By Frederick R. Maue

Both large and small correctional systems, jails and prisons are challenged with managing bad behavior. Behavior resulting in disciplinary infractions in offenders with mental illness raises the question, "Are these rules/infractions resulting from manifestations of mental illness or is mental illness a contributing factor?" To avoid litigation, correctional systems must provide three key elements: access to care, proper treatment, and qualified staff to provide for and monitor care. Administrative segregation challenges a system's ability to meet a reasonable standard of care that incorporates these key elements. The following summarizes key court cases that help to answer:

- What is the constitutional right of care for mentally ill offenders in segregated housing?
- What practical components constitute a successful treatment program that provides necessary treatment and ensures success in meeting future court challenges?

Key Legal Elements and Cases

The Eighth Amendment of the U.S. Constitution prohibits "cruel and unusual punishment." This has been interpreted to mean that federal or state governments must provide the necessities of life to individuals in custody. These necessities include shelter, clothing, food and medical care. For pretrial detainees, their rights are based on the 14th Amendment, which states that they cannot be deprived of life liberty or property without due process of law.

Key legal cases that have determined the quality of care to inmates are as follows:

***Estelle v. Gamble* (429 U.S. 97, 1976)** — This case said that deliberate indifference to meeting the inmate need for medical care violated the Eighth Amendment. Appeals courts have equated deliberate indifference with recklessness. The case set the standard for provision of medical care in the incarcerated population. Gamble was injured

while working on a prison assignment. He claimed his civil rights were violated due to not receiving adequate medical care. The court stated that the case was one of medical civil liability and that this did not equal a constitutional violation.

***Farmer v. Brennan* (511 U.S. 825, 1994)** — Inmate Farmer, a pre-operative transsexual patient, was assaulted in prison. He filed a civil rights suit claiming that prison officials were "deliberately indifferent" to the likelihood that his feminine characteristics would result in such an assault. The court held that a prison official may be held liable under the Eighth Amendment for acting with deliberate indifference to an inmate's health and safety if he or she knows that an inmate faces a substantial risk of serious harm and disregards such risk by not taking reasonable measures to abate it.

To avoid litigation, correctional systems must provide three key elements: access to care, proper treatment, and qualified staff to provide for and monitor care.

Courts have shown deliberate indifference as evidenced by proving there are such systems of care with gross deficiencies in staffing, facilities and equipment, or that providers deny access to care. Correctional administrators must ask themselves if deficient conditions exist, for offenders who are medically or mentally ill, in administrative segregation, resulting in possible constitutional risk for cruel and unusual punishment.

***McGuckin v. Smith* (974 F.2d 1050, 9th Cir. 1992)** — In this case, the court attempted to define a serious medical need, placing emphasis on professional judgment plus significant pain and impairment to the inmate. A serious medical need exists if the failure to treat an inmate's condition could result in further injury or unnecessary infliction of pain. Either result is not the type of routine discomfort that is "part of the penalty criminal offenders pay for their offenses."

Case law suggests that a diagnosis based on professional judgment and resting on a standardized diagnostic reference manual is thought to be valid. Each state system should have a clear definition of what constitutes a serious mental illness (SMI) consisting of two components: 1) major psychiatric illness and 2) level of functional impairment.

***Ruiz v. Estelle* (503 F. Supp. 1265, S.D. Tex. 1980)** — This case decided that conditions in Texas Department of Criminal Justice Administrative segregation units clearly violated constitutional standards for mentally ill offenders confined to administrative segregation units for extended periods. Department officials were deliberately indifferent to inmate medical and psychiatric needs.

This is a classic case of a prolonged court battle on the issues outlined above. However, multiple state prison systems have had similar challenges resulting in close monitoring of these conditions and systematic improvements in inmate health care.

***Wolff v. McDonnell* (418 U.S. 539, 1974)** — The court ruled that inmates facing serious disciplinary charges must have: a written notice of violation 24 hours before the hearing, a written statement of evidence and reasons for misconduct, the right to call witnesses, the right to present documentary evidence, and the right to legal aid for illiterate inmates.

***Sandin v. Conner* (115 S. Ct. 2993, 1995)** — The court ruled that deprivation of privileges must be significant and atypical for protected liberty interest (14th Amendment). In this case, 30 days of disciplinary time was not significant. Liberty interest may be fused with the Eighth Amendment in that segregated confinement that is harsh or prolonged may be cruel and unusual punishment.

Good time credit loss is significant. Thus, due process must be followed and evidence must be presented to support the disciplinary decision.

***Huggins v. Coughlin* (548 N.Y.S. 2d 105)** — The court ruled that the offender's mental condition must be considered in a disciplinary custody decision or sanction. In any disciplinary hearing where there is an indication that mental illness may have contributed to the actions of the inmate, that mental condition should be given consideration at least when it comes to deciding a sanction, but also as to whether the hearing should be held at all. The offender must be physically and mentally present during the hearing.

***Madrid v. Gomez* (889 F. Supp. 1146 Calif. 1995)** — The court found that cruel and unusual punishment existed to place certain (mentally ill) inmates in the Pelican Bay-Special Housing Unit (SHU). The court stated that this included "Those who the record demonstrates are a particularly high risk for suffering very serious or severe injury to their mental health, including overt paranoia, psychotic breaks with reality, or massive exacerbations of existing mental illness as a result of conditions in the SHU." An Eighth Amendment violation existed to place in unit inmates with:

- Mental illness;
- Borderline personality disorder;
- Brain damage;
- Mental retardation;
- Chronic depression; and/or
- Impulse control disorders.

Metzner (2005) has summarized the court issues as follows: "Unlike the involuntary transfer of an inmate to a psychiatric institution, assignment to administrative segregation, under usual circumstances (less than one year), does not represent such a significant and atypical hardship or stigmatization so as to give rise to a liberty interest. Consistent with this premise, courts have repeatedly rejected prisoners' disciplinary appeals so long as it could be demonstrated that the disciplinary decisions were not 'sufficiently arbitrary so as to be a denial of due process,' or so long as a modicum of evidence could be found to support the conclusion reached by the disciplinary board."

Challenges

Common problems found by correctional systems at risk of constitutional violations include lack of training of security and treatment personnel; inadequate cooperation and communication between treatment, security and administrative staff; and lack of policies and procedures on placement and follow up.

The questions prison/jail systems must consider regarding the disciplinary process for mental health offenders in administrative segregation include:

- Are mental health personnel notified of placement in administrative segregation?
- How long after placement in administrative segregation before an evaluation is completed by a mental health professional?
- How long is it from the placement date to the misconduct hearing date?
- Are all mentally ill offenders being identified and tracked?
- What is the average and maximum time spent by mentally ill offenders in administrative segregation?
- How does the hearing officer or misconduct review committee use input from mental health professional(s) for decision-making?

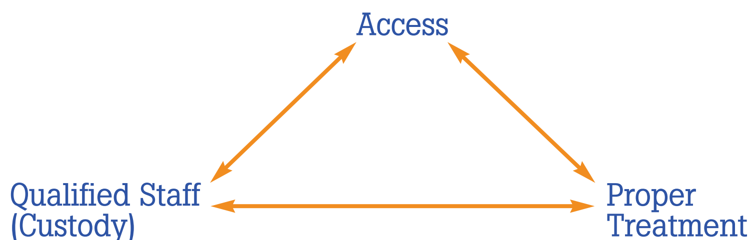
If policy and procedures are in place, and if staff are trained and the procedures are followed, liability will be reduced for correctional systems. The key elements in a successful disciplinary review process for inmates with serious mental illness are as follows:

- Screen all inmates for suicide potential and mental illness — both past and present;
- Promptly notify mental health professional(s) of mentally ill offender placement;
- Conduct a monthly review of housing locations for all mentally ill offenders — both in the general population and administrative segregation;
- Include mental health professionals' input in misconduct hearing procedures;
- Ensure that mental health professionals monitor mentally ill offenders in administrative segregation on a weekly basis;
- Allow mental health professionals to review misconduct infraction(s) prior to hearing;
- Provide staff assistance to a mental health offender at the misconduct hearing;
- Allow mental health professionals to conduct a detailed clinical assessment to address decision-making capacity (competency) level; and
- Establish diversion and disposition follow-up procedures prior to and after the disciplinary hearing.

Key factors of clinical assessment to address for disciplinary hearings are:

- Offender decision-making capacity;
- Impact of punishment in mentally ill offender;
- Mental health diagnosis and treatment plan;
- Medication compliance history;
- Need for informal assistance at misconduct hearing by mental health professional;
- Diversion alternatives for treatment and alternative sanctions;
- Disciplinary infraction — was it the result of mental illness, anti-social behavior or a combination of both; and
- Mitigating circumstances such as interpersonal conflicts (e.g., fight with cellmate), interpersonal transition (e.g., loss of parole appeals) and grief issues (e.g., death of a loved one).

Figure 1. The keys to minimizing liability risk comprise the Treatment Triangle



Reviewing Policies and Procedures

Opportunities exist for mental health input and assessment at the misconduct issuance level, supervisory review level and/or hearing officer level.

Policies and procedures often have unclear definitions for what constitutes mental illness and criminal responsibility/nonresponsibility for mentally ill offenders. Problematic areas in policy/procedures also include:

- When to make a clinical referral;
- Competency — decision-making criteria;
- Disposition — post-hearing retrospective review of hearing officer decision by inmate's unit manager or counselor;
- Confidentiality issues — sharing of clinical and misconduct information between custody and security;
- Monitoring requirements — how often and by what discipline(s);
- Referral criteria — when should custody staff request a mental health evaluation on an offender with no mental health history but showing symptoms of a mental illness;
- Timeframes for completion of assessments by mental health professional(s); and
- Diversion options — providing appropriate mental health treatment for mentally ill inmates with minor infractions as an alterative to administrative segregation placement.

Continuous quality improvement measures are necessary to ensure the standard of care for mentally ill offenders has created change. This can be done by keeping track of the:

- Number of mentally ill inmates who receive misconduct tickets;
- Number of inmates in disciplinary confinement;
- Length of time spent in confinement by mentally ill offenders versus non-SMI offenders;
- Number of diversions to treatment as alternative to administrative segregation placement;
- Number of SMI offenders having or not having decision-making capacity; and
- Length of time from date of placement of mentally ill offenders to date of completion of mental health evaluation.

The ability of a correctional system to manage SMI or severe behavioral offenders is a test of good cooperation, communication and training of system personnel at all levels. The keys to success are:

- the availability of alternative sanctions such as infirmary observation cell placement;

- inpatient mental health placement or outpatient treatment;
- appropriate treatment defined by a detailed assessment by qualified mental health personnel; and
- well-qualified staff with training and seamless communication.

Driven by court challenges, large correctional systems have successfully developed procedures to manage these difficult waters. One should look to correctional systems in states such as Texas, Georgia, Ohio and Pennsylvania for further guidance on these issues. These states have implemented significant changes in delivery of mental health care to a broader group of inmates as a result of court challenges to their systems of mental health care.

Guidance also can be obtained from Rold (1992), an attorney who lists nine guiding principles that protect the rights of mentally ill offenders in disciplinary custody:

- Make it an alternative duty of hearing officers to inquire into the mental health status of the inmate when the issue is presented fairly, even if the inmate fails to raise it;
- Inquire into the consequences of the mental health treatment of proposed dispositions and the use of clinically appropriate sanctions;
- Make available a variety of disciplinary dispositions that take into account the mental health cases for behavior, including dismissal of charges;
- Limit the maximum time spent in punitive segregation, as adopted by many states;
- Review the mental status of inmates discharged from psychiatric hospitalization who "owe" segregation time before returning them to solitary confinement;
- Have a mental health professional review the mental health status of inmates before placement in segregation and regularly while in segregation;
- Prohibit the placement or maintenance in solitary confinement of inmates with severe mental disorders or current psychotic disability;
- Provide the opportunity to inmates to submit proof of mental health factors underlying the misconduct; and
- Make counsel available for inmates unable to assist themselves.

If policy and procedures are in place, and if staff are trained and the procedures are followed, liability will be reduced for correctional systems.

Finally, correctional systems and their administrators should develop a common value system, ensuring administrative, custody and treatment personnel adopt a commitment to fairness in dealing with difficult-to-manage mentally ill inmates. Often these high-intensity cases occupy much staff time and attention.

Williams and Dale (2001) discuss professional value as important and challenging in forensic mental health work in secure settings. These include:

- Respecting the detained person as a human being, regardless of behavior, crime or diagnosis;
- Accepting and applying current principles of ill health and needs for care and treatment upheld by the medical and psychiatric professions;
- Reserving negative judgments for behavior rather than people;
- Delivering an equally high quality of care to each individual;
- Treating all individuals with equality and fairness;
- Maintaining confidentiality; and
- Respecting class, gender, age, sexual orientation, ethnic origin, culture, language, religion and physical characteristics.

This article has attempted to summarize many key ideas to foster better offender management in jail and prison correctional systems. The framework for this guidance has come from many of the legal cases listed. Readers are encouraged to review these cases and the articles below for further study and reference. More legal challenges will come in the future. The question in the end is whether correctional systems will be prepared to state that they are giving the best care possible to these difficult-to-manage inmates based on lessons learned from past experience.

REFERENCES

American Psychiatric Association. 1994. *Diagnostic and statistical manual of mental disorders, fourth edition*. Washington, D.C.: American Psychiatric Association.

American Psychiatric Association. 2000. *Psychiatric services in jails and prisons, second edition.* Washington, D.C.: American Psychiatric Association.

Cohen, F. 1998. *The mentally disordered inmate and the law*. Kingston, N.J.: Civic Research Institute.

Drapkin, M. 1999. *Management and supervision of jail inmates with mental disorders*. Kingston, N.J.: Civic Research Institute.

Metzner, J. 2005 Mental health input into the disciplinary process. Paper presented at the National Commission on Correctional Health Care Summer Mental Health Conference, Chicago, July 2005.

Moore, J. 2003. *Management and administration of correctional health care*. Kingston, N.J.: Civic Research Institute.

Rold, W.J. 1992. Consideration of mental health factors in inmate discipline, *Correct Care*, 6(2): 4, 8, 14. Chicago: National Commission for Correctional Health Care.

Wettstein, R.M. 1998. *Treatment of offenders with mental disorders*. New York, N.Y.: The Guilford Press.

Williams, M.A. and C. Dale. 2001. The application of values to professional forensic mental health work in secure settings. In *Forensic Mental Health*. 14-1-14-3. Kingston, N.J.: Civic Research Institute.

Frederick R. Maue, M.D., is a psychiatric consultant and former retired chief of clinical services for the Pennsylvania Department of Corrections.