]

This standard for the forcible (or nonconsenual) administration of drugs eliminates this court's earlier additional requirement of the "least intrusive means" concept. That is, other means to control the danger short of drugs -- such as, temporary isolation and soft restraints -- need not be expressly eliminated in the clinical decision to use forced medication.[70]

On the other hand, the Rennie standard assumes that the exercise of professional judgment -- so heavily relied upon in Youngberg -- includes whether, and to what extent, the patients will suffer harmful side effects. Those side effects are not controlling or necessarily determinative and, most important, they are not part of any need for consent.[71] Rather, these considerations simply play a role in the clinical judgment to forcibly medicate, and it is impossible to imagine a clinician stating: "No, come to think of it, I never considered the side effects. We just went ahead and injected Jones."

Only three of the ten judges deciding the case joined in the opinion of the court. Six others concurred in the result and one dissented. Much of the debate centered on the vitality or emphasis to be given to the "least intrusive means" concept. Judge Adams, for example, agreed that, while the least intrusive means test did not survive Youngberg, with "forcible use of antipsychotic drugs, a state-employed physician must, at the very least, consider the side effects of the drugs, consult with other professionals and investigate other options available before that physician can be said to have discharged full professional judgment."[72]

Chief Judge Seitz wrote, "The State is not restricted to helping the patient only if he wishes to be helped."[73] Judge Seitz is even more

restrictive of patients' rights than the opinion for the court in that he seems to eliminate the need for a threshold judgment on dangerousness. His view is "that the Due Process Clause at a minimum requires the authorities to administer antipsychotic drugs to an unwilling patient only where the decision is the product of the authority's professional judgment."[74]

Judge Weis, joined by two colleagues, strongly believes that Youngberg does not govern the standard for long-term forcible administration of antipsychotic drugs.[75] Youngberg dealt with physical restraints which are unlikely to have permanent aftereffects.

> By contrast, the long-term administration of antipsychotic drugs may result in permanent physical and mental impairment. As our earlier opinion noted, all antipsychotic drugs affect the central nervous system and induce a variety of side effects.*** The permanency of these effects [description omitted] is analogous to that resulting from such radical surgical procedures as a pre-frontal lobotomy.[76]

It appears as though all of the judges in Rennie believe the Constitution supports the forcible administration of antipsychotic drugs to involuntarily committed mental patients.[77] The clearest agreement is where the patient is determined to be dangerous to self or others -- although none of the judges address the vital issue of nature, degree, and imminence of harm -- and the drugs are administered on a short-term basis. The rather mild disagreements in the Third Circuit relate to the emphasis to be given the consideration of less drastic alternatives and the analysis to be used for long-term treatment, which raises issues of long-term consequences.

While neither Rennie nor the Rivers case, which is discussed later, directly addresses the mentally disordered prisoner, we may unhesitatingly assume that the prisoner is legally entitled to no more and may well receive less. On the other hand, the standards charted here consistently focus on consent to treatment as the norm, with emergencies and present danger to self or to others as the most compelling exceptions.[78]

Bee v. Greaves[79] was decided a year after Rennie and the Tenth Circuit Court of Appeals expressed some different views about forcibly medicating pretrial detainees. The precise issue was whether a presumptively competent pretrial detainee may initially be forcibly injected with Thorazine and then forced to submit to further injections based on the continuing threat of force. Bee, who was hallucinating, was booked into the Salt Lake County Jail and first insisted on receiving Thorazine. After medical evaluation the drug was prescribed and Bee voluntarily took it. He did so for about 60 days and then complained about drug-related problems.[80]

A judge determined that Bee was competent to stand trial and the court ordered that Bee be medicated with Thorazine each evening. Parenthetically, the decision that Bee was competent to be tried involved an affirmative finding that he understood the charges and could assist counsel in his defense.[81] The jail staff conceded that they forcibly injected Bee when he refused to take the medicine orally. A jail medic testified this was for the purpose of "intimidating him so he wouldn't refuse the oral medication anymore."[82]

The defendants did not dispute Bee's claim that the side effects of Thorazine are extremely disabling and, at worst, can cause serious, permanent injury.[83] Defendants asserted that detainees have no right to refuse medical care while confined but, if there was a narrow right to refuse, the government's interests in security and maintaining a defendant's trial competence outweighed defendant's interests.[84]

The trial court accepted the government's position and granted summary judgment. In a far-reaching decision, the court of appeals reversed and remanded. The court found broad, legal support for Bee's argument that detainees have constitutional rights, grounded in the concept of liberty, as expressed in the Fourteenth Amendment Due Process Clause, to refuse treatment with antipsychotic drugs. The court relied on the general applicability of the doctrine of informed consent as to a course of treatment; a constitutionally protected right of privacy, which includes bodily integrity; and a liberty interest to avoid needless bodily restraints.[85]

Bee also claimed that the enforced medication impinged on his First Amendment right to the communication of ideas, a right which required protection of the capacity to produce ideas.[86] Again, the court agreed, based on Thorazine's capacity to severely and permanently affect thinking and communication.[87]

Finding that Bee, and thus pretrial detainees generally, have a protected liberty interest and a First Amendment interest in avoiding forcible medication is only the beginning of the analysis. The court next had to determine if the competing governmental interests are sufficiently compelling to override the detainee's rights.

First, the court notes that the government's duty is to provide medical care <u>when it is desired by the detainee</u>.[88] "Absent legitimate government objectives...," stated the court, "we believe that involuntary medication may itself amount to unconstitutional punishment."[89]

Second, in responding to the government's claim of a need to keep Bee competent for trial, the court stated:

> Generally speaking, a decision to administer antipsychotics should be based on the legitimate

> treatment needs of the individual, in accordance with accepted medical practice. A state interest unrelated to the well being of the individual or those around him simply has no relevance to such a determination.[90]

The third, and final, asserted governmental interest -- protection of staff and others -- gave the court more problems:

> The third interest asserted by defendants is the jail's duty to protect the jail staff and others from a violent detainee. Admittedly, this is a serious concern. Bee does not dispute that forcible medication with antipsychotic drugs may be required in an emergency. Absent an emergency, however, we do not believe forcible medicaton with antipsychotic drugs is 'reasonably related,' to the concededly legitimate goals of jail safety and security.
>
> Determining that an emergency exists sufficient to warrant involuntary medication with this type of drug requires a professional judgment-call that includes a balancing of the jail's concerns for the safety of its occupants against a detainee's interest in freedom from unwanted antipsychotics. Any decision to administer antipsychotic drugs forcibly must be the product of professional judgment by appropriate medical authorities applying accepted medical standards. It requires an evaluation in each case of all the relevant circumstances, including the nature and gravity of the safety threat, the characteristics of the individual involved, and the likely effects of particular drugs.
>
> The availability of alternative, less restrictive courses of action should also be considered. In view of the severe effects of antipsychotic drugs, forcible medication cannot be viewed as a reasonable response to a safety or security threat if there exist 'less drastic means for achieving the same basic purpose.' Our constitutional jurisprudence long has held that where a state interest conflicts with fundamental personal liberties, the means by which that interest is promoted must be carefully selected so as to result in the minimum possible infringement of protected rights... Thus, less restrictive

> alternatives, such as segregation or the use of less controversial drugs like tranquilizers or sedatives, should be ruled out before resorting to antipsychotic drugs.[91]

One aspect of the court's treatment of the third interest appears to contradict part of the court's earlier analysis. Previously the court seemed to hold that only the treatment needs of the individual could serve as a legitimate basis for forced medication. Under the third interest, and in accordance with the court's carefully formulated norms, forced medication does seem available to quell an emergency if no less restrictive options exist. This would amount to use of the drug for control, and not treatment, purposes.

In addition, the Bee decision is plainly at odds with Rennie on the mandate of least drastic alternative analysis. The court stated,

> We recognize that the Supreme Court has declined to apply a 'less intrusive means' analysis to a decision regarding treatment of an involuntarily committed mental patient. See Romeo, 457 U.S. at 322-24. Romeo is distinguishable both because it involved temporary physical restraints rather than mental restraints with potentially long term effects, see Rennie v. Klein, 720 F. 2d 266, 274-77 (3d Cir. 1983) (Weis, J., concurring), and because Romeo had been certified as severely retarded and unable to care for himself, see Romeo, 457 U.S. at 309-10. In this case, the question is whether an emergency exists sufficient to justify the state injecting a pretrial detainee, who has not been declared mentally incompetent under appropriate state procedures, with a potentially dangerous drug. Under these circumstances, we believe the state is required to consider less restrictive alternatives. Cf. Wolfish, 441 U.S. at 574, (Marshall, J., dissenting) ('There is no basis for relaxing this [less restrictive alternatives] requirement when the rights of presumptively innocent detainees are implicated.'). Indeed, the jail regulations of the detention center in this case specifically suggest segregation as the appropriate measure when mentally ill patients 'upset or provoke' other inmates. The jail regulations also contemplate that commitment 'shall be considered for inmates with moderate to severe mental problems.'[92]

Readers may be puzzled about the appropriate course of action to follow when two distinguished federal courts disagree on a matter as fundamental as the requirement of least drastic alternative analysis regarding forcible medication. The most prudent legal course to follow would be to adopt the more protective procedures of Bee. This is not because that approach is mandatory outside of the Tenth Circuit but because it is more cautious, it can be followed with little or no additional burden on jail or prison staff, and it is more respectful of human autonomy and decency.

A recent decision by the Arizona Supreme Court dealt specifically with the rights of convicted prisoners to refuse antipsychotic medication as a matter of state constitutional law. In Large v. Superior Court,[93] the court decided that inmates do indeed have a right to be free from arbitrary chemical restraint, although the right to refuse is not absolute.[94] Absent a true emergency -- something more immediate and compelling than generalized security claims -- the forced administration of dangerous medication is not permitted. Even with a specific emergency, procedural safeguards are required.[95]

Where forced medication is based on treatment needs then due process under the Arizona Constitution requires the exercise of professional judgment evidenced by a treatment plan which complies with legislative or departmental regulations governing the matter.[96] Justice Cameron dissented in the belief that an inmate's surviving right of privacy allowed a competent prisoner the right to refuse the ingestion or injection of dangerous drugs.[97]

Thus, the majority of the Arizona court leaves the state power to administer dangerous drugs against a prisoner's will in non-emergency situations if done for a treatment purpose and in accordance with the criteria and procedural safeguards written into law. Large stops far short of Bee in not requiring a finding of incompetence and in not requiring a "least intrusive alternative analysis." Large does rule out the reflexive use of drugs simply for control purposes, but it leaves Arizona prison inmates very much in the hands of the attending doctors when medication is solely for treatment purposes.

Another decision deserves extended discussion in our consideration of consent issues. In Rivers v. Katz, the New York Court of Appeals rendered a decision extraordinarily protective of the rights of patients civilly committed to New York State Hospitals.[98] In Rivers civilly committed patients refused various medications and hospital personnel followed detailed administrative regulations for the patient's appeal of the forcible medication decisions.[99] The court emphasized that none of these patients had been judicially determined to be mentally incompetent and that commitment and competency decisions were wholly distinct.[100]

The court's ultimate decision is as follows:

> We hold, therefore, that in situations where the
> State's police power is not implicated [i.e. no

> emergency exists], and the patient refuses to consent to the adminstration of antipsychotic drugs, there must be a judicial determination of whether the patient has the capacity to make a reasoned decision with respect to proposed treatment before the drugs may be administered pursuant to the State's parens patriae power. The determination should be made at a hearing following exhaustion of the administrative review procedures provided for in 14 NYCRR 27.8. The hearing should be de novo, and the patient should be afforded representation by counsel (Judiciary Law Sec. 35[1][a]). The State would bear the burden of demonstrating by clear and convincing evidence the patient's incapacity to make a treatment decision. If, after duly considering the State's proof, the evidence offered by the patient, and any independent psychiatric, psychological or medical evidence that the court may choose to procure, the court determines that the patient has the capability to make his own treatment decisions, the State shall be precluded from administering antipsychotic drugs. If, however, the court concludes that the patient lacks the capacity to determine the course of his own treatment, the court must determine whether the proposed treatment is narrowly tailored to give substantive effect to the patient's liberty interest, taking into consideration all relevant circumstances, including the patient's best interests, the benefits to be gained from the treatment, the adverse side effects associated with the treatment and any less intrusive alternative treatments. The State would bear the burden to establish by clear and convincing evidence that the proposed treatment meets these criteria.[101]

The court also suggested a detailed list of factors to be considered in evaluating competence to refuse treatment:

(1) the person's knowledge that he has a choice to make;
(2) the patient's ability to understand the available options, their advantages and disadvantages;
(3) the patient's cognitive capacity to consider the relevant factors;
(4) the absence of any interfering pathologic perception or belief, such as a delusion concerning the decision;
(5) the absence of any interfering emotional state, such as severe panic, depression, euphoria or emotional disability;

(6) the absence of any interfering pathologic motivational pressure;
(7) the absence of any interfering pathologic relationship, such as the conviction of helpless dependency on another person; and
(8) an awareness of how others view the decision, the general social attitude toward the choices and an understanding of his reason for deviating from that attitude if he does.[102]

Interestingly, the State did not disagree with the proposition that competent mental hospital patients had a right to refuse psychotropic medication. The only real debate was whether the detailed administrative review procedures were adequately protective of that right. Clearly, the Rivers decision disagreed with the State and not only placed the competency decision in the courts, but gave the courts a fair involvement in the nature and the course of the prescribed treatment for those found incompetent.

Rivers v. Katz, unlike virtually all of the decisions previously noted in this section, is based exclusively on state law; on the Due Process Clause of the New York State Constitution. The most significant impact of that approach is that the state has no apparent grounds for appeal into the federal courts since the decision is wholly grounded on independent state law.[103]

Preliminary data and observations about the impact of the decision show that civil patients are winning very few of their court challenges.[104] Patients report that when medication is refused they often lose such privileges as honor cards, cigarettes, or time spent at home. Some can be harassed to a point where an emergency is precipitated.[105]

One authority points out that studies from other states show that "refusniks" spend more time in the hospital, are restrained more often, and spend more time in seclusion. If patients do not act out, they may simply be sent home but with no improvement in their mental condition.[106]

Obviously, the consent-forced medication issue is somewhat different in prison. Prison officials cannot simply release the nonconsenting inmate. On the other hand, the withdrawal of privileges and the use of seclusion is at least as easy to impose. However, as more courts require informed consent, the prison treatment and security community are on notice that, no matter how difficult, inmate autonomy must be respected.

The Rivers v. Katz decision in New York should be briefly contrasted with a federal court's decision upholding Wisconsin's claim of a right to forcibly medicate patients. In Stensvad v. Reivitz a patient claimed the right to refuse psychotropic medication he had been taking for perhaps eleven years.[107] Under the Wisconsin statutory scheme, subject to a few exceptions not applicable here, civilly committed mental hospital

patients were subject to forcible medication. Indeed, the law could fairly be read as creating a statutory presumption of incompetence as to medication decisions.[108]

Judge Shabaz upheld the statutory scheme finding that the prior decision to commit was also an acceptable decision as to incompetency with respect to treatment decisions. In addition, it was determined that the exercise of professional judgment required by Youngberg v. Romeo was present and, in effect, overrode any specific constitutional objections the patient might have.[109]

Stensvad is at odds with other judicial decisions, certainly including Rivers v. Katz, which refuse to equate incompetency with commitability. In addition, the Wisconsin court actually avoids the difficult competency question by upholding the statutory scheme. A statute which called for particularized decisions on an individual's competency would be more acceptable than the present Wisconsin law and also be more in line with current thinking on the matter.[110]

As a matter of sound policy every jurisdiction, through legislation or administrative regulations, should adopt rules dealing with:

1. Informed consent: its precise content and a standardized form.
2. The conditions when consent is not required (for example, clear and present danger of causing [serious] injury to self and/or others).
3. Least restrictive measures: what they are and when they need not be used.
4. Authorization: who may authorize, administer, and review.
5. Charting requirements.
6. Duration of forced treatment-medication orders.
7. Cooperative measures between corrections and Mental Health.

FOOTNOTES - CHAPTER V

[1]These terms are taken from T. Gutheil & P. Applebaum, Clinical Handbook of Psychiatry and the Law 15 (1982). In general, this is an excellent resource for mental health professionals involved with the criminal justice system.

One writer states:

> Those who have expressed concern about the divided loyalties of psychiatrists intimate that clarification and differentiation of the psychiatrist's professional role is most urgently required in institutional settings such as hospitals, prisons, schools, and the armed services.

Merton, Confidentiality and the "Dangerous" Patient: Implications of Tarasoff for Psychiatrists and Lawyers, 31 Emory L.J. 263, 273 (1982).

[2]This refers to the duty arising from the landmark decision in Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 551 P.2d 334, (1976).

> The purpose of ordinary rules of evidence is to promote the ascertainment of the truth. Another group of rules, however, are designed to permit the exclusion of evidence for reasons wholly unconnected with the ascertainment of the truth. These reasons are found in the desire to protect an interest or relationship. The term "privilege" is used broadly to describe such rules of exclusion. For relevant communications to be excluded by operation of a privilege, as Wigmore states:
>
> (1) The communications must originate in a confidence that they will not be disclosed; (2) This element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties; (3) The relation must be one which in the opinion of the community ought to be sedulously fostered; (4) The injury that would inure to the relation by the disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of litigation.

[3]Graham, Evidence and Trial Advocacy Workshop: Privileges -- Their Nature and Operation, 19 Crim. L. Bull. 442 (1983) (emphasis in original).

Privilege, more accurately termed testimonial privilege, is narrower than the right of confidentiality and applies in judicial or judicial-like settings.

For an excellent discussion of privilege and confidentiality see M.C. MacDonald, K.C. Meyer, Health Care Law: A Practical Guide Sec. 19.00 et seq. (1987).

[4]As an example, "Mr. Jones, I am Mr. Smith, a psychologist employed by the Department of Corrections. I have been asked to meet with you and evaluate your present mental condition in order to help decide whether you should or should not be transferred to a mental hospital. Do you have any questions about who I am and what use may be made of what you say to me?"

If the therapist is fairly certain that other uses will be made of this information, that too should be volunteered.

[5]In Estelle v. Smith, 451 U.S. 454 (1981), the Supreme Court imported the Fifth Amendment's privilege against self-incrimination to the pretrial psychiatric evaluation of a person accused of capital murder, who was later convicted and sentenced to death, and who presented no pyschiatric testimony on his own behalf. Dr. Grigson gave lethal testimony on dangerousness at the penalty phase, and his failure to provide a Miranda-type warning resulted in a denial of the condemned inmate's constitutional rights.

This decision strives to limit itself to the unique penalty of death although the same factors on the fairness of the type of disclosure here seem generally applicable.

In Eng v. Kelly, civ. 80-385-T (W.D.N.Y., January 27, 1987), the court expressed the view that all psychiatric problems of inmates should be considered confidential except for those related to security matters.

[6]T. Gutheil & P. Applebaum, supra note 1, at 10. The authors state that nearly three-quarters of the states now have such statutes.

For an interesting general discussion of privileges, see Saltzburg, Privileges and Professionals: Lawyers and Psychiatrists, 66 Va. L. Rev. 597 (1980).

[7]See, e.g., Alaska Rules of Court, Rule 504, Ala. Code Sec. 34-26-2; Ariz. Rev. Stat. Ann. Sec. 32-2085; Ark. Stat. Ann. Sec. 28-1001, Rule 503; Cal. Evid. Code Sec. 1010 et seq.; Colo. Rev. Stat. Sec. 13-90-107(g); Conn. Gen. Stat. Ann. Sec. 52-146c et seq.; Delaware Rules of Ev.R. 503; Fla. Stat. Ann. Sec. 90-503; Ga. Code Ann. 38-418; Hawaii Rev. Stat. Title 33, ch. 626, 1980 Special Rules Pamphlet, Rule 504.1; Idaho Code Sec. 54-2314; Ill. Rev. Stat., ch. 91 1/2, Sec. 801 et seq.; Ind. Stat. Sec. 25-33-1-17; Ky. Rev. Stat. Sec. 421.215; La. Rev. Stat. Sec. 13:3734; Maine Rules of Ev. 503; Md. Cts. & Jud. Proc. Code Sec. 9-109; Mass. Gen. Laws Ann., ch. 233, Sec. 20B; Mich. Comp.

[7] (continued)
Laws Ann. Sec. 330.1750; Minn. Stat. Ann. Sec. 595.02; Miss. Code Sec. 73-31-29; Mo. Rev. Stat. Ann. Sec. 337.055; Mont. Code Ann. Sec. 26-1-807; Neb. Rev. Stat. Sec. 27-504; Nev. Rev. Stat. Sec. 49.215 et seq.; N.H. Rev. Stat. Ann. Sec. 330-A.19; N.J. Stat. Ann. Sec. 45:14B-28; N.M. Rules of Ev. 504; N.Y. Civ. Prac. Law and Rules Sec. 4507; N.C. Gen. Stat. Sec. 8-53.3; N.D. Rules of Ev. 503; Okla. Stat. Ann. Tit. 12 Sec. 2503; Ore. Rev. Stat. Sec. 40.230; Tenn. Code Ann. Sec. 24-1-207; Utah Code Ann. Sec. 58-25-8; Vt. Stat. Ann. Tit. 12 Sec. 1612; Va. Code Sec. 8.01-400.2; Wash. Rev. Code Sec. 18.83.110; Wis. Stat. Ann. Sec. 905.04; Wyo. Stat. Ann. Sec. 33-27-103. See also D.C. Code Sec. 14-307.

The foregoing enactments vary in scope and application and no attempt is made here to classify them or the decisions construing the provisions and their exceptions. See generally 44 A.L.R. 3d 24.

For consideration of the privilege as applied to social workers, see 50 A.L.R. 3d 563.

In New York, CPLR Sec. 4507 (McKinney Supp. 1983-84) psychologists are granted the privilege as follows:

> The confidential relations and communications between a psychologist *** and his client are placed on the same basis as those provided by law between attorney and client, and nothing in such article shall be construed to require any such privileged communications to be disclosed.

[8] Judicial Conference Advisory Committee on Rules of Evidence, 56 F.R.D. 183, 230-61 (1972).

Note that the rejected proposal apparently extends "confidential communication" to group therapy -- a proposition generally rejected -- and includes diagnosis, where many jurisdictions include only treatment relationships.

[9] Boyle, Confidentiality in Correctional Institutions, 26 Canadian J. of Crim. & Corrections 26, 27 (1976).

[10] See Hudson v. Palmer, 468 U.S. 517 (1984); Block v.Rutherford, 468 U.S. 576 (1984). The term "expectations of privacy" is a legal term of art and goes beyond the hopes, desires, or even demands of inmates or detainees. It refers to those situations where the law finds the expectation "reasonable."

In Katz v. United States, 389 U.S. 347, 351 (1967), Justice Stewart rejected the notion of Fourth Amendment rights turning on whether or not the right is asserted in a "protected area." He noted that the Fourth Amendment protects people, not places.

This analysis cannot be taken to mean that the place is unimportant in Fourth Amendment analysis. Indeed, it is difficult to imagine how an expectation of privacy can be judged as reasonable without some reference to the place involved.

[10] (continued)

Although notions of privacy are at the core of the Fourth Amendment and search and seizure law, it should be plain that in the context of this discussion, the Fourth Amendment, as such, is peripheral.
See J. Gobert & N. Cohen, Rights of Prisoners 176 (1981).

[11] 661 F. Supp. 895 (E.D.Pa. 1987), *aff'd in part and vacated in part*, 885 F.2d 1021 (3rd Cir. 1988).

[12] *Id.* at 919 (citations omitted). We should note that it is most unusual to find this type of candor reported in judicial decisions.

[13] *See* Draft Minimum Standards (or the Delivery of Mental Health Services in New York City Correctional Facilities Sec. 7.2(a) (N.Y.C. Bd. of Correction, 1982)).

The Standards for Health Services in Correctional Institutions promulgated by the American Public Health Association are more specific than most on this point but are still needlessly general.

> Full confidentiality of all information obtained in the course of treatment should be maintained at all times with the only exception being the normal legal and moral obligations to respond to a clear and present danger of grave injury to the self or other, and the single issue of escape. The mental health professional shall explain the confidential guarantee, including precise delineation of the limits. The prisoner who reveals information that falls outside the guarantee of confidentiality shall be told, prior to the disclosure, that such information will be disclosed, unless doing so will increase the likelihood of grave injury. IV (B) (3)

[14] A.B.A., Standards for Criminal Justice, The Defense Function, 4-3.7(d) (1980).

A lawyer may reveal the expressed intention of a client to commit a crime and the information necessary to prevent the crime; and the lawyer must do so if the contemplated crime is one which would seriously endanger the life or safety of any person or corrupt the processes of the courts and the lawyer believes such action on his or her part is necessary to prevent it.

[15] 17 Cal.3d at 439, 551 P.2d at 340.

[16] D. Wexler, Mental Health Law: Major Issues 158 (1981). The reference, of course, is outside the prison or jail setting.

See McIntosh v. Milano, 168 N.J. Super. 466, 403 A.2d 500 (1979) for elaboration on the duty to warn.

[17]Bowers, Givelber and Blitch, How Did Tarasoff Affect Clinical Practice? Annals, March 1986, at 70.

[18]Id. at 83.

[19]This work is almost exclusively concerned with the inmate-as-inmate. However, it should be noted that Tarasoff-like claims arise when an inmate is furloughed, given work or education-release, or paroled. For example, where a furloughed jail inmate killed a woman easily identifiable as a prospective victim, the First Circuit Court of Appeals held that absent some special relationship between the state and the plaintiff -- e.g., being in custody -- the Fourteenth Amendment simply provided no remedy for errors in release or failure to warn.

See Estate of Gilmore v. Buckley, 787 F.2d 714 (1st Cir. 1986), cert. denied, 479 U.S. 882 (1986).

[20]Kaslow, Ethical Problems in Prison Psychology, 7 Crim. Justice & Behavior 3, 4 (1980).

[21]Quijano & Logsdon, Some Issues in the Practice of Correctional Psychology in the Context of Security, 9 Professional Psychology 228, 231 (1978).

[22]P. Lane, Prison Counseling and the Dilemma of Confidentiality in Conference on Corrections (V. Fox ed. 1978). The author concludes, unremarkably, that each decision is an individual one.

[23]See generally F. Rozovsky, Consent to Treatment: A Practical Guide (1984); Symposium, Informed Consent, 1 Behav. Science & the Law Autumn 1983, at 1-116.

For an extensive review of consent issues, with an emphasis on physical medicine see Deardoff, Informed Consent, Termination of Medical Treatment, and the Federal Tort Claims Act: A New Proposal for the Military Health Care System, 115 Military L. Rev. 1 (1987).

[24]See II Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship 397 (President's Commission for the Study of Ethical Problems in Medicine and Behavioral Research, 1982).

[25]R. Faden & T. Beachamp, A History and Theory of Informed Consent 344 (1986).

[26]In at least one case, this is precisely what the court decided concerning psychosurgery. Kaimowitz v. Department of Mental Health, Civ. No. 73-1934-AW (Wayne Co., Michigan, Cir. Ct., July 10, 1973), published in 1 M.H.L.R. 147-159 (Sept.-Oct. 1976). Kaimowitz was as concerned about risks and knowledge as with institutional coercion.

[27]Sconiers v. Jarvis, 458 F. Supp. 37 (D. Kan. 1978).

[28]Id. at 40.

[29]The religious objections were dismissed either because the inmate had not expressed them or because the inmate failed to show that he was a sincere adherent of an established religion which prohibits psychotropic medication.

[30]Mackin, Some Problems in Gaining Informed Consent from Psychiatric Patients, 31 Emory L.J. 345, 371 (1982).

G. Annas, L. Glantz & B. Katz, Informed Consent to Human Experimentation: The Subject's Dilemma 34 (1977) argue that the primary functions of informed consent are to promote individual autonomy and encourage rational decision-making. It appears to this observer that rational decision-making and autonomy go hand-in-glove and that the avoidance or acceptance of harm (or pain) needs separate mention as a qualitatively different phenomenon.

[31]T. Gutheil & P. Applebaum, supra note 1, at 118-19.

[32]Other writers are not so reserved or sanguine about the problems. In describing similar problems in English prisons, one scholar argues that the Prison Medical Service overuses drugs because it saves time and possibly violence. She estimates that up to 40 percent of those treated with powerful psychotropic drugs will suffer some degree of side-effects.

Apparently the view of the Home Office is that drugs will be administered without consent only if life is endangered without it, serious harm to the inmate or others is likely, or there would be an irreversible deterioration in the inmate's condition.
Brazier, Prison Doctors and Their Involuntary Patients, 1982 Public Law 282, 283.

[33]445 U.S. 480, 494 (1980). In Jones v. United States, 463 U.S. 354, n.19, Justice Powell writes, "[t]he Court has held that a convicted prisoner may be treated involuntarily for particular psychiatric problems...."

[34]In Lappe v. Loeffelholz, 815 F.2d 1173, 1176-77 (8th Cir. 1987), the court uncritically found that once a Vitek hearing was held, and while the inmate remained at the treatment facility, intramuscular injections of psychotropic medication could be prescribed and administered without consent. This position was taken in the context of resolving another issue; that is, whether such injections could continue without a new hearing after the inmate was returned to the prison.

Since a Vitek hearing does not necessarily address competence nor the specific need for psychotropic medication Lappe's uncritical acceptance of the right to forcibly medicate based on a Vitek hearing is suspect.

[35]A. Stone, Mental Health and Law: A System in Transition 103 (N.I.M.H. 1975).

In the context of requiring a full judicial hearing in the face of a protesting patient, Dr. Stone ranks more to less severe treatments as follows:

[35] (continued)

1. Ablation or destruction of histologically normal brain cells by any medical or surgical procedure (there is a growing consensus that such psychosurgery is experimental and should be subject to stricter regulations governing experimentation on humans).
2. Electroshock therapy or any other convulsive therapy.
3. Coma or subcoma insulin therapy.
4. Behavior modification utilizing aversive therapy.
5. Inhalation therapy (CO^2, etc.).
6. Medically prescribed, highly addictive substances (e.g., methadone). Id. at 105.

Professor Bruce Winnick takes a similar approach:

> Two conclusions may be reached from the foregoing analysis. First, because the verbal and many of the behavioral techniques are not seriously intrusive, do not result in longlasting effects, and are readily capable of being resisted even when the subject is nonconsenting, these techniques do not so infringe on fundamental rights as to create a constitutional right to refuse the treatments. Second, the therapeutic interventions in the higher range of the continuum do present significant, pervasive invasions of the subjects' minds and bodies with effects that are often longlasting and always incapable of being resisted when the subject is nonconsenting. When applied involuntarily, these techniques invade such fundamental constitutional rights as the first amendment right to be free from interference with mental processes, the due process right of privacy and the fundamental liberty interest associated with bodily integrity.

Winnick, Legal Limitations on Correctional Therapy and Research, 65 Minn. L. Rev. 331, 373 (1981).

[36] See D. Wexler, Mental Health Law: Major Issues 245 (1981).

[37] See Roth, Meisel & Lidz, Tests of Competency to Consent to Treatment, 134 Am. J. Psychiatry 279, 281 (1977).

[38] See, e.g., G. Annas, L. Glantz & B. Katz, supra note 30, at 104.

[39] Id. at 44 (italics in original). Ruth Macklin, on the other hand, reaches the general conclusion that the same standards should be used in the research and treatment contexts. Indeed, because of our tendency to put so much trust in doctors we may accept risks we might otherwise be unwilling to accept, with shock therapy used as a primary example. Macklin, Some Problems in Gaining Informed Consent from Psychiatric Patients, 31 Emory L.J. 345, 352-53 (1982).

[40]These observations are made as the result of a distillation of many legal decisions and the thoughts of many scholars. I do not, however, rely on any single or sharply defined authority for my points. In addition, while this may read like a personal position, which it is, it is also a fair distillation of the law on point.

The reference to "help or hurt" is included in order to pick up such activities as body cavity searches which require either consent or some reasonable cause. The consent issue, however, turns primarily on situations where the expressed objective is to help the inmate.

For an excellent discussion of the autonomy concept see Schultz, From Informed Consent to Patient Choice: A New Protected Interest, 95 _Yale L.J._ 219 (1985).

[41]N. Morris, The Future of Imprisonment 25-26 (1974) (citation omitted).

[42]344 F.2d 463 (8th Cir. 1965).

[43]_Id._ at 465. This decision also is a good example of the then prevailing "hands-off" doctrine.

[44]310 F. Supp. 600 (W.D. Mo. 1970).

[45]_Id._ at 605 (emphasis added) (citations omitted).

[46]288 F. Supp. 329 (W.D. Mo. 1968).

[47]_Id._ at 337.

[48]_Id._ The court also indicated its general deference to the discretion of institutional administrators.

[49]326 F. Supp. 787 (W.D. Mo. 1970), _aff'd_, 442 F.2d 928 (8th Cir. 1971).

[50]_Id._ at 788. Oddly, the court relied on _Ramsey_ and _Haynes_, neither of which dealt with a religious objection.

[51]_See_ G. Annas, L. Glantz & B. Katz, _supra_ note 30, at 121. The authors also suggest that the cases were inartfully presented due to the lack of counsel.

[52]477 F.2d 877 (9th Cir. 1973). _See_ Note, Aversion Therapy: Punishment as Treatment and Treatment as Cruel and Unusual Punishment, 49 _S. Cal. L. Rev._ 880, 959-81 (1976).

[53]477 F.2d at 877.

[54]J. Mittford, Kind and Unusual Treatment: The Prison Business 128 (1973).

[55]_Id._ at 878. After the reversal and remand, no further judicial history appears. The writer was told that the use of the drug "anectine" has long since been discontinued.

[56]379 F. Supp. 338 (W.D. Mo. 1974).

[57]D. Wexler, supra note 36, at 247. The court's procedural concerns about transfer would now be resolved with reference either to Meachum v. Fano, 427 U.S. 215 (1976) or Vitek v. Jones, 445 U.S. 480 (1980).

[58]423 F. Supp. 830 (M.D. Pa. 1976).

[59]Id. at 832. Farview patients apparently included transferees from the corrections system. No further reported proceedings were found.
For an interesting case involving medical experimentation at the Maryland House of Correction, see Bailey v. Lally, 481 F. Supp. 203 (D. Md. 1979).

[60]488 F.2d 1136 (8th Cir. 1973).

[61]Id. at 1139-40.

[62]Id. at 1140-41.

[63]See Annot., Civil Liability for Physical Measures Undertaken in Connection with Treatment of Mentally Disordered Patients, 8 A.L.R. 4th 464 (1981).

[64]Kaimowitz v. Department of Mental Health, No. 73-19434-AW (Cir. Ct. of Wayne Co., Mich., July 10, 1973), in 13 Crim. L. Rptr. 2452 (1973).

[65]See D. Wexler, supra note 36, at Ch. 8 for a view of Kaimowitz which is supportive of the result but critical of the court's reasoning.

[66]720 F.2d 266 (3d Cir. 1983), mod. and remanded, 653 F.2d 836 (1981), vacated and remanded, 458 U.S. 1119 (1982).

[67]458 U.S. 1119 (1982).

[68]457 U.S. 307 (1982).

[69]Rennie v. Klein, 720 F.2d at 269-70.

[70]A study of patient violence attributed much of the blame for an increasing rate of violence to the decision in Rennie. They write:

> After Rennie v. Klein the pattern of drug prescription changed dramatically at our hospital. Medication was no longer prescribed unless the patient consented to take it, or unless the patient had already become intolerably aggressive or combative. Paranoid and litigious patients were especially reluctant to take psychotropic medication. Many patients aggressively asserted their right to go

[70] (continued)

> unmedicated, and some flaunted their control over staff to the point of provoking other patients into aggressive reactions. A nine-month sampling of persistent medication refusers who were considered potentially dangerous showed that 40 percent eventually injured either themselves or someone else.

Adler, Kreeger & Ziegler, Patient Violence in a Private Psychiatric Hospital in Assaults Within Psychiatric Facilities 81, 87-88 (J. Lion & W. Reid eds. 1983).

[71] 720 F.2d at 269.

[72] Id. at 272.

[73] Id. at 273.

[74] Id. at 274. The chief judge goes on, however, to note that as a general matter the physician must consider harmful side effects and possible alternatives to the drug, and, inter alia, whether the prescription is in response to or in anticipation of violent outbreaks. Economic or administrative convenience as part of a simple "warehousing" scheme is not justified.

Thus Judge Seitz would seem to desire to provide "binding guidance" rather than binding rules. The result seems the same.

[75] Id. at 275.

[76] Id. at 275-76 (citations omitted).

[77] See Rogers v. Okin, 634 F.2d 650 (1st Cir. 1980), vacated and remanded sub nom. Mills v. Rogers, 457 U.S. 291 (1982) when the Court had the identical issue as in Rennie and in the remand did not specifically comment on the "least intrusive means" concept.

[78] See Appendix A.

[79] 744 F.2d 1387 (10th Cir. 1984), cert. denied, 469 U.S. 1214 (1985) Thoughtful decisions involving civilly committed patients distinguish the type of treatment interventions permitted based, in part, on the rationale for intervention. For example, emergency commitments provide no predicate for highly intrusive, or certainly long-term, treatments. See, e.g., Bell v. Wayne Co. General Hospital, 384 F. Supp. 1085 (E.D. Mich. 1974).

[80] 744 F.2d at 1389.

[81] Even if Bee had been found incompetent to be tried, there is no a priori connection between that finding of incompetence and incompetence to decide on a course of medical treatment. Granted, the decision to

[81] (continued)
forcibly medicate an incompetent detainee carries with it greater indicia of propriety. Nonetheless, a specific determination of incompetency should be the rule and especially so when the person already is experiencing and complaining of deleterious side-effects.

[82] 744 F.2d at 1390. Bee submitted to the threat and took the drug for about three more weeks.

[83] Id.

[84] Id. at 1391, 1394.

[85] The court relied heavily on the following cases: Davis v. Hubbard, 506 F. Supp. 915 (1980); Whalen v. Roe, 429 U.S. 589 (1977); Youngberg v. Romeo, 457 U.S. 307 (1982); and Vitek v. Jones, 445 U.S. 480 (1980).

[86] 744 F.2d at 1394.

[87] Id. It was recently reported that a Bethesda, Maryland psychiatrist was under investigation by the State's Commission on Medical Discipline for comments he made on the Oprah Winfrey television show. The accused doctor spoke out against anti-psychotic drugs and now stood accused of precipitating wholesale patient refusals of their medication. Not surprisingly, the doctor argues that his First Amendment rights are being trampled on. Albany Times Union, Sept. 20, 1987, at 2.

[88] 744 F.2d at 1395 (emphasis in original). The court's point is essentially accurate. However, there are life-threatening situations where the duty of the custodian is to preserve life even if the inmate wishes to expire or continue to suffer in a life-endangering situation. Prison officials routinely force lifesaving dialysis on nonconsenting inmates, for example.

[89] 744 F.2d at 1395.

[90] Id.

[91] Id. at 1395-96 (citations omitted).

[92] Id. at 1396, n.7 (citations omittted). See U.S. v. Charters, 829 F.2d 479 (4th Cir. 1987) for a decision involving a federal prisoner held at Butner Federal Correctional Institution. The prisoner had been found incompetent to be tried. The reviewing court correctly held that this decision is distinct from the ability to make medication decisions. Consequently, it was held that the detainee, if competent, could refuse psychotropic medication and if found medically incompetent, by a court then the court must also decide whether the detainee might have consented if able to or, in the alternative, whether the medication is in the detainee's best interests.

[92] (continued)

More recently, Charters was reviewed by the en banc court and the panel decision reversed. 44 CrL 2220 (4th Cir. Dec. 9, 1988). The court held that due process is satisfied if the decision to medicate is left to prison doctors without an adversary hearing. The patient is entitled only to the exercise of "professional judgment" and, if challenged, the standard for review is whether the decision was arbitrary, a substantial departure from acceptable judgment or practice, or no professional judgment was exercised.

The American Psychiatric Association joined as amicus for the victorious government position while the American Psychological Association served as amicus to the losing inmate.

This decision rather obviously is a great setback to inmate and patient autonomy and a major victory for institutional psychiatrists who wish to avoid judicial oversight.

[93] 148 Ariz. 399 (1986).

[94] Id. at 406.

[95] Id. at 408.

[96] Id. at 409.

[97] Id. at 410 (Cameron, J., dissenting).

[98] 67 N.Y.2d 485 (1986).

[99] Id. at 490. The medication decision, including the treating doctor's initial decision, was reviewed and upheld on four different occasions.

[100] Id. at 495.

[101] Id. at 497-98.

[102] Id. at 497, n.7.

[103] One strategy the State is preparing to employ is to reduce the administrative review steps presently required in the belief that the Rivers decision only mandated judicial review and not the continuation of any particular administrative format.

Conversations with mental hygiene staff reveal that initial refusal rates are about .05% of recent admissions and that even this relatively small number declines greatly after about three weeks hospitalization.

See People v. Medina, 705 P.2d 961 (Colo. 1985) for a similar approach to the question of forcibly medicating a mental patient.

[104] Talan, When Mental Patients Say No, Newsday Pt. III, 1, 3 (October 20, 1987).

[105] *Id.*

[106] The reference is to Clarence Sundrum, Chairman of New York's Commission on Quality of Care; a watchdog agency which has oversight functions over mental hospitals.

[107] 601 F. Supp. 128 (W.D. Wisc. 1985).

[108] *See* Brooks, The Right to Refuse Antipsychotic Medications: Law and Policy, 39 *Rutgers L. Rev*. 339 (1987) for an interesting review of the consent issue. The article is an excellent source for additional bibliographic material in this area.

[109] *Stensvad v. Reivitz*, 601 F. Supp. at 131.

[110] Persons convicted of crime could not be placed in the same category of statutory presumptions because no judicial decision has been made as to the required anterior finding of mental illness.

STANDARDS BY LEGAL TOPIC

By Fred Cohen and Pamela Griset

These fifteen sets of standards address legal issues relating to the institutional care of the mentally disturbed inmate. We reviewed several other sets of standards, but have not included them in this analysis because they failed to consider legal issues involved in the delivery of mental health and mental retardation services within the correctional environment or because they gave such scant attention to the particular problems of the mentally disordered offender. We included standards established by the states of Georgia and Pennsylvania and the Federal Bureau of Prisons, not to imply that other public authorities had inadequate standards, but because those standards illustrated particular legal issues. An annotated bibliography of sources follows the table.

Our format should help the reader find particular topics and compare standards regarding them. The five categories and nineteen subcategories of legal issues presented on the vertical axis of the table by no means exhaust the universe of relevant issues; they merely reflect those legal areas covered by the various standard-setting bodies. We did not include issues that we deemed legally relevant if they did not appear in at least three sets of standards. Where we considered the omissions critical, we have noted the fact in our discussion.

In order to retain as much data as possible and to preserve the intent of the standards, we have reproduced the actual wording of the standards. Occasionally, however, we have paraphrased or summarized the original language because it is repetitive or excessively long.

While the discussion following some of the standards provides useful clarification and insight, it does not carry the force of the actual recommendations. We have, consequently, omitted such commentary.

Three sets of standards differentiate their recommendations by level of importance. The American Medical Association labels some of their recommendations as "essential;" the American Association of Correctional Psychologists employs an "essential"/"important" dichotomy; and the American Correctional Association uses a three-part rating scheme: "mandatory," "essential," and "important." Where standards are numbered, the numbers appear in the table.

Several of the standards stress the need for written policy and operating procedures. We have excluded these prefacing remarks from the table. The reader should also note that while stressing the importance of standardized procedures, the standards fail to outline the *content* of these procedures.

Finally, we must remind the reader that since organizations with divergent interests and unique perspectives drafted these standards, they vary widely in emphasis. Thus while we tried to make each subcategory as discrete as possible, some categories overlap. We advise the reader to consult the original sources for further clarification.

DISCUSSION

TREATMENT/HABILITATION ISSUES.

Treatment/habilitation issues receive the widest coverage of the five major legal areas identified. The standards share a fundamental philosophic position: adequate mental health care is a prisoner's right, and correctional agencies have an obligation to make such care available.

Access: All of the standards explicitly recognize the right of access to mental health services. A few specify that such treatment should compare in quality and availability to that obtainable by the general public.

Refusal: Along with the affirmative right to treatment, half of the standards recognize the right to refuse treatment, although that right may be constrained under certain circumstances — e.g., to save a life, to prevent permanent and serious injury to self or others, to comply with court orders. Noteworthy is the Federal Bureau of Prisons (1983), which recommends the provision of legal counsel to inmates wishing to resist treatment.

Emergency: Several standards note the need to provide around-the-clock emergency care. They therefore urge that custodial and treatment personnel be trained to recognize and respond to emergency situations.

Diagnosis: Many standards acknowledge the right to diagnosis. Several recommend a two-part procedure for identifying the mentally disturbed offender: reception screening, to occur when each inmate arrives at the correctional facility, and a later, more comprehensive health appraisal.

Modalities: The standards strongly emphasize the preparation of individualized, written treatment plans and the provision of a variety of treatments; however, all but one standard are silent on what *particular* treatments correctional facilities should offer.

The American Public Health Association would have each facility provide the following services: crisis intervention, short- and long-term therapy (group and individual), family therapy, counseling, medication, and inpatient hospitalization. The Association considers permissible for prisoners only those treatments accepted for use on the general public. The mentally disturbed offender should not be subject to experimental treatment, and the Association expressly forbids psychosurgery, electroconvulsive therapy, and other controversial treatments.

Medication: Those standards which address this issue agree that psychotropic drugs should be used only as a part of the total therapeutic program; they should never be used for punishment. The standards discourage the long-term use of tranquilizers.

Situs: Several standards recommend that correctional departments maintain separate facilities or specially designated units for the treatment of mentally disturbed inmates. The Federal Bureau of Prisons (1983) suggests that mentally retarded inmates should be placed outside of the Bureau's institutions.

Staff: The importance of trained custodial staff receives some recognition. Four of the standards detail minimally acceptable inmate-staff ratios.

Omissions: Four important treatment/habilitation issues receive scant attention and, consequently, do not appear in the table. Only the American Public Health Association mentions the concept of the least drastic or least restrictive alternative as applied to the involuntary treatment of the mentally disturbed offender. When conditions warrant ". . . interventions may be mandated, but only with the least drastic measure . . ." (1976:28).

The standards pay little notice to prisoners' rights to review and terminate treatment. The National Advisory Commission on Criminal Justice Standards and Goals (1973: 374) recommends that "cases should be reviewed each month to reassess original treatment goals, evaluate progress, and modify programs as needed." The Georgia Department of Offender Rehabilitation (1981: 17) recommends that treatment plans be subject to review twice annually. Termination-of-treatment issues are addressed by the Georgia Department of Offender Rehabilitation (1981: 19) and the American Association of Correctional Psychologists (1980: 112). Both stress that written procedures are necessary for the orderly discharge of the inmate client from treatment; both are silent on the content of these procedures.

None of the standards mentions the right to remain silent during psychiatric interviews.

TRANSFER ISSUES.

Three-quarters of the standards consider the special issues relating to the placement of the mentally disturbed inmate in a mental health facility, within either corrections or the mental health department.

Criteria: The standards agree unanimously that prisoners who require treatment or habilitation not available in the correctional facility should be transferred to a facility where proper care is available. Such a facility can be under the jurisdiction of the corrections or the mental health department.

Involuntary: Seven of the nine standards which discuss procedural issues in involuntary transfer stipulate that judicial proceedings be initiated prior to moving the mentally disturbed inmate. Most require that transfer proceedings conform to those followed at civil commitment hearings. Two standards do not require judicial participation in transfer proceedings. The American Correctional Association (1981 — Guidelines) calls for two separate hearings, one before an institutional disciplinary committee and one before a medical review board where the inmate is represented by a staff member. The American Law Institute's (1962) standards call for a multi-disciplinary review before transfer — but without a judicial officer present. However, given that these standards are the oldest reviewed, it seems likely that the groups would issue different recommendations today.

Emergency: Three of the standards require that a hearing be held shortly after an emergency transfer.

Omissions: The American Bar Association issues the only set of standards dealing with *voluntary* transfers, review of the need for continued mental health placement, and issues surrounding return. Their recommendations follow:

> —If a prisoner desires treatment or habilitation in a mental health or mental retardation facility, the prisoner may make an application for voluntary admission to a mental health or mental retardation facility. If the correctional institution believes such treatment or habilitation is warranted, the application should be endorsed by the chief executive officer of the correctional institute and accompanied by the report of an evaluation conducted by a mental health or mental retardation professional. The prisoner should be admitted to such a facility if it accepts the endorsed application (7-10.3).
>
> —If an application for voluntary admission is rejected by the mental health or mental retardation facility and the correctional officials believe that the applicant is severely mentally ill or seriously mentally retarded, the chief executive officer of the correctional facility or a designee may file a petition for court-ordered transfer to a mental health or mental retardation facility (7-10.4).
>
> —Committed severely mentally ill or seriously mentally retarded prisoners should be entitled to the same kind of periodic review by the institution providing treatment or habilitation and by the courts as provided for involuntary civil commitment (7-10.6).
>
> —When the prisoner, the mental health or mental retardation facility and the correctional facility agree that the prisoner no longer meets the transfer criteria, the prisoner should be returned promptly to the correctional facility (7–10).

Only two standards mention the important issue of parole and good time credits. The Law Enforcement Assistance Administration (4-415) recommends that the sentence of a transferred prisoner continue to run and that he remain eligible for credits for good behavior. According to the American Bar Association, a prisoner in a mental health or mental retardation facility should be eligible for parole release consideration on the same terms as offenders in adult correctional facilities (7-10.10). Furthermore, they recommend that such prisoners be entitled to earn good time credits on the same terms as offenders in adult correctional facilities (7–10.10).

CUSTODIAL ISSUES.

There is unanimous agreement among those considering certain basic non-treatment rights of the mentally disturbed inmate: all stress the importance of cooperation and consultation between custodial and treatment personnel. One standard specifically notes that discipline cannot be used to enforce treatment, while another rejects the use of psychotropic medicine for disciplinary purposes.

CONSENT ISSUES.

All six of the standards which address this issue agree that the informed consent practices of the jurisdiction should serve as the model for corrections. Components of informed consent include notification of the nature, consequences, risks, and alternatives involved in the proposed treatment.

CONFIDENTIALITY.

Eleven of the standards discuss confidentiality. Most agreed that the promise of confidentiality traditionally associated with the doctor/patient relationship applies within correctional facilities.

Applicability: The promise of confidentiality is limited under certain circumstances. The American Public Health Association would exempt situations posing a clear and present danger to self or others and information regarding escape. The inmate patient would be fully informed of the limits of the confidential guarantee prior to entering into a therapeutic relationship.

Records: There is general consensus that the health record is a confidential document which should be maintained separately from the confinement record.

Third Party: The standards agree that inmates must give written approval before confidential material can be transferred to a third party except in specifically defined situations. The Comptroller General's standards note that specific guidelines should exist regarding what mental health information should be shared with parole and probation agencies, but they do not specify the content of these guidelines.

CONCLUSION

These fifteen sets of standards were issued by groups representing a diversity of interests and perspectives. Nevertheless they share a strikingly similar approach to the legal issues surrounding the care of mentally disturbed inmates. Insofar as setting standards for fundamental principles or procedures, corrections and mental health professionals seem to share a common vision.

Most of the groups also *fail* to consider many important issues. They pay little or no attention to issues surrounding the use of least drastic restrictive alternatives, review and termination of treatment, rights during psychiatric interviews, voluntary and mixed acceptance transfers, review and termination of transfer, parole, and good time credits. While most of the standards stress the need for written policy and structured operating procedures, they do not expand on the content of these policies and procedures.

Finally, the standards rarely mention mentally retarded inmates as a separate group. While not ignored, this group is clearly not the focus of consideration, nor do the standards consider what special habilitation standards and program components this group may require. To the extent that the needs of the mentally retarded offender differ from those of the mentally ill offender, the standards' silence on those distinctions warrants notice.

STANDARDS: LEGAL ISSUES AND THE MENTALLY DISTURBED INMATE

LEGAL ISSUES	AMERICAN BAR ASSOCIATION (1984)	AMERICAN MEDICAL ASSOCIATION
I. TREATMENT/HABILITATION A. ACCESS	Correctional facilities should provide a range of mental health and mental retardation services and should have adequately trained personnel readily available to provide such services (7–10.2)(a).	Information regarding access to health care or services is communicated orally and in writing to inmates upon arrival at the facility (137, Essential).
B. REFUSAL	A prisoner, unless involuntarily transferred to a mental health or mental retardation facility, should be permitted to decline habilitation or mental health treatment except: 1) when required by court order; or 2) when reasonably believed to be necessary in an emergency to save the life of a person or to prevent permanent and serious injury to the person's health or to prevent serious injury to others (7–10.9)(a).	
C. EMERGENCY		The facility is required to provide 24 hour emergency medical care (154). A physician must be on call 24 hours per day and health care personnel on duty 24 hours a day (151, Essential).
D. DIAGNOSIS		Policy requires post-admission screening and referral for care of mentally ill or mentally retarded inmates whose adaptation to the correctional environment is significantly impaired (144). Receiving screening is to be performed by qualified health care personnel on all inmates upon arrival at the facility (140). A health appraisal for each inmate is completed within 14 days after arrival at the facility (142, Essential).

AMERICAN ASSOCIATION OF CORRECTIONAL PSYCHOLOGISTS (1980)	AMERICAN PUBLIC HEALTH ASSOCIATION (1976)	AMERICAN CORRECTIONAL ASSOCIATION (1981 — STANDARDS)
Policy exists regarding access to psychological services for daily referrals of nonemergency problems covering both scheduled and unscheduled care (22, Essential). Diagnosis and treatment services are provided to inmates as part of the institution's total program (28, Essential).	Mental health services should be made available at every correctional institution.	Policy specifies the provision of mental health services for inmates in need of such services to include, but not limited to, services provided by qualified mental health professionals (2-4283, Essential).
Policy outlines the provision of involuntary treatment in accordance with state and federal laws applicable to the jurisdiction in conformity with professional ethics and principles promulgated by the American Psychological Association. The decision to apply such techniques shall be documented and based on interdisciplinary review (15, Essential).	The jurisdiction may not mandate treatment for any individual, unless a person, by reason of mental disability, poses a clear and present danger of grave injury to himself or others. Interventions may be mandated in response to a) an immediate emergency, or b) on a continuing basis, only after civil judicial direction by the appropriate court, in which proceedings the individual is accorded an independent, psychiatric evaluation and due process of law.	Policy provides inmates with the option to refuse to participate in psychological or psychiatric treatment (2-4334, Essential). When health care is rendered against the patient's will, it is in accord with state and federal laws and regulations (2-4314, Essential).
Policy exists regarding access to psychological services for post-admission inmates with emergency problems (22, Essential). Crisis evaluations are conducted within 24 hours after staff members have been notified (27, Essential).	Each correctional institution should provide for the emergency health needs of inmates.	Policy provides for 24 hour emergency medical care (2-4279, Mandatory). Correctional and other personnel are trained to respond to signs and symptoms of mental illness and retardation within a 4 minute response time (2-4285, Mandatory).
Receiving screening is performed on all inmates upon admission to the facility before being placed in the general population or housing area. The screening includes inquiry into: 1) past and present history of mental disturbance, and 2) current mental state, including behavioral observation. Inmates identified as having mental problems are referred for a more comprehensive psychological evaluation (25, Essential). Assessment of all inmates referred for a special comprehensive psychological appraisal is completed within 14 days after the date of referral (26, Essential). All newly committed inmates with sentences over one year shall be given a psychological evaluation within one month of admission (24, Essential).	Each inmate should receive a reception health assessment. Those evaluative procedures clearly necessary to detect health problems requiring immediate action to protect the inmate and the institution shall be completed before the inmate is placed in any holding unit or integrated into the institutional population. All other evaluative procedures shall be completed within 7 calendar days of initial reception.	Policy requires that all inmates receive medical screening upon arrival at the facility. This includes inquiry into past and present treatment or hospitalization for mental disturbances or suicide and observations of behavior, which includes state of consciousness, mental status, appearance, conduct, tremor and sweating (2-4289, Mandatory). A health appraisal is completed within 14 days for each inmate, which includes collection of additional data to complete the mental health history (2-4291, Essential). A comprehensive individual mental health evaluation on specifically referred inmates is to be completed within 14 days after their date of referral (2-4293, Essential).

STANDARDS: LEGAL ISSUES AND THE MENTALLY DISTURBED INMATE (Continued)

LEGAL ISSUES	AMERICAN CORRECTIONAL ASSOCIATION (1981 — GUIDELINES)	FEDERAL BUREAU OF PRISONS (1983 — PSY. MANUAL)
I. TREATMENT/HABILITATION A. ACCESS	All inmates are provided access to a comprehensive mental health program increasing their probability of functioning within normal limits of socially accepted standards.	Inmates have the right to receive treatment for mental disturbances performed by qualified professionals.
B. REFUSAL	If an inmate chooses to refuse treatment recommended as necessary by the medical staff, a Refusal to Submit to Treatment form shall be signed and filed in the inmate's medical record.	Prisoners have the right to refuse to participate in psychological or psychiatric treatment. Only in life threatening situations can the individual's preferences be disregarded. Legal counsel should be available and consulted.
C. EMERGENCY	Inmates exhibiting psychotic, homicidal, or suicidal behavior shall be placed in the institutional infirmary under suicide watch by at least one trained corrections officer. A psychiatric evaluation shall be performed within 12 hours.	Whenever possible, local community resources should be used for extreme emergencies only.
D. DIAGNOSIS	Specially referred inmates shall receive a review by a multi-disciplinary mental health team within 14 days of referral.	All inmates newly admitted to the institution shall be appraised in a consistent manner to identify the presence of severe emotional, intellectual, and/or behavioral problems. Prisoners found to be different in terms of their emotional or intellectual characteristics will be seen for more comprehensive testing in individual sessions.

U.S. DEPARTMENT OF JUSTICE (1980)	LAW ENFORCEMENT ASSISTANCE ADMINISTRATION (1979)	COMPTROLLER GENERAL (1979)
Screening and referral for care are provided to mentally ill or retarded inmates whose adaptation to the correctional environment is significantly impaired (5.29). Inmates are informed orally and in writing of procedures for gaining access to health care services (5.18).	A confined person has a protected interest in receiving needed routine and emergency medical care in a timely manner consistent with accepted medical practice and standards (4-105).	Consider establishing a program for the care of mentally retarded inmates at one or several institutions.
	A confined person has a protected interest to choose whether to participate in a treatment program except that: a confined offender may be required to undergo examination or a course of treatment reasonably believed to be necessary for preservation of his mental health. Furthermore, he may be required if such treatment is an order of a court or reasonably believed to be necessary to protect the health of other persons or, in an emergency, to save the life of the person (4-126).	
The facility has available 24 hour emergency medical care; if such care is not provided within the facility, a written plan outlines procedures for securing emergency care (5.12).	Appropriately trained persons are reasonably available to provide emergency medical care (4-105).	
Policy provides for screening and referral of mentally ill and mentally retarded inmates (5.04). Receiving screening is to be performed on all inmates by qualified health personnel or a specially trained correctional officer upon admission into the facility before the inmate is placed in the general population or housing area; the screening includes behavioral observation, including state of consciousness and mental status, appearance, conduct, tremor and sweating (5.15). Health appraisal data collection is completed for each inmate within 14 days after admission to the facility (5-16).	A newly admitted confined person is to receive a thorough examination within 2 weeks after his initial admission to a facility (4-105).	Revise screening policy to specify and provide for comprehensive identification of inmates to be referred for treatment.

STANDARDS: LEGAL ISSUES AND THE MENTALLY DISTURBED INMATE (Continued)

LEGAL ISSUES	AMERICAN LAW INSTITUTE (1962)	UNITED NATIONS (1975)
I. TREATMENT/HABILITATION A. ACCESS	Reception Classification Boards shall recommend a program for medical and psychological treatment as may be necessary (304.1).	Offenders should have adequate access to medical care for the treatment of mental illness (32). There is an ethical obligation to preserve the mental health of prisoners (20).
B. REFUSAL		A prisoner should not be forced by administration of drugs, or otherwise to submit, to any form of medical treatment against his will (50).
C. EMERGENCY		
D. DIAGNOSIS	The Reception Classification Boards shall examine all persons committed to the Department of Corrections for medical and psychological condition and history (304.1).	

NATIONAL ADVISORY COMMISSION ON CRIMINAL JUSTICE STANDARDS AND GOALS (1973)	GEORGIA DEPARTMENT OF OFFENDER REHABILITATION (1981)	PENNSYLVANIA CORRECTION/MENTAL HEALTH TASK FORCE (1981)
Each correctional agency should provide for the psychiatric treatment of emotionally disturbed offenders; a continuum of diagnosis, treatment, and aftercare is provided (11.5). Medical care should be comparable in quality and availability to that obtainable by the general public (2.6).	The superintendent will establish and maintain counseling and psychological services and programs (2.00).	Inmates should have access to mental health services available to residents of the community (5).
Emergency medical treatment is available on a 24 hour basis (2.6).	Policy outlines steps to be followed when an individual crisis occurs (11.001). At least one counselor will be on call 24 hours a day, 7 days a week, for emergency counseling (11.002). An inmate scheduled for emergency evaluation or treatment will be placed in specially designated areas with close staff supervision and security (8.002).	Correctional institutions should develop or expand mental health treatment services to allow an inmate to receive emergency mental health treatment in prison (2).
Each inmate should be examined by a physician within 24 hours after admission to determine his physical and mental condition (9.7). A diagnostic report, including a tentative diagnosis of the nature of the emotional disturbance, should be developed. Diagnosis should be a continuing process (11.5).	Incoming inmates with sentences over one year will be given a psychological evaluation within one month of intake. This evaluation includes behavioral observations, a records review, and group testing to screen for emotional and mental problems. Referral for more intensive, individual assessment is made as needed (7.001). All inmates will participate in individual assessments conducted within the first 120 days of permanent institutional assignment (8.003). An inmate having severe psychological disturbances will receive a special comprehensive psychological examination within 14 days after referral (8.006).	Policy requires the screening and referral of cases involving mentally ill or retarded inmates whose adaptation to the correctional environment is significantly impaired (2).

STANDARDS: LEGAL ISSUES AND THE MENTALLY DISTURBED INMATE (Continued)

LEGAL ISSUES	AMERICAN BAR ASSOCIATION (1984)	AMERICAN MEDICAL ASSOCIATION (1979)
I. CONT'D E. MODALITIES/TREATMENT PLAN		A written individualized treatment plan exists for inmates requiring close medical supervision (150).
F. MEDICATION		Psychotropic medications are prescribed only when clinically indicated as one facet of a program of therapy, and are not allowed for disciplinary reasons. The long term use of minor tranquilizers is discouraged. "Stop-order" time periods are stated for behavior modifying medications (163, Essential).
G. SITUS		
H. STAFF (Training & Ratio)		All correctional personnel who work with inmates are trained by the responsible physician to recognize signs and symptoms of emotional disturbance and/or developmental disability, particularly mental retardation (130, Essential).

AMERICAN ASSOCIATION OF CORRECTIONAL PSYCHOLOGISTS (1980)	AMERICAN PUBLIC HEALTH ASSOCIATION (1976)	AMERICAN CORRECTIONAL ASSOCIATION (1981 — STANDARDS)
A written treatment plan exists for all inmates requiring psychological services (31, Essential). Only those treatment methodologies accepted by the state psychology community are used. The facility will provide a multiplicity of appropriate programs (37, Essential).	Direct treatment services should be provided in a context of varied modalities, with emphasis on eclectic breadth.	A written individual treatment plan is developed for each inmate requiring close medical supervision (2-4304, Essential).
	Psychotropic medication shall be prescribed in accordance with generally accepted standards of good practice in the general community.	Psychotropic medications are prescribed only when clinically indicated as one facet of a program of therapy (2-4317, Mandatory). Psychotropic drugs are prescribed and administered only by a physician, qualified health personnel, or health trained personnel (2-4322, Essential).
Prison systems have their own resources for handling severely disturbed inmates, either in a separate facility or specially designated units (33, Important). Inmates awaiting emergency evaluation and or treatment are housed in a specially designated area with close supervision and sufficient security to protect these individuals (30, Essential).		
Psychology staff is to receive orientation training and regular continuing education (13, Essential). At least one full-time psychologist for every 200 prisoners; at least one full-time psychologist for every 100-125 inmates in specialized units; staffing patterns in jails vary with the size of the jailed population (12, Essential).		

STANDARDS: LEGAL ISSUES AND THE MENTALLY DISTURBED INMATE (Continued)

LEGAL ISSUES	AMERICAN CORRECTIONAL ASSOCIATION (1981 — GUIDELINES)	FEDERAL BUREAU OF PRISONS (1983 — PSY. MANUAL)
I. CONT'D E. MODALITIES/TREATMENT PLAN	The mental health staff shall develop individualized treatment programs for mentally ill and mentally retarded inmates.	Regularly committed offenders should have access to appropriate treatment modalities. In deciding which modalities to use, a safe guideline for decision is to use only those methods widely accepted and practiced by the professional psychology community. Do not use physical, aversive behavior modification techniques.
F. MEDICATION	The long term use of minor tranquilizers shall be discouraged unless clinically indicated; psychotropic medications shall be dispensed only when clinically indicated.	
G. SITUS		If an inmate is found to be mentally retarded, every effort should be made to find a placement for such an individual outside Bureau of Prisons institutions.
H. STAFF		One full-time psychologist for every two general functional units and one full-time psychologist for each specialized functional unit.

U.S. DEPARTMENT OF JUSTICE (1980)	LAW ENFORCEMENT ASSISTANCE ADMINISTRATION (1979)	COMPTROLLER GENERAL (1979)
A written individualized treatment plan approved by a physician or qualified mental health professional exists for each mentally ill or retarded inmate. Special programs exist for inmates with severe emotional disturbances and retarded and developmentally disabled inmates who require close medical, psychiatric, psychological, or habilitative supervision (5-30).		
Psychotropic medications are prescribed only by a physician as one facet of a program of therapy; there are appropriate procedures for monitoring reactions. The long term use of minor tranquilizers is discouraged (5-35).		Psychotropic drug use should conform with generally accepted medical practices.
		Consider providing semi-protected environments for psychotic inmates needing less than hospital-level care.
All staff with custodial and program responsibility are trained regarding recognition of symptoms of mental illness and retardation (5-29). Interdisciplinary treatment and custody teams are assigned to separate living units for inmates with severe emotional disturbances, mental illness, or retardation (5-31).		

STANDARDS: LEGAL ISSUES AND THE MENTALLY DISTURBED INMATE (Continued)

LEGAL ISSUES	AMERICAN LAW INSTITUTE (1962)	UNITED NATIONS (1975)
I. CONT'D E. MODALITIES/TREATMENT PLAN		Prisoners should not be subjected, even though willing, to electroconvulsion therapy, psychosurgery, or any other form of medical treatment that is in the least degree controversial (50, 51).
F. MEDICATION		
G. SITUS	The Department of Corrections should provide a medical-correctional facility to keep prisoners with difficult or chronic psychiatric problems (304.2).	
H. STAFF (TRAINING & RATIO)		

NATIONAL ADVISORY COMMISSION ON CRIMINAL JUSTICE STANDARDS AND GOALS (1973)	GEORGIA DEPARTMENT OF OFFENDER REHABILITATION (1981)	PENNSYLVANIA CORRECTION/MENTAL HEALTH TASK FORCE (1981)
There should be a program for each offender. In addition to basic medical services, psychiatric programs should provide for education, occupational therapy, recreation, and psychological and social services (11-5).	Only those treatment methods accepted by the state counseling and psychological community will be used in institutions (10-005).	There is a written treatment plan for each inmate requiring close psychiatric and psychological supervision (2).
The mentally ill should not be housed in a detention facility (i.e., a jail) (9-7).		There should be a specialized living unit and/or specially trained staff to treat inmates who exhibit severe mental health problems but are not commitable under the Mental Health Procedures Act (2).
	Each institution has at least one full time counselor responsible for all counseling and psychological services (3-001). Counselor caseloads vary by level of services provided but should not exceed 100 inmates (3-010—3-301). At a minimum, institutions will provide one qualified counselor to serve as a resource for the counseling staff regarding treatment of mentally retarded inmates (13-003).	Staff charged with custodial and program responsibility are to be trained regarding the recognition of symptoms of mental health illness and retardation (2).

STANDARDS: LEGAL ISSUES AND THE MENTALLY DISTURBED INMATE (Continued)

LEGAL ISSUES	AMERICAN BAR ASSOCIATION (1984)	AMERICAN MEDICAL ASSOCIATION (1979)
II. TRANSFER A. CRITERIA	Prisoners who require treatment or habilitation not available in the correctional facility should be transferred to a mental health or mental retardation facility (7-10.2)(b).	Policy requires that patients with acute psychiatric illnesses who require health care beyond the resources available in the facility are transferred or committed to a facility where such care is available (113).
B. INVOLUNTARY-PROCEDURES DUE	At a minimum, the following procedural protections should be provided: 1) the right to legal counsel, furnished by the state if the prisoner is financially unable to secure counsel; 2) the right to be present, to be heard in person and to produce documentary evidence; 3) the right to call and cross-examine witnesses; 4) the right to review mental evaluation reports; and 5) the right to be notified of the foregoing rights. In order to commit the prisoner, the judge must find by clear and convincing evidence that the prisoner meets the criteria for involuntary commitment and cannot be given proper treatment in prison (7-10.5).	
C. EMERGENCY	An emergency exists when the chief executive officer or his designee believes that an immediate transfer is necessary to prevent serious injury to the prisoner or to protect the safety of other prisoners. The transfer may be authorized provided that an involuntary transfer hearing is initiated not later than 48 hours after the transfer is effected (7-10.7).	
III. CUSTODIAL A. DISCIPLINE		Policy requires consultation between the facility administrator and the responsible physician or their designees prior to imposition of disciplinary measures regarding patients who are diagnosed as having a psychiatric illness (112).
B. ASSIGNMENTS-HOUSING & PROGRAM		Policy requires consultation between the facility administrator and the responsible physician or their designees prior to housing or program assignment actions regarding patients who are diagnosed as having a psychiatric illness (112).
C. ISOLATION/RESTRAINT		Policy requires that inmates removed from the general population and placed in segregation are evaluated at least 3 times weekly by qualified health care personnel (147). The use of medical restraints is guided by policy.

AMERICAN ASSOCIATION OF CORRECTIONAL PSYCHOLOGISTS (1980)	AMERICAN PUBLIC HEALTH ASSOCIATION (1976)	AMERICAN CORRECTIONAL ASSOCIATION (1981 — STANDARDS)
Facilities unable to provide acute, chronic, and convalescent care due to resource constraints should refer inmates in need of such to a more appropriate facility (32, Essential).		Inmates who are severely disturbed and/or mentally retarded are referred for placement in either appropriate non-correctional facilities or in specially designated units for handling this type of individual (2-4926, Essential).
Transfers shall follow due process procedures as specified in state and federal statutes (34, Essential).		Transfers which result in inmates being placed in non-correctional institutions follow due process procedures as specified in law prior to the move being effected. Transfers which result in inmates being placed in special units within the facility, which are specially designated for the care and treatment of the severely mentally ill or retarded, follow due process procedures as specified in law prior to the move being effected (2-4297, Essential).
		A hearing is held as soon as possible after an emergency transfer of an inmate to a non-correctional institution or a special unit within the facility specifically designated for the care and treatment of the severely mentally ill or retarded (2-4297, Essential).
Policy requires that the responsible psychologist be consulted prior to taking disciplinary sanctions (35, Important).	No reward, privilege or punishment shall be contingent upon mental health treatment.	Policy requires that, except in emergency situations, there shall be joint consultation between the warden and the responsible physician or their designees prior to taking disciplinary measures regarding the identified mentally ill or retarded patient (2-4298, Essential).
		Policy requires that, except in emergency situations, there shall be joint consultation between the warden and the responsible physician or their designees prior to taking housing or program assignment action regarding the identified mentally ill or retarded patient (2-4298, Essential).
		Policy governs the use of restraints for medical and psychiatric purposes (2-4312, Essential).

STANDARDS: LEGAL ISSUES AND THE MENTALLY DISTURBED INMATE (Continued)

LEGAL ISSUES	AMERICAN CORRECTIONAL ASSOCIATION (1981 — GUIDELINES)	FEDERAL BUREAU OF PRISONS (1983 — PSY. MANUAL)
II. TRANSFER A. CRITERIA	Inmates whose condition is beyond the range of services available in the facility shall be transferred to a non-correctional facility or a specially designated correctional unit in a state mental hospital.	When treating an inmate is beyond the capacity of a regular institution, transfer is warranted.
B. INVOLUNTARY-PROCEDURES DUE	All inmates to be transferred to facilities for the severely mentally ill or retarded shall be provided a hearing before the institutional disciplinary committee and a medical review board. The clinical hearing should be attended by the inmate, a board certified psychiatrist, a staff psychiatrist, and the institutional Medical Director. The hearing before the institutional disciplinary committee should be conducted in accordance with normal procedure for disciplinary hearings and includes: 24 hours advance written notice of the time and place of the hearing; provisions for a staff representative for presenting any extenuating or mitigating evidence; presentation of witnesses and evidence; examination of witnesses by the staff representative or the committee; summary record of the proceedings; and the right to appeal the decision.	
C. EMERGENCY	Emergency transfer hearings shall be conducted within 72 hours following an emergency psychiatric transfer.	
III. CUSTODIAL A. DISCIPLINE		There is consultation between the warden, or a designee, and mental health staff if a mentally ill or retarded inmate is affected by any disciplinary action.
B. ASSIGNMENTS-HOUSING & PROGRAM	All program changes regarding inmates identified as mentally ill or retarded shall be made only after consultation between the warden and the responsible physician, or designees.	There is consultation between the warden, or a designee, and mental health staff if a mentally ill or retarded inmate is affected by a housing or program assignment change.
C. ISOLATION/RESTRAINT		

U.S. DEPARTMENT OF JUSTICE (1980)	LAW ENFORCEMENT ASSISTANCE ADMINISTRATION (1979))	COMPTROLLER GENERAL (1979)
Policy requires that inmates with acute or chronic illnesses (including psychiatric illnesses) who require health care beyond the resources available to the facility are transferred or committed to a facility where proper care is available (5-32).	A confined person requiring care not available in the facility is transferred to a hospital or other appropriate place providing the care (4-108).	
	Transfers shall be by civil commitment proceedings in the appropriate court. Legal services shall be provided to each indigent confined person for civil proceedings in which a confined person is a defendant or may be bound by a proceeding he did not initiate (4-108).	
Psychotropic medications are not to be provided for disciplinary purposes (5-35).		

STANDARDS: LEGAL ISSUES AND THE MENTALLY DISTURBED INMATE (Continued)

LEGAL ISSUES	AMERICAN LAW INSTITUTE (1962)	UNITED NATIONS (1975)
II. TRANSFER A. CRITERIA	When an institutional physician or psychologist finds that a prisoner suffers from a mental disease or defect and is of the opinion that he cannot be given proper treatment at that institution, the warden shall recommend that he be transferred to the medical correctional facility or a hospital outside of the Department of Corrections (304.4).	
B. INVOLUNTARY-PROCEDURES DUE	If two psychiatrists approved by the Department of Mental Hygiene find that a prisoner cannot be properly treated in the Department of Corrections, he may be transferred with the recommendation of the warden, an order of the Director of Corrections, and the approval of the Department of Mental Hygiene (304.4).	
C. EMERGENCY		
III. CUSTODIAL A. DISCIPLINE		
B. ASSIGNMENT-HOUSING & PROGRAM		
C. ISOLATION/RESTRAINT		

NATIONAL ADVISORY COMMISSION ON CRIMINAL JUSTICE STANDARDS AND GOALS (1973)	GEORGIA DEPARTMENT OF OFFENDER REHABILITATION (1981)	PENNSYLVANIA CORRECTIONAL/ MENTAL HEALTH TASK FORCE (1981)
Psychotic offenders should be transferred to mental health facilities (11-5).	Hospital services obtained through the Department of Human Resources provide intensive inpatient psychiatric treatment for inmates requiring care which is beyond the scope of facility services (10-401).	See Pennsylvania's Mental Health Procedures Act of 1976, as amended.
Transfers between correctional and mental institution, whether or not maintained by the correctional authority, should include specified procedural safeguards available for new or initial commitments to the general population of such institutions (2-13).	Transfers of inmates to institutions especially designated for the treatment of the severely mentally disturbed will follow due process procedures, as specified in state and federal statutes, prior to transfer. Transfers of inmates to special units specifically designated for the treatment of the severely mentally disturbed will follow due process procedures, as specified in state and federal statutes, prior to the transfer (12-010).	Follows procedures of Pennsylvania's Mental Health Procedures Act of 1976, as amended, which includes the right to: notice, counsel, confrontation and cross examination, presentation of evidence, and the assistance of an expert in mental health. The act should be amended to allow an authorized mental health review officer the power to order transfer and involuntary treatment (3).
	Policy requires that the assigned counselor be consulted prior to taking disciplinary sanctions regarding emotionally disturbed inmates (2-019).	
	Policy requires that the assigned counselor be consulted prior to making housing or program assignment changes regarding emotionally disturbed inmates (2-019).	

STANDARDS: LEGAL ISSUES AND THE MENTALLY DISTURBED INMATE (Continued)

LEGAL ISSUES	AMERICAN BAR ASSOCIATION (1984)	AMERICAN MEDICAL ASSOCIATION (1979)
IV. CONSENT A. APPLICABILITY		All examinations, treatments and procedures governed by informed consent practices applicable in the jurisdiction are likewise observed for inmate care (168).
B. COMPONENTS		
V. CONFIDENTIALITY A. APPLICABILITY		
B. RECORDS		The active health record is maintained separately from the confinement record; access to the health record is controlled by the health authority (165).
C. THIRD-PARTY		Written authorization by the inmate is necessary, unless otherwise provided by law or administrative regulation having the force and effect of law, for the transfer of health records and information (166).

AMERICAN ASSOCIATION OF CORRECTIONAL PSYCHOLOGISTS (1980)	AMERICAN PUBLIC HEALTH ASSOCIATION (1976)	AMERICAN CORRECTIONAL ASSOCIATION (1981 — STANDARDS)
All psychological examinations, treatments, and procedures affected by the principle of informed consent in the jurisdiction are likewise observed for inmate care (14, Essential).		Policy provides that all informed consent standards in the jurisdiction are observed and documented for inmate care (2-4313, Essential).
Policy outlines the degree to which confidentiality of information can be assured (16, Essential).	Full confidentiality of all information obtained in the course of treatment should be maintained at all times with the only exception being the normal legal and moral obligations to respond to a clear and present danger of grave injury to the self or other, and the single issue of escape. The mental health professional shall explain the confidential guarantee, including precise delineation of the limits. The prisoner who reveals information that falls outside the guarantee of confidentiality shall be told, prior to the disclosure, that such information will be disclosed, unless doing so will increase the likelihood of grave injury.	
Policy specifies which psychological reports are placed in the inmate's central file and which are maintained in other secured files (47, Essential).	Sensitive or highly personal data shall not be included in the medical record.	Policy upholds the confidentiality of the health record. The active health record is maintained separately from the confinement record; access to the health record is controlled by the health authority (2-4319, Essential).
Written authorization by the inmate is necessary for transfer of psychological record information to any third party, unless otherwise provided for by law or administrative regulation having the force and effect of law (51, Essential). The inmate is made aware of what is being reported to any decision-making third party and is given the opportunity to refute the information contained in such reports (52, Important).		Health record information is transmitted to specific and designated physicians or medical facilities in the community upon the written authorization of the inmate (2-4320, Essential).

STANDARDS: LEGAL ISSUES AND THE MENTALLY DISTURBED INMATE (Continued)

LEGAL ISSUES	AMERICAN CORRECTIONAL ASSOCIATION (1981 — GUIDELINES)	FEDERAL BUREAU OF PRISONS (1983 — PSY. MANUAL)
IV. CONSENT A. APPLICABILITY	The informed consent of the inmate shall be required for all examinations, treatments and procedures governed by informed consent standards in the community. This requirement shall be waived for emergency care involving inmates who do not have the capacity or ability to understand the information given.	
B. COMPONENTS	An inmate shall be requested to sign a written consent form authorizing any medical procedure which is considered dangerous and involves a risk to the individual's life or health status after receiving an explanation of the procedures, alternatives, and risks involved.	
V. CONFIDENTIALITY A. APPLICABILITY		Material learned in treatment should be confidential within the limits established by safety and security requirements. The appropriate "test" for exempting a psychological report from inmates is the "actual harm test."
B. RECORDS	All medical records are confidential. Active medical records should be maintained separately from the confinement record.	
C. THIRD-PARTY	Medical records shall be released to other persons only on written authorization of the inmate, except for medical staff who require records for supplying clinical services and to agency staff performing an investigation of the facility.	

U.S. DEPARTMENT OF JUSTICE (1980)	LAW ENFORCEMENT ASSISTANCE ADMINISTRATION (1979)	COMPTROLLER GENERAL (1979)
Informed consent of inmates is required for all examinations, treatments, and medical procedures for which informed consent is required in the jurisdiction (5-44).		
Therapeutic medical treatment is permitted provided the inmate gives full written consent after being informed of the treatment's likely effects, the likelihood and degree of improvement and/or remission, the hazards of the treatment, the inmate's ability to withdraw from the treatment without penalty at any time (5-57).		
Policy provides that access to the health record is controlled by the health authority and that the health record is not in any way part of the confinement record (5-39). Inmates are given access to non-evaluate summaries, but not to raw data, from psychiatric and psychological assessments in their health files (5-40).	Medical records are maintained in a confidential and secure manner (4-105). An inmate can be denied access to portions of his file containing diagnostic opinion relating to mental health problems the disclosure of which might affect adversely a course of on-going treatment (4-122).	A central psychological file for each inmate should be established. There is a need to reemphasize the keeping of adequate records, treatment actions, and the importance of protecting their confidentiality.
Written authorization by the inmate is necessary for transfer of medical records unless otherwise provided by law. All material in the inmate's health file is made available to the inmate's private physicians, or medical facilities on the written authorization of the inmate (5-40; 5-43).	The department may not disclose information about a confined person except pursuant to the written consent of the person, unless disclosure would be pursuant to a court order, to recognized treatment or custodial personnel, to designated government agencies, or in an emergency (4-121).	Revise guidelines to more specifically describe the nature of inmates' mental health information to be furnished to the Parole Commission and probation officers.

STANDARDS: LEGAL ISSUES AND THE MENTALLY DISTURBED INMATE (Continued)

LEGAL ISSUES	AMERICAN LAW INSTITUTE (1962)	UNITED NATIONS (1975)
IV. CONSENT A. APPLICABILITY		
B. COMPONENTS	The content of the prisoners' files shall be confidential (304-3).	
V. CONFIDENTIALITY A. APPLICABILITY		
B. RECORDS		
C. THIRD PARTY		

NATIONAL ADVISORY COMMISSION ON CRIMINAL JUSTICE STANDARDS AND GOALS (1973)	GEORGIA DEPARTMENT OF OFFENDER REHABILITATION (1981)	PENNSYLVANIA CORRECTION/MENTAL HEALTH TASK FORCE (1981)
	In all mental health services, the principle of informed consent is followed for inmate care (5-001).	
	Informed consent is the permission given by the client for a specified treatment, examination, or procedure after receiving the material facts about the nature, consequences, risks, alternatives, and level of confidentiality involved in the proposed technique (5-001).	
	Policy describes the degree of confidentiality of inmate information (5-004).	
	Policy specifies which counseling and psychological reports are placed in the inmate's central file and which reports or materials are maintained in other secured files (17-0122). Psychological test protocols and other raw data are kept separately from the central file, are secured, and not made available to any inmate or untrained person (17-013).	
	The inmate must give written approval before mental health records are transferred to any third party, unless otherwise provided by law or administrative regulation having the force and effect of law (17-015). The inmate in a therapeutic relationship is advised of any information reported to any decision-making third party and is allowed to refute such information if desired (17-016).	

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—Section 7-10 deals specifically with the mentally ill and mentally retarded prisoner. Transfer issues receive wide coverage.

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1979 — *Standards for Health Services in Prisons.* Chicago: American Medical Association.

—Health care is defined as ". . .the sum of all actions taken, preventive and therapeutic, to provide for the physical and mental well-being of a population." (pg. 2). Several recommendations apply specifically to the mentally disturbed offender.

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1980 — *Standards for Psychology Services in Adult Jails and Prisons.* Beverly Hills: Sage.

—These standards are concerned with providing psychological services to all inmates, regardless of whether or not they have been officially labeled as mentally ill or mentally retarded.

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—Section IV deals specifically with mental health care.

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—This volume is intended as a supplement to the Standards for Adult Correctional Institutions manual listed above. Mental health care services receive separate coverage (ACA number 4.13.4).

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—Health care services include the provision of care to the mentally ill and retarded inmate; several recommendations apply specifically to the mentally disturbed offender.

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1979 — *Prison Mental Health Care Can Be Improved By Better Management and More Effective Federal Aid.* Report to the Congress of the U.S. Washington, D.C.: U.S. General Accounting Office.

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Georgia Department of Offender Rehabilitation
1981 — *Standards for Counseling and Psychological Services*

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Pennsylvania Correction/Mental Health Task Force
1981 — *The Care and Treatment of Mentally Ill Inmates*

—These recommendations serve as additions and modifications to the Pennsylvania Mental Health Procedures Act of 1976, as amended.

APPENDIX B

QUICK REFERENCE CHART TO LEADING CASES ON ADEQUACY OF PRISON MENTAL HEALTH CARE*

Prison System/Case	Total Inmate Population	Percent Estimated as Mentally Ill	Number and Type of Staff**	Psychiatric Care Adequate/Inadequate
Alabama Prison System Newman v. Alabama, 503 F.2d 1320 (5th Cir. 1974)	4000	10% psychotic 60% in need of care[c]	On-site care: 1 PT psychologist (4 hrs/wk) Off-site care: Access to State Mental Hospital	Inadequate
California				
Folsom and San Quentin Toussaint v. McCarthy, 801 F.2d 1080 (9th Cir. 1986)	3500	No data	On-site care: 2 psychiatrists 1 psychologist	Adequate
Colorado State Prison Ramos v. Lamm, 639 F.2d 559 (10th Cir. 1980)	1400	5-10% seriously ill 10-25% seriously ill[a]	On-site care: 1 PT psychiatrist once every 1 or 2 mos.	Inadequate
District of Columbia Inmates of Occoquan v. Barry, 650 F. Supp. 169 (D.D.C. 1986)	1637	No data	On-site care: 1 psychiatrist (2 hrs/wk)	Inadequate
Idaho State Prison Balla v. Idaho State Board of Corrections, 595 F. Supp. 1558 (D. Idaho 1984)	920	9% on psychotropic medication[b]	On-site care: 2 FT psychologists	Inadequate

Prison System/Case	Total Inmate Population	Percent Estimated as Mentally Ill	Number and Type of Staff**	Psychiatric Care Adequate/Inadequate
Indiana State Prison Wellman v. Faulkner, 715 F.2d 269 (7th Cir. 1983)	1950	10-20% need mental health care[b]	On-site care: 1 Ph.D. psychologist 2 PT clinicians Off-site care: 62 bed facility	Inadequate
Kentucky:				
Kentucky Correctional Institution for Women Canterino v. Wilson, 546 F. Supp. 174 (W.D.Ky. 1982)	199	144 inmates emotionally disturbed 33-50% on psychotropic medication[b]	On-site care: 1 PT psychologist 1 PT psychiatrist (8 hr/wk) 1 psychiatric social worker (8 hr/wk)	Adequate
Maine Lovell v. Brennan, 566 F. Supp. 672 (D.Me. 1983)	402	No data	On-site care: 3 FT psychologists 1 PT psychologist 1 inmate paraprofessional 3 social workers	Adequate
Maryland:				
Maryland House of Corrections Johnson v. Levine, 450 F. Supp. 648 (D.Md. 1978)	1780	No data	On-site care 2 FT psychologists 14 counselors (listed as "classification staff") Off-site care: Access to 28 bed Mental Health Hospital	Adequate
New Hampshire State Prison Laaman v. Helgemoe, 437 F. Supp. 269 (D.N.H. 1979)	280	5-50% seriously ill[a, b] (estimates so widely varying that court refused to make finding)	On-site care: 1 psychologist 1 psychiatric social worker 2 counselors 1 PT psychiatrist	Inadequate

Prison System/Case		Total Inmate Population	Percent Estimated as Mentally Ill	Number and Type of Staff**	Psychiatric Care Adequate/Inadequate
New Mexico Duran v. Anaya, 642 F. Supp. 510 (D.N.M. 1986)					Inadequate
Oregon Prison System Capps v. Atiyeh, (need correct cite)	OSCI:	1000	25-30/week seen by psychiatrist[b]	On-site care: 1 PT psyschologist (2 hrs/wk)	Adequate
	OSP:	1500	47 seriously ill at Psychiatric Security Unit (PSU) 20 inmates per week seen by psychiatrist[b]	On-site care: 1 PT psychiatrist (20 hrs/wk) 1 FT Ph.D. psychologist 1 B.A. counselor	Adequate
	Substance Abuse Program:	300[b]		On-site care: 13 counselors Off-site care: Access to 117 bed State Hospital	Adequate
Puerto Rico Feliciano v. Barcelo, 497 F. Supp. 14 (P.R. 1979)		4200 in 19 institutions	50%[a]		Inadequate
Rhode Island Palmigiano v. Garrahy, 639 F. Supp. 244 (D.R.I. 1986)		260	No data	No data	Inadequate
Ferola v. Moran, 622 F. Supp. 814 (D.C.R.I. 1985)		No data	No data	On-site care: 1 psychiatrist	Adequate
South Dakota Cody v. Hillard, (D.S.D. 1984)		538	20-25% psychotic inmates 95% personality disorders[b]	On-site care: 1 volunteer psychiatrist (5 hrs/wk) 1 FT psychologist 7 counselors 2.5 drug/alcohol counselors	Inadequate

Prison System/Case	Total Inmate Population	Percent Estimated as Mentally Ill	Number and Type of Staff**	Psychiatric Care Adequate/Inadequate
Tennessee:				
Grubbs v. Bradley, 552 F. Supp. 1052 (D.Tenn. 1982)	7000	No data	Equivalent of 54 3/4 health care workers	Adequate
DCI	275		1 PT psychiatrist (15 hrs/wk) PT psychologists (75 hrs/wk) 2 FT psychologists 2 psychological examiners 6 psychological social workers	Adequate
TSP	1900		1 psychological examiner 1 counselor 1 PT psychiatrist (4 hrs/wk) 1 PT psychologist (4 hrs/wk)	
Fort Pillow	750		1 unlicensed counselor 1 PT psychiatrist (2 hrs/wk) 1 PT psychological examiner (2 hrs/wk)	
Brushy Mountain	400		1 psychological examiner 4 counselors (no psychiatric training)	
Turney Center	630		1 social worker 1 counselor 1 PT psychiatrist (2 hrs/month)	
Memphis Correctional			1 FT psychological examiner 2 psychologists to do evaluations	
BCRCF	485		8 counselors	

Prison System/Case	Total Inmate Population	Percent Estimated as Mentally Ill	Number and Type of Staff**	Psychiatric Care Adequate/Inadequate
Tennessee (Con't):				
MCRCF	481		1 PT psychological examiner 8 counselors	
LCRCF	431		1 FT psychological examiner	
TP for Women	281		2 licensed psychological examiners 2 counselors 1 PT psychiatrist (3 hrs/wk)	
Nashville RC	419		4 licensed psychological examiners 4 counselors (B.A.) 1 PT psychiatrist (5 hrs/wk)	
TOTAL BREAKDOWN FOR TENNESSEE	7000		Psychiatrists (0 FT, 6 PT, 30 hrs/wk)	3/4
			Psychologists (4 FT, PT, 80 hrs/wk)	6
			Counselors:	
			licensed	24
			unlicensed	5
			Psychological examiners	12
			Social workers	7
			TOTAL HEALTH CARE WORKERS	54 3/4

Prison System/Case	Total Inmate Population	Percent Estimated as Mentally Ill	Number and Type of Staff**	Psychiatric Care Adequate/Inadequate
Texas Prison System Ruiz v. Estelle, 503 F. Sup. 1265 (S.D.Tex. 1980)	24,575 in 18 units	5-20% seriously ill 15-70% in need of treatment[a, b]	On-site care: 20 unlicensed psychologists PT psychiatrists (1 day/mo.) Off-site care: Treatment Center capacity for 60 inmates 2 PT psychiatrists 1 FT psychologist 1 FT sociologist 1 PT sociologist	Inadequate
Virgin Islands:				
Golden Grove Adult Correctional Facility Barnes v. Virgin Islands, 415 F. Supp. 1218 (V.I. 1976)	120	50% in need of care[d]	On-site care: No mental care staff	Inadequate
West Virginia Crain v. Bordenkircher, 342 S.E.2d 422 (W.Va. 1986)	No data	No data	No data	Inadequate

*Unless otherwise noted, the data presented here is derived exclusively from the cited judicial decision. This chart is intended only as a quick reference to most of the leading decisions on point but it is no substitute for a closer study of the particular jurisdiction and the case.

**Off-site care not included if case offered no data regarding off-site facilities.

[a]Estimate taken from expert testimony.

[b]Estimated by the in-house mental health care staff.

[c]No details on formula for arriving at these estimates.

[d]Estimate taken from the report of a commission appointed by the court.

[e]Though the court did not make a finding regarding off-site care, Mr. Robert Mandela, Director of Forensic Services for California, reported in an interview on 1/26/86 that Folsom Prison psychotic inmates do have access to the California Medical Facility at Vacaville and the acutely psychotic are transferred to the state mental hospital at Atascadero.

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