CHAPTER 3

Legal Issues Regarding the Provision of Care in a Correctional Setting

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For nearly two centuries in the United States, inmates' legal rights were significantly limited during their incarceration, with the government rarely interfering with a penal institution's inmate management on behalf of the inmate. This approach became known as the "hands-off approach." In 1871, a Virginia court articulated this approach in the case of *Ruffin v. Commonwealth* (1871) when writing,

> A convicted felon…punished by confinement in the penitentiary instead of with death…is in a state of penal servitude to the State. He has, as a consequence of his crime, not only forfeited his liberty, but all his personal rights except those which the law in its humanity accords to him. He is for [the] time being a slave of the state.

During the turbulent times of the 1960s, the courts moved away from this hands-off attitude. A closer scrutiny of inmates' rights emerged in a new judicial "hands-on" approach that involved more oversight by the legal system. The U.S. Supreme Court strengthened the foundation for this philosophical change in the case of *Cooper v. Pate* (1964). In *Cooper*,

the Court ruled for the first time that state prison inmates have standing to sue in federal court to address their grievances. The Court specified that inmates' legal rights were not left behind as they crossed the threshold from their life in the community into the world of corrections.

Mental health care providers and correctional officials should be familiar with common legal mechanisms used by inmates to address concerns regarding the care they are provided. This chapter focuses on five areas related to inmate litigation:

1. The government's legal duty to protect inmates
2. Tort claims alleging medical negligence
3. Claims alleging a violation of constitutional rights
4. Involuntary treatment and transfer of inmates
5. Prison litigation reform

Common legal terms that are often used in litigation are defined in Table 3–1.

TABLE 3–1. Correctional litigation terminology

Legal term	Definition
Pro se	Translated as "for oneself." The filing of a complaint unrepresented and unassisted by legal counsel. The majority of prisoners' complaints are *pro se* complaints.
In forma pauperis	Translated as "in the manner of a pauper." In pleadings, *in forma pauperis* grants an inmate the right to sue without assuming the costs or formalities of pleading.
Sua sponte	Translated as "of one's own will." Refers to a court's acting of its own volition, without a motion being made by either of the adverse parties.
Consent decree	A recorded agreement of parties to a lawsuit concerning the form that the judgment should take.
Magistrate judge	A judge who has jurisdiction over federal 42 U.S.C. §1983 claims with consent of both parties.[a]
Special master	A person often appointed in prison condition cases to oversee court-mandated remedial measures.

[a]See section "Inmates' Constitutional Right to Treatment" for further discussion.

LEGAL DUTY TO PROTECT INMATES

The government does not have an affirmative obligation to protect its citizens absent a "special relationship." That is, the U.S. government has no constitutional duty to provide income, food, health care, housing, or employment to its citizens, even if the government elects to do so. Taking someone into custody, however, changes this dynamic. In this situation, a special relationship is created that obligates the government to protect inmates from harm (Cohen and Gerbasi 2005).

The U.S. Supreme Court articulated this affirmative obligation in *DeShaney v. Winnebago County Department of Social Services* (1989), a case that actually involved a small child rather than an adult prisoner. Joshua DeShaney was a 3-year-old child living with his father, Randy, and stepmother. Joshua's stepmother reported that Joshua's father had hit Joshua and left marks on him. Randy denied all accusations to the investigating social workers, and Joshua was maintained in Randy's custody. A year later, Joshua was admitted to a local hospital with multiple bruises and abrasions, and the Winnebago County Department of Social Services (DSS) was notified of suspected child abuse. A child protection team recommended that Joshua be returned to his father's care. Despite repeated in-home observations by DSS of suspicious bruising and another emergency room visit for injuries believed to be a result of child abuse, Joshua was maintained under the care of his father. In March 1984, Randy DeShaney beat 4-year-old Joshua so severely that the child entered into a life-threatening coma. Although Joshua lived, he experienced permanent brain damage that resulted in his being confined to an institution for individuals with profound retardation.

Joshua and his mother brought a civil rights claim against the Winnebago County DSS. They alleged that by failing to protect Joshua from his father, DSS had deprived Joshua of his liberty without due process of law, in violation of his rights under the Fourteenth Amendment.

The U.S. Supreme Court held that a state's failure to protect an individual against private violence does not constitute a violation of the due process clause. Joshua and his mother had argued that because the state had known that Joshua had faced a special danger of abuse at his father's hand, a special relationship had existed, and therefore the state had had a duty to protect Joshua. The Court emphasized that because the state had not actually taken Joshua into protective custody, the state had no affirmative obligation to protect him. Chief Justice William Rehnquist specifically noted,

> The affirmative duty to protect arises not from the State's knowledge of the individual's predicament or from its expression of intent to help him,

> but from the limitation which it has imposed on his freedom to act on his behalf.... In the substantive due process analysis, it is the State's affirmative act of restraining the individual's freedom to act on his own behalf—through incarceration, institutionalization, or other similar restraint of personal liberty—which is the "deprivation of liberty" triggering the protections of the Due Process Clause, not its failure to act to protect his liberty interest against harms inflicted by other means. (*DeShaney v. Winnebago County Department of Social Services* 1989, p. 201)

The *DeShaney* Court specifically noted that incarceration represents a form of state restraint that triggers a constitutional duty to protect inmates. This legal concept is important in how courts have subsequently analyzed harms that inmates have experienced while incarcerated.

TORT CLAIMS ALLEGING MEDICAL NEGLIGENCE

Tort law governs the legal resolution of complaints regarding medical treatment. A *tort* is a civil wrong. Tort law seeks to financially compensate individuals who have been injured or who have suffered losses due to the conduct of others. Inmates maintain the right to sue for medical negligence during their incarceration. In cases involving the death of an inmate, the plaintiff is generally a surviving spouse or family member who seeks financial compensation for the loss of his or her loved one. Torts are typically divided into one of three categories: 1) strict liability, 2) intentional torts, and 3) negligence.

Strict liability imposes liability on defendants without requiring any proof of lack of due care, and this standard is not used in malpractice litigation. The most common example of strict liability is harm caused to an individual resulting from a product proven to be unreasonably dangerous and defective (Schubert 1996).

Intentional torts involve actions in which an individual either intends harm or knows that harm may result from his or her behavior (Schubert 1996). Examples of intentional torts that involve mental health care include assault (an attempt to inflict bodily injury), battery (touching without consent), false imprisonment, and violation of a person's civil rights.

Negligent torts occur when a clinician's behavior unintentionally causes an unreasonable risk of harm to another. Medical malpractice is based on the theory of negligence. The four elements required to establish medical negligence are commonly known as the "four Ds": **D**ereliction of **D**uty that **D**irectly results in **D**amages (see Table 3–2). A *duty* is most commonly established for a clinician when the patient seeks treatment, and treatment is provided. The provision of services does not require

TABLE 3–2. The "four D's" of negligence

Dereliction	Deviations from minimally acceptable standards of care
Duty	Established when there is a professional treatment relationship between a clinician and patient
Directly causing	Relationship between dereliction of duty and harm caused
Damages	The amount of money awarded the plaintiff to compensate for harm caused

the patient's presence and can even extend to assessment and treatment provided over the telephone.

Dereliction of duty is usually the most difficult component of negligence for the plaintiff to establish. Dereliction of duty is divided into acts of commission (providing substandard care) and acts of omission (failure to provide care). Acceptable care does not have to be perfect care but is care provided by a reasonable practitioner. This standard requires that the provider exercise, in both diagnosis and treatment, that reasonable degree of knowledge and skill that ordinarily is possessed and exercised by other members of the profession in similar circumstances (Black 1979). An important issue is whether the standard of mental health care for inmates should be lower than, the same as, or higher than that provided for individuals who are not incarcerated. In an important policy statement regarding the treatment provided to those incarcerated, a task force established by the American Psychiatric Association (2000) provided guidance on this issue when noting the following:

> The fundamental policy goal for correctional mental health is to provide the same level of mental health services to each patient in the criminal justice process that should be available in the community. This policy goal is deliberately higher than the "community standard" that is called for in various legal contexts. (p. 6)

Two aspects of causation generally cited as establishing negligence include the foreseeability of the bad outcome and the clinicians' role in *directly* causing the harm.

Damages are the amount of money the plaintiff is awarded in a lawsuit. Various types of damages may be awarded. *Special damages* are for those actually caused by the injury and include payment for lost wages and medical bills. *General damages* are more subjective in nature and provide financial compensation for the plaintiff's pain and suffering, mental an-

guish, loss of future income due to injury, and loss of companionship. A third category of damages includes *exemplary* or *punitive damages*. Punitive damages may be awarded when the defendant has been determined to have acted in a malicious or grossly reckless manner. Because punitive damages generally involve harm that is intentionally caused, they are rarely awarded in suicide malpractice cases.

INMATES' CONSTITUTIONAL RIGHT TO TREATMENT

Legal Overview

Inmates may also sue correctional providers claiming that the care provided, or not provided, violated their constitutional rights. Lawsuits alleging that the care provided was unconstitutional have important differences from medical malpractice lawsuits described above. The two constitutional amendments that are most commonly cited as potentially being violated in these types of claims are the Eighth Amendment and the Fourteenth Amendment.

The Eighth Amendment to the U.S. Constitution was ratified as part of the Bill of Rights in 1791. One provision of this amendment prohibits the federal government from imposing cruel and unusual punishment on those convicted of a crime. In 1878, the U.S. Supreme Court provided examples of cruel and unusual punishments, which included publicly dissecting, burning alive, or disemboweling a convicted person (*Wilkerson v. Utah* 1878).

How does the Eighth Amendment now relate to constitutional standards of medical care provided to convicted inmates? Consider the following scenario: An inmate is alone in his cell and notices the onset of a squeezing severe chest pain, accompanied by a tingling in his left arm and hand and shortness of breath. He believes he is suffering from an acute heart attack and experiences pain that becomes increasingly intolerable. He contacts the correctional officer and requests help. The correctional officer ignores his request. Because the inmate is incarcerated, he has no other capability to obtain care for the pain he is experiencing. He is "tortured" by this ripping chest pain. As a result, this lack of care by his prison providers exposes him to a cruel and unusual punishment in violation of the Eighth Amendment. Consequently, convicted prisoners are the only category of individuals in the United States who have a constitutional right to health care.

The legal mechanism that authorizes an inmate to sue a provider or correctional official for failing to provide constitutionally adequate care originates from a federal statute known as 42 U.S.C. § 1983. This statute,

also known as the Ku Klux Klan Act, was passed in 1871 to help protect black individuals by providing them a civil remedy for abuses the Klan committed against them. Section 1 of this federal statute reads as follows:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law.... (Federal Statute 42 U.S.C. § 1983 [1871])

The importance of this statute is that it established a legal mechanism to sue an individual for a violation of a constitutional right. In 1964, the U.S. Supreme Court held that state inmates could also bring forth a civil rights suit against prison officials for a violation of their constitutional rights (*Cooper v. Pate* 1964). Thus, the door was opened for prison inmates to sue for a violation of their Eighth Amendment rights if the conditions of their medical care represented cruel and unusual punishment. These particular claims are often referred to as "Section 1983" claims.

How, then, do correctional providers know when their care, or lack of care, equates with a violation of an inmate's Eighth Amendment right to such care? In the case of *Estelle v. Gamble* (1976), the U.S. Supreme Court attempted to answer this question. J.W. Gamble, an inmate in the Texas prison system, was allegedly injured when a bale of cotton fell on him while he was unloading a truck as part of his prison work. Although he continued to work for 4 hours, he later complained of back stiffness and was given a pass to go to the prison hospital for evaluation and treatment. During the ensuing 3 months, inmate Gamble was seen by medical personnel on 17 different occasions and received a variety of treatments for his back injury and other problems.

On February 11, 1974, Gamble brought a civil rights action under 42 U.S.C. § 1983 against two correctional officials and the medical director, claiming that he was subjected to cruel and unusual punishment in violation of the Eighth Amendment because of the care, or lack thereof, provided to him. In particular, Gamble complained that a failure to request an X ray of his back resulted in inadequate assessment and treatment, causing his condition to worsen and thereby subjecting him to cruel and unusual punishment.

The *Gamble* Court majority noted that although a failure to conduct an X ray or use additional diagnostic techniques may represent negligence, the presence of medical malpractice *alone* does not constitute cruel and unusual punishment. The Court specifically stated, "Medical mal-

practice does not become a constitutional violation merely because the victim is a prisoner" (*Estelle v. Gamble* 1976). Therefore, the standard establishing a violation of an inmate's Eighth Amendment rights in regard to the medical care provided *is higher than* what is required to establish medical negligence, which was discussed in the previous section of this chapter.

The *Gamble* Court noted that a violation of an inmate's constitutional rights was established if prison personnel demonstrated "deliberate indifference" to a prisoner's "serious illness or injury." Table 3–3 summarizes key points of the *Gamble* Court ruling, in an attempt to clarify the "deliberate indifference" standard.

The phrase "serious medical need" has been defined by at least two lower courts. The First Circuit Court of Appeals commented that a serious medical need is one that

> has been diagnosed by a physician as mandating treatment, or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention.…The "seriousness" of an inmate's needs may also be determined by reference to the effect of the delay of treatment. (*Gaudreault v. Municipality of Salem* 1990)

This definition has been criticized because a layperson may not find "so obvious" the signs and symptoms of mental illness and understand how such an illness could affect an inmate's behavior (Cohen and Dvoskin 1992).

Two years later, the Ninth Circuit provided an alternative definition to what constitutes a "serious medical need":

> A "serious" medical need exists if the failure to treat a prisoner's condition could result in further injury or the "unnecessary and wanton infliction of pain."…Either result is not the type of "routine discomfort [that] is 'part of the penalty that criminal offenders pay for their offenses against society.'"…The existence of an injury that a reasonable doctor or patient would find important and worthy of comment or treatment; the presence of a medical condition that significantly affects an individual's daily activities; or the existence of chronic and substantial pain are examples of indications that a prisoner has a "serious" need for medical treatment. (*McGuckin v. Smith* 1992)

After the enunciation of the deliberate indifference standard, some confusion arose across jurisdictions regarding how to more precisely evaluate the mind-set of prison officials accused of being deliberately indifferent to an inmate's needs. As previously emphasized, the U.S. Supreme Court in *Estelle v. Gamble* (1976) specified that the deliberate indifference

TABLE 3–3. "Deliberate indifference" defined

Deliberate indifference to serious medical needs constitutes the unnecessary and wanton infliction of pain, and such indifference must offend evolving standards of decency.

An inadvertent failure to provide adequate medical care does not constitute deliberate indifference.

Deliberate indifference may be established by

— Prison doctors in their response to a prisoner's needs,

— Correctional officers in intentionally denying or delaying access to medical care, or

— Personnel who intentionally interfere with treatment once proscribed.

Source. *Estelle v. Gamble* 1976.

standard was higher than the negligence standard used in medical malpractice cases. The next highest standard in evaluating someone's mindset (i.e., *mens rea*, or guilty mind) in regard to his or her actions involves analyzing whether the person had a "reckless" mind at the time of his or her acts. Two types of recklessness have been defined:

1. *Subjective recklessness:* A person knows of a particular situation or risk and disregards it
2. *Objective recklessness*: A person does not know of a particular situation or risk but, based on the circumstances, should have known

Because the *Gamble* Court did not provide specific guidance as to which recklessness standard was to be used in evaluating inmates' deliberate indifference claims, courts have varied in how they analyzed deliberate indifference claims, resulting in a confusing trail of court rulings.

Eventually, this confusion was resolved by the U.S. Supreme Court in the interesting case of *Farmer v. Brennan* (1994). Dee Farmer, a biological male, was a preoperative transsexual who received a federal sentence for credit card fraud. For years prior to Farmer's conviction and sentence, Farmer wore women's clothing, took female hormones, received silicone breast implants, and even underwent a botched black market testicle removal. After being convicted, Farmer was eventually transferred to the U.S. Penitentiary in Terre Haute, Indiana, and was placed in the general population of male inmates without voicing objection to this placement. During this time, Farmer allegedly smuggled hormone drugs into prison and wore the prison clothing off one shoulder, in a "feminine manner." Within

2 weeks of being placed in the facility, Farmer was beaten and raped by another inmate. Farmer subsequently filed a civil rights claim alleging that prison officials were deliberately indifferent to the placement of Farmer in this potentially harmful situation. In particular, Farmer asserted that because this penitentiary had a violent environment and a history of inmate assaults, correctional officials should have known that Farmer was at high risk for sexual victimization.

A critical issue in analyzing this case was what standard of recklessness would apply in determining whether prison personnel were deliberately indifferent to Dee Farmer. Was the standard *subjective recklessness*, whereby the inmate must show that the prison officials had *actual knowledge* of the risk or potential danger, or was it *objective recklessness*, indicating that the inmate must only show that the prison officials *should have known* of the risk or potential danger, even when they did not have actual knowledge?

The U.S. Supreme Court ruled that the appropriate test in evaluating an inmate's deliberate indifference claim is *subjective recklessness*. According to the *Farmer* Court,

> A prison official may be held liable under the Eighth Amendment for acting with "deliberate indifference" to inmate health or safety only if he knows that inmates face a substantial risk of danger of serious harm and disregards that risk by failing to take reasonable measures. (*Farmer v. Brennan* 1994)

The Court also commented that a fact finder could conclude that the prison officials had the necessary knowledge, despite claims to the contrary, in situations that involved obvious dangers to inmates. In other words, although the deliberate indifference standard requires knowledge of the risk, prison officials cannot escape liability by pretending that they did not know of the risk when it is actually obvious that they did know.

"Serious Medical Need" and Mental Health Needs

In the *Estelle v. Gamble* (1976) holding, the U.S. Supreme Court stated that prison officials may not be deliberately indifferent to an inmate's serious *medical* needs. Although the Court did not specifically note that mental health needs were equivalent to medical needs, lower courts have held that no distinction should be made between medical and mental health needs when considering deliberate indifference claims.

In *Bowring v. Godwin* (1976), Larry Bowring, who was serving a sentence for robbery, attempted robbery, and kidnapping, claimed that his Eighth and Fourteenth Amendment rights were violated because his denial of parole was based, in part, on a psychological evaluation that stated

he would not successfully complete a parole period. Bowring asserted that the state must provide him with a psychological diagnosis and treatment so that he would qualify for parole, and a failure to do so constitutes cruel and unusual punishment. In conducting an analysis of Bowring's claim, the Fourth Circuit Court of Appeals specifically noted,

> We see no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart. Modern science has rejected the notion that mental or emotional disturbances are the products of afflicted souls, hence beyond the purview of counseling, medication and therapy. (*Bowring v. Godwin* 1976)

This same court noted that a prisoner is entitled to psychological or psychiatric treatment if a physician or other health care provider concludes that

1. the prisoner's symptoms are evidence of a serious disease or injury,
2. such disease or injury is curable or may be substantially alleviated, and
3. the potential for harm to the prisoner by reason of delay or the denial of care would be substantial.

The *Bowring* court also emphasized that the right to mental heath treatment was limited to treatment that could be provided on a reasonable cost and time basis and was medically necessary rather than merely desirable.

Deliberate Indifference and Pretrial Detainees

The Eighth Amendment discussion above applies only to *convicted* prisoners. Does this mean that pretrial detainees serving their time in a jail are not afforded the same constitutional protections and right to be free from deliberate indifference that are given to convicted prisoners? Obviously, the answer is "no." In fact, the U.S. Supreme Court has noted that pretrial detainees have a right to be free from punishment altogether (*Bell v. Wolfish* 1979) because they have not been convicted of a crime. In *City of Revere v. Massachusetts General Hospital* (1983), the U.S. Supreme Court emphasized that the due process clause of the Fourteenth Amendment

> does require the responsible government or governmental agency to provide medical care to persons…who have been injured while being apprehended by the police. In fact, the due process rights of a [pretrial detainee] are at least as great as the Eighth Amendment protections available to a convicted prisoner.

Therefore, in cases involving pretrial detainees, deliberate indifference claims are analyzed under the Fourteenth Amendment's due process clause, and such reviews are conducted in a manner similar to those involving convicted prisoners.

Inmate Suicides and Deliberate Indifference

When an inmate attempts or actually commits suicide, the possibility of a civil rights action claiming deliberate indifference by correctional staff should be anticipated, in addition to claims of medical negligence. Does a risk of suicide equate with the required "serious medical need" component to establish deliberate indifference? In *Partridge v. Two Unknown Police Officers* (1986), the Fifth Circuit Court evaluated a case involving the suicide of Michael Partridge, a pretrial detainee arrested by a Houston police officer on suspicion of burglary and theft. Upon his arrest, Michael was described as hysterical. Michael's father was at the scene of the arrest and informed the arresting officer that his son had had a nervous breakdown. When placed into the police car, Michael became agitated and violent and tried to kick the windows and doors out of the car. During the drive to the jail, he intentionally struck his head against the Plexiglas divider, but he appeared composed by the time he arrived at the jail.

The transporting officers did not report Michael's behavior at the scene or during transport to anyone at the jail, and he was subsequently placed in solitary confinement. Three hours later, Michael tied a pair of socks to the upper bars of his cell and hanged himself. Clinical records within the jail documented that Michael had attempted suicide during a prior confinement. Michael's parents filed a Section 1983 claim alleging that the Houston police officers were deliberately indifferent to their son's risk of suicide.

The Fifth Circuit Court noted the following in evaluating if a suicide risk represents a serious medical need:

> A serious medical need may exist for psychological or psychiatric treatment, just as it may exist for physical ills. A psychological or psychiatric condition can be as serious as any physical pathology or injury, especially when it results in suicidal tendencies. And just as a failure to act to save a detainee from suffering from gangrene might violate the duty to provide reasonable medical care absent an intervening legitimate government objective, failure to take any steps to save a suicidal detainee from injuring himself may also constitute a due process violation under *Bell v. Wolfish.* (*Partridge v. Two Unknown Police Officers* 1986)

Section 1983 claims have also been forwarded for failure to adequately train governmental employees in the identification and appropri-

ate interventions for potentially suicidal inmates. In the case of *Colburn v. Upper Darby Township* (1991), the Third Circuit Court of Appeals noted that to establish deliberate indifference to an inmate's constitutional rights based on failures in a training program, "the identified deficiency must be closely related to the ultimate injury." The *Colburn* court noted that in this type of Section 1983 claim, the plaintiff must 1) identify specific training not provided that could reasonably be expected to prevent the suicide that occurred and 2) demonstrate that the risk reduction associated with the proposed training is so great and so obvious that it can reasonably be attributed to deliberate indifference.

In this same case, the *Colburn* court provided their methodology regarding how to analyze Section 1983 claims that involved pretrial detainees who committed suicide. According to the standard outlined by this court, the plaintiff must prove that

1. the inmate had a particular vulnerability to suicide,
2. the custodial officers knew or should have known of this vulnerability, and
3. the officers acted with "reckless indifference" to the inmate's particular vulnerability.

The court emphasized that the vulnerability to suicide could not be a "mere possibility" but must represent a "strong likelihood." In addition, the court noted that in evaluating if the officers should have known that the inmate was vulnerable to suicide, the vulnerability had to be "so obvious that a lay person would easily recognize the necessity for preventative action" (*Colburn v. Upper Darby Township* 1991).

Common acts of omission or commission involving inmate suicide that are noted both in tort claims and in Section 1983 claims are highlighted in Table 3–4.

Deliberate Indifference and Other Clinical and Custodial Care Issues

Claims of deliberate indifference are not limited to inmate suicides or suicide attempts. Section 1983 claims alleging violation of an inmate's constitutional rights are potentially wide-ranging and may include failure to appropriately diagnose, treat, or monitor care given. In addition, courts may consider if a correctional facility was deliberately indifferent to the impact of placement in isolation or segregated units such as security housing units. For example, in the case of *Jones'El v. Berge* (2001), a federal district court noted that the confinement conditions in a Wisconsin supermax prison may be unconstitutional for inmates with serious

TABLE 3–4. Common tort and Section 1983 claims involving inmate suicide

Failure to properly screen for suicide
Failure to adequately train custodial staff in suicide recognition and prevention
Failure to communicate information regarding suicide potential
Failure to identify risk of suicide
Failure to appropriately intervene to diminish suicide risk
Failure to adequately treat a suicidal inmate
Failure to provide a safe environment
Failure to provide an appropriate emergency intervention following a suicide attempt

Source. Cohen 2008.

mental illness. The authors of Chapter 16, "Supermax Units and Death Row," in this handbook further discuss legal rulings related to the constitutional violations associated with the placement of inmates with mental illness in such settings.

Continued Care After Release From Incarceration

One might expect that the constitutional obligation to provide care to an inmate ceases upon his or her release from incarceration, particularly in light of the previously discussed case of *DeShaney v. Winnebago* (1989), which held that an affirmative obligation of the state was created when the person was taken into the state's *custody*. However, three more recent cases indicate that the grasp of this custody requirement may reach beyond the walls of a jail or prison. In the first case, *Wakefield v. Thompson* (1999), the Ninth Circuit Court addressed a Section 1983 claim by Timothy Wakefield that a correctional officer at San Quentin Prison was deliberately indifferent to his serious medical needs by refusing to provide him with prescription psychotropic medication upon his release from prison. According to Wakefield, his prison psychiatrist had written a 2-week prescription for thiothixene for treatment of his diagnosed organic delusional disorder. In his lawsuit, Wakefield asserted that on the day of his release, the correctional officer told him that no medication was available and refused to call the medical staff to check on his prescription. Wakefield claimed that because he was without his necessary antipsychotic medication, he had a relapse of his mental condition, which led to a violent outburst and his rearrest.

The Ninth Circuit Court concluded that Wakefield did have an adequate Section 1983 claim that the officer was deliberately indifferent to his serious medical needs by failing to provide his prescribed medications, in violation of Wakefield's Eighth and Fourteenth Amendment rights. In explaining why the state may have an obligation beyond medical care required during actual incarceration, the court noted,

> It is a matter of common sense, however, that a prisoner's ability to secure medication "on his own behalf" is not necessarily restored the instant he walks through the prison gates and into the civil world. Although many patients must take their medication one or more times a day, it may take a number of days, or possibly even weeks for a recently released prisoner to find a doctor, schedule an examination, obtain a diagnosis, and have a prescription filled. Accordingly the period of time during which prisoners are unable to secure medication "on their own behalf" may extend beyond the period of actual incarceration. Under the reasoning of Estelle and DeShaney, the state's responsibility to provide a temporary supply of medication to prisoners in such cases extends beyond that period as well. (*Wakefield v. Thompson* 1999)

The court in *Wakefield* held that the state must provide an outgoing prisoner (who needs medication) a "sufficient supply" of medications for a period of time reasonably necessary to permit the inmate to consult a doctor and obtain a new supply. This ruling neither stated exactly how many days of medication must be prescribed nor required that a doctor or doctor's appointment be provided.

In what appears to be an extension of the *Wakefield* holding, the New York case of *Brad H. v. City of New York* (2000) addressed obligations by jail personnel in regard to discharge planning for jail inmates. In 1999, a class action lawsuit was brought forward on behalf of the nearly 25,000 inmates with mental illness who are released annually from New York City jails. According to the plaintiffs, inmates with mental illness were released with minimal, if any, coordinated follow-up care. The alleged practice of jail discharge involved releasing the inmates with mental illness in the isolated Queens Plaza between 2 A.M. and 4 A.M. with $1.50 in cash and a $3 Metrocard. The complaint alleged that this practice violated inmates' rights under New York State laws and regulations that require discharge planning by providers of mental health treatment.

In January 2003, a settlement agreement was reached that provided various services to qualifying class members. Services included connection with community mental health services, assistance in obtaining medications upon discharge, a discharge summary, aftercare appointments, and assistance with public housing. For additional information regarding

discharge placement obligations of correctional personnel, see Chapter 15, "Clinically Oriented Reentry Planning," in this handbook.

The third case, *Lugo v. Senkowski* (2000), represents yet another view regarding what care, if any, clinicians are obligated to provide after an inmate's discharge. Mr. Lugo was a New York prison inmate who was paroled from New York's Clinton Prison. His release occurred shortly after he underwent surgery for removal of a kidney stone. As part of his surgery, a metal stent was left in the kidney. Mr. Lugo's physician informed him that he would need subsequent surgery to remove this stent. Mr. Lugo's parole release occurred before this surgery could be arranged. Mr. Lugo subsequently sued, alleging that he was not provided any assistance in obtaining the surgery that had been recommended by his doctor. The judge interpreted the *Wakefield* (1999) ruling as requiring the state to provide care that they had initiated, and this continued obligation should remain for a "reasonable period of time."

Although this case did not involve an inmate with mental illness, it raises the question of how future courts may interpret psychiatric care that is initiated and requires ongoing monitoring for safety upon release. For example, might a mental health care provider have an obligation to arrange for white blood cell monitoring in the community for a released inmate who has recently started taking the antipsychotic clozapine? The cases outlined above suggest that a mental health practitioner should consider the following when an inmate under his or her care is going to be released:

1. Provide psychiatric medications long enough for an inmate to reasonably access a treating provider in the community.
2. Coordinate discharge planning and reentry into the community when feasible.
3. Consider what monitoring may be necessary for treatment that is begun but not yet completed, and that requires further intervention for completion of the treatment.

CONSTITUTIONAL ISSUES REGARDING SYSTEMS OF CARE

In addition to Section 1983 claims involving specific failures in individual cases, the entire mental health care system can be evaluated to determine if it meets a constitutionally acceptable standard. One of the most famous cases that provided guidelines for adequate mental health care was that of *Ruiz v. Estelle* (1980). David Ruiz was a Texas prison inmate repeatedly incarcerated for aggravated robbery. In 1972, he filed a 15-page handwritten civil rights complaint alleging numerous violations of his constitutional

rights, to include the lack of medical care, unlawful placement in solitary confinement, and harassment by prison officials. His lawsuit was later combined with six other lawsuits into a class action on behalf of all Texas prisoners. After a yearlong trial, the judge ruled in favor of Ruiz and the prisoners. Texas was ordered to make massive changes in its prison system. The federal government's monitoring of the Texas prison system lasted until 2002, when the federal court turned the system back over to state control. The court outlined six requirements of a constitutionally acceptable mental health program; these are described in Table 3–5.

INVOLUNTARY TREATMENT AND TRANSFER OF INMATES

Involuntary Medication for Treatment Purposes

Inmates do not give up their right to refuse treatment as a condition of their confinement; however, involuntary treatment may be administered in a life-threatening situation if the failure to treat could result in the inmate's death or serious harm. In addition, most jurisdictions provide a review mechanism that allows the involuntary treatment of an inmate when he or she poses a threat of danger to self or others, or is gravely disabled (e.g., unable to attend to his or her basic needs of daily living). The provider should be familiar with his or her jurisdiction's legal requirements for the involuntary administration of medications in both jail and prison settings, because the mechanism for forced treatment may differ in the two environments.

In some jail settings, the involuntary administration of medication to jail inmates in nonemergency settings follows a process similar to that used for individuals being considered for involuntary psychotropic medication in the community. For example, in California, providers who recommend involuntary medicating of a jail inmate must first present their reasoning for doing so to a judge at a court hearing.

Are such judicial hearings constitutionally *required* for prison inmates before involuntary medications may be given? The U.S. Supreme Court ruled that a nonjudicial administrative review mechanism is constitutionally permissible, as outlined in the case of *Washington v. Harper* (1990). Walter Harper was a convicted robber incarcerated in the Washington State penal system who had episodes of violent behavior when he did not take his antipsychotic medication. He was transferred on two occasions to the Special Offender Center (SOC), a state institution for offenders with mental illness, where he was diagnosed with manic-depressive disorder. The SOC had an institutional review policy for evaluating when anti-

TABLE 3–5. Guidelines for a constitutionally acceptable mental health program

1. The prison must have a systematic program of screening and evaluations of prisoners to identify those who need mental health treatment.
2. Treatment for a prisoner must entail more than just segregation and close supervision.
3. The prison must employ enough mental health professionals to be able to identify and treat the mentally ill in an individualized manner.
4. The treating professionals must keep accurate, complete, and confidential records of the mental health treatment process.
5. A prisoner cannot be treated with a prescription for behavior-altering medications in dangerous amounts, by dangerous methods, or without acceptable supervision and periodic evaluations.
6. The prison must have a basic program to identify, treat, and supervise inmates with suicidal tendencies.

Source. *Ruiz v. Estelle* 1980.

psychotic drugs could be administered against an inmate's wishes. According to this policy, a special review committee examined the involuntary medication recommendations made by the treating psychiatrist. The review committee consisted of a psychiatrist, psychologist, and SOC official, none of whom could be involved in the inmate's current diagnosis or treatment. This special committee decided to approve the involuntary administration of medication only if 1) the committee psychiatrist was in the majority recommending medication and 2) the inmate had a "mental disorder" and was "gravely disabled" or posed a "likelihood of serious harm" to self or others.

This SOC policy also provided inmates with many procedural due process rights, including the following:

- Right to notice of the hearing
- Right to attend the hearing
- Right to present evidence and cross-examine witnesses
- Right to representation by a disinterested lay adviser versed in the psychological issues
- Right to appeal the decision to the SOC's superintendent
- Right to periodic review of any involuntary medication ordered

Harper filed a Section 1983 suit claiming that the SOC's failure to provide a judicial hearing before the involuntary administration of antipsychotic medication violated the due process clause of the Fourteenth Amendment. The U.S. Supreme Court held that the due process clause permits the state to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his or her will, if he or she is dangerous to self or others and if the treatment is in his or her medical interest. The major point of this case is that prison officials are *not* constitutionally required to arrange a judicial hearing to obtain court approval of involuntary medication of a prisoner with mental illness.

Involuntary Medication for Competency to Stand Trial Restoration

Occasionally, jail providers may be faced with a situation in which a pretrial detainee who has been found incompetent to stand trial has a court order that authorizes the involuntary administration of psychotropic medications even when the inmate has not been found to be a danger to self or others or to be gravely disabled. This order, referred to as a *Sell* order, arises out of the case of *Sell v. United States* (2003). In this case, the U.S. Supreme Court provided guidance on when pretrial detainees may be involuntarily medicated to restore their competency to stand trial even when they are not considered a danger to themselves or others and are not gravely disabled. Charles Sell was a St. Louis dentist who had a long-standing history of delusional disorder. He was eventually charged with multiple counts of Medicaid fraud and one count of money laundering. While Sell was released on bail, his mental status reportedly deteriorated, and he was eventually charged with one count of conspiring to murder the FBI agent who had arrested him.

Sell was found incompetent to stand trial. After being ordered to a hospital for competency restoration, he refused to take the antipsychotic medication prescribed for his delusional disorder. Sell challenged any involuntary medication administration, and the case was appealed to the U.S. Supreme Court. The issue before the court was whether the U.S. Constitution permits the government to involuntarily administer antipsychotic drugs to a criminal defendant with mental illness for the purpose of rendering the individual competent to stand trial. The U.S. Supreme Court outlined conditions that must be met prior to the involuntary administration of medication, and these factors are sometimes referred to as the *Sell* criteria:

1. The court must find that an important government interest is at stake. Both person and property crimes can be viewed as serious offenses that justify the government's interest in adjudicating criminality.

2. The court must find that the medication significantly furthers the state's interests. For example, the medication should likely render the defendant competent to stand trial and not have severe side effects that would interfere with the trial competency.
3. The medication must be the most appropriate method of restoring trial competency, which cannot be achieved with less intrusive treatments.
4. The medication must be medically appropriate, based on its efficacy and side effects.

If a jail provider receives a *Sell* order from the court authorizing involuntary medication, he or she should carefully review the order to verify that it allows such administration in the jail setting as opposed to a hospital setting. Some orders specify that forced medication for trial competency may be given only in a hospital setting. In this circumstance, the provider should seek guidance from the court regarding whether or not the *Sell* order permits forced medication at the jail. Individuals found incompetent to stand trial are often sent to a state hospital for competency restoration and may be involuntarily medicated under a *Sell* order in that setting. After the hospital determines that the defendant is trial competent, the inmate is usually returned to jail to await his or her competency hearing. Such defendants sometimes refuse the medications that were forced on them at the hospital. Does the *Sell* order still apply while they await their trial in jail? In other words, does a hospital's opinion that the inmate is no longer incompetent to stand trial negate the conditions of the *Sell* order? No clear rule on this issue exists, and providers should contact the court to clarify whether or not such continued involuntary medication administration is permitted at the jail while the inmate awaits the competency hearing.

Involuntary Transfer of Prisoners to a Psychiatric Hospital

Prisoners also have constitutional rights in regard to their being transferred to a psychiatric facility against their will. In the case of *Vitek v. Jones* (1980), the U.S. Supreme Court provided criteria to be considered before a prisoner could be involuntarily sent to a psychiatric hospital. At issue was a Nebraska statute that authorized a state prisoner's transfer to a state mental hospital without the inmate's consent. Mr. Jones had been convicted of robbery and sentenced to a prison term of 3–9 years. Eight months after he began serving his sentence, he was transferred to the prison hospital, and 2 days later, he was housed in solitary confinement at the prison adjustment center. While there, he suffered serious burns after

he set his mattress on fire. He was subsequently sent by ambulance to the burn unit of a private hospital, where he remained for approximately 4 months. Mr. Jones was then considered for a possible transfer from the burn unit to a nonprison psychiatric hospital.

Under the governing Nebraska statute, if a physician or psychologist finds that an inmate has a mental disease or defect and determines that the inmate cannot be given proper treatment at the prison, the director of correctional services may arrange for the inmate's transfer to a psychiatric facility. Mr. Jones was examined by a psychiatrist, who recommended that Mr. Jones be sent to a psychiatric hospital, and Mr. Jones reportedly told the psychiatrist that he agreed with this decision. A year later, he challenged his transfer under the due process clause of the Fourteenth Amendment, arguing that inadequate procedures were afforded him regarding the decision to have him serve his sentence in a psychiatric facility as opposed to a state prison.

The U.S. Supreme Court agreed with Mr. Jones that he had a protected liberty interest under the Fourteenth Amendment and noted that Nebraska's reliance on the opinion of a physician or psychologist in determining the conditions for transfer did not provide adequate due process protections. The *Vitek* Court commented,

> Involuntary commitment to a mental hospital is not within the range of conditions of confinement to which a prison sentence subjects an individual. While a conviction and sentence extinguish an individual's right to freedom from confinement for the term of his sentence, they do not authorize the State to classify him as mentally ill and to subject him to involuntary psychiatric treatment without affording him additional due process protections. Here, the stigmatizing consequences of a transfer to a mental hospital for involuntary psychiatric treatment, coupled with the subjection of the prisoner to mandatory behavior modification as a treatment for mental illness, constitute the kind of deprivations of liberty that requires procedural protections. (*Vitek v. Jones* 1980, pp. 491–494)

The *Vitek* Court upheld minimum procedures outlined by the district court that must be followed before transferring a prisoner to a mental hospital (see Table 3–6). The procedural guidelines summarized in Table 3–6 are typically provided to inmates who are being considered for transfer to a psychiatric facility. Hearings to consider this move are commonly referred to as *Vitek* hearings. *Vitek* hearings are not required for prison-to-prison transfers or in psychiatric emergencies where short-term crisis stabilization is required.

TABLE 3–6. *Vitek* procedures required for prisoner transfer to a psychiatric hospital

1. Written notice that a transfer to a mental hospital is being considered.
2. A hearing after the prisoner is given written notice that a transfer is being considered and sufficient time to prepare for this hearing. At the hearing, the evidence being relied upon for the transfer must be presented and the inmate must have an opportunity to be heard in person and to present documentary evidence.
3. An opportunity to present testimony of witnesses by the defense and to confront and cross-examine witnesses called by the state, unless there is a good cause finding for not permitting such presentation, confrontation, or cross-examination.
4. A right to an independent decision maker at the hearing.
5. A written statement by the fact finder as to the evidence relied on and the reasons for transferring the inmate.
6. Availability of "qualified and independent assistance" provided by the state (a licensed attorney is not required).
7. Effective and timely notice of all of the above rights.

Source. *Vitek v. Jones* 1980.

PRISON LITIGATION REFORM

As noted at the beginning of this chapter, the U.S. Supreme Court held in *Cooper v. Pate* (1964) that prison inmates could sue for a violation of their constitutional rights under the Civil Rights Act of 1871. As time passed, concern arose that inmates were increasingly using this mechanism to file frivolous civil rights claims. In 1994, the U.S. Department of Justice conducted a study to evaluate Section 1983 claims made by inmates. In 96% of these lawsuits, the inmate proceeded *pro se* (without counsel). In 94% of the cases, the inmate won nothing as a result of his or her claim (Hanson and Daley 1994). Additional findings from this study are highlighted in Tables 3–7 and 3–8.

In 1995, Congress passed the Prison Litigation Reform Act (PLRA) as one mechanism to address concerns regarding the costs and time demands associated with frivolous civil rights lawsuits brought by inmates. When Senator Bob Dole introduced the PLRA as a Senate bill, he stated that the PLRA was necessary "to provide for appropriate remedies for prison condition lawsuits, to discourage frivolous and abusive prison lawsuits, and for other purposes" (Dole 1995). Senator Dole provided vari-

TABLE 3–7. U.S. Department of Justice report on Section 1983 litigation

Inmate plaintiffs in Section 1983 lawsuits	
State prison inmates	62%
Jail inmates	36%
Parolees (released inmates)	2%
Defendants in Section 1983 lawsuits	
Correctional officers	26%
Wardens/jail administrators	22%
Medical staff (doctors and nurses)	9%
Elected officials	7%
Arresting officers	6%

Source. Hanson and Daley 1994.

TABLE 3–8. Top five issues in Section 1983 lawsuits

Issue	Percentage of lawsuits
Physical security	21%
Medical treatment	17%
Due process	13%
Challenges to conviction	12%
Physical conditions	9%

Source. Hanson and Daley 1994.

ous examples of inmate lawsuit abuses: an inmate sued because he preferred creamy rather than chunky peanut butter, another sued a prison barber for a defective haircut, and yet another claimed a civil rights violation because prison officials had failed to invite him to a pizza party for a departing prison employee (Dole 1995).

The PLRA was not unanimously lauded by members of the U.S. Senate, and some senators expressed their concerns regarding the potential consequences of this legislation. For example, Senator Ted Kennedy (1996) warned that the PLRA effectively stripped federal courts of their remedial power, and he argued that the bill was "patently unconstitutional, and a dangerous legislative incursion into the work of the judicial branch."

Likewise, Senator Joe Biden (1995) cautioned that the PLRA could prevent meritorious lawsuits from being heard by courts.

In reality, the PLRA does contain several key provisions designed to discourage or prevent prisoners from bringing lawsuits into court. First, the statute requires indigent inmates to pay the filing fee (up to $150). The entire fee can be paid in installments over time. Second, the PLRA requires that before a prisoner forwards a case to court, he or she first exhaust all administrative remedies that are available. Third, this statute restricts attorneys' fees, making it potentially more difficult for inmates to find legal representation. Fourth, the PLRA contains a "three strikes" provision, which bars prisoners who have previously filed three or more frivolous complaints or appeals from filing *in forma pauperis* (Latin for "in the manner of a pauper"). Federal and state courts grant this status to individuals without funds so they can pursue litigation with a waiver of the normal costs. The PLRA restricts this ability in defined circumstances.

In regard to claims for mental or emotional injuries, the PLRA (1995) specifies the following: "No Federal civil action may be brought by a prisoner confined in a jail, prison, or other correctional facility for a mental or emotional injury suffered while in custody without a prior showing of physical injury." The PLRA does not define what constitutes a "mental or emotional injury," explain what is meant by "prior showing," or define "physical injury." One could envision a scenario in which an inmate was threatened with a shank to his throat or witnessed the brutal stabbing of his cell mate. Under the PLRA, if no physical injury resulted, the inmate might be restricted from filing a claim for a mental or emotional injury.

Has the PLRA achieved its goal of decreasing the frequency of inmate lawsuits? In a study examining data made available by the federal court system and the Bureau of Justice Statistics, Schlanger (2005) examined jail and prison inmate civil rights suits filed in federal court both before and after the passage of the PLRA. She noted a sharp decline in inmate lawsuit rates immediately following passage of the PLRA, in marked contrast to a nearly 25-year history of increasing inmate lawsuits prior to this legislation. It remains unclear whether this decline represents a decrease in only frivolous litigation or a drop in some genuine lawsuits due to the higher hurdles of the PLRA.

CONCLUSION

This chapter has highlighted important aspects involving the standard of care provided to inmates and their legal rights to care as they traverse through the criminal justice system. Because incarceration prevents inmates from independently accessing care as they might in the community,

the courts have ruled that they have a constitutional right to treatment. Clearly, an inmate does not lose the right to appropriate mental health care because he or she has been charged with or found guilty of a crime. This point was clearly emphasized by the U.S. Supreme Court in the case of *Wolff v. McDonnell* (1974): "There is no iron curtain drawn between the Constitution and the prisons of this country."

SUMMARY POINTS

- Mental health care providers can be sued for negligence regarding the care they provide inmates.
- Mental health care providers can be sued for violating an inmate's constitutional rights if they are found "deliberately indifferent" to an inmate's serious medical needs.
- The standard for deliberate indifference is higher than that for medical negligence and requires an awareness and disregard of the risk or situation alleged to cause the harm.
- Inmates have a constitutional right to treatment.
- Providers should be familiar with their jurisdictional requirements for involuntary medication administration and transfer of inmates.
- The Prison Litigation Reform Act was passed to decrease frivolous inmate lawsuits, and trends do show a subsequent decrease in inmate lawsuit filings.

REFERENCES

American Psychiatric Association: Psychiatric Services in Jails and Prisons: A Task Force Report of the American Psychiatric Association, 2nd Edition. Washington, DC, American Psychiatric Association, 2000

Bell v Wolfish, 441 U.S. 520 (1979)

Biden J: Statement of Senator Joe Biden. 141 Congressional Record S14, 628 (September 29, 1995)

Black HC: Black's Law Dictionary. St. Paul, MN, West Publishing, 1979

Bowring v Godwin, 555 F.2d 44 (4th Cir. 1976)

Brad H v City of New York, 712 N.Y.S.2d 336 (Sup. Ct. 2000); 716 N.Y.S.2d 852 (N.Y. App. Div. 2000)

City of Revere v Massachusetts General Hospital, 463 U.S. 239 (1983)

Cohen F: Suicide, in The Mentally Disordered Inmate and the Law, 2nd Edition. Edited by Cohen F. Kingston, NJ, Civic Research Institute, 2008, pp 14–16

Cohen F, Dvoskin J: Inmates with mental disorders: a guide to law and practice. Ment Phys Disabil Law Rep 16:339–341, 1992

Cohen F, Gerbasi J: Legal issues, in Handbook of Correctional Mental Health. Edited by Scott CL, Gerbasi JB. Washington, DC, American Psychiatric Publishing, 2005, pp 259–283
Colburn v Upper Darby Township, 946 F.2d 1017 (3d Cir. 1991)
Cooper v Pate, 378 U.S. 546 (1964)
DeShaney v Winnebago County Department of Social Services, 489 U.S. 189 (1989)
Dole R: Statement of Senator Robert Dole. 141 Congressional Record S14, 413, Daily Edition, September 27, 1995
Estelle v Gamble, 429 U.S. 97 (1976)
Farmer v Brennan, 555 U.S. 825 (1994)
Federal statute 42 U.S.C. § 1983 (1871)
Gaudreault v Municipality of Salem, Massachusetts, 923 F.2d 203, 208 (1st Cir. 1990)
Hanson RA, Daley HWK: Challenging the conditions of prisons and jails: a report on Section 1983 litigation. Washington, DC, U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, December 1994
Jones'El v Berge, 164 F.Supp.2d 1096 (W.D. Wis. 2001)
Kennedy T: Statement of Senator Ted Kennedy. 142 Congressional Record S2296, Daily Edition, March 19, 1996
Lugo v Senkowski, 114 F.Supp.2s 111 (N.D. N.Y. September 25, 2000)
McGuckin v Smith, 974 F.2d 1050 (9th Cir. 1992)
Partridge v Two Unknown Police Officers, 791 F.2d 1182, 1187 (5th Cir. 1986)
Prison Litigation Reform Act, 42 U.S.C. § 1997e(e), 1995
Ruffin v Commonwealth, 62 Va.790 (1871)
Ruiz v Estelle, 503 F.Supp. 1265 (S.D. Tex 1980)
Schlanger M: Prison conditions lawsuits: subject matter and time trends, December 15, 2005. Available at: http://law.wustl.edu/courses/Schlanger/Prisons2006/Reading/Prison_Lawsuits_trends.pdf. Accessed March 25, 2009.
Schubert FA: Grilliot's Introduction to Law and the Legal System, 6th Edition. Boston, MA, Houghton Mifflin, 1996, pp 537–541
Sell v United States, 539 U.S. 166 (2003)
Vitek v Jones, 445 U.S. 480 (1980)
Wakefield v Thompson, 177 F.3d 1160 (9th Cir. 1999)
Washington v Harper, 494 U.S. 210, 215–217 (1990)
Wilkerson v Utah, 99 U.S. 130 (1878)
Wolff v McDonnell, 418 U.S. 539 (1974)