VITEK AND BEYOND: THE EMPIRICAL CONTEXT OF PRISON-TO-HOSPITAL TRANSFERS*

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I
INTRODUCTION

In the 1980 case of *Vitek v. Jones*,[1] the United States Supreme Court held that the transfer of a prison inmate to a mental hospital required an administrative hearing to determine whether the transfer was appropriate. This decision "broke new ground in the area of corrections law" since it concluded that "at least one change in a prisoner's status, by its very nature, could not be accomplished without some formal factfinding procedure."[2]

A recent and comprehensive analysis of *Vitek* precludes the necessity of reviewing the legal precedents or reasoning of the case here.[3] The Supreme Court decided *Vitek*, however, without the benefit of any descriptive and analytic account of the empirical context in which decisions are made to transfer prisoners to mental hospitals. Without such information it is not possible to assess the extent to which *Vitek* addresses the central issues in the transfer process. This article, after summarizing the very limited existing research on the prison-to-mental hospital transfer process, presents the results of a study undertaken to fill that informational gap.

The study gathered statistical data on the types of transfers that occur in six of the United States, the nature of the facilities to which prisoners are transferred, and the perceptions of the staff at the prisons and mental hospitals involved in the transfer of prisoners. One conclusion from this study is that *Vitek* must be read broadly as applying to the transfer of prisoners to mental health facilities operated by departments of corrections (DOCs), and not just to the transfer of prisoners to hospitals operated by departments of mental health (DMHs). This is essential

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1. 445 U.S. 480 (1980).

2. Churgin, *The Transfer of Inmates to Mental Health Facilities: Developments in the Law*, in MENTALLY DISORDERED OFFENDERS: PERSPECTIVES FROM LAW AND SOCIAL SCIENCE (in press).

3. *See id.*

because most prisoners are transferred to prison-run hospitals which are largely indistinguishable from maximum security civil institutions. The second conclusion is that while *Vitek* may have a beneficial impact in reducing the "overidentification" of inmates—the transfer of prisoners to mental hospitals simply because they are management problems—it leaves unresolved what is perceived by the staff at both prisons and transfer facilities as being a much more serious problem: the "underidentification" of inmates—the failure to treat those prisoners who are actually mentally disordered and in need of hospitalization, but who languish unidentified in the general prison population.

II

EXISTING STUDIES

The paucity of information about the population of inmates selected for transfer to mental hospitals presents a serious problem for both policymakers and social scientists. One recent attempt to rectify this situation at the descriptive level was a mail survey of "forensic directors" in departments of mental health or departments of corrections in all fifty states and the federal system.[4] This survey found that 10,895 prisoners were admitted to mental health facilities in 1978, and that on any given day in that year, 5,158 prisoners resided in mental health facilities. The largest group of "mentally disordered offenders" were those considered "disordered" simply by virtue of transfer to mental hospitals.[5] This group constituted 54.1% of all "mentally disordered offenders" admitted to U.S. mental health facilities in 1978, and 36.5% of the average daily census for this group.[6] The actual number of prisoners receiving mental health treatment is probably even higher since these admission and census figures do not reflect prisoners in regular prison units who receive "outpatient" mental health care (e.g., voluntary psychotropic medication, counseling from social workers, and the like).

At the risk of stating the obvious, in no sense are these figures to be taken as an index of the "true" prevalence of mental illness in the U.S. prison population. There may be mentally ill persons who are not transferred to a mental hospital. There were 278,141 persons in U.S. prisons on the first day of 1978.[7] Our survey found that the census of state inmates receiving care in mental health facilities on an average day was 5,158. This is a "transfer rate" of 1.9%.[8] A leading review of correctional psychiatry concluded that "approximately 15 to 20 percent of prison

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4. Steadman, Monahan, Hartstone, Davis, & Robbins, *Mentally Disordered Offenders: A National Survey of Patients and Facilities,* 6 L. & HUM. BEHAV. 31 (1982).

5. "Mentally disordered offender" is an umbrella term which includes persons found incompetent to stand trial; found not guilty by reason of insanity; found to be mentally disordered sex offenders; or administratively transferred from a prison to a mental health facility. While this term has been used routinely in the literature it is not totally accurate since neither incompetent defendants nor persons acquitted by reason of insanity are convicted offenders.

6. Steadman, Monahan, Hartstone, Davis, & Robbins, *supra* note 4, at 33.

7. Weiss & Henney, *Crime and Criminals in the United States,* in 2 CRIMINOLOGY REVIEW YEARBOOK 697, 719 (1980).

8. This figure may slightly overestimate the treated rate since our data are based on admissions rather than individuals, and therefore any inmate readmitted to a mental health facility in 1978 would have been counted separately for each admission.

inmates manifest sufficient psychiatric pathology to warrant medical attention . . . . The number of prisoners manifesting psychoses or otherwise severe psychiatric disturbances is, however, considerably less than 20 percent, probably on the order of 5 percent or less of the total prison population."[9] The extent to which the "treated" rate for mental illness among prisoners of 1.9% is drawn from the "true" estimated rate of "5 percent or less" for "psychoses or otherwise severe psychiatric disturbances" is unknown.[10]

There are apparently only two other studies with data relevant to prison-to-mental hospital transfer issues.[11] One of the few comprehensive reports of prison-mental hospital transfers describes the procedure used in South Carolina since 1976 for transferring inmates to a forty-eight bed psychiatric unit operated by the Department of Corrections.[12] Under this procedure one "contact person" at each state prison was made responsible for referring inmates. Contact people included nurses, wardens, social workers, and chaplains. They were initially instructed to refer for a transfer evaluation any inmate who seemed "fit for a state hospital." The staff of the receiving psychiatric unit had the ability to "shape" the contact persons' choice of inmates referred for transfer by discussing any "inappropriate" referrals with the referral source and explaining the problem.

> If any institution attempted to take advantage of the psychiatric unit by deliberately making inappropriate referrals (e.g., troublesome, acting-out types) or by refusing to accept an undesirable inmate back after psychological treatment had been completed then the institution was "punished." This punishment consisted of . . . advising the institution in question that if the situation was not rectified immediately, the . . . psychiatric unit would refuse to accept other referrals from this institution.[13]

Consultation and the threat of sanctions resulted in an "inappropriate transfer rate" (i.e., the admitting clinician observed no treatable mental illness) of only 6%, and part of this 6% consisted of malingerers who mimicked disordered symptoms to get access to medication.[14] The report concluded that "the cost of hiring more highly trained personnel [as referral agents was] not worth the miniscule reduction in the number of inappropriate referrals that would be possible."[15] This study does not seem to consider, however, the possibility that more highly trained personnel might *increase* the number of *appropriate* referrals. That is, while untrained wardens and others may indeed be accurately screening out the bulk of those who would not benefit from transfer, they may be overlooking many other prisoners with less flagrant symptomology who would benefit. Indeed, the "shaping" procedure adopted seems more likely to be effective at screening "out" the wrong kinds of referrals than in screening "in" the right ones. Also, the technique of blacklist-

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9. Roth, *Correctional Psychiatry,* in MODERN LEGAL MEDICINE, PSYCHIATRY, AND FORENSIC SCIENCE 677, 688 (1980).

10. *See* Monahan & Steadman, *Crime and Mental Disorder: An Epidemiological Approach,* in CRIME AND JUSTICE: AN ANNUAL REVIEW OF RESEARCH 145 (1983).

11. Gearing, Heckel & Matthey, *The Screening and Referral of Mentally Disordered Inmates in a State Correctional System,* 11 PROF. PSYCHOLOGY 849 (1980); Halleck, *A Critique of Current Psychiatric Roles in the Legal Process,* 1966 WIS. L. REV. 379.

12. Gearing, Heckel & Matthey, *supra* note 11.

13. *Id.* at 850.

14. *Id.*

15. *Id.* at 854.

ing an institution that refuses to take back a successfully treated inmate seems to be more of a punishment of the mentally ill inmates in the institution who are thereby deprived of the opportunity for transfer than of the "offending" institution.

The other study provides additional indirect support for the appropriateness of most prison-to-mental hospital transfer decisions. Half of sixty inmates transferred from the Wisconsin State Prison to the Wisconsin State Hospital for the Criminally Insane had a history of mental hospitalization pre-dating their imprisonment. An additional 20%, although having no history of mental hospitalization, revealed such disordered symptoms that the issue of mental illness had been raised in the probation officer's pre-sentence report. Some of these people were transferred to the mental health facility immediately after their arrival at prison.[16]

These two reports suggest that relatively few inmates recommended for transfer to a mental health facility are inappropriately recommended. Most inmates transferred have some mental disorder. However, both studies dealt only with a single mental health facility, and the second study relied upon prisoner records rather than clinical examinations to infer mental disorder. Some caution is therefore appropriate in drawing conclusions on the issue of the appropriateness of inmate transfer decisions.

On the other issues surrounding the transfer of prisoners to mental hospitals, particularly the appropriateness of decisions *not* to transfer inmates—that is, the "underidentification" of disordered inmates—there is no research at all. This study attempts to address the "appropriateness of transfer" issue touched on by prior studies. Further, it begins to explore issues in the transfer process on which even suggestive data are not presently available. Our conceptualization is guided by what seem to be the key empirical issues highlighted by *Vitek*, a case which, from both a social science and a policy view, may come to be valued principally for having stimulated additional inquiry into important and poorly understood issues concerning the relationship between prisons and mental hospitals.

III

THE STUDY

To examine the process by which male prisoners[17] are transferred to inpatient mental health facilities, interviews were conducted in six states—Arizona, California, Iowa, Massachusetts, New York, and Texas—between October 1980 and January 1981.[18] Two persons[19] conducted interviews averaging ninety minutes and ranging from thirty minutes to three hours. The standardized interview

16. Halleck, *supra* note 11, at 391.

17. Since males accounted for 95.9% of the prisoners transferred to mental health facilities in 1978, Steadman, Monahan, Hartstone, Davis, & Robbins, *supra* note 4, at 33, we focused this study on male transfers only.

18. Vitek v. Jones, 445 U.S. 480 (1980), was decided on March 25, 1980. This study, therefore, was conceived and designed before the *Vitek* decision, but was implemented after it.

19. The authors express their appreciation to Dr. Sharon Kantorowski Davis who served as the second interviewer.

schedule covered both factual information (e.g., number of inmates transferred) and opinions (e.g., evaluation of problems in transfer procedures).

This study incorporates data from eighty-two interviews. Respondents were selected from both mental health and correctional agencies and included administrators, treatment staff, and security staff at both the mental health facilities *to which* the largest number of mentally ill inmates were transferred and the state prisons *from which* the largest number of mentally ill inmates were transferred. At the mental hospitals, we interviewed the facility director, the chief of security, two clinical service providers, and a line staff representative, for a total of five respondents. The five persons interviewed at each prison were the warden, the treatment director, two direct clinical service providers, and a correctional officer. In addition, administrators at the central offices of each state DOC and the New York State DMH were interviewed. At the DOC central offices two people were interviewed: the agency's commissioner (or a deputy commissioner), and the treatment director. In New York we also interviewed the DMH deputy commissioner and forensic director. Overall, interviews were conducted with one "human service agency" administrator, twelve administrators from DOC central offices, two administrators from DMH central offices, thirty-one prison staff, thirty DOC mental health facility staff, and six DMH mental hospital staff.

This article focuses on four issues: (1) the facility to which inmates are being transferred; (2) whether these facilities justify the label "mental hospital"; (3) whether there is a serious problem of "overidentifying" inmates for transfer; and (4) whether there is a serious problem of "underidentifying" inmates for transfer.

A. Where are Inmates Being Transferred?

A portion of the majority opinion in *Vitek v. Jones*[20] discusses why the case was not moot.[21] Jones, a convicted robber serving a three to nine year prison sentence, was transferred to the penitentiary hospital and placed in solitary confinement.[22] Jones subsequently set his mattress on fire. Prison authorities then determined "that he was suffering from a mental illness or defect and could not receive proper treatment in the penal complex, [and] he was transferred to the security unit of the Lincoln [Nebraska] Regional Center, a state mental hospital under the jurisdiction of the Department of Public Institutions."[23] Jones then joined a class action challenging the transfer procedures to the state mental hospital on due process grounds. Before the district court decided the case, Jones was transferred back to the psychiatric ward of the prison. However, he "prayed for an injunction against further transfer to Lincoln Regional Center."[24] The district court held that the case was not moot because Jones "[was] subject to and [was] in fact under threat of being transferred to the state mental hospital . . . ."[25] By the time the United

20. 445 U.S. 480 (1980).
21. *Id.* at 486-87.
22. *Id.* at 484.
23. *Id.*
24. *Id.* at 485.
25. *Id.* at 486 (quoting Miller v. Vitek, 437 F. Supp. 569 (D. Neb. 1977)).

States Supreme Court decided the case in 1980, Jones had been paroled from prison, violated his parole, and was once again back in prison.[26] Justice Blackmun, one of the four dissenters in *Vitek* argued however, that the case was moot because Jones "[did] not reside in the psychiatric unit of the Nebraska Penal and Correctional Complex, nor [was] he receiving or accepting psychiatric treatment" when the case reached the Supreme Court.[27]

The unanswered question is whether the "transfer issue" would have been raised if Jones had been transferred to the "psychiatric unit" of the prison instead of a mental hospital run by an agency, independent of the prison system. Do transfers to *prison* mental health facilities—that is, mental health facilities operated by the departments of corrections—invoke the same due process protections for prisoners as do transfers to the state mental hopsitals that *Vitek* was most directly concerned with? At least one legal scholar thinks so:

> It is one thing to conclude that you must have a hearing to be transferred from a correctional to a mental health facility. What if the transfer is simply between two correctional institutions, one of which is essentially a hospital facility? Probably, whether the facility is under the jurisdiction of the department of mental health or the department of corrections makes little difference. It is the nature of the institution itself which has consitutional significance. However, there is a broad gray area. Where the institutions are all within the corrections framework, will a court be willing to go behind the reason given for a transfer? The named plaintiff in *Vitek* had been confined in a psychiatric wing of the penal complex. No one argued that this implicated a liberty interest. If a corrections department has its own medical facility, it is likely that the court would have to be presented with substantial information concerning the differences between life in a "normal" prison unit and the medical facilty before finding a protected interest. The mere transfer would not be sufficient; some additional deprivation or "stigma" must be identified.[28]

Our research suggests that if *Vitek* is not applied to prison-operated mental health facilities, its impact will be severely limited.

In our six target states, the large majority of mentally disordered inmates transferred for mental health services were transferred to special units and facilities operated *within* the department of corrections. Five of the six target states transferred most of the mentally ill prisoners to DOC-run facilities or units. Correctional agencies in Arizona, Massachusetts, and Iowa transferred virtually all of their mentally disordered inmates into their own mental health facilities. The DOCs in California and Texas transferred most of their mentally ill inmates into treatment facilities or units operated within the DOC, while using a DMH secure facility as a secondary placement option, with no more than ten inmates transferred to DMH facilities in the preceding year. Only New York typically transferred its mentally ill inmates to a DMH-operated facility. Overall, there were approximately 4,900 inmates transferred in 1980 to mental health facilities or centers in our six target states. Eighty-eight percent (4330) of these transfers were *intra* organizational transfers.

It is also interesting to note that of our six study states, three[29] had changed

26. 445 U.S. at 486.
27. *Id.* at 505 (Blackmun, J., dissenting).
28. Churgin, *supra* note 2.
29. Arizona, California, and Texas.

their primary mental health placement from DMH to DOC since 1978, thereby reflecting a possible recent shift in transfer practices. While the exact proportion of inmates currently being transferred intra- rather than interorganizationally is uncertain, it is clear that this population is sizeable and may be increasing.

B. Do These Facilities Justify the Label "Mental Hospital"?

With regard to the nature of DOC-operated facilities, our visits to DOC mental hospitals in Massachusetts, Iowa, Arizona, and California suggested that typically these facilities were not drastically different from maximum security mental hospitals operated by state DMHs. DOC facilities appeared to possess treatment programs and staffing patterns more similar to secure DMH mental hospitals than to traditional state prisons.

When asked to describe the treatment provided in the facility, almost all the respondents in each state reported that the facility used some combination of individual and/or group therapy, psychotropic medication, behavior modification, family therapy, or milieu therapy. Our brief visit to each facility did not allow us the opportunity to assess the extent to which these programs existed in practice, the quality of the treatment provided, or to what extent they may vary across agency lines.

The staff pattern of the mental health facilities for prison transfers in the six target states is presented in table 1.

Table 1

STAFFING PATTERNS AT TRANSFER FACILITIES BY TYPE OF TRANSFER

	Intraorganizational					Interorganizational	
	Mass.**	Iowa**	Calif.*	Texas-Huntsville*	Arizona**	N.Y.*	Texas-Rusk**
Bed Capacity	442	80	940	70	40	186	354
Mean Census	355	75	900	65	30	172	275
Number of Psychiatrists	7	3	7	1	1	12	2
Patients/Psychiatrist Ratio***	49/1	25/1	127/1	65/1	30/1	14/1	138/1
Number of Psychologists	7	1	5	4	2	5	8
Patients/Psychologist Ratio***	49/1	75/1	180/1	16/1	15/1	34/1	34/1
Number of Social Workers	11	5	6	0	1	4	11
Patients/Social Worker Ratio***	32/1	15/1	150/1	—	30/1	43/1	25/1
Number of Nurses	Unknown	12	6	0	6	27	21
Patients/Nurse Ratio***	Unknown	6/1	150/1	—	5/1	6/1	13/1

* Used exclusively for inmates tranferred from prison population.

** Includes other mentally disturbed offenders as well as transfers (e.g., person found not guilty by reason of insanity, persons found incompetent to stand trial).

*** Ratio is based on the average daily census divided by number of staff positions.

This table shows that the DMH facility utilized in New York for mentally ill inmates contains the most enriched staffing pattern. With the possible exception of California, however, the facilities in the other four states all seem to possess clinical staffing patterns which clearly would warrant a mental health identification. It is our belief that given the apparent treatment that occurs within the DOC mental health facilities and the staff that are present there, any "stigma" of "unnecessary" treatment that could occur from an inappropriate transfer to a DMH mental hospital is just as likely to occur in intra-agency transfers to a DOC-operated mental health facility.

That mental health facilities operated by DOCs are more similar to civil mental hospitals operated by DMHs than they are to state prisons is illustrated by a comparison of staffing ratios of the three types of facility. In Massachusetts, for example, there is one *psychiatrist* for every forty-nine persons at the DOC facility to which prisoners are transferred, one for every sixty-eight persons at a representative civil mental hospital and one for every 699 persons at a representative maximum security prison. Likewise, there is one *psychologist* for every forty-nine persons at the transfer facility, one for every 119 persons at a representative civil mental hospital, and one for every 233 persons at the maximum security prison in Massachusetts. If anything, then, transfer facilities operated by DOCs may be more like "mental hospitals" than correctional facilities operated by state DOC's.[30]

C. Is There a Serious Problem of "Overidentifying" Inmates for Transfer?

A frequent concern in the area of prison-to-mental hospital transfer is that prison authorities will attempt "to take advantage of the psychiatric unit by deliberately making inappropriate referrals (e.g., troublesome, acting-out types)."[31] The prime factor in the Supreme Court's *Vitek* holding was the infringement of a prisoner's "liberty interest" in the instance of a transfer to a hospital for reasons having nothing to do with his mental health needs. But how serious a problem is this? Is it more serious for transfers between prisons and hospitals run by state DMHs than for transfers between prisons and prison-operated mental hospitals?

All persons interviewed in our study were asked to describe the individual problems that precipitated an inmate's transfer to a mental hosptial. The results are presented in table 2.

The potential for using mental hospitals as "dumping grounds" for difficult to manage (but not mentally disordered) inmates is illustrated by the fact that for transfers to hospitals operated by the prison system, 13.1% of the responses of the treatment staff and 19.3% of the responses of the custody staff concerned "manage-

30. *See supra* Table 1 at p. 607.
31. Gearing, Heckel & Matthey, *supra* note 11, at 854.

Table 2

TYPE OF PROBLEM EXHIBITED BY INMATES IDENTIFIED FOR TRANSFER BY TYPE OF TRANSFER AND TYPE OF STAFF

Problem	Intra-Agency Transfer*				Inter-Agency Transfer**			
	Treatment Staff		Custody Staff		Treatment Staff		Custody Staff	
	N	%	N	%	N	%	N	%
Psychotic	16	19.0	5	8.8	4	19.0	1	7.1
Other Mental Disorder	35	41.7	19	33.3	6	28.6	4	28.6
Mentally Disordered and Dangerous	6	7.2	0	—	1	4.8	0	—
Bizarre, Inappropriate Behavior	7	8.3	11	19.3	3	14.3	2	14.3
Management Problem/Violent Behavior	11	13.1	11	19.3	5	23.8	6	42.9
Other	9	10.7	11	19.3	2	9.5	1	7.1
TOTAL	84	100.0	57	100.0	21	100.0	14	100.0

* Data presented reflects information collected from 67 respondents.

** Data presented reflects information collected from 15 respondents.

ment problems" or "violent behavior" *without* any mention of mental disorder.[32] The figures for transfers to hospitals operated by DMHs are even more revealing: 23.8% of the responses of the treatment staff and 42.9% of the responses of the custody staff concerned problems of management in general or violent behavior in particular. The fact that management problems are approximately twice as likely to be mentioned as precipitating inter-agency transfers than as precipitating intra-agency transfers may underscore the fact that it is more tempting for correctional authorities to "dump" problem inmates into facilities operated by other agencies for which the correctional authorities bear no responsibility than to simply shift problem inmates between facilities (i.e., prisons and prison mental hospitals) run by the correctional authorities themselves. Even with intra-agency transfers, however, "overidentifying" inmates as mentally disordered, and in need of hospitalization, when in fact they are simply management problems appears to be a significant issue.

D. Is There a Serious Problem of "Underidentifying" Inmates for Transfer?

Vitek concerned an inmate who claimed to have been inappropriately transferred to a mental hospital. Our data suggest that such transfers are not an uncommon phenomenon. Yet what of the other side? Are significant numbers of inmates who require hospitalization to treat their mental health needs being inappropriately retained in prisons? While this "right to transfer"[33] issue was not before the court in *Vitek*, our data allow some estimation of whether, at least in the

32. For a discussion of mental disorder, see Monahan & Steadman, *supra* note 10.

33. For a suggestion that such a right exists, see Churgin, *supra* note 2.

perception of the staff dealing with them, the major issue is "overidentifying" management problems as mental health problems or "underidentifying' inmates in actual need of transfer.

All interviewees were asked to identify "major weaknesses" in the way that inmates were identified for transfer. These responses are presented in table 3.

Table 3

WEAKNESS IN IDENTIFICATION PROCESS BY TYPE OF TRANSFER*

	Intra-Agency Transfer		Inter-Agency Transfer		Total	
	%	(N)	%	(N)	%	(N)
Lack Mental Health Intake Assessment	4.4	(4)	13.3	(4)	6.6	(8)
Inadequate staff training	8.8	(8)	16.7	(5)	10.7	(13)
Not enough clinical staff	18.7	(17)	16.7	(5)	18.2	(22)
Miss mentally ill inmates	29.7	(27)	26.7	(8)	28.9	(35)
Manipulated by inmates	5.5	(5)	0.0	(0)	4.1	(5)
Identify management problems	11.0	(10)	10.0	(3)	10.8	(13)
Other	21.9	(20)	16.6	(5)	20.7	(25)
	100.0	(91)	100.0	(30)	100.0	(121)

* Table is based on 61 respondents (48 intra-agency, 13 inter-agency) and 121 responses. Percentages are calculated on the number of *responses*, not respondents. An additional 14 persons involved in intra-agency transfers (21%) said there were weaknesses in identification, and an additional 5 intra-agency and 2 inter-agency respondents said they were not informed enough to answer the question.

These data clearly show that "underidentifying" ("missing") inmates who are actually mentally disordered was mentioned by the staff as a "major weakness" in the transfer process almost three times as often (28.9%) as was "overidentifying" management problems for transfer (10.8%). Further, many of the other weaknesses mentioned bear at least indirectly on the underidentification problem: lack of mental health assessment at prison intake (6.6%), not enough clinical staff (18.2%), and inadequate staff training (10.7%). Some prison psychologists fear that the quiet crazy are not identified.

Additional support for the proposition that staff are more concerned with "underidentification" than with "overidentification" came from their responses to a question of whether, in their opinion, "too many, too few, or just the right number of persons were transferred" from prisons to mental hospitals. Table 4 displays these responses.

Eight percent of the staff involved with transfers to hospitals within the prison system thought that "too many" prisoners were being transferred and 14.3% of the

Table 4

NUMBER OF INMATES TRANSFERRED BY TYPE OF TRANSFER AND TYPE OF STAFF

	Intra-Agency Transfers*						Inter-Agency Transfers**					
	Treatment Staff		Custody Staff		Total		Treatment Staff		Custody Staff		Total	
	%	(N)	%	(N)	%	(N)	%	(N)	%	(N)	%	(N)
Too Few	48.6	(17)	42.9	(12)	46.0	(29)	33.3	(3)	60.0	(3)	42.9	(6)
Just Right	45.7	(16)	46.4	(13)	46.0	(29)	55.6	(5)	20.0	(1)	42.9	(6)
Too Many	5.7	(2)	10.7	(3)	8.0	(5)	11.1	(1)	20.0	(1)	14.3	(2)

* Data was collected from 63 respondents. Four respondents felt they were unable to answer the question.

** Data was collected from 14 respondents. One respondent felt that he was unable to answer the question.

staff involved in inter-agency transfers felt likewise. This compares with 46% and 42.9% of the staff in both types of transfer, respectively, who believed that "too few" prisoners were being transferred. Over four times as many staff, therefore, felt that *more* prisoners deserved transfer than felt that *fewer* deserved it.

IV

CONCLUSIONS

The data we have presented indicate that the United States Supreme Court in *Vitek*[34] addressed an important problem in prison and mental health law by providing safeguards to reduce the risk of a prisoner's being inappropriately transferred to a mental hospital. The data also indicate, however, that if *Vitek* is to have the effect of protecting the "liberty interests" of prisoners, it must be read broadly to include transfer to *any* mental hospital and not just a civil hospital operated by a state DMH. Further, *Vitek* dealt only with the "negative right" of a prisoner to be protected from unnecessary state intervention in his or her life in the form of transfer to a mental hospital. The much more difficult issue—yet the one our data suggest is in more urgent need of resolution—of the "positive right" of prisoners who *are* mentally disordered and in need of hospitalization *to be* transferred to a hospital remains to be addressed.

More prisoners serving active sentences are admitted to mental hospitals each year than the *combined* number of persons hospitalized after having been adjudicated incompetent to stand trial, found not guilty by reason of insanity, or adjudged mentally disordered sex offenders.[35] Why, then, are there scores of studies on each of these other three types of "mentally disordered offender"[36] and virtually none on prison-to-mental hospital transfers? Perhaps the low visibility of transfer decisions in the past has impeded empirical work. Unlike the courtroom

34. 445 U.S. 480 (1980).
35. Steadman, Monahan, Hartstone, Davis, & Robbins, *supra* note 4, at 33.
36. *See generally* Monahan & Steadman, *supra* note 10.

adjudication of incompetence, insanity, or mentally disordered sex offender status, the "adjudication" of suitability for transfer occurs in the hospital consulting room when the admitting clinician says, "OK, we'll take him." By mandating a formal, visible hearing in order to transfer an inmate, *Vitek* may provide precisely the kind of discrete forum that attracts the attention of researchers. With burgeoning prison populations and the attendant problems of severe overcrowding, the temptation for prison wardens to "transfer out" as many inmates as possible may grow more acute. At the same time, with increasingly severe cutbacks in the funding of mental health and other human services, the temptation for mental hospital superintendants to refuse admission to prisoners may grow equally strong. How these competing challenges are resolved may be among the most interesting questions to confront social scientists in this area for some time.