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The Role of Health Care Staff in Relationship to Use of Force Incidents in the Custody Setting

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Chapter
of the
American
Correctional
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Introduction



The application of force to contain violent behavior is a necessary tool of law enforcement and corrections personnel. Trends in both criminal justice and population demographics have led to inmate populations that, in general, demonstrate increasingly violent behavior but are, in addition, often both older and sicker than previously seen. Serious mental health disorders are commonplace in jails and prisons, as shrinking resources have reduced access to treatment facilities, both before and during incarceration. Such trends have resulted in more conspicuous roles for medical and mental health professionals in the management of correctional institutions. While generally viewed as a positive development, the emerging interface between health care and criminal justice raises questions about roles and responsibilities that challenge fundamental principles of professional ethics.

While several of the largest jails and prisons have already developed policies that delineate medical and custody staff procedures relative to use of force for inmate management, there remains a need to conceptualize the underlying rationale that describes and preserves professional integrity for all concerned. More problematic is the situation in some smaller facilities where new technologies for less-than-lethal force are being implemented without any consideration of related medical issues.

From the standpoint of health professionals is the question of whether participation in use-of-force incidents crosses the line from safeguarding inmate welfare to serving as accessory to security measures which, however necessary, cannot be viewed as appropriate to the practice of medicine. In particular, when, if ever, should health professionals determine which techniques can be "safely" applied to particular inmates with known medical conditions? To what extent should health professionals be on standby to treat inmates who are injured by use-of-force techniques?

As troubling as these possibilities may seem to many health professionals, the reality is that use of less-than-lethal force techniques will be increasingly applied in modern correctional environments. At the same time, health care staff are bound to their obligation to respond to any knowledge of serious medical need. The well-established legal principle of “deliberate indifference” does not permit health professionals to divorce themselves from custody functions that will clearly endanger their patients. Therefore, guidelines are needed to assist both health and correctional professionals in carrying out their respective functions in a manner which is compatible with legal and ethical obligations.

Legal Issues

In addition to the concept of “deliberate indifference to serious medical need,” a violation of the Eighth Amendment of the Federal Constitution which guarantees against “cruel and unusual punishments,” are the Federal Supreme Court criteria used in analyzing use of force cases. Such cases are judged according to the following considerations: (1) Was the need for use of force adequately established? (2) Was the amount of force applied necessary and appropriate to the circumstances? (3) What was the extent of injury suffered as the result of force? (4) What was the degree of threat as viewed through the eyes of a reasonable correctional officer? (5) What efforts were made to temper the situation prior to resorting to force?

In addition, to the above considerations, growing numbers of incidents related to management of severe mental health disorders raises an additional question. In the case of persons with serious mental illnesses, what efforts were undertaken to prevent avoidable deterioration and might have precluded the ultimate use of force?

Emergency versus Controlled Use of Force

To those who function in correctional settings, it is clear that all situations calling for use of force cannot be regarded equally.

In an *emergency* situation where there is an immediate threat of harm, it is generally accepted that there is little time to consider options, and action must be taken to intervene

with knowledge that a certain degree of harm may be unavoidable. So long as such action is carried out responsibly and according to approved procedure, it is sanctioned and there is minimal opportunity for health care staff to intervene except to treat any injuries that ensue.

However, under other circumstances there is the possibility of the *controlled use of force*. Examples include “cell extractions” in which an unwilling inmate is removed from a cell, or when specific weaponry is used to quell disturbances involving either individuals or groups of inmates. These situations provide opportunities for alternative approaches to force to be considered, as well as notification of health care staff to be present or available in response to the incident. This is clearly the most problematic dilemma for health professionals. While it may not be controversial to attempt a non-violent solution to a situation through mental health counseling, is the announcement that negotiations have failed tantamount to approval to proceed with force? Does a medical statement that there are no contraindications to use of oleoresin capsicum spray (pepper spray) constitute “clearance” for its use? Does health staff have a duty to anticipate and assure that medical conditions posing special risks are somehow identified and communicated to custody staff in advance of forceful interventions?

Use of Psychotropic Medications

The involuntary administration of psychotropic medications constitutes the use of force and requires a careful assessment of the individual to determine whether this intervention is appropriate. In the correctional environment, there is a temptation for custody staff to call upon medical and mental health professionals to administer medications in order to subdue acting-out behavior that may not be based on mental illness. The important distinction to be made is whether the inmate is “mad” (mentally ill) or “bad” (misbehaving in the absence of a diagnosable mental disorder). To use medications as a means of countering the latter form of behavior is a serious breach of professional ethics. It is imperative that medical and mental health staff utilize their professional training to evaluate each instance where restraint through medication is being requested and that they establish clear limits when diagnostic indications are lacking.

By itself, the application of force is not a therapeutic intervention. Efforts should be made to, as comprehensively as possible, use accepted treatment strategies to stabilize the inmate's condition and prevent the future need for drastic measures. The overall management of a mentally ill inmate is a psychiatric problem, and it requires clear direction from mental health professionals. By the same token, criminal or other inappropriate behavior that is not based on mental illness should be managed by custody staff. Determining which approach should be taken in a given instance can be difficult, and it requires both health and custody personnel to maintain a clear understanding of their respective roles and responsibilities.

In the custody setting, administration of psychotropic medications without consent is appropriate only on a limited basis in response to an emergency situation¹. Other occasions calling for involuntary treatment, such as in response to a court order, should be carried out in licensed facilities, which are staffed and equipped to monitor the inmate medically and able to provide the full range of services necessary to fulfill the goals of comprehensive treatment planning.

Medical Consequences of Less-than-Lethal Force Techniques

Contributing to the difficulty for health care staff to meaningfully participate in use-of-force management decisions is the lack of scientific data describing risks associated with such techniques. Medical education is generally nonexistent in this subject area. While some literature describes techniques, such as the T.A.S.E.R. electronic immobilization device ("stun gun") to be safe, experience has revealed incidents of sudden death associated with its application. Similarly, other devices that deliver rubber "bullets" as projectiles via a firearm or grenade-like devices are generally considered non-lethal, yet have occasionally been associated with death. Chemical agents,

¹"Emergency" is defined as a situation in which action to impose treatment over the inmate's objection is immediately necessary for the preservation of life or the prevention of serious bodily harm to the inmate or others, and it is impracticable to first gain consent.

including oleoresin capsicum (OC), chlorobenzylidene malononitrile (CS or "Tear Gas") and chloroacetophenone (CN) ("Mace"), have varying toxicities that depend to an extent on characteristics of the environment in which they are delivered as well as any underlying health conditions that may affect individual response, such as



asthma. While medical professionals may have a *general* sense of what conditions can place an inmate at risk for complications of these agents, little information is available to permit an accurate assessment. The field of less-than-lethal force techniques remains fraught with hearsay and anecdote from the perspective of medical science.

Specific Considerations and Confounding Factors

Before a rational policy for a health care role in use-of-force situations can be developed, various aspects of the issue must be examined. Some of the key considerations are as follows:

- What alternatives to the use of force exist? If there are "medical contraindications" to the proposed technique, is it appropriate to escalate to a higher level of force? Is a non-forceful approach available?
- What are the medico legal implications if health care staff fail to detect a medical condition that will result in complications of a use-of-force method?
- What is the likelihood that inmates with identified health conditions that "contraindicate" a use-of-force method will deliberately misbehave with assumed impunity?
- Will inmates learn to falsely claim medical conditions known to preclude use-of-force techniques?
- Will custody staff develop a lower "threshold" for use of force if health care staff indicate that there is no medical reason to withhold such force?

- How will use-of-force techniques be applied to groups of inmates who are acting out when only some of them are known to have health conditions placing them at special risk for complications?

Recommendations:

The following recommendations are intended to serve as a starting point for policy development in facilities wishing to adopt less-than-lethal force techniques. It is expected that there will be further definition of the issues and specific technical recommendations as additional information becomes available.

For now, the following recommendations represent the consensus of discussion and are offered for consideration:

- Health care staff working in correctional settings must recognize that the emergency and controlled use of less-than-lethal force techniques is inevitable.
- Correctional health care staff should become knowledgeable about the methods and procedures for use of force that may be employed within their institutions and the associated potential health consequences.
- Each facility should establish policy and procedures describing, in detail, roles and responsibilities relative to the application of use of force. Policies and procedures must address the degree to which on-site health care staff are trained, qualified and equipped to provide medical interventions to treat inmates who are the subjects of force. Although the majority of available methods for less-than-lethal force will not likely require advanced levels of care, procedures for evacuation to emergency facilities should be specified.
- In all instances of troublesome behavior, interventions that delay or divert the need for force should first be used. In doing so, both inmate and staff safety are preserved. Equally important is the avoidance of the physical and emotional trauma to the inmate that inevitably accompanies the application of force, a technique that should always be considered a last resort.

- Health care staff should not undertake routine screening procedures designed specifically for the purpose of determining the eligibility of inmates to be “safely” subjected to less-than-lethal force techniques.
- For those inmates who are incarcerated in medically supervised settings (e.g., infirmaries, sheltered living units, correctional treatment centers), correctional staff should consult on a case-by-case basis with health care staff *prior to* application of the controlled use of force.
- Under no circumstances should health care staff provide “clearance” for the use of force on an inmate. This does not preclude issuance of an “advisory” to custody staff about a health condition that may constitute a risk for complications of a specific technique.
- Options for non-forceful methods of resolving the situation² should be explored, as well as clarification of known medical conditions that would pose unusual health risks to the inmate. Based upon a meaningful assessment of the health risks to the inmate, correctional personnel must then use any health advisories in the context of the overall situation to make an informed decision about the advisability of proceeding with force.
- The involuntary administration of psychotropic medications constitutes a use of force and should be prohibited as a method for controlling behavior in persons lacking valid diagnostic indications.
- A treatment plan must be developed to address the overall treatment needs of all mentally ill inmates for whom the application of use of force is used or considered.
- It is appropriate for health care staff to be available on standby during use-of-force incidents in order to respond to medical complications of the procedures. Being on the premises, even if present within view of

²In particular, this is likely to involve a mental health consultation

the incident, does not constitute active participation in the application of force.

Recognizing that there will be situations in correctional settings where the lines between the security and health functions become blurred, health professionals should function according to the guiding principle that their obligation is to their inmate-patients. While it is necessary for correctional staff to take action to

preserve the safety and security of the entire institution, the challenge to health professionals is to support that endeavor while maintaining clear sight on the health ramifications of what is occurring. To serve as medical educators and guides to corrections personnel during use-of-force incidents is a perilous path for health professionals, but one that may ultimately lead to better understanding of disordered behavior and methods for managing it.

This policy was formulated by the Institute for Medical Quality Corrections and Detentions Health Care Committee. Members include Karen Tait, MD, former president of the CA-NV Chapter of ACHSA, John H. Clark, MD, former president, National ACHSA, Barbara Cotton, former president, National ACHSA, John Hagar, Esq., and Rebecca Craig, Immediate Past President, National ACHSA (our members remain committed to correctional medicine and professional ethics!). Many thanks to Rebecca for allowing its use in this publication.

California-Nevada Chapter Swears in New Board Members

The California-Nevada Chapter Board of Directors met at the West Valley Detention Center in Rancho Cucamonga on Friday, February 16, 2001 and inducted new members of the Board, who were the victors in the recent election.

Board changes include:

Joe Goldenson MD, President

Kathy Wild RN , President-elect

Vicki Schlone, member-at-large

John Heary, member-at-large

Royanne Schissel RN, Past President

Kandy Heinen RN, Secretary (new term)

Alan Abrams, member-at-large

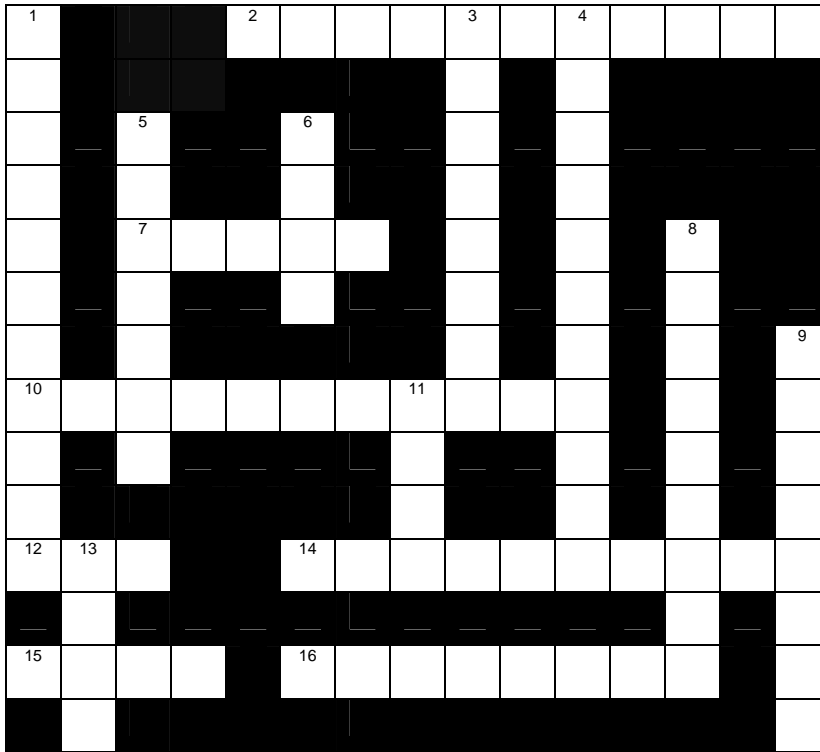
Kathy Yetz, member-at-large

Congratulations to the new members, and special congratulations to Kandy Heinen for her new term!



New board members being sworn in. R-L: Vickie Schlone, Kathy Yetz, Kandy Heinen, Joe Goldenson, Alan Abrams, Kathy Wild, & John Heary. Royanne Schissel is at far right.

Legalities



People who work for the California State Department of Corrections may be familiar with this puzzle. It has some good information in it for everybody in the correctional health field.

Answers can be found on page 9

Across

2. An inmate who uses feces to draw a picture of a nude woman on his wall but stops when given art supplies is a _____.

7. The Eighth Amendment of the U.S. Constitution prohibits _____ & unusual punishment.

10. CDC cannot be deliberately ____ to an inmate's serious medical or mental health needs.

12. The procedures CDC is required to use in administering involuntary psychiatric meds are patterned after the _____ Act.

14. The California Constitution _____ a right to privacy.

15. Medical and custody should always work as a _____.

16. It is critically important to _____ everything in the inmate's medical file.

Down

1. In looking at restrictions on inmate's rights, courts will consider whether the restriction was "reasonably to a legitimate _____ interest."

3. The state is not required to reimburse an employee for _____ damages.

4. PLRA is the acronym for the new Federal _____ which modifies inmate rights to bring lawsuits.

5. Inmate medical _____ must be legible

6. Inmates who win, even partially, in Federal court are entitled to attorney's _____.

8. _____ inmates have a right to consent or to refuse medical/mental health treatment.

9. The name of the case that imposes a duty to warn is _____.

11. An inmate's refusal of the Mantoux skin test on religious grounds may be protected under _____ (acronym).

13. _____ review is one important element in staying out of legal trouble.

Conference 2001: Mark Your Calendars!

The 2001 CA-NV Chapter Conference is presently slated for September 20-22 at the Wyndham Gardens Hotel in Costa Mesa, CA (subject to change). The agenda is being finalized at press time, and fliers should be mailed soon.

Patti Gonzalez, from the San Diego County Health Department is again in charge of the arrangements. Gladys Hradecky, from the San Diego County Sheriff's Department, recently stepped down as the conference treasurer, and was replaced by Keith Miller of the San Bernardino County Sheriff's Department.

Watch your mail for further information.



Patty Gonzalez sits by as Gladys Hradecky, Keith Miller, and Kathy Wild discuss conference plans.

HEPP

HIV Education Prison Project



HEPP news is a forum for correctional problem solving which targets administrators and HIV/AIDS care providers including physicians, nurses, outreach workers, and case managers. It is published monthly and distributed by fax. The Brown University Office of Continuing Medical Education provides CME credits to physicians who accurately respond to the questions on the last page of the newsletter.

It can be viewed online at
www.hivcorrections.org

For other subscribing information, please contact Kevin Connor at (909) 463-5102.

Rio Hondo Community College

Rio Hondo Community College is offering college courses over the internet with focuses on the Administration of Justice and Correctional Science. These classes contain items of interest to all who work in corrections!

Registration dates for the fall semester are anticipated to be between August 1, 2001, and October 1. Check their website around August 1.

Cost of classes is as follows:

Tuition: CA residents: \$11.00/unit

Out of state and international: \$125.00/unit

Number of units x (\$11.00 or \$125.00) =

College Service fees: All students: \$12.00/semester

Total fees: one 3 unit class would cost \$33.00 + \$12.00 = \$45.00; two 3 unit classes would cost (\$45.00 + \$33.00) = \$78.00

You can contact the college at: Rio Hondo College
3600 Workman Mill Road
Whittier, CA 90601
Attn: Admissions-Distance Learning Project
Telephone: (562) 908-3406



More information can be found at their website: <http://www.rh.cc.ca.us/leo>

\$10 Gift Certificates

A gift certificate, good for \$10 off dues, conferences, regional meetings, or any other CA-NV ACHSA chapter activities will be issued to members who submit articles, news items, or other contributions to *the State Pen* (that's \$10.00 for each contribution!). Get out your pens, fire up the word processors, and send us the latest on your work sites, your accomplishments, case studies, humorous or sad stories (or whatever else you may have). We want your input to make *the State Pen* a networking and outreaching format. Contributions need not be grand or wordy, but please type or print!



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<http://members.tripod.com/~achsa/index.htm>
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Thanks to Mr. Alan Wild for the use of this logo!

The CA-NV Chapter Board of Directors

Here are the current members of the CA-NV Chapter Board of Directors. Board members serve in an unpaid capacity, with the length of their terms established by the chapter bylaws (interested parties may view these on the chapter web page). Members may be contacted via their e-mail addresses, or by writing them c/o the chapter's mailing address, 2140 Shattuck Avenue, PO Box 2491, Berkeley, CA 94704. Alternately, they may be reached via the chapter's e-mail, ca_nvachsa@lycos.com

Position	Name	Organization	E-mail
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Member at Large	Vicki Schlone	California Department Of Corrections	vlschlone@aol.com
Member at Large	Alan Abrams MD JD	California Department Of Corrections	aabrams@n2.net
Member at Large	Kathy Yetz	San Diego Juvenile Hall	xxxxx
Member at Large	John Heary	San Bernardino Sheriff's Department	Jheary@sanbernardinosherriff.org
Nevada Representative	Vacant	xxxxx	xxxxx

Application For the California/Nevada Chapter of the ACHSA

Name _____
 Mailing Address _____
 Name of Organization/Institution _____
 Address _____
 Work Telephone No. _____
 Specialty/Discipline _____
 Position _____

Are you a member of ...

ACA? Yes No

National ACHSA? Yes No

The American Correctional Health Services Association (ACHSA) is an affiliate of the American Correctional Association (ACA). Although not mandatory for ACHSA membership, please indicate if you are a member of the ACA on application.

In order to be a member of the California/Nevada Chapter of the ACHSA, you must be a member of the national ACHSA; please indicate if you are a member of the national ACHSA on application.

Annual dues for ACHSA are: \$45.00 (National) and \$25.00 (State). Total due = \$70.00

Please make check payable to: ACHSA, California/Nevada Chapter, and send to: Treasurer, 2140 Shattuck Ave., Box 2491, Berkeley, CA 94704.

Membership is open to all individuals interested in correctional health services

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