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MENTAL HEALTH AND INCARCERATION: WHAT A BAD COMBINATION

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The District of Columbia has one of the highest per capita incarceration and criminal justice supervision rates in the United States[1] and among the highest in the world. The local prison population has risen dramatically over the past decade for a variety of reasons including increased rates of re-incarceration for parole violations and the imposition of longer sentences for drug offenses. Recent acts of Congress have seriously impacted the sentencing laws in the District including determination of where persons sentenced for violating local D.C. laws will serve such sentences. On August 5, 1997, President Clinton signed into law The National Capital Revitalization and Self-Government Improvement Act of 1997 (the "Revitalization Act"),[2] which effectively "federalized" the local prison population by transferring authority for incarcerating D.C. prisoners to the United States Bureau of Prisons. Thus, while there are still "local prisoners," there is no longer a local prison, nor do the D.C. prisoners remain "local." Rather, persons convicted of crimes in the District of Columbia are now held in prisons operated by, or contracted on behalf of, the federal government.

The Revitalization Act also mandated the creation of a District of Columbia Truth-In-Sentencing Commission to make recommendations to the Council of the District of Columbia to completely revamp the local sentencing structure.[3] Changes included altering the sentence a judge may impose from an indeterminate to a determinate sentencing structure, abolishing parole for thirty-seven felony offenses, and requiring offenders to serve at least 85% of any prison sentence imposed for those offenses. These recommendations became law in August 2000.

The Revitalization Act also abolished the local D.C. Board of Parole and authorized the United States. Parole Commission to make all parole grant and release decisions, including the specific terms of supervised release, the decision to revoke supervised release, and the length of any prison sentence upon revocation of supervised release. Although several state legislatures have enacted major

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1 JEROME G. MILLER, NATIONAL CENTER ON INSTITUTIONS AND ALTERNATIVES, Hobbling a Generation: Young African American Males in D.C.'s Criminal Justice System (1992).

2 Pub. L. No. 105-33, 111 Stat. 712 (1997) (codified at D.C. Code Ann. § 24-101 *et seq.* (West 2003).

3 (D.C. Code Ann. § 24-111 (West 2003).

changes in their sentencing and corrections policies,[4] nowhere else in the country has Congress imposed such significant changes in the entire criminal justice system, from the sentencing phase to incarceration to parole supervision.

Currently there are approximately 11,000 men and women incarcerated who have been convicted for violating a D.C. criminal code offense. Because of the Revitalization Act, approximately 9,000 prisoners are in the custody of the Bureau of Prisons and are housed in federal, state, or private facilities operated by or contracted for by the Bureau of Prisons for such term of imprisonment as the court has directed.[5] Therefore, the District of Columbia Central Detention Facility (otherwise known as the D.C. Jail) and the privately operated Corrections Corporation of America Correctional Treatment Facility ("CCA/CTF") are the two local facilities that house D.C. code offenders. Currently, there are approximately 717 prisoners housed at CCA/CTF and nearly 1900 at the Jail.

MENTAL HEALTH TREATMENT AT THE D.C. JAIL

Despite years of litigation, one of the most serious problems facing D.C. prisoners is the lack of adequate access to medical care and mental health treatment. Caring for and coping with the mentally ill offender is a major problem in most correctional facilities. Second only to AIDS, mental illness is the principal health problem that prisoners experience behind bars.

In *Campbell v. McGruder,*[6] and *Inmates of D.C. Jail v. Jackson,*[7] D.C. courts upheld plaintiffs' challenges to the totality of the conditions at the D.C. Jail.[8] The court found that the delivery of medical care, including mental health services, was inadequate. The D.C. Jail ("the Jail") is located in Southeast Washington D.C. and is operated by the D.C. Department of Corrections largely, though not completely, as a pre-trial detention facility. The Jail has housing units for both men and women, an infirmary, and an intermediate care mental health cell block.

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4 Four states adopted revisions to selected mandatory and "truth in sentencing" laws: Connecticut, Louisiana, Mississippi and North Dakota. Five states expanded the role of drug treatment as a sentencing option: Arkansas, California, Idaho, Oregon and Texas. Seven states passed legislation to ease prison overcrowding: Arkansas, Iowa, Mississippi, Montana, North Carolina, Texas and Virginia. RYAN S. KING & MARC MAUER, THE SENTENCING PROJECT, STATE SENTENCING AND CORRECTIONS POLICY IN AN ERA OF FISCAL RESTRAINT 5 (2002).

5 Section 11201(b) of the Revitalization Act mandates that the Lorton Correctional Complex be closed no later than December 31, 2001, that the Bureau of Prisons shall be responsible for the custody, care, subsistence, education, treatment and training of such persons and that at least 50% of the DC sentenced felon population be housed in private contract facilities. 111 Stat. 712 (codified at D.C. Code Ann. § 24-101 (West 2003)).

6 C.A. No. 1462-71 (D.D.C. 1971) (WBB)

7 C.A. No. 75-1668 (D.D.C. 1975) (WBB)

8 These cases have been consolidated. Opinions in these cases have been published at *Campbell v. McGruder*, 416 F. Supp. 100 (D.D.C. 1975); 416 F. Supp. 106 (D.D.C. 1975); 416 F. Supp. 111 (D.D.C. 1976); *aff'd in part and remanded*, 580 F.2d 521 (D.C. Cir. 1978); *on remand*, 554 F. Supp. 562 (D.D.C. 1982).

Prisoners in the Jail are confined in single and double cells. All persons incarcerated by the Department of Corrections are first confined at the Jail prior to their eventual placement at another facility. Until recently there has been a court imposed population ceiling of 1,674 prisoners at the Jail as a result of the *Campbell* lawsuit.

The *Campbell* case was filed in 1971 on behalf of a class of plaintiffs consisting of all D.C. Jail pre-trial detainees. In 1974, *Inmates of D.C. Jail* was filed on behalf of a class consisting of all sentenced prisoners at the D.C. Jail. Following a trial in 1975, Judge William B. Bryant held that the conditions of confinement in the D.C. Jail were so severe that they violated the constitutional rights of the persons confined there. Over the next ten years, Judge Bryant repeatedly ordered remedial actions, culminating in 1985 with the negotiation and entry of a court-approved stipulation. The stipulation required that the D.C. Department of Corrections reduce the population at the Jail to not more than 1,674 prisoners, improve the system for classifying prisoners, implement improvements in the medical and mental health system, and implement pretrial release programs.[9] The court found that the Jail was so overcrowded that prisoners were being subjected to "both physical and psychological damage."[10]

In 1993, After finding that the District had failed to comply with the stipulation, and with other orders of the court, Judge Bryant appointed a Special Officer on April 22, 1993, to monitor and report on the District's compliance.[11] On September 15, 1993, experts engaged by the Special Officer submitted lengthy reports on serious, life-threatening deficiencies in medical and mental health care at the Jail.[12] These reports described medical and mental health systems that were in complete disarray. A subsequent report on February 2, 1994, described thirty-six court-ordered provisions that the Department of Corrections had violated. By 1995 the Court was unconvinced that the Jail staff could independently comply with the medical and mental health requirements and placed such services under court-ordered, five year receivership. Plaintiffs' attorneys argued that the Stipulation was necessary in order to "break the defendants' pattern of resistance, indifference and incompetence."[13] Jail officials recently petitioned the court to relieve them of the court-imposed population cap for sixty days to prove that they can provide adequate services with increased populations. Director

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9 Order, August 22, 1985; Stipulation, August 22, 1985.

10 Memorandum and Order, March 21, 1975 at 2.

11 Order Appointing Special Officer, April 22, 1993.

12 Expert Reports on Medical and Mental Health Services at the District of Columbia Jail (Sept. 15, 1993).

13 *See* Plaintiffs' Memorandum of Points and Authorities in Support of Motion for Appointment of a Receiver, filed by Plaintiff's attorneys Patrick Hickey at Shaw, Pittman, Potts and Towbridge (attorney in *Campbell*) and Jonathan Smith at D.C. Prisoners' Legal Services Program (attorney in *Inmates*).

Odie Washington said in an interview that he hoped that after the two-month stay, the "parties will be satisfied that the jail can provide adequate conditions for a larger inmate pool and will agree to abolish the cap."[14]

Medical screening and clearance are required for every D.C. Code offender entering the D.C. Jail. As a part of that screening, an assessment should be conducted by a mental health technician to determine the mental health needs of the offender. The mental health technician is generally a psychiatric nurse who is licensed by the District to conduct such diagnoses. Mental health offenders are housed in South Three (one of eighteen cellblocks at the D.C. Jail) that houses twenty to thirty prisoners. Male and female offenders who are diagnosed as being acute or chronic are housed in this unit, which is staffed twenty-four hours with mental health personnel. Offenders who need to be stabilized are given psychotropic medications and are seen by a psychiatrist within about four weeks after their arrival. The offenders can participate in individual and group counseling sessions and meet with the staff psychiatrist monthly. The office of mental health services determines which clients will be transferred to St. Elizabeth's Hospital and this transfer is uneventful unless agency politics prevent the immediate transfer and, according to a staff caseworker, offenders are left to deteriorate while waiting. When D.C. Code offenders are sent to the CCA/CTF, they have already completed this initial screening process, but the staff completes a suicide evaluation to determine the mental health status of offenders housed there.

The District's failure to comply with court orders has not only been costly because of attorneys' fees and sanctions, but, most importantly, has also resulted in significant harm to prisoners. According to the Criminal Justice Mental Health Standards, correctional facilities should provide a range of mental health services for prisoners and should provide adequately trained personnel readily available to provide such services.[15] The available evidence suggests that even after three decades of litigation, the D.C. Jail often fails to meet this standard.

THE LAW AND MENTAL HEALTH IN PRISONS

The Bureau of Justice Statistics reports that over 238,800 individuals with mental illnesses are confined in U.S. jails and prisons.[16] As prison populations have grown so have the numbers of prisoners with mental illness. During the past decade, state mental health hospitals have rapidly been closing because of deinstitutionalization, while hundreds of new prisons have opened. As a result,

14 Serge F. Kovaleski, *D.C. Seeks Lifting of Inmate Cap at Jail*, WASH. POST, , Mar. 2, 2002, at B02.

15 A.B.A., CRIMINAL JUSTICE MENTAL HEALTH STANDARDS 7-10.2 (a) (1989).

16 Paula M. Ditton, BUREAU OF JUSTICE STATISTICS, Mental Health and Treatment of Inmates and Probationers (U.S. Dep't of Justice 1999).

jails and prisons have become the institutions most likely to house the mentally ill. Overcrowding that is endemic in prisons today leads to greater violence, a lack of privacy, excessive noise, and other stressful conditions that are hard on everyone, but particularly so on those vulnerable to emotional and psychiatric problems.

While not every mental health problem constitutes a serious need, the denial of adequate care for serious mental health needs may constitute deliberate indifference.[17] Deliberate indifference is the legal standard for determining whether the conduct of the corrections official meets the requirements of a constitutional challenge. In Eighth Amendment conditions cases, the plaintiff must prove that the defendants acted with "deliberate indifference;" knowledge of the actual conditions that existed, and knowledge of the likely consequence that those conditions would cause harm. The standard for deliberate indifference falls somewhere between mere negligence (carelessness) and actual malice (intent to cause harm).[18] The Supreme Court applied this standard first to medical care cases[19] and later, in *Wilson v. Seiter,*[20] to all conditions of confinement cases. The question posed is: Are corrections officials deliberately indifferent to the serious mental health needs of the prisoner? Courts have upheld an inmate's right to mental health care by equating psychiatric care with medical care. The Fourth Circuit Court of Appeals saw "no underlying distinction between the right [of a prisoner] to medical care for physical ills and its psychological or psychiatric counterpart."[21]

Although prisoners are not entitled to their choice of treatment or the best possible treatment, in order to avoid a constitutional violation, prison officials must exercise some form of professional judgment and must provide some treatment. The failure to train correctional staff to deal adequately with mentally ill prisoners can constitute deliberate indifference.[22] Mental conditions such as acute or severe depression generally constitute a serious medical need for which prison officials must provide treatment.[23] After *Wilson*, courts also look to con-

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17 Smith v. Jenkins, 919 F.2d 90, 92-93 (8th Cir. 1990); Langley v. Coughlin, 888 F.2d 252, 254 (2d Cir. 1989); Waldrop v. Evans, 871 F.2d 1030, 1033 (11th Cir 1989); *rehearing denied,* 880 F.2d 421 (11th Cir. 1989); Ramos v. Lamm, 639 F.2d 559, 574 (10th Cir. 1980), *cert. denied,* 450 U.S. 1041 (1981).

18 Estelle v. Gamble, 429 U.S. 97, 104 (finding mere negligence or medical malpractice insufficient to state a cause of action absent showing of acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs).

19 Estelle v. Gamble, 429 U.S. at 104 (1976).

20 501 U.S. 294, 303 (1991) (finding "no significant distinction between claims alleging inadequate medical care and those alleging inadequate 'conditions of confinement'").

21 Bowring v. Godwin, 551 F.2d 44, 47 (4th Cir. 1977).

22 Langley v. Coughlin, 709 F. Supp. 482, 483-85 (S.D.N.Y. 1989).

23 Peterkin v. Jeffes, 661 F. Supp. 895, 917, 923 (E.D. Pa. 1987) (citing abnormally high incidence of chronic depression among death row inmates as sufficiently serious medical need).

sistent and repeated failures over an extended period, coupled with actual knowledge of the substandard conditions and the harm they may cause, to establish deliberate indifference. A constitutional violation occurs only where the deprivation alleged is objectively "sufficiently serious" and the official has acted with "deliberate indifference" to inmate health or safety needs.[24]

Care that grossly departs or dramatically deviates from professional standards amounts to deliberate indifference.[25] Grossly incompetent or inadequate care constitutes deliberate indifference, especially in cases in which the prisoners' medication is discontinued abruptly and without justification, and consequent harm can be demonstrated.[26] Courts have also condemned deficiencies in various aspects of psychiatric care and treatment of mentally ill prisoners, including the lack of mental health screening upon intake[27] and the failure to follow up with inmates known or suspected to have mental disorders.[28] Prisoners have a right to have psychotropic medications continued if discontinuation would amount to grossly inadequate psychiatric care.[29] In a Georgia case, the representative of a prisoner successfully brought an action against the state for deliberate indifference to his health when he had a history of mental illness and had been taking antidepressants, but the prison psychiatrist discontinued his anti-depressants. In that case, a prison official had received a report that the inmate was thinking about suicide and failed to take any precautions.[30]

Most of the cases in which the court has found constitutional violations in the mental health area focus on the lack of adequate and qualified staff.[31] In *Inmates of Occoquan v. Barry*,[32] the district court determined that the "woefully short" mental health staff supported a finding of unconstitutionality. The Honorable Judge June Green found that two psychologists were not enough to meet the needs of 1,900 inmates, especially because there was no staff psychiatrist and only

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24 Farmer v. Brennan, 511 U.S. 825, 832-834 (1994).

25 Smith v. Jenkins, 919 F.2d 90, 93 (8th Cir. 1990).

26 Waldrop v. Evans, 871 F.2d 1030, 1033 (11th Cir. 1989) and Greason v. Kemp, 891 F.2d 829, 835 (11th Cir. 1990)

27 Balla v. Idaho State Bd. of Corr., 595 F.Supp. 1558, 1577 (D. Idaho 1984); Ruiz v. Estelle, 503 F. Supp 1265, 1339 (S.D. Tex. 1980); Inmates of Allegheny County Jail v. Pierce, 487 F. Supp. 638, 642, 644 (W.D. Pa. 1980).

28 Arnold ex rel. H.B. v. Lewis, 803 F. Supp. 246, 257 (D. Ariz. 1992).

29 Waldrop v. Evans, 871 F.2d 1030, 1033 (11th Cir. 1989).

30 Greason v. Kemp, 891 F.2d 829, 834 (11th Cir. 1990).

31 *See e.g.,* Wellman v. Faulkner, 715 F.2d 269, 272 (7th Cir. 1983) (requiring on-site psychiatrist); Ramos v. Lamm, 639 F.2d 559, 578 (10th Cir. 1980) (requiring one full-time psychiatrist for 1,400 inmates, of wham an estimated 10% were "seriously mentally ill"); Jones v. Metzger, 456 F.2d 854 (6th Cir. 1972) (requiring doctor be on call at all times); Cody v. Hilliard, 599 F. Supp. 1025, 1058-59 (D.S.D. 1984) (finding number of staff inadequate); Alberti F. Sheriff, 406 F. Supp. 649, 677 (S.D. Tex. 1975) (requiring prison officials to obtain services of psychiatrist); Miller v. Carson, 401 F. Supp. 835, 879 (M.D. Fla. 1975) (noting minimal attempt at rehabilitation due to "no trained personnel").

32 717 F. Supp. 854 (D.D.C. 1989).

one psychiatrist who came from the outside only two afternoons a week. One of the psychologists testified that there was a large backlog of inmates who needed testing in order to move to a lower level security facility and that he was struggling to provide even emergency services. At the time, the staff used Q block at Occoquan to house mentally ill inmates. Inmates remained locked in their cells for twenty hours a day with no social contact and received no treatment, except for medication and an occasional visit from the psychologist. The psychologist testified that he tried to walk through Q block daily, but he would often just call and talk to the officers there. He admitted that those on suicide watch received a visual check every thirty minutes, but said this was ineffective. The psychologist testified further that the corrections staff did not receive training on how to deal with mentally ill inmates in Q block, and that the inmates in Q block were "abandoned to their hallucinations and their delusions . . . . [I]t makes the illness more difficult to treat, in come cases may make it untreatable."[33] The Court concluded that housing mental health inmates in Q block showed deliberate indifference to their psychiatric health needs.[34]

In *Cabrales v. County of Los Angeles*,[35] the Ninth Circuit determined that deliberate indifference was established where the mental health staff could only spend "minutes per month" with disturbed inmates. In *Langley v. Coughlin*,[36] the district court held that the use of untrained or unqualified personnel and inadequate supervision by a psychiatrist supported the plaintiffs' constitutional claims. Furthermore, the Seventh Circuit found that the absence of an on-site psychiatrist in a large prison was unconstitutional,[37] and other courts have required prison officials to keep adequate mental health records.[38] In many prison settings, officials issue psychotropic medications to "troublesome" prisoners without regular monitoring or counseling. However, psychotropic medications must be administered under the continued supervision of a qualified psychiatrist and cannot be used as a form of punishment.[39] In *Vitek v. Jones*, the U.S. Supreme Court held that it is unconstitutional to require a change in an inmate's behavior without a legitimate reason. Thus, a corrections facility cannot force prisoners to undergo psychiatric treatment as a form of punishment.[40]

Regardless of the elaborate constitutional standards that these and other federal courts have established over the last thirty years, individuals with mental

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33 *Id.* at 864.

34 *Id.* at 868.

35 864 F.2d 1454, 1461 (9th Cir. 1988)

36 715 F. Supp. 522, 540 (S.D.N.Y. 1989)

37 Wellman v. Faulkner, 715 F.2d at 272-73 (7th Cir. 1983).

38 Balla v. Idaho State Bd. of Corr., 595 F.Supp. 1558, 1577 (D. Idaho. 1984).

39 Lightfoot v. Walker, 486 F. Supp. 504, 522 (S.D. Ill. 1980) (prohibiting use of psychotropic medication simply to control inmate behavior).

40 Vitek v. Jones, 445 U.S. 480, 492, (finding that major changes in conditions of confinement amounted to "grievous loss to inmate").

health problems routinely face inadequate care in incarceration facilities, including the D.C. Jail. The following case studies illustrate some of the problems I have observed in the D.C. Jail.

DETECTION OF MENTAL HEALTH PROBLEMS AT INTAKE SCREENING

Mr. B.D. is an older offender who has been charged with committing a very serious offense and is currently being held at the D.C. Jail awaiting trial. According to information from his family, he is highly educated, speaks three foreign languages, has studied oversees and has served in the U.S. military. Yet, he sits in solitary confinement (by choice), unable to put any comprehensible sentences together and barely able to effectively communicate with his attorney. He is completely withdrawn. No one, except his attorney (who has no formal training in detecting mental illness), has suspected that he may be suffering from depression.

Although prisoners have the constitutional right to adequate medical diagnosis and treatment, including psychiatric care, many like B.D. do not receive it. It is estimated that only 16% of all inmates reported current mental illness or an overnight stay in a mental hospital.[41] Many offenders come to the criminal justice system with mental health-related factors, including histories of physical and mental abuse, extensive drug histories and psychological problems that have often gone undiagnosed or un-addressed. Inmates fail to report such factors for a variety of reasons, including wanting to avoid the stigma associated with mental illness in the community and the inability to navigate through programs that are difficult to access. For women offenders, mental health issues are often multiplied.

Generally, persons with mental illness have a sixty% greater chance of being arrested than those who are not mentally ill but commit the same offense.[42] A recent study on jails and prisons in New York concluded that the rising cost of managed health care, the population growth of jails and prisons, and the punishment of "quality of life" crimes have contributed to the incarceration of thousands of people with mental illness. These mental health issues are often exacerbated by incarceration. If effective screening is not performed, then many prisoners who do not want to disclose information or are aware of their illness go undetected.

For these reasons, intake screening is an essential element in the provision of mental health services in a jail setting. A screening process must be in place that

41 The Sentencing Project, MENTALLY ILL OFFENDERS IN THE CRIMINAL JUSTICE SYSTEM: AN ANALYSIS AND PRESCRIPTION 2 (2002), *available at* http://www.sentencingproject.org/news/pub9089.pdf.

42 BAZELON CENTER FOR MENTAL HEALTH LAW, ENDING THE CRIMINALIZATION OF PEOPLE WITH MENTAL ILLNESS (2001).

can identify high-risk inmates, including those at risk for psychosis, suicide and self-destructive behavior as well as those who require special housing and increased supervision based on mental illness. The initial screening at the D.C. Jail is conducted as part of the intake clinical history and physical examination. When mental health issues go undetected the results can be deadly. Historically, inmates at the Jail have made suicide attempts by drinking disinfectant, overdosing on medications, hanging with bed clothing and self-inflicting skin lacerations. Proper and consistent treatment must also be provided to inmates during the incarceration period.

Treatment of Mental Health Issues During Incarceration

On January 22, 2002, I represented Mr. J.H. at a preliminary interview before the U.S. Parole Commission. I met with J.H. two times prior to the date of our final revocation hearing scheduled for February 27, 2002. He was coherent, could understand the defenses discussed, and we practiced the presentation he would make on his own behalf at the final hearing. Two days prior to the hearing he was abruptly transferred to CCA/CTF. When he was transported to the Jail for his hearing, he was physically disheveled and disoriented. He asked the same questions repeatedly and complained that his tongue felt heavy. He could barely navigate his surroundings. When asked if he had been given psychotropic medication, he answered affirmatively. In my limited capacity, I tried to ascertain his ability to understand the proceedings. While he was able to recite important dates and numbers, it became apparent that he was lethargic and could barely keep his eyes open during the proceedings. I requested the Parole Commission hearing examiner that the hearing be postponed, but the client repeatedly yelled that he wanted to continue the hearing. The hearing examiner had to be convinced that it was in the best interest of the client to continue the hearing until a later date. Thus far, I have been unable to pinpoint why he was abruptly transferred and given psychotropic medications, what medications he was given, and who determined the need for such.

Mental health care in prisons must be consistent because mentally ill prisoners are more vulnerable and have difficulty protecting themselves unless they are properly diagnosed and medicated. Likewise, parole officers must also be cross-trained to detect and understand the characteristics of mental illness and its effects on daily functioning. In J.H.'s case, the parole officer was not familiar enough with the client to assist me in assessing his mental ability. I was recently notified that the United States Parole Commission has deferred his parole decision pending the completion of a mental health evaluation.

DISCHARGE PLANNING OF MENTAL HEALTH PRISONERS

Mr. T.P suffers from schizophrenia for which he was diagnosed at an early age. On August 15, 2000, Mr. T.P. was released from the D.C. Jail after being granted parole. His mother had been aware of his impending release date and was in regular communication with his case manager at the D.C. Jail. On the day before his pending release, the case manager assured his mother that he would be released on the morning of August 15, 2000. Having heard the horrible stories of prisoners being released in the middle of the night, the mother repeatedly asked for assurance that T.P. would be released the next morning when she could pick him up. The case manager again assured her that she could pick him up the next morning.

However, when the case manager ended her workday, personnel in the records office noticed his release date and began the process of releasing Mr. T.P. Despite all efforts, he was released at 1:00 a.m., and no one bothered to notify his family of his release. He was given $2.50 for carfare, but did not know where to go. He wandered through the streets of D.C. in his prison jumpsuit until he came to a neighborhood that was familiar to him. He was found by his mother's in-laws. He was sitting on the porch two doors down from where these relatives lived. The relatives called his mother and notified her that he was there. They gave him a pair of jeans and a t-shirt and took him home. It is truly a mystery how he was able to recollect the neighborhood of his relatives when this was his first release after serving nineteen years in prison. Though he had been on psychotropic medication throughout his entire incarceration he was also released without any supply of medication.

T.P.'s mother and father called D.C. Superior Court, the Office of Parole Supervision, and worked hard to stabilize T.P. and to place him in the Spring Road Mental Health Clinic where he reported daily while living at home. Due to the collaboration among his parole officer, psychiatrist, and caseworker, T.P. was successfully in the community for nearly a year until he was arrested by the U.S. Marshal Service for violating the conditions of his parole. He allegedly submitted one urine sample that tested positive for marijuana. Both of his parents, his caseworker and a psychiatrist attended and testified at his parole revocation hearing. His psychiatrist testified that he was working with T.P. teaching him to be more assertive. T.P. expressed his concern that the neighborhood in which he had to walk after leaving the Spring Road Clinic everyday to go home was a drug-infested area and the guys would often ask him to participate in smoking marijuana. The hearing examiner revoked his parole, but, convinced that further incarceration was not necessary, scheduled a release date of November 2, 2001. This, however, is not the end of the story. The U.S. Parole Commission has recently determined that T.P. could not be released because his case manager had

submitted insufficient release planning information. Mr. T.P. remains housed at the D.C. Jail.

The failure to establish a continuum of care has many harmful consequences for the offender and for the community. During their incarceration, most inmates with mental illness receive minimal mental health services. When their release date arrives, moreover, they are usually discharged without a referral to community treatment and without income, insurance, medication or housing. They do not receive any of the support they need to obtain treatment, maintain their psychiatric stability, and stay out of trouble. Offenders with mental illness who receive no discharge planning are likely to re-offend, thereby creating both financial and social costs for their communities. The District's failure to provide adequate care to mentally ill offenders perpetuates the "revolving door" of repeated incarcerations – it sets people up to re-offend. All of society benefits from establishing links between jails and community treatment providers because the goal of discharge planning is to create a smooth transition for the offender back into the community. The days and weeks immediately following the release of a person with mental illness from jail or prison are critical. The offender's actions and access to resources during this time are likely to determine whether the individual will succeed or fail in the community.

Jails must provide pre-discharge planning to all mentally ill prisoners and ensure immediate access to essential services following their release. Although federal law prohibits the use of Medicaid funds to pay healthcare providers for health care costs of incarcerated individuals, it does not require state or local governments to terminate benefits eligibility for those individuals. Nevertheless, many states terminate inmate eligibility to Medicaid, Supplemental Security Income and other entitlements such as Social Security Disability Insurance when mentally ill individuals are incarcerated. As a result, many former inmates must reapply for benefits upon release to the community, a process that can take weeks or months.

Conclusion

Since *Wilson,* a prisoner claiming that the conditions of his confinement violate the Eighth Amendment must show a culpable state of mind on the part of prison officials. Such indifference may be shown by repeated examples of negligent acts, which disclose a pattern of conduct by the prison medical staff or by showing systemic or gross deficiencies in staffing, facilities, equipment or procedures. The long duration of cruel prison conditions may make it easier to establish knowledge and hence some form of intent. The medical care, including mental health care, a prisoner receives is just as much a condition of his confinement as the food he is fed, the clothes he is issued, the temperature he is subjected to in this cell, and the protection he is afforded against other inmates. Thus, as retired Justice Powell has concluded, "Whether one characterizes the

treatment received by [the prisoner] as inhumane conditions of confinement, failure to attend to his medical [or mental health] needs, or a combination of both, it is appropriate to apply the 'deliberate indifference' standard articulated in *Estelle.*"[43]

Clearly, in the case studies presented above, strong arguments could be made that the prison officials fell short in their responsibilities to both Mr. T.P. and Mr. B.D. In the case of Mr. B.D. the staff at the initial screening should have been sufficiently equipped to suspect and detect that he may be suffering from depression. In the case of Mr. T.P., the case management and mental health staff fell short of their responsibilities by releasing him without adequate medication, and without taking steps to ensure that his mental health treatment would continue in the community. In the case of Mr. J.H., I am still gathering facts to establish who determined that he needed medication and whether appropriate dosages were administered. We can conclude in these cases that the prison officials knew of and disregarded the risk to the inmate's mental health or knew that substantial harm existed and exhibited a deliberate indifference to that harm.

Accurate screening, adequate diagnosis and treatment while in prison, discharge planning, and community follow-up are all necessary ingredients to success for mentally ill offenders. Jail mental health professionals must be equipped to recognize and respond to inmates who are experiencing symptoms of mental illness and ensure their access to appropriate medications in the proper dosage. Better legal enforcement and improved coordination of the existing mental health and corrections staff might be the best remedy to some of the problems described.

Untreated mental illness and co-occurring substance abuse disorders propel "the revolving door between jail and the street for individuals who have committed relatively minor crimes — many of them "nuisance crimes." Public perceptions about the dangerousness of people with mental illness are often unsubstantiated. Violent behavior is most likely to occur when people with mental illness have a co-occurring substance abuse problem. Alcohol and drug abuse also raise the likelihood of violence in the non-mentally ill. One major problem arises from the splintered nature of the many mental health and treatment options that are provided. Many psychiatric programs are designed to treat either the mentally ill or people with a chemical dependency. Many substance abuse programs do not accept people with mental illness. We must encourage these programs to overcome political and agency inertia.

If jail and prison officials employ qualified staff to conduct adequate screenings, proper diagnosis and treatment, and the necessary discharge planning, prisoners' claims of "deliberate indifference" in mental health cases would become obsolete.

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43 Wilson, 501 U.S. 294 at 303.