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California Reeling: Court Orders Mental Health Staffing

I have written a good deal about **Coleman v. Wilson**, 912 F.Supp 1282 (E.D. Cal. 1995)(the original decision) in my Landmark Cases Appendix in Fred Cohen, The Mentally Disordered Inmate and the Law, App. B-104 (1998). If one reads enough correctional law decisions from California you would expect to be immune from shock, particularly after **Plata v. Schwarzenegger**, No. C01-1351 (February 14, 2006), leading the state's correctional medical system into a receivership that will cost over $8 million annually simply to administer.

In what is now **Coleman v. Schwarzenegger**, Senior Judge Lawrence K. Karlton, in the summer of 2006, ordered California to hire some 750 new mental health care staff to improve treatment for inmates.* These new hires range from psychiatrists to nurses and clerks with an estimated annual cost of $30 million a year. One immediately thinks of that Malibu beach house that $30 million could buy, unfurnished of course.

Special Master Michael Keating issued a Report on July 27, 2006 that provides agonizing detail related to California's Department of Finance (DOF) requests of the legislature for funding needed to provide adequate mental health staffing in California's prisons.

When the dust from the numbers game settles there appears to be a series of delays and misstatements by California officials as to the numbers

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Death at a Young Age: Custodial Suicide and Qualified Immunity

Perez v. Oakland County, Mich., ____ F.3d ____ (6th Cir. 2006), illustrates so much about what is dubious in the law of custodial. Eighteen-year-old Ariel Perez hung himself from a bed sheet tied to a vent in his single jail cell and died three days later as a result. Perez had been convicted of felony larceny at age 17 and thus began the downward spiral of hallucinating, hearing voices, in and out of jail, various efforts at treatment, suicide attempts (one at age 14) and ideation, and then the completed suicide.

In this 42 U.S.C. § 1983 case relying on the Eighth Amendment and its demanding test of deliberate indifference, the district court granted defendants' motion for summary judgment and with three separate opinions a Sixth Circuit panel upheld the lower court. There is a split on whether there was deliberate indifference and a split on whether qualified immunity was applicable. Ultimately, two judges agreed on qualified immunity and that ended Perez's father's claim for damages.

Background

The law in this area is rather easily stated: Defendants must be shown to have been deliberately indifferent to the decedent's serious mental health needs.[1] These components are often described as objective (seriousness) and subjective (deliberate indifference). While the law at this abstract level is easily stated, the devil is in the nuances and the facts. Here, the facts show overwhelmingly that the youthful suicide was seriously mentally ill and persistently suicidal.

This area of law also is significantly fact driven. With that in mind, we will provide a rather full and perhaps tedious factual narrative. Readers with a low tolerance for detail may wish to skip to the "good parts;" the somewhat Talmudic legal discussion that follows this section.

Perez was born in 1983. He did not complete high school, and was diagnosed as having Attention Deficit Hyperactivity Disorder (ADHD) and as being learning disabled when he was six years old. Perez began serving sentences in the Oakland County Jail at a fairly young age. In February of 2001, when he was 17 years old, he pleaded guilty to two charges of felony larceny from a building and was given a six-month sen-

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tence on May 11, 2001. It was initially determined that due to Perez's age he should serve his time in a boot camp. However, after he reported to a boot camp counselor that he was experiencing hallucinations and hearing voices telling him to quit or escape, Perez was transferred to the Oakland County Jail in late June, 2001. When Perez arrived at the jail, he was met by defendant Roberta Rice, an inmate caseworker. Perez told Rice that he had been hearing voices for the past two years telling him to hurt himself, but he did not listen to the voices. He also stated that he had tried to hang himself at the ages of 14 and 17.

Rice determined that Perez should get a psychiatric evaluation, which was conducted by Dr. Sarath Hemachandra on July 5, 2001. Dr. Hemachandra noted Perez's history of hearing voices and considering suicide, his learning disability, his ADHD diagnosis and the fact that Perez had taken Ritalin as a child. Dr. Hemachandra diagnosed Perez with schizoaffective disorder, a personality disorder and a learning disorder. He prescribed psychiatric medication, individual counseling and substance abuse counseling. He also noted that Perez should be "watched closely."

Perez was housed with a roommate and placed on a 30-minute "active behavior watch" (ABW), based on the assessments of Rice and Hemachandra. On July 10, 2001, Rice met with Perez because he was refusing to take his Zyprexa medication. Rice decided to discontinue the 30-minute ABW following this meeting.

On August 20, 2001, Perez was in a crisis state, and jail staff determined that he was suicidal. They placed him in an attorney booth until Rice could see him. Rice met with Perez, and he indicated that he was considering hurting himself by cutting his wrist with a razor or hanging himself with a sheet. He said "I feel like I'm going crazy." Rice told Perez that she wanted him moved to the front holding tanks so that he could be closely supervised. He stated that he would commit suicide if he was placed in such a holding tank, but the move was made, and he was placed on an "active suicide watch" (ASW).

Rice met with Perez the next day, August 21, 2001. Perez stated that he felt better and wanted to be moved out of the holding cell. He indicated that he had no suicidal thoughts or intentions and he said he would not cause trouble if moved to the main jail. Rice downgraded Perez's status from ASW to ABW. She thought he seemed stable, and she approved his reassignment to the main jail.

Rice again met with Perez on September 19, 2001, after Perez he been placed in an observation cell as a result of a fight he had had with another inmate. Perez stated that he was not suicidal, that he had been taking his medications and that he had been doing fine prior to the fight. Rice brought up the idea of Perez's being placed in a single cell due to his trouble getting along with other inmates, and Perez agreed to this. Rice also determined that Perez did not appear suicidal and no watch was necessary. Jail officials asked Rice if Perez could be placed in an 11-man cell, but she said this placement was inappropriate in light of Perez's age, mental health treatment and learning disability. Perez continued to be incarcerated without incident until his release on October 9, 2001.

Perez was again incarcerated at the Oakland County Jail for two days in late April, 2002, after an altercation with his father. While Perez was at the jail, Rice responded to a phone call from Perez's sister, Jennifer Perez. Jennifer Perez told Rice that Perez had not been compliant with his mental health treatment, that he had been hearing voices telling him that he was no good and that he should kill himself and that her father wanted Perez to get treatment. Rice gave Jennifer Perez the name of the medications Perez had been given while he was incarcerated and the phone numbers of Collaborative Solutions and Mercy Network. Perez was again incarcerated at the Oakland County Jail in late August 2002, but the reasons for this incarceration are not clear from the record.

Between his April and August incarcerations, Perez received treatment at St. Joseph Mercy Hospital and the North Oakland Medical Center (NOMC) for depression and suicidal thoughts. A petition for hospitalization was prepared on Perez's behalf, a doctor

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Prevalence of Mental Illness in Prisons: The New Data

Editor's Introduction: Doris J. James and Lauren E. Glaze, Bureau of Justice Statistics (BJS) Special Report, Mental Health Problems of Prison and Jail Inmates (September 2006), was so stunning in its epidemiological findings that I could hardly believe what I was reading:

At midyear 2005 more than half of all prison and jail inmates had a mental health problem, including 705,600 inmates in State prisons, 70,200 in Federal prisons, and 479,900 in local jails. These estimates represented 56% of State prisoners, 45% of Federal prisoners, and 64% of jail inmates. The findings in this report were based on data from personal interviews with State and Federal prisoners in 2004 and local jail inmates in 2002. (Special Report at p. 1)

On second reading, I noted that the operative term is "mental health problem" and not, for example, a serous mental illness. So, how did the Report define mental health problem: A recent history or symptom of a mental health problem occurring within the past 12 months. History includes a clinical diagnosis or treatment by a mental health professional. Symptoms were based on DSM IV criteria.

My bet then was placed on symptoms over history and unlike my usual luck at the track, this time I was sort of right. Forty-three percent of State prisoners and over half of jail inmates reported symptoms of mania. Fifteen percent of state prisoners and 24% of jail inmates reported symptoms that met criteria for psychosis.

Twenty-four percent of State prisoners had a recent history of mental health problems and this accounts for my "sort of."

In any event, and despite some methodological misgivings on my part, I thought the "Special Report" deserved special treatment in this publication. I invited some friends, who also happen to be authentic experts, to give me about 1000 words on their reaction to the Special Report.

The invitees very kindly responded affirmatively. The invited commentators did not have the opportunity to read each other's work and I, in turn, did not edit their submission to eliminate any overlapping material.

Thus, each essay is its own small island and bears the imprint of that writer's approach to this area. Terry Kupers, e.g., does not pause to question the numbers but screams out for social policy change responsive to the huge number of persons with mental illness in penal settings.

Jamie Fellner, reflecting her important work with the Human Rights Watch, calls for diversion and more treatment and support in prison settings.

Jeff Metzner notes the methodological flaws, but then takes the findings of the Report and addresses needed corrective action. Dr. Metzner is an exceptional expert in correctional mental health cases and he not only can testify, he knows how to fix things.

Hans Toch, a former colleague of mine, stayed very close to my special invitation to address the validity of statistics. In his usually grand, rather continental style, he raises serious questions about this Report, about prevalence statistics in general.

*A final thought from one who is not even qualified for amateur status in discussing statistics. One does not need perfect or even complete data to move ahead with some social policy. If I know you are enthusiastic about the death penalty, believe prisoners have far too many rights, and wish to overrule **Miranda** and **Roe v. Wade**, how much more do I need to know you are not a liberal?*

The better the prevalence data, of course, the more detailed and certain the fix. The fix, however, seems clear even with some data that may be seriously questioned: We know there are far too many people in penal settings with mental illness, people who should have been diverted; and there are far too few well-trained persons working in penal settings offering mental health care.

Better data can tell us just how many doctors are needed. We know enough now to know we need more.

Prevalence Estimates; The Numbers Game

by Hans Toch, Distinguished Professor, School of Criminal Justice, State University of New York

In September the Bureau of Justice Statistics (BJS) published a report proclaiming that "at midyear 2005 more than half of all prison and jail inmates had mental health problems, including…56% of State prisoners, 45% of Federal prisoners, and 64% of jail inmates" (James & Glaze, 2006, p. 1). These estimates were derived from a survey of prisoners that is periodically administered by BJS. Comparable prisoner surveys have been run every five or six years since 1972. Results of the preceding BJS survey, covering midyear, 1998, were summarized in a 1999 report. This report opens by recording that "16% of State inmates, 7% of federal inmates, and 16% of those in local jails reported either a mental condition or an overnight stay in a mental hospital" (Ditton, 1999, p. 1). According to comments cited in the *New York Times* (Butterfield, 1999), this set of 1998 data "confirms the belief of many state, local and Federal experts that jails and prisons have become the nation's new mental hospitals." If such was indeed the conclusion to be drawn at the time, what might we have to say today? The 1998 statistics may have been daunting, but they are relatively underwhelming compared with the more recently publicized claims.

Aside from an improbably cataclysmic increase in the prevalence of psychological disorders among prisoners, how can we account for enormous discrepancies in non-mental health prevalence estimates? And what can we possibly assume that these estimates are estimates of? For openers, it is obvious that whatever was being relied upon by the researchers as the basis for their inferences has varied markedly from one survey to the next. If apples were being harvested by BJS in 1998, oranges are being gathered in 2004. And one cannot help wondering about the munificence of the harvest. What documentation could anyone reasonably invoke for the conclusion that *over half* of prison and jail inmates have "mental health problems?" And what could it mean to draw distinctions between a majority of problem-ridden prisoners and a deviant minority accorded a clean bill of mental health?

And yet, distinctions are drawn by BJS. More surprisingly, differences that are now being highlighted by BJS are often similar in direction and kind to those recorded in 1998. Thus in both of the surveys mental health problems were found to be more prevalent among female and white offenders. Mental health-related problems were also found to be more common among prisoners convicted of violent offenses and repeat offenders. And such problems in both surveys were associated with histories of homelessness and early experiences of victimization. Both of the surveys reported that

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mental health problems were often related to involvements in prison disciplinary violations.

What with discrepant criteria for mental illness, some differences among differences could obviously be expected. BJS now indicates that "inmates age 24 or younger had the highest rate of mental health problems and those age 55 or older had the lowest rate" (James & Glaze, 2006, p. 4,) while in 1999, BJS reported that "offenders between 45 and 54 were the most likely to be identified as mentally ill" (Ditton, 1999, p. 3). Mental health problems—as now defined—are linked by BJS to substance dependence or abuse. No such relationship was discussed in 1999, though there is allusion to drug and alcohol usage. The issue of comorbidity is of great practical importance, but estimates must of necessity vary depending on how one defines substance abuse and mental illness, and their overlap.

The recent survey included a self-administered "symptom" checklist, which had been previously deployed in epidemiological studies in the community. But the community is not the prison, and it should have been obvious that some tweaking might need to be done to adapt an instrument used in the free world for administration in confinement settings. For a prison inmate to report "increased/decreased interest in sexual activities" would thus hardly appear to be a manifestation of pathology, nor would mention of a "loss of interest or pleasure in activities," or of "feelings of worthlessness or excessive guilt" or "persistent anger or irritability." But based on agreement with precisely such statements, BJS analysts concluded that 30% of jail inmates exhibit five or more "major depressive disorder symptoms"— more than the number required for a psychiatric diagnosis. And based on the same "symptoms," they indicated that "54% of jail inmates…met the criteria of mania," which is unusual as a stand-alone category.

Serious diagnosing is a procedure that calls for intimate personal assessment. The process requires painstaking sensitivity and experience-based acumen. Such an enterprise cannot be approximated by a clerk or a machine collating items from a checklist included in a questionnaire. What can, of course, be derived from a questionnaire (as used by BJS eight years ago) are factual details, such as whether a respondent recalls having been hospitalized. Such responses tell us whether a person may have a history of diagnosed mental illness. This in turn can raise a presumption of continuing difficulties—especially for some serious conditions such as schizophrenia, which tend to be chronic or periodically recurrent.

Several facts must be kept in mind when one consumes prevalence statistics: The first fact is that the diagnostic constellations that are listed in the DS Manual describe many—*but not all*—serious psychological difficulties that a person may experience. Most real-life problems refuse to fit neatly in predefined categories, and many problems vary disquietingly over time, as a person moves from situation to situation. The second fact is that the lines between what is problematic and non-problematic are difficult to draw, and consequently such lines are often drawn to taste. In order to inventory persons who are "mentally ill" we must take it for granted that we can distinguish such persons from each other and from the rest of the population. But there are no agreed-upon lines of demarcation that enable such distinctions. Where we may decide to draw lines depends on our level of tolerance for symptomatic behavior, on the sorts of services we feel we can provide, and on our taxonomic predilections,

The Bureau of Justice Statistics elected to define the borders around prison mental health problems with disarming generosity. Paradoxically, prisons mostly tend to define such borders with miserly care. One reason for the conservative stance of many prison administrators and their mental health staff is that the misbehavior of difficult prisoners can be more expeditiously dealt with if one ignores indications that such behavior may be a manifestation of emotional disturbance. Nominating the inmate as a person with mental health problems can also be expensive, because it implies that the inmate is now entitled to professional services.

From a client perspective, some prisoners find the prospect of being diagnosed attractive because of the corollary entitlement to assistance, including medication. Others regard the prospect of being classified as non-resilient or vulnerable to be demeaning, pejorative and stigmatizing. The more resistant inmates—even when placed in intolerably stressful settings of the sort that are currently fashionable in prisons, may steadfastly testify that they are doing "just fine" while they are transparently manifesting grossly symptomatic behavior.

In the aggregate, the numbers game can be intrinsically unproductive. If we were to somehow arrive at truly valid, reliable estimates of prevalence of mental-health problems, the statistic would tell us very little. Numbers cannot specify the magnitude of a social problem because we cannot visualize human suffering in numerical terms. Nonetheless, it is obvious that numerical estimates are here to stay. Statistics serve as political ammunition, and the fact that they are fairly meaningless is not likely to curb our insatiable penchant for tendentious quantification.

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Mental Health Problems of Prison and Jail Inmates

by Jeffrey L. Metzner, M.D., Clinical Professor of Psychiatry, University of Colorado Health Sciences Center

The Bureau of Justice Statistics (BJS) recently issued a special report entitled "Mental Health Problems of Prison and Jail Inmates[1], which reported that more than half of all prison and jail inmates had a mental health problem. The findings were based on data from personal interviews with state and federal prisoners in 2004 and local jail inmates in 2002.

Careful reading of this report raises significant methodological issues, which likely explains certain suspect findings. For example, 43% of state prisoners and 54% of jail inmates described symptoms that were reported to meet the criteria for mania and an estimated 15% of state prisoners and 24% of jail inmates reported symptoms that met the criteria for a psychotic disorder. Neither one of these findings are consistent with clinical experience within correctional mental health systems, although it is clear that a significant percentage of inmates do have such illnesses. The methodological problems included using a survey instrument that collected information on experiences of inmates in the past 12 months (i.e., determining one year prevalence rates) that did not assess the severity or duration of the symptoms. The reader should refer to the article written by Professor Hans Toch in this newsletter for a more comprehensive analysis of the methodology used.

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Despite methodological flaws, this report presents important data which is consistent with clinical experience and other published reports[2-9]. This article will briefly summarize such findings and selected implications for correctional mental health systems.

Important, but generally not new, findings included the following:

1. Symptoms of mental disorder were highest among jail inmates.
2. Over 70% of inmates who had a mental health problem met criteria for substance dependence or abuse.
3. Jail inmates who had a mental health problem were three times as likely as jail inmates without to report being physically or sexually abused in the past.
4. A quarter of state prisoners had a history of mental health problems.
5. Female inmates had higher rates of mental health problems than male inmates.
6. State prisoners who had mental health problems were twice as likely as those without to have been homeless before their arrest.
7. Violent criminal record was more prevalent among inmates who had a mental health problem.
8. State prisoners who had mental health problems had longer sentences than prisoners without.
9. Rule violations and injuries from a fight were more common among inmates who had a mental health problem.
10. One in three state prisoners and one in six jail inmates with a mental health problem had received treatment since their admission.

Implication of Findings

Mental Health Screening. The first six findings emphasize the need for adequate mental healthcare screening upon admission to either a jail or state prison. In a jail setting, the high comorbidity rate of substance abuse/dependence in mentally ill inmates often makes the initial diagnostic process complicated, which has an obvious impact on subsequent treatment. It is likely that this particular finding accounts for the high reported prevalence rate of mania in this BJS Special Report, because the use of crack cocaine and other street drugs can result in a clinical picture very similar to a manic disorder. The higher prevalence rate of mental disorders among jail inmates as compared to prison inmates is likely explained by the differences in missions between jails and prisons, a higher incidence of acute intoxication among newly admitted jail inmates and the diversion of mentally ill inmates from the criminal justice system to the mental health system.

The not unexpected findings related to the high prevalence of mentally ill jail inmates having been physically or sexually abused in the past and the higher prevalence rate of mental health problems among female inmates should help structure screening instruments used during the admission process as well as treatment programs in both jails and prisons. Related primarily to resource issues, treatment programs addressing past abuse issues both for male and female inmates are often lacking in correctional institutions.

Many correctional mental health systems continue not to be very active in seeking past mental health care records. However, the findings of this Special Report should serve to reinforce the need for obtaining such records related to the high prevalence of inmates with a history of mental health problems.

The need for adequate discharge planning for mentally ill inmates, in both jails and prisons, with particular reference to help with housing is emphasized related to the prevalence of homelessness among this population.

Mental Health Treatment and Programming. The finding that 17%–34% of all the inmates who were identified as having had a mental health problem receiving treatment since admission is an interesting one. This low percentage may be consistent with the previously referenced methodological problems. The low percentage of those inmates receiving treatment may be a reflection that the percentage of inmates reported to have mental health problems was inflated due to methodological issues. This hypothesis is supported by an earlier BJS report that indicated nearly one in eight state prisoners were receiving some form of mental health treatment at midyear 2000.[10] Another more distressing possibility is that many inmates with mental illnesses were not receiving treatment for various reasons, which generally involve inadequate resources.[11]

The need for inmates to have adequate access to substance abuse treatment, which should be coordinated with their mental health treatment of their serious mental disorders, should be apparent by the significant association between these two problems.

It is an interesting question why State inmates with mental health problems had longer sentences than prisoners without such problems. It is unclear from this data how much this finding is related to the higher prevalence of violence along inmates with mental health problems, a higher rate of management difficulties as evidenced by the higher number of rule violations and/or inadequate treatment being received by mentally ill inmates which would contribute to both of the above factors.

As usual, the BJS continues to provide nationally based data that should stimulate further policy development and, hopefully, additional resources for correctional mental health systems.

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Prevalence and Policy

by Jamie Fellner, Director, U.S. Program, Human Rights Watch

According to a new Federal Bureau of Justice Statistics (BJS) report, about half of the jail and prison population in the United States —1,254,800 men and women — has a mental health problem. The figure is staggering, but not surprising.

It testifies to the persistent failure of the state and federal governments to stem the tide of the mentally ill swept into the criminal justice system. It also testifies to public ignorance — or is it deliberate indifference? — to the tragedy of putting the mentally ill behind bars.

People with mental illness often end up in prison because the community mental health system in the United States is in shambles — fragmented, underfunded, unable to serve the population that most need its services, including the poor and homeless. The new BJS report reveals that approximately one in five state inmates with mental health problems had received treatment in the year before arrest; only half had ever received any mental health treatment. It found that state inmates with mental health problems were twice as likely to have been homeless before arrest as other inmates, and provides some other statistics that point to their personal histories at the economic and social margins of society.

Untreated and unstable, some people with mental illness will break the law and then they confront punitive law enforcement and sentencing policies. BJS reports that 51% of state inmates with mental health problems were convicted of nonviolent offenses, primarily drug and property offenses. One in five had no prior criminal sentence. Another one in three were non-violent recidivists. Alternatives to incarceration may well have served community safety interests just as well as prison for many of these offenders. But politicians remain loathe to reform their "tough on crime" legislation or to support and fund programs, like mental health courts, that divert offenders with mental illness from the criminal justice system.

As a result, prisons receive men and women suffering from mental health disorders, including such serious illnesses as schizophrenia, bipolar disorder, and major depression. The BJS reports that 34% of state inmates and 24% of federal inmates with mental health problems have received treatment after admission to prison. As a quantitative matter, on their face these figures suggest many inmates are not receiving services they need. But even with regard to those inmates who do get some sort of treatment, the figures say nothing about its quality, nature or effectiveness.

As we documented in *Ill Equipped: U.S. Prisons and Offenders with Mental Illness* (available on line http://www.hrw.org/reports/2003/usa1003), prison mental health services are all too often wholly inadequate. They are crippled by understaffing, insufficient facilities, and limited programs. The significant steps that many state correctional systems have made to improve their mental health services have been swamped by the tsunami of inmates who need them.

Prisoners who are mentally ill are far more likely to end up in segregation than other inmates.

With little or no effective mental health treatment and support, offenders with mental illness are forced to navigate on their own prison environments that pose unique challenges for them. These inmates often prove to be ill equipped to cope with the stresses and rules of prison life. They are likely to be victimized by other inmates; they have difficulty following the rules. Again, the new BJS statistics are revealing: 58% of state prison inmates with mental health problems have been charged with rule violations, compared to 43% of inmate without such problems. The former are more than twice as likely to be charged with verbal assault as the latter. In addition, BJS reveals that inmates with mental health problems are twice as likely as those without to be injured in a fight.

Mentally ill prisoners face prison rules that were never designed to accommodate their unique needs. They face correctional officers ill trained to work with them and ignorant of the nature and significance of their symptoms. Prisoners who are mentally ill are far more likely to end up in segregation than other inmates. Data that is available from individual states reveals a significantly disproportionate presence of these most vulnerable of inmates in this harshest form of confinement.

What state and federal governments just do is easy to prescribe. They must dramatically increase the scope and effectiveness community mental health systems. They must reform needlessly harsh sentencing laws and law enforcement practices to reduce the number of persons with mental illness needlessly ending up in prison. They must also improve the quantity and quality of prison mental health services, rehabilitative programming and reentry services provided to people behind bars.

Financial considerations have played a role in frustrating the needed reforms. But more is at work here than money. The lack of funds reflects inadequate commitment, compassion and common sense on the part of elected officials. These officials need to address the crisis of mental health care in the United States, even if doing so is not a "vote-getter." They need to abandon the politically popular but counter-productive and unnecessarily punitive "tough on crime" policies that have given the U.S. the highest incarceration rate in the world. They must accept responsibility for those who are incarcerated and ensure prisons have the funds needed to help turn inmates lives around and to, at the very least, provide the necessary mental health services.

During the deinstitutionalization era, the United States succeeded in shutting down the large, barren public mental health hospitals in which hundreds of thousands of people with mental illness were involuntarily confined and received little treatment. It now involuntarily confines tens of hundreds of thousands of people with mental illness in

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large, barren prisons in which they receive little treatment. Prisons are today's mental health facilities. Could there be a sadder commentary on how this wealthiest of countries treats its most vulnerable residents?

The BJS Special Report and Social Reality

by Terry A. Kupers, M.D., M.S.P., Institute Professor at The Wright Institute, Berkeley, California, and Contributing Editor of Correctional Mental Health Report

The Special Report from the Bureau of Prison Statistics (BJS), "Mental Health Problems of Prison and Jail Inmates" (September, 2006) confirms what we knew and did not want to mention: There are a huge and unprecedented number of individuals suffering from serious mental illness (SMI) behind bars today (56% of State prisoners, 45% of Federal prisoners and 64% of jail inmates); the proportion of prisoners suffering from serious mental illness has actually been rising even as the incarcerated population multiplies; over 70% of prisoners have a substance abuse problem; prisoners with mental health problems are twice as likely as other prisoners to have been homeless prior to incarceration, jail prisoners with a mental health problem are three times as likely as others to have a history of sexual and physical abuse, and state prisoners with a mental health problem are twice as likely as those without to have been injured in a fight since being incarcerated. Our society has been systematically transferring the population of people with serious and persistent mental illness from state and federal hospitals to jails and prisons, usually with an intervening period of community residence, where many will turn to illicit substances and become homeless prior to their arrest. Then, in jail and prison, they are victimized and do not receive the treatment their psychiatric condition warrants.

The question is: Why does our society rely on prisons to deal with mental illness? But before we can get to that question, we have to consider the destructive effects of what social psychologists would call an attribution error. Will we focus on the narrow question whether one or another individual with mental illness broke the law and was arrested — i.e., attribute the problem to the bad behaviors on the part of a whole lot of individuals? Or will we ask why, at this point in history, so many people with mental illness wind up behind bars — i.e., attribute the problem to a tragic situation? The former approach leads to arguments over diagnosis. Is it really Schizophrenia, or is a particular individual acting out his psychopathy, or worse, is he merely malingering?

On the other hand, could it actually be the situation rather than the individuals that cries out for our attention? As a society, we have opted to deinstitutionalize, we have opted to make successive cuts in public mental health and other social welfare programs, we have decimated the "safety net" that once provided housing and supported work opportunities for emotionally disabled people, we have declared a "war on drugs" and prolonged prison sentences for all manner of offenses. If we attribute the massive explosion of people with mental illness behind bars to individuals' criminal inclinations, then the question we must address from a historical perspective is why we have so many disturbed criminals in our midst compared to the number in 1970, when the prison population was one tenth what it is today and the proportion with mental illness was smaller? But if we look at the successive social policy decisions that led to the mass incarceration, or trans-institutionalization, of people suffering from serious mental illness, then we arrive at the ugly reality that our society has been "disappearing" psychiatrically disabled individuals into correctional settings for decades. In other words our society has reneged on the promises of the New Deal and the War on Poverty.

Society "disappears" people with mental disabilities into the jails and prisons, and then fails to consign sufficient funds to provide them adequate treatment there.

What the BJS does not mention is that our concept of mental illness has shifted, and the stigma we attach to it has become nasty. Not too long ago the standard teaching in psychiatry was that individuals suffering from SMI were no more violence-prone than the average citizen — unless they were non-compliant with treatment and partook of illicit substances, in which case their risk of violence would be expected to rise. But today, with an unwritten policy of many parole boards to count SMI as a risk factor in determining whether it is safe to parole prisoners, and with recently legislated post-release civil commitment procedures for felons with SMI, there is a tendency to stigmatize those with SMI as representing a relatively high violence risk. And, in all too many cases, the individuals being considered for parole or post-release civil commitment are more disturbed and unpredictable than they would have been had they not spent years being victimized on a prison yard or enduring forced idleness and isolation in some form of isolated confinement. On average, they have not received adequate mental health treatment during their incarceration and they have almost certainly been traumatized — two eventualities that are known to make mental illness more severe and less remitting. Then we punish them with an even longer period of lock-up.

Another implication of the BJS Report is that it is unfair to blame the staff who work in jails and prisons for the shortcomings of treatment programs that are extremely underfunded, relative to the immense need. Society disappears people with mental disabilities into the jails and prisons, and then fails to consign sufficient funds to provide them adequate treatment there. I know this statement will be thrown back at me someday when I am on the witness stand, but I would argue that the more inadequate the funding for correctional mental health programs within a correctional system, the more common is the attribution by clinicians of malingering. It really gets down to a matter of not diagnosing what you know you do not have the wherewithal to treat. So the short supply of mental health services are reserved for those prisoners who are provably worthy of services, and the greater the budget shortfall the higher the bar for proving worthiness.

Who is to blame? The overburdened clinician who erroneously diagnoses "merely malingering" in a prisoner who had three state psychiatric hospital admissions and was taking anti-psychotic medications and receiving Social Security total disability (SSI) prior to his arrest? Or a society that disappears people suffering from serious mental illness into jails and prisons? It is

Deliberate Indifference and the Ostrich Instruction: Expanding the Analogical Base

by Fred Cohen

Deliberate indifference, of course, is that intellectually elusive mental state that is a prerequisite for constitutionally grounded liability in a correctional mental (or physical) health care case. The initially unexplained mental element first appeared in **Estelle v. Gamble**, 429 U.S. 97 (1976), and then was defined in **Farmer v. Brennan**, 511 U.S. 825 (1994).

We have not yet developed an electronic or x-ray device by which to establish any mental element let alone calculated indifference. Whether the issue is a defendant's intent to do harm, knowing violation of the law, recklessness or negligence, the requisite mental element will be established either by an admission or confession, or more likely, an inference drawn from the defendant's conduct.

Deliberate indifference is a variant on recklessness that involves a high degree of risk creation and the disregarding of that risk.

Inferences should not be disparaged as some sort of second-best evidence. An inference, after all, is the mental process of moving from one proposition believed to be true to another proposition whose truth follows logically from the first. A person holding a smoking gun while standing over a supine body with a bullet hole in its chest may deny firing the shot that caused the bullet hole. Indeed, there may well be another explanation. However, it is a reasonable inference that the smoking gun in the hand of our candidate for defendant status was the instrumentality of harm and the person in possession very likely pulled the trigger. This, of course, is an inference establishing conduct and not necessarily any particular mental element.

Once causation is inferentially agreed upon there is the matter of intent, malice, recklessness or negligence and no decision can be made on mental element without more facts. Did the victim attack the accused? Was the accused caught in the act of burglary? A gun fancier whose antique weapon went off accidentally? A jealous husband? And so on.

Returning to correctional mental health matters, the **Farmer v. Brennan** test for deliberate indifference is located somewhere between the mental state of intent — acting with a purpose to achieve a particular result — and negligence — failing to act with the degree of care that a reasonably prudent person would have used in the circumstances. Deliberate indifference is a variant on recklessness that involves a high degree of risk creation and the disregarding of that risk.

Recklessness itself has two variations. In one, the "mild" version, the requirement is that the actor either knew or *should have known* about the risks. This is more common in civil law. In the other, the "hot" version, the actor must be shown to have *actually known* of the risks. This is more common in the criminal law.

Farmer v. Brennan opted for the "hot" or actual knowledge version thus making it more difficult for inmate plaintiffs to prevail and easier for harm-causing defendants to escape liability. This requirement returns us to the earlier discussion of "who knew!?" and the efficacy of inferences. Clinicians accused of deliberate indifference in diagnosing or treating mental illness are not likely to sign a deliberate indifference confession after some version of a **Miranda** warning.

Indeed, it is fair to say that deliberate indifference almost always will be a matter of an inference drawn from conduct, including statements.

The primary purpose for composing this brief essay is to introduce our readers to an area of law well outside the borders of corrections, yet quite relevant to an enhanced understanding of mental health law. As we specialize and learn more and more about less and less, our cache of analogies shrinks. What follows, then, will expand the analogical base and perhaps add some dimension to deliberate indifference.

The Ostrich or Willfully Blind Instruction

Suppose X is driving Y's car some distance and is to be paid $1,000 for his trouble. There is a secret compartment in the car containing a cache of heroin and when X arrives at the destination, drug enforcement agents immediately arrest him and then charge him with knowingly transporting illegal drugs.

X will claim, "Who knew!?" The government will charge that there were "flags of suspicion" here that when uninvestigated suggest "willful blindness," which, in turn, supports the inference that X consciously chose not to pursue the truth. That failure, it will be argued, is the equivalent of actual knowledge allowing for the "ostrich" instruction.

This hypothetical is a close case with the key red flag the amount of money offered X. We are not told how far he had to drive or whether there would be significant food and lodging expanses, all of which dilute the red flag duty of inquiry. If the trip was from Tucson to Phoenix (120 miles), and the car was to be dropped off at night in an area widely known for its drug trafficking, then the red flags increase in number and intensity as does the inference of "knowingly."

Pre-trial detainee A has been arrested and held for public intoxication. He screams at a deputy that, "I can't take it any more. I am going to kill myself if you don't get my wife in here." The deputy could see a number of scars on A's left arm suggesting prior cuttings.

The deputy had removed A's belt and shoes and told A, "Be quiet and sleep it off." A few minutes later, A climbed the bars of his cell and fell forward on the concrete floor causing a fractured skull from which he died.

Was the deputy deliberately indifferent? Can it be said that he knew of a high degree of risk of suicide yet took inadequate steps to counter the risk?

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Custodial Suicide: A Different Result

In **Fidler v. San Mateo Co**., 2005 WL 3299894 (N.D. Cal.), the parents of Angela Ramirez, age 23, sued for damages based on the death by suicide of their daughter. The parents claimed that defendants knew their daughter was mentally ill and failed to properly respond to her symptoms after being denied access to her medication.

The defendants moved for summary judgment, which was denied. The district court found that there were reasonable questions of fact as to deliberate indifference, qualified immunity, and the existence of County unconstitutional policy.

The ruling was issued on December 6, 2005. On December 20, 2005 San Mateo County settled for $475,000. See Prison Legal News, p. 26 (Aug. 2006). It was reported that after numerous cries for help and numerous self-inflicted injuries, Angela slipped unnoticed into a shower area and hanged herself with a bed sheet. It took jailers one and one-half to two hours just to locate her.

Ramirez's parents initially sought $11 million but settled due to the difficulties of prevailing on suicide cases in federal court. Under state law, damages were capped at $250,000 for each parent.

Had this been the Sixth Circuit and a **Perez**-like panel there would have been exquisite questions as to the precise content and nature of the knowledge and any ameliorative action taken by staff. ■

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Yes, of course. The decedent threatened suicide and there were obvious signs (the scars) that the threat could be serious. On the other hand, there were no sharp implements available, nothing obviously useful as a ligature, and nothing to believe A might commit suicide as he did.

I would argue that the deputy was deliberately indifferent with the only soft spot being the precise nature of the risk. That is, is the deputy off the hook if the means of suicide were novel and not foreseeable? As for actual knowledge of (some) risk, there are the words and the scars and that could be enough for a jury to impute the requisite knowledge.

In **United States v. Alston-Graves**, 435 F.3d 331 (D.C. Cir. 2006), the defendant appealed from convictions on conspiracy and wire fraud. Among other things, she questioned the instruction allowing the jury to find "knowingly" and to convict if she closed her eyes to obvious facts.

The defendant had been involved in an elaborate scheme to induce lenders to make loans. She unsuccessfully argued that she did a few favors for one Smith but never knew Smith was defrauding others.

The trial judge charged the jury:

> When the word "knowingly" or the phrase "the defendant knew" is used in these instructions, it means that the defendant realized what she was doing and was aware of the nature of her conduct and did not act through ignorance, mistake or accident.
>
> The government may prove that the defendant acted "knowingly" by proving, beyond a reasonable doubt, that this defendant deliberately closed her eyes to what would otherwise have been obvious to her. No one can avoid responsibility for a crime by deliberately ignoring what is obvious. A finding beyond a reasonable doubt of an intent of defendant to avoid knowledge or enlightenment would permit the jury to find knowledge. Stated another way, a person's knowledge of a particular fact may be shown from a deliberate or intentional ignorance or deliberate or intentional blindness to the existence of that fact.
>
> It is, of course, entirely up to you as to whether you find any deliberate ignorance or deliberate closing of the eyes and any inferences to be drawn from any such evidence. You may not conclude that defendant had knowledge, however, from proof of a mistake, negligence, carelessness, or a belief in an inaccurate proposition. 435 F.3d at 336

As it turns out this instruction was found to be erroneously given because the facts on the record established knowledge without regard to "willful ignorance." The error was harmless however, and the conviction affirmed. Note, however, how this charge parallels the inquiry into deliberate indifference as to mental health care or suicide prevention.

In the above jail suicide hypothetical, the risk of suicide was obvious; the means were not. If A had said simply, "I just can't take this anymore." or "What the hell do I have to live for?" then we have a much closer question on actual knowledge of any risk of suicide.

Perhaps more on point would be a jail policy of never screening for suicide risk on mental illness. The hypothetical policy was adopted after a well-known consultant told the Sheriff that, "What you don't know can't hurt you. If you screen you may know, if you don't, you can't know!"

Given the risks of jail suicide — perhaps four times greater than prison — and the high percentage of detainees with serious mental illness, then this policy itself would represent "willful blindness" or the ostrich posture.

United States v. Carrillo, 435 F.3d 767 (7th Cir. 2006), resembles the drug delivery hypothetical described earlier, except that the facts are far more complicated. Defendant Miranda (no, not that one) drove a car packed with heroin from Mexico to the Chicago area. She received thousands of dollars for the first and a subsequent trip, which ended with seizure of the car and drugs packed into the drive shaft.

Miranda claimed the money was a gift, that she was just learning how to drive in order to make visiting her daughter in Mexico easier, and, basically, how could she know about drugs secreted in the drive shaft.

The Seventh Circuit explained that the logic of the ostrich instruction case is that given what the defendant knew, it would be permissible for a jury to conclude that the defendant strongly suspected involvement in illegal activity, but purposely avoided finding out for sure. There is no need to search in vain for an "act" that occurred in the veiled isolation of a defendant's psyche. The focus is on what the defendant knew and whether the defendant knew enough to support an inference that he or she remained deliberately ignorant of facts constituting criminal knowledge.

The court went on to establish that the test is not whether some objectively reasonable person was deliberately ignorant

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Remission Rates for Depression: Something to Be Modest About: Results from STAR*D

by James Knoll, M.D.*

Despite some disagreement over what the current buzzword "evidence-based practice" actually means, most would openly concede that psychiatry has indeed suffered from a lack of systematic guidance when it comes to inadequate treatment responses (Menza, 2006). Now comes STAR*D (the Sequenced Treatment Alternatives to Relieve Depression), which sought to systematically and sequentially examine the response of patients who do not remit with standard treatment. The study was large, complex, and funded by the NIMH at considerable cost. It was designed to be relevant to clinical practice in the "real world" by having less restrictive exclusion criteria. Subjects with both chronic (non-psychotic) major depression and co-morbid medical disorders were included.

The distinction between "remission" and "response" is critical to understanding the results of STAR*D.

The STAR*D research team has published the results in sequential steps, which they refer to as "levels." At the present time, the results of Levels 1, 2, and part of Level 3 have been published. STAR*D raises many issues relevant to clinical practice, and is best approached by reading the published articles sequentially. Here, I will only briefly outline the study, and then list the main "take home" points of Levels 1, 2, and part of Level 3.

Level 1

Level 1 treated subjects (N = 4,041) with open-label citalopram (an SSRI) at doses up to 60mg per day (Trivedi et al., 2006a). Level one is notable for simulating real world clinical practice where the initial treatment is commonly an SSRI. The primary outcome was remission of symptoms, which was determined by a score of 7 or less on the 17-item Hamilton Rating Scale for Depression (HRSD-17) at the end of the study. The 16-item Quick Inventory of Depression Symptomatology-Self-Report (QIDS-SR-16) was used to measure the secondary outcomes of remission (a score of 6 or less at the end of the study) and response (a reduction in baseline scores of 50 percent or more). The overall remission rate with citalopram treatment was 27.5%. The distinction between "remission" and "response" is critical to understanding the results of STAR*D and how it compares to previous clinical trials of antidepressants. STAR*D chose to set the bar high (or more sensibly?) by focusing on remission, as opposed to mere response which previous studies have used.

Level 2

The Level 2 study was designed to offer treatment alternatives to participants in Level 1 who were unable to tolerate or obtain remission following the 11.9 week initial trial of citalopram (Rush et al., 2006). The participants in the Level 2 study were given options that are typically available in an adult outpatient psychiatric treatment setting. The study offered subjects seven second-line treatments. They could choose to switch medications entirely, augment their current medication and/or incorporate cognitive therapy (the results of the cognitive therapy have not yet been published). The authors acknowledged that the use of this randomization strategy (essentially patient preference) may have introduced a potential confounding variable (Nierenberg et al., 2006). The augmentation options included: sustained-release bupropion (up to 400mg per day) or buspirone (up to 60mg per day). Bupropion was administered to 565 patients and was chosen because of its ability to block the reuptake of dopamine *and* norepinephrine, while buspirone was given to 286 patients and worked as a partial agonist at postsynaptic serotonin receptors (5HT-1A receptors).

As for those who ended up switching medications, 727 adult outpatients who were unable to tolerate citalopram or achieve remission were switched to one of the following medications: sustained release bupropion (max daily dose of 400mg), sertraline (max daily dose of 200mg), or extended release venlafaxine (max daily dose of 375mg). These medications were used to determine if there was a benefit in choosing a medication outside the pure SSRI class (as suggested by prevailing clinical wisdom), or simply using another SSRI.

The Level 2 results suggested that remission rates did not significantly differ among all approaches. For the augmentation strategies, remission rates were as follows: 29.7% with sustained-release bupropion and 30.2% with buspirone; however, buspirone was not as well tolerated as bupropion. For the switch strategies, remission rates were: 21.3% for sustained-release bupropion, 18.1% for sertraline, and 24.4% for extended release venlafaxine. Thus past wisdom may need to be retooled, as the results suggest that switching to another class of antidepressant may not be any more effective than switching to another SSRI.

Level 3

At Level 3, patients who did not achieve remission or could not tolerate treatment from Level 2 were randomly assigned to mirtazapine (N = 114) up to 60 mg per day, or nortriptyline (N = 121) up to 200 mg per day (Trivedi et al., 2006c). The remission rates of the two treatments did not statistically differ: 12.3% for mirtazapine, and 19.8% for nortriptyline. There were also no significant differences in tolerability or adverse events. The study concluded that switching to a third antidepressant after two consecutive unsuccessful antidepressant trials resulted in low

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(< 20%) remission rates (Fava et al., 2006). (See table for a summary of "take home" points from STAR*D Levels 1, 2, and 3.)

The results from the other part of Level 3 and Level 4 are due to be published in the September '06 issue of the *American Journal of Psychiatry* (Stegman, 2006). The other part of Level 3 consisted of augmentation options; either Cytomel (thyroid agent, up to 50 mcg per day), or lithium (up to 1,350 mg per day, shooting for a serum level of 0.6 to 1.2). In Level 4, subjects were randomized to either Parnate, a monoamine oxidase (MAO) inhibitor (up to 60 mg per day), or extended release venlafaxine + mirtazapine. Apparently, there was some consideration of including electroconvulsive therapy (ECT) in Level 4; however, this ultimately proved impractical (Stegman, 2006).

"Take Home" Points From STAR*D Levels 1, 2, and 3

- Remission rate for treatment with citalopram = 27.5% (Trivedi et al., 2006a).
- Switching to another class of antidepressant may not be any more effective than switching to another SSRI (Rush et al., 2006; Nierenberg et al., 2006).
- Either augmentation or switching appears reasonable (Nierenberg et al., 2006).
- Switching antidepressants as a third step after two consecutive failed antidepressant trials provides only a modest (< 20%) chance of producing remission (Fava et al., 2006).
- Psychiatrists may wish to consider routinely using ratings instruments to measure symptoms and side effects (measurement-based care) (Trivedi et al., 2006b).
- Remission from depression is not as common as previously thought (Fava et al., 2006).
- Predictors of a better antidepressant response: being well-educated, employed, married, white, female, few complicating problems (Fava et al., 2006).
- Predictors of a poorer antidepressant response: co-occurring anxiety, substance abuse, general medical conditions, poorer quality of life (Fava et al., 2006).

Commentary

Where is the silver lining to the modest remission rates from depression? One might hope that the results will be startling enough to prompt serious attention to this disorder. In other words, it could serve as a call to arms that major depression is a very serious, chronic and treatment-resistant illness that warrants aggressive treatment and careful consideration by both medical and insurance agencies (think parity).

It will be interesting to see if studies such as STAR*D, which suggest more modest expectations for treatment, cause some consternation over how treatment expectations should be communicated to patients. The APA website gives a rather glib endorsement that uses the word "respond" to describe very high rates of success: "(Depression) is…among the most treatable of mental disorders: between 80% and 90% of people with depression eventually respond well to treatment, and almost all patients gain some relief from their symptoms." (American Psychiatric Association, 2005).

Certainly, it will be important not to be misleading or communicate unwarranted optimism. On the other hand, it will be necessary to avoid bald statements of percentages from research studies. For example, one might imagine how a patient would respond to the following information: "Mr. Jones, there is about a 70% chance this medication will *not* relieve your depression. However, it is *very* likely to cause some type of sexual dysfunction. Now, shall we begin treatment?" The editorial published in the same journal issue as the level 3 results pinpoints a number of salient issues worth keeping in mind. Firstly, clinical trials such as STAR*D suggest "how groups of patients do on average," and do not necessarily tell us how each of our individual patients will respond to treatment. Secondly, popular treatments are constantly evolving so that long-term sequential studies, while laudable, may be akin to "chasing a moving target."

Today's moving targets include a number of approaches that were not tested in STAR*D. In particular, there is interest in augmentation with stimulants, mood stabilizers and atypical antipsychotics. In the community, Dr. Rush and his research group have ventured into the operating room to implant vagal nerve stimulators (VNS) for patients suffering from chronic, treatment-resistant depression (Stegman, 2006). While corrections is not likely to embrace such a cutting edge approach, many of the augmentation strategies mentioned above are indeed cost-effective. For example, thyroid agents, lithium, and buspirone are typically inexpensive. Risk-oriented psychiatrists can be expected to have concerns about prescribing lithium, tricyclic antidepressants, and MAO inhibitors to depressed patients in a jail or prison setting, due to the high lethality of these agents in overdose.

As I view the problem of chronic depression through my correctional mental health lens, it is more than apparent to me that the list of poor predictors of antidepressant response reads like a profile of the average inmate seeking treatment. As a result, one could speculate that many depressed inmates will require something more than simple SSRI monotherapy. This will likely mean more intensive treatment, possibly with multiple agents — prospects which correctional administrators are likely to find depressing.

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Some Good Deeds Go Unpunished: Suicide and Good Samaritan Law

Hwan Youn, a radiologist, became acutely distressed as a result of serious marital discord with his wife. He was arrested for spousal abuse and his medical partner asked him to resign. Decedent's neighbor, Dr. Jason Smotherman became concerned about Youn's mental state, heavy drinking, and suicide threats.

Smotherman called Dr. Gary Kula, a psychiatrist, and asked him to see Youn out of professional courtesy. Kula had no prior relationship with Youn and nothing resembling a contractual relationship.

Kula, with his wife, left the lunch he was having and spent an hour and a half with Youn prescribing Valium, and with the aid of others, removed alcohol and sharp objects from Youn's home.

Dr. Smotherman again called Dr. Kula who went to Youn's home when Youn refused to take his medication. Youn took the medication, went to sleep, but killed himself the next day.

Evidently grateful for Dr. Kula's help, the surviving wife sued him for negligence and Kula defended under Oklahoma's Good Samaritan Act. Immunity under 75 O.S § 5 requires (1) the absence of a prior contractual relationship between the rescuer and the injured person, (2) the characterization of the rescuer's act as having been done in good faith, voluntarily and without compensation and (3) the injured person's apparent need of emergency medical aid.

Plaintiff's expert, an unnamed professor from the Harvard program in law and psychiatry, testified by affidavit that, "where Good Samaritan immunity is broad, it is generally understood by physicians and mental-health professionals as protective only when the presence of a doctor at the scene of a medical emergency is coincidental." Plaintiff's expert also attested that Good Samaritan immunity "does not apply to acute psychiatric care, where the psychiatrist is, as Dr. Kula admits, acting as a consultant, . . ., nor in situations where the initial consultation is followed up by subsequent care in the presence of an available alternative," particularly, referral to the available on-call psychiatrist at the Hospital, and where, as in the present case, the psychiatrist "took it upon himself to provide continuity of care, including additional visits, family interviews, medication prescription, and referral to see him the following Monday." The expert ultimately opined that Kula's actions in dealing with Decedent "could . . . rise to the level of gross negligence," and "it may also be determined that Dr. Kula's negligent acute psychiatric care was the direct and proximate psychiatric cause of [Decedent's] suicide the next day."

Undaunted by the Harvard connection, the Oklahoma Court of Civil Appeals in **Youn v. Kula**, 125 P.3d 705 (Ok. Civ. App. 2005), ruled as follows:

> The uncontroverted evidence in the present case demonstrated Kula was a doctor licensed to practice psychiatry, a method for treatment of mental conditions. At the time he was called, Kula was eating lunch at a restaurant with his wife, and took his wife with him to Decedent's home. At the time he spoke to Decedent, Kula had no prior relationship with Decedent, and saw Decedent in good faith, voluntarily and without expectation of compensation. Kula rendered treatment in the "emergency" circumstance of Decedent's threats and/or attempts at suicide, a circumstance in which Decedent appeared "to be ill or in need of succor," and at risk of death or serious bodily harm absent treatment, in this case, by Kula. The Act extends immunity for emergency treatment rendered "wherever required," and Kula rendered emergency treatment to Decedent where required at Decedent's home. Plaintiffs admitted they had "no evidence to establish that . . . Kula . . . failed to exercise slight care when rendering assistance to the deceased, i.e., that the defendant was grossly negligent." 125 P.3d at 709

The trial court's grant of judgment for Kula is upheld.

COMMENT: I fully understand this is not a correctional mental health decision. However, our newsletter is read by many psychiatrists and psychologists who drive home and who also have troubled neighbors. Whether this decision will cause you to not interrupt lunch is, of course, a personal decision. ■

Andrea Yates[1]: Money in Madness

Andrea Yates may not quite be a household name but as soon as you saw the headline you knew that this is the woman who drowned her five children, who raised an unsuccessful insanity defense, and whose conviction was overturned due to false testimony by the state's prominent psychiatrist. You also probably know that on retrial in July of this year Andrea Yates was found not guilty by reason of insanity.

Ms. Yates thereafter was committed to North Texas State Hospital where she will likely spend the rest of her days. Had her conviction been sustained she would have been imprisoned and confined to a high security, correctional mental health unit. What's the difference?

Well, one difference is in expert fees. Dr. Park Dietz reportedly was paid $105,000 for the false testimony that led to the reversal. He was paid a mere $37,000 for the second trial.[2]

Dr. Michael Weiner and his firm, the Forensic Panel, were paid an astounding $242,966.74 for work on the second trial. Juror Bobby Chism described Weiner as aloof and self-serving. Little did he know he was also very expensive.

Weiner uses a so-called "peer review" process to fortify his expert testimony. The

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of staff needed and requested. At one point DOF refers to the need for a court order to go forward. Judge Karlton provided one on July 28, 2006:

> IT IS HEREBY ORDERED that:
>
> Michael Genest, Director of the California Department of Finance, is joined in his official capacity as a defendant in this action. The Clerk or the Court is directed to serve a copy of this order on Mr. Genest at the California Department of Finance, 915 L Street, Sacramento, CA 95814.
>
> Defendants shall prepare and present to the special session of the Legislature, scheduled to occur in August 2006, a budget proposal for the allegation of no less than the 530.65 permanent and 21.2 limited term positions recommended by the Department of Finance's Unit Review in 2005, together with an allocation of sufficient funding to execute and complete a workload study in time to include its findings and recommendations in the FY 2007/08 budget. The 530.65 permanent positions should be in addition to the 208 permanent positions already allocated to implement the revised Program Guide.
>
> The Clerk of the Court is directed to unseal documents # 1851, 1881, 1882, 1883, 1891, 1892, 1893, 1910, 1918, and 1921.
>
> The Clerk of the Court is directed to send a copy of the Special Master's supplemental report and attached exhibits, filed July 28, 2006, together with a copy of this order to Robert Sillen, Court-Appointed Receiver, c/o Judge Thelton E. Henderson, United States District Court for the Northern District of California, 450 Golden Gate Avenue, San Francisco, CA 94102, and to serve a copy of the same documents on Michael Bien and Lisa Tillman, counsel for the respective parties.
>
> DATED: July 28, 2006
>
> Lawrence K. Karlton
>
> Senior Judge
>
> United States District Court

Judge Henderson was noted to be copied because he is the Judge in **Plata** and Robert Sillen is the Receiver. There was some talk about the merger of **Plata** and **Coleman**, but conversations with counsel persuade me that will not happen.

Hiring some 750 staff is not going to be easy. It is likely that the state will have to raise wages and benefits and that will have a ripple effect on other agencies and also lead to an intrastate agency brain drain.

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Of course, there should be no gloating over these developments. However when California, indeed, the nation, started down the get-tough-on-crime and lock-'em up path, there was a bill that had to come due for housing, safety, and medical, mental health, and dental care. It came due early and substantially in California. Other states with bulging prison populations are next in line.

** See Fred Cohen, California Ordered to Add Some 700 Acute Mental Health Care Beds, 8 CMH 40 (September/October 2006), for an earlier order confined to mental health beds.* ■

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seven peer reviewers, picked by him, billed at $350.00 an hour but Dr. Weiner then charged each of them $75.00 an hour probably as a type of referral fee.

The prosecutor's office, however, later refused to pay the mark-up. In any event, peer reviewed or not, the Dietz-Weiner team did not prevail.

Professor Stephen Morse and Judge Morris Hoffman writing in the *New York Times*, OP-Ed (July 30, 2006), "The Insanity Defense Goes Back on Trial," make the point that the insanity defense is less about science than morality. Indeed, an insanity defense resembles an early morality play performed on a modern stage with dramatic lines taken from science.

Ultimately, it is all about blameworthiness; about holding someone accountable or not for what are invariably shocking, horrifying crimes; crimes like those committed by Andrea Yates. Entrepreneurs like Dietz and Weiner aside, if the clinically depressed, psychotic Andrea Yates does not fit the insanity defense, no one does. It certainly cost Harris County a lot of money to present a losing morality play.

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Endnotes

1. See Fred Cohen, "Yates Conviction Overturned: Dr. Park Dietz Gave False Testimony," 6 CMH 87 (Mar/Apr 2005); and James Knoll, "Splitting the Wrongfulness Hair: Texas v. Yates, 7 CMH 22 (July/Aug 2005).

2. The fee information on Dietz and Weiner is from Rick Casey, Second Yates Expert Paid $242,966.74, Houston Chronicle (Sept. 30, 2006). ■

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diagnosed him as suffering from schizophrenia and he was given antipsychotic medication. Additionally, he was placed in a psychiatric ward at NOMC from mid-May through early June. In early October 2002, Perez went to the NOMC emergency room and stated that he was hearing voices telling him to hurt his sister and break into a restaurant. Perez was again diagnosed with schizophrenia and another petition for hospitalization was prepared on his behalf.

Incarceration Period During Which Perez Committed Suicide

On October 24, 2002, Perez returned to the Oakland County Jail after violating his probation. Early in the morning on October 25, 2002, Perez told a guard that he was hearing voices. He asked to speak to a counselor immediately, but said he did not feel suicidal. A half-hour to an hour later, Perez attempted suicide by tying his pants around his neck and the bars of his holding cell. A deputy placed Perez on ASW status, and he was placed in an observation cell. Rice came to see him soon after, and she continued the suicide watch. Dr. Hemachandra also saw Perez on an emergency basis that day. Perez told Dr. Hemachandra that he had attempted suicide in order to see a counselor and obtain medication (Lithium and Zypreza, which he had been taking prior to his incarceration) sooner. Dr. Hemachandra prescribed these medications and recommended that Perez be kept under close supervision.

Perez and Rice met on October 28, 2002, and Perez stated that he felt better since receiving the medication and that he did not feel suicidal. He told Rice that he had not wanted to kill himself when he attempted suicide, but instead, he had made the attempt because he wanted to be taken out of the holding cell and given medication. Rice discontinued Perez's ASW status and approved his transfer back to the general prison population, finding that he was cooperative and his thought process appeared to be within the normal limits. He was moved to a 10-man cell on October 30, 2002.

On November 4, 2002, Rice and Perez met again, following a report she received that Perez was refusing to take his medication. Perez told Rice he thought he did not need the medication, that he had lied about his symptoms in the past in order to get the medication, hoping that it would help him cope with his term in jail. He said he had been depressed in the past, but that he had become a Christian and had a purpose in life. He further stated that he did not feel suicidal, and that he wanted a cell assignment that would allow him to work on his General Educational Development Test (GED). Rice noted that Perez "appears manipulative in order to get his way," that he did not appear suicidal and that he "appears stable at this time." She determined no watch was needed.

On November 8, 2002, Dr. Hemachandra evaluated Perez again. Dr. Hemachandra's report from this session documented Perez's history of ADHD, cannabis dependence, suicide attempts, paranoia and mood swings. Dr. Hemachandra asked Perez if he had been hearing voices, and Perez said that he had not. He said he never had and that he lied about hearing voices in order to get medication to help his insomnia and depression. Dr. Hemachandra again diagnosed Perez with schizoaffective disorder, cannabis dependence, a learning disorder and a personality disorder. He did not, however, find evidence of suicidal intent. Dr. Hemachandra recommended Perez be given individual counseling and substance abuse counseling. He also prescribed Zyprexa and Lithium for Perez and explained to Perez that it was important for him to take these medications.

On November 18, 2002, Perez met with Rice after Deputy John Jorganson requested Perez be approved for single cell housing because Perez had been stealing from other inmates in his 10-man cell. Perez admitted to Rice during their meeting that he had been stealing from the other inmates. Perez also told Rice that he was not taking his psychiatric medication since he believed he did not need it. Rice asked Perez why he had not discussed this decision with Dr. Hemachandra, and Perez responded by telling Rice that his cellmates encouraged him to continue getting the medication so that he could sell it to them. Perez stated he did not feel suicidal, he had frequent contact with his family and he was not feeling depressed or anxious. Rice found that Perez's "insight appears limited" and "judgment appears poor," but that he did not appear at risk of suicide, was stable and could be housed in a single cell without supervision.

The next day, November 19, 2002, Rice reviewed Perez's case with Dr. Hemachandra because of Perez's refusal to take his medication. Consistent with the standard protocol designed to minimize unused medication in the jail environment, Dr. Hemachandra discontinued Perez's medications, but moved Perez's next scheduled psychiatric appointment up from November 29 to November 26.

On November 22, 2002, in the evening, Deputy Michael Monroe was working in the C-Block area where Perez was housed. He was relieved that evening by Deputy Terry Montgomery. Clock rounds of Perez's cell were performed at 5:47 pm and 7:03 pm, a gap of 76 minutes. Perez was not on any kind of special watch. According to other inmates, Perez placed a sheet over his cell during this period, which blocked the view into the cell. After their 7:03 pm rounds, jail personnel discovered that Perez had hung himself with a bed sheet that had been tied to the vent of his cell. He died on November 26, 2002 from injuries sustained as a result of this action.

Critical Factors

Perez was consistently diagnosed as seriously mentally ill. In addition, Perez was known to have attempted suicide by hanging once at age 14 and again at age 17. Perez also is quoted as repeatedly faking suicidality in order to achieve some secondary gain.

The "hustle" aspect of the last observation will be familiar to readers who work in this area and often have to distinguish the hustle from the authentic. Nonetheless, in this case, even discounting for more than occasional hustles, it is fair to conclude that Perez represented a real threat to commit suicide. Indeed, I believe all three members of the panel agree with that despite their divergent approaches.

When Perez committed suicide he was not under any special watch procedures; he was single-celled for security, not mental health reasons; and in blocking visibility into his cell, Perez surely violated jail rules although such violation would not be attributed to caseworker Rice.

Legal Framework

The Sixth Circuit approaches "serious medical need" as one diagnosed by a physician or "obvious to a layman." Deliberate indifference, the requisite mental element, requires actual knowledge of a substantial risk, here suicide, and then disregard of that risk.

Perez, Sr., the father, argues that Rice violated his son's rights by failing to provide appropriate mental health treatment or monitoring while jailed. The lead opinion agrees that, while this is a close case, the plaintiff satisfied both prongs of the deliberate indifference test.

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Perez posed a strong likelihood of another suicide attempt. There are the threats, attempts, elevated watch statuses, and housing decisions, all of which create at least a genuine issue of fact. Summary judgment, of course, is not appropriate where the issue of fact remains in dispute.

Qualified Immunity

Qualified immunity protects government officials performing discretionary functions when their conduct does not violate clearly established statutory or constitutional rights of which a reasonable person would have known. The rationale for such immunity is to avoid inhibiting discretionary action and deterring able people from public service.

The standard analytical approach is to first ask if a federal right was violated and, if so, whether the right was clearly established at the time. The panel already had ruled that a constitutional right was violated. Thus, the only question relates to "how clearly established." And it is on this point that the lead opinion heads into some uncharted waters without, I am afraid, the right equipment.

Keep in mind, "clearly established" relates to knowledge fairly attributable to the actor whose conduct is at issue. Here, it is caseworker, Rice. What was well settled at the time of this suicide?

The lead opinion concedes, as it must, that it was well settled in the Sixth Circuit and elsewhere that Perez had a right to treatment for his serious medical needs; treatment that was not deliberately indifferent. This, however, is too general for this panel.

The lead opinion then notes:

> In **Comstock v. McCrary**, 273 F.3d 693 (2001), this court held that once a prisoner has been deemed suicidal, it is clearly established that the prisoner is entitled to continuing medical treatment. Here, Perez was not deemed to be suicidal at the time he was moved to the single cell. Additionally, Perez was not generally deprived of medical treatment involving his mental health needs. Thus, Perez Sr. would have to prove that his son's right to have his serious medical needs treated without deliberate indifference encompassed a right to a correct assessment of his suicide risk or an effective suicide-monitoring arrangement. See **Danese v. Asman**, 875 F.2d 1239, 1244 (6th Cir. 1989) ("The 'right' that is truly at issue here is the right of a detainee to be screened correctly for suicidal tendencies and the right to have steps taken that would have prevented suicide. The general right to medical care, for example, is not sufficient to require a police officer to have known that he had to determine that Danese was seriously contemplating suicide and stop him from following through."). Perez identifies no pre-November 2002 published decision of the U.S. Supreme Court or this court requiring such a determination, nor have we found any.
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> If no binding precedent is available that directly holds that conduct materially or fundamentally similar to Rice's was unlawful in October-November 2002 under the circumstances, as is the case here, the court may still find that Rice violated a clearly established right through one other avenue: showing "a generally applicable principle from either binding or persuasive authorities whose 'specific application to the relevant controversy' is 'so clearly foreshadowed by applicable direct authority as to leave no doubt in the mind of a reasonable officer that his conduct was unconstitutional.'" **High v. Fuchs**, 74 F. App'x 499, 502 (6th Cir. 2003) (quoting **Summar v. Bennett**, 157 F.3d 1054, 1058 (6th Cir. 1998)).
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> However, Perez Sr. failed to show such a principle. On the contrary, by October 2002 this circuit's published case law had established that inmates have no general right to be correctly screened for suicidal tendencies. **Danese v. Asman**, 875 F.2d 1239, 1244 (6th Cir. 1989), cited by **Davis v. Fentress County**, 6 F. App'x 243, 249 (6th Cir. 2001) ("Nor has this court recognized a generalized right of a prisoner to be protected against committing suicide."). The circuit's published case law also held that "the generalized right of a prisoner to be free from deliberate indifference [to a known serious medical need] cannot support a finding that there was a clearly established right to be protected from committing suicide." **Rich v. City of Mayfield Heights**, 955 F.2d 1092, 1096-97 (6th Cir. 1992).
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> We acknowledge that Rice may have demonstrated poor judgment in several ways. She made critical decisions based ultimately on her own assessment of Perez's risk of suicide, even though she had suicide-detection and prevention training but no advanced psychiatry or psychology degree; she may have underestimated Perez's risk of suicide; additionally, making a cell-assignment decision or recommendation without first consulting Perez's treating physician or prison psychiatrist Hemachandra may have been ill-advised. These arguable errors might make Rice liable for negligence or negligent infliction of emotional distress, but those are properly the subject of state-law tort claims, not an Eighth Amendment claim. We find no case law to suggest that any of these errors clearly violated Perez's Eighth Amendment rights.[2] ____ F.3d at ____.

Concurrence

Judge Griffin joins Judge Cudahy in the application of qualified immunity but disagrees as to the finding that Rice was deliberately indifferent. The record, it is argued, does not show that Rice was aware of a strong likelihood of suicide and that she acted with deliberate indifference to that very high level of risk.

Judge Griffin's point seems to focus on a strong likelihood at the particular time of the suicide. Parenthetically, he does not realize that a person who is at risk for suicide is not in a constant state of readiness to commit the self-destructive act. The compulsion to self-destruct ebbs and flows and not every floodtide will lead to suicide. That, however, surely is not the point in a case such as this.

The point is knowledge of a high degree of risk as then measured by the response to that risk. Here, that is the single-cell placement without medical input and with no special observation included. For Judge Griffin, there is no deliberate indifference.

Dissent

Judge Moore concludes that summary judgment is not justified as to the constitutional violation (as did the lead opinion), but she dissents on the grant of summary judgment. Thus, there are two votes for a constitutional violation trumped by two votes on qualified immunity. She believes

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this case is governed by **Comstock**, supra.

The principle established by Comstock is that once a prisoner is deemed suicidal, that prisoner is entitled to continuing medical treatment. This is not a question of screening; it is Rice's summary dismissal of Perez's risk of suicide.

It is Rice's disregard of known evidence of suicide risk and her failure to seek and continue medical care that is at issue. Rice plainly was aware of Perez's suicide risk and she should have obtained medical advice before making the fatal cell change.

COMMENT: There is no need to further belabor the facts or law. The prevailing view here appears to fully equate suicide risk with suicide judgments made in the narrow window surrounding the death. However, even if one accepts that dubiously narrow view, Rice still may have been deliberately indifferent.

Application of qualified immunity here seems totally misplaced. On the clarity of the law at issue, surely there is a reasonable ground between overarching generalities (a right to treatment) and fact-specific situations of the specific and narrowly framed sort relied upon here. I would not argue that once a suicide risk, always a risk. There is no duty of lifetime special care. The duration of the duty depends on the recency of the facts creating the danger.

A step back from all of this clutter and we have a young man in custody dead by his own hand when his custodians had current information and absolutely knew he was at risk. He could have been saved.

Endnotes

1. In some custodial suicide cases, plaintiffs' pursue a failure to protect theory of liability. Not here. The psychiatrist in this case, Dr. Hemachandra, apparently settled and is not part of this appeal. Neither is the Sheriff and some previously named deputies.

2. The claim against the County was based on a policy of allowing caseworkers like Rice to make screening and housing decision that implicated medical needs of inmates. The lead opinion finds such

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but whether the particular person (or defendant) was. Miranda was very close to the drug dealers and, in a word, her explanations of lack of knowledge just did not wash.

Conclusion

Deliberate indifference, like its first cousin "knowingly" in the criminal law, rests on a foundation of actual knowledge of specified risks. When "knowingly" is an element of a particular crime there will be cries of, "I didn't know it was there." "I knew it was a lot of money but I thought he just liked me." Or "I didn't know I'd get caught." (Well, not that one.)

The "who knew" defense is very similar to the "who knew the inmate meant . . . ." or "was really sick" or "required immediate care." In seeking to expand our understanding of deliberate indifference, then, decisions such as **Alston-Graves** and **Carrillo** hopefully add to that understanding.■

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