Commentary: The Role of Mental Health in the Inmate Disciplinary Process

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The article by Michael S. Krelstein, MD,[1] which presents the results of a nationwide survey examining the role of mental health professionals in the inmate disciplinary process, is a significant contribution to the correctional mental health literature. Dr. Krelstein succinctly summarizes the case law that has provided the framework for the prison disciplinary process. The Supreme Court's current conservative posture concerning the rights of prisoners is exemplified in *Sandin v. Conner*,[2] which views placement in an administrative segregation unit for less than one year as not representative of a significant and atypical hardship in the context of ordinary incidents of prison life. As a result, due process is not ordinarily required for such placements, because liberty interests are generally not violated under this standard.

Despite this invitation to forego due process hearings, it has been my experience that prison systems have continued to provide such hearings for a variety of reasons, some of which may be related to the integrity of the disciplinary process. In addition to establishing a structure that can provide a clear and consistent message to inmates who are violating prison rules and regulations, these hearings can also serve to decrease abuse of the disciplinary system by correctional officers (i.e., writing up inmates for rule violations that are unfounded). Segregation units, especially disciplinary segregation, are usually designed to be experienced by the inmate as an atypical hardship in the context of ordinary prison life, despite the Supreme Court's perception. This recognition by prison administrators probably also contributes to the continuation of these due process hearings.

The impetus for prison mental health care professionals to have an increasing role in the inmate disciplinary process is described by Dr. Krelstein as arising from recent class action litigation challenging the quality of mental health care services in prisons. This statement is accurate, but it may be helpful to provide more history to understand better the subsequent evolution of mental health input into the disciplinary process.

An overview of class action litigation in correctional psychiatry has been summarized recently in this Journal.[3] In prison systems with constitutionally inadequate mental health services, it is not difficult to find inmates in segregation units who have serious mental illnesses and were placed in these units because of a rule infraction that often was related to their mental illness. Some of these inmates were obviously psychotic at the time of their rule infractions. Inmates housed in these segregation units (the jail-within-a-prison usually referred to in correctional systems as administrative, disciplinary, or punitive segregation) are usually locked down in their cell 22 to 23 hours a day for weeks, months, or, less commonly, years. The clinical condition of an inmate with a serious mental illness placed in a segregation unit often deteriorates or does not improve because of lack of adequate psychiatric treatment. Such a finding is often a crucial issue that contributes to plaintiffs' prevailing in class action litigation relevant to mental health services and often is the initial im-

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petus leading to an increasing role for mental health professionals in the inmate disciplinary process.

The long-term remedy for this important symptom of an inadequate mental health system is to implement a constitutionally adequate system. Providing adequate mental health services to inmates will significantly decrease, but not eliminate, rule infractions by inmates with serious mental illnesses that are directly related to symptoms of their illness. However, such a remedy is a long-term process, which often occurs in a stepwise fashion over many years. Consequently, there are many short-term measures initiated to minimize or correct problems associated with the constitutional deficiencies found, especially related to placement of mentally ill inmates in segregation units.

A frequent initial step is implementation of a mental health screening assessment of all inmates in the segregation units, to identify those with serious mental illnesses who are being harmed by continued placement in the segregation units. The subsequent remedial actions related to this specific procedure are beyond the scope of this commentary. It is not surprising that an associated step in this process is assessment of the disciplinary hearing procedure. How it was possible that inmates who were obviously mentally ill and in need of treatment were placed in such units is the question that generally precipitates this assessment. The absence of input by mental health professionals into the disciplinary process is the frequent answer to this question.

It should be remembered that this assessment of the disciplinary process is occurring in the context of the remedial phase of the class action litigation. Lawyers, who are very knowledgeable in the area of due process but understandably do not have mental health expertise, are very involved in fashioning remedial plans during this stage of the litigation. As a result, initial remedial measures often involve due process procedures related to issues of competency to proceed and responsibility, which may be theoretically sound from a legal perspective but are often not helpful to the inmate and are burdensome to the evolving mental health system. Mental health input related to mitigation and disposition may also be requested, often as an afterthought, as part of these initial remedial measures.

The ensuing policies and procedures developed are frequently written and reviewed by attorneys, clinicians, and administrators who have little experience in criminal procedures or forensic psychiatry. They are often poorly written, especially concerning relevant definitions and the nature of the required mental health assessments. For example, the definition of nonresponsibility is frequently vague or absent. The procedures are often unclear about whether the required mental health assessments are based on review of records only or necessitate a face-to-face interview with the inmate. Many of the prison's mental health clinicians lack the forensic skills needed to address adequately the issues of competency and responsibility, which exacerbates the problems associated with these policies and procedures.

Dr. Krelstein's national survey provides a very useful summary and analysis of the considerable diversity among the states in prison policy concerning the role of mental health services in the inmate disciplinary process. Convincing arguments are provided to show why state officials should proceed with caution before incorporating mental health defenses into prison disciplinary proceedings. The reasons provided by New York prison officials[4,5] in justifying before various federal courts the policy that mental health clinicians should not directly participate in disciplinary hearings are particularly compelling, especially when related to issues of dual agency and allocation of limited clinical resources.

Both of these concerns have slippery slope implications related to other aspects of the disciplinary process. For example, should a mental health clinician attend and/or be a member of the institutional classification committee that reviews all inmates in a prison's segregation units? Many correctional systems have answered this question in the affirmative. Dual-agency difficulties can be avoided by having a mental health clinician who is not involved in the segregated unit inmate's care attend these meetings. Most systems do not follow this model, because the mental health input provided by such a clinician is not particularly helpful to the correctional classification process because of the clinician's lack of familiarity with the mental health needs of the inmate in question. Thus, potential and actual dual-agency dynamics should be recognized and addressed. Allocation of mental health staff resources becomes a concern, because these classification meetings frequently involve several full days per week of a clinician's time, which obviously impacts a clinician's availability for providing direct treatment services.

Dr. Krelstein also discusses the potential creation of additional tensions between mental health and custody staffs due to mental health clinicians' participation in disciplinary hearings related to responsibility assessments. This problem generally results from mental health clinicians without adequate training or experience in forensic practice performing the responsibility examinations, which may result in inappropriate conclusions of nonresponsibility. Such results are often perceived by correctional staff as providing the inmate with a get-out-of-jail-free pass that is likely to cause tension between mental health and correctional staffs, especially if a correctional officer has been assaulted by the inmate.

Similar to the low rate of successful not-guilty-by-reason-of-insanity pleas in the nonincarcerated population, it is rare that inmates would meet most nonresponsibility standards in prisons that have constitutionally adequate mental health services, if the assessment was made by a forensically experienced mental health clinician. Inmates who meet such a standard would generally be diverted out of the disciplinary system process to a structured psychiatric setting prior to the disciplinary hearing. Thus, the use of valuable clinical resources for these forensic assessments is hard to justify in a correctional mental health system from the perspective of limited clinical resources.

It is useful for mental health staff to be notified when caseload inmates are issued notice of serious (i.e., major) rule violations, because their actions leading to the violations are often clinically significant. A procedure should be in place that results in timely notification of mental health staff of such occurrences, which should facilitate provision of mental health input to the disciplinary process, when indicated, relevant to the inmate's competency to proceed with the disciplinary hearing, mitigating factors, and dispositional recommendations. Mental health staff should also be available to the disciplinary hearing officers for consultation purposes, when a non-caseload inmate appears to be demonstrating symptoms of a serious mental illness.

It has been my experience that mental health input relevant to mitigating circumstances and dispositional recommendations are perceived by many hearing officers in the disciplinary process to be very helpful. Resultant dispositions may include revisions of the inmate's treatment plan to include components that may have helped in avoiding the rule infraction, such as closer monitoring of medication, participation in an anger management group therapy, and often an abbreviated stay in the disciplinary segregation unit.

Establishment of a diversion system that bypasses the disciplinary hearing process and involves appropriate mental health treatment, especially for mentally ill inmates with minor infractions, can often be beneficial to both the inmate and the correctional system. The correctional system saves money because the disciplinary hearing process is expensive (e.g., $150 to $200 per disciplinary hearing in the Georgia Department of Corrections).[6] The inmate benefits by having a rehabilitative approach substituted for a punitive one.

Dr. Krelstein's recommendation to reemphasize Eighth Amendment remedies (e.g., improve clinical care) in current disciplinary policy revisions is very reasonable. Most prison mental health clinicians have expertise in providing clinical care to inmates with serious mental illnesses in contrast to performing forensic assessments. Few studies are present in the literature that are relevant to the relationship between provision of adequate mental health treatment to inmates with serious mental illnesses and the frequency of rule violations by these inmates. Condelli *et al.*[7] found significant reductions in serious rules infractions, suicide attempts, correctional discipline, and the use of crisis care, seclusion, and hospitalization among inmates in the New York prison system who had been admitted to an intermediate care program for inmates with psychiatric disorders. This study, which is consistent with experience in other correctional mental health systems, lends support to Dr. Krelstein's recommendation that the best intervention is to improve the clinical services available to inmates.

References

1. Krelstein MS: The role of mental health in the inmate disciplinary process: a national survey. J Am Acad Psychiatry Law 30:488–96, 2002
2. Sandin v. Conner, 515 U.S. 472 (1995)
3. Metzner JL: Class action litigation in correctional psychiatry. J Am Acad Psychiatry Law 30:19–29, 2002
4. Powell v. Coughlin, 953 F.2d 744, 749 (2nd Cir. 1991)
5. Zamakshari v. Dvoskin, 899 F.Supp. 1097 (S.D. N.Y. 1995)
6. DeGroot J: Personal communication, August 20, 2002
7. Condelli WS, Dvoskin JA, Holanchock H: Intermediate care programs for inmates with psychiatric disorders. Bull Am Acad Psychiatry Law 22:63–70, 1994