Commentary: Mental Health in the Inmate Disciplinary Process

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Dr. Krelstein's article "The Role of Mental Health in the Inmate Disciplinary Process: A National Survey"[1] makes the point that mentally ill inmates are often involved in disciplinary hearings, and that, as a result of recent class action lawsuits, mental health professionals are being asked to take an increasing role in the disciplinary process. Although these lawsuits may be intended to protect the rights of mentally ill inmates, the need for them highlights some very persistent problems with the incarceration of the mentally ill.

First, and most obvious, is that too many people with mental illness are incarcerated. Of the nearly two million people incarcerated in prisons and jails in the United States, approximately 8 to 19 percent have significant psychiatric disorders.[2] This is hardly the vision Dorothea Dix had in mind when, more than 150 years ago, she advocated having the mentally ill transferred from jails to hospitals. Of course, the very conditions of incarceration, such as prolonged idleness, social isolation, and the constant threat of violence, may exacerbate mental illness.[3] This, coupled with the stigma of mental illness and difficulty in accessing care, leaves many mentally ill inmates in jails and prisons who are suffering and symptomatic.

It is no surprise that these same inmates, perhaps suffering from acute symptoms of psychosis, confusion, depression, or severe anxiety, manifest the kinds of behavioral problems that place them at risk for committing rule infractions and ending up in disciplinary hearings. After all, they may be unable (not unwilling) to cooperate, follow directions, or stay out of trouble.

Second, there are even greater risks for the symptomatic mentally ill than disciplinary hearings, loss of rights, longer sentences, or administrative segregation. Correctional officers, charged with keeping a safe, orderly, and peaceful environment and faced with containing bizarre, aggressive, and/or threatening behavior, may find it necessary to use force and physical restraint. Yet, these correctional officers may not be adequately trained to recognize signs and symptoms of mental illness. For example, in one study, 84 percent of jails reported that corrections officers receive either no training or less than 3 hours of training in the special problems of the mentally ill.[4] As a result, mentally ill inmates can find themselves subjected to "detention restraint" procedures (that is, restraints applied for disciplinary rather than medical purposes) and therefore do not receive the level of medical supervision necessary to ensure their safety, sometimes with dire consequences. Of course, there is also the well-known risk of suicide, a serious problem in our nation's jails and prisons.

Third, lack of clarity, understanding, and/or consensus about the roles and responsibilities of mental health staff in correctional settings and in custody-related matters is common. When this happens, there is often confusion or disagreement about whether something is a "medical" or "custody" matter. Tension between mental health and custody staff intensifies, with struggles over power and authority. The result is an inability of correctional and mental health staff to work cooperatively and effectively together. These are the circumstances that place mentally ill inmates at greatest risk, because correctional officers must be able to identify and be willing to refer inmates who appear to be suffering from symp-

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toms of mental illness, preferably before rule infractions or suicide attempts occur and before disciplinary hearings or restraints are necessary.

So, what is the best way to "protect" the rights of incarcerated mentally ill inmates? It is to ensure a clear and proper role for mental health professionals in the prison and jail setting—the most important of which is to identify those inmates who have mental illness and provide them with adequate, appropriate care. In addition, mental health staff must be available to train correctional officers in recognizing and understanding mental illness and to consult with them about their various interactions with mentally ill inmates.

This, however, is not as simple as it seems. As suggested in Dr. Krelstein's article, the role of the mental health professional in correctional settings is complex and not always well defined. The national survey of policies that he performed reveals that various states and systems have different ideas about the responsibilities and expectations of mental health professionals in disciplinary hearings, and some appear to have no policy at all. In fact, the proper role for psychiatrists and psychotherapists in forensic settings and situations is an area of much discussion and debate in the literature.[5]

There have been, of course, many attempts to set guidelines and standards for the role of mental health professionals in correctional settings.[3,6,7] Included in them is often a recognition of the potential for difficulty when the role of the mental health professional is confused or unclear. As an example, the American Public Health Association Standards devote an entire section to "Professional Independence: Separation of Functions," which goes to some length to support and protect the role of mental health professionals by keeping those involved in providing direct therapeutic services separate from decision-making administrative processes and forensic decisions.

In this regard, Dr. Krelstein's most important contribution comes in his "Discussion" section, where he makes the point that "mental health clinicians are primarily trained, and therefore best suited, to provide comprehensive clinical care to all mentally ill inmates. . . ." He quite appropriately emphasizes the general consensus that there is a need to protect this role by keeping it separate from the disciplinary hearings, except for consultation. By our doing so, the greatest interest and protection of the mentally ill, the right to treatment, will be better served.

References

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