

Class Action Litigation in Correctional Psychiatry

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Class action litigation has been instrumental in jail and prison reform during the past two decades. Correctional mental health systems have significantly benefited from such litigation. Forensic psychiatrists have been crucial in the litigation process and the subsequent evolution of correctional mental health care systems. This article summarizes information concerning basic demographics of correctional populations and costs of correctional health care and provides a brief history of such litigation. The role of psychiatric experts, with particular reference to standards of care, is described. Specifically discussed are issues relevant to suicide prevention, the prevalence of mentally ill inmates in supermax prisons, and discharge planning.

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During the past two decades, class action litigation has been used to bring about prison reform. In particular, correctional mental health systems have benefited from such litigation, which has frequently resulted in correctional institutions becoming more humane and safer for both prisoners and correctional staff. Forensic psychiatrists have been crucial in the litigation process and the subsequent evolution of correctional mental health care systems. This is an overview and brief history of the litigation that has included a focus on correctional mental health care systems.

The number of persons incarcerated in prisons and jails in the United States has risen dramatically during the past two decades, with a significant increase in inmates with serious mental illness. This article summarizes information concerning basic demographics of correctional populations and correctional health care costs and briefly reviews major court decisions concerning the right to mental health treatment in jails and prisons. The role of psychiatric experts is described, with particular reference to issues relevant to standards of care based on my own

experiences with this type of litigation. Specifically discussed are suicide prevention, the prevalence of mentally ill inmates in super-maximum-security (supermax) prisons, and discharge planning. The term “inmates” is used throughout to refer to both pretrial detainees and prison inmates, despite clear differences in their legal status.

Basic Demographics

There were 1,931,859 persons incarcerated in prisons and jails within the United States at midyear 2000, which represented a 56 percent increase in the total number of inmates in custody when compared with the correctional population in 1990 at year's end. The total correctional population included 92,688 women, accounting for 6.7 percent of all prisoners nationwide. Inmates in state prisons, the District of Columbia, and the federal prison system accounted for two thirds of the incarcerated population (1,310,710 inmates). These inmates were housed in approximately 1,668 different facilities.¹ The remaining third (621,149) were held in more than 3,300 local jails.^{2,3}

Studies and clinical experience have consistently indicated that 8 to 19 percent of prison inmates have psychiatric disorders that result in significant functional disabilities and another 15 to 20 percent will require some form of psychiatric intervention during

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their incarceration.^{4,5} According to Bureau of Justice statistics, an estimated 283,800 mentally ill offenders were incarcerated in U.S. prisons and jails at midyear 1998. Approximately 16 percent of state prison and jail inmates reported a mental or emotional condition and/or said they had stayed overnight in a mental hospital or program.⁶

There have been numerous reports and studies about the prevalence of mental disorders among prison and jail inmates.⁷⁻¹⁷ Despite methodological problems in many of these studies, the 8 to 19 percent prevalence rates are consistent with recently obtained statistics in both small and large prison systems across the United States (e.g., 24% of the inmates in the Vermont Department of Corrections during July 2001 were listed on the mental health caseload; during 2000, approximately 18% of the prison inmate population in Massachusetts were listed; 13.5% of the inmate population in the Ohio Department of Rehabilitation and Correction were listed on the caseload during 1999; the Georgia Department of Corrections had 12.5% of their inmate population on the mental health caseload during the first half of 2001; during July 2001, 6.1% of all inmates in the Michigan Department of Corrections were on the active correctional mental health program caseload and another 6% of the inmates, who had a history of mental health treatment in the Michigan Department of Corrections, had inactive status—that is, they were not being seen on a regularly scheduled basis by mental health staff.¹⁸⁻²² The variation in the mental health caseload percentages across systems is most likely explained by several factors that include different criteria for eligibility for mental health treatment (e.g., do anxiety disorders qualify?) and criteria used for discharging inmates from mental health treatment.

A very high prevalence rate of substance abuse disorders among male prisoners has been reported frequently.²³ High base rates of mental disorders in prison populations, associated with significant addictive disorder comorbidity, were also found in the National Institute of Mental Health Epidemiologic Catchment Area Study.²⁴

Health Care Costs of Incarceration

It is not surprising that many correctional systems have been successfully sued because they did not have the needed financial resources to provide adequate mental health care. The annual costs per inmate for

physical, mental, and dental care have been rising because of continued increases in pharmaceutical costs, an aging prison population, increased incidence of infectious diseases such as AIDS and hepatitis C, and increased numbers of mentally ill inmates. The nationwide expenditure by states on prisoner medical and dental care of \$2.5 billion was approximately 12 percent of total prison operating expenditures, with health care, as a percentage of department of corrections budget, ranging among the states from approximately 5 percent to almost 17 percent. The mental health costs as a percentage of correctional health care budgets, when known, range from 5.41 percent (Minnesota) to 42.66 percent (Michigan), with an average of 17 percent among 16 reporting states. Medical and dental care per inmate costs an annual average of \$2,386.00 or \$6.54 per day. By comparison, in 1995, on average, each U.S. resident spent \$1,807.00 annually or \$4.95 per day for personal health care.^{25,26}

Right to Treatment

Major problems in identifying prisoners with mental illnesses and providing treatment to them have been experienced by correctional systems throughout the United States. Cohen^{27,28} and Sturm²⁹ have written extensively about the legal bases for requiring mental health services in correctional facilities and the process of corrections litigation. In *Cooper v. Pate* (1964),³⁰ the U.S. Supreme Court established that prisoners had constitutional rights. *Estelle v. Gamble* (1976)³¹ clearly established an inmate's constitutional right to medical care. The Court decided that "deliberate indifference" to the serious medical needs of prisoners constitutes unnecessary and wanton infliction of pain, which violates the Eighth Amendment's protection against cruel and unusual punishment. In *Bowring v. Godwin* (1977),³² a federal court of appeals found "no underlying distinction from the right to medical care for physical ills and its psychological or psychiatric counterpart." *Bell v. Wolfish* (1979)³³ stood for the proposition that denial of health care to pretrial detainees may result in the infliction of needless suffering or death and that the Due Process Clause mandates appropriate medical or mental health intervention incident to the captivity.²⁸ *Ruiz v. Estelle* (1980)³⁴ provided a useful framework for required components of a constitutionally adequate mental health

system in the context of litigation involving the Texas Department of Corrections.

These landmark decisions have established the right of inmates to file cases in state and federal court to challenge the conditions of their confinement in correctional facilities. Such lawsuits are commonly known as Section 1983 lawsuits, because they are filed under § 1983 of Title 42 of the U.S. Code. Section 1983 lawsuits stem from legislation passed by the U.S. Congress after the Civil War to protect African Americans in the South from reprisals during Reconstruction. During the early 1960s this Act was interpreted by the U.S. Supreme Court to allow prison and jail inmates to raise claims challenging the conditions of their confinements on the grounds that the conditions violated their constitutional rights.³⁵

Early Prison Litigation

Sturm²⁹ provides a very thoughtful and detailed history of the litigation process involving correctional institutions. Until the 1960s, the courts adopted a hands-off approach to prison cases. Correctional institutions were isolated from and invisible to society. Conditions in these facilities were frequently wretched. Various Southern prisons had implemented a “plantation” model that was dependent on inmate labor, management by inmate trustees, and the financial self-sufficiency of the prison system. Specific problems identified in prisons included the use of building tenders or trustees (i.e., inmate guards), excessive use of force (i.e., staff brutality), inmates segregated by race (with unequal conditions and programs), and denial of free speech and religion. During the 1960s, courts began applying the First Amendment and Due Process Clause to prisons, which resulted in the invalidation of many prison rules and procedures. These cases demonstrate the importance of our Constitution in protecting basic human rights.

Newman v. Alabama (1977)³⁶ was the first case won on the theory that the totality of conditions in the prison constituted cruel and unusual punishment. Areas litigated in such cases include, but are not limited to, overcrowding, security (includes classification system) and inmate supervision, health care, excessive use of force, discipline, access to legal services, and sanitation and safety conditions.

Efforts to establish adequate mental health systems in prisons were accelerated during the 1970s as a result of successful class action lawsuits. Class ac-

tion litigation has clearly been one of the most significant forces of change regarding conditions in correctional institutions. The National Prison Project (established by the American Civil Liberties Union), various public interest and advocacy groups, private attorneys, and the Special Litigation Section of the Civil Rights Division of the U.S. Department of Justice have been instrumental in such litigation. Sturm²⁹ has also identified the important role of “crucial insiders” in this litigation. During 1988, at least one prison in each of 21 states incurred a certified class action lawsuit involving the provision of adequate mental health services for inmates.³⁷

Litigation has clearly facilitated the development of policies and procedures designed to provide at least minimally adequate treatment of inmates within correctional systems. Professional organizations have been instrumental in developing national standards and guidelines for health care services in correctional institutions.^{38–44} Trial courts frequently refer to national standards and guidelines developed by these organizations, despite the Supreme Court’s rejection of the wholesale adoption of professional standards as a basis for defining constitutional standards.^{29,45}

In *Estelle v. Gamble*,³¹ the Court made it clear that a single episode of medical malpractice was not equivalent to deliberate indifference (i.e., was not a constitutional violation). However, repetitive occurrences of providing health care that does not meet the standard of care has been found to be “systemic malpractice,” which may meet the deliberate-indifference standard required for a finding of a constitutional violation. This is one of the reasons that professional health care organizations’ guidelines and standards are relevant in many trial courts.

Evolution of Prison Litigation

Prison litigation has evolved from a test-case model to the current implementation model of reform. *Brown v. Board of Education* (1954)⁴⁶ popularized the litigation strategy known as the test-case model of law reform, which dominated the early days of the prisoners’ rights movement. The strategy focused on bringing cases that would establish new constitutional protections for inmates, which would then set precedents that would affect many correctional systems. Many prison regulations were invalidated by the courts during the 1960s based on the First Amendment and Due Process. The test-case

model emphasizes the liability phase of litigation. However, this type of litigation was not uniformly effective in either promoting constitutional compliance or initiating systemic reform.²⁹

An implementation model of litigation has evolved that focuses on achieving and maintaining institutional reform. Judges and litigators have developed more cooperative forms of fact-finding, remedial formulation, and monitoring that minimize the negative effects of the adversary process and enhance the possibility of cooperative approaches to solving problems identified through litigation or threat of litigation.²⁹ One of the best examples of this model was the consent decree issued in *Dunn v. Voinovich* (1993),^{47,48} which was a class action suit that focused on the mental health services available to inmates in the Ohio Department of Rehabilitation and Correction.

However, strong forces continue to oppose prison reform, especially if it is mandated by judicial interventions. Cohen⁴⁹ describes in detail the conservative tone established by the present Supreme Court, which means that an inmate's basic constitutional rights to minimal physical and psychological care are not likely to be enriched or expanded in the near future. The Prison Litigation Reform Act (PLRA) of 1996 (18 U.S.C. § 3626 (b)),² has had a negative impact on the legal-claims process of inmates. The PLRA established new procedural requirements for litigation by prisoners and significantly limited the ability of the courts to order relief.

The role of experts in correctional mental health litigation has become more complex and essential, especially related to the implementation model.⁵⁰ Psychiatrists often serve as the court's expert and/or the agreed-upon expert(s) among the parties in these lawsuits, especially after resolution of the initial liability issues.

Class action litigation in correctional facilities can be conceptualized as having the following three phases: the liability phase (legally determining whether constitutional deficiencies exist), the remedial phase (developing a remedy to identified constitutional deficiencies), and the implementation phase (implementing the remedial plan). Examples of the psychiatric expert's role in these phases are described briefly in the following sections.

The Liability Phase

From the 1960s through the 1980s, the liability phase was generally the shortest and "easiest" phase

from the plaintiff's attorney's perspective, because the facts of the case often clearly favored the plaintiffs. However, there were obviously many obstacles for the plaintiffs to overcome during this phase.

Class action litigation in correctional facilities during the past decade has focused on overcrowding, environmental health and safety, violence, and health care. Relevant to this article, several class action suits in various state prison systems have focused solely on the adequacy of mental health care provided to inmates with serious mental illnesses. This is becoming more common in the so-called supermax facilities, which are described further in a later section.

Standards of care are obviously important in determining the adequacy of mental health systems in this type of litigation. An essential role of the psychiatric expert is to identify for the court the standards of psychiatric care that are relevant to the correctional mental health system in question and provide an objective analysis of the specific correctional mental health system in place at the time of the litigation. The development of national standards and guidelines by various health care organizations, especially the National Commission on Correctional Health Care and the American Psychiatric Association (APA) has provided a useful framework for the expert in articulating pertinent standards of care.^{43,44}

The Remedial Phase

The remedial phase has become less difficult with time as models have been developed across the country that provide blueprints for remedial plans that could be tailored to the specific systems in question.

*Ruiz v. Estelle*³⁴ is frequently cited as providing a useful framework for designing remedial plans relevant to correctional mental health systems.^{28,44} This decision described six minimal essential elements for such services: (1) systematic screening and evaluation, (2) treatment that is more than mere seclusion or close supervision, (3) participation by trained mental health professionals, (4) accurate, complete, and confidential records, (5) safeguards against psychotropic medication prescribed in dangerous amounts, without adequate supervision, or otherwise inappropriately administered, and (6) a suicide prevention program.

The national standards and guidelines by various health care organizations have also facilitated development of remedial plans.^{43,44} They have incorpo-

rated and expanded the framework established in *Ruiz v. Estelle*. Significantly, the guidelines for psychiatric services in jails and prisons developed by a task force of the APA addressed quality of care by stating “the fundamental policy goal for correctional mental health care is to provide the same level of mental health services to each patient in the criminal justice process that *should* (emphasis added) be available in the community.”⁴⁴

Cohen⁵¹ has emphasized an access concept as a conceptual framework for remedial plans that essentially states that constitutionally adequate correctional mental health systems are characterized by adequate access for inmates to necessary physical and human resources within a reasonable period.

Standards of care are obviously important in determining the adequacy of proposed remedial plans. A crucial role of the psychiatric expert is to identify for the court standards of psychiatric care relevant to the remedial plan. This may become difficult when needed data are not available or new correctional practices are evolving. Examples of these difficulties are provided in the section of this article regarding standards of care.

Implementation Phase

Implementation of the remedial plan is the most difficult phase. This phase is frequently time consuming (three or more years) and expensive. Certain basic elements of remedial plans have been implemented without significant difficulty, because they have been accepted for many years as a standard of care. For example, results of a 1994 national survey of all state prison systems showed that virtually all departments of corrections provide reception mental health screening or prompt mental health screening of all newly admitted inmates.^{1,52} Rowan and Hayes⁵³ and Cox⁵⁴ have been instrumental in the correctional mental health field in developing suicide-prevention protocols⁴³ that have been adopted by many correctional mental health care systems.

The largest barrier to implementation of many remedial plans is invariably the availability of resources (both physical and human). Adequate physical resources are needed for treatment program space and supplies. Adequate human resources (i.e., enough properly trained and/or experienced mental health staff) are needed to identify and/or provide treatment to inmates with serious mental illnesses. Obviously, both cost money, and personnel are fre-

quently difficult to recruit when the prison is located in a rural area. Even more difficult and time consuming is capital construction and renovation. Even when funded by the legislature, these generally require two to five years for completion.

Most correctional systems that have been successfully sued in class action litigation relevant to mental health services have lacked adequate services in a residential treatment setting for inmates with serious mental illnesses. Such treatment settings have a variety of names: special living units, special needs units, residential treatment programs, extended outpatient programs, and intermediate care units. The author⁵⁵ and Haddad⁵⁶ have provided a summary of such programs.

The expert’s role in this phase often involves a delicate balance between monitoring (i.e., is the remedial plan being implemented as ordered?) and consultation with both the plaintiffs and defendants on a wide variety of subjects. The balance is also affected by the nature of the monitoring that is established by the involved parties or by the court. The continued annual growth of the correctional population, which often results in overcrowding, and the frequent difficulty in changing long-standing institutional cultural beliefs and practices are other major challenges to successful implementation of remedial plans.

Standards of Mental Health Care

I have chosen to discuss three specific standards of care involved in correctional mental health care for three reasons: First, they provide different examples of pitfalls or difficulties encountered by the forensic psychiatrist in formulating opinions that often have far-reaching consequences in this type of litigation. Second, suicide rates in jails and prisons are commonly discussed in a manner that is misleading. Finally, standards of mental health care are currently being shaped by class action litigation involving supermax prisons and discharge planning for inmates with serious mental illnesses.

Suicide Prevention

The suicide rate in a specific jail or prison has often been used to support the legal argument that the mental health system in a particular facility does not meet the standard of care, which has obvious liability implications. Suicide was the third leading cause of death in prisons between 1995 and 1999 and the

second leading cause of death in jails from July 1, 1998 to June 30, 1999. Before the early 1980s, good data that could serve as a norm for comparison purposes were not available to calculate the suicide rate nationwide in correctional institutions. This often made it difficult for experts to assess the adequacy of such programs and the standards of care.

Data became available during the 1980s. The National Center on Institutions and Alternatives (NCIA), a nonprofit agency that promotes criminal justice reform in the United States, reported that the suicide rate in county jails (107/100,000 inmates) was approximately nine times greater than that in the general population.⁵⁷ Hayes⁵⁸ also described the NCIA's national survey results pertinent to suicides in prisons during 1993. Based on a total prison population of 889,836 inmates, the national suicide rate for 1993 was reported as 17.8 per 100,000 inmates, which was considered to be more than 1.5 times the rate in the general population.

Studies by Hayes and others have been invaluable to the field of correctional mental health in raising awareness concerning the problems of suicides in correctional facilities and in stimulating development of effective suicide prevention programs.^{43,59} These needed data served as one of the foundations for programs now considered to represent the standards of care for suicide prevention.^{41,42} Detailed discussions of the specific components are provided in a National Commission on Correctional Health Care (NCCHC) publication.⁴³ There is little doubt that successful implementation of suicide prevention programs results in a significantly decreased suicide rate in correctional facilities.^{54,60} It is for this reason that so much emphasis in correctional mental health systems is appropriately placed on suicide prevention programs.

However, the suicide rates per 100,000 inmates that have been referenced in this section are misleading. These rates have been calculated based on the average daily population (ADP) nationwide of persons incarcerated in either jails or prisons. There are a number of reasons that such rates should not be calculated in this fashion, the most compelling one being that this method does not factor in the admission rates for jails and prisons. Annual prison admission rates, which include newly sentenced inmates and individuals returned to custody, are equal to approximately 50 percent of the average daily prison population. In rounded figures, the ADP of the na-

tion's prisons in 1995 was approximately 1 million with approximately 500,000 total admissions. In contrast, during 1995, the ADP of the nation's jails was approximately 500,000, with between 10 million and 13 million admissions during that same period. O'Toole⁶¹ correctly points out that although the ADP may serve as a defining statistic for prisons, at least for the purpose of calculating suicide rates, ADPs are only marginally useful for calculating such rates in jails. This is especially true, because research has demonstrated that most jail suicides occur during the first 24 hours of incarceration.

O'Toole⁶¹ uses a hypothetical jail and prison, each of which has an ADP of 1,000 inmates. Consistent with the previously described admission rates during 1995, this jail would be expected to have approximately 23,000 admissions in a 12-month period, which means that more than 23,500 inmates would have been incarcerated in this jail during that same period. The 1,000-bed prison would be expected to admit 500 inmates during the same period, which would mean that approximately 1,500 inmates were incarcerated in this prison during the study period. Assuming that both the jail and prison during 1995 each had 10 suicides, the suicide rate reported for each would be the same, if the previous method for calculating such rates was used, despite the fact that the jail would have processed more than 23,500 individuals and the prison only 1,500. This obviously would not be a fair comparison.⁶¹

The other major methodological flaw in the suicide rate calculations involves equating the correctional population with the free world general population. Minorities and younger male adults are overrepresented in jails and prisons compared with the free world. At the very least, the reported suicide rates should be adjusted to reflect both gender and age.

The national age-adjusted suicide rate in the United States during 1992 was 11.1 per 100,000 persons. White men, aged 20 to 24 years, had a suicide rate of 26.6 per 100,000, which compared with a rate of 21.2 per 100,000 African-American men of the same age. For 20- to 24-year-old women, the suicide rate was 4.4 per 100,000 white women and 2.4 per 100,000 African-American women. These rates were based on population reports compiled by the United States Bureau of the Census during 1992.⁶²

Finally, using the annual suicide rate in a specific prison or jail as a benchmark for the adequacy of the suicide-prevention program is problematic. The low base rate of inmates who commit suicide during a specific year may lead to inaccurate conclusions. Reviewing the suicide rate within the jail or prison during a five-year period would result in a more accurate assessment of the adequacy of the suicide prevention program.

Expert witnesses can unintentionally mislead the court regarding the adequacy of a correctional mental health system, especially in the liability and remedial phases of the litigation, if their opinions are based on suicide rates that are not appropriately adjusted and matched, as previously described, for comparison purposes to either the general population or other correctional facilities.

Prevalence of Inmates with Serious Mental Illness in Supermax Prisons

It is often difficult to determine the appropriate standard of mental health care in a correctional facility, especially if the facility is not a standard prison or jail. For example, what is the standard of care for treating inmates with serious mental illnesses in supermax prisons? This section provides a summary of relevant issues and articulates the standard that has evolved during the past five years.

During the past decade many prison systems have constructed facilities or units with the specific purpose of incarcerating inmates under highly isolated conditions with very limited access to programs, exercise, staff, or other inmates. The use of these facilities in more than 30 states represents a philosophical change in correctional management of troublesome inmates from a "dispersion" approach to a "concentration" approach. The underlying premise of the concentration approach is that general-population prisons will be safer and more efficiently managed if the troublemakers are completely removed.⁶³

The National Institute of Corrections described results of a nationwide survey of supermax housing practices during December 1996.⁶⁴ A surprising result, based on survey findings and discussions with department of corrections staffs from many states, was the lack of a common definition of supermax housing. In other words, housing that qualifies as super-maximum security in one jurisdiction may not be considered so in another jurisdiction. The surveyed states indicated a need for supermax beds rang-

ing from 0 to 20 percent of the system's overall bed capacity.

The scientific literature is sparse concerning the impact of locking an inmate in an isolated cell for an average of 23 hours a day with limited human interaction, with minimal or no participation in programs, and in an environment that is designed to exert maximum control over the individual. It has been this psychiatrist's experience that mental health clinicians working in such facilities frequently report that it is not uncommon to observe many inmates, who did not have preexisting serious mental disorders, become irritable and anxious and display other dysphoric symptoms when housed in these units for long periods.

Zinger and Wichmann⁶⁵ provide a very useful literature review relevant to the psychological effects of 60 days in segregation. They point out that the literature in this area is conflicting, filled with speculations, and often based on far-fetched extrapolations and generalizations. Methodologic shortcomings apparent from reviewing the literature include reliance on anecdotal evidence, wide variation in the conditions of confinement in different prisons, and an overreliance on field and laboratory experiments pertinent to sensory deprivation.

Zubek *et al.*⁶⁶ conceptualize segregation units as having three main characteristics: social isolation, sensory deprivation, and confinement. Each of these elements can vary significantly, as do different inmates' responses to segregation. In general, decreased or altered social interactions of inmates in supermax facilities appear to be more of a problem from a mental health perspective than does sensory deprivation. Many of the surroundings in such facilities are characterized by sensory overstimulation (e.g., inmates yelling to communicate or for other reasons). Radios and television sets, which are usually available in these housing units, can eliminate or decrease sensory deprivation, although the severe disruption in normal social interactions remains a problem.

There is general consensus among clinicians that placement of inmates with serious mental illnesses in these settings is contraindicated, because many of these inmates' psychiatric conditions will clinically deteriorate or not improve.⁶⁷ In other words, many inmates with serious mental illnesses are harmed when placed in a supermax setting. In addition to potential litigation, this is one of the main reasons that an increasing number of supermax facilities ex-

clude from admission inmates with serious mental illnesses.

A mental health screening process, which should include screening assessments at the sending facility and the receiving supermax prison, is the mechanism used for timely identification of inmates with serious mental illnesses. In addition to such inmates, developmentally delayed inmates are usually excluded from admission, unless there is a specialized mental health program within the supermax prison similar to residential treatment programs for general-population inmates with serious mental illnesses.^{55,56}

These programs (also known as special needs units, special living units, or intermediate care units) should offer at least 10 to 15 hours a week of out-of-cell, structured therapeutic activities in addition to at least another 10 hours a week of unstructured exercise or recreation time. These inmates retain their supermax classification, which means that the correctional officer staffing should be rich in numbers to comply with security regulations (e.g., two correctional officers may be required to escort each inmate who is removed from the cell).

Regardless of the policy for admission or exclusion of inmates with serious mental illnesses, mental health staff should regularly perform rounds in all the housing units within a supermax prison as a further mental health screening procedure. This screening process is necessary, because it is frequently not possible to predict a particular inmate's reaction to extended confinement in a segregation (i.e., lockdown) unit. Establishment of a psychiatric liaison consultation model with the correctional and health care staffs, along with the rounds process, can facilitate timely identification of inmates who are exhibiting acute symptoms of mental illness and the provision of appropriate clinical interventions.

The standard of care relevant to supermax prisons and inmates with serious mental illnesses has become clearer as the result of clinical experience and litigation. Although there may be exceptions, it is my opinion that the standard of care should now require either exclusion of seriously mentally ill inmates through the previously referenced screening processes or their transfer to a specialized mental health program within the supermax prison, as previously described.

Supermax prisons that house inmates with serious mental illnesses without providing them with necessary mental health treatment (e.g., residential treat-

ment programs) have significant liability risks and do a disservice to both the correctional staff and the supermax inmates (especially, those with serious mental illnesses). The correctional staff in such a facility has to deal with more behavioral management problems, with a subsequent increase in staff injuries and decrease in staff morale. Inmates with serious mental illnesses suffer because their mental illnesses are not adequately treated, often resulting in either clinical deterioration or lack of improvement. Finally, other inmates experience the stress and distress of living in an environment that is not only extremely restrictive, but also frequently chaotic.

Discharge Planning

One last example relevant to developing standards of care involves discharge planning. For many reasons, such as overcrowding, class action litigation is now paying more attention to the discharge planning process for inmates with serious mental illnesses.

The number of U.S. adults on probation or parole has significantly increased in the past two decades. A total of 3,417,613 adult men and women were on probation in the United States at year-end 1998, representing a growth of 3.7 percent during the year. The adult parole population grew 1.5 percent to a total of 704,964 by December 31, 1998.⁶⁸ In other words, approximately 2.9 percent of the U.S. adult population, or 1 in every 34 adults, was incarcerated or on probation or parole at year's end in 1998. A significant percentage of these persons were receiving psychiatric treatment before probation or parole.

Discharge planning is an essential component of mental health treatment. It is the process of planning and arranging for a patient with mental illness to continue to receive an appropriate level of treatment after discharge from the care of the current provider. The earlier correctional mental health litigation did not emphasize discharge planning, because the focus was on implementing very basic mental health services in the prison or jail system. However, as these mental health systems have developed and matured, discharge planning services are now receiving more intense scrutiny.

The extent of discharge planning services that should be provided to an inmate depends on a variety of factors, including the nature and severity of the inmate's mental illness, the scope of mental health services provided to the inmate during incarceration,

and the inmate's ability to function independently after discharge.

Obstacles to effective transition to the community include homelessness, symptoms associated with mental illness (such as denial, socialization skills deficits, and cognitive impairments), lack of financial resources and barriers to obtaining entitlements, comorbid substance-use disorders, and difficulties accessing the mental health treatment system.^{69,70}

Adequate discharge planning includes: (1) creating a written service plan that identifies the needs of the inmate and the appropriate resources available to him or her after release, (2) referring and linking (facilitating the connection of) inmates to community-based mental health services, (3) providing inmates with the temporary supply of medication when clinically appropriate, (4) referring and/or linking inmates to appropriate available housing if they are likely to be homeless after their release, and (5) assisting the inmate to obtain necessary financial benefits.

The APA guidelines emphasize that timely and effective discharge planning is essential to continuity of care and is an integral part of adequate mental health treatment. The guidelines recommend that discharge planning be part of the initial treatment plan, because discharges from correctional facilities often occur on short notice.

The important potential of the family, when available, in the discharge planning process is also recognized by the APA guidelines.⁴⁴ Steadman *et al.* describe the importance of "boundary spanners" (liaisons for coordination of activities among correctional, mental health, and judicial staff) in the discharge treatment process.⁷¹ Silberberg *et al.* argue for increased use of mandatory outpatient treatment for mentally ill offenders, which will require adequate funding to ensure sufficient community mental health resources, education of judges concerning the benefits of current mental health treatments, and improved training for psychiatrists in the psychotherapeutic aspects of mandated outpatient care.⁷² However, whether coercion itself results in better psychiatric outcomes remains controversial. There are model programs that have incorporated principles of adequate discharge planning with very encouraging results.⁷²⁻⁷⁵

At this writing, a class action suit, *Brad H. v. City of New York*, is in litigation in a state trial court. The suit claims that inmates who are or will be confined

in New York City jails for 24 hours or more and who, during their confinement, have received, are receiving, or will receive treatment for mental illness, have a right to adequate discharge planning based primarily on New York City's statutory and administrative law.⁷⁶ The outcome of this case has significant potential for shaping nationwide correctional mental health practices relevant to discharge planning.

In a related case, *Wakefield v. Thompson* (1999), the U.S. Ninth Circuit Court of Appeals ruled that a state must provide an outgoing prisoner, who was receiving and continues to need medication, with a supply sufficient to ensure that the inmate has the medication during a period reasonably long enough for the inmate to consult a doctor to obtain a new supply.⁷⁷ This decision did not establish a constitutional right for a mentally ill inmate to receive discharge planning but appears to establish a constitutional right to implement medically necessary components of the discharge plan (e.g., administration of an adequate supply of discharge psychotropic medications) when such planning for an inmate with serious mental illness has occurred.

Remember that the APA guidelines⁴⁴ use the term "should be" in contrast to "is" when describing the fundamental policy goal for correctional mental health care as providing the same level of mental health services to each patient in the criminal justice process that should be available in the community. It is my opinion that the standard of care requires that discharge planning occur in a timely fashion for inmates with serious mental illnesses, although the extent of discharge planning services will vary as previously summarized. I do not believe that correctional mental health staff members should be responsible for establishing needed community resources when they are not currently available. However, reasonable attempts should be made to link inmates in need of specific services to available resources in the community. It is recommended, but not required, from a standard-of-care perspective, that mental health staff advocate for relevant services that are needed in the community but are not currently available to inmates who are discharged.

Conclusions

Mental health systems are now recognized to be an essential component of correctional systems throughout the United States. Class action litigation has facilitated the development of many of these sys-

tems, because it has helped to obtain needed resources and decreased long-standing institutional barriers. Involvement by forensic and clinical psychiatrists in this litigation process often results in very positive changes within the correctional mental health system. These changes benefit both inmates and correctional staff from a variety of perspectives that include better living and working environments. Many opportunities remain for psychiatrists to contribute to this rewarding specialty of psychiatry.

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References

1. Beck AJ, Maruschak LM: Mental health treatment in state prisons, 2000. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics Special Report, NCJ 188215, 2001, pp 1–8
2. Beck AJ: Prison and jail inmates at midyear 1999. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics, NCJ 181643, 2000, pp 1–12
3. Beck AJ, Karberg JC: Prison and jail inmates at midyear 2000. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics Bulletin, NCJ 185989, 2001, pp 1–12
4. Metzner JL: Guidelines for psychiatric services in prisons. *Crim Behav Ment Health* 3:252–67, 1993
5. Morrissey JP, Swanson JW, Goldstrom I, Rudolph L, Manderscheid RW: Overview of Mental Health Services by State Adult Correctional Facilities: United States, 1988. Washington, DC: U.S. Department of Health and Human Services, publication (SMA)93-1993, 1993, pp 1–13
6. Ditton PM: Mental health and treatment of inmates and probationers. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics Special Report, NCJ 174463, 1999, pp 1–12
7. Roth LH, Ervin FR: Psychiatric care of federal prisoners. *Am J Psychiatry* 128:56–61, 1971
8. James JF, Gregory D, Jones RK, Rundell OH: Psychiatric morbidity in prisons. *Hosp Community Psychiatry* 31:675–7, 1980
9. Steadman HJ, Monahan J, Hartsone E, Davis SK, Robbins PC: Mentally disordered offenders: a national survey of the patient and facilities. *Law Hum Behav* 6:31–8, 1982
10. McCarthy B: Mentally ill and mentally retarded offenders in corrections, in *Sourcebook on the Mentally Disordered Prisoner*. Edited by Tracy TF. Washington, DC: US Department of Justice, 1985, pp 13–30
11. Neighbors HW: The prevalence of mental disorder in Michigan prisons. Washington University (St. Louis), Department of Psychiatry, *DIS Newsletter* 7:8–11, 1987
12. Jemelka R, Trupin E, Childs J: The mentally ill in prisons: a review. *Hosp Community Psychiatry* 40:481–91, 1989
13. Goldstrom ID, Manderscheid RW, Rudolph LA: Mental health services in state adult correctional facilities, in *Mental Health, United States*. Edited by Manderscheid R, Sonnenschein M. Washington, DC: U.S. Government Printing Office, 1992, pp 231–54
14. Lamb RH, Weinberger LE: Persons with severe mental illness in jails and prisons: a review. *Psychiatr Serv* 49:483–92, 1998
15. Teplin LA: The prevalence of severe mental disorder among male urban detainees: comparison with the epidemiologic catchment area program. *Am J Public Health* 80:663–9, 1990
16. Teplin LA: Psychiatric and substance abuse disorders among male urban jail detainees. *Am J Public Health* 8:290–3, 1994
17. Metzner JL, Cohen F, Grossman LS, Wettstein RM: Treatment in jails and prisons, in *Treatment of Offenders with Mental Disorders*. Edited by Wettstein RM. New York: The Guilford Press, 1998, pp 211–64
18. Powell T, personal communication, July 2001
19. Appelbaum K, personal communication, June 2001
20. Cohen F: Fourth annual report as required by the Dunn Consent Decree in the United States District Court for the Southern District of Ohio, Case No. C1-93-0166, 1999
21. DeGroot J, personal communication, June 2001
22. Rome L, personal communication, July 2001
23. Beck A, Gilliard D, Greenfeld L, *et al*: Survey of state prison inmates, 1991. Washington DC: U.S. Department of Justice, Bureau of Justice Statistics, NCJ 136949, 1993, pp 1–34
24. Regier DA, Farmer ME, Rae DS, *et al*: Comorbidity of mental disorders with alcohol and other drug abuse: results from the epidemiologic catchment area (ECA) study. *JAMA* 264:2511–18, 1990
25. Stephan JJ: State prison expenditures, 1996. Washington, DC: US Department of Justice, Bureau of Justice Statistics, NCJ 172211, 1999, pp 1–23
26. Lamb-Mechanic D, Nelson J: Prison Healthcare Survey: An Analysis of Factors Influencing Per Capita Costs. Washington, DC: U.S. Department of Justice, National Institute of Corrections, NIC 014999, 2000
27. Cohen F: Legal Issues and the Mentally Disordered Prisoner. Washington, DC: U.S. Department of Justice, National Institute of Corrections, 1988
28. Cohen F: *The Mentally Disordered Inmate and the Law*. Kingston, NJ: Civic Research Institute, 1998
29. Sturm SP: The legacy and future of corrections litigation. *Univ Penn Law Rev* 142:638–738, 1993
30. *Cooper v. Pate*, 378 U.S. 546 (1964)
31. *Estelle v. Gamble*, 429 U.S. 97 (1976)
32. *Bowring v. Godwin*, 551 F.2d 44 (4th Cir. 1977)
33. *Bell v. Wolfish*, 441 U.S. 520 (1979)
34. *Ruiz v. Estelle*, 503 F.Supp. 1265 (S.D. Tex. 1980)
35. Hanson RA, Daley HWK: Challenging the conditions of prisons and jails: a report on Section 1983 litigation. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics, NCJ 141652, 1995, pp 1–48
36. *Newman v. Alabama*, 559 F.2d 283, 289 (5th Cir. 1977)
37. Metzner JL, Fryer, GE, Uery D: Prison mental health services: results of a national survey of standards, resources, administrative structure, and litigation. *J Forensic Sci* 35:433–8, 1990
38. American Correctional Association Standards for Adult Correctional Institutions (ed 3). College Park, MD: American Correctional Association, 1990
39. American Bar Association: Criminal Justice Mental Health Standards. Washington, DC: American Bar Association, 1985
40. Dubler NN, ed: Standards for Health Services in Correctional Facilities (ed 2). Washington, DC: American Public Health Association, 1986
41. Standards for Health Services in Jails. Chicago, IL: National Commission on Correctional Health Care, 1996
42. Standards for Health Services in Prisons. Chicago, IL: National Commission on Correctional Health Care, 1997
43. Correctional Mental Health Care: Standards and Guidelines for Delivering Services. Chicago, IL: National Commission on Correctional Health Care, 1999

44. *Psychiatric Services in Jails and Prisons* (ed 2). Washington, DC: American Psychiatric Association, 2000
45. *Rhodes v. Chapman*, 452 U.S. 337, 348 n.13 (1981)
46. *Brown v. Board of Education*, 347 U.S. 483 (1954)
47. *Dunn v. Voinovich*, Case No: C1-93-0166 (Ohio So. Dist. 1993)
48. Cohen F, Aungst S: Prison mental health care: dispute resolution and monitoring in Ohio. *Criminal Law Bull* 33:299–327, 1997
49. Cohen F: *The Mentally Disordered Inmate and the Law*. Kingston, NJ: Civic Research Institute, 1998
50. Metzner JL, Dubovsky SL: The role of the psychiatrist in evaluating a prison mental health system in litigation. *Bull Am Acad Psychiatry Law* 14:89–93, 1986
51. Cohen F: Captives' legal right to mental health care. *Law Psychol Rev* 17:1–39, 1993
52. Metzner JL, Miller RD, Kleinsasser D: Mental health screening and evaluation within prisons. *Bull Am Acad Psychiatry Law* 22: 451–7, 1994
53. Rowan JR, Hayes LM: *Training curriculum on suicide detection and prevention in jails and lockups*. Washington, DC: U.S. Department of Justice, National Institute of Corrections, 1995
54. Cox J, Landsberg G, Pravati M: The essential components of a crisis intervention program for local jails: the New York local forensic suicide prevention crisis service model. *Psychiatr Q* 60: 103–18, 1989
55. Metzner JL: An introduction to correctional psychiatry: part III. *J Am Acad Psychiatry Law* 26:107–16, 1998
56. Haddad J: Treatment for inmates with serious mental illness who require specialized placement but not psychiatric hospitalization. *Correctional Mental Health Report* 1, 59:60–2, 1999
57. Hayes LM: National study of jail suicides: seven years later. *Psychiatr Q* 60:7–29, 1989
58. Hayes LM: *Prison Suicide: An Overview and Guide to Prevention*. Washington, DC: U.S. Department of Justice, National Institute of Corrections, 1995
59. Rowan JR, Hayes LM: *Training curriculum on suicide detection and prevention in jails and lockups*. Washington, DC: U.S. Department of Justice, National Institute of Corrections, 1995
60. Freeman A, Alaimo C: Prevention of suicide in a large urban jail. *Psychiatr Ann* 31:447–52, 2001
61. O'Toole M: Jails and prisons: the numbers say they are more different than generally assumed. *Am Jails Magazine* XI:27–31, 2001
62. Kachur SP, Potter LB, James SP, Powell KE: Suicide in the United States 1980–1992. *Violence surveillance summary series*, No. 1. Atlanta: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 1995
63. Riveland C: *Supermax Prisons: Overview and General Considerations*. Washington, DC: U.S. Department of Justice, National Institute of Corrections, 1999
64. National Institute of Corrections: *Supermax housing: a survey of current practice*. *Spec Issues Correct March*:1–13, 1997
65. Zinger I, Wichmann C: *The psychological effects of 60 days in administrative segregation*. Ottawa, Ontario, Canada: Research Branch Correctional Service of Canada, 1999, pp 1–90
66. Zubek JP, Bayer L, Shephard JM: Relative effects of prolonged social isolation and confinement: behavioral and EEG changes. *J Abnorm Psychol* 74:625–31, 1969
67. Work Group on Schizophrenia: *American Psychiatric Association practice guidelines: practice guideline for the treatment of patients with schizophrenia*. *Am J Psychiatry* 154(suppl):1–63, 1997
68. Bonczar TP, Glaze LE: *Probation and parole in United States, 1998*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics Bulletin, NCJ 178234, 1999 pp 1–8
69. Barr H: *Prisons and Jails: Hospitals of Last Resort: The Need for Diversion and Discharge Planning for Incarcerated People with Mental Illness in New York*. New York: Urban Justice Center (available online at www.urbanjustice.org/publications/index.html)
70. Martell DA, Rossner R, Harmon RB: Base-rate estimates of criminal behavior by homeless mentally ill persons in New York City. *Psychiatr Serv* 46:596–601, 1995
71. Steadman HJ, Morris SM, Dennis DL: The diversion of mentally ill persons from jails to community-based services: a profile of programs. *Am J Public Health* 85:1630–5, 1995
72. Silberberg JM, Vital TL, Brakel SJ: Breaking down barriers to mandated outpatient treatment for mentally ill offenders. *Psychiatr Ann* 31:433–40, 2001
73. Project Link: *Prevention and jail and hospital recidivism among persons with severe mental illness*. *Psychiatr Serv* 50:1477–80, 1999
74. Clark RE, Ricketts SK, McHugo GJ: Legal system involvement and costs for persons in treatment for severe mental illness and substance use disorders. *Psychiatr Serv* 50:641–7, 1999
75. Watson A, Hanrahan P, Luchins D, Lurigio A: Paths to jail among mentally ill persons: service needs and service characteristics. *Psychiatr Ann* 31:421–9, 2001
76. *Brad H v. City of New York* 712 S.2d 336 (N.Y. 1999)
77. *Wakefield v. Thompson*, 177 F.3d 1160 (9th Cir. 1999)