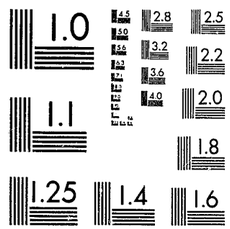

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U.S. Department of Justice
National Institute of Corrections

SOURCE BOOK

ON THE MENTALLY DISORDERED PRISONER

NATIONAL INSTITUTE OF CORRECTIONS

Raymond C. Brown, Director

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SOURCEBOOK

on the Mentally Disordered Prisoner

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March 1985

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Foreword

The care of the mentally disordered inmate raises complex policy and programmatic questions for the correctional administrator. The resolution of these questions is often hindered by the lack of pertinent information, especially information available in a single source.

The need for a general Sourcebook for correctional administrators in this complicated area was appropriately recognized by the Advisory Board of the National Institute of Corrections. The present Sourcebook was designed to provide information on such issues as:

a) the number of mentally ill and mentally retarded inmates under custody in State correctional facilities and available program services based on a national survey;

b) applicable standards; and

c) relevant case law.

We wish to acknowledge the contribution of corrections and mental health personnel across the country in the development of this manual. In particular, we appreciate the time and effort of the individuals who completed the national survey questionnaires or guided the project staff on their field visits to selected States.

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

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November 1984

PART 1
EXECUTIVE SUMMARY

EXECUTIVE SUMMARY By Karl H. Gohlke

What should today's prisons do about mentally disordered prisoners? Who are these inmates? How do other state and federal facilities handle this group of inmates? Do they have special legal rights? What standards guide programming for them? Can prisons afford to meet such standards? Can they afford not to?

In an attempt to begin answering these questions the New York State Department of Correctional Services undertook to develop a sourcebook which had two goals: to gather information concerning the care and treatment of mentally disordered prisoners and to present the findings to those who manage this clientele. We gathered information on current practice from the departments of correction and of mental health in each of the fifty states, the District of Columbia, and the federal government. In addition we commissioned an intensive analysis of constitutional case law concerning these inmates and two detailed investigations into the standards established by a variety of professional groups regarding aspects of their care.

In our endeavc we must employ notoriously unsatisfactory terms, for which there are, as yet, no universally accepted definitions. Our phrase "mentally disordered prisoners" includes those inmates of correctional institutions who have been convicted and who are mentally ill, mentally retarded, developmentally disabled, or who act out in a fashion which is disturbing but is not considered by clinicians to be "mental illness." Tangentially we refer to those prisoners in jail awaiting trial, but we do not cover their special situation; nor do we consider those found incompetent to stand trial if they are placed in some institution other than a correctional facility. On the other hand we *do* include those found guilty but mentally ill and those defined in some jurisdictions as "sexually dangerous persons," if they are sentenced to a correctional facility. However imprecise such terms as mentally ill or developmentally disabled are, they do permit us to begin assembling a knowledge base.

In this summary we present a general statement of our findings. The reader can then turn to a detailed explanation of the survey, the complete case law review, and the two analyses of professional standards, one of which is keyed to legal questions and the other to administrative concerns. Thus the reader can first get the overall picture, then examine those sections of the sourcebook which most arouse curiosity.

THE PROBLEM FOR PUBLIC ADMINISTRATORS

1 Level of Service for Social Deviants

Just about everyone — the public, elected and appointed officials, those involved in inmate care and management — believes prison inmates least deserve tax dollars, particularly in the area of quality programming. Medical service, which costs a great deal anywhere, can cost even more in prison, where the high-stress environment exacerbates the major medical and psychiatric problems the inmates brought to prison with them. To make matters worse, prisons have trouble attracting and retaining staff whose credentials show them capable of providing sufficient and appropriate levels of care and treatment.

Correctional and mental health administrations have long engaged in an uneasy collaboration. Not only does each area disagree among themselves about what care and treatment are appropriate for their clientele, they disagree with each other where their concerns overlap. And both face a public which cannot agree on how the society should treat prisoners or mental health clients. Both disciplines suffer when highly sensational events occur — when a mass murderer escapes from jail or a "temporarily insane" person goes on trial for raping and sodomizing small children. Both professions are expected to be infallible and to protect the community completely while simultaneously preserving civil liberties. Such a no-win situation means that administrative and judicial opinions regarding the public safety or rehabilitation often contradict each other.

When in the 1960s both the mental health and correctional fields received a lot of bad publicity for "warehousing" their clientele and providing inadequate services, a national consensus coalesced urging the provision of more humane and effective care. In the twenty years since then, significant progress has been made demonstrating the efficacy of treatment and habilitation programs in each area, and the fields have made substantial gains in discovering which managerial strategies best implement such programs.

But strong disagreement still exists in a number of areas regarding what services are proper and appropriate for prisoners who desire or are in need of mental health services. Those with a client-centered perspective operate out of a totally different philosophy from those with an institution-centered perspective. One extreme regards the mentally disordered prisoner as entitled to the care and privacy one would enjoy in the private and civilian sector; the other, focused on maintaining order and discipline in a large correctional setting, desires as little differentiation as possible in the administration of rules and sanctions. If we add to this the bureaucratic infighting endemic within and between agencies, it is hardly surprising that no one has come to total agreement on the subject. Without consensus on policy, however, and without the dollars to back up the policy, major conflicts break out among the personnel actually charged with prisoner management, and the disparity between service levels at different institutions grows.

2 Standards for the Care of Mentally Disordered Inmates

Although it lagged behind the health and social welfare field, the correctional field has been professionalizing its practices and developing a comprehensive set of standards for the administration of service delivery. The American Correctional Association, through its affiliate, the Commission on Accreditation for Corrections, took the lead, but the U.S. Department of Justice, the American Bar Association, and a number of professional associations in the clinical areas have since formulated standards for care and treatment of inmates, many of which are similar to those of the Commission on Accreditation for Corrections.

Although some decision-makers in the correctional field thought they could not possibly comply with what they were sure would be impossible or impracticable requirements, many have come to realize that they can, that in fact such standards help them to run the prison in a less stressful — and hence less explosive — fashion. Litigants and reformers also turn to the standards to persuade governmental decision-makers to institute appropriate levels of care and service delivery. Moreover, federal guidelines for reimbursement in the health and social welfare field are often tied to accreditation standards, a factor which can persuade the fiscally conservative, particularly when they face malpractice or civil rights suits. Finally, the adoption of professional standards for

service delivery raises the prestige of those in the correctional field, for it associates them with other professionals who operate according to established standards.

3 Budgetary Problems

Correctional administrators often assume that their agencies have to humbly creep in to sweep up those few tax dollars left over after all the more popular agencies have been granted their appropriations. They see themselves as being the least popular even on the criminal justice continuum. Yet their clientele is more complex than that of many education, health, and social welfare agencies, each of which enjoys more social acceptance and governmental budgetary support. Many people think that correctional administrators inherit those who have failed to benefit from all the public and private social welfare programs and whose behavior is so anti-social or horrendous that they have alienated the clinicians and support network in the social welfare field. This produces a very unclear mission for correctional administrators, which makes it difficult to choose appropriate management methods, for the question remains whether prisoners, irrespective of their needs, *deserve* parity of care with their noncriminal counterparts.

In the last ten years correctional agencies have competed much more aggressively for their share of the tax dollar. Exposes of inhumane care, national media coverage of prison disturbances (and the inmate grievances which led to those riots), and actions by the federal judiciary have made the public expect a higher level of service from correctional institutions. Accreditating organizations have been increasingly successful in persuading correctional administrators to seek accreditation status as word gets around within the field that accreditation pays off in the end. New training programs for prison management staff have helped them to better understand and deal with the prison population, while at the same time the programs make it easier for correctional administrators to convince executive and legislative budgeting bodies of their needs. Interagency agreements have shaped more creative budget packages, capturing federal funds through entitlement programs, some of which require accreditation-level service delivery; improved management of correctional agencies which has also stretched the budget dollar. Indeed, it often seems that high-quality care comes as a by-product of changed managerial perspectives and improved correctional administration.

THE OBLIGATION TO PROVIDE ACCESS TO PROFESSIONAL CARE AND TREATMENT

1 Prisoner Entitlement to Professional Services

The lack of consensus about whether the mentally disordered inmate should get professional care and treatment derives in part from the old debate between punishment versus treatment of the criminal. It also stems from the relatively high cost of such service, especially for those whom society wants both out of sight and out of mind. Finally, there is the difficulty of supply. Prisons rarely abut centers of health and education, and their work environment attracts far fewer qualified applicants than do jobs on the outside.

But while the public and professional sentiment does not support "country clubs" for inmates, neither does it tolerate a cruel and inhumane level of treatment. Well-publicized instances of very substandard custodial care and malfeasance produced a public demand that the conditions of confinement for prisoners should not be inhumane and should comply with the professional practices found in the outside community. The public does sympathize more readily with issues of malpractice and appropriate care for the acutely ill than it does with the less clear areas of crime and appropriate punishment, but the courts are much more decisively meting out damages and requiring administrative action when the care and treatment of prisoners who are ill or handicapped falls below community standards of decency.

2 The Mentally Disordered Inmate Disrupts Good Order and Discipline

As does any community, the prison community prefers to operate without disorder. In maximum security prisons especially, both inmates and staff are very sensitive to deviance, to who you are and what you're doing. "Odd" people upset the equilibrium. The prison environment, fostering a survival-of-the-fittest ethos where predators prey on the weak, exacerbates an inmate's predisposition to mental disorder to the point where the inmate acts out. This often produces a violent reaction among the other inmates or even with the staff, which sets in motion an ever-escalating vicious cycle. How the staff handle individual instances of emotional illness can have serious consequences for the staff and for the institution as a whole.

3 Reconciling the "Different Care for Different Folks" Dilemma

Although the correctional field has for some time supported the *principle* of classification and differentiation between inmates with different needs, its willingness or ability to put these principles into *practice* has been compromised by inertia and a belief in uniformity of rules and sanctions. Most prison administrators fear the political consequences of an escape or riot more than their failure to provide professional services. Moreover, the increased demand for services is occurring at the same time the prisons suffer from overcrowding. Not only does this complicate decision-making — where should the prison dollar go — but it also tends to widen the gap between service delivery at different institutions.

If prison officials differentiate among prisoners and then set up a schedule of programs in order of priority for funding, they can make best use of their limited funds. While it seems as though it would be easier to have one set of rules and sanctions for all inmates, inflexibility limits significantly a prison's ability to function under stress. How adaptable a prison is, how creatively it manages it resources, depends largely upon whether the correctional administrator appreciates that a portion of the population has special needs — ones at variance with those of the other prisoners — which require skillful management. If administrators spend enough money to care for the mentally

disordered prisoner properly, they will retain better control of the facility as a whole and they will keep overall expenditures down. The hostility which such service differential arouses in staff and other inmates can be overcome by continuous reassessment of prison needs, by program planning, and by clearly informing staff and inmates about program changes.

GUIDELINES FOR ADMINISTERING PROGRAMS FOR THE MENTALLY DISORDERED PRISONER

1 Responsibility for Identification and Treatment

Responsibility for the care and treatment of mentally disordered prisoners varies from state to state, many of which have separate and distinct constitutional and statutory authority for this job. In some states separate agencies exist; in others they are confederated, often with corrections, under a health, education, and welfare umbrella agency. The legal assignment of responsibility to one agency rather than another does not appear to act as the major obstacle to the provision of professional services; the trouble results, rather, from bureaucratic infighting.

In order to obtain sufficient funding and to maintain continuity of service, administrators in each interested agency must *together* formulate clear and complete policies and administrative guidelines so that the services meet professional standards and so that the program will actually work in prisons. The administrators must seriously try to mesh the new programs with existing correctional policies and guidelines. Where the new programs conflict with existing rules and procedures, all parties must strive to make reasonable accommodations and to explain these changes to all the interested administrators and staff. No program will work unless everyone cooperates, which they are much more likely to do if they have been seriously consulted during formulation of the programs. Once policies and guidelines have been agreed upon, the head of the correctional agency should formally issue them. Correctional administrators will truly serve their own best interests if they attract and retain qualified providers of service irrespective of bureaucratic barriers. And if problems do develop when implementing the programs, administrators should take speedy corrective action.

2 Placement of Mentally Disordered Inmates

Just as civilian communities can vary considerably in their tolerance of deviant behavior, so do correctional facilities. How separate and structured the care and treatment of the mentally disordered inmate must be depends upon the individual institution. In a maximum security prison, with its high level of aggressive interaction among the inmates and between the inmates and staff, the mentally disordered inmate must be removed from the general population for his own protection and if he is a danger to others. Irrespective of whether he is "mad" or "bad," officials must separate that inmate and manage his life in a particularized manner according to a specific plan.

When the inmate's ability to interact positively in a social situation is so impaired that he endangers himself or others, the more client-centered principles of the mental health field help achieve the correctional goal of keeping prisoners confined in conditions of good order and safety. Both correctional and mental health systems are subject to due process constraints centering around the disenfranchisement of an inmate or patient and the need to justify any loss of parity of privilege with other inmates. Most mental health workers understand the stigma attached to those characterized as mentally disordered; they try, therefore, to orient treatment towards "mainstreaming" the patients — sending them back into the general population — as soon as practical. This means that aftercare focuses on helping the client to function in a socially acceptable fashion in the larger community. Because of this, clinical staff in prisons tend to avoid separating the inmate from the general prison population, unless it is absolutely necessary, and they try to return him to normal activities as soon as possible.

Although the courts have upheld the correctional administrator's right to transfer an inmate from one facility or program to another without cause, administrators clearly cannot place an inmate in a "mental hospital" without cause. Further, the courts have established that how long a patient stays in a mental hospital depends upon his *need* for treatment and upon the *availability* of treatment.

While the courts have been clear on the issue of committing an inmate to a mental hospital for treatment and although the inmate has a legal right to treatment, the courts have not established *what treatment* is appropriate. The correctional administrator and clinician have, therefore, much more discretion about whether to provide treatment and habilitation services. As a result, programs for outpatient and intermediate care tend to lag behind other programs and depend almost entirely for their existence upon managerial initiative.

Our survey clearly demonstrated that most states have established formal programs for treatment of the acutely ill offender and have been developing units with specially trained staff for those prisoners prone to victimization. "Intermediate care" or "special needs" units now serve as a buffer between the inpatient or hospital environment and the general confinement situation. These units appear to satisfy client needs and institutional needs for additional care and supervision without crossing the socio-legal demarcation of transfer to the "mental hospital." A combination of these intermediate units and small inpatient sections in prison hospitals seems to satisfy legal requirements for emergency care and stabilization of the patient without the additional burden of the civil commitment procedures through the courts.

Some states have solved the problem by setting aside one or more facilities to function in a more therapeutic fashion. Such an arrangement permits correctional departments to gather sufficient clinical and operations specialists in one place and meet the demands of a population which would cause trouble in a more traditional prison environment. One seasoned correctional administrator noted, "If Charlie jumps on a table in Vacaville, everyone says he's had a bad day. If Charlie jumps on a table in the mess hall at Folsom, they drop the gas."

3 Legal and Professional Rules Applying to Mentally Disordered Inmates

The fundamental rule is that inmates have a right to treatment; in addition, the professional

and legal guidelines which exist for the civilian community apply to prisoners as well. Qualified personnel in an appropriate setting following professional practices and protocols must provide treatment in a timely fashion for acutely ill inmates. It is, therefore, in the administrator's best interest to ensure that inmates have access to professional services if they are available within the department or in the community. To withhold or to deny access to available treatment would violate an inmate's constitutional rights.

The inmate has the right to be informed of any treatment he will receive and to give his consent. The person providing treatment must disclose to the inmate whether a particular procedure or treatment represents a risk, and the prisoner may not participate in any experimental procedures. Before an inmate can be treated without his consent, the courts must grant the administrator sanction.

Confidentiality is a difficult principle to practice in a correctional environment. Statutes pertaining to the care and treatment of the mentally ill often require anonymity for the client. In a secure correctional environment, which has a particular interest in knowing where an inmate is physically, it is difficult to keep his access to clinical services confidential. Moreover classification and case management personnel often want clinical information when they must make decisions which could relate to the inmate's likelihood to escape or otherwise put the outside community at risk.

Clinicians experienced in providing treatment at prisons have found a reasonable middle ground. The substance of the inmate's disclosures to clinical staff are not related to others without his expressed consent, and the clinical records are kept separate from the case management records system. The clinician discloses a confidence only when the inmate presents a clear danger to others. Whether the inmate experiences difficulty interacting with the general inmate population or with staff other than clinicians usually depends on how professionally the staff of both the clinical and the general program behave. If the staff treat inmates and inmate-patients with respect, then confidentiality produces few problems.

The "least restrictive environment" principle applies to the mentally disordered inmate. The further removed an inmate is from the general entitlements of general confinement, the more correctional administrators should be prepared to justify and document the reasons for their actions. Although the courts have allowed administrators broad latitude regarding the placement of inmates in particular programs or facilities, officials cannot segregate an inmate, place him in isolation, or subject him to physical or chemical restraints without cause. Only a qualified clinician may approve isolation and physical or chemical restraints, and they must never be used for punishment. It is, moreover, improper for the clinician to leave global standing orders; the clinician must instead evaluate each case regularly and keep informed as to the efficacy of the procedure.

Force cannot be used for punishment, may not be excessive, and must only be sufficient to achieve limited objectives. The better trained the staff, particularly in interpersonal communication, the less probable their need to use force. Teamwork among well-trained staff can minimize the risk of injury both to the patient and to staff. It is very undesirable to use weapons, including teargas, against mentally disordered inmates unless they pose imminent danger to others. Clinicians must maintain complete records, and all involved parties must file full reports when they have used isolation or physical or chemical restraints. The courts also require that chiefs of service and correctional administrators review such cases to ensure that the institution has adhered to established policies and procedures.

Maintaining discipline among mentally disordered inmates can present problems if staff lose sight of what they are trying to do. Moreover, the rules and sanctions which induce compliance with normal people have little usefulness with the acutely disordered inmate. In particular, staff should not administer sanctions which affect "good time" or isolate the mentally disturbed inmate from other inmates pro forma, but should use such techniques wisely and with restraint. The better the coordination between the disciplinarian, the hearing officer, and the inmate management staff, the more successful the administration of discipline will be. The case manager must advocate a realistic and workable plan which gives proper consideration both to the mentally disordered individual's needs and to the safety, security, and good order of the institution as a whole.

4 Setting Up a Program for the Mentally Disordered Inmate

To achieve the successful implementation of sophisticated programming, executives must take the lead in formulating clear policies and administrative procedures. Everyone — staff, managers, and inmates — watch to see what those in charge of the correctional agency do. If they perceive that the agency head really wants a program to work, they will try much harder to make it succeed. If they perceive that the program has neither the confidence nor the wholehearted support of the agency head, then those with other solutions will seek to follow their own designs, by-passing or subverting a program apparently in place.

From the beginning, when planning programs and how they will actually work, everyone who will be directly or indirectly affected — facility administrators, middle-managers and supervisors, and line-staff — must participate. Everyone perceived as having a major concern with special programming, whether these concerns are legitimate or not, should be consulted and their concerns addressed. The more problems that administrators anticipate, identify, and find ways to overcome at the planning stage, the less difficulty they should have with implementation.

Properly written operations manuals are invaluable for the administration of highly specialized and professional programs. They clearly state a program's mission, goals, objectives, and professional protocols; in addition, they say who is to do what, when, how, and why. They should cite legal requirements, detailing what must be done and what may not be done, so that staff and management know precisely what their obligations are. Manuals must explain how one program in a prison fits together with all the others at that particular facility and in the department as a whole, thereby lessening the possibility of conflict and mismanagement of the clientele.

Always staff programs with qualified people whose credentials signal that they are properly trained for the job. Any savings that an institution realizes by using subprofessional or paraprofessional workers will be offset by higher management costs attributable to negligence, inmate-staff conflicts, and political problems with employees and advocacy groups. When a prison has difficulty attracting adequate personnel, administrators should go directly to the appropriate professional associations to get help in the recruitment process.

Once a department or facility initiates a program, it should provide staff directly involved with the program with formal in-service training, and they should make sure to inform the entire department and other correctional facilities about the program. Duty descrip-

tions for facility administrators, middle-managers and supervisors, and line-staff who are directly and indirectly involved in the program should be modified to clearly state what each must do with regard to the new program. Design dispute resolution mechanisms, if they don't already exist, so that problems can be settled quickly. This both removes impediments to successful implementation of a program and fosters participatory management principles. Operations manuals and in-service training should be updated continuously as everyone agrees on ways to resolve policy and administrative problems.

Departmental planners and facility administrators must pay close attention to how a program will affect the institutional environment. The more they know about the social systems which exist in the respective institutions, the more sophisticated their strategies for program implementation can be. To impose a major program change which deviates from normal policies and rules for order and discipline without careful planning and consultation almost guarantees immediate opposition and major morale problems. Planners must work actively to win staff and inmate acceptance of new programs if they wish to minimize conflict and risks. Because the prison environment is volatile, its management must be dynamic.

Department and facility managers must consciously develop a system for monitoring and evaluating the utility of these programs, which by their nature cost a good deal, have high levels of managerial risk, and require dynamic management. Advocacy groups, employee organizations, oversight bodies, and the media examine them closely and hold those in charge responsible for any slips or inadequacies. Defusing conflicts and getting the bugs out of operations should guarantee that the program works and should satisfy accountability rquirements.

COSTS AND BENEFITS OF PROVIDING PROFESSIONAL SERVICE DELIVERY

In the last two decades the public has put considerable pressure on the government to provide better treatment for sick, handicapped, or mentally disordered prisoners. As a result, administrative and court-directed initiatives have begun to forge policies and administrative guidelines for the care and treatment of such prisoners. Legally and ethically, correctional administrators must now provide these inmates with access to professional services on a level consistent with similar services in the community at large. A prisoner has no less entitlement to professional services due to his status than a non-prisoner. Professional and governmental standard-setting organizations have promulgated specific guidelines for the administration of these programs, and many of these standards are being incorporated into law. Our data clearly shows that professional service delivery has gained momentum nationally and has been gaining support from governmental decision makers.

Our site visits to a nationwide cross-section of correctional facilities where programs exist for the mentally disordered reveal that the morale of the inmates and staff appears to be high and quite supportive of the special programming. Administrators, staff, and inmates all say they function under less stress, there are fewer fights, and all appear generally optimistic that the programs are achieving their goals. An esprit de corps animates management and staff, who feel they are accomplishing something significant. Although both clinical and security staff acknowledge they had difficulties integrating what are often opposing philosophies and operational guidelines, they now express considerable satisfaction that the resolution of these problems improved life in the prison as a whole.

We found the budgetary impact to be minimal on a departmental level, for the departments and respective institutions found that the additional costs for clinical staff and services were offset by lower overall security costs. Facility managers could deploy classification, case management, and security staff more strategically, and could save money by improved management of staff resources for inmates requiring special care. Using operations manuals and improving in-service staff training helped all the staff, the inmates, and those directly involved in special programs. While we could not obtain actual figures for this, the prison management perceived a great saving of time — and hence money — since they had to respond to far fewer complaints from staff, inmates, advocacy groups, and the media. Indeed, they believed such programs had actually won them positive support for better institutional management and service delivery to the mentally disordered inmate.

The early experience with attempting to implement the community mental health model in the correctional community was as problematic as it was in the outside community. Nevertheless the correctional, mental health, mental retardation/developmental disabilities disciplines have found significant ways to collaborate and integrate service delivery. A growing part of the correctional community now appreciates the benefits of using more skillful assessment and management techniques with inmates who have special needs. Whether timely care, treatment, and habilitation within the prison setting will prove to be beneficial only for intra-mural purposes or whether it will have long-term benefits for the clientele and the outside community is difficult to ascertain at this time. There seems no question, however, that such programs make prisons run more smoothly.

PART 2

MENTALLY ILL AND MENTALLY RETARDED OFFENDERS IN CORRECTIONS

MENTALLY ILL AND MENTALLY RETARDED OFFENDERS IN CORRECTIONS:

A REPORT OF A NATIONAL SURVEY

by BRIAN McCARTHY

What is the nature and extent of the current corrections response to mentally ill and mentally retarded offenders? How many inmates of state and federal prisons are currently classified as either mentally ill or mentally retarded or both? How were these inmates identified and evaluated? What methods and resources are available to manage and treat them? The New York State Department of Correctional Services has recently completed a survey which addresses these questions. This chapter will describe that survey and its principal findings and discuss some implications of those findings. We ascertained one overall problem right away. Most correctional systems do not have sufficient information available at the system level to make intelligent and informed planning possible. It therefore behooves all corrections systems to elicit the necessary data from the individual prison level.

INTRODUCTION

The survey was conducted as one part of the larger research project which resulted in the production of this sourcebook. The survey was designed to generate data describing the nature and extent of the current corrections response to mentally ill and mentally retarded offenders and, in so doing, to provide a context within which relevant legal, clinical, and administrative issues could be profitably discussed.

Conducted in 1983, the survey was designed and administered by Ms. Lynette Feder of the New York State Department of Correctional Services research and planning staff in consultation with staff of the National Institute of Corrections. Brian McCarthy, who is also a member of the New York State Department of Correctional Services research and planning staff, analyzed the survey data and was the principal author of this report.

This survey differs from previously reported surveys in three important respects: (1) previous surveys focused on *specific facilities;* we examined state and federal *systems;* (2) earlier surveys considered both sentenced and nonsentenced offenders, while our principal concern was with those offenders who had been convicted of a crime and sentenced to state or federal prisons; and, (3) while previous studies focused exclusively on either mentally ill or, in one case, mentally retarded offenders, we collected data on both mentally ill and mentally retarded offenders committed to correctional custody. (For a more detailed description of the methods employed in earlier reported research, please refer to the appendix to this chapter.)

The corrections survey instrument was a written protocol consisting of 31 questions. It was mailed to the central administrative offices of the department of corrections in each of the fifty states. In addition, the Federal Bureau of Prisons and the Washington, D.C. Department of Corrections were also surveyed. At the same time a similar survey protocol was sent to the forensic mental health director in each state. Numerous follow-up telephone calls were made to insure a high response rate, to clarify ambiguous responses and to obtain data missing from the questionnaires as they were initially returned to project staff. All but two surveyed corrections departments returned completed questionnaires. Only 30 of 51 surveyed forensic mental health directors responded to the survey.

The corrections questionnaire asked each respondent to report the number of inmates currently under corrections custody who were classified as mentally ill or mentally retarded or both. Respondents were also asked to identify all programs either within corrections or within any other agency in that jurisdiction whose *major* function is to manage or treat mentally ill or mentally retarded offenders and also all programs managing or treating such offenders but only as *part* of larger programs whose client population includes individuals who are not classified as mentally ill or mentally retarded offenders. The corrections questionnaire then asked specific questions about the patient, facility, treatment, and staffing characteristics of these programs. In addition, the questionnaire also investigated in some detail other ways in which corrections may respond to some mentally ill or retarded offenders (e.g., through the use of protective custody). In this way corrections respondents were given the opportunity to describe the current nature and extent of their system's response to mentally ill or retarded offenders even if their system does not now have specific facilities, units, or programs designated to deal with these inmates.

Before summarizing the principal findings of the survey we must make several important points. First, corrections respondents were asked to specify the number of inmates under custody who were identified as mentally ill or mentally retarded or both as of 31 May 1983. NIC and project staff believed this was an appropriate approach, given the principal purpose of the survey. The data thus generated *cannot*, however, be interpreted as direct measures of the incidence of mental illness or mental retardation in prison populations, just as the rate of incarceration cannot be interpreted as a direct measure of the incidence of crime in the society at large. Rather, these data directly measure one aspect of correction's response to mental illness and mental retardation among prisoners (i.e., the extent to which individual systems have chosen to officially identify individual prisoners as mentally ill or retarded). Second, no operational definitions of mental illness or retardation were provided to survey respondents. Instead, respondents were asked to describe those procedures and criteria by which inmates are screened and evaluated with respect to mental illness. Once again, this was an approach which was consistent with the principal purpose of the survey. This approach does require, however, the readers exercise caution when making comparisons among jurisdictions. Finally, the reader must remember that the questionnaire asked responding departments to specify the extent to which procedures were in place to identify and evaluate inmates for possible mental illness or retardation and the programmatic resources available to manage and treat those inmates found to be mentally ill or retarded. The survey *did not* generate data which would make it possible to *assess the quality* of the individual procedures and programs described by respondents. While adequate clinical supervision and careful programmatic evaluation are critical in insuring that high quality services are provided, this survey did not attempt to systematically explore these issues. With these points in mind, the principal findings of the survey will be reviewed.

HOW MANY INMATES ARE CURRENTLY CLASSIFIED AS MENTALLY ILL AND/OR MENTALLY RETARDED?

Before examining the numbers of inmates classified either as mentally ill or mentally retarded or both, we must emphasize the exact nature of the questions we asked and the limitations of the data elicited.

Our survey sought to describe the nature and extent of the current corrections' response to mentally disordered inmates. Consistent with this, we imposed no operational definitions on the terms "mentally ill" or "mentally retarded" in the survey instrument itself or in the accompanying instructions. The National Institute of Corrections wanted us to afford each corrections department the opportunity to include all those inmates it had classified as mentally ill or retarded by whatever procedures and criteria it normally used. Moreover, no definition of mental illness or mental retardation is cut in stone.

As a consequence, corrections administrators and forensic services personnel exercise substantial discretion both in determining the general criteria for official classification and in applying those criteria to specific inmates. The numbers reported represent the cumulative results of these general and specific decisions by individual departments. They therefore *directly* measure only one type of correction's response to mentally disordered prisoners — the extent to which corrections departments have decided to officially *label* inmates as mentally ill or retarded. This is an appropriate measure, however, given the principal purpose of this survey. The reader must nevertheless recognize that we cannot interpret these numbers as *actual* counts or estimates of the total number of mentally disordered inmates.

The numbers do *not* establish the prevalence of either mental illness or mental retardation in corrections because factors other than mental disorder may in some jurisdictions and under certain circumstances intervene to prevent an inmate from being officially classified as mentally disordered. Determining the prevalence of mental illness and retardation among corrections inmates (an important research task currently being pursued by other investigators) was clearly beyond the scope of this survey.

Summary

Responding departments classified as either mentally ill or mentally retarded or both approximately 33,800 inmates currently under custody. Of this total, approximately 24,000 (or 6.0 percent of the total inmate population) are classified as mentally ill. A smaller number (approximately 9,800, or 2.5 percent of all inmates) are classified as mentally retarded. (Note that a 1967 study by the National Institutes of Mental Health suggested that 9 percent of the offender population was retarded, based on IQ scores of 69 or below on a standardized test being the generally acceptable measure for identifying mental retardation.) Only 250 are officially classified as both mentally ill and mentally retarded.

Departments varied enormously in both the number and the percentage of inmates classified as mentally ill or retarded. The number classified as mentally ill ranged from 1 in 1 department to 3,743 in another. Similarly, 9 departments reported no mentally retarded inmates under custody, while 2 others reported 1,817 and 1,940 respectively.

When we examined the percentage of mentally disordered inmates in the total corrections population, we once again observed substantial variation among departments. The modal category of those classified as mentally ill included 15 departments which so classified between 2.5 and 4.99 percent of all inmates under custody. The large majority of responding departments (38 of 48, or 79.2 percent) classified between 1 and 7.5 percent of their total inmate populations as mentally ill. Nevertheless, 4

departments reported less than 1 percent as mentally ill, while 5 others reported more than 10 percent so classified.

The modal category for those classified as mentally retarded was "less than 1 percent," which included 17 departments. Nine other departments reported no inmates classified as mentally retarded. Thus the majority of responding departments (26 of 44, or 59.1 percent) reported less than 1 percent of their total inmate population as mentally retarded. At the other extreme, 1 department reported more than 19 percent of its total inmate population as mentally retarded.

Although the large majority of inmates classified as mentally ill are concentrated in a few departments, most departments do classify a small but significant proportion of their total inmate population as mentally ill. We must also note, moreover, that mentally ill inmates present management problems and service needs disproportionately greater than their numbers.

Those inmates classified as mentally retarded are even more concentrated in a few departments. Each of 3 departments classified more than 1,000 inmates as mentally retarded, more than 50 percent of the total number of inmates so classified by *all* responding departments. The majority classified less than 1 percent of their total population as mentally retarded, and 9 reported no such inmates under custody as of 15 May 1983. Survey responses thus clearly indicate that corrections departments identify mental retardation neither as widely nor as frequently as mental illness.

Such extreme variation raises questions about what factors may be affecting the levels of mental illness and retardation identified in individual departments. Why do some corrections departments classify a much smaller percentage of inmates as mentally disordered? Is it because they have a smaller proportion of mentally disordered inmates in their populations (a lower prevalence rate of mental disorder)? Is it because they choose for some reason not to classify as mentally disordered inmates who in other departments would be so classified (a lower classification rate)? Is it a combination of both of these? Indeed, each type of variation is itself a complex phenomenon. For example, the prevalence of mental disorder in prison populations is a function of at least three factors: the prevalence of mental disorder in the society at large; the extent to which mentally disordered individuals are diverted to institutions other than corrections; and the extent to which conditions of confinement precipitate mental illness among inmates who were not mentally ill at the time of commitment.

The rate at which a department classifies inmates mentally disordered, on the other hand, is a function not only of the prevalence of mental disorder in the inmate population but also of the department's policy with respect to the mentally disordered inmate and the ways in which that policy is reflected in procedures, the implementation of procedures, and the allocation of resources.

Two examples drawn from our survey data illustrate ways in which the prevalence rate and the classification rate vary among departments of corrections:

Variations in the prevalence rate

One department classified more than 17 percent of its total inmate population as mentally retarded, while 9 others reported no mentally retarded inmates currently under custody. When we examined the procedures by which all incoming inmates are screened and evaluated for mental retardation, we found that the department reporting the highest percentage of mentally retarded inmates and one of the departments reporting no mentally retarded inmates used the same procedures (group-administered Beta II and WRAT tests followed by an individually administered WAIS-R for those scoring below 70 on the group-administered tests). In follow-up discussions with personnel from each department we discovered that the jurisdiction with the highest percentage of retarded inmates made no systematic attempt to divert mentally retarded criminal defendants or offenders to institutions other than those administered by the department of corrections unless the issue of competence to stand trial was raised. Conversely, officials of the other department reported that every effort is made to find non-corrections placement for all mentally retarded individuals who come to the attention of the criminal justice system and, furthermore, that most of these attempted diversions are successful. As a consequence few mentally retarded persons are ever committed to correctional custody. The aggressive use of alternative placements has thus dramatically decreased the rate at which retardation is prevalent in this second corrections department.

Variation in the classification rate

One department reported that it does not directly provide any mental health services beyond crisis intervention (although visiting mental health department staff provide some very limited services on an outpatient basis to inmates in the general population). This department further reported that it classifies as mentally ill only those inmates who were transferred to a small inpatient forensic services unit also administered and staffed by employees of the department of mental health. The inmates who were so classified and transferred comprised less than 1 percent of the total inmate population. A second department also reported that department of mental health employees provided mental health services and that a very limited number of inpatient forensic services beds were available. This second department, however, offered a much broader array of mental health services on an outpatient basis to inmates in the general prison population. Furthermore, all inmates receiving mental health services of any kind were classified as mentally ill, whether those services were provided on an inpatient or outpatient basis. A total of 3,743 inmates were classified as mentally ill and were receiving some mental health services in this second department. This number represents 12.5 percent of the department's total inmate population. There may be differences in the prevalence rate of mental illness between these two departments, but it is also clear that different procedures for classifying inmates as mentally ill and different policies regarding the allocation of resources to mental health services importantly affect the rate at which inmates in each department are classified as mentally ill.

The relationship between a department's policies and procedures vis-a-vis mentally disordered offenders and the rate at which that department classifies inmates as mentally disordered is very complex, but clearly differences in both prevalence and classification rates contribute to the extreme variation observed among jurisdictions with respect to the numbers and percentages of inmates classified as mentally ill or retarded.

Description of Findings

The questionnaire asked departments of corrections to report the number of inmates under corrections custody as of 15 May 1983 who were:

- classified solely as mentally ill,
- classified solely as mentally retarded, and
- classified as both mentally ill and mentally retarded.

Fifty departments with a combined total inmate population of approximately 414,000 returned completed questionnaires, while 2 departments with a combined total population of approximately 5,200 inmates did not respond to the survey. Of the responding departments, 48 (with a combined total population of approximately 400,000 inmates) counted or estimated the number of inmates classified as mentally ill at 24,000, or 6.0 percent of the total inmate population. Forty-four departments (with a combined total of approximately 390,000 inmates under custody) counted or estimated the number of inmates classified as mentally retarded at 9,800 inmates, or 2.5 percent of the total inmate population. Finally, only 13 departments counted or estimated the number of inmates classified as both mentally ill and mentally retarded, a group which numbered only about 250.

1. Inmates classified as mentally ill.

Departments vary substantially in the extent to which they classify inmates as mentally ill. Table 1 presents a grouped frequency distribution of the number of inmates so classified.

Table 1 reveals that while the median number of inmates classified as mentally ill is 149 per corrections department, the range is very broad, extending from one department which classified only 1 inmate as mentally ill to another department which reported 3,743 inmates so classified. Most departments have relatively few inmates classified as mentally ill, and the majority of mentally ill inmates are under custody in a small minority of departments. Nineteen departments each reported fewer than 100 inmates classified as mentally ill currently under custody. Fourteen others each reported between 100 and 500 inmates in this classification. The total number of inmates classified as mentally ill in these 33 departments is 3,920. Thus, approximately two-thirds of the responding departments house only about 17 percent of the total number of inmates classified as mentally ill.

Conversely, 9 departments each reported that they currently had under custody more than 1,000 inmates (for a total of 15,823) who are classified as mentally ill. Therefore, two-thirds of the total number of inmates classified as mentally ill were under custody in only 20 percent of the responding departments.

A somewhat different picture emerges when we consider the number of inmates classified as mentally ill in each department as a percentage of the total number of inmates under custody in that department. Table 2 presents a grouped frequency distribution of these percentages.

Table 1
Number of Inmates Classified as Mentally Ill

Mentally Ill Inmates Per Corrections Department	Number of Corrections Departments	Total Classified Mentally Ill N	%
More than 1,500	4	9,653	40.1
1,000-1,500	5	6,170	25.7
500- 999	6	4,309	17.9
100- 499	14	3,065	12.7
Less than 100	19	855	3.6
Unknown	2		
No Response	2		
Totals	52	24,052	
Median	149		
Range	1-3743		

Table 2
Percentage of Total Inmate Population Classified as Mentally Ill

Percentage of Total Inmate Population Classified Mentally Ill	Number of Corrections Departments
More than 10	5
7.5 — 10	3
5.0 — 7.49	13
2.5 — 4.99	15
1.0 — 2.49	10
Less than 1	2
Unknown	2
No response	2
Total	52
Median	3.9
Range	0.1 — 22.0

As Table 2 demonstrates, the range is once again very substantial (from 0.1 to 22 percent), while the median, at 3.9 percent, is far below the highest percentage reported. We would expect to find this in a distribution which includes a few very large scores.

The most populous category is that which includes the median; 15 departments classify between 2.5 and 4.99 percent of their total inmate population as mentally ill. In addition, the two immediately adjacent categories (1.0 to 2.49 percent and 5.0 to 7.49 percent) are the next most populous categories, containing 13 and 10 departments respectively. Thus approximately 80 percent of those 48 departments which counted or estimated this group classified between 1.0 and 7.49 percent of their total inmate population as mentally ill. At the extremes only 2 departments classified less than 1 percent of their total population as mentally ill, while 8 departments classified more than 7.49 percent as mentally ill. Therefore, although a large proportion of those inmates classified as mentally ill are concentrated in a few departments, it is also true that the majority of departments classify more than 2.5 percent of their total inmate population as mentally ill.

2. Inmates classified as mentally retarded.

The number of inmates classified as mentally retarded is substantially smaller than the number classified as mentally ill. While more than 24,000 mentally ill inmates were reported, state and federal corrections departments classified only about 9,800 inmates as mentally retarded. This represents approximately 2.5 percent of the total inmate population. Table 3 displays a grouped frequency distribution of the number of inmates classified as mentally retarded.

Table 3
Number of Inmates Classified as Mentally Retarded

Mentally Retarded Inmates per Corrections Department	Number of Corrections Departments	Total Number Classified Mentally Retarded	
		N	%
More than 1,500	2	3,757	38.3
1,000 — 1,500	1	1,379	14.1
500 — 999	3	2,019	20.6
100 — 499	9	2,106	21.5
Less than 100	20	541	5.5
0	9	0	0.0
Unknown	6		
No response	2		
Totals	52	9,802	
Median	30		
Range	0-1,940		

Forty-four of the fifty responding corrections departments counted or estimated the number of inmates classified as mentally retarded. Nine classified no inmates currently under custody as mentally retarded. Twenty others each reported fewer than 100 inmates so classified. The total number of mentally retarded inmates reported by these departments was 541. Thus two-thirds of the reporting departments accounted for only about 5.5 percent of the total number of inmates classified as mentally retarded.

Conversely, 3 departments each reported more than 1,000 mentally retarded inmates; taken together these 3 departments account for more than half of all such inmates reported nationwide. Indeed, when combined with the 2,019 mentally retarded inmates reported by those 3 departments which each reported custody of between 500 and 999 such inmates, nearly 75 percent of all mentally retarded inmates were reported by only 6 departments. Mentally retarded prisoners thus tend to be even more concentrated in a few departments than was the case with inmates classified as mentally ill.

Table 4 presents the percentage of the total inmate population whom corrections classified as mentally retarded as of 15 May 1983.

Table 4
Percentage of the Total Inmate Population Classified as Mentally Retarded

Percentage of the Total Inmate Population Classified Mentally Retarded	Number of Corrections Departments
More than 10	1
7.5 — 10	2
5.0 — 7.49	6
2.5 — 4.99	3
1.0 — 2.49	6
Less than 1.0	17
0	9
Unknown	6
No Response	2
Total	52
Median	0.5
Range	0.0 — 19.1

As we can see from Table 4, nearly 60 percent of all reporting departments (26 of 44) classify as mentally retarded less than 1 percent of their total inmate populations. At the other extreme, 3 departments classify as mentally retarded 7.5 percent or more of the inmates under their custody. Thus the majority of corrections departments report that they classify few inmates as mentally retarded and that those few so classified represent a small percentage of the total inmates under custody.

HOW DO CORRECTIONS DEPARTMENTS IDENTIFY AND EVALUATE MENTALLY ILL AND MENTALLY RETARDED INMATES?

Most inmates are committed to corrections because they are convicted criminals, not because they are mentally ill or retarded. When they are initially received by corrections, some are retarded and/or mentally ill. Others who are neither retarded nor mentally ill at the time of commitment have previous histories of mental illness and even institutionalization (though these histories may not always be adequately represented in documents accompanying the inmates when they first arrive). Finally, some inmates with no previous history of mental illness may nevertheless become mentally ill during their incarceration. It is the task of corrections personnel to identify and evaluate most of the inmates in each of these categories. It is therefore critical that corrections departments have in place procedures and resources adequate to effectively accomplish this task.

Before describing the identification and evaluation procedures currently employed by corrections, however, we will first consider another group of individuals charged with or convicted of crime who have been found mentally ill or retarded by the courts *prior to* commitment and whose commitment is conditioned by that finding. This group is composed of four legally distinct categories:

1. **The Incompetent —** those individuals whose trial is postponed or interrupted because either: (a) their competence to stand trial has been questioned and must therefore be evaluated; or (b) they have been found incompetent to stand trial;
2. **The Insane —** those individuals who, though competent to stand trial, have nonetheless been found not guilty by reason of insanity.
3. **The Guilty but Mentally Ill —** those individuals who, though competent to stand trial and found guilty when tried, have also been found by the court to have been mentally ill but not legally insane at the time they committed the offense(s); and finally
4. **The "Abnormal Offender" —** those individuals who have been committed under special statutes (e.g., as "sexually dangerous persons" or "mentally disordered sex offenders").

While the majority of mentally disordered inmates do not fall into any of these four categories, some jurisdictions may under certain circumstances commit individuals in each category to prison. In addition, these four categories of individuals have been the focus of most previous research on mentally disordered offenders. Moreover, the category of commitment may have important consequences for the appropriate management and treatment of the individual. The questionnaire therefore asked how many individuals currently in prison fit these four categories.

Summary

Most state and federal departments of corrections report that they *never* have custody of persons whose criminal prosecution has resulted in adjudicated mental disorder (i.e., those individuals found incompetent, insane, guilty but mentally ill, or committed as "abnormal offenders"). The total number of such persons who are currently under corrections custody is very small when compared to the total inmate population, and those who are in corrections are concentrated in a few jurisdictions. Most people held pending a determination of their competence to stand trial are housed in locally administered facilities, principally jails, hospital forensic units, or community mental health centers. Almost all those found incompetent to stand trial or not guilty by reason of insanity are held in facilities administered by state departments of mental health. In addition, while some jurisdictions do commit to corrections inmates who have been found guilty but mentally ill, the numbers so committed are not now very large, nor does it appear that the provisions under which they are committed offer significant guidance to corrections authorities with respect to how they should manage or treat such inmates.

Finally we must note two developments with important consequences for corrections. First, the trend is away from use of "abnormal offender" statutes and toward regular criminal commitment. Second, a number of jurisdictions have recently instituted "guilty but mentally ill" statutes and more may do so. If either or both of these trends continue, the need for prison mental health services will increase concomitantly. In addition, these trends emphasize the need for adequate identification and evaluation of mentally disordered offenders in corrections as well as the need to further develop policies, procedures, and programs to manage and treat such inmates effectively.

Description of Findings

1. Persons held pending a determination of their competence to stand trial.

Only 12 of 50 responding corrections departments reported that they ever receive persons to be held pending a determination of their competence to stand trial. Of these 12 departments, 11 reported current custody of one or more persons in this legal status. Nine departments were able to count or estimate how many such persons were currently under custody. As of 15 May 1983, the total number was 128, 80 of whom (or more than 60 percent) were held in only 2 departments — which reported totals of 50 and 30 respectively. The remaining

48 persons were held in 7 departments; the median number of such cases was 7 and the range was from 1 to 13. One corrections department reported that it did not currently have custody of any such person, but that it did occasionally receive such inmates.

The reader should be mindful of two things with regard to this category. First, the actual number of persons in this legal status is greater than the estimated number (128) because two departments which did report current custody of such persons were unable to estimate how many they currently held. While each of these departments has a large inmate population (in excess of 25,000), it is nevertheless unlikely that they house enough persons in this category to substantially alter the finding that the proportion of such inmates is very small when compared to the total inmate population. Second, the two departments which reported holding the largest numbers of persons pending a determination of competence are also departments which house substantial numbers of other pretrial detainees and are thus not typical of state departments of corrections nationwide.

2. Persons found incompetent to stand trial or not guilty by reason of insanity.

Incompetent and insane individuals (i.e., those in the first two categories) are technically not offenders because their potential or actual mental disorder has prevented their trial or conviction. Survey responses indicate that such individuals are seldom committed to corrections.

Only 5 responding corrections departments reported that they ever receive persons found incompetent to stand trial. Of these, 3 reported that they did not currently have anyone under custody in this category while a fourth reported custody of only 1 such person. The fifth department, which reported receiving persons in this category could not provide a count or estimate how many such persons were currently under its custody, but once again it seems unlikely that an accurate count from this department would substantially alter our findings. Similarly, only 2 corrections departments reported that they ever received persons found not guilty by reason of insanity. Of these, 1 reported that it currently had only 2 such inmates, while the other reported that it had no persons in this category currently under custody.

3. Mental health as the principal custodian of the incompetent and the insane.

The majority of state and federal corrections departments reported that

- persons are most often held at the local level (in either jails or hospital forensic units) pending a determination of their competence to stand trial, and that
- persons found incompetent to stand trial or not guilty by reason of insanity are most often confined in institutions administered by state departments of mental health.

This finding is consistent with previously reported research (see, for example, Steadman, et al.: 1982), and also with data elicited by the questionnaires we sent to each state mental health department, (30 of which returned completed questionnaires in time for their responses to be included in this analysis).

Responses to the mental health survey indicated that most state departments of mental health do receive patients found incompetent to stand trial or not guilty by reason of insanity. The total number of patients in each of these categories who are currently under care is substantial (i.e., 2,082 or 2,248 respectively). The situation is somewhat different with respect to those persons held pending a determination of the competence to stand trial. A smaller number of state mental health departments receive such patients (though still a large majority of departments responding to the survey, i.e., 24 of 30, or 80 percent). Furthermore, the number of patients under care pending a determination of their competence is much smaller than the number held subsequent to a finding of incompetence to stand trial (390 versus 2,082). This disparity tends to support the finding that evaluations of competence to stand trial are more frequently done in local rather than state institutions. We should note, however, that part of this disparity may arise from the fact that persons are held *pending* a determination of competence for shorter periods of time (typically 30 to 60 days) than are those adjudged incompetent to stand trial.

4. Persons found guilty but mentally ill.

In all jurisdictions, mental disorder at the time of trial may postpone the trial on the grounds of incompetence. In most jurisdictions mental disorder at the time of the offense may prevent conviction on the grounds of insanity. In 8 jurisdictions, however, a person may be found "guilty but mentally ill" if the trier of fact determines, after conviction, that the person was mentally ill but not legally insane at the time the offense was committed. In 6 of these states the imprisonment of persons found guilty but mentally ill must be accompanied by such treatment as is "psychiatrically indicated," while the 2 remaining states direct corrections departments to provide only such treatment as they "deem necessary."

Corrections departments in only 3 of these states reported current custody of guilty but mentally ill inmates. The total was 251, with the 3 departments reporting 66, 85, and 100 respectively. This represents 7.7, 8.3 and 73.5 percent of the total number of inmates classified as mentally ill in each state. Obviously, the proportion of guilty but mentally ill inmates is very high in one state.

It does not appear, however, that these statutes, as currently written, significantly constrain corrections departments in the discretion they exercise with respect to the provision of mental health services to mentally disordered offenders.

5. "Abnormal Offenders."

A number of jurisdictions have historically diverted certain convicted offenders directly into treatment programs to which they are committed in lieu of a standard prison sentence. This category has generally been limited to certain sex offenders (e.g., those found to be "mentally disordered sex offenders" or "sexually dangerous persons"), although in a few jurisdictions it also includes others (e.g., "defective delinquents"). Most frequently the departments of mental health administer these programs, a fact confirmed by the questionnaires we sent mental health departments. Eleven of the 30 responding state departments of mental health reported that they had some such individuals under custody at the time of the survey. The number totalled 1,209. In 2 states, however, departments of *corrections* reported having individuals committed under these special statutes under custody. One department reported 23, while the second reported that it administered a separate facility exclusively for the confinement of "repetitive and compulsive sexual offenders," who now numbered 250.

In recent years states have tended to abolish these "abnormal offender" programs, a trend with important consequences for prison mental health services. Recently, for example, California abolished this dispositional alternative and sex offenders are now sentenced under generally applicable provisions of the penal code. However, the California Department of Mental Health still reports custody of 814 "abnormal offenders." Most of these would have been committed to corrections had their dispositions occurred after the law was changed. It seems probable, therefore, that some states will see an increase in the number of corrections inmates who are in need of mental health services.

IDENTIFYING AND EVALUATING MENTALLY DISORDERED OFFENDERS AFTER COMMITMENT TO CORRECTIONS

As we have seen, most mentally disordered inmates have *not* been officially identified as such by the courts as part of their current commitment to corrections. Moreover, even that small minority of inmates who are committed as incompetent, insane, guilty but mentally ill, or "abnormal" have been committed on the basis of their mental status either when they committed their crime or when they were tried for the offense. It is, however, an inmate's mental status at *reception into corrections,* and at any *subsequent* time during incarceration, that determines his or her need for mental health services there. Corrections departments must, therefore, have policies and procedures that permit prompt, effective identification and evaluation of mentally ill and retarded prisoners and that refer these inmates to appropriate mental health programs and services. Both law and good administrative practice strongly support this position. Prisoners have a constitutional right to appropriate mental health services. Prisons can provide these services only if they accurately identify and evaluate the population in need. In addition, organizations which have promulgated correctional standards have unanimously recommended that prisons make a vigorous attempt to identify and refer for appropriate treatment those inmates who are mentally ill or mentally retarded.

Our survey, therefore, asked each department of corrections to describe:

- those procedures routinely used to screen, identify, and evaluate incoming inmates who are mentally ill or retarded; and
- those procedures used to determine the current mental status and service needs of inmates already in custody suspected of being mentally ill or retarded.

Summary

All responding departments of corrections reported generally similar procedures for identifying and evaluating incoming mentally disordered offenders. A mental health staff member interviews the new inmate and administers one or more standardized tests. All departments also reported procedures by which line staff could refer inmates already under custody to the mental health staff for evaluation. Once again, a clinical interview, supplemented by whatever tests the interviewing clinician thinks appropriate, is the usual procedure employed to evaluate prisoners so referred. Prisoners thought to be mentally retarded, however, are generally evaluated by standardized tests. All responding departments reported the availability of psychiatrists and licensed clinical psychologists either on staff or on contract to conduct detailed clinical evaluations of mentally disordered offenders. Normally they draw up an individual treatment plan following their diagnosis.

The more detailed discussion of screening and evaluation procedures which follows describes only the *basic structure* of the process and the *extent* to which corrections departments across the nation use individual elements of that process. Our survey sought to develop the general picture of how corrections departments are currently identifying and meeting mental health needs, to identify those issues which most concern administrators and

mental health professionals in corrections, and to generate a context which would facilitate both discussion and future research in this area; it did *not* try to assess the *effectiveness* of particular programs or procedures. To evaluate the *quality* of needs assessment or service delivery would require much more specific and extensive research. The survey responses do, nevertheless, identify issues of concern and areas for further research.

For example, many respondents urged effective coordination both among mental health staff and between mental health and other corrections staff. Some respondents noted the waste of time and money when extensive evaluation and treatment planning prove ineffective because appropriate programs are not available or because decisions based on other criteria (e.g., security classification) preclude the delivery of those services to particular inmates. Mental health staff must know about and be responsive to the legitimate concerns of other corrections personnel. On the other hand, the survey also clearly indicates that corrections administrators should consider carefully how to use the information obtained during screening and evaluation so as to make workable decisions about the development of treatment programs, the allocation of resources for mental health programs, and the most effective delivery of mental health services to individual inmates.

Survey responses emphasize the critical role line officers and their immediate supervisors play in initially identifying and referring for evaluation those inmates already in custody who may be mentally ill or retarded. This highlights the necessity to *train* line officers and first-line supervisors so they will be able to do this promptly and well.

Several corrections departments routinely screen all incoming inmates using certain tests (e.g., the "Draw-A-Person and "House-Tree-Person" tests) whose effectiveness has been widely questioned. Corrections departments should, therefore, carefully reexamine which screening tests they are using to make sure they are effective.

Finally, while most departments employ similar screening and evaluation processes, they arrive at *results* (i.e., the number of prisoners classified as mentally ill or retarded and the services provided to those so classified) which differ markedly. Differences in policy, in the availability of alternative placement options, as well as other factors probably account for this.

Discussion of Findings

1. Screening incoming inmates.

All corrections departments which responded to the survey (50 of 52 departments) indicated they routinely use some procedures to screen and identify those incoming inmates who are mentally ill or retarded. The nature and complexity of these procedures, however, varies somewhat among departments, as does the larger reception and classification process of which these procedures are usually a part.

We abstracted five basic elements of a mental health screening and identification process:

- *a review of records* received with the inmate which might indicate the possibility of mental retardation or current mental illness (e.g., the presentence report or any other reports, including clinical evaluations, ordered by the court prior to its disposition of the case, any history of previous treatment and/or institutionalization for mental illness, etc.);
- *observation* by corrections staff of the inmate's behavior immediately following commitment and especially during the reception/classification process;
- *testing,* which includes the use of a variety of intelligence, achievement, and projective protocols;
- *interviewing,* which is specifically designed, at least in part, to screen for possible mental illness or retardation; and,
- *referral* to mental health professionals for more extensive evaluation and diagnosis of those inmates who are identified by one or more of the above procedures as possibly mentally ill or retarded.

All responding departments reported that their procedures include a review of pertinent records, behavioral observation by corrections staff, and referral to mental health professionals of those inmates whose mental status appears to warrant more extensive evaluation. Departments vary, however, with regard to their use of tests and interviews as routine procedures to screen all incoming inmates for mental illness and retardation.

Table 5 displays the extent to which combinations of the five basic screening procedures are routinely employed by state and federal corrections departments to initially assess the mental status of incoming inmates.

Table 5
Procedures to Routinely Screen All Incoming Inmates for Mental Illness and Retardation

	No. of Departments MI	MR
Record Review plus Staff Observation plus Referral	6	5
Record Review plus Staff Observation plus Interview plus Referral	9	—
Record Review plus Staff Observation plus Test(s) plus Referral	2	6
Record Review plus Staff Observation plus Interview plus Test(s) plus Referral	33	38
No Responses	2	3
	52	52

An inspection of Table 5 reveals that a majority of corrections departments employ all five basic procedures to screen all incoming inmates for possible mental illness or mental retardation.

2. Initial screening for mental illness.

In screening all incoming inmates for possible mental illness:

- 42 departments routinely employ an interview in addition to a review of records and staff observations of inmate behavior;
- 35 departments test all incoming inmates; and,
- 33 departments both interview and test all incoming inmates.

A variety of corrections personnel conduct the interviews designed to screen incoming inmates for possible mental illness. Table 6 displays the types of interviewers as specified by responding corrections departments.

Table 6
Personnel Who Conduct Routine Interviews to Screen Incoming Inmates for Mental Illness

Psychologist	17
Psychology Staff	12
MSW	1
Nurse	2
Corrections Counselor	6
Interviewer Not Specified	4
No Routine Interview	8
No Response	2
	52

Table 6 indicates that mental health professionals usually conduct these interviews, although some departments use a variety of other interviewers. In addition, one department which receives persons found guilty but mentally ill reported that a psychiatrist evaluates upon reception all inmates so committed.

Thirty-five departments reported the use of one or more tests to screen all incoming inmates for possible mental illness. Nine of these departments reported the routine use of one screening test, while 7 departments administer two such tests to all incoming inmates. Six departments administer three tests and 1 department administers four tests.

Twelve departments, which reported the routine use of one or more tests to screen incoming inmates for possible mental illness, did not identify the specific test or tests currently in use for this purpose. Table 7 displays the frequency with which specific tests are used in those 23 departments which did identify the tests administered to all incoming inmates.

Table 7
Tests Employed to Screen All Incoming Inmates for Mental Illness

	Number Corrections Departments In Which The Following Tests Were Used: Alone	In Conjunction w/Other Tests	Total
Minnesota Multiphasic Personality Inventory	7	11	18
Bender Visual Motor Gestalt Test		6	6
Sixteen Personal Factor Questionnaire	1	3	4
Draw-a-Person Test		4	4
Clinical Analysis Questionnaire		3	3
Incomplete Sentences Blank		3	3
Buss-Durkie Hostility Inventory		1	1
California Personality Inventory		1	1
House-Tree-Person Test		1	1
Motivated Analysis Test		1	1
Rorschach Test	1		1
Wide Range Interest — Opinion Test		1	1

The Minnesota Multiphasic Personality Test (MMPI) is the test most frequently used to screen incoming inmates for mental illness. Eighteen of the 23 departments which specified specific routine screening tests reported using the MMPI. The MMPI is the only routine screening test employed in 7 departments, while 11 others use it in conjunction with other tests. The test with which it is most frequently paired is the Bender Visual Motor Gestalt Test (Bender-Gestalt) a test reported in routine use in 6 departments. Five of those departments use it in conjunction with the MMPI, while the sixth uses it in conjunction with the Buss-Durkie Hostility Inventory and the Incomplete Sentences Blank Test. Similarly, all corrections departments which reported using the Draw-a-Person or House-Tree-Person tests as part of their initial screening process use these tests in conjunction with the MMPI. In addition to those tests already mentioned, five other tests are routinely used to screen all incoming inmates in one or more departments, but none are in widespread use.

3. Initial screening for mental retardation.

Thirty-eight departments reported the use of both tests and interviews to screen all incoming inmates for possible mental retardation (see Table 5 above). Six other departments, which routinely administer one or more tests to detect mental retardation, do not use interviews to screen all incoming inmates. Five departments do not routinely employ either tests or interviews but rely on a

record review and staff observation to initially screen incoming inmates for possible mental retardation. As was the case with screening for mental illness, all responding departments said extensive evaluation and diagnosis by mental health professionals was available upon referral for those inmates initially identified as possibly mentally retarded.

The variety of personnel who screen incoming inmates for mental retardation resembles that which screens for mental illness. In fact many jurisdictions use a single initial interview to determine both mental illness and mental retardation. As would be expected and as Table 8 indicates, mental health staff conducts these screening interviews in most jurisdictions.

Table 8
Personnel Who Conduct Routine Interviews to Screen Incoming Inmates For Mental Retardation

Psychologist	15
Psychology Staff	13
Nurse	2
Corrections Counselor	5
Interviewer Not Specified	3
No Routine Interview	11
No Response	3
	52

Forty-four departments routinely use one or more tests to screen all incoming inmates for mental retardation. Nineteen use one screening test, 12 departments administer two, and 7 administer three tests. While 6 jurisdictions did not specify which test or tests they used, Table 9 displays the frequency with which the remaining 38 jurisdictions reported using specific tests.

The Revised Beta Examination is most frequently used to screen incoming inmates for mental retardation. Twenty-five of the 38 departments which identified specific screening tests employ the Revised Beta Examination either alone (9 departments) or in conjunction with other tests (16 departments). The Wide Range Achievement Test (WRAT) is employed as a routine screening test in 12 departments, 11 of which use it in conjunction with the Revised Beta, while the twelfth uses it in conjunction with the Ravens Progressive Matrices Tests. Five departments use the Culture Fair Intelligence Test; in 4 of which it is the only such test administered to all incoming inmates, while the fifth uses it in conjunction with the General Aptitude Test Battery. Fifteen other tests are routinely used to screen all incoming inmates, but none are in widespread use. Three are used in 2 different departments each, while the remaining 12 are used in only 1 department each.

Table 9
Tests Employed To Screen All Incoming Inmates For Mental Retardation

	Number of Corrections Departments In Which The Following Tests Were Used		
	Alone	In Conjunction w/Other Tests	Total
Revised BETA Examination	9	16	25
Wide Range Achievement Test		12	12
Culture Fair Intelligence Test	4	1	5
General Aptitude Test Battery		3	3
Wechsler Adult Intelligence Scale (Revised)	1	2	3
Test of Adult Basic Education	1	1	2
Quick Test		2	2
Adult Basic Learning Examination		1	1
California Achievement Tests	1		1
Gates-McKillop Reading Diagnostic Test		1	1
Minnesota Vocational Interest		1	1
Otis-Lennon Mental Ability Test		1	1
Peabody Picture Vocabulary Test		1	1
Pictorial Test of Intelligence		1	1
Ravens Progressive Matrices Test		1	1
Short Test of Educational Ability		1	1
Shipley Group Intelligence Test	1		1
Stanford-Binet Intelligence	1		1

4. Referral and evaluation of mentally disordered offenders.

All responding corrections departments reported that mental health professionals are available upon referral to perform more extensive evaluation and diagnosis of those inmates identified as possibly needing specialized treatment, management, or programming because of their mental illness or retardation. Those inmates identified through the routine intake screening procedures are referred directly to mental health professionals for further evaluation. If mental illness is suspected, the evaluation usually begins with a clinical interview by a psychologist and whatever additional tests the clinician may feel are appropriate. While some departments did identify the tests commonly used at this stage of an inmate's evaluation, most noted only that the choice of tests was within the professional discretion of the individual clinician. We cannot, therefore, systematically describe the *types* of tests used or the relative *frequency* with which particular tests are employed. All responding departments report the availability of further referrals for psychiatric and neurological evaluation.

When initial screening indicates the possibility of mental retardation, most departments refer the inmate to a psychologist for further evaluation. Forty-five departments described their follow-up evaluation procedures in some detail. The Weschler Adult Intelligence Scale (Revised) (WAIS-R) is used in 33 of these departments, while the remaining 12 reported that the individual clinician conducting the evaluation chooses the tests. In addition to intelligence testing, a number of departments also use interviews, behavioral observations, and tests (including the Vineland Social Maturity Scale [Revised] and the Prison Functional Behavior Scale) to assess the extent to which retardation will impair the inmate's ability to adapt to prison life. Finally, corrections may administer a variety of vocational and educational tests to facilitate program placement decisions.

THE PROVISION OF MENTAL HEALTH SERVICES IN CORRECTIONS

What mental health and other appropriate services (e.g., special education) are currently available to meet the special needs of mentally disordered inmates? Who provides them, and under whose auspices? Where are they provided and at what levels?

Before discussing the delivery of mental health services in corrections, we will first examine the extent to which corrections departments transfer mentally ill and mentally retarded offenders to other agencies or departments. This type of transfer has obvious programmatic implications because the extent to which it is used helps determine both the type and the level of mental health services needed in corrections. Such transfers also raise important legal and administrative issues, which are discussed in other sections of this sourcebook.

Description of Findings

1. Transfers of mentally disordered offenders from corrections to other agencies.

In certain circumstances in some jurisdictions, corrections departments transfer mentally ill or mentally retarded inmates who are under criminal sentence to institutions administered by other agencies. To determine the extent of such transfers, our questionnaire asked each corrections department for the number of inmates transferred in this way and for the agency under whose jurisdiction the inmates were placed.

Transfers of mentally ill inmates

Table 10 displays the number and percentage of inmates classified as mentally ill who had been transferred from corrections to facilities administered by other agencies (principally departments of mental health) at the time of the survey.

Table 10
Transfer of Mentally Ill Inmates from Corrections to Other Agencies

Number of Inmates Per Jurisdiction Transferred from Corrections to Other Agencies	Number* (and Percentage) of Corrections Departments N	%	Total Number (and Percentage) Of Inmates Transferred N	%
More than 100	3	6.2	452	44.4
75 — 100	2	4.2	157	15.4
50 — 74	2	4.2	106	10.4
25 — 49	4	8.3	123	12.1
10 — 24	5	10.4	89	8.7
1 — 9	20	41.7	92	9.0
0	12	25.0		
Unknown	2			
No Response	2			
Totals	52		1,019	100

*Percentage based on those 48 departments which reported both the total number of inmates classified as mentally ill and the number of those inmates transferred to other state agencies.

Table 10 indicates that the transfer of mentally ill inmates from corrections to mental health is a widespread but not frequently used mechanism. Approximately three-fourths of all responding corrections departments reported that one or more inmates who had been committed to corrections and classified as mentally ill had subsequently been transferred to an institution administered by another agency and were being held there at the time of the survey although these inmates were also still under criminal sentence. The total number of inmates in this category is only 1,019 nationwide, however, or 4.2 percent of the 24,052 inmates classified as mentally ill by those 48 jurisdictions which reported both the total number of inmates mentally ill and the number of those inmates transferred to other agencies.

The extent to which mentally ill inmates are transferred between agencies varies substantially across departments. Five corrections departments each reported transferring more than 75 such inmates and, although these departments comprise only 10.5 percent of all reporting departments, they nonetheless account for approximately 60 percent of all reported transfers of this type. At the other extreme, nearly two-thirds of reporting corrections departments (32 of 48), each transferred fewer than 10 mentally ill inmates to other agencies. Of these 32 corrections

departments, approximately one-third (12) reported no such transfers, while the remaining two-thirds (20) reported a total of 92 transfers. These 92 transfers comprise less than 10 percent of all reported inter-agency transfers.

The relative infrequency with which mentally ill inmates are transferred out of corrections is further emphasized when we compare the percentage of inmates so transferred to the total number of inmates under custody who are classified as mentally ill. Table 11 presents these data.

Table 11
Percentage of Mentally Ill Inmates Transferred from Corrections to Other Agencies

Percentage of Mentally Ill Inmates Transferred from Corrections to Other Agencies	Number* (and Percentage) of Corrections Departments		Total Number (and Percentage) Of Inmates Transferred	
	N	%	N	%
100	4	8.3	127	12.5
75 — 99.9	0	—	0	—
50 — 74.9	0	—	0	—
25 — 49.9	5	10.4	230	22.6
10 — 24.9	7	14.6	99	9.7
Less Than 10	20	41.7	563	55.2
0	12	25.0		
Unknown	2			
No response	2			
Totals	52		1,019	

*Percentages based on the 48 departments which reported both the total number of inmates classified as mentally ill and the number of those inmates transferred to other state agencies.

Table 11 indicates that four corrections jurisdictions reported transferring to other agencies 100 percent of the inmates they have classified as mentally ill, but the total *number* of inmates transferred is only 127, which is less than 13 percent of the total number of mentally ill inmates nationwide who were transferred from corrections to other agencies. On the other hand, 20 corrections departments reported 55 percent of the total number of these inter-agency transfers, but each indicated that less than 10 percent of its mentally ill inmates were currently housed in institutions administered by other agencies.

Departments also vary considerably with respect to the length of time transferred inmates remain in those other institutions to which they are transferred. Several departments reported that they transferred to other agencies only inmates who were chronically psychotic, in need of long-term hospitalization, and who had been found dangerous to themselves or others (i.e., civilly commitable.). Such inmates could usually expect to remain in the other state institution for the duration of their confinement.

Other departments (including the one reporting the largest number of transfers) pursue a very different transfer policy. They normally transfer only inmates in acute distress, who remain in other state institutions only until they have been stabilized (typically six months or less), at which point they return to corrections.

A number of persons who were interviewed in conjunction with this project indicated their belief that mentally disordered inmates were more likely to be transferred to other agencies if they were female because in many departments the number of such inmates is so small that it is more efficient to transfer them than to provide most mental health services in corrections. Unfortunately this point could not be verified with survey data. Although the questionnaire asked respondents to break down the number of mentally disordered inmates by sex the number of respondents who did so was too small to permit analysis.

Despite the fact that transfers are in widespread use, the survey responses clearly indicate that they are not used frequently. Transfers do not constitute a major portion of the corrections response to the mentally ill offender, nor do most corrections personnel see them as an adequate solution to the problems posed by most mentally ill inmates. Several corrections officials noted, for example, that some acutely psychotic inmates are stabilized at mental health facilities, principally by means of forced psychotropic medications, and that such inmates often quickly revert to their prior state when returned to prisons, where forced medication is *not* the policy. Survey responses also indicate that in most jurisdictions mental health officials may on their own authority refuse to accept the transfer of mentally disordered inmates and/or unilaterally transfer such inmates back to corrections.

Responding mental health departments specified several reasons for exercising this authority. Sometimes they lack bedspace or appropriate programing; sometimes they believe individual inmates are not mentally ill (another illustration of the lack of consensus on how to distinguish the "mad" from the "bad"); and sometimes they think the inmate too dangerous for them to safely manage in the available setting or not amenable to available treatment. Indeed, some corrections respondents expressed the view that those inmates who were most disturbed and difficult to manage or treat in corrections were also those least likely to be accepted or retained in facilities administered by other agencies. Whether or not this view accurately reflects the situation nationwide, it is clear that the vast majority of inmates classified as mentally ill by corrections remain within the correctional departments during their criminal confinement.

Finally, we must consider what happens to the inmates classified as mentally retarded. As we mentioned, some jurisdictions try to place many or most mentally retarded individuals who come to the attention of the criminal justice system in situations other than prison.

Responses to this survey indicate, however, that those retarded individuals who *are* committed to corrections almost invariably remain there. Only 4 responding corrections departments reported that any retarded inmates under their custody were currently in institutions administered by other agencies. One department reported 20 inmates so transferred, while the other 3 each reported only 1 inmate in this category. It therefore seems clear that the development within corrections of management procedures and mental health services adequate to meet the special needs of mentally ill and retarded inmates is an important task for corrections administration and forensic services staff alike.

2. The current level of mental health services in corrections.

Most inmates who had been classified as mentally ill were receiving some type of psychiatric care within their respective corrections institutions at the time we conducted this survey. Responding corrections departments* reported a total of 18,788 inmates classified as mentally ill, of whom 17,579 (or 93.6 percent) were currently receiving some psychiatric care.

Inpatient psychiatric services were being provided for 3,746 (or 21.3 percent), while the remaining 13,833 inmates (or 78.7 percent) were receiving outpatient psychiatric services. Corrections departments vary widely in the extent to which they currently provide inpatient psychiatric care.

As the data in Table 12 indicates, while 8 corrections departments reported that 100 percent of those inmates classified as mentally ill were currently receiving inpatient psychiatric care, 7 others reported no inpatient psychiatric care was currently being provided to mentally ill inmates. Similarly, 10 departments reported 25 to 99.9 percent of those inmates classified as mentally ill were currently receiving inpatient psychiatric care, while in 15 other departments less than 25 percent of inmates classified as mentally ill were currently receiving such care. Analysis indicated, however, that the current level of inpatient psychiatric care was *not* systematically related either to the rate at which departments classified inmates as mentally ill or to the rate at which corrections departments transfer mentally ill inmates to other state agencies. These data therefore indicate that observed variations in the level of inpatient psychiatric care cannot be explained either by differences in the recognized rate of mental illness among inmates or by the differential availability of psychiatric services outside corrections.

*This section is based on an analysis of responses from 40 corrections departments. As was previously noted, survey questionnaires were sent to all 50 state departments of corrections plus the Federal Bureau of Prisons and the Washington, D.C. Department of Corrections. All but 2 state departments of corrections responded. Of the 50 questionnaires returned to project staff, 48 included counts or estimates of the total number of inmates classified by corrections as mentally ill (with a total of 24,052 inmates so classified). Four of these departments reported that they transfer to other agencies all inmates who are classified as mentally ill. Forty-four departments reported current custody in corrections of one or more inmates who had been classified as mentally ill. The responses from 4 of these 44 departments did not contain sufficient information about their mental health services to permit their inclusion in their analysis. Hence, this section is based on responses from 40 corrections departments.

Table 12
Percentage of Mentally Ill Inmates Currently Receiving Inpatient Psychiatric Care in Corrections

Percentage of Mentally Ill Inmates Currently Receiving Inpatient Psychiatric Care in Corrections	Number* (and Percentage) of Corrections Departments		Total Number of Inmates Receiving Inpatient Psychiatric Care in Corrections
	N	%	
100	8	20.0	1,114
75 — 99.9	3	7.5	269
50 — 74.9	3	7.5	470
25 — 49.9	4	10.0	525
Less Than 25	15	37.5	1,368
0	7	17.5	0
Totals	40		3,746

*Percentages based on the 40 departments which reported both the total number of inmates classified as mentally ill and the number of those inmates transferred to other state agencies.

More than two-thirds of all inmates classified as mentally ill by these 40 departments (13,012 of the 18,788, or 69.3 percent) were reported to be in "separate inpatient or outpatient psychiatric facilities, units or programs whose *major* or *secondary* function is the treatment of mentally ill inmates." Table 13 displays the variation in the extent to which individual corrections departments placed inmates classified as mentally ill in separate psychiatric facilities, units, or programs.

Table 13
The Use of Separate Facilities, Units, or Programs within Corrections Designed to Provide Psychiatric Care to Inmates Classified Mentally Ill

Percentage of Mentally Ill Inmates in Separate Psychiatric Facilities, Units, or Programs within Corrections	Number and Percentage of Corrections Departments		Inmates in Separate Psychiatric Facilities, Units, or Programs
	N	%	
100	16	40.0	9,391
75 — 99.9	4	10.0	1,950
50 — 74.9	2	5.0	425
25 — 49.9	6	15.0	620
Less Than 25	9	22.5	626
0	3	7.5	0
Totals	40		13,012

As Table 13 indicates, the majority of corrections departments place most inmates classified as mentally ill in separate facilities, units, or programs which are designed to provide psychiatric services. Twenty-two departments place 50 to 100 percent of these inmates in such separate facilities, units, or programs. These 22 departments classified a combined total of 12,323 inmates as mentally ill, of whom 11,766 (or 95.5 percent) were in separate psychiatric facilities, units, or programs. By contrast, 18 departments reported that they utilized this type of separate placement for less than 50 percent of these inmates. They classified a total of 6,465 inmates as mentally ill, of whom only 1,246 (or 19.3 percent) were in separate psychiatric facilities, units, or programs.

These inmates included all those receiving inpatient psychiatric care. In addition, two-thirds of those receiving outpatient psychiatric care (9,266 of 13,833, or 67 percent) were also in these separate facilities, units, or programs. An additional 4,567 inmates who were receiving outpatient psychiatric care were not in separate psychiatric facilities, units, or programs. Many of this last group were in the general prison population, but some departments reported holding some of these inmates in a variety of other settings (e.g., protective custody).

3. Modes of treatment.*

Responding departments of corrections used a variety of treatments. Thirty-three of the 40 provided individual psychotherapy to at least some inmates classified as mentally ill. Twenty-three of these departments reported that "most or all" mentally ill inmates were currently receiving individual psychotherapy, while the 10 others reported that "some" were. Of the remaining 7 departments, 4 reported that "few or none" of those inmates classified mentally ill were currently receiving individual psychotherapy, while 3 departments did not complete that portion of the questionnaire.

A similar pattern of responses was reported with respect to the current use of group psychotherapy. Once again 33 departments reported that at least some inmates classified as mentally ill were currently receiving group psychotherapy, 4 departments provided this type of treatment to "few or none," and 3 departments did not complete this portion of the questionnaire. Of the 33 departments which reported fairly frequent use of group psychotherapy, 15 reported that "most or all" received such treatment, while the 18 others reported that only "some" did. In other words, individual psychotherapy is in widespread and frequent use, and group psychotherapy is also in widespread but somewhat less frequent use.

Corrections departments also make widespread and fairly frequent use of psychotropic medication. Thirteen of the 40 departments reported that such medications were currently administered to "most or all" of those mentally ill inmates in separate psychiatric facilities, units, or programs. Twenty other departments reported that "some" of these inmates were currently receiving psychotropic medications. Five departments reported that "few or none" of these inmates were currently being so medicated, while the remaining 2 departments did not complete this question.

In contrast, corrections departments seldom, if ever, use electroshock therapy. Twenty-six departments never use such treatment, while 12 others reported that "few or none" of those inmates classified as mentally ill were currently receiving such treatment. Once again, 2 departments did not respond to this question.

Responding departments also listed a variety of other treatments or services which they currently provided to at least some inmates classified as mentally ill. Table 14 lists these and indicates the number of departments which reported their current use.

Table 14
Types of Treatment or Service Currently Being Provided to Inmates in Separate Psychiatric Facilities, Units, or Programs Within Departments of Corrections

Types of Treatment or Service	Number of Corrections Departments
Coping Skills Training	17
Pastoral Counseling	16
Recreational Therapy	14
Therapeutic community	13
Biofeedback	9
Supervised Therapeutic Work	9
Behavior Modification	8
Peer Counseling	8
Relaxation/Stress Management	8
Alcohol/Drug Abuse Groups or Courses	5
Special Therapy for Sex Offenders	4

All 40 departments reported that their mental health treatment staff included psychiatrists, psychologists, and psychiatric nurses. While each department reported that it had at least one full-time psychologist and one or more psychiatric nurses on staff, most departments also reported that part-time consultants provided the psychiatric coverage. Most departments reported the presence on staff of one or more masters-level social workers who were principally (though not necessarily exclusively) assigned to the treatment of mentally ill inmates. In addition, some departments have assigned to mental health facilities, units, or programs, therapy aides and/or corrections officers specially trained in the management of mentally ill inmates.

Licensed psychologists provide most individual and group therapy. While psychiatrists are available in all departments, they typically provide direct care to only "some" or a few of those inmates classified as mentally ill.

4. Programs and services for mentally retarded inmates.

Most mentally retarded inmates are not currently in separate facilities, units, or programs. In the 40 reporting departments, only 527 mentally retarded inmates (or 7.3 percent of the 7,218 inmates classified as mentally retarded by these departments) participated in such programs. Of these 527, more than half were under custody in 2 departments, which reported 188 and 102 mentally retarded inmates in such separate facilities, units, or programs. Indeed, 27 of the 40 departments reported no mentally retarded inmates in separate programs. The response of one department with a large number of inmates classified as mentally retarded appears to typify how most corrections departments handle this group: "Except for crisis counseling, epileptic episodes, or psychotic states, mentally retarded inmates have not been found to need special programming." Thus many mentally retarded inmates appear to be doubly damned. It is unlikely that they will receive special programming in corrections and even less likely that they will be transferred to other agencies where such special programming is more readily available.

*Most departments provided general descriptions of the available treatment modalities. On the other hand only a few departments provided aggregated data describing the characteristics of the inmates being treated. Indeed, such data does not appear to be generally available at the department level. We view this lack of aggregated data as a critical deficiency, not only because it makes research more difficult but more importantly because it impedes the type of system-wide planning and careful programmatic evaluation necessary to insure that mental health services are effectively and efficiently provided.

APPENDIX
PRIOR STUDIES

During the initial task of determining the scope of this project, we examined six research surveys which had studied the mentally ill or mentally retarded offender. We briefly summarize here the methodology, the specific population studied, and some of the general variables investigated in each study.

Brown and Courtless (1968)

In 1963, Brown and Courtless mailed questionnaires to a total of 207 adult and juvenile penal and correctional institutions in the 50 states and the District of Columbia to investigate the extent of retardation in prison populations. They obtained partial and complete responses from 174 institutions (84 percent). Complete IQ information was returned on 90,477 (40 percent) of the total inmate population surveyed. The researchers sought to determine not only the prevalence of retardation within correctional facilities, but also ". . .the offense patterns, management problems, and treatment programs affecting inmates with low reported intelligence." They defined mental retardation as measured intelligence falling below an IQ of 70. Fully 9.5 percent of the inmates with complete IQ information fell into the retarded range. In addition, "only six institutions (4.5 percent of the replying) provided a full range of programs including individual and group psychotherapy and academic and vocational as well as specialized education programs."

Scheidemandel and Kanno (1969)

After a thorough investigation to identify all facilities regularly treating adult mentally ill offenders in the United States, Scheidemandel and Kanno sent questionnaires to a total of 167 such facilities (most of which were under mental health auspices, though some were correctional). One hundred thirty-one (78 percent) of the 167 facilities responded. The researchers included in the term "mentally ill offender" the following categories: persons being held pending determination of their competency to stand trial, persons being held who have been found incompetent to stand trial, persons found not guilty by reason of insanity, persons convicted of a crime who are found to be mentally ill at time of sentencing, persons who become mentally ill while serving a sentence in a penal institution, and sex offenders not included in the above categories. This nationwide survey investigated a number of variables on patient, facility, treatment and staff characteristics. Using survey results, the authors estimated approximately 29,000 admissions of mentally ill offenders in 1967 and concluded that "there is no apparent consistency in policy or practice in the treatment of mentally ill offenders. In some relatively few states they are the exclusive responsibility of the state correctional system; in others, treatment is provided by state mental health facilities; in still others, by both."

Eckerman (1972)

Eckerman identified 73 federal, state, and municipal mental health or correctional facilities having a ". . . definite (comprehensive or special) program for treating mentally disordered offenders." He sent all 73 a questionnaire, which 68 (93 percent) completed and returned. The term "adult mentally disordered offender" included the following categories: persons adjudicated incompetent to enter a plea or stand trial; persons found not guilty by reason of insanity, persons adjudicated under special statutes, and persons who become mentally disturbed while serving a prison sentence and are transferred to a special institution falling within his previously specified

criteria. The questionnaire investigated a number of variables concerning patient, facility, treatments, and staffing characteristics. Among other things, Eckerman found that "While there are differences in the types of treatment programs found in various institutional settings, there is a good deal more similarity than diversity. From the kinds of diagnostic techniques employed to the forms of treatment provided, programs are quite comparable when compared across institutional types."

Sheldon and Norman (1978)

Using Eckerman's list of institutions serving the mentally disordered offender, Sheldon and Norman conducted a follow-up telephone survey in 1976 to provide more detailed information about these specialized forensic programs. Their study focused on facility and treatment characteristics. The authors did not specify the total number of institutions surveyed and the response rate. Nor is the term "mentally disordered offender" defined. They did find, however, that "in compiling and analyzing the data for the various state programs, it became apparent that not much therapy, either group or individual, is available to the mentally disordered offender population. . .The treatment of choice in most facilities is skilled psychotherapy combined with chemotherapy supported by an accepting environment. . .".

Steadman Et Al. (1982)

The Steadman group telephoned the mental health forensic director in each state and the name of a contact person who had statewide information on the placement options available for and the number of mentally disordered offenders admitted to state mental health and correctional facilities. They then sent the contact a questionnaire which investigated patient characteristics and determined under whose auspices (e.g., mental health, corrections, etc.) the facility provided the program. The term mentally disordered offender included the following four categories: persons incompetent to stand trial; persons found not guilty by reason of insanity; mentally disordered sex offenders; and transfers from prisons to mental health facilities. Steadman's group obtained data from all 50 states plus the District of Columbia and the federal system. Though they found that "most of the 52 jurisdictions surveyed . . . did not keep even simple descriptive statistics on the admissions or census of mentally disordered offenders," they concluded that "the data we have presented here reveal that approximately 20,000 persons were institutionalized in the United States as mentally disordered offenders in 1978."

Roth (1982)

Roth sent questionnaires to 233 institutions and units within institutions that met the criteria of being "public facilities primarily for the care and treatment of the mentally disordered offender." He obtained responses from 127 of the 168 institutions (75 percent), which he had later determined met the eligibility criteria. The term "mentally disordered offender" included adults and juveniles who were: not guilty by reason of insanity, incompetent to stand trial, adjudicated under special statutes, adjudicated guilty but mentally ill, convicted and sentenced offenders who become mentally ill while serving a sentence and are transferred for treatment, juveniles who are convicted of or involved in crimes and are committed for treatment of mental illness, defendants being evaluated for competence to stand trial, and defendants being examined for criminal responsibility. Roth's survey analyzed patient, facility, treatment, and staffing characteristics. Among his findings was "all respondents operate under state auspices, with the exception of five federal facilities and a unit of a municipal mental health department. Nearly two-thirds of the respondents are governed by mental health authorities, and nearly one-fourth by corrections authorities. Most of the remainder, classified as "Social Services/Other," are operated by departments with responsibility for youth, community rehabilitation, social services, or institutions; a few operate under cooperative agreements between corrections and mental health authorities. Overall 57 percent of the respondents are units of larger facilities, rather than separate institutions. . ."

As the reader can see, all but one survey (Steadman's National Survey of Patients and Facilities) used a facility specific approach rather than a system approach. Frequently these surveys included only facilities with service models — facilities "regularly treating adult mentally ill offenders" (Scheidemandel and Kanno) or those having an "established program which provided psychiatric care for mentally disordered offenders" (Eckerman). If a state had no formal institution or program within an institution specifically designed for the treatment of mentally disordered offenders, it is possible they would not be included in the survey.

All the surveys except one (Brown and Courtless) deal with both presentenced and convicted offenders who were mentally disordered.

All but one survey (Brown and Courtless) dealt exclusively with the mentally ill offender. Brown and Courtless also examined the extent of mental retardation in correctional facilities nationwide.

PART 3
LEGAL ISSUES AND THE MENTALLY DISORDERED INMATE

LEGAL ISSUES AND THE MENTALLY DISORDERED INMATE

by FRED COHEN

I. INTRODUCTION AND OVERVIEW

A. Introduction

We are concerned here 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 itself a complex and important question. Issues accepted for resolution in court are not 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 establishes 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, we shall 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] We will note in the text where it seems important to make a distinction concerning the illness.

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 *not* include inmates who are only mentally retarded. This is *not* 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 note early on 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.

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[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.L. 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* 125, 126 N.5 (1982).

[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.

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. A mentally retarded inmate might be entitled to such habilitative efforts as will maximize his 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 most important point we must make 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, we must establish at the outset that the source of inmate claims and rights also may be located in the various state constitutions, statutes, administrative regulations or perhaps administrative directives, and 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 who 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]

We 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. The friction here is not over 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 we 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 the prison inmate's claim to psychiatric or psychological care. His presence in prison does not rest on any explicit or implicit diagnosis or 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, albeit 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 constitutionaly bound to provide services for the mentally retarded, once a service *is* provided, a set of

[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* 7, 9 (1982) 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.

[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 (3d Cir. 1983).

[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 clearly is eligible for punishment so long as it is not cruel or unusual.

rights and reciprocal obligations arises. In *Youngberg v. Romeo,*[10] a decision to which we shall return, the Court dealt with a profoundly retarded, institutionalized adult whose representatives conceded that no amount of training could make possible his release.

In 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 *Romeo* 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. The reader should note that this highly structured 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 reduces the number of arguably relevant categories, it does *not* 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 assignment of peripheral status to a number of relevant categories, our central concern focuses on a large number of prisoners, a number that exceeds by far all persons in the other relevant categories.

Manageability, as dictated by economics and time, probably is the most important factor in determining the focus of this work, but there are other reasons. As Professor Dix points out, 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, first enacted in Michigan in 1975, has since gained acceptance in seven or eight other jurisdictions.[17]

Although 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 this 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 other inmates.[18]

This novel verdict 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]

[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]*See Id* at 316.

[14]Hartstone, Steadman & Monahan, *Vitek* and Beyond (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 (1981).

[15]Hartstone, Steadman & Monahan, *Vitek* and Beyond, note 12, at 126.

[16]Dix, Special Dispositional Alternatives for Abnormal Offenders in Mentally Disordered Offenders 136-157 (J. Monahan & H.J. Steadman, eds., 1983).

[17]*See* P.W. Low, J.C. Jeffries & R.J. Bonnie, *Criminal Law* 107-109 (1983 Supp.).

[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 §768.36 (1976).

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]

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 in prison, it is widely believed, is responsible for increasing tension in prison, which in turn, causes more mental illness than previously existed.[25] Others argue that increasingly narrow criteria for civil commitment of the mentally ill and adherence to the general policy of deinstitutionalization has resulted in higher rates of conviction and imprisonment of persons who earlier would have entered the mental health system.[26]

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. 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 applications of mental illness labels 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. They might insist on treatment

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

[21]Ill. Rev. Stat. Ch. 38 §1006-2-6(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.J. Beran & B.G. 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,* 103 S. Ct. 3043 (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 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 causal acceptance of the propositions that a conviction of a crime (here, attemped 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.

[25]"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.P. Thornberry, et al., Overcrowding in American Prisons: Policy Implications of Double-Bunking Single Cells XI (Univ. of Georgia; July, 1982).

[26]This perception is thinly supported but widely held. The 1983 NIC program plan 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).

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 1981 annual Meeting, American Sociological Association, Aug. 1981, Toronto, Canada.).

Also *see* 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.

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 certainly police officers on the outside, correction personnel cannot ignore the individual or his behavior. They must and will respond, although how 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."

A final impression relates to how much relevant law the front-line operatives — the correction and clinical personnel — know and understand. (Precious little it seems, 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 was actually the case and of calling for more substantive and procedural adjustments than was actually the case.

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,*[27] *Mapp v. Ohio,*[28] or even *Wolff v. McDonnell*[29] 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.

B. Overview

This section highlights in a general way the detailed material which follows. It may be read as an additional introduction or, more likely, a fairly sweeping overview of the body of this material. Section A attempts to capture your interest, while this section attempts to retain it and lead you to the detail which begins at Chapter II.

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 a law. A prisoner's custody is sufficiently complete that he must depend on his keeper for food, water, clothing, and medical care. There are 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.

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 needs of inmates.[30] This less-than-demanding duty places the constitutional obligation of care a notch below the general standards of reasonableness for determining medical malpractice. What we must stress, 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.

The essence of the Eighth Amendment is an obligation on 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. Thus they may view some psychological stress and possible deterioration as an inherent part of imprisonment and thus beyond the pale of legal protection. Whatever the cause, however, there exists the legal duty to *identify and treat* inmates with serious mental disorders.

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. There is an ironic twist here in that the duty to diagnose illnesses necessarily 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 uninjured, 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 infliction of pain and suffering — and that may well include preventable deterioration — is avoided.

A number of federal courts have insisted that deficient prison systems prepare plans to learn about the inmates' skills, background, or psychological difficulties. Many courts have insisted that mental health specialists be involved in this process and that certain standardized tests be used.

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 rehabilitative needs than the more restrictive right to treatment.

Thus another message we can derive from the cases analyzed in the ensuing chapters is that 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 greater the deficiency, the more extensive the likely relief.

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

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 a major case 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.

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, contacts, beds, and so on.

A final word on treatment and how the term is used in this document. Treatment in this context 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 relational skills is not the type of treatment we refer to here.

The use of isolation with mentally disturbed inmates often creates legal entanglements. No case has been found which totally forbids isolation, even though some experts find its use — especially with suicidal inmates — counter-productive. The inmate's mental condition is — and should be — a factor in the calculus to determine 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 closely follow local rules on such items as duration, authorization, and monitoring.

Thus far, we have referred only to mentally disordered prisoners. Pretrial detainees have at least the same right to diagnosis, adequate records, and treatment as persons convicted of crime. Indeed, in the legal hierarchy of rights retained by those in some form of confinement, convicted prisoners occupy the lowest rung. Thus it is safe to assume that whatever rights the convicted possess are possessed by the unconvicted detainee as well.

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 nice doctrinal issues, but for present purposes the bottom line is the nature, rather than the specific source, of the right. And 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 prevalent; incompetence 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

[27] 384 U.S. 436 (1966).

[28] 367 U.S. 643 (1961).

[29] 418 U.S. 539 (1974).

[30] This section does not attempt to document specific statements such as the one to which this footnote is attached. The reader will find citations to the cases noted here and adequate documentation in the main body of this work.

indifference" standard which applies to the convicted; and, jails simply must have ready access to diagnostic and treatment resources and personnel.

The mentally retarded inmate presents yet another package of problems, problems which confound many correctional administrators. Since the right to treatment as analyzed and developed in this work flows from a medical/disease or injury model, it is not at all clear that the retarded inmate has the equivalent of a right to treatment. Habilitation claims now fall on deaf ears when urged on behalf of the civilly confined. It seems all the more likely that such claims will continue to be ignored when raised by the convicted.

While the constitutional basis for a right to care or habilitation is dubious, at times a right to special education and training (habilitation, in fact) is ordered by a trial judge and simply complied with or consented to by the state. The decision involving the Texas Department of Corrections is a good example of an extensive program for retarded inmates resulting initially from a court order and later as a result of negotiation and agreement.

While all prisons and jails must provide basic treatment at least for the seriously disordered inmate, the choice as to *what* type of care 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.

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 minimum safeguards are now constitutionally required 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 ("This person 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 Section IV. Perhaps the most basic question relates to whether *Vitek*-mandated procedures apply where the transfer is to a treatment facility within the prison system. The answer suggested here is that where 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 in the institutional setting presents recurring and profound legal questions regarding confidentiality and privilege, the duty to disclose where 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 compeling 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 that mental health personnel be required 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 clear and present 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.

Where a mental health professional has reason to believe that his patient presents a serious danger of violence to an identifiable other, a duty arises to use reasonable care to protect the intended victim. The surest, safest response would be for the clinician to alert appropriate security personnel and allow them to implement needed security.

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 to this problem. 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.

In turn, however, inmates have gained little ground in the effort to require consent either to various forms of psychotherapy or drug therapy. Drugs which 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. Thus at times there will be a threshold argument concerning whether this or that is punishment or treatment. However, even accepting an intervention as treatment does not wholly insulate it from legal challenge. If a due process "liberty" interest is implicated or a First Amendment interest in religious freedom or expression, then a constitutional barrier to the intended treatment may be found.

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 rudimentary constitutional right to physical and psychological care is not likely to be enriched or expanded. It means continued deference to prison officials and 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 refine prisoners' rights.

The right and 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. Without the moral and judicial leadership of our highest court, it should be interesting to observe what happens when the in-need constituency has no lobby, no important pressure groups, and no vote.

Those readers interested in a more detailed analysis may turn to the following chapters where we examine in some detail the law, the definitions, and conclusions we have presented here.

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 section 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, "Prison 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

[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).

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]

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 prisoner's rights.[5]

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 delineate the general analytical postures available and to select the one which most nearly points in the correct direction.[6]

One posture is the frequently cited view announced in *Coffin v. Reichard*[7] 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.[8]

Diametrically opposed to the *Coffin* posture 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.[9]

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,*[10] 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, "In summary, prisoner status lies in the gray area between slaves and citizens."[11] The authors find three general principles descriptive of prisoners' claims which 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.[12]

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

[4]*See* e.g., *Ruffin v. Commonwealth,* 21 Gratt. 790 (Va. 1891).

[5]H.B. 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]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.

[7]142 F.2d 443, 445 (6th Cir. 1944), *cert. denied,* 325 U.S. 887 (1945).

[8]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. *See* Goshnaver, Necessity and Prisoners' Rights, 10 *N. Eng. on Crim. & Civil Confinement* 276 (1984).

[9]*Meachum v. Fano,* 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 can 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.

[10]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. Overcrowding in American Prisons: Policy Implications of Double-Bunking Single Cells VII (Univ. of Georgia, July, 1982).

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

[12]*Id* at 12, 13.

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."[13] 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;[14] and, in the Chief Justice's repeated public pronouncements of the need to cleanse the federal courts of prison litigation.[15]

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*[16] 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.[17]

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, "It 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."[18]

This 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.[19] 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 categories. 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.

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.

Inmates have a right to be free of cruel and unusual punishment, a right which now may be reserved exclusively for convicted prisoners.[20] 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.

One of the most fundamental rights inmates possess is the right of access to the courts.[21] 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.[22] *Johnson* was decided in the

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

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

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

[16]433 U.S. 119 (1977).

[17]*Id* at 123, 124.

[18]*Id,* at 132.

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

[20]*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 Amendments' prohibition against cruel and unusual punishment. *See* also *Bell v. Wolfish,* 441 U.S. 520 (1979).

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

[22]393 U.S. 483 (1969).

context of a prison which provided inmates with no apparent alternatives to the so-called jailhouse lawyers.[23]

Johnson should be understood as an analogue to the injunction that "thou shalt not discriminate." It is a constitutional ruling which 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.[24] *Bounds,* then, added "affirmative action" to the right of access to the courts.[25]

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.[26]

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 jurally denuded 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.

In *Estelle v. Gamble*[27] 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, "at most it is medical malpractice, and as such the proper forum is the state court under the Texas Tort Claims Act."[28]

As one authoritative work puts it, "Tort remedies may be critically important to the prisoner who sustains an injury in prison."[29] This is not the appropriate occasion even 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.[30] 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 Sec. 1983.[31] In practical effect, this 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 will look more to injunctive remedies.

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 such duties which involved frisking them.[32]

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. §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.

[23]In *Wolff v. McDonnell*, 418 U.S. 539, 577-580 (1974). The Court extended the *Johnson v. Avery* rationale to civil rights actions.

[24]430 U.S. 817 (1977).

[25]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.

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

[27]429 U.S. 97 (1976).

[28]*Id* at 107.

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

[30]*See* 42 USC 1983. *Also see* 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).

[31]*Procunier v. Navarette.* 434 U.S. 555 (1978). *Also see Ward v. Johnson,* 890 F.2d 1098 (4th Cir. 1982) extending judicial-type immunity to prison officials when serving on a disciplinary tribunal.

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

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*[33] 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.[34]

We should note that Justice Rehnquist did not bind himself or the Court to the acceptance of the Fourth Amendment safegards in jail or prison. The Justice simply accepted that position in stipulative (or *arguendo*) fashion.[35] 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 that searches conducted in prison are inherently reasonable, according to the Rehnquist view.

In general, then, a prisoner has no expectation of privacy. 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 no realistic opportunity for subsequent challenge.[36]

An inmate may, however, have significant protections in the area of custodial interrogation[37] 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.[38] This is *not* a recognition of an inmate's right to privacy. Rather, it is the continuation of an extensive set of pretrial safegards designed to protect an accused's privilege against self-incrimination and right to counsel.

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 us 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,*[39] which involves the transfer of a prison inmate to either a mental hospital or mental health facility.

The most significant decision involving prison disicipline is *Wolff v. McDonnell.*[40] A more recent decision, *Hewitt v. Helms,*[41] promises to be a close second to *Wolff,* but the decision is too new for us 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[42] as a result of flagrant or serious misconduct.

[33]441 U.S. 520 (1979).

[34]441 U.S. at 558 (citations in quotation omitted).

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

[36]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). *See also* 553 F. Supp. 567 (S.D. Texas, 1982) on the award of attorney fees.

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

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

[39]445 U.S. 480 (1980).

[40]418 U.S. 539 (1974).

[41]103 S. Ct. 864 (1983).

[42]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).

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 county.[43]

Whatever procedural rights inmates would be found to have 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.[44]

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 safegards of the Fourteenth Amendment. At a minimum this is to assure that the right is not arbitrarily abrogated.

Once it is decided that the due process clause 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 procedural safegards 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.[45]

At the core of procedural due process is the requirement of some kind of hearing before an impartial tribunal.[46] 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.[47]

The above are the only unconditional procedural rights in disciplinary proceedings extended to inmates. The Court determined that inmates might call witnesses or present documentary evidence when permitting them to do so will not be unduly hazardous to institutional safety or correctional goals.[48] 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.[49]

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.[50] 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, create the potential for havoc and for making these proceedings longer than need be and unmanageable.[51]

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,

[43]418 U.S. at 555-556.

[44]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).

[45]See J.E. Nowak, R.D. Rotunda & J. Nelson Young, Constitutional Law 449 (1978).

[46]418 U.S. at 557.

[47]*Id* at 563.

[48]*Id* at 566.

[49]*Id* at 570.

[50]*Id* at 570-571.

[51]*Id* at 567.

that due process required that the 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.[52]

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, the prison-to-prison transfer may be more of a loss than the *Wolff*-type 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*[53] and *Montanye v. Haymes,*[54] the Supreme Court dealt with the inter-prison transfer question and handed the inmates a damaging defeat. Justice White made it clear that not even 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 procedural rights, not even to a hearing. Should a state elect to condition a transfer on the occurrence of a specific event — e.g., proof of misconduct — then due process may apply.

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.[55] Although the Supreme Court seems not to have spoken directly to the issue, *Meachum's* reasoning and *dicta* in *Moody v. Daggett*[56] 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.[57]

The Court was even more explicit, albeit 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.*[58]

Whatever the practical importance of the classification decision, it is reasonably clear that the Court is not likely to decide 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.[59]

In our previous discussion of *Wolff* and prison disciplinary proceedings, the matters at stake for the inmate clearly were loss of good time credits and, less

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

[53]427 U.S. 215 (1976).

[54]427 U.S. 236 (1976).

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

[56]429 U.S. 78 (1976).

[57]427 U.S. at 224.

[58]429 U.S. 78, 88 n.9 (1976) (emphasis added).

[59]*Cf. Withers v. Levine,* 449 F. Supp. 473 (D. Md. 1978), *aff'd* 615 F.2d 159 (4th Cir. 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.

clearly, confinement to disciplinary segregation.[60] *Hewitt v. Helms*[61] 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 well represents the leading edge 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.[62] It is not that the Commonwealth adopted simple procedural guidelines, admirable in itself and not to be penalized by the imposition of procedural hurdles. Here, the rules 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 first recognized, in a most grudging way, 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 rather 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 decision-maker 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.[63]

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 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.[64]

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.[65]

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.[66]

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.[67] 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

[60] In *McKinnon v. Patterson*, 568 F.2d 930 (2nd 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 mem.*, 434 U.S. 1052 (1978).

[61] 103 S. Ct. 864 (1983).

[62] *Id* at 871.

[63] *Id* at 874.

[64] *Id* at 876.

[65] *Id* at 877.

[66] *Id* at 878.

[67] *Id*.

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.[68]

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 open-ended, 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 henceforth, 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.[69]

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, for those who favor written laws and regulations for the governance of prison life, 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. [70]

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; that is, to parole and good-time credits. Where rules govern the day-to-day operation of a prison, he suggests, then administrative discretion should prevail.

In this section, the objective was to provide 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 focused on the development and status of federal constitutional rights.

This section 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.[71] We barely noted important matters of access to literature, problems of media coverage, claims based on religious freedom, visitation questions, and many others.

We hope we have presented enough law so that the reader understands somewhat the less-than-clear picture of the inmate as a jural entity. Among the more important points to take from this section 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.*
2. *The Court repeatedly has 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. *Somewhat earlier thinking by correction officials to the effect that "no rules are good rules" may now be tempered by Justice Rehnquist's views on "housekeeping" procedural rules that do not necessarily create liberty interests.*

[68] *Id* at 880.

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

[70] 103 S. Ct. at 870.

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

4. *Not previously expressed in the text is the observation that correctional authorities may not always see that at times their interests coincide with the legal claims put forward by inmates. For example, if corrections "loses" a general conditions-overcrowding case, then the "loss" means fewer inmates, more programs, more personnel (typically professionals or specialists), and less tension.*

III. THE RIGHT TO TREATMENT

A. Treatment: In General

This section is central to an overall coverage of the legal rights of the mentally disordered offender. Consequently, we will deal with the many issues encompassed by treatment in some detail and will also use extended quotations from legal material. The quoted material should provide the reader with specific facts and details of judicial decrees and orders, which will help the reader assess the legal health of individual prisons or prison systems.

The key to this section, of course, is whether ot not a prison inmate has a legal right to treatment.[1] Statements made earlier should leave no doubt that *Estelle v. Gamble*[2] established that prisoners have an Eighth Amendment right to treatment for physical ailments and that 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; he was examined and given some medication.

Gamble's 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:

> . . .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, several key questions were left 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]

[1]This question, as alluded 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 Section III (J).

[2]429 U.S. 97 (1976).

[3]551 F.2d 44 (4th Cir. 1977).

[4]429 U.S. at 104-105.

[5]*Id* at 105-106, Justice Marshall stated that the various courts of appeal were in essential agreement with this standard.

Despite a broadly shared fear of malpractice litigation, psychiatrists actually are quite safe. Indeed, it is reported that, "no reported decision by an Amercian court has been found that deals with a psychiatrist's liability for purely verbal therapy." Horan & Milligan, Recent Developments in Psychiatric Malpractice, 1 *Behav. Sci's & The Law* 23, 27 (1983).

[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 44, 47 (4th Cir. 1977). No post-*Estelle* decision to the contrary has been found.

[8]*Id.*

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]

Having established the groundwork for a constitutional right to care, we shall next closely examine the cases dealing with satisfactory and unsatisfactory diagnostic-classification systems.

B. Classification

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.[11] As was discussed earlier, *Meachum* makes 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 [12]

We will approach this topic 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,[13] a landmark overall prison conditions case, is also one of 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 Multiphasic 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. Furthermore, Dr. Jose Garcia, Chief of Mental Health Services at TDC, testified that all of the tests were culturally and racially biased.[14]

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."[15]

The court determined that in order to meet basic minimum standards for mental health treatment, among other things, "There must be a systematic program for screening and evaluating inmates in order to identify those who require mental health treatment."[16]

[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. *See* subsection G *infra* for further discussion of rehabilitation.

[10]Letter to Fred Cohen from Donald C.J. Gehring, Aug. 25, 1983, Deputy Attorney General, Commonwealth of Virginia.

[11]*See* e.g., Nat'l Adv'y Comm'n on Criminal Standards and Goals Standards 6.1 §6.2 emphasizing classification based on risk and program factors.

It is also the case that some prison assignments are made simply on the basis of the availability of space.

[12]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.

[13]*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). *See* also 553 F. Supp. 567 (S.D. Texas, 1982) on the award of attorney fees.

[14]503 F. Supp. at 1332-1333.

[15]*Id* at 1333. Inadequate training or education is a recurring problem throughout this area. Subsequently we shall note how low levels of training contribute to the legal deficiency of various prisons and prison systems.

[16]*Id* at 1339.

Pugh v. Locke[17] 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.[18]

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.[19]

Barnes v. Government of Virgin Islands[20] 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.[21]

> 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.[22]

The Puerto Rican prison system was the subject of a devastating legal attack in *Feliciano v. Barcelo*.[23] 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 so an inadequate screening or classification system, in which guards, who had no training in the area, carried out what evaluations there were.[24]

In addition to finding many aspects of the Puerto Rican prison system unconstitutional, the district judge entered a detailed order concerning classification.[25]

[17]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) remanded on other grounds sub. nom. *Alabama v. Pugh*, 438 U.S. 781 (1978).

[18]406 F. Supp. 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.

[19]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).

[20]415 F. Supp. 1218 (D. Virg. Islands, 1976).

[21]*Id* at 1229.

[22]*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."

[23]497 F. Supp. 14 (D. Puerto Rico, 1979).

[24]*Id* at 29.

[25]"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 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 of 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.

Laaman v. Helgemoe involved yet another constitutional challenge to overall prison conditions, this time aimed at the New Hampshire State Prison (NHSP).[26] At NHSP, a new inmate goes through a period labelled "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.[27] The only way mentally ill inmates could receive treatment at NHSP was to apply to be screened, and then be 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.[28] To remedy this situation, the court entered an even more detailed order than was entered in the decision involving Puerto Rico.[29]

In *Palmigiano v. Garrahy*, prisoners and pretrial detainees challenged conditions at the Rhode Island Adult Correctional Institutions (ACI).[30] After a recitation of problems caused by a deficient classification system, which tracks 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."[31] Nor, said the court, had the prison officials obeyed a statute requiring them "to furnish the means as shall be best designed to effect. . .rehabilitation."[32]

It was also determined that the classification system failed to comply with yet another statute, which requires that each inmate shall be evaluated as to his proper security status and for such medical or rehabilitative care as may be indicated.[33]

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 detail a court is likely to impose on the system.

[26]437 F. Supp. 269 (D.N.H. 1977).

[27]*Id* at 283.

[28]*Id* at 290.

[29]"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 are included to illustrate the commonality of legal concerns for "special needs" categories of inmate.

[30]443 F. Supp. 956 (D.R.I. 1977) remanded on issue of deadlines, 599 F.2d 17 (1st Cir. 1979).

[31]R.I.G.L. §42-56-1 (Supp. 1976).

[32]443 F. Supp. at 980 R.I.G.L. §42-56-19 (Supp. 1976).

[33]R.I.G.L. §42-56-29 (Supp. 1976). This heavy reliance on state law is still somewhat unusual. However, as the Supreme Court becomes more conservative in the creation of federal liberty interests, we can expect 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 the ostentation of 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 in the very process of denying a right to rehabilitation actually grant it in the form of ordering the implementation of another right. The link between classification and "help," however denominated, is not ineluctible, but is is close. 443 F. Supp at 987-988.

We should also note the ease 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 subsection is important, but the reader should not overlook the fact that the legal issues involved here are an inmate's constitutional right to treatment for serious mental disorders and the concommitant 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 presumptively 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[34] 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.[35]

In *Johnson v. Levine*[36] 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.[37]

To conclude this area, 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.[38] There must be acceptable tests and other evaluative devices that are not racially biased or ineffective 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 system that is disorganized, that cannot show consistent development, use, and review of classification information and conclusions is a system vulnerable to legal challenge.

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.

There are fundamental, conceptual, definitional, and empirical questions about treatment that rarely are addressed by the courts. For example, is there treatment if it can be established that there 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 a process or is it an end itself? If it is more process than end — and that seems generally acceptable — then what are the ends of treatment? Cure? Relief of suffering? Amelioration? What?

If it is agreed that treatment is a process of intervention within a healing-relief of suffering or pain model, and that the presence of a mental health professional implies, but hardly guarantees, 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, albeit 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 bona-fide effort to cure or improve the patient.

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[34]535 F. Supp. 435 (N.D. Ind. 1981).

[35]*Id* at 493. Interestingly, the court did find that the overcrowding in the prison system violated the Eighth Amendment and a reduction was ordered.

[36]450 F. Supp. 648 (D. Md. 1978); *aff'd* 588 F.2d 1378 (4th Cir. 1978). Parole and release procedures also were upheld.

[37]450 F. Supp. at 652.

[38]Nathan Glazer, who is generally critical of activist courts and especially in the 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 (Theberge, L.J., ed., 1979).

(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.[39]

Another landmark case, *Wyatt v. Stickney,*[40] 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.[41]

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.[42] However, courts do, and in our judgment should, express skepticism when, let us say, a simple regiment 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. *Beware of the hyphen* expresses 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 and when recognized seems to be simply enfolded in the judicial orders issued to improve various state facilities.

As a final point prior to examining the leading cases, the reader should try to distinguish the type of treatment rights spawned by *Estelle* from the more expansive type of treatment claims encountered somewhat earlier, claims that equated treatment with efforts to achieve personal growth, a satisfactory life, happiness, and so on.[43] The type of treatment referred to in this work more often than not is 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 I.

The expansive version of treatment is forward-looking and includes what some refer to as cultivation of functioning.[44] 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, in turn, raises immediate questions about the mental health of the inmate. The correctional response may be as concerned with "curing" the incident as with "curing" the inmate.

Turning 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.[45]

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

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[39]373 F.2d 451 (D.C. Cir. 1966).

[40]325 F. Supp. 781 (M.D. Ala. 1971).

[41]*See* Hoffman & Dunn, Guaranteeing the Right to Treatment in Psychiatrists and the Legal Process: Diagnosis and Debate 298 (Bonnie, R.J., ed., 1977).

[42]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 dynamic therapy seems more successful than any other. Morse, Failed Explanations and Criminal Responsibility: Experts and the Unconscious, 68 *Va. L. Rev.* 971, 1000-1001 (1982).

[43]*See* Joint Comm'n on Mental Illness and Health. Action for Mental Health, Ch. II (1963).

[44]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.H. Swartz, "Mental Disease": The Groundwork for Legal Analysis and Legislative Action, 111 *U. Penna. L. Rev.* 389 (1963).

[45]503 F. Supp. 1265, 1332 (S.D. Tex. 1980), *aff'd* in part, 679 F.2d 1115 (5th Cir. 1982), *cert. denied* 103 S. Ct. 1438 (1983).

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.[46]

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.[47]

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).[48]

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.[49]

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 (a 1:4 ratio), while mental health professionals were hardly in evidence. Psychotropic medication and unadorned confinement constituted TDC's inadequate response to inmates' serious mental disorders.[50] 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.[51] . . . 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.[52]

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.[53]

Judge Justice's six components for a minimally adequate mental health treatment program . . .[are]: 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.[54]

In *Finney v. Hutto* the court found that mental health care for mentally or emotionally ill prisoners in the Arkansas system consists of nothing more than the administration of drugs or, for violent inmates, transfer

[46]503 F. Supp. at 1265.

[47]*Id* at 1333-34.

[48]*Id* at 1334. That, of course, is precisely what TDC officials believed about Mr. Gamble and his back pains.

[49]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 is doing his doctoral thesis on prison decision-making and the mentally disordered inmate.

The "price" may include harsh isolation, sharing cell space with highly undesirable inmates, being placed in physical jeopardy, and so on.

[50]503 F. Supp. at 1334-36. These pages are rich in detail and should be consulted by those needing such details.

[51]*Id* at 1339.

[52]*Id*.

[53]*Id*.

[54]*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.

to the state hospital for a temporary hold.[55] 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.[56]

The challenge to the Maryland House of Corrections in *Johnson v. Levine*[57] 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, however, 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.[58]

This case combined the absence of treatment — mentally ill inmates are warehoused — with uncivilized overall conditions to conclude that SCA did not meet minimum constitutional standards. This court forced the remedy issue by requiring transfer to a mental hospital of the actively psychotic inmates — threatening to join any recalcitrant agencies as defendants — and the use of segregation for acting-out inmates not found to be mentally ill.[59]

Newman v. Alabama involved a similar situation, a combination of no treatment and dubious isolation practices and conditions.[60]

> 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.[61]

Living conditions for mentally disordered prisoners in the Puerto Rican prison system appear to have closely resembled those in the Maryland House of Correction and the Alabama system.[62] 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 generally were 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 would tamper with the records and order medication.[63]

The court held that the above conditions violated the inmates' constitutional rights.[64]

The problems of adequate treatment were a bit more sophisticated in the New Hampshire prison system. A semblance of mental health care was available. Indeed, the case even included a debate about how much time should be spent on diagnosis and how much on treatment, and there was a discussion of manageable caseloads.[65] What was 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.[66]

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

[55]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).

[56]410 F. Supp. at 260.

[57]450 F. Supp. 648 (D. Md. 1978); *aff'd* 588 F.2d 1378 (4th Cir. 1978).

[58]450 F. Supp. at 657. It is difficult to resist the comparison between indefinite confinement of the mentally ill and determinate confinement for criminal offenders.

[59]*Id* at 657-658. (Citations omitted).

[60]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).

[61]349 F. Supp. at 284. The court pointed out, in Footnote 5, that "The 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, F. Supp. 387 (1972)."

[62]*Feliciano v. Barcelo,* 497 F. Supp. 14 (D. Puerto Rico 1979).

[63]*Id* at 30.

[64]*Id* at 34. *See Santana v. Collazo,* 714 F.2d 1172 (1st Cir. 1983) 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.

[65]*Laaman v. Helgemoe,* 437 F. Supp. 269 (D.N.H. 1977).

[66]*Id* at 290.

institution and make arrangements to implement the provision of such care.[67]

The Menard Correctional Center in Illinois succumbed to a broad-based attack on its health care delivery system.[68] 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 ongoing 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.[69]

In *Hoptowit v. Ray* the Ninth Circuit upheld the district court's finding that health care was inadequate at the Washington State Penitentiary.[70] The penitentiary lacked basic psychiatric services and had deficiencies in staff and programs.

However, the Court of Appeals 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."[71]

Thus, a review of the leading decisions where relief was granted produces a pattern of either no mental health care[72] 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."

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.[73] 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 had been received to provide for therapeutic services for inmates on self-lockup and a stress and relaxation therapy group was being conducted by an outside consultant two days a week. In addition, psychotherapy groups were run by a consulting psychiatrist.[74] Outside of the prison, 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.[75]

Although the troubling theme of desirable (not attained) *v* 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

[67] *Id* at 328.

[68] *Lightfoot v. Walker*, 486 f. Supp. 504 (S.D. Ill. 1980).

[69] *Id* at 521-22.

[70] 682 F.2d 1237 (9th Cir. 1982).

[71] *ID* at 1253. *See* the various standards noted in the text at 99 ff.

[72] *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 inpatient psychiatric population.

[73] *Hendrix v. Faulkner*, 525 F. Supp. (N.D. Ind. 1981); *aff'd* in part, vacated and remanded on the issue of costs; 715 F.2d 277 (7th Cir. 1983).

[74] 525 F. Supp. at 495-96.

[75] *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.

to immediate, and perhaps life-sustaining care and that right almost certainly calls for some kind of on-site care.[76]

In *Grubb v. Bradley* inmates successfully challenged many of the conditions in 12 of Tennessee's penal institutions but the court upheld the provisions of mental health care.[77] 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.[78]

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.[79]

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.

Canterino v. Bland involved inmates at the Kentucky Correctional Institute for Women (KCIW) who won a significant overall victory in court by demonstrating unconstitutional disparities with the male 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.[80]

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.[81] 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.[82]

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 an on-going, self-help program called rational behavior counseling.[83]

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.[84]

This review and analysis of the leading decisions on adequate treatment for mentally disordered inmates points up several sharp conclusions. The constitutional minima — the deliberate indifference standard — is relatively easy to meet. The cases echo the theme of generally undesirable yet constitutionally acceptable levels of care, care that is below professional standards but constitutionally acceptable.

Even with a less-than-demanding standard for assessing mental health services, many jurisdictions failed the federal constitutional test, or, less often, a state law test. Reliance on psychotropic drugs alone, simple confinement, reacting only to crisis believed to stem from mental disorders, group therapy alone, and heavy reliance on untrained or nonprofessional personnel appear to be the critical factors in a finding of unconstitutionality.

Each jurisdiction has a number of options available in deciding on mental health care policy. The mix between on-site and off-site care, the proportion of various mental health professionals, the reliance on various modalities of recognized treatment are important examples of — let us call it — local option. *There is no option to do nothing!*

The number of mentally disordered inmates in any given system varies greatly and, one suspects, varies on the basis of available perceptions and resources rather than objective diagnosis or testing. It would be interesting for a court to be confronted by a claim of "no mental health care" which was answered by "no mentally disturbed inmates."

One envisions a subsequent battle of experts with one side finding all "bad guys" and the other finding many "mad guys." And who would be correct?

D. Isolation

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,

[76] *Cf. Schmidt v. Wingo*, 499 F.2d 70, 75-76 (6th Cir. 1974).

[77] 552 F. Supp. 1052, 1130 (M.D. Tenn. 1982).

[78] *Id* at 1130.

[79] *Id*.

[80] 546 F. Supp. 174 (W.D. Ky. 1982).

[81] *Id* at 200, n. 22.

[82] *Id* at 200.

[83] *Id*.

[84] *Id* at 215.

to be immeasurably worse than any torture of the body . . . .[85]

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, we 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.[86] Legal problems do arise concerning the procedures used, especially for disciplinary isolation, and also where the conditions of isolation involve the wanton infliction of pain, deny basic human needs, or are grossly disproportionate to the crime warranting imprisonment.[87] Even where confinement is extraordinarily long[88] or where isolation might cause psychiatric deterioration, courts have been extremely reluctant to interfere.[89]

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? Both aspects of the question include an empirical dimension.

That is, the questions seem to presuppose that isolation is damaging, damaging in a way that exceeds the pain that many of us feel in being denied the basics of 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.[90] Suicidal inmates, for example, can be pushed over the brink if isolated. Inmates who are in great fear can regress to a form of panic reaction which is psychologically devastating. According to Toch, paranoid-schizophrenics often have a counterproductive reaction to isolation.[91]

At least one other authority has found that the isolation of some inmates actually may produce positive results.[92] 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.[93]

It seems reasonably well established that it is not unconstitutional *per se*, although it may be exceedingly poor policy, to isolate a mentally disordered inmate. The mental condition of the inmate — like the age of a juvenile who is incarcerated — becomes a factor in the constitutional calculus, along with duration and the overall conditions of confinement. It was recently decided that while juveniles (not convicted of crimes) 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.[94]

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 imposed. 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.

McCray v. Burrell, involving the Maryland Penitentiary, is a fascinating case which raises many questions about isolation as well as the interaction between punishment and treatment.[95] 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:

[85] C. Dickens, American Notes and Pictures From Italy 86 (1903).

[86] *Cf. LaReau v. MacDougall,* 473 F.2d 974, 978 (2nd 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); 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).

[87] *See Rhodes v. Chapman,* 452 U.S. 337, 347 (1981). The procedural issues suggested in the text are not addressed here.

[88] *Sostre v. McGinnis,* 442 F.2d 178 (2nd Cir. 1971); *cert. denied* 404 U.S. 1049 (1972).

[89] *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.

There is some irony in the reluctance in that some of the earliest affirmative rulings for inmates involved conditions in solitary confinement. *E.J. Jordon v. Fitzharris,* 257 F. Supp. 675 (N.D. Cal. 1966); *Wright v. McMann,* 387 F.2d 519 (2d Cir. 1967).

[90] *See generally* H. Toch, *Men In Crisis: Human Breakdown in Prison* (1975).

[91] 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.

[92] P. Suedfeld, *Restricted Environmental Stimulation: Research and Clinical Applications* (1980).

[93] 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.

[94] *Santana v. Collazo,* 714 F.2d 1172 (1st Cir. 1983).

[95] 516 F.2d 357 (4th Cir. 1975).

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 acordance 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 *'psychologist/psychiatrist should be contacted immediately after the confinement of the inmate should be evalated within a twenty-four (24) hour period.'* (Emphasis added.) 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.[96]

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.[97] 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 uncrusted 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.[98]

The district court found that the inmate's confinement in these cells was not intended 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.[99]

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, but it remained to decide whether cruel and unusual punishment had been inflicted.[100]

The court determined that two separate violations had occurred. First, when the initial protective measures were taken — and they were not in doubt — then a clinician should have been contacted immediately and an evaluation performed within twenty-four hours. The Administrative directive was held to be the constitutional minima 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.[101]

The conditions of confinement in the MO cell *per se* fall short of the current standards of decency of present-day society. Indeed, it is probably of no legal consequence that the inmate may or may not have been mentally disordered. The previously described conditions in the MO cell cannot constitutionally be used for any inmate.

[96] *Id* at 365-66.

[97] *Id* at 366.

[98] *Id* at 367..

[99] *Id.*

[100] *Id.*

[101] *Id* at 369.

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.[102] Where prison officials defend a practice by saying it is treatment and not punishment, then that argument triggers the "seek help" obligation. If officials characterize this type of penal practice as punishment, then they face squarely the demands of 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, "It is clear that [solitary] confinement is not *per se* violative of the Eighth Amendment.[103]

After upholding the isolation cells at three other prisons, Judge Lord reviewed the Huntingdon Correctional Institution.

> 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 the 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.[104]

Judge Lord's reference to psychiatric cases seems almost casual and clearly is not central to his finding the Glass Cage as unconstitutional. In *Laaman v. Helgemoe,* however, we encounter a much more direct reference to the special needs and problems of the mentally disordered inmate and the use of isolation.[105]

The isolation cells in New Hampshire are described as having "the potential of devastating psychic, emotional, and physical damage."[106]

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 . . . .[107]

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.[108]

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.[109]

In arriving at its decision, the Court relied heavily on the landmark case of *Newman v. Alabama,*[110] 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 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.[111]

To conclude this area, we should reemphasize 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 will not likely 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.

E. Records

The right to receive, and the obligation to provide, treatment creates important ancillary duties. The preparation and maintenance of adequate medial records often is 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; providing records for 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.[112]

In *Ruiz,* records that consisted merely of the complaint registered by the inmate and documentation of prescribed medication were found to be inadequate. The records at corrections facilities failed to include diagnosis by the physician, the results of tests, entries indicating the care actually provided, and admission and discharge summaries.[113]

A further deficiency in the medical record-keeping at TDC facilities was that inmates frequently made or transcribed the records and that 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.[114]

The essence of the ruling is that "accurate, complete, and confidential records of the mental health treatment process must be maintained."[115]

In *Hendrix v. Faulkner*[116] 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.[117] 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 medical records procedure was being reevaluated.[118]

As an important aspect of the low-level 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.[119]

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.[120] 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.[121]

Surprisingly, the court did not find anything constitutionally objectionable about the use of inmates in the medical records department.

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[102] This aspect of the decision clearly needs to be reconsidered in light of *Helms v. Hewitt,* 103 S. Ct. 864 (1983).

[103] *Imprisoned Citizens' Union v. Shapp,* 451 F. Supp. 893, 896 (E.D. Pa. 1978). Most of the issues had been settled by consent decree.

[104] *Id* at 898.

[105] 437 F. Supp. 269 (D.N.H. 1977).

[106] *Id* at 280.

[107] *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.

[108] *Jackson v. Meachum,* 699 F.2d 578, 581 (1st Cir. 1983). The inmate had been diagnosed as suicidal.

[109] *Id* at 583-84.

[110] 559 F.2d 283 (5th Cir. 1977), *cert. denied* 438 U.S. 915 (1978).

[111] 699 F.2d at 582-83.

[112] 503 F. Supp. 1265, 1323 (S.D. Tex. 1980), *aff'd* in part, 679 F.2d 1115 (5th Cir. 1982), *cert. denied* 103 S. Ct. 1438 (1983).

[113] 503 F. Supp. at 1323.

[114] *Id.*

[115] *Id* at 1339.

[116] 525 F. Supp. 435 (N.D. Ind. 1981).

[117] *Id* at 504.

[118] *Id* at 504, 520.

[119] *Barnes v. Government of Virgin Islands,* 415 F. Supp. 1218, 1235 (D. Virgin Islands 1976).

[120] 492 F. Supp. 650 (W.D. Mo. 1980).

[121] *Id* at 676.

> 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.[122]

Record-keeping in the New Hampshire penal system fared no better than in Missouri. In *Laaman v. Helgemoe*[123] 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.[124] 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 both inside and outside the prison.[125]

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.[126]

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,*[127] and those objectives should serve as a guide for those concerned with reviewing their practices and for those contemplating 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.

F. Substance Abuse Programs

In *Marshall v. United States*[128] the Supreme Court considered a challenge to the Narcotic Addict Rehabilitation Act of 1966[129] insofar as the Act excluded from discretionary rehabilitative commitment, in lieu of penal confinement, addicts with two or more prior felony convictions. The most likely 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 and very 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.[130] 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.[131]

Marshall stands as a major barrier, then, to any constitutional claims brought by narcotic addicts or alcoholics to rehabilitative care after conviction and confinement. We might pause here and ask why it is that 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.[132] Counsel for the state conceded that narcotic addiction was an illness, citing *Linder v. United States* to support this view.[133]

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[122]*Id* at 681.

[123]437 F. Supp. 269 (D.N.H. 1977).

[124]*Id* at 287.

[125]*Id.*

[126]*Id* at 327.

[127]503 F. Supp. 1265 (S.D. Tex. 1980), *cert. denied* 103 S. Ct. 143.

[128]414 U.S. 417 (1974).

[129]18 U.S.C. §4251-4255.

[130]414 U.S. at 421-22.

[131]*Id* at 428-29.

[132]370 U.S. 660 (1962).

[133]*Id* at 667, n. 8 *Linder,* 268 U.S. 5 (1925), recognized addicts as diseased for the purpose of receiving treatment.

Five years later, the Court dealt with the question of whether it was constitutionally permissible to punish a chronic alcoholic for being drunk in a public place.[134] 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.[135]

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.[136]

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.[137]

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.[138] 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.[139]

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 squarely with the question 'whether failure to provide treatment for alcoholic prisoners constitutes cruel and unusual punishment, in violation of the Eighth Amendment. . . .'"[140] 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 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 treat-

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[134]*Powell v. Texas,* 392 U.S. 514 (1968).

[135]*Id* at 532.

[136]Even the latter statement needs some clarification. Justice White, in concurring and providing the survey 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."*Id* at 560. Justice White upheld the conviction based on the state of the record and not an express or tacit rejection of alcoholism as a disease.

[137]*See* C. Winick, The Alcohol Offender Ch. 15 & The Drug Offender Ch 16 in Psychology of Crime and Criminal Justice (Toch, H., 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).

[138]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).

[139]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 (3rd Cir. 1981).

[140]*Id* at 458. The court also dealt with a similar claim based on state law.

ment 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.[141]

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.[142] 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.[143]

In *Palmigiano v. Garrahy* the court found a variety of conditions at the Rhode Island Adult Correctional Institution (ACI) below constitutional minima.[144] 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.[145]

The chief physician at ACI testified that between 70 and 80 percent of inmates enter and remain drug abusers. The court found no written or unwritten protocols or policies despite the powerful dimensions of the problem.[146]

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.[147]

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 amore vigorous analysis of "serious disease" and the "deliberate indifference" standard. However, this court, shown a problem of crippling dimensions with an insidious effect on prison life, elected to press the constitutional treatment button.[148]

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 these matters as diseases, or if seen as diseases, 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.

G. Rehabilitation

In more than a few cases issues involving treatment and rehabilitation are confounded and dealt with in overlapping fashion.[149] 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.[150]

The supposed differences between treatment — to which there now is 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' problems.[151]

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.[152]

Ohlinger v. Watson, a fascinating decision we will discuss 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."* (emphasis added)[153]

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 who were confined under indeterminate life sentences on a finding that they possessed a mental disturbance predisposing them to the commission of sex offenses.[154]

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 consitutionally 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.[155]

The opinion in *Ohlinger* uses the terms rehabilitation and treatment interchangeably. This appears to be more sloppy than considered. For example, in reviewing the appellant's 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."[156]

Ohlinger considered the relevance of *Bowring v. Godwin*[157] but found it inapplicable precisely because

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[141] *Id* at 458-59.

[142] 585 F.2d 1183 (3rd Cir. 1978).

[143] *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.

[144] 443 F. Supp. 956 (D.R.I. 1977), *aff'd* 616 F.2d 598 (1st Cir. 1980).

[145] *Id* at 972.

[146] *Id.*

[147] *Id* at 989.

[148] 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 treatment unit. 406 F. Supp. 649, 667 (S.D. Tex. 1975); *Id* at 677.

The court decided that the totality of the conditions at Harris County's Jail were unconstitutional. High among the problems were inmates with substance abuse problems 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.

[149] It is also the case that mentally retarded inmates may present claims to habilitation adding additional semantic and conceptual complexity to the area.

[150] 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 at Section III (C), *supra.*

Two authorities suggest that rehabilitation is simply the wrong word since most inmates arrive at prison without ever having acquired 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).

[151] *See page 59 supra* for earlier discussion. The concepts of rehabilitation and treatment as cultivation of functioning have much in common.

[152] *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).

[153] 652 F.2d 775, 779 (9th Cir. 1980).

[154] *Id* at 777.

[155] *Id* at 777-78. The California case referred to is: *People v. Feagley,* 14 Cal.3d 338, 359, 535 P.2d 373, 386, 121 Cal. Rptr. 509 (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.

[156] 652 F.2d at 780.

[157] 551 F.2d 44 (4th Cir. 1977).

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 creates both a hybrid constitutional and a *statutory* claim to psychiatric care.[158]

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.

In one instance 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.[159]

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 participate 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 unquestionable 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 arbitrarily. In such case due process must be afforded.[160]

More recently, in *Rhodes v. Chapman* the Court refused to equate undoubted prison overcrowding with cruel and unusual punishment.[161] Diminished job and education opportunities due to overcrowding were found not to violate the Eighth Amendment even when viewed as "desirable aids to rehabilitation."[162]

The right to avoid degeneration *is* explicitly recognized by some courts.[163] 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."[164]

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[158]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.J. Steadman, eds., 1983).

[159]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 rehabiliation" 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).

[160]*Meachum v. Fano,* 427 U.S. 215, 234 (1976). 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).

[161]452 U.S. 337 (1981).

[162]*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.

[163]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, *Public Law* 282, 286 (1982).

[164]564 F.2d 388, 403 (10th Cir. 1977).

The nature of this emergent duty to prevent degeneration was synthesized by the court in *Laaman v. Helgemoe.*[165] The court said the conditions of incarceration should not threaten an inmate's 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.[166]

In *Laaman* the court calculated the scarcity of rehabilitation, recreation, and skills training as part of its overall balance sheet that prison life in New Hampshire causes prisoners to degenerate and lose whatever social conscience and skills they may have had.[167] In its expansive order, the court required vocational training programs, meaningful access to services and programs that are offered, and mandated certain programs as well, with emphasis on pre-release inmates.[168]

In *Pugh v. Locke*[169] 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 the opportunity to participate in job and educational programs.[170]

Canterino v. Wilson is a somewhat unusual decision resting on equal protection grounds in the process of comparing the programs available to female inmates with those available to men. This type of analysis does not lead to the creation of rights.[171] Rather, the problem is the fairness or rationality with which desirable items — here rehabilitative programs — are distributed and the basis 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."[172] Judge Johnstone found that equal protection was violated in the maldistribution 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.[173]

Thus it should be kept in mind that while a system may not be legally obliged to provide rehabilitative opportunities, where such opportunities are provided, 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 empirical overlap between rehabilitation and treatment and with the minimal obligations of 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' debilitation, mentally or physically, 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.

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

H. Suicide

Our 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.[174] Only about 10 percent of all prison deaths are suicides and, indeed, in terms of actual

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[165]437 F. Supp. 269 (D.N.H. 1977).

[166]*Id* at 316. *See* also *James v. Wallace,* 406 F. Supp. 318 (M.D. Ala. 1976).

[167]437 F. Supp at . 325.

[168]*Id* at 329-30.

[169]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).

[170]406 F. Supp. 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.

[171]546 F. Supp. 174 (W.D. Ky. 1982).

[172]*Id* at 211.

[173]*Id* at 207.

[174]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, 19082, 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).

numbers, prison suicides are only about a quarter of the jail suicides.[175]

Professor Hans Toch, perhaps the most prominent scholar of prison violence, writes about 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.[176]

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.[177]

Among the more serious mistakes in dealing with suicidal inmates is the reflexive use of isolation, and, still worse, unsupervised or unprofessionally 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.[178] Also, these suicidal inmates were cared for randomly by technicians and not professional clinicians.[179]

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.[180]

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 . . ."[181] Judge Justice condemned the practice of ignoring or punishing inmates who attempted suicide, something which frequently occurred in Texas.

A recent, and quite sophisticated, set of jail standards identifies suicide prevention as one of its four primary service goals.[182] 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.[183] Also the standards urge cooperation between the Departments of Health and Correction, especially in sharing relevant mental health information.[184]

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 potent.[185]. 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.

[175]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).

[176]H. Toch, Peacekeeping: Police, Prisons, and Violence, 61-62 (1976).

[177]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., §314A.

[178]486 F. Supp. 504, 521 (S.D. Ill. 1980).

[179]*Id* at 521.

[180]*Id* at 527.

[181]503 F. Supp. 1265, 1339 (S.D. Tex. 1980), *aff'd* in part, 679 F.2d 1115 (5th Cir. 1982), *cert. denied* 103 S. Ct. 1438 (1983). *See* also *Gioia v. State*, 22 A.D. 2d 181, 254 NYS 2d 384 (1964) recognizing a duty to prevent suicide when a suicidal tendency is, or should have been, noted.

[182]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).

[183]*Id* at Sec. 2.4.

[184]*Id* at Sec. 7.4 (b).

[185]The *New York Times* reported 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).

I. 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*[186] 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.[187]

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.[188]

> 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.'

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 reading of the cases 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.[189]

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.[190] 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 arrangemnets for psychiatric or psychological assistance.[191] Needless to say this litany of "not availables," along with generally poor conditions, was found inadequate.[192]

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 the 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'."[193] 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.[194]

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.[195]

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 question as doublebunking, reading material, strip searches, and the like. There is less of a problem with medical and psychological needs. No one speaks of the need to closely

[186]441 U.S. 520 (1979).

[187]*See* e.g. *Brenneman v. Madigan*, 343 F. Supp. 128, 142 (N.D. Cal. 1972).

[188]441 U.S. at 531-535.

[189]*See Jones v. Diamond*, 636 F.2d 1364 (5th Cir. 1981).

[190]527 F. Supp. 1252 (S.D. W.Va. 1981).

[191]*Id* at 1273.

[192]*See Lareau v. Manson*, 651 F.2d 96 (2nd Cir. 1981) for a discussion of due process and Eighth Amendment standards.

[193]*Inmates of Allegheny County Jail v. Pierce*, 487 F. Supp. 638 642-43 (W.D. Pa. 1980).

[194]*Id* at 641.

[195]*Id* at 644.

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.[196] The court of appeals substantially upheld the lower court's order:

> 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.[197]

In *Jones v. Wittenburg* the inmate challenged the conditions of the Lucas County Jail.[198] 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."[199]

In *Alberti v. Sheriff of Harris County, Texas* a challenge to the jail conditions was successfully brought.[200] The court ordered an immediate screening program to detect psychological and psychiatric problems.[201] In addition, the jail officials were ordered to find a new location to house mentally ill and mentally disturbed inmates.[202]

Analysis of numerous decisions fails to disclose any sharp 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.[203] 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.[204] They must be classified in a reasonable fashion and be provided with access to mental health professionals. 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 situs and the nature of the problem.

J. Mentally Retarded Offenders

Miles Santamour and Bernadette West well describe 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 suffer 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.[205]

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. Ask about programs, and you get an empty smile — there are none, you will be told.

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.[206]

Let us begin this topic with a critical, threshold question: does the mentally retarded inmate have a constitutional right to treatment (or habilitation), and if so, what is the source of such right?[207]

[196]580 F.2d 521, 549 (D.C. Cir. 1978).

[197]*Id* at 6548-49. The order was amended for additional flexibility on the 48-hour time limit.

[198]509 F. Supp. 653 (N.D. Ohio 1980).

[199]*Id* at 687.

[200]406 F. Supp. 649 (S.D. Tex. 1975).

[201]*Id* at 677.

[202]*Id.*

[203]There is some attention given to distinguishing housing minima for detainees and 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.

[204]*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).

[205]M.B. Santamour & B. West, Retardation and Criminal Justice: A Training Manual for Criminal Justice Personnel 14 (President's Committee on Mental Retardation, 1979).

[206]B. Rowan, "Corrections" in the Mentally Retarded Citizen and the Law 650, 661 (M. Kindred, ed., Pres's Committee on Mental Retardation, 1976). The author also reports the same problems noted in the text as reported by Santamour and West, *supra* note 209.

[207]I.Q. scores of 69 or below on a standardized test is the generally acceptable measure for identifying the mentally retarded. Earlier research suggested that about 9 percent of the offender population is retarded. *See* B. Rowan & T. Courtless. The Mentally Retarded Offender (N.I.M.H. 1967).

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.[208] 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.[209]

Thus, by keeping mental retardation out of the sickness model — presumably for good reasons — the retarded inmate's claims to help, however such help is denominated, 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.[210] Romeo, a profoundly retarded adult, did not challenge the legitimacy of his initial commitment or seek release. He claimed that 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.[211]

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 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.[212] Also freedom from undue bodily restraint was recognized as a fundamental liberty interest which also survives criminal conviction and incarceration.[213]

Justice Powell's penchant for compromise, and his search for the thinnest possible slice when new rights are recognized, causes him to craft, let us say, less than clear opinions. The Justice 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. In determining what is reasonable, deference must be shown to the judgment exercised by qualified professionals. Indeed, so long as such judgment is exercised, constitutional minima have been met.[214]

Exactly what all this means for the mentally retarded citizen in civil confinement is hardly clear.[215] 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 jeopardy. And those who prescribe the training are protected so long as they exercised judgment, not good judgment, simply judgment.

Justice Powell also stated, "Persons 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."[216] 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 *Romeo*, 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

[208]*See* Chapter III, *supra*. Also *see* 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.

[209]Brief of the American Psychiatric Association as *Amicus Curiae* at 4, n. 1 quoted in *Youngberg v. Romeo,* 102 S. Ct. 2452, 2454 n. 1 (1982).

[210]102 S. Ct. 2452 (1982).

[211]*Id* at 2455. Treatment was used synonymously with habilitation.

[212]*Id* at 2458. *See* discussion on point in Chapter II.

[213]*Id.*

[214]*Id* at 2461. The Court expanded on 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 2462, n. 30.

[215]*See* e.g., the several interpretations discussed in *Rennie v. Klein,* 720 F.2d 266 (3d Cir. 1983). Also *see* 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.

[216]102 S. Ct. at 2461. The Justice cites *Estelle v. Gamble* to support this proposition.

in prison — three times the number of who are outside — the vast majority of such inmates are only mildly retarded.[217]

Should a person as profoundly retarded as Romeo appear at the prison gates (an I.Q. of between eight 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 also 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.

A mentally retarded inmate's special claim to help is derived from his 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.[218]

The *Ruiz* decision, once again, sets the tone for judicial consideration of the mentally retarded inmate.[219] Judge Justice found that between 10 and 15 percent of TDC inmates were retarded and that they were distributed throughout the TDC system.[220] The Judge echoed Santamour and West concerning the retarded inmates' special problems and added that:

1. They are abnormally prone to injury, 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.[221]

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.[222]

The judge's constitutional rationale is located in the Eighth Amendment and in 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.[223]

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 analysis was important in analyzing the use of isolation cells for the mentally disordered inmate.[224] 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 *Romeo* 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 amelioration-of-danger objective 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, they are placed in an Intellectually Impaired Offender Program and housed in special units.[225]

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 basic training course for correctional officers designed to develop skills in the identification and reaction to mentally ill and mentally retarded inmates.[226]

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[217] M. Santamour & B. West, *op cit supra*, note 209 at 9. Indeed, the point seems to be that the vast majority clearly are educable.

[218] The survey of various standards at pg. 99 *et seq.* reveals that the mentally ill and retarded offender more often than not are joined for purposes of establishing a right to appropriate care.

[219] *Ruiz v. Estelle*, 503 F. Supp. 1265 (S.D. Tex. 1980), *aff'd* in part, 679 F.2d 1115 (5th Cir. 1982), *cert. denied* 103 S. Ct. 1438 (1983).

[220] 503 F. Supp. at 1344.

[221] *Id.*

[222] *Id* at 1346.

[223] *Id* at 1345.

[224] *See* Section D, *supra*.

[225] Interview with James Shaddock, Chief Psychologist, Texas Dept. of Corrections; Jan. 9, 1984.

[226] 541 F. Supp. 21, 48 (W.D. Ken. 1981).

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 one who may be violent, must be identified and dealt with. This may be limited to protective measures or, whether or not legally mandated, it may include habilitation efforts. In either case there is a legal duty at least to use standard testing procedures.

Earlier, we noted that the creation and maintenance of adequate records was a vital component of the basic right to treatment.[227] 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.[228] 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 generally, and medical care particularly.

In concluding this subsection, it seems appropriate to shift the focus from the mentally retarded inmate to the mentally retarded accused. One must be concerned about the relatively large percentage 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.[229]

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.[230] 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, and this approach appears to be followed in practice.[231] 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.

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[227] *See* Section E, *supra*.

[228] *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.

[229] R.C. 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).

[230] *Jackson v. Indiana*, 406 U.S. 715 (1972) deals with important questions of competency to be tried and does concern the plight of severely disabled accused. Competence — the ability to aid counsel and grasp the essence of the charges — is not limited to mental retardation.

[231] 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. *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*,[1] 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.

Baxstrom v. Herold[2] is the earliest Supreme Court decision which is most related to *Vitek*, yet it is easily

[1] 445 U.S. 480 (1980).

[2] 383 U.S. 107 (1966).

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 Baxtrom'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 Baxtrom 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.[3]

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. Chief Justice Warren wrote:

> Where the State has provided for a judicial proceeding to determine the dangerousness 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.[4]

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.[5] *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.

Shortly after charging prison officials with corruption, inmate Schuster was transferred to a mental hospital where he remained for many years. He was never seriously reviewed for parole — consistent with the *de facto* policy in many jurisdictions — during his confinement in a corrections-administered mental health facility.[6]

The Second Circuit concluded that prison inmates had an equal protection right to be committed by substantially the same procedures as are 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. As we shall see, that is *not* the approach taken more recently, and more authoritatively, by the Court in *Vitek.*

Baxstrom involved a prison-to-mental hospital transfer, whereas *Meachum v. Fano,*[7] 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?[8]

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.[9]

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.[10]

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 — e.g., 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.[11]

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.[12]

At the risk of being redundant, we 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 as 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 §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.[13]

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

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[3] *Id* at 110.

[4] *Id* at 114-15. For interesting follow-up data in 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).

[5] United States ex rel. *Schuster v. Herold,* 410 F.2d 1071 (2d Cir. 1969), *cert. denied* 393 U.S. 847 (1969).

[6] *Id* at 1081.

[7] 427 U.S. 216 (1976). *See* also *Montanye v. Haymes,* 427 U.S. 236 (1976).

[8] *Id* at 216.

[9] *Wolff v. McDonnell,* 418 U.S. 539 (1974).

[10] 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. 382 (1981).

[11] Neb. Rev. State. §83-180 (1).

[12] 427 U.S. at 489-90.

[13] *Id* at 493-94.

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 minimum 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.[14]

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.[15]

Although an administrative hearing procedure clearly is constitutionally permissible, again agreeing with Professor Churgin, it may be wiser to rely on the regular civil commitment processes.[16] This approach makes available the entire range of statutory commitments, from emergency[17] to voluntary, from short to longer terms. The American Bar Association Standards create yet another option titled "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.[18]

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 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?
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?

As to the first question -- what facilities are covered — the Court provides no clear answer, 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 the actual impact would be quite limited.[19]

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, seems 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."[20] 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, that three of these states had changed to this pattern since 1978, and that the mental health

[14]Churgin, The Transfer of Inmates to Mental Health Facilities in Mentally Disordered Offenders 207, 218-219 (J. Monahan & Steadman, H., eds., 1983).

[15]*Id* at 221.

[16]*Id* at 221-22. Wiser because prisoners do not often have in place a decision-making body along the lines of a parole board.

[17]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.

[18]A.B.A., Criminal Justice Mental Health Standards 7-10.4 (1st Tent. Draft, 1983).

[19]*See* Churgin, *op cit supra* note 14 at 226.

[20]Hartstone, Steadman & Monahan, *Vitek* and Beyond: The Empirical Context of Prison-to-Hospital Transfers, 45 *Law & Contemp'y Prob's* 125, 130 (1982).

facilities in corrections were not drastically different than their mental-health-operated counterparts.[21]

Thus, *Vitek* should be read as applicable to prison-to-mental-hospital transfers as well as prison-to-prison-hospital transfers. Suppose that an inmate is serving time in a prison which has what New York terms 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?[22] The answer is not very clear.

The critical factors appear to be the probability of stigma, a drastic change in confinement,[23] and enforced treatment. On balance, *Vitek* seems applicable.

What criteria and evidentiary standards are applicable for 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.[24]

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 *v* confinement. It is the situs and the objectives of confinement, since liberty has already been taken. 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 overboard and vague in light of *O'Connor v. Donaldson.*[25] 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 requirements 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.[26]

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*[27] 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.[28]

The handiest analogue here appears to be the *Addington* standard of "clear and convincing." The Court's noted premise in *Addington* is the inmate's individual interest in avoiding arbitrary classifications as mentally ill and the risk of error in a *Vitek* situation appears sufficiently substantial to warrant substantial evidentiary safeguards against error.[29]

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.[30] 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

[21]*Id* at 130-31.

[22]In *Hewitt v. Helms,* 103 S. Ct. 864 (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 received 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,* 52 U.S.L.W. 4155 (Jan. 23, 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.

[23]Satellite units often have very secure cells, and inmates have been confined in such isolation and security for over three months.

[24]*See* N.Y. Correct. Law §402 (1) (McKinney Supp. 1983-84).

[25]*See* e.g., Commonwealth ex rel. *Finken v. Roop,* 234 Pa. Super. 155, 339 A.2d 764 (1975) *cert. denied,* 424 U.S. 960 (1976). In *Kolender v. Lawson,* 103 S. Ct. 1855, 1858 (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. 422 U.S. 563 (1975).

[26]Churgin, *op cit supra,* note 14 at 228. This seems clearly correct. Another author argues that the state *should* show dangerousness. Gottlieb, *Vitek v. Jones:* Transfer of Prisoners to Mental Institutions, *Am. J.L. & Med.* 175, 206 (1982).

[27]441 U.S. 418 (1979).

[28]*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.

[29]441 U.S. 418 (1979). In *Jones v. United States,* 103 S. Ct. 3043 (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.B. Wexler, Mental Health Law: Major Issues 590-68 (1981).

[30]N.Y. Correct. §404 (1) (McKinney Supp. 1983-84).

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 engaged 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 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.

With regard to good-time credits and parole eligibility the ABA Standards are more clear and 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 facilities.
>
> (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.[31]

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.[32]

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. §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 §4241, until his maximum sentence is served. He cannot, in this situation, oridinarily 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.[33]

Sawyer v. Sigler[34] 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 meritious 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.[35]

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.[36]

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 reasons in *Sawyer v. Sigler,*[37] which seems eminently sound in general and as applied to mentally disordered inmates undergoing treatment.

It will be recalled that *Bowring v. Godwin*[38] is one of the earliest decisions to clearly apply the *Estelle v. Gamble* right to medical care to psychiatric and psychological treatment. *Bowring* involved the fact situation of a parole board denying 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.[39]

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.[40]

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.[41]

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.[42]

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,[43] we may infer that the court used a form of the rational-basis test[44] 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 ineligibility.

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.*[45]

To conclude this section 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

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[31] A.B.A., Criminal Justice Mental Health Standards, 7-10.10 (1st Tent. Draft 1983). *See* also 2 Mental Disability Law Rptr. 669-70 (1978).

[32] 325 F. Supp. 699 (W.D. Mo. 1971). 18 U.S.C. §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 to sanity or health or until the maximum sentence without reduction for good time or commutation of sentence, shall have been served.

[33] 298 F.2d 592, 593 (8th Cir. 1962).

[34] 320 F. Supp. 690 (D. Neb. 1970), *aff'd* 445 F.2d 818 (8th Cir. 1971).

[35] 320 F. Supp. at 699.

[36] 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 challenged.

[37] 520 F. Supp. 690 (D. Neb. 1970), *aff'd* 445 F. 2d 818 (th Cir. 1971).

[38] 551 F.2d 44 (4th Cir. 1977).

[39] 551 F.2d at 46. By implication, the treatment was to be aimed at "parole readiness."

[40] 423 F. Supp. 1190, 1192 (N.D. W Va. 1976).

[41] *Id* at 1194.

[42] *Id* at 1194-95.

[43] *Greenholtz v. Inmates of the Nebraska Penal & Correctional Complex,* 442 U.S. 1 (1979).

[44] *See* e.g., *Dandridge v. Williams,* 397 U.S. 471 (1970).

[45] Where parole boards do not have to give reasons for their decision 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 the last 15 months.

inmate-patient. *Burchett v. Bower*[46] 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.[47]

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.[48]

In re Hurt[49] 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 professionals 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.[50]

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.[51]

More typical of judicial handling of this matter is the pre *Vitek* decision in *Cruz v. Ward*.[52] 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.[53]

Over the strong dissent of Judge Kaufman, the court decided that there was no indication that these were punitive transfers.[54] 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.[55]

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.[56]

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 or practice. 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.[57]

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, 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.

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[46]355 F. Supp. 1278 (D. Ariz. 1973).

[47]*Id* at 1281.

[48]*Id* at 1282.

[49]437 A.2d 590 (D.C. App. 1980).

[50]*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 §24-303(b)].

[51]*Id*.

[52]558 F.2d 658 (2nd Cir. 1977), *cert. denied* 434 U.S. 1018 (1978).

[53]558 F.2d 658 at 662.

[54]*Id*.

[55]*Id*.

[56]*Id* at 663, 665.

[57]*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. It is the prison or secure mental hospital setting which 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.

We will analyze complex issues, and more, in this section. However, let me state 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 and recognition that the need for information to provide needed treatment generally outweighs even compelling demands for disclosure.[3] Where the relationship with the inmate is for diagnosis-evaluation-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 concretely 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. Disclosure of the type recommended above is most appropriate when the inmate-clinician contact is *not* for treatment but 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 it was not until 1828 that New York passed the first statute granting doctors the right to refuse to testify.[6] The late-arriving and narrow medical doctor-

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[1]These terms are taken from T.G. Gutheil & P.S. 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, 51 P.2d 334, 131 Cal. Rptr. 14 (1976).

[3]Graham, Evidence and Trial Advocacy Workshop: Privileges — Their Nature and Operation, 19 *Crim. L. Bull.* 442 (1983) (emphasis in original).

> 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.

Privilege, more accurately termed testimonial privilege, is narrower than the right of confidentiality and applies in judicial or judicial-like settings.

[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 convicted and sentenced to death, and who made no use of psychiatric testimony himself. The ubiquitous 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 recommended here seem applicable.

[6]T.G. Gutheil & P.S. Applebaum, *supra* at 10, n. 1. 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).

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
> (I) 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 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 proceedings 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]

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] On the other hand, the attorney-client relationship is vital to detainees and inmates, since they have 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.

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.

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 clear and present 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.[11]

Not according confidentiality to these various categories serves various purposes. The undoubted 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.[12]

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 respected 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

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[7]*See* e.g., Alaska Rules of Court, Rule 504, Ala. Code §34-26-2; Ariz. Rev. Stat. Ann. §32-2085; Ark. Stat. Ann. §28-1001, Rule 503; Cal. Evid. Code §1010 *et seq.*; Colo. Rev. Stat. § 13-90-107(g); Conn. Gen. Stat. Ann. §52-146c *et seq.*; Delaware Rules of Ev.R. 503; Fla. Stat. Ann. §90-503; Ga. Code Ann. §38-418; Hawaii Rev. Stat. Title 33, ch. 626, 1980 Special Rules Pamphlet, Ruole 504.1; Idaho Code §54-2314; Ill. Rev. Stat., ch. 91 1/2, §801 *et seq.*; Ind. Stat. §25-33-1-17; Ky. Rev. Stat. §421.215; La. Rev. Stat. §13:3734; Maine Rules of Ev. 503; Md. Cts. & Jud. Proc. Code §9-109; Mass. Gen. Laws Ann., ch. 233, §20B; Mich. Comp. Laws Ann. §330.1750; Minn. Stat. Ann. §595.02; Miss. Code §73-31-29; Mo. Rev. Stat. Ann. §337.055; Mont. Code Ann.§26-1-807; Neb. Rev. Stat. §27-504; Nev. Rev. Stat. §49.215 *et seq.*; N.H. Rev. Stat. Ann. §330-A.19; N.J. Stat. Ann. §45:14B-28; N.M. Rules of Ev. 504; N.Y. Civ. Prac. Law and Rules §4507; N.C. Gen. Stat. §8-53.3; N.D. Rules of Ev. 503; Okla. Stat. Ann. Titl. 12 §2503; Ore. Rev. Stat. §40.230; Tenn. Code Ann. §24-1-207; Utah Code Ann. §58-25-8, Vt. Stat. Ann. Tit. 12 §1612; Va. Code §8.01-400.2; Wash. Rev. Code §18.83.110; Wis. Stat. Ann. §905.04; Wyo. Stat. Ann. §33-27-103. *See* also D.C. Code §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 §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]*Lanza v. New York*, 370 U.s. 139 (1962); *Bell v. Wolfish*, 441 U.S. 520 (1979). 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.

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.J. Gobert & N.P. Cohen, Rights of Prisoners 176 (1981).

[11]*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)

[12]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.

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.[13]

Professor David Wexler raises the question of just how the therapist may discharge the duty to warn, suggesting that alerting the would-be victim would be the standardized safe response.[14] 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 would-be 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, we enter the world of professional ethics and individual judgment.

One authority would solve the ethical question 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.'[15]

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.[16]

Another observer admonishes the prison counselor or therapist to consider:

1. The role conflict in seeking to balance the therapeutic needs of the patient *vis a vis* 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.[17]

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 the therapist ultimately having to exercise his 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 postulate of the law concerning how treatment decisions should be made is most clearly embodied in the doctrine of informed consent.[18] 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 equality concerning the information base of the treater's expertise in an effort to allow the sick or endangered person to apply his personal value system to the alternatives presented.[19]

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[13]17 Cal. 3d at 439, 551 P.2d at 340, 131 Cal. Rptr. at 25.

[14]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.

[15]Kaslow, Ethical Problems in Prison Psychology, 7 *Crim. Justice & Behavior* 3, 4 (1980).

[16]Quijano & Logsdon, Some Issues in the Practice of Correctional Psychology in the Context of Security, 9 Professional Psychology 228, 231 (1978).

[17]P.J. 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.

[18]*See generally,* F.A. Rozovsky, Consent to Treatment: A Practical Guide (1984); *Symposium,* Informed Consent, 1 *Behav. Science & the Law* 1-116 (1983).

[19]*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).

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 the inherent coercion of the institutional setting.

In one federal case, a prisoner confined in Leavenworth complained that prison clinicians authorized the injection of psychotropic medicine over his general objection and in the face of religious objections.[20] 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 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 cognizable claim.[21] Thus the right to care is converted into a duty to accept it with no intermediate concerns expressed about competency and consent.[22]

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 unconsented to administration of psychotropic medication.

An inmate's *right* to care should not be so easily converted to a *duty* of uninformed and unquestioning obligation to accept. 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.[23] 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 inpatients are careful to point out the side effects:

> The anticholingeric 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 regularity.
>
> 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

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[20]*Sconiers v. Jarvis,* 458 F. Supp. 37 (D. Kan. 1978).

[21]*Id* at 40.

[22]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.

[23]Mackin, Some Problems in Gaining Informed Consent from Psychiatric Patients, 31 *Emory L.J.* 345, 371 (1982).
G.J. Annas, L.H. Glantz & B.F. 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.

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.[24]

Accepting all of the above as accurate, and accepting further the potential benefits of such medication, when it comes to weighing risk — the authors suggest — that the inmate-patient should be involved in that decision and his consent generally required.[25]

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. Which agency administers the treatment facility would seem equally irrelevant. The objectives of autonomy and protection from harm simply are not related to the situs of care or administrative arrangements.

Does the inmate's legal status dilute his claims to autonomy or harm prevention to the point where consent to treatment either is not generally required or consent applies but in some diluted form? Where does the person convicted of crime fit on the extreme positions that a clinician always knows best and and acts in the best interests of the individual, or 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 than conviction and punishment for crime and because the transferee was subject to a mandatory behavior modification program.[26]

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.

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.[27]

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.[28] 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.[29] The circularity of this

[24]T.G. Gutheil & P.S. Applebaum, *supra*, note 1 at 118-19.

[25]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, Public Law 282, 283 (1982).

[26]445 U.S. 480, 494 (1980). In *Jones v. United States*, 103 S. Ct. 3043, 3052, n. 19 J. Powell writes, "The Court has held that a convicted prisoner may be treated involuntarily for particular psychiatric problems. . . ."

[27]A.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:

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).

[28]*See* D.B. Wexler, Mental Health Law: Major Issues 245 (1981).

[29]*See* Roth, Meisel & Lidz, Tests of Competency to Consent to Treatment, 134 *Am. J. Psychiatry* 279, 281 (1977).

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.[30] Voluntariness, however, seems to be more of a problem with *research* on prisoners than it is with traditional treatment modalities. One important study concluded *"that more detailed disclosures and no therapeutic privileges should be the rule in the experimental setting."*[31]

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, it is the inmate who may "fake it" in order to obtain what he sees 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.

Professor Norvall Morris squarely 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.[32]

The judicial decisions in this area are supportive of Professor Morris' views, often without being as direct or thoughtful. In *Haynes v. Harris*[33] 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 adminsitrative authorities.[34]

In the later case of *Ramsey v. Ciccone*[35] 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.[36]

In *Peek v. Ciccone*[37] 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: "The 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. . . ."[38]

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.[39]

In *Smith v. Baker* a prisoner confined in the Missouri State Penitentiary claimed that his federal rights were violated when he was injected with prolixin with a hypodermic needle against his will and religious beliefs.

[30]*See* e.g. G.J. Annas, L.H. Glantz & B.F. Katz, *supra* note 22 at 104.

[31]*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. Mackin, Some Problems in Gaining Informed Consent from Psychiatric Patients, 31 *Emory L.J.* 345, 352-53 (1982).

[32]N. Morris, The Future of Imprisonment 25-26 (1974).

[33]344 F.2d 463 (8th Ciur. 1965).

[34]*Id* at 465. This decision also is a good example of the then prevailing "hands-off" doctrine.

[35]310 f. Supp. 600 (W.D. Mo. 1970).

[36]*Id* at 605 (emphasis added).

[37]288 F. Supp. 329 (W.D. Mo. 1968).

[38]*Id* at 337.

[39]*Id*. The court also indicated its general deference to the discretion of institutional administrators.

The court dismissed the Eighth Amendment claim of improper or inadequate medical care by following the decision in *Ramsey v. Ciccone*.[40] 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 or any federal right."[41]

Clearly these decisions leave prisoners with very little voice in the medical or psychiatric care they receive. It should be noted, however, 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, there is little diversity of opinion to be found or to be expected.[42]

Mackey v. Procunier involved a challenge to a behavior modification-type program experimentally used at the California Medical Facility at Vacaville.[43] The protesting inmate conceded that he had consented to ECT but not to the drug succinylcholine.

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.'[44]

The inmate (one of 64 involved) had described the drug as a "breath-stopping and paralyzing 'fright drug'."[45]

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."[46]

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.[47] 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.[48]

Souder v. McGuire involved a former inmate at Pennsylvania's Farview State Hospital for the criminally insane who claimed a violation of his constitutional rights occurred when he and other inmates were forcibly treated with psychotropic drugs.[49] 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.[50]

One of the most decisive 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.[51] Inmates challenged the unconsented-to injection of apomorphine, a drug that caused vomiting for 15 minutes to an hour and which 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.[52]

To remedy the situation at ISMF, the court ordered that before apomorphine treatments can be used the following conditions must 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.[53]

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 unusal 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 *sine qua non* of this treatment program; and it must be informed and is revocable.

Thus, the treatment community must be on notice that while it is true that most judicial decisions are rather permissive and deferential to clinical judgments as to proper treatment, there are instances where the direct effects of treatment are physically or emotionally painful and where, at a minimum, informed consent is the norm.[54]

The well-known *Kainowitz*[55] 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.[56]

Of the several important decisions dealing with the constitutional right of involuntarily committed mental patients to refuse antipsychotics, the recent decision in *Rennie v. Klein* may well be the most important.[57] 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,[58] which remanded the case for reconsideration in light of *Youngberg v. Romeo*.[59]

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.[60]

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 — e.g., temporary isolation, soft restraints — need not be expressly eliminated in the clinical calculus to

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[40] 326 F. Supp. 787 (W.D. Mo. 1970), *aff'd* 442 F.2d 928 (8th Cir. 1971).

[41] 326 F. Supp. at 788. Oddly, the court relied on *Ramsey* and *Haynes*, neither of which dealt with a religious objection.

[42] *See* G.J. Annas, L.H. Glantz & B.F. Katz, *supra*, at 121, n. 22. The authors also suggest that the cases were inartfully presented due to the lack of counsel.

[43] 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).

[44] J. Mitford, Kind and Unusual Treatment: The Prison Business 128 (1973).

[45] 477 F.2d at 877./

[46] *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.

[47] 379 F. Supp. 338 (W.D. Mo. 1974).

[48] D. Wexler, *supra*, note 27, 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. 445 (1980).

[49] 423 F. Supp. 830 (M.D. Pa. 1976).

[50] *Id* at 832. Farview patients apparently included transferees from the corrections systems. 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).

[51] 488 F.2d 1136 (8th Cir. 1973).

[52] 488 F.2d at 1139-40.

[53] *Id* at 1140-41.

[54] *See* Anno, Civil Liability for Physical Measures Undertaken in Connection with Treatment of Mentally Disordered Patients, 8 *A.L.R.* 4th 464 (1981).

[55] *Kainowitz 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).

[56] *See* D. Wexler, *supra*, note 22 at Ch. 8 for a view of *Kainowitz* which is supportive of the result but critical of the court's reasoning.

[57] 720 F.2d 266 (3rd Cir. 1983), *mod. and remanded*, 653 F.2d 836 (1981) *vacated and remanded*, 102 S. Ct. 3506 (1982).

[58] 102 S. Ct. 3506 (1982).

[59] 457 U.S. 307 (1982).

[60] 720 F.2d at 269-70.

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go forward with forced medication.[61]

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.[62] 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 10 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 the "least intrusive means" concept. Judge Adams, for example, agreed that while the least intrusive means test did not survive *Youngberg*, he argues that 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."[63]

Chief Judge Seitz wrote, "The State is not restricted to helping the patient only if he wishes to be helped."[64] 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."[65]

Judge Weis, joined by two colleagues, strongly believes that *Youngberg* does not govern the standard for long-term forcible administration of antipsychotic drugs.[66] *Romeo* 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.[67]

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.[68] 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 *Rennie* does not directly address the mentally disordered prisoner, we may unhesitatingly assume that the prisoner is legally entitled to no more and likely will 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 others as the most compelling exceptions.[69]

As a matter of sound policy every jurisdiction, through legislation or administrative regulations, should adopt rules dealing with:

1. Informed consent: of what content it should consist and uniform form it should take.
2. The conditions when consent is not required (e.g., clear and present danger of causing [serious] injury to self 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: the herein of adequate record-keeping.
6. Duration of forced treatment-medication orders.
7. Cooperative measures on point between corrections and mental health.

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[61] 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 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.R. Lion & Reid, W.H., eds., 1983).

[62] *Id* at 269.

[63] *Id* at 271-72.

[64] *Id* at 273.

[65] *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.

[66] *Id* at 275.

[67] *Id* at 275-76.

[68] *See Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980), *vacated and remanded* subnom. *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.

[69] *See pp. 99 et seq.*

PART 4

STANDARDS BY LEGAL TOPIC
STANDARDS BY ADMINISTRATIVE TOPIC

This section of the sourcebook presents two commentaries on standards for the care and treatment of mentally disordered prisoners. In the first selection Pamela Griset and Fred Cohen compare fifteen sets of standards as they address *legal* rights of mentally disordered prisoners. Then Dennis McCarty analyzes five sets of standards as they apply to the *administration* of service delivery to mentally disordered prisoners. **The reader should refer to the original sources if seeking the exact wording of particular standards.**

The state's duty to provide medical care for prison inmates has long been recognized (Carraba, 1981; Isele, 1980; Neisser, 1977). The quality and extent of this care have historically been somewhat limited, but an inmate who is sick or injured can realistically expect to receive at least some form of treatment in a timely manner. The prospects for obtaining necessary mental health care, by contrast, are often far less certain.

Several factors have hampered efforts to provide meaningful mental health services. The first concerns *quality*. No clear consensus exists as to which types of psychiatric intervention are most effective or how to best apply the various strategies in a correctional setting. Intensive treatment programs such as therapeutic communities and specialized units seem to work best, but both are expensive to operate and tend to be highly stressful environments in which to work.

A second type of problem relates to the *acceptability* of mental health care in general. Many inmates and officers do not fully accept the premise that mental health services are an essential part of overall health care. This doubt is reinforced by the fact that few programs clearly delineate why treatment is necessary, what will happen to those who receive it, and what results participants can expect. Many suspect that housing units reserved for the mentally ill serve merely as havens for those not strong enough to live in the general population. Such a perception of mental health services being for the weak and crazy makes therapy anathema for some disturbed inmates who might otherwise be willing to accept professional help. Moreover, mental health staff and correction officers often do not accept or do not approve of the way in which the other group relates to inmates. As a result neither group can talk comfortably with the other, making effective integration of mental health services into routine facility operations much more difficult.

Finally, there is the problem of *accessibility*. Many prison mental health units are inadequately staffed, so personnel seldom have time to see all of the inmates in need of an evaluation or treatment. Inmate access to services may also be limited by the actions of correction officers who believe that mental health care is more of a luxury than a necessity and refuse to make referrals in non-crisis situations.

These and related problems convinced some prison administrators that while providing mental health care in prison was a desirable ideal, they could not readily deliver such services. They chose to transfer psychotic inmates to inpatient psychiatric facilities and put less seriously disturbed prisoners in isolation or refer them to regular medical staff for stabilization.

This practice is no longer viable. More and more inmates are being diagnosed as mentally ill or developmentally disabled, and recent court decisions have tightened the criteria which must be met before a prisoner can be sent to a state hospital forensic unit. Penal staff have begun to look for new ways of dealing with what is potentially a very disruptive segment of the inmate population. At one time prison superintendents would have had little help in establishing policies for dealing with these inmates. They would have turned to key aides and perhaps received some advice from their Department of Corrections central office. Now, however, they can develop programs based on the recommendations of national organizations which have drafted comprehensive standards for the specific purpose of making adult correctional facilities more professional and easier to manage.

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 is 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 measures. . ." (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 mention 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 faciltiy (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 distinction warrants notice.

STANDARDS: LEGAL ISSUES AND THE MENTALLY DISTURBED INMATE

LEGAL ISSUES	AMERICAN BAR ASSOCIATION (1983)	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).I	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 shall be permitted to decline habilitation or mental health treatment except: 1) when required by court order; or 2) when reasonably believed by the responsible physician, mental health or mental retardation professional, 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).	
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 integrate 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)	U.S. DEPARTMENT OF JUSTICE (1980)	LAW ENFORCEMENT ASSISTANCE AMINISTRATION (1979)	COMPTROLLER GENERAL (1979)
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	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.
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.		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).	
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.	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).	
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.	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 (1983)	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 medication 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)	U.S. DEPARTMENT OF JUSTICE (1980)	LAW ENFORCEMENT ASSISTANCE ADMINISTRATION (1979)	COMPTROLLER GENERAL (1979)
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.	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).		
F. MEDICATION	The long term use of minor tranquilizers shall be discouraged unless clinically indicated; psychotropic medications shall be dispensed only when clinically indicated.		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.
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 Prison institutions.			Consider providing semi-protected environments for psychotic inmates needing less than hospital-level care.
H. STAFF		One full-time psychologist for every two general functional units and one full-time psychologist for each specialized functional unit.	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 wih 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)	NATIONAL ADVISORY COMMISSION ON CRIMINAL JUSTICE STANDARDS AND GOALS (1973)	GEORGIA DEPARTMENT OF OFFENDER REHABILITATION (1981)	PENNSYLVANIA CORRECTION/MENTAL HEALTH TASK FORCE (1981)
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).	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).
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).		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).
H. STAFF (TRAINING & RATIO)			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 (1983)	AMERICAN MEDICAL ASSOCIATION (1979)	AMERICAN ASSOCIATION OF CORRECTIONAL PSYCHOLOGISTS (1980)	AMERICAN PUBLIC HEALTH ASSOCIATION (1976)	AMERICAN CORRECTIONAL ASSOCIATION (1981 — STANDARDS)
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).	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).	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)
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; 5) and 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 (7-105).		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).
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).				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).
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).	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).
B. ASSIGNMENTS-HOUSING & PROGRAM		Policy requires consultation between the facility administrator and the responsible physician or their designee prior to housing or program assignment actions regarding patients who are diagnosed as having a psychiatric illness (112).			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).
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.			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 charge.
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)	NATIONAL ADVISORY COMMISSION ON CRIMINAL JUSTICE STANDARDS AND GOALS (1973)	GEORGIA DEPARTMENT OF OFFENDER REHABILITATION (1981)	PENNSYLVANIA CORRECTIONAL/ MENTAL HEALTH TASK FORCE (1981)
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).		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.
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).		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).
C. EMERGENCY					
III. CUSTODIAL A. DISCIPLINE					
B. ASSIGNMENT-HOUSING & PROGRAM					
C. ISOLATION/RESTRAINT					

STANDARDS: LEGAL ISSUES AND THE MENTALLY DISTURBED INMATE (Continued)

LEGAL ISSUES	AMERICAN BAR ASSOCIATION (1983)	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 adminsitrative 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)	U.S. DEPARTMENT OF JUSTICE (1980)	LAW ENFORCEMENT ASSISTANCE ADMINISTRATION (1979)	COMPTROLLER GENERAL (1979
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.		Informed consent of inmates is required for all examinations, treatments, and medical procedures for which informed consent is required in the jurisdiction (5-44).		
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.		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).		
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.		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.
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.		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 are 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)	NATIONAL ADVISORY COMMISSION ON CRIMINAL JUSTICE STANDARDS AND GOALS (1973)	GEORGIA DEPARTMENT OF OFFENDER REHABILITATION (1981)	PENNSYLVANIA CORRECTION/MENTAL HEALTH TASK FORCE (1981)
IV. CONSENT A. APPLICABILITY				In all mental health services, the principle of informed consent is followed for inmate care (5-001).	
B. COMPONENTS	The content of the prisoners' files shall be confidential (304-3).			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).	
V. CONFIDENTIALITY A. APPLICABILITY				Policy describes the degree of confidentiality of inmate information (5-004).	
B. RECORDS				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).	
C. THIRD PARTY				The inmate must give written approval before mental health records are transferred to any third party, unless otherwise provided by law of 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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1983 — *First Tentative Draft, Criminal Justice Mental Health Standards.* Washington, D.C.: American Bar Association

—Section 7-10 deals specifically with the mentally ill and mentally retarded prisoner. Transfer issues receive wide coverage.

American Medical Association
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.

American Association of Correctional Psychologists
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.

American Public Health Association
1976 — *Standards for Health Services in Correctional Institutions.* Washington, D.C.: American Public Health Association

—Section IV deals specifically with mental health care.

American Correctional Associatioin
1981 — *Standards for Adult Correctional Institutions, 2nd Edition.* College Park, Maryland: American Correctional Association.

—Psychiatric care is included in the definition of medical care. Several recommendations apply specifically to the mentally disturbed inmate.

American Correctional Association
1981 — *Guidelines for the Development of Polices and Procedures: Adult Correctional Institutions.* College Park, Maryland: American Correctional Association.

—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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1980 — *Federal Standards for Prisons and Jails.* Washington, D.C.: U.S. Government Printing Office.

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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.

—These recommendations are concerned with the delivery of mental health care within federal and state prisons.

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1973 — *Corrections.* Washington, D.C.: U.S. Department of Justice.

—The right to mental health care is included in the right to medical care generally although several recommnendations deal specifically with the mentally disturbed offender.

Georgia Department of Offender Rehabilitation
1981 — *Standards for Counseling and Psychological Services*

—These recommendations are concerned with the delivery of counseling and psychological services to all inmates, regardless of whether or not they have been officially labeled as mentally disturbed.

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.

STANDARDS BY ADMINISTRATIVE TOPIC

by Dennis McCarty*

Efforts to improve the American correctional system began almost as soon as the first jail was constructed. The physical conditions and quality of care in most colonial prisons was so poor that prisoners often became ill after just a brief period of incarceration. Some inmates even starved to death if they could not afford to purchase food or arrange to have meals prepared for them while they were in custody (Burns, 1975). Dutch officials in New Amsterdam issued a series of reform regulations as early as 1657, but their British neighbors were typically content to leave day-to-day administration in the hands of individual jailers (Sellin, 1980). The first set of guidelines in the English-speaking part of the new world were prepared by the Philadelphia Prison Society in the latter half of the eighteenth century (Bergsmann, 1981).

Many state and national commissions have since found legitimate reasons to criticize the way in which criminal offenders are treated in this country. All too often, however, they have either failed to propose realistic alternatives or have done so for a very narrow range of issues. One of the most noteworthy developments in the correctional reform movement has thus been the promulgation of comprehensive operational standards. Standards establish criteria for the performance of key organizational activities and, if adopted and implemented, can frequently result in the improvement of both services and overall institutional management. Typically, multidisciplinary task forces composed primarily of officials directly involved in inmate care draft such standards, so the standards have a greater credibility among practitioners than suggestions proposed by outside observers. It is not uncommon for federal courts to use the standards as a yardstick of sorts in assessing whether a given set of conditions constitutes cruel and unusual punishment (Connors, 1977).

The American Correctional Association published its first *Manual of Correctional Standards* in 1946. One of the principal conceptual problems the Association encountered concerned the level of care that the recommendations ought to characterize. Some authorities argued that the standards should reflect *minimally acceptable practices* which would have optimal chances of widespread attainment. Others insisted that the standards should be of an *optimal* nature even though they might be beyond the reach of many administrators. The latter approach was ultimately rejected as being an unrealistic vehicle for reform; an optimal set of standards would have little to offer those who were seeking interim measures of improvement pending the availability of more staff and better facilities. The standards cited have thus been formulated by people in the field who consider them attainable and realistic.

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PRISON MENTAL HEALTH STANDARDS.

Although I examined several sets of national standards as part of my research, some, such as those proposed by the American Psychological Association (1977), address the delivery of mental health care generally, so I have not included them here because they do not explicitly concern the unique setting of an adult prison. Others, such as those of the National Advisory Commission on Criminal Justice Standards and Goals (1973), I omitted because inmate mental health care received such scant attention. I finally selected five sets of standards:

Standards for Health Services in Prison,
prepared by the American Medical Association (1979);

Standards for Adult Correctional Institutions,
prepared by the American Correctional Association (1981)

Federal Standards for Prisons and Jails,
prepared by the U.S. Department of Justice (1980);

Standards for Psychological Services in Adult Jails and Prisons,
prepared by the American Association of Correctional Psychologists (1980); and

Standards for Health Services in Correctional Facilities,
prepared by the American Public Health Association (1976).

Two of the five sets encompass a broader context of inmate health care and two address facility management as a whole. The reader should also note that while the Department of Justice and the American Public Health Association do not differentiate their recommendations by level of importance, the American Medical Association labels standards as "essential" or non-essential but still important; the American Association of Correctional Psychologists uses an "essential"/"important" dichotomy

and indicates whether the standard is "specific" for psychological services or, with a minor change in the language, would be applicable to an overall set of "general" mental health standards; and the American Correctional Association employs a "mandatory," "essential," and "important" rating system. The standards of all five organizations apply equally to male and female institutions.

The discussion which follows provides a narrative overview of the detailed table. The table is divided into six principal sections: administration, physical plant, staffing and professional development, identification and evaluation, inmate management and treatment, and research. The reader can use the table to see what the standards propose and how they compare with one another. To make the table as concise as possible, I have had to summarize or paraphrase particularly lengthy standards or those which make references to matters not directly pertaining to the mentally ill. In a few instances, when the intent of the standard would not be clear out of context, I took the provision in the table from the "comment" or "discussion" accompanying the standard rather than from the standard itself. Furthermore, omission of the comment altogether would be somewhat misleading since the reader might infer that an organization did not consider a certain issue at all. The reader should always consult the original standard to be sure of its exact wording.

OVERVIEW OF THE STANDARDS.

The five organizations whose standards appear in the table serve professional memberships with different perspectives on the mentally ill and mentally retarded offender. Consequently, the standards do not always address the same topics. The emphasis varies, and recommendations are not uniformly specific in all areas. Nevertheless a fairly clear consensus emerges regarding the broad principles which should guide the development of inmate services. Each organization drew freely from earlier standards, even copying, in many instances, the exact language of suggested procedures. The Department of Justice standards, for example, agree about 95 percent with those of the American Correctional Association (Allison, 1979). Where areas of disagreement do exist, they more typically reflect differences of opinion regarding the optimal implementation of a given principle rather than a dispute over the principle itself.

WRITTEN STANDARD OPERATING PROCEDURES.

All five sets of standards stress the need for written standard operating procedures. A written procedures manual clarifies what is expected of each employee and ensures that care will be provided in a consistent, uniform manner.

STAFFING AND PROFESSIONAL DEVELOPMENT.

The standards are very vague as to the number of professional staff who should be employed at each prison. The American Medical Association (107) and Department of Justice (5.09) state only that there should be "adequate staff as determined by the health authority." The American Public Health Association (XI) argues that the staff should be of a "sufficient number and diversity" to deliver responsibly the services outlined in their standards. According to the American Correctional Association (2-4072, Important), each facility should "systematically determine its personnel requirements . . . to ensure inmate access to staff and the availability of support services." Only the American Association of Correctional Psychologists (12, Essential) establishes a specific staff-to-staff inmate ratio: one full-time psychologist for every 200-250 inmates in the general population and one full-time psychologist for every 100-125 inmates in specialized units. The AACP does not set any minimally acceptable qualifications for mental health personnel other than to indicate that the chief psychologist should have a Ph.D., but all five sets of standards recommend that prisons follow state licensing requirements and that they keep verification of the mental health staff's credentials on file.

The potential contribution of on-line correctional personnel is reflected in the standards' collective concern for adequate training. Correction officers have an enormous amount of power over the lives of prison inmates and usually have more information about an individual's overall behavior than the professional staff. The standards thus maintain that custodial personnel should receive both basic and in-service training so that they can use the influence associated with their position in the most constructive manner possible. The training should include, among other things, instruction in how to recognize the signs and symptoms of mental illness and mental retardation. Officers should also be taught the appropriate method for referring inmates to the medical/mental health unit, what steps to take in cases of psychiatric emergencies, and procedures for transferring inmates to other institutions. In the opinion of the American Correctional Association (2-4091, Essential) and the Department of Justice (21.05; 21.06), annual in-service instruction for professional staff should total at least 40 hours.

The standards agree unanimously that inmates must never be allowed to provide direct patient care. Written policy should also bar them from scheduling health appointments, handling medication, or determining the access of other inmates to health care services. Prisons may use volunteers, but only under certain conditions. Four of the five sets of standards call for tight controls over the selection, training, responsibility, and accountability of all non-paid staff. The American Correctional Association (2-4494, Essential) also specifies that volunteers should not provide direct care services unless certified to do so.

AUTONOMY OF MENTAL HEALTH STAFF IN PROFESSIONAL MATTERS.

Most of the standards recommend that all security regulations applicable to administrative and security personnel be applied to mental health staff as well. Just as the warden should have decision-making power over an inmate's participation in furloughs or work-release programming, however, the standards unanimously recommend that overall responsibility for the care of mentally ill/mentally retarded inmates be in the hands of the designated health authority (head psychologist). The American Public Health Association (p. viii) does not want corrections to even administer physical or mental health services:

> All health care service units in correctional institutions should ultimately be accountable to a governmental agency whose primary responsibility is health care delivery rather than the administration of such institutions. It is felt that health agencies are more likely to possess the competence to evaluate and conduct health programs than those agencies whose expertise is in security and custody. Accountability to such an agency aids in promoting and maintaining the integrity and excellence of health services.

The standards also state that the confidential relationship that exists between doctor and patient outside of prison should extend to inmate patients and their physician. To accomplish this goal, the standards suggest maintaining health records apart from the general confinement record, and having the health authority (head psychologist) strictly control access to them. The American Association of Correctional Psychologists (52, Important) and the American Public Health Association (IV C) further recommend that any limits which may exist in the principle of confidentiality be explicitly discussed with all inmates entering into a therapeutic relationship.

I do not mean to suggest that the standards encourage mental health staff to jealously guard all of the information which they obtain. Confidentiality is deemed to be crucial in regard to "content," but it need not be consistently adhered to with respect to the client's "condition." In fact, most of the standards encourage mental health personnel to share information that would have a bearing on an inmate's medical management or ability to participate in regular facility programming.

Some issues pertaining to autonomy and confidentiality are not uniformly addressed in the standards. The American Medical Association (111) and the Department of Justice (5.14), for example, recommend that a physician have access to an individual's confinement record whenever the doctor deems it necessary, but the American Correctional Association does not take a stand on the matter one way or the other. The American Medical Association (159) and the American Association of Correctional Psychologists (15, Essential) suggest that mental health staff not be responsible for placing involuntary restraints on disruptive inmates when the behavior is not part of a mental disturbance, but again the American Correctional Association is silent. Finally, the American Association of Correctional Psychologists (18, Essential) and the American Public Health Association (IV B) indicate that on-line mental health staff should not be asked to "talk to troublemakers" or participate in administrative decisions such as furloughs and suitability for work release. Since the American Correctional Association standards do not mention this contingency either, it is possible to infer that the ACA may not want the responsibilities of custodial and mental health personnel to be distinguished quite as sharply as some professional organizations would prefer.

CORRECTIONAL-MENTAL HEALTH COOPERATION.

Despite the general consensus that mental health staff should be given a considerable degree of autonomy, the standards very clearly call for a close working relationship among correctional personnel, the prison administrator, medical/mental health staff, and other facility employees. Three of the five sets suggest that the superintendent meet with the chief health authority (or head psychologist according to the American Association of Correctional Psychologists) at least four times a year to discuss mutual concerns. The health authority (head psychologist) is also expected to submit quarterly reports on the overall functioning of the program and an annual statistical summary.*

Day-to-day cooperation is fostered by standards that would require classification officers to consult with the health authority (head psychologist) prior to taking any steps that would change the status of a mentally ill or mentally retarded inmate. The standards define "status changes" to include new housing and program assignments, transfers to other facilities, and the implementation of any punishment stemming from a disciplinary infraction. They also recommend that treatment plans routinely include directions to non-medical staff regarding how they should interact with the person being treated.

IDENTIFICATION OF THE MENTALLY DISORDERED.

While there is some ambiguity as to the appropriate scope of mental health staff responsibility, little discrepancy exists regarding the overriding objectives associated with inmate care: the standards unanimously recommend that prisons make a vigorous attempt to identify all mentally ill and retarded inmates, and that both types should then be referred for appropriate treatment.

The identification process should reportedly begin during intake, with a brief screening by booking officers for signs of mental disturbance. The American Medical Association (142, Essential), the American Correctional Association (2-4291, Essential), and the Department of Justice (5.16) also call for a routine health appraisal within 14 days of admission that includes comments on the individual's mental status. The American Association of Correctional Psychologists (24, Essential) goes a step further to suggest that inmates receive a separate psychological evaluation during the first month of incarceration.

Some disturbed inmates, of course, will either escape detection during the initial classification or substantially deteriorate at some point following admission. The standards expect that staff training will enable correctional staff to identify these individuals quickly and schedule them for a professional assessment. The standards recommend completing evaluations of inmates referred for routine testing within 14 days from the date of referral. Emergency evaluations should be completed within 12 hours according to the American Medical Association (144) and within 24 hours according to the American Association of Correctional Psychologists (27, Essential).

TREATMENT.

If disturbed inmates remain at the prison, the physical facilities should be "adequate" as determined by the health authority or head psychologist (AMA, 107; Dept. of Justice, 5.09; AACP, 6 Essential; APHA, VI D). The American Correctional Association (2-4296, Essential) and the American Association of Correctional Psychologists (33, Important) specifically recommend that prisons designate separate units for those most seriously disturbed, and the Department of Justice (2.10) suggests that at least one special-purpose cell be set aside for prisoners who are uncontrollably violent or self-destructive. Prisons should reserve special housing areas with close observation for those awaiting emergency evaluations or treatment (American Medical Association, 144; American Association of Correctional Psychologists, 30, Essential).

Four of the five sets of standards state that prisons should prepare written and individualized treatment plans for inmates requiring close mental health supervision.

*The identification of professional responsibility in the standards has been a controversial issue. In the early drafts of the ACA, AMA, APHA, and DOJ standards, a physician had to approve and supervise all services, treatment plans, and diagnoses. Psychologists and other mental health profesionals compared this practice to that of a urologist not permitting psychotherapy because he/she did not believe in it or an internist diagnosing mental retardation when he/she might well be better trained to diagnose an automotive problem. The American Association of Correctional Psychologists is adamant in its insistence that qualified professionals other than physicians be given an appropriate range of authority (Powitsky, 1981).

The type of care individual prisoners require will obviously vary according to their particular needs. The American Association of Correctional Psychologists (37, Essential) therefore recommends that prisons have a "multiplicity of programs" available for inmate treatment. Only the American Public Health Association (IV C), however, actually lists specific services which prisons ought to make available; it recommends that every facility provide crisis intervention, brief and extended evaluation/assessment, short- and long-term group and individual therapy, therapy with family and significant others, counseling, medication, and inpatient hospitalization.

The standards strongly recommend that prisons use psychotropic medication, when clinically indicated, as one facet of a therapy program. They clearly stress, however, that medication is not simply another tool for the indefinite management of disruptive behavior. The American Medical Association (163, Essential), the American Correctional Association (2-4317, Mandatory), and the Department of Justice (5.34) further note that the prescriber must reevaluate the on-going need for medication prior to renewal and that all prescriptions must have stop-order time periods. The American Medical Association (163, Essential) and Department of Justice (5.34) even discourage the long-term use of minor tranquilizers.

Some inmates will occasionally need psychiatric care beyond that which is available at the institution. The standards unanimously recommend that the prison transfer them to an appropriate facility where they can obtain such care. Medical records should accompany the inmate or be sent as soon as possible thereafter.

The practices described above are in keeping with the broader recommendation found in all the standards that there be a continuity of care from intake to release. In keeping with this ideal, the American Medical Association (136), the American Correctional Association (2-4299), Important), and the American Association of Correctional Psychologists (39, Important) propose that prisons refer disturbed inmates about to be released to appropriate service providers in the community. All five sets of standards recommend that prisons send copies of health records to an inmate's personal physician if the inmate so desires when freed from custody. The Department of Justice would give inmates access to non-evaluative material and evaluation/summaries in their records.

INMATE RIGHTS.

The standards express an explicit concern for inmate rights. They all state that new prisoners should be told at admission of the procedures for obtaining health care and that access to such care is a right which should not be impeded either by officers or by other inmates. Correctional facilities should apply the principle of informed consent for all examinations and treatments in the same way that it is practiced in the broader jurisdiction where the prison is located. Prisons must also follow state and federal regulations when they wish to use involuntary treatment or to transfer an inmate to an inpatient psychiatric hospital.

The two organizations which address the issue of using inmates for medical and pharmacological experimentation both prohibit it (American Correctional Association, 2-4313, Mandatory; Department of Justice, 5.50).* Any other type of research must receive prior administrative approval and conform to current ethical standards.

Discussion.

The five sets of organizational standards reviewed here reflect the most current thought available on the nature and delivery of professional mental health care in state prisons. As such, they constitute an invaluable resource for administrators interested in improving the quality of inmate services. Full implementation cannot only increase the efficiency and cost effectiveness of the health care delivery system in general, but it can do so in a way that encourages a sense of professionalism among staff members and helps deflect criticism that not enough is being done to safeguard inmate welfare as well. A few final comments are nevertheless in order.

First, I must reiterate that agreement among the sponsoring organizations far overshadows the conflict a reader might observe for any one standard. The table has a total of 57 categories, each of which represents a different administrative or service-oriented issue which at least one set of standards addresses. The American Public Health Association, which offers recommendations in only 24 categories, has the least comprehensive standards of those surveyed. Such a finding seems reasonable since this group had no comparable standards on which to build when they first designated a task force to develop public health recommendations for correctional institu-

*The National Conference of Commissioners on Uniform State Laws *would* allow inmates to be used for such experiments. For an excellent discussion of the controversy, the reader may wish to consult sections 4-601 and 4-602 of the Conference's Model Sentencing and Corrections Act (1979).

tions. At the other end of the spectrum, the organization most frequently cited in the table (51 categories, 89 percent) was the American Correctional Association. Standards from each of the other three groups appeared in at least 43 (75 percent) of the possible areas. Some disagreement was inevitable given the total number of suggested practices, but it is nevertheless apparent that correctional and mental health professionals do share a common vision as to how prisons ought to manage mentally ill and mentally retarded inmates. If anything, it is remarkable that they were able to agree on so much. The message for facility administrators is thus clear: a superintendent may wish to adapt certain standards to conform with local tradition and circumstances, but corrections professionals have definitely mandated a structure for the overall mental health program.

Some questions have arisen about the decision to write standards primarily from the perspective that inmates need "mental illness" services rather than "mental health" services. The illness approach leads to activities that emphasize separating the mad from the bad; it seems more justifiable to spend available money on inmates already totally psychotic, decompensated or suicidal. Most existing standards "represent a good effort, but obviously they are still based on an illness model rather than a proactive correctional management framework" (Powitsky, 1981; 6).

Some officials are also disappointed by the fact that the standards give little explicit attention to the mentally retarded. Many recommendations implicity apply to the developmentally disabled, but the five sets of standards specifically mention the retarded inmate a total of only 17 times. Even then, most of the references address the generic need to identify these inmates and refer them for "appropriate" care. The standards provide very little guidance for administrators who are interested in actual programming details or who wish to gain insights into the ways that the management of a retarded inmate may differ from that of the mentally ill.

The standards tend to be vague in other areas as well. Several standards, for example, declare that written procedures are necessary in a variety of situations ranging from volunteer services to involuntary restraints. They then specify the broad issues that such procedures should address in each area (supervision, accountability, etc.) but do not state what the *content* of these procedures should be. Administrators are told *what* to do but not *how* to do it. Another vague proposal is the reference of disturbed inmates about to be released to community agencies which can then provide needed follow-up care. While the standards establish the desirability of such a policy, they do not discuss how corrections should coordinate the planning of this service with parole or how they should actually make these referrals. Some critics have even alleged that the standards break down in precisely those areas where the standards may be most needed — the conceptualization and implementation of staffing and treatment services. A standard calling for "adequate" personnel is hardly a standard at all if no one agrees about what constitutes adequacy.

In fairness, I should note that the standards do not seek to provide detailed instructions for implementation. The American Medical Association and American Correctional Association both have written supplementary materials designed to do this. Standards must also leave some room for discretion because state law and conditions at individual prisons vary so greatly. If the standards were too rigid or inflexible, they would not have earned such widespread support, and most facility superintendents might have resisted implementation because they would have had such limited opportunities to affect their own programs. A certain degree of vagueness can also help forge a consensus among different factions, when additional detail would only provoke more debate. The standards were never intended to delineate actual prison operations; indeed, if an administrator simply incorporated a given set of standards into a facility procedures manual, that would still not guarantee a particular management philosophy or outcome. Rather than being blueprints, the standards suggest a framework for overall facility planning. Some critics feel that administrators have been given too much discretion in how they may interpret the standards, but perhaps compliance can be achieved in several ways.

An administrator might best use the standards by first checking the relevance and consistency of individual provisions for achieving desired outcomes, especially considered in the light of state legal requirements, past experiences, projections of future inmate populations, professional opinions about how to improve the quality of services, and the experience of similar institutions. Final selection of a given option should occur because that option can deliver a certain number and type of service, at a certain time, given the likelihood of the prison obtaining the necessary financial and professional resources. The last variable is obviously crucial. Many standards can be put into effect at no extra cost, but comprehensive implementation could require a significant investment.

Organizational standards are not, of course, the only good source of information for program planners. The U.S. Bureau of Prisons has prepared an extensive Psychological Services Manual for federal prisons, and many state correctional systems have drafted standards for the facilities under their jurisdiction as well. Also worthy of note is the prescriptive package on the mentally retarded offender and corrections written by Miles Santamour and Bernadette West (1977). Whereas the standards speak generally of a need for interdisciplinary treatment, Santamour and West provide considerable detail about sheltered workshops, pre-vocational training, and suitable activities for daily living programs (grooming, laundering, housekeeping, etc.). Their information does not compete with the standards, for the authors do not identify any one set of procedures as constituting the "preferred" method of care. Rather, they review the major options available to administrators and provide relevant background information.

While full compliance with the standards is clearly a worthwhile goal, it is really only a beginning. The reader will recall that the standards represent minimally acceptable practices, and as such describe a level of care that can only be reasonably expected of every adult correctional facility. The Department of Justice (5.04; 5.29) and the American Medical Association (144), for example, write of the need to provide care for inmates "whose adaptation to the correctional environment is *significantly* impaired" (emphasis added). Many inmates who are borderline retarded or who have a mental disability that does not prevent them from following the daily routine might also be able to benefit from treatment but would probably not cross the threshold indicated above at facilities which honor the letter rather than the spirit of the standards.

Some might argue that the standards really represent a plateau of mediocrity rather than an outstanding achievement, but when used in conjunction with other resource material, the standards can obviously serve as an effective basis for formulating a clear, practical direction for reform. Given the proper motivation, virtually any administrator can use the guidelines found in the standards as a foundation for providing humane care in an effective manner to prisoners with a mental disability.

PROFESSIONAL STANDARDS FOR THE CARE AND MANAGEMENT OF THE MENTALLY ILL AND MENTALLY RETARDED OFFENDER

	AMERICAN MEDICAL ASSOCIATION	AMERICAN CORRECTIONAL ASSOCIATION	U.S. DEPARTMENT OF JUSTICE	AMERICAN ASSOCIATION OF CORRECTIONAL PSYCHOLOGISTS	AMERICAN PUBLIC HEALTH ASSOCIATION
I. ADMINISTRATION A. RESPONSIBILITY FOR DISTURBED OFFENDERS	Disturbed offenders shall be the responsibility of a Designated Health Authority (may be a physician, health administrator or agency.) (101, Essential)	Disturbed offenders shall be the responsibility of a Designated Health Authority (may be a physician, health administrator or agency.) (2-4271, Essential)	Disturbed offenders shall be the responsibility of a Designated Health Authority (may be a physician, health administrator or agency.) (5.01)	A full time psychologist in charge of Psychological Services. (4, Essential)	A governmental agency whose primary responsibility is health care delivery rather than the administration of correctional facilities. (p. viii)
B. AUTHORITY OF TREATMENT STAFF 1. Treatment Issues	Medical matters are the sole province of the responsible physician. (101, Essential; 102, Essential)	Psychiatric matters involving medical judgment are the sole province of the responsible physician. (2-4272, Mandatory; 2-4271, Essential)	The responsible physician shall be under no restrictions imposed by the facility administrator regarding medical decisions. (5.02)	The Table of Organization shall show Psychological Services as a separate entity. (4, Essential) Treatment staff shall have professional autonomy within the constraints of appropriate security. (5, Essential)	All mental health personnel shall base all treatment decisions including the decision to treat or not to treat on professional grounds only. (IV B)
2. Access to Confinement Records	The physician shall have access to an inmate's confinement record when the physician deems it relevant. (111)		The physician shall have access to an inmate's confinement record when the physician deems it relevant. (5.41)		
3. Facility Rules	Security regulations applicable to facility personnel shall also apply to health staff. (102, Essential)	Security regulations applicable to facility personnel shall also apply to health staff. (2-4272, Mandatory)	Security regulations applicable to facility personnel shall also apply to health staff. (5.02)	Security regulations applicable to facility personnel shall also apply to health staff. (5, Essential)	
4. Other				Psychological resources shall only be used for purposes appropriate for treatment. (18, Essential)	Mental Health staff who participate in administrative decision making processes shall not provide direct treatment. (IV B)
C. CONFIDENTIALITY	The confidential relationship of doctor and patient extends to inmate patients and their physician. (165) The health authority should share with the facility administrator information about the inmate's medical management and security. (165)	The confidential relationship of doctor and patient extends to inmate patients and their physician. (2-4319, Essential) The health authority should share with the facility administrator information about the inmate's medical management, security, and ability to participate in programs. (2-4319, Essential)	The principle of confidentiality protects the patient from disclosure of confidences entrusted to a physician during the course of treatment. (5.39) The health authority should share with the facility administrator information about the inmate's medical management and security. (5.39)	There shall be a written policy regarding the degree of confidentiality that can be maintained. (16, Essential) Inmates in a therapeutic relationship shall be made aware of what will be reported to any decision making third party and be given the opportunity to refute the information contained in the report. (52, important) Written policy should specify which psychiatric reports should be placed in the inmate's central file. (47, Essential)	There shall be full confidentiality with the only exceptions being the obligation to respond to a clear and present danger of grave injury to self or others and the single issue of escape. (IV B) The limits of confidentiality shall be explained to inmates and periodically reviewed to insure continued awareness. (IV C)
D. HEALTH RECORDS 1. Maintenance	Health records shall be kept separate from the confinement record. (165)	Health records shall be kept separate from the confinement record. (2-4319, Essential)	Health records shall be kept separate from the confinement record. (5.39)	Health records shall be kept separate from the confinement record. (50, Essential)	
2. Control	Health records shall be controlled by the health authority. (165)	Health records shall be controlled by the health authority. (2-4319, Essential)	Health records shall be controlled by the health authority. (5.39)	Psychological records shall be controlled by the chief psychologist. (50, Essential)	
3. Inmate Access		Written policy governs inmate access to their case record. (2-4123, Essential) (There are no standards specifically regarding health records.)	Inmates shall have access to non-evaluative materials and evaluation summaries in their medical records but not raw data from psychological assessments. (5.40)		

PROFESSIONAL STANDARDS FOR THE CARE AND MANAGEMENT OF THE MENTALLY

	AMERICAN MEDICAL ASSOCIATION	AMERICAN CORRECTIONAL ASSOCIATION
4. Release to a Third Party	Written authorization from the inmate must be obtained before health records can be released to another party unless otherwise provided by law. Records shall be available to physicians in the community upon written consent of the inmate. (166)	Health record information shall be transmitted to physicians in the community upon written request of the inmate. (2-4320, Essential)
5. Transfer	Summaries or copies of the health record are routinely sent to the facility to which an inmate is transferred. (166)	Summaries, originals, or copies of health records shall accompany the inmate to the facility to which he/she is transferred. (2-4320, Essential)
E. TREATMENT-CUSTODY INTERFACE 1. Broader Mental Health Role		
2. Regular Meetings	The superintendent and health authority shall meet at least quarterly. (103)	The superintendent and health authority shall meet at least quarterly. (2-4273, Essential)
3. Quarterly Reports	There shall be a quarterly health care report and annual statistical summary. (104, Essential)	There shall be a quarterly health care report and annual statistical summary. (2-4273, Essential)
4. Consultation	The superintendent and responsible physician should consult prior to action being taken in the following areas for a disturbed inmate: Housing, programming, transfers or discipline. (112)	The superintendent and responsible physician should consult prior to action being taken in the following areas for a disturbed inmate: Housing, programming, transfers or discipline. (2-4298, Essential)
F. PROGRAM EVALUATION	Every policy and procedure in health care delivery shall be reviewed at least annually. (106)	Every policy and procedure in health care delivery shall be reviewed at least annually. (2-4274, Essential)
II. PHYSICAL PLANT A. HEALTH FACILITIES	If health services are delivered at the facility, there shall be adequate space equipment, supplies and materials as determined by the health authority. (107)	Space, equipment, supplies and materials for health services are provided and maintained as determined by the health authority. (2-4277, Essential)

LL AND MENTALLY RETARDED OFFENDER (Continued)

U.S. DEPARTMENT OF JUSTICE	AMERICAN ASSOCIATION OF CORRECTIONAL PSYCHOLOGISTS	AMERICAN PUBLIC HEALTH ASSOCIATION
Health records shall be available to the inmate's private physician with the consent of the inmate. (5.40)	Written authorization from the inmate is necessary for the transfer of psychological records to any third party unless otherwise provided by law. (51, Essential)	The health record shall not be released to anyone not a member of the health staff or who has not been legally authorized to receive it. (IX)
Summaries or copies of the health record are routinely sent to the facility to which an inmate is transferred. (2-4320, Essential)	Health records shall arrive either before or with the inmate when he/she is transferred. (54, Essential; 53, Important)	Health records shall accompany the inmate whenever he/she is transferred. (IX)
		Mental health professionals should work toward the enhancement of the mental health of the facility as a whole. (IV D)
	The superintendent and chief psychologist shall meet at least monthly. (7, Important)	
There shall be a quarterly health care report and annual statistical summary. (8, Important)	There shall be a quarterly health care report and annual statistical summary. (8, Important)	
	The superintendent and responsible psychologist should consult prior to action being taken in the following areas for a disturbed inmate: Housing, programming, transfers or discipline. (35, Important)	
	There shall be a review of the quality of services at least once a year by both the chief psychologist and an outside agent. (9, Essential; 10, Essential) Formal evaluations of the effectiveness of psychological services, treatment and programs shall be required. (40, Important)	There shall be regular, systematic independent and internal audits of health care services and programs. (X)
If medical services are delivered at the facility, there is adequate space for the examination and treatment of inmates in private, and adequate equipment, supplies, and materials as determined by the health authority for primary health care delivery. (5.09)	If psychological services are delivered at the facility, there shall be adequate space, equipment, supplies, funds and materials as determined by the chief psychologist. (6, Essential)	Adequate facilities should be provided for the medical care of inmates. (VI D)

PROFESSIONAL STANDARDS FOR THE CARE AND MANAGEMENT OF THE MENTALLY

	AMERICAN MEDICAL ASSOCIATION	AMERICAN CORRECTIONAL ASSOCIATION
B. SPECIAL UNITS		Inmates who are severely disturbed and/or mentally retarded are referred for placement in appropriate non-correctional facilities or in specially designated units for handling this type of individual. (2-4296, Essential)
C. TEMPORARY DETENTION AREAS	Those awaiting emergency evaluations shall be housed in a special area with constant supervision by trained staff. (144)	
III. STAFFING AND PROFESSIONAL DEVELOPMENT A. QUALIFICATIONS 1. Licenses	State licensing requirements apply to health care staff. (122, Essential)	Appropriate state and federal licensing requirements apply to health care staff. (2-4284, Mandatory)
2. Verification of credentials	Verification of credentials shall be on file. (122, Essential)	Verification of credentials shall be on file. (2-4284, Mandatory)
3. Other		
B. JOB DESCRIPTIONS	There shall be written job descriptions approved by the health authority. (123, Essential)	There shall be written job descriptions approved by the health authority. (2-4284, Mandatory)
C. STAFF-INMATE RATIO	There shall be adequate staff as determined by the health authority. (107)	The facility shall systematically determine its personnel requirements in all categories on an on-going basis to insure inmate access to staff and availability of support services. (2-4072, Important)
D. IN-SERVICE TRAINING 1. Medical/Mental Health Staff	All health services staff shall receive orientation and training appropriate to health care activities. (124)	All professional specialists shall have 40 hours training prior to beginning work, 40 hours during the first year, and 40 hours each year thereafter. (2-4091, Essential)
2. Correctional Staff Working with Inmates a. Recognition of Disturbed Inmates	Correctional staff shall be trained by the responsible physician to recognize the signs and symptoms of mental illness/mental retardation. (130, Essential)	Correctional and other personnel should be trained to recognize the signs and symptoms of mental illness/mental retardation. (2-4285, Mandatory)

LL AND MENTALLY RETARDED OFFENDER (Continued)

U.S. DEPARTMENT OF JUSTICE	AMERICAN ASSOCIATION OF CORRECTIONAL PSYCHOLOGISTS	AMERICAN PUBLIC HEALTH ASSOCIATION
	Prison systems shall have their own resources for handling severely disturbed inmates in a separate facility or specially designated unit. (33, Important)	
The facility has at least one special purpose cell or room for the temporary detention of individuals who are uncontrollably violent or self-destructive. (2.10)	Inmates awaiting emergency evaluation or treatment shall be housed in a special area with close observation. (30, Essential)	Intake screening shall be done in an area conducive to the encounter. (I A)
State licensing requirements apply to health care staff. (5.06)	State license and/or certification requirements apply to all aspects of psychological services. (2, Essential)	All health care providers shall be licensed in their specialty. (IX)
Verification of credentials shall be on file. (5.06)	Verification of credentials shall be on file. (2, Essential)	Verification of credentials shall be on file. (IX)
	At least one person at the facility responsible for psychological services shall have a Ph.D. (3, Essential)	
There shall be written job descriptions approved by the health authority. (5.07)	There shall be written job descriptions approved by the facility administrator and in conformity with professional guidelines established by the American Psychological Assoc. (1, Essential; 11 Essential)	
There shall be adequate staff as determined by the health authority. (5.09)	There shall be 1 full-time psychologist for 200-250 inmates. In specialized units, there shall be 1 full-time psychologist for 100-125 inmates. (12, Essential)	Health staff should be of sufficient number and diversity for health staff to be able to deliver responsibly the services outlined in the standards. (XI)
All new employees shall receive 40 hours training prior to beginning work, 40 hours during the first year, and 40 hours each year thereafter in areas related to the employee's occupational specialty. (21.05; 21.06)	Psychology staff shall receive orientation training and regular continuing education. (13, Essential) Part-time and consultant staff shall attend orientation sessions conducted by the chief psychologist. (41, Important)	
Correctional staff shall be trained to recognize the signs and symptoms of mental illness/mental retardation. (5.29; 21.05)	At least one officer per shift with training in the recognition of the signs and symptoms of mental illness should be within sight and sound of all inmates. (20, Essential)	

PROFESSIONAL STANDARDS FOR THE CARE AND MANAGEMENT OF THE MENTALLY

	AMERICAN MEDICAL ASSOCIATION	AMERICAN CORRECTIONAL ASSOCIATION
b. Emergencies	Correctional staff shall be trained to respond to medical emergencies, how to obtain care, and procedures for transferring inmates to appropriate medical facilities. (128, Essential)	Correctional staff shall be trained in emergency medical procedures. (2-4092, Essential)
E. USE OF INMATES	Inmates shall not provide direct patient care, schedule health care appointments, determine the access of other inmates to health care or handle medications. (133, Essential)	Inmates shall not provide direct patient care, schedule health care appointments, determine the access or other inmates to health care or handle medication. (2-4288, Essential)
F. USE OF VOLUNTEERS	There shall be written procedures for the selection, training, length of service, staff supervision, definition of responsibilities, and authority of volunteers. (132)	There shall be written procedures specifying the lines of authority, responsibility, and accountability for volunteer services programming. (2-4488, Essential) Volunteers shall provide professional services only when certified to do so. (2-4494, Essential) Volunteers shall complete orientation training appropriate to the nature of the assignment. (2-4490, Essential)
IV. IDENTIFICATION AND EVALUATION A. INTAKE SCREENING	There shall be post-admission screening and referral for care of mentally ill/mentally retarded inmates whose adaptation to the correctional environment is significantly impaired. (144)	New inmates shall receive a mental health screening. (2-4389, Essential)
B. CLASSIFICATION 1. Special Needs		The special needs (including those related to mental illness and mental retardation) shall be identified and addressed through the classification process. Classification shall be completed within four weeks of admission and reviewed every twelve months. (2-4408, Essential; 2-4397, Essential; 2-4404, Essential)
2. Health Appraisals	A health appraisal, including comments on mental status shall be conducted on all inmates within 14 days of admission. (142, Essential)	A health appraisal including a review of mental status shall be conducted on all inmates within 14 days of admission. (2-4291, Essential)
C. EVALUATION 1. Routine	Assessment of psychiatric problems identified at screening or after admission will be provided within 14 days. (142, Essential)	Comprehensive mental health evaluations on specially referred inmates shall be completed within 14 days of referral. (2-4293, Essential)

L AND MENTALLY RETARDED OFFENDER (Continued)

U.S. DEPARTMENT OF JUSTICE	AMERICAN ASSOCIATION OF CORRECTIONAL PSYCHOLOGISTS	AMERICAN PUBLIC HEALTH ASSOCIATION
Correctional staff shall be trained to respond to medical emergencies, how to obtain care, and procedures for transferring inmates to appropriate medical facilities. (5.22)	Correctional staff shall be trained to respond to medical emergencies, how to obtain care, and procedures for transferring inmates to appropriate medical facilities. (44, Important)	
Inmates shall not schedule health care appointments, determine the access of other inmates to health care services, handle medication, or carry out direct clinical care services that require trained health care personnel. (5.36; 5.37)	Inmates shall not be given responsibility for test administration, scoring, or the filing of psychological data. (25, Essential)	
There shall be written procedures for the recruitment, supervision, orientation, training, coordination, role, and accountability of volunteers. (21.15)	There shall be written policy for the selection, training, term of service, supervision, responsibility, and level of authority of all volunteers. They shall have an appropriate orientation. (45, Important)	
There shall be post-admission screening and referral of mentally ill/mentally retarded inmates whose adaptation to the correctional environment is significantly impaired. (5.04; 5.29)	Inquiries shall be made during intake screening into past and present history of mental disturbance. Inmates with problems shall be referred for a more comprehensive evaluation. (23, Essential)	All new inmates shall receive an intake screening. The screening shall include an assessment of coping mechanisms and ego strengths. Inquiries will be made regarding mental illness and mental health treatment. (I A)
The special needs (including those related to mental illness and mental retardation) shall be identified and addressed through the classification process. Classification shall be completed within four weeks of admission and reviewed every twelve months. (9.06; 9.07; 9.08)		
A health appraisal including a mental health history shall be conducted on all inmates within 14 days of admission. (5.16	All inmates shall receive a psychological evaluation within one month of admission. (24, Essential)	
	Assessments of inmates referred for comprehensive psychological appraisals shall be completed within 14 days of referral. (26, Essential)	

PROFESSIONAL STANDARDS FOR THE CARE AND MANAGEMENT OF THE MENTALL

ILL AND MENTALLY RETARDED OFFENDER (Continued)

	AMERICAN MEDICAL ASSOCIATION	AMERICAN CORRECTIONAL ASSOCIATION	U.S. DEPARTMENT OF JUSTICE	AMERICAN ASSOCIATION OF CORRECTIONAL PSYCHOLOGISTS	AMERICAN PUBLIC HEALTH ASSOCIATION
2. Emergency	Those awaiting emergency evaluations shall be housed in a special area with constant supervision by trained staff. Inmates shall be held no more than 12 hours before emergency care is rendered. (144)			Inmates awaiting emergency evaluation/treatment shall be housed in a special area with close observation. Crisis evaluations shall be done within 24 hours of referral. (27, Essential)	
V. INMATE MANAGEMENT AND TREATMENT A. FACILITY RESOURCES 1. Types of Care	The facility shall provide chronic and convalescent care. (155) If the mentally ill are kept at the prison, the facility must provide a safe and humane environment, adequate staffing for someone to be in sight and sound of all inmates, and trained staff to provide treatment and close supervision. (113)	The facility shall provide chronic and convalescent care. (2-4305, Essential) The institution shall provide psychological and psychiatric services. (2-4022, Essential) Severely disturbed inmates shall be referred for placement in appropriate non-correctional facilities or in specially designated units for the handling of this type of individual. (2-4296, Essential)	The facility shall provide chronic and convalescent care. (5.25) Treatment shall be provided which is approved as medically sound and in conformance with medically accepted standards by a committee of outside medical consultants. (5.51)	The facility shall provide acute, chronic, and convalescent care. (28, Essential) The facility shall provide a multiplicity of appropriate programs. Only those treatment methods accepted by the state psychological community and not specifically prohibited by headquarters in a multi-facility operation will be used. (37, Essential)	The facility shall provide treatment of varied modalities with emphasis on eclectic breadth. Included are crisis intervention, brief and extended evaluation/assessment, short and long term group and individual therapy, therapy with family and significant others, counseling, medication and inpatient hospitalization. (IV C)
2. Level of Care		The institution shall fulfill the rights of inmates to basic medical care. (2-4329, Mandatory)	The facility shall provide services and treatment needed to maintain basic health. (1.06)		Health care services should be of comparable standard to that prevailing in the community at large. (p. viii)
3. Notice of Care Available	Inmates shall be given verbal and written notice regarding procedures for gaining access to health care. (137, Essential)	Inmates shall receive written orientation materials regarding procedures for gaining access to health care. (2-4395, Essential)	Inmates shall be given verbal and written notice regarding procedures for gaining access to health care. (5.18; 8.08)	Inmates shall be given written information at admission regarding the procedures for gaining access to psychological services. (21, Essential)	New inmates shall be told about the mental health services available and procedures for application. (I A)
4. Access to Care	Inmate health complaints are solicited daily and acted upon by health trained correctional staff. Appropriate triage and treatment by health staff should follow. (145, Essential)	Inmates should have unimpeded access to health care. (2-4300, Mandatory)	No inmate or correction officer shall inhibit or delay an inmate's access to medical services or interfere with medical treatment. (5.19)	There are written procedures approved by the chief psychologist regarding inmate access to psychological services. (22, Essential)	Inmates should be allowed unimpeded access, implicit or explicit, to health care services. (p. vii)
B. ADMINISTRATIVE SEGREGATION		Written policy allows the administrative segregation of inmates whose continued presence in the general population poses serious threat to life, property, self, staff, other inmates or the security of the institution. (2-4214, Essential)	Written policy allows the administrative segregation of inmates whose continued presence in the general population poses serious threat to life, property, self, staff, other inmates or the security of the institution. (11.03)		
C. TREATMENT PLANS	Written individualized treatment plans shall be prepared for inmates requiring close medical supervision. The plan shall include directions to non-medical staff regarding their roles in the care, treatment, and habilitation of the inmate. (150)	Written individualized treatment plans shall be prepared for inmates requiring close medical supervision. The plan shall include directions to non-medical staff regarding their roles in the care, treatment, and habilitation of the inmate. (2-4304, Essential)	Written individualized treatment plans shall be prepared for inmates requiring close medical, psychiatric, psychological or habilitative supervision. The plan shall include directions to non-medical staff regarding their roles in the care, treatment, and habilitation of the inmate. (5.30)	Written individualized treatment plans shall be prepared for all inmates requiring psychological services. The plan shall include directions to non-medical staff regarding their roles in the care, treatment, and habilitation of the inmate. (31, Essential; 36, Essential)	
D. INFORMED CONSENT	All examinations, treatments, and procedures governed by informed consent practices in the jurisdiction will likewise be observed for inmate care. (168)	Informed consent standards used in the jurisdiction shall be observed and documented. (2-4313, Essential)	Informed consent is needed for all examinations, treatments and medical procedures for which informed consent is needed in the jurisidction. (5.44; 5.51)	All psychological examinations, treatments and procedures affected by the principle of informed consent in the jurisdiction are likewise observed for inmate care. (14, Essential)	
E. PSYCHOTROPIC MEDICATION 1. When Appropriate	Psychotropic medication shall be used when clinically indicated as one facet of a program of therapy. (163, Essential)	Psychotropic medication shall be used when clinically indicated as one facet of a program of therapy. (2-4317, Mandatory)	Psychotropic medication shall be used when clinically indicated as one facet of a program of therapy. (5.35)		Psychotropic medication shall be used for bona fide medical reasons. (VIII)

PROFESSIONAL STANDARDS FOR THE CARE AND MANAGEMENT OF THE MENTALLY ILL AND MENTALLY RETARDED OFFENDER (Continued)

	AMERICAN MEDICAL ASSOCIATION	AMERICAN CORRECTIONAL ASSOCIATION
2. Who Should Prescribe		Psychotropic medication shall be prescribed by a physician or authorized health provider by agreement with the physician following a physical exam. (2-4322, Essential)
3. Use for Disciplinary Purposes	The use of psychotropic medication for disciplinary purposes is forbidden. (163, Essential)	The use of psychotropic medication for disciplinary purposes is (implicitly) forbidden. (2-4317, Mandatory)
4. Long Term Use of Minor Tranquilizers	The long term use of minor tranquilizers is discouraged. (163, Essential)	
5. Renewal	The prescribing provider must reevaluate a prescription prior to renewal. (163, Essential)	The prescribing provider must reevaluate a prescription prior to renewal. (2-4317, Mandatory)
6. Stop Order Time Periods	Stop order time periods are required for all medications. (163, Essential)	Stop order time periods are required for all medications. (2-4317, Mandatory)
F. EMERGENCIES	Written procedures should provide for the provision of emergency medical care 24 hours a day. (154, Essential)	Emergency medical care should be available on a 24-hour basis. (2-4279, Mandatory)
G. INVOLUNTARY RESTRAINTS	Written policy guides the use of medical restraints. The policy should identify the authorization needed, when, where, duration and how they may be used. The same kind of restraints should be used for inmates that would be medically appropriate for the general population within the jurisdiction. Health care staff shall not participate in the disciplinary restraint of inmates. (159)	Written policy guides the use of medical restraints. The policy should identify the authorization needed, when, where, duration and how they may be used. The same kind of restraints should be used for inmates that would be medically appropriate for the general population within the jurisdiction. (2-4312, Essential)
H. INVOLUNTARY TREATMENT AND THE RIGHT TO REFUSE TREATMENT	In certain exceptional cases, a court order for treatment may be sought, just as it might in the general community. (168)	Involuntary treatment may be provided but only in accordance with state and federal laws. (2-4313, Essential) Written policy provides inmates with the option of refusing to participate in psychological or psychiatric treatment. (2-4334, Essential)

U.S. DEPARTMENT OF JUSTICE	AMERICAN ASSOCIATION OF CORRECTIONAL PSYCHOLOGISTS	AMERICAN PUBLIC HEALTH ASSOCIATION
Psychotropic medication shall be prescribed by a physician who has examined the inmate. (5.35)		Psychotropic medication shall be prescribed by legally authorized persons specifically trained in psychopharmacological therapeutics (IV C) and who are involved in a genuine professional-patient relationship. (VIII)
The use of psychotropic medication for disciplinary purposes is forbidden. (5.35; 6.18)		Mental health treatment shall be provided for valid emotional or psychological reasons only, as determined by mental health staff. (IV B)
The longer term use of minor tranquilizers is discouraged. (163, Essential)		
The prescribing provider must reevaluate a prescription prior to renewal. (5.34)		
Stop order time periods are required for all medications. (5.35)		
Emergency medical care should be available on a 24 hour basis. (5.12) Provisions should be made for counseling inmates on an emergency basis. (7.02)	Written procedures approved by the chief psychologist shall be prepared regarding access to psychological services on emergency and non-emergency bases. (22, Essential)	Each facility should provide for the emergency health needs of inmates. (I F)
Restraints may be used for medical reasons, including the prevention of inmate self-injury, by direction of the medical officer. The restraints shall not be more confining than called for by the circumstances and should not be applied for longer than necessary. Inmates should be properly supervised when placed and kept in restraints. (6.17)	Written policy guides the use of restraints. The use of these devices are appropriate only as part of a psychological treatment regimen. Psychological services staff should not be responsible for the administrative restraint of disruptive inmates when such behavior is not part of a mental disturbance. (15, Essential)	
	Involuntary treatment may be provided but only in accordance with state and federal laws. (15, Essential)	No mandated treatment shall be provided unless the individual, by reason of mental disturbance, poses a clear and present danger to himself or others. Mandated treatment should consist of the least drastic measures in response to an immediate emergency or on a continuing basis only after civil judicial direction by an appropriate court. No reward, privilege, or punishment should be contingent upon mental health treatment. (IV B)

PROFESSIONAL STANDARDS FOR THE CARE AND MANAGEMENT OF THE MENTALL'

	AMERICAN MEDICAL ASSOCIATION	AMERICAN CORRECTIONAL ASSOCIATION
I. TRANSFERS 1. Necessity	Inmates, including those with acute psychiatric illness, needing care beyond available resources shall be transferred to a facility where appropriate care is available. (113)	Inmates needing health care beyond available resources shall be transferred to a facility where appropriate care is available. (2-4310, Essential)
2. Due Process		Transfers shall be done according to due process as specified by law. In case of emergency, a hearing shall be held as soon as possible afterwards. (2-4297, Essential)
3. Procedures	Written procedure for routine transfer shall include an assessment of the individual's suitability for travel. The facility shall provide any medication needed en route and special instructions for the transportation staff. (118)	Written procedure for routine transfer shall include an assessment of the individual's suitability for travel. The facility shall provide any medication needed en route and special instructions for the transportation staff. (2-4311, Essential)
J. RELEASE PREPARATION	Inmates shall be referred to community care when indicated. (136)	Inmates shall be referred to community care when indicated. (2-4299, Important)
VI. RESEARCH A. GENERAL POLICY		The institution supports and engages in research activities relevant to its programs. (2-4108, Important) Operational personnel shall assist research staff in carrying out research and evaluation. (2-4113, Important)
B. REQUIRED APPROVAL		The superintendent shall approve all research requests prior to implementation. (2-4111, Essential)
C. HUMAN RIGHTS	Research shall comply with state and federal guidelines and shall involve an appropriate Human Subjects Review Committee. (169)	Written policy shall govern voluntary inmate participation in non-medical, nonpharmacological, noncosmetic research. (2-4114, Essential)
D. EXPERIMENTS		Inmates shall not be used for medical, pharmacological or cosmetic experiments. This does not preclude individual treatment with special procedures not generally available. (2-4314, Mandatory)

ILL AND MENTALLY RETARDED OFFENDER (Continued)

U.S. DEPARTMENT OF JUSTICE	AMERICAN ASSOCIATION OF CORRECTIONAL PSYCHOLOGISTS	AMERICAN PUBLIC HEALTH ASSOCIATION
Inmates with psychiatric illnesses who need care beyond available resources shall be transferred to a facility where appropriate care is available. (5.32)	If diagnostic and treatment service care are needed but unavailable at the facility, the inmate shall be transferred to a facility where such services are available. (28, Essential; 32, Essential)	Medical criteria alone shall dictate if an inmate shall be transferred to a civilian health center for emergency care. (I F)
	Transfers shall be done according to due process specified by state and federal statutes. (34, Essential)	
Written procedure for routine transfer shall include an assessment of the individual's suitability for travel. The facility shall provide any medication needed en route and special instructions for the transportation staff. (5.42)	When an inmate is transferred, the least restrictive restraints possible should be used. The inmate shall be accompanied by a trained staff member. (54, Essential)	
	Written policy should insure that provisions are made for post release follow-up care when appropriate. (39, Important)	
	Psychological Services shall be encouraged and opportunities provided for basic research. (55, Important)	
	Research requests shall be approved prior to implementation by a Research Advisory Committee. Psychological Services shall be represented on the committee. (57, Essential)	
	Research shall conform to the ethics of the National Committee for the Protection of Human Subjects. (56, Essential)	
There shall be no medical or pharmacological testing for experimental or research purposes. (5.50)		

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