COMMENTARY

Mischief, Mayhem, and Remediation

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Institutional rules are necessary to preserve safety and security in correctional systems. An assessment of relevant mental health problems is a key element of a fair disciplinary process. Though these hearings are administrative in nature, we recommend that mental health evaluations related to disciplinary matters be completed by qualified and well-trained professionals using consistent standards. There are important opportunities to interrupt an untreated mental illness by identifying mental health problems during such evaluations and making appropriate referrals for treatment. We propose the use of intrafacility diversionary programs for drug offenses and other misconduct.

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Placing a person who breaks rules into a correctional facility may not immediately correct their propensity for breaking rules. Prohibition of certain acts in a jail or prison is necessary to ensure the safety and security of these environments for residents, staff, and visitors alike. Some inmates, even those with character pathology, may thrive in the context of this structure. Incarcerated persons with serious mental illness, whether related to cognitive impairment, poor impulse control, impaired reality testing, or other relevant symptoms, may be less amenable to discipline. Failure of extant institutional processes to manage inmate behavior presents a vexing problem for custody and administrative staff. Furthermore, it complicates health care services and may raise ethics concerns for all involved parties.

We agree with several key points made by Obegi in his analysis of the California Department of Corrections and Rehabilitation's system for determining responsibility for institutional infractions.[1] There should be mental health input into a correctional disciplinary process when an inmate's mental illness may have been a factor. Though lacking the same gravity as the outcome of a criminal trial, institutional sanctions, by design, will make the conditions of confinement even less pleasant than usual. Inmates in disciplinary housing, especially those with preexisting mental illness, are at risk for new or exacerbated mood, cognitive, and psychotic symptoms.[2]

We understand Obegi's concern that referring to institutional disciplinary proceedings as "quasi-forensic" minimizes their importance. We think ensuring that an inmate is morally culpable when facing a charge for misbehavior is a matter of fundamental fairness. Thus, when mental health input is relevant, these assessments are forensic in nature. Professionals charged with evaluating inmates in this context should be appropriately credentialed and trained. They should be cognizant of ethics pitfalls like dual agency. Evaluators must be aware of their own biases and capable of managing them. We further agree with Obegi that mental health opinions should be direct and communicated well to adjudicators. Circuitous language to avoid the appearance of speaking to the ultimate issue is simply unhelpful for administrative staff with limited clinical and legal training.

We caution, however, against conflating institutional disciplinary matters with criminal cases. Sanctions including the loss of commutation credits or parole opportunities usually have the effect of extending an inmate's time behind the wall, though the additional loss of freedom is bound by the limits of their original sentence. The additional stigmatization is incremental and pales in comparison to the stigma of becoming a felon. We fear that putting institutional disciplinary matters on equal footing with criminal cases in the community will result in prolonged exposure to restricted housing settings for those in prehearing detention. The administrative

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nature of prison disciplinary hearings enables officials to efficiently address threats to safety and security, while allowing flexibility to quickly and creatively offer rehabilitative services to the inmate.

In other words, it is neither surprising nor concerning to us that there are different tests for responsibility inside and outside of California prisons, especially if the Durham-like focus of their Rules Violation Report is more likely to pick up the influence of a serious mental illness on an inmate's behavior. Especially for individuals lacking insight into their serious mental illness, a period of incarceration can be an opportunity to save lives by offering clinically appropriate treatment, using *Harper* hearings when necessary, and making referrals to structured aftercare.[3,4] Salem and colleagues found that nonemergency involuntary antipsychotic medication reduced the incidence of disciplinary charges of those inmates qualifying for this protocol.[5]

Having a test for responsibility in correctional disciplinary hearings is not universal. Forensic psychologists for Rutgers University Correctional Health Care are charged with completing psychological assessments for inmates in mental health treatment in the New Jersey Department of Corrections. The regulations in the State of New Jersey do not specify the standard to use for assessing responsibility in these evaluations.[6] Psychologists at Rutgers University Correctional Health Care, however, are trained to use the M'Naughten-like insanity test as found in the New Jersey statute for criminal justice.[7] Some may consider this as too strict a standard to apply for a matter that is not quite criminal in nature, though others may believe that the Durham-like test in the California system swings too far in the other direction. Logically, using a standardized test for responsibility will produce more consistent and predictable results from evaluations. While the exact language is best left to individual jurisdictions, we support others taking California's lead in explicitly articulating these standards.

Obegi suggests that the differences between the regulations used by the California prison system compared with their state's insanity test makes mental health assessments more challenging and expresses concern that a liberal standard of responsibility creates a risk that diagnoses traditionally not eligible for consideration (like a substance use disorder) will be used to excuse misconduct. Maybe so, but identifying when a previously unrecognized mental illness had an influence on misbehavior is also an opportunity for a meaningful clinical intervention.

Institutional discipline related to substance use is a topical example. More than half of state prisoners have one or more substance use disorders, and these are clearly linked to mortality postrelease.[8,9] Despite prohibition, opioid abuse may continue during incarceration through various illicit sources,[10] with accompanying risks of morbidity, mortality, and disciplinary misadventures. Uptake of effective treatment options, especially medications for opioid use disorder (MOUD), has been inconsistent across correctional systems.[7]

Drug court and similar diversion programs have existed for decades in various communities, though the results of these initiatives have been mixed. A 2019 study of the outcomes of Baltimore drug court cases showed no benefit in terms of long-term mortality, though the authors point out that only seven percent of their sample were offered MOUD.[11] Treatment for opioid use disorder inclusive of medication has been linked to decreased drug use, decreased criminal activity, and decreased mortality in the community.[12] A 2018 study of Massachusetts government data revealed that, after a nonfatal opioid overdose, the prescription of agonist MOUD was uncommon, but when used was associated with reduced all-cause and opioid-related mortality.[13] Early data from Rhode Island suggest that inmates with opioid use disorder released on buprenorphine also experienced a reduced risk of death in the community.[14]

It would make sense, then, to use drug-related institutional infractions as an opportunity to reduce risk and save lives. While research regarding the effects of MOUD during incarceration is scarce, a study surveying the inmate participants in Rhode Island's program indicated a perception that access to MOUD reduced the availability of illicit opioids.[15] Should this perception reflect reality, lessening the presence of illegal drugs inside correctional facilities would align the interests of correctional officers, administrators, and health care staff.

We anticipate that an institutional drug court would come with its own challenges. If health care staff are required to certify adherence with a drug treatment program, this creates a dual agency problem that may be prohibited by correctional accrediting organizations. For example, the National Commission on Correctional Health Care standards do not allow health care staff to participate in the collection of forensic information.[16] This could be addressed by a limited waiver of confidentiality as a condition of participation

in a voluntary diversionary program. While it is reasonable to worry that inmates mandated into treatment would be less motivated to participate, available research suggests that the opposite is more likely, and those facing legal pressure often have better outcomes than those seeking treatment voluntarily.[17] Another consideration is that inmates without a specific opioid use disorder may deliberately get caught using opioids with a goal of getting a controlled substance prescribed to them at little to no personal risk. Such a concern can be mitigated by careful assessment, seeking collateral information, and having a range of medication options to offer (i.e., both agonist and antagonist MOUD).

Other potential interventions by mental health professionals can steer the disciplinary process toward rehabilitation. Research supports treatment following the Risk-Needs-Responsivity model, such as Thinking for a Change (inmate-focused cognitive-behavioral therapy)[18] and Cage Your Rage (inmate-focused anger management),[19] as being effective for reducing violent disciplinary charges.[20] Unit Management programs in the Ohio Department of Rehabilitation and Correction use such approaches with broad objectives to bolster self-regulation strategies, enhance communication, reduce antisocial attitudes, and improve the welfare of inmates while incarcerated and after release. Research conducted on Unit Management programs suggests that participation is effective at reducing institutional misconduct, with even better results observed with program completion.[21] Suggestion of effective psychosocial programming as an alternative sanction may reduce usage of, and perhaps the need for, restrictive housing.

In summary, we appreciate The Journal's shining a light on forensic assessments performed by psychologists and psychiatrists for disciplinary hearings in prison and jail systems. Both inmates and correctional staff will benefit from qualified and well-trained professionals using consistently applied standards to provide relevant opinions about the influence of a mental illness on rule infractions. Whether mischief (like misusing topical methyl salicylate to simulate a menthol cigarette) or mayhem (like vigorously threatening cell mates for alleged telepathic molestations), the disciplinary process should not be overlooked as an opportunity for remediation by identifying inmates in need of important health care services.

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