Virtual Mentor
American Medical Association Journal of Ethics
February 2008, Volume 10, Number 2: 92-95.

CLINICAL CASE

Correctional Mental Health

Commentary by Jeffrey L. Metzner, MD

Mr. Sampson is incarcerated in a state prison and has been to see Dr. Lee several times. He has a longstanding history of psychiatric illness that includes self-injury, repeated suicide attempts, sudden violent outbursts resulting in the hospitalization of other inmates, and psychotic symptoms such as delusional beliefs. Dr. Lee has tried her best to manage his illness with a combination of antipsychotic medications, but treatment has proved difficult due to spotty compliance. Mr. Sampson has taken his medications intermittently and has recently missed clinic appointments because of his current confinement in a disciplinary housing unit.

The prison administrators are putting pressure on Dr. Lee to move Mr. Sampson to the inpatient mental health facility, which Mr. Sampson strenuously objects to, claiming that he will "really lose it in there." He says that his compliance problems are due to his being in solitary confinement. Dr. Lee knows that this is only partially true; she believes that moving him, while directly against his wishes, would minimize potential harm to other prisoners and please the correctional officers.

Commentary

Both case law and national guidelines on correctional health care provide clear instruction to the prison physician concerning standard of care questions. The 1976 case *Estelle v. Gamble* clearly established inmates' constitutional right to medical care [1], deciding that "deliberate indifference" to the serious medical needs of prisoners constituted unnecessary and wanton infliction of pain, which violated the Eighth Amendment's protection against cruel and unusual punishment. In *Bowring v. Godwin*, a federal court of appeals found "no underlying distinction from the right to medical care for physical ills and its psychological or psychiatric counterpart" [2, 3]. In other words, this constitutional right to medical treatment also includes psychiatric treatment for inmates with serious mental illness.

The National Commission on Correctional Health Care (NCCHC) [4]—which evolved from an American Medical Association project during the late 1970s—and the American Psychiatric Association (APA) [5] have published standards and guidelines pertinent to both the structure of a correctional health care system and the nature of the treatment to be provided. The APA guidelines for psychiatric services in jails and prisons addressed quality of care concerns by stating "the fundamental policy goal for correctional mental health care is to provide the same level of mental health services to each patient in the criminal justice process that *should* [emphasis

added] be available in the community" [5]. This goal recognizes that the level of mental health care offered in the community is often inadequate due to lack of funding.

From a clinical perspective, the treatment questions in this case are easily answered. This inmate has a serious mental disorder that is associated with psychotic features. His active psychotic symptoms are probably due both to his medication nonadherence and his current stay in isolation. He needs a diagnostic assessment followed by appropriate treatment in a therapeutic environment that should include the use of antipsychotic medication, education concerning the nature of his mental illness and his treatment needs, and therapy designed to promote recovery. Based on the information in the brief case description, such an environment will most likely be the correctional institution's inpatient mental health facility.

Like free citizens in the community, inmates can be psychiatrically hospitalized involuntarily if they meet certain criteria that generally include a mental disorder that results in danger to self or others or grave disability. The nature and extent of the due process required (e.g., judicial hearing, an administrative hearing that determines whether the criteria for involuntary hospitalization have been met) depends on the jurisdiction. The other clinical concern associated with involuntary hospitalization—the therapeutic alliance between patient and physician—is beyond the scope of this essay.

The fact that Mr. Sampson is in isolation, also known as a segregation unit (i.e., a housing unit in which inmates are generally locked in a cell 23 hours per day for either punitive or administrative reasons) indicates that he has violated prison rules in a way that has resulted in his separation from the general prison population. Based on his history of violent outbursts, it is also likely that his violence is related to his partially treated mental illness, although psychiatric assessment is needed to confirm this hypothesis.

Broader Questions for Physicians Who Treat Prisoners

The more interesting discussion generated by this clinical example involves a couple of other questions. First, what if the prison mental health staff did not have access to inpatient psychiatric hospitalization? Is it ethical for a physician to practice medicine in a setting that does not have adequate health care resources? And further, do locked-down environments (i.e., segregation units) cause mental illness? Should inmates with serious mental illness be placed in such units?

It is uncommon for correctional institutions to have adequate access to inpatient psychiatric care for inmates who need it [3]. But it is nevertheless ethical for physicians to practice in such institutions for various reasons. It gives them the opportunity to provide treatment and mitigate some of the negative impact of insufficient resources. These physicians are also able to advocate for needed improvements in the correctional health care system [6].

Physicians should be aware of the tendency to become "insidiously institutionalized," to the point that they discard common sense and practice under unreasonable conditions due to institutional and bureaucratic pressures. For example, clinicians frequently evaluate inmates in a setting that does not allow for acceptable sound privacy from other inmates or correctional staff because it is difficult (but not impossible) to obtain office space. The NCCHC and APA guidelines can be valuable tools for the clinician who is trying to obtain necessary resources and conditions because they help to establish the standard of correctional health care.

The impact of segregation units on an inmate's mental health is a hotly debated topic, especially in the context of litigation. Claims that long-term segregation necessarily causes particular kinds of psychological harm are often described as being scientifically proven and have been published in journals, presented at educational meetings, and verbalized in testimony [7]. In my opinion, most of these claims significantly overstate what is known about the psychological impact of long-term segregated confinement, especially on inmates who have no pre-existing mental illness.

On the other hand, there is consensus among clinicians that inmates who *have* serious mental illness should not be placed in extreme isolation because many of these inmates' psychiatric conditions will not improve or will deteriorate [8]. In other words, many inmates with serious mental illnesses are harmed when placed in such settings [9]. Thus, these inmates are usually excluded from admission to extreme isolation housing, unless the institution has a specialized mental health program in place that is similar to residential treatment programs for general population inmates. These units, also known as intermediate care, supportive living, special needs, or psychiatric services units, or protective environments, are designed for inmates who have had significant difficulty functioning in the general population within the prison due to symptoms related to their mental disorders. They offer enhanced mental health treatment for such inmates [10]. A more extensive discussion of this controversy can be found elsewhere [7].

References

1. *Estelle v Gamble*, 429 US 97 (1976).
2. *Bowring v Godwin*, 551 F2d 44 (4th Cir 1977).
3. Metzner JL. Class action litigation in correctional psychiatry. *J Am Acad Psychiatry Law*. 2002;30(1):19-29.
4. National Commission on Correctional Health Care. *Standards for Health Services in Prisons*. Chicago, IL: National Commission on Correctional Health Care; 2003.
5. American Psychiatric Association. *Psychiatric Services in Jails and Prisons.* 2nd ed. Arlington, VA: American Psychiatric Publishing; 2000.
6. American Psychiatric Association. *Opinions of the Ethics Committee on the Principles of Medical Ethics with Annotation Especially Applicable to Psychiatry.* 2001 ed. Washington, DC: American Psychiatric Association;

2001. http://www.psych.org/psych_pract/ethics/ethics_opinions52201.pdf. Accessed January 2, 2008.
7. Metzner J, Dvoskin J. An overview of correctional psychiatry. *Psychiatr Clin North Am*. 2006;29(3):761-772.
8. Work Group on Schizophrenia. Practice guideline for the treatment of schizophrenia. American Psychiatric Association. *Am J Psychiatry*. 1997;154(4 suppl):1-63.
9. Metzner JL. Mental health considerations for segregated inmates. In: *Standards for Health Services in Prisons*. Chicago, IL: National Commission on Correctional Health Care; 2003:241-254.
10. Metzner JL. An introduction to correctional psychiatry: part III. *J Am Acad Psychiatry Law*.1998;26(1):107-116.

Jeffrey L. Metzner, MD, is a clinical professor of psychiatry at the University of Colorado School of Medicine in Denver. He has provided consultation to judges, special masters, monitors, state departments of corrections, city and county jails, the U.S. Department of Justice, the National Prison Project, and others involved in the field of correctional psychiatry in more than 30 states. He was a member of the Institute of Medicine Committee on Ethical Considerations for Revisions to Department of Health and Human Services Regulations for Protection of Prisoners Involved in Research.

Related in VM

Forced Medication of Prison Inmates, February 2008

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Copyright 2008 American Medical Association. All rights reserved.