The Role of Mental Health in the Inmate Disciplinary Process: A National Survey

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An effective system of inmate discipline is an important aspect of a safely run prison or jail. Historically, mentally ill inmates have had few or no protections against discipline routinely applied to their non-mentally ill peers. Arising from recent class action lawsuits challenging the quality of mental health care delivery in the nation's prisons, prison mental health professionals have been called on to play an increasing role in the inmate disciplinary process. Referral questions include whether an inmate is competent to proceed with disciplinary proceedings and whether mental illness may have contributed to the rule violation. Prison mental health professionals participating in inmate disciplinary proceedings must therefore be familiar with relevant clinical, legal, and ethics issues. Little has been written in the psychiatric literature, however, examining this important role for prison mental health professionals. After first reviewing core legal and constitutional concepts, the author presents the results of a nationwide survey examining the role for mental health professionals in the inmate disciplinary process. To the author's knowledge, this is the first study to provide a comprehensive review of this subject.

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Most prison systems have procedures for punishing prisoners who violate prison rules and for removing inmates from the general population for disciplinary or safety reasons. (For the purpose of this article, the terms "prisoner" and "inmate" will be used interchangeably. "Mental health" and "custody" are sometimes used to denote the mental health and custodial staffs of the prisons.) Serious offenses that bring about disciplinary action can result in significant punitive consequences for a prisoner. For example, a guilty finding on a serious offense can result in the loss of "good-time" credits, lengthy terms in administrative segregation or security housing units, and/or a referral to the district attorney for what, in some states, could be a third-strike prosecution and life imprisonment.[1–3]

Although the number of mentally ill inmates involved in disciplinary proceedings is unknown, it is estimated that 8 to 19 percent of prisoners have significant psychiatric or functional disabilities,[4] and the mentally ill are probably overrepresented in prison disciplinary proceedings.[1,2] Historically, rule-violating mentally ill inmates have had few or no protections against punishment routinely applied to their non-mentally ill peers. Thus, after a rule infraction, severely disturbed (i.e., psychotic) inmates have regularly been placed in administrative segregation units without adequate treatment or regard to the impact of the punishment on the inmate's mental state. This concern led a California district court in *Coleman v. Wilson*[5] (a class action lawsuit challenging the adequacy of mental health care in virtually the entire California prison system) to accuse California prison officials of having a policy of intentionally inflicting severe harm on mentally ill inmates.

As a result of recent class action lawsuits challenging the quality of mental health care in the nation's prisons,[5–7] prison mental health care professionals have been called on to play an increasing role in the inmate disciplinary process. Referral questions include whether an inmate is competent to proceed

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with disciplinary proceedings and whether mental illness may have contributed to the disciplinary infraction. In some jurisdictions, mental health professionals may also be asked questions about "psychological responsibility" and appropriate punishment. Little has been written in the psychiatric literature, however, on the subject of the role of mental health in the inmate disciplinary process.[1–4] Policy and opinion on the subject are complex, and prison mental health professionals participating in inmate disciplinary proceedings must become familiar with often intricate clinical, legal, and ethics issues. The purpose of the present study is to stimulate interest in what one hopes will become a growing body of literature on this topic.

This article is divided into three sections. In the first, core legal and constitutional concepts are reviewed. In the second, the results of a nationwide survey of prison policy are presented. In the third, survey results are discussed. To the author's knowledge, this is the first comprehensive examination of the role of mental health in the inmate disciplinary process.

Core Legal and Constitutional Concepts

The Eighth Amendment of the U.S. Constitution prohibits cruel and unusual punishment and this has been construed as directing the state to provide for the basic human needs of prison inmates. Although the Constitution does not mandate comfortable prisons, neither does it permit inhumane ones. The state violates the Constitution when it demonstrates deliberate indifference to the serious medical needs of its prisoners.[8–13] Failure to treat a medical need is said to be in breach of the Eighth Amendment if it results in further significant injury to the inmate or if it causes the "unnecessary and wanton infliction of pain."[14] (The routine discomfort that an inmate experiences from incarceration "to pay a debt to society" does not constitute a serious medical need.[15]) Legally convicted prisoners are entitled to psychological or psychiatric care for serious mental or emotional illness. "There is no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart."[16] An inmate therefore suffers "Eighth Amendment pain" whenever he or she must endure an untreated serious medical (or mental) illness for any appreciable time.[17] Such a denial of rights is the potential risk when a mentally ill inmate is punished without clinical input or oversight.

The Due Process clause of the Fourteenth Amendment provides that no person shall be deprived of liberty without due process of the law. Because a prisoner can lose "good-time" credits as a result of being found guilty of a disciplinary charge, and because the loss of good-time credits can increase the duration of imprisonment, the minimum procedural due process requirements stipulated in the Constitution must be adhered to by prison authorities during inmate disciplinary proceedings. In establishing these minimal standards, the U.S. Supreme Court in *Wolff V. McDonnell*[18] determined that inmates accused of rules violations must be given a hearing that includes timely notification of the offense, the opportunity to call witnesses, and the opportunity to present documentary evidence in support of his or her defense. (Such a defense, in theory, could include the opportunity to call mental health witnesses to provide mental health testimony).

However, these rights are not unlimited. Prison officials may not allow inmates to call witnesses if doing so would be unduly hazardous to institutional safety or correctional goals or if it would be irrelevant or unnecessary or would extend the hearing beyond reasonable limits.[19] Furthermore, prison disciplinary sanctions are "not comparable with a criminal conviction,"[20] and the constitutionally required procedures for imposing such a sanction are not as exacting as those applicable to a conviction.[18] Although a defendant's mental condition can be relevant, disciplinary violations typically do not trigger the right to present a formal penal law insanity defense in most states. Such limited due process is similar to that found in parole revocation (*Morrissey*) hearings. In *Morrissey* hearings, parolees are entitled to an "effective, but informal hearing" where "due process is flexible. . .as the particular situation demands."[21] The *Morrissey* Court further emphasized that there was "no thought to equate this to a criminal prosecution in any sense."[21] The Supreme Court has therefore established a flexible standard for disciplinary and parole revocation proceedings that balances the interest of prisoners against institutional needs. Prison officials are thus allowed broad latitude in the formulation of policy, so long as minimal due process standards are met.

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,"[20] or so long as "a modicum of evidence" could be found in the record to support the conclusion reached by the disciplinary board.[19] More recently, The Supreme Court (in *Sandin v. Conner*[22]) has invoked the protection of the Due Process clause in prison disciplinary proceedings only in extreme circumstances—for example, when the restraint imposes an "atypical and significant hardship" on the inmate in relation to the ordinary incidents of prison life.[22] Since *Sandin*, inmates appealing disciplinary decisions on alleged due process violations, (for example, that their mental status at the time of the offense was not appropriately considered by the hearing officer), must first demonstrate that the disciplinary punishment imposed an "atypical and significant hardship" that violated a liberty interest that deserved due process protection.[23] Unlike the involuntary transfer of an inmate to a psychiatric institution[24] or the involuntary administration of psychotropic medications,[25] assignment to administrative segregation, under usual circumstances (e.g., for less than one year), does not represent such a significant and atypical hardship or stigmatization (in relation to the ordinary incidents of prison life) so as to give rise to such a liberty interest.[22] Thus, the *Sandin* Court advocated a "return to the due process principles correctly established and applied in *Wolff v. McDonnell*."[22] From this constitutional perspective, inmates enter steep legal terrain when lobbying for greater disciplinary due process protections (i.e., consideration of mental health defenses).

A National Survey on the Role of Mental Health in the Inmate Disciplinary Process

Methods of Investigation

A nationwide survey was conducted to compare different disciplinary procedures across the country. The following request was made to various prison officials and mental health administrators by e-mail:

> Sir/Madam:
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> In California, mental health input into the inmate disciplinary process is a relatively new phenomenon, a byproduct of the 1995 *Coleman v. Wilson* class action lawsuit. In brief, when an inmate (who is followed by mental health) violates a serious institutional rule, a mental health practitioner must evaluate: (1) whether or not the inmate has the ability to comprehend the nature of the charges or the disciplinary process and/or needs a staff assistant, and (2) whether or not the behavior resulting in the rule violation may have been influenced by mental illness.
>
> Would you be so kind as to provide me with any information you have pertaining to your state's policy on this topic. If you do not have the time, I would be most appreciative to simply know whether this, or a similar process, occurs in your state. If you are uncertain, could you please identify someone else I could trouble for help.
>
> Thank you very much for your time and efforts.

The electronic survey was sent to all 50 states and to the Federal Bureau of Prisons (FBOP). A follow-up e-mail with the same request was sent if a response was not received within 45 calendar days. Phone calls were placed selectively to states that did not respond to the survey.

An attempt was also made to obtain as many printed copies of formal policy as possible. Although all states have policy on the disciplinary process, many do not yet have written policy on the role of mental health in the disciplinary process. Other policies are undergoing revision, and new regulations have yet to be released in documented form. To study these states, legal research was conducted on the Internet (search engines: Lexis-Nexis, Findlaw, and Google) in an attempt to identify key documents and case law. The following key words were used for this research: inmate, prisoner, discipline, disciplinary, policy, procedure, regulation, due process, Eighth and Fourteenth Amendments, mental health, psychiatric, psychologic, competency, insanity, *Wolff v. McDonnell*, 418 U.S. 539, and *Sandin v. Conner*. 515 U.S. 472. Approximately 100 additional documents were reviewed by using this research tool.

Results

Twenty-eight of 50 states and the FBOP responded to the initial electronic survey. Policy from 12 additional states was obtained by the Internet or by telephone interview for a total of 41 of 51 potential responders (Table 1), representing 80 percent of the available sample. In all, 22 printed policy documents (21 state documents plus policy from the FBOP) were reviewed, representing 43 percent of the available sample (Table 2).

Approximately 30 policy elements, summarized in Table 3, were identified. These policy elements were roughly clustered into the following six categories: formal versus informal policy; policy on competency; policy on disposition; policy on responsibility; policy

Table 1 Responders to Survey

Alabama	Iowa	Nebraska	Tennessee
Alaska	Kansas	New Jersey	Texas
Arizona	Kentucky	New Mexico*	Utah
California	Maine*	New York	Vermont*
Colorado	Maryland	North Carolina	Virginia
Connecticut	Massachusetts*	North Dakota	Washington
Florida	Michigan	Ohio	Wisconsin*
Georgia	Minnesota	Oklahoma	Wyoming
Idaho	Mississippi	Oregon	Federal Bureau of Prisons
Illinois*	Missouri	South Carolina	
Indiana	Montana		

* Information obtained was the product of research conducted over the Internet. Direct contact was not made with state officials.

on inmate referral; and miscellaneous policy. Of note, policy elements were not mutually exclusive, nor did they fall squarely into one category or another. Data are presented in this group format primarily for heuristic purposes.

Formal Versus Informal Policy

Not all states have a formal policy on the role of mental health in the inmate disciplinary process. In some states, mental health has either no role or only a minor role (e.g., as a consultant to custody) when mentally ill inmates are brought up on disciplinary charges. Other states have a more formal policy in which mental health staff regularly consult with custody on disciplinary matters to suggest appropriate sanctions, placement, and treatment (see later section on Disposition). Whereas many states have no explicit policy detailing the role of mental health in the inmate disciplinary process, most states have correctional administrative policy mandating adequate medical and mental health treatment for mentally ill inmates housed in administrative detention, consistent with Eighth Amendment court decrees.

Policy on Competency

Consistent with legal precedent set down by the *Wolff* Court, most, if not all, states require a determination of competency prior to proceeding with

Table 2 Disciplinary Policy Provided

Alabama	Maryland	Texas
California	Massachusetts	Utah
Colorado	Michigan	Vermont
Florida	Minnesota	Virginia
Georgia	Missouri	Washington
Indiana	New Jersey	Federal Bureau of Prisons
Kentucky	New York	
Maine	Ohio	

Table 3 Categorization of Policy Elements

Formal versus informal policy:
- Institution has a formal policy on mental health's role in the inmate disciplinary process
- Institution has an informal policy on mental health's role in the inmate disciplinary process
- Institution has no policy on mental health's role in the inmate disciplinary process

Policy on inmate referral:
- Source of referral:
  - Custody
    - Mandatory
    - Discretional
  - Mental health
  - Inmate
  - Other
- Referral trigger:
  - Inmate identified as having serious mental health problems
  - All inmates with history of mental health treatment
  - Unusual behavior at time of rule infraction

Policy on disposition:
- Mental health gives input regarding clinical needs of inmate prior to disposition
- Mental health consults with custody about appropriate sanctions
- Mental health notifies custody about contraindications to disciplinary detention and punishment
- Mental health gives clearance for disciplinary detention

Policy on competency:
- Mental health renders an opinion on inmate's competency to proceed with disciplinary procedures
- Mental health does not render an opinion on inmate's competency to proceed with disciplinary procedures
- Custody evaluates inmate for competence to proceed with disciplinary procedures
- If found incompetent:
  - Inmate is provided with a staff assistant or advocate
  - Inmate is treated for restoration of competency
    - Disciplinary proceeding is postponed

Policy on responsibility:
- Mental health renders an opinion on inmate responsibility for rule infractions
- Mental health does not render an opinion on inmate responsibility for rule infractions
- Mental health renders an opinion about effect of mental illness on inmate's rule violating behavior but stops short of providing ultimate opinion on disciplinary responsibility
- If found not responsible due to mental illness:
  - Inmate hospitalized, rule violation expunged
    - Rule violation documented in clinical chart
    - Rule violation documented in shadow chart
  - Disposition of inmate not specified

Miscellaneous policy:
- No inmate shall be punished for symptoms of mental illness
- Hospitalized mentally ill inmates are not subject to disciplinary proceedings
- Mental health clinicians may attend disciplinary hearings to provide clinical input
- Effect of psychiatric medications on behavior is considered
- Effect of psychiatric medications on behavior is irrelevant
- Mental health believes in personal responsibility for inmate behavior, even if mentally ill

disciplinary hearings. This competency requirement is often codified into correctional administrative policy regulating the conduct of disciplinary hearings. The determination of competency may be made with or without mental health input. The survey identified two methods among the states to deal with incompetent inmates: restoration of competency and/or provision of a staff assistant. In states in which restoration is attempted, disciplinary hearings are generally postponed and the inmate is treated (with or without hospitalization) until competency is restored. If competency cannot be restored within a reasonable period of time (usually six months), the charge can be dropped, although the rule violation is often documented in the clinical record or in a shadow file. In other states, determination of incompetence leads to the assignment of a staff assistant or advocate who is a prison employee, a custody officer, another inmate, or (sometimes) a law student. Inmates are usually not allowed representation by an attorney during disciplinary proceedings.

Policy on Disposition

Most states have a formal or informal policy that directs custody to consult with mental health on the disposition of mentally ill inmates found guilty of rule violations. Perhaps best detailed in the National Commission on Correctional Health Care guidelines[26] and in the American Correctional Association guidelines[27] for the health evaluation of inmates in disciplinary segregation, such policies require that health care staff "immediately review the health care needs of offenders placed in disciplinary segregation to determine if there is any known health contraindication to segregation placement."[26] In addition, "A mechanism must be in place to ensure that mentally ill offenders who are placed in a segregation unit . . .receive regular, periodic contact and continued evaluation and/or treatment from a qualified mental health professional."[27] Custody is to be alerted if placement in disciplinary segregation is unacceptable due to a significant deterioration in an offender's condition. Under these guidelines, mental health clinicians can lobby for alternatives (e.g., psychiatric treatment, increased level of care, or hospitalization) to the normal disciplinary sanctions or for no sanctions at all.

Policy on Responsibility

Fewer states have formal policy regarding mental health input into the ultimate issue of disciplinary responsibility. Regarding this matter, the survey identified three broad categories of policy, potentially representing three different views or positions. (1) Prison mental health clinicians should not provide testimony and/or determine disciplinary responsibility. (2) Prison mental health clinicians should provide testimony and/or determine disciplinary responsibility. (3) Prison mental health clinicians should provide forensically relevant clinical data, but should stop short of providing explicit opinions regarding disciplinary responsibility.

Position one: *Prison mental health clinicians should not provide formal testimony and/or determine disciplinary responsibility*. Representing this first position are New York and Texas. In both states, prison officials agree that mental health professionals should not provide formal opinion on ultimate issues of disciplinary responsibility and competency. Although mental health professionals may informally consult with custody about a rule-violating inmate's mental condition at the time of the alleged incident and at the time of the hearing, formal determination of competency and responsibility fall to the judgment of the hearing officer. Under Texas policy, mental health may communicate with custody regarding the disciplinary management of seriously mentally ill inmates, but are prohibited from performing forensic evaluations including sanity at the time of the alleged disciplinary infraction or competence to undergo disciplinary proceedings. In New York, where mental health clinicians are instructed not to provide "clinical conclusions" during disciplinary hearings, it is nevertheless permissible to provide factual testimony about events that the clinician actually observed at the time of the alleged rule violation.

In addition to New York and Texas, prison officials from a substantial number of less populated states throughout the country informally expressed the view that mental health clinicians should neither volunteer to, nor be placed in the position of having to, provide ultimate opinions on disciplinary responsibility.

Position two: *Prison mental health clinicians should provide testimony and/or determine disciplinary responsibility*. Representing this second position is the FBOP, which explicitly directs disciplinary hearing officers to refer mentally ill-appearing inmates to a mental health professional for "determination of whether the inmate is responsible for his conduct or is incompetent."[28] The FBOP further directs that

custody not take action against an inmate who is determined by mental health clinicians to be incompetent or not responsible for personal conduct. Standards are specified per modified M'Naghten criteria (i.e., a person is not responsible for his or her conduct if, at the time of the conduct, the person as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his or her acts). Once M'Naghten criteria are met, hearing officers are instructed to rule formally that the inmate did not commit the prohibited act because the person was not mentally competent and therefore not responsible for his or her conduct. If the inmate is found incompetent, disciplinary proceedings are postponed until competency is restored, assuming such can occur in a reasonable period of time.

In Georgia, mental health clinicians determine whether, in accordance with modified American Law Institute criteria, the inmate was responsible for his/her conduct. In Kentucky, mental health clinicians determine whether the inmate lacked substantial capacity to conform volitional behavior to institutional requirements. Under Michigan policy, a prisoner who is mentally ill is not responsible for misconduct if s/he lacks substantial capacity to know right from wrong or is unable to conform conduct to department rules. In North Carolina, mental health clinicians provide opinion as to whether hospitalized mentally ill inmates should or should not be held accountable for behavior that elicits disciplinary action.

Position three: *Prison mental health clinicians should provide forensically relevant clinical data but should stop short of providing explicit opinion regarding disciplinary responsibility*. Representing this third position are California, Florida, Maryland, and Ohio. In California, mental health professionals are asked to determine whether the behavior resulting in the rule violation may have been influenced by mental illness. (This somewhat subjective determination contrasts significantly with California's more stringent M'Naghten insanity standard.) In Florida, mental health input is limited to a description of the role, if any, that mental impairment may have played in the behavior in question. In Maryland, mental health professionals may make recommendations regarding the effect of an inmate's mental state on his/her ability: (1) to understand the nature of the adjustment proceedings; (2) to participate meaningfully in the adjustment proceedings; and (3) to conform to institutional standards at the time of the alleged infraction. In Ohio, mental health clinicians are asked whether there are mental health issues that may have impacted the inmate's behavior at the time of the charge.

It is important to note that independent of a state's formal policy on the matter of mental health and disciplinary responsibility (e.g., whether a state has no policy, encourages mental health to provide informal recommendations, or formally assigns mental health staff the role of determining disciplinary responsibility) such input is usually considered to be only one of several factors pointing in the direction of guilt or innocence. Thus, although mental health clinicians may have various degrees of opportunity to influence the hearing officer, it is unusual for such input to become the sole basis for disciplinary decision making. In general, hearing officers are required only to consider the mental health staff's input, which most frequently function as a potential mitigating influence in sentencing and disposition.

Policy on Inmate Referral

In most states, hearing officers are required to refer inmates known to suffer from serious mental illness (generally defined as a substantial disorder of thought or mood that severely impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life) but are given significant discretion over the referral of inmates with less serious mental conditions. Several states have developed classification systems with multiple levels of illness severity and treatment intensity to differentiate serious from nonserious mental illness. In some states, all rule-violating inmates who are under observation by mental health staff are referred for a disciplinary evaluation. In California, only those mentally ill inmates who have allegedly committed serious rule violations are routinely referred for psychiatric assessment. In most states, the decision to refer to mental health staff resides principally with custody. In Michigan, inmates themselves can raise the defense of not guilty due to mental illness, thereby prompting a mental health referral, although hearing officers can quash the referral if it is determined that the claim is frivolous. In New Jersey, hearing officers may select any one of several potential referral questions (e.g., competency, responsibility, brief description and history of mental illness,

compliance with treatment, potential for decompensation if placed in segregation).

Miscellaneous Policy

Several states have policy that explicitly forbids the punishment of mentally ill rule-violating inmates. In Utah, acutely mentally ill inmates are not to be disciplined for behavior that is directly related to or is a result of diagnosed mental illness. In Alabama, inmates are not to be punished for symptoms of a serious mental illness. A variant of this no-punishment policy is used when already-hospitalized mentally ill inmates commit behavioral infractions. Under such circumstances, prison policy may declare that such hospitalized prisoners are not subject to disciplinary proceedings.

In Ohio, clinicians may speak regarding the impact of psychiatric medications on rule-violating behavior. This contrasts with Michigan policy, which considers issues surrounding medication side effects not to have a bearing on the determination of responsibility. Among the more interesting policies is the informal position (voiced off the record by members of some correctional mental health departments) on the personal responsibility that all inmates have, including the mentally ill, for control over their own behavior.

Discussion

The findings of this survey demonstrate that considerable diversity exists among the states in prison policy regarding the role of mental health personnel in the inmate disciplinary process. Although most, if not all states, have policies requiring assessment of competency and mechanisms to involve mental health in disciplinary decision making, this study identified no clear consensus on the question of whether prison mental health professionals should provide ultimate opinions on disciplinary responsibility.

This study is relevant because many states are currently revising prison administrative policy to incorporate appropriate mental health standards into disciplinary proceedings. The issues are considerably complex, however, and confusion and controversy can arise. Perhaps the greatest potential controversy is on the question of the role of mental health in the determination of disciplinary responsibility. Although several states and the FBOP have determined that mental health should have a role in evaluating disciplinary responsibility, there is a larger consensus among the states that prison mental health officials ought not to provide explicit disciplinary conclusions. New York prison officials, for example, in justifying policy before various federal courts,[29,30] rationalized that mental health clinicians should not directly participate in disciplinary hearings because such inclusion would create dual agency dynamics that would compromise the therapeutic role of clinicians, place clinicians at risk for retribution by accused prisoners, shift limited clinical resources away from the treatment of mentally ill prisoners, encourage prisoners to malinger to avoid punishment, and create additional tensions between mental health and custody.

There are additional reasons why state officials should proceed with caution before incorporating mental health defenses into prison disciplinary proceedings. Unintended liberty interests could be created by well meant but improperly designed policy. For example, to ensure equal protection and due process, clinicians would have to master a standardized (and probably labor intensive) approach to each evaluation, consuming already limited clinical resources. Additional resources would be needed to ensure adequate training and oversight, not to mention the costs of hospitalization and treatment for those inmates found not guilty by reason of insanity or incompetent to stand trial. Poor training, prejudices of the clinical (or custodial) staff, and lack of accountability could lead to inconsistent, unreliable, or invalid insanity determinations, resulting in unstable jurisprudence. Custody could object to the mental health's insanity determinations, which excuse an inmate's antisocial or violent behavior, further straining custodial-clinical staff relations. The fate of rule-violating prisoners acquitted of disciplinary charges would be unclear. Would all such inmates be involuntarily hospitalized? If so, would further due process protection vis-à-vis *Vitek* be invoked? Who would determine when an inmate deemed insane could eventually be returned, if ever, to the general population? Would inmates have the right to refuse a mental health defense to stay out of the insanity loop? Complex questions arise as prison officials contemplate the inclusion of mental health defenses in inmate disciplinary proceedings.

Given this, I suggest a reemphasis of Eighth Amendment remedies (e.g., improved clinical

care) in current disciplinary policy revisions. Prison mental health clinicians are primarily trained, and therefore best suited, to provide comprehensive clinical care to all mentally ill inmates, independent of disciplinary status. Ideally, mental health clinicians and custody should work together to identify severely mentally ill inmates and to keep them out of trouble by providing appropriate treatment. For those mentally ill inmates receiving disciplinary sanctions, it is desirable for mental health staff to assess for potential mental health concerns and to communicate with custody for consideration in the adjudication process. Mental health clinicians, by the nature of their training, can play a unique role in protecting against cruel and unusual punishment by consulting with custody on matters of disposition and recommending accommodation for safe segregation, treatment, or hospitalization based on the clinical needs of the inmate and available institutional resources. Although an informal advocacy for dismissal of disciplinary charges may be appropriate at times, I suggest that, for reasons discussed herein, it may be detrimental to the clinical care of our nation's mentally ill inmates to transform the role of the prison mental health clinician into that of a forensic expert who routinely makes ultimate decisions about an inmate's level of disciplinary responsibility.

The primary weakness of this study is that the data were not acquired by a standardized questionnaire, making a statistical analysis impossible. Moreover, the subjective nature of the survey (e.g., responding officials were relied on for the data's accuracy when printed policy was unobtainable) introduces the additional risk of error by omission and commission. Keeping in mind the busy schedule of most prison officials, the survey was purposefully kept informal and brief, to increase the number of responses and thus to capture a broad picture of major nationwide trends. Nevertheless, significant limitations and error can occur when subjective and imprecise terminology (e.g., few, some, substantial, many, most, consensus, nearly all) is substituted for statistical analysis. Future studies should be conducted in which formal policy in all 50 states is collected to define more precisely the magnitude of the trends reported in this study.

Conclusions

Prison mental health professionals must be familiar with a complex set of clinical, legal, and ethics issues when participating in inmate disciplinary proceedings. Policy and opinion on the subject are evolving, shaped by complex forces similar to mental health issues encountered under criminal law. Although most clinicians, civil libertarians, and prisoner advocates would agree that mentally ill inmates should not be punished for behavioral symptoms of their mental illness, state officials confront considerable challenges when attempting to translate this humanistic value into practical prison policy.

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