No. 09-1233

IN THE

Supreme Court of the United States

ARNOLD SCHWARZENEGGER, GOVERNOR OF THE STATE OF CALIFORNIA, ET AL.,
Appellants,

v.

MARCIANO PLATA AND RALPH COLEMAN, ET AL.,
Appellees.

On Appeal from the United States District Courts for the Eastern and Northern Districts of California

BRIEF OFAMERICAN PSYCHIATRIC ASSOCIATION, CALIFORNIA PSYCHIATRIC ASSOCIATION, AMERICAN PSYCHOLOGICAL ASSOCIATION, CALIFORNIA PSYCHOLOGICAL ASSOCIATION, AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW, JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW, FORENSIC MENTAL HEALTH ASSOCIATION OF CALIFORNIA, NATIONAL ALLIANCE ON MENTAL ILLNESS, AND NAMI-CALIFORNIA AS *AMICI CURIAE* IN SUPPORT OF APPELLEES

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Bowring v. Godwin, 551 F.2d 44 (4th Cir. 1977) 10

Clark-Murphy v. Foreback, 439 F.3d 280 (6th Cir. 2006) 4, 10

Coleman v. Wilson, 912 F. Supp. 1282 (E.D. Cal. 1995) 4, 6, 8, 10, 11, 12

DeShaney v. Winnebago County Dep't of Soc. Servs., 489 U.S. 189 (1989) 9, 13

Estelle v. Gamble, 429 U.S. 97 (1976) 5, 9

Farmer v. Brennan, 511 U.S. 825 (1994)............. 4, 13

Ginest v. Board of County Comm'rs, 333 F. Supp. 2d 1190 (D. Wyo. 2004) 8

Greason v. Kemp, 891 F.2d 829 (11th Cir. 1990) 10

Madrid v. Gomez, 889 F. Supp. 1146 (N.D. Cal. 1995) 8

McGuckin v. Smith, 974 F.2d 1050 (9th Cir. 1992) 12

Morales Feliciano v. Rosselló González, 13 F. Supp. 2d 151 (D.P.R. 1998) 8

Ruiz v. Estelle, 503 F. Supp. 1265 (S.D. Tex. 1980)...8, 10, 11, 12

Tillery v. Owens, 719 F. Supp. 1256 (W.D. Pa. 1989), *aff'd*, 907 F.2d 418 (3d Cir. 1990) 8

Wellman v. Faulkner, 715 F.2d 269 (7th Cir. 1983).. 8

Youngberg v. Romeo, 457 U.S. 307 (1982) 9

CONSTITUTION AND RULES

U.S. Const.:

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Amend. XIV (Due Process Clause)........................ 9

Sup. Ct. R. 37.6 1

LEGISLATIVE MATERIALS

Criminal Justice Responses to Offenders with Mental Illness: Hearing Before the Subcomm. on Crime, Terrorism, and Homeland Security of the H. Comm. on the Judiciary, 110th Cong. (2007).................. 27-28

ADMINISTRATIVE MATERIALS

Council of State Governments, Criminal Justice / Mental Health Consensus Project (June 2002), *available at* http://consensusproject.org/downloads/Entire_report.pdf 27

Darrell K. Gilliard & Allen J. Beck, U.S. Dep't of Justice, *Prison and Jail Inmates at Midyear 1996* (Jan. 1997), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/pjimy96.pdf 7

Doris J. James & Lauren E. Glaze, U.S. Dep't of Justice, *Mental Health Problems of Prison and Jail Inmates* (Sept. 2006), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/mhppji.pdf 7

OTHER MATERIALS

American Psychiatric Ass'n:

Position Statement, *Psychiatric Services in Jails and Prisons*, APA Doc. No. 198804 (1988), *available at* http://archive.psych.org/edu/other_res/lib_archives/archives/198804.pdf... 3

Psychiatric Services in Jails and Prisons (2d ed. 2000)............................... 7-8, 10, 12, 22, 28

James Bonta & Paul Gendreau, *Reexamining the Cruel and Unusual Punishment of Prison Life*, 14 L. & Human Behav. 347 (1990) 25

1 Fred Cohen, *The Mentally Disordered Inmate and the Law* (2d ed. 2008) 13

Cheryl Corcoran et al., *The Stress Cascade and Schizophrenia: Etiology and Onset*, 29 Schizophrenia Bull. 671 (2003) 26

Verne C. Cox et al., *Prison Crowding Research: The Relevance for Prison Housing Standards and a General Approach Regarding Crowding Phenomena*, 39 Am. Psychol. 1148 (1984) 25

Gerald Gaes & William J. McGuire, *Prison Violence: The Contribution of Crowding Versus Other Determinants of Prison Assault Rates*, 22 J. Res. in Crime & Delinq. 41 (1985) 25

Stuart Grassian & Nancy Friedman, *Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement*, 8 Int'l J.L. & Psychiatry 49 (1986) 17

Handbook of Correctional Mental Health (Charles L. Scott ed., 2d ed. 2010) 7

Kathryn A. Burns, *Pharmacotherapy in Correctional Settings* 321 .... 11, 22

Shama B. Chaiken & Catherine Prudhomme, *Creating Wellness Through Collaborative Mental Health Interventions* 345 19

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Amanda Ruiz, *Continuous Quality Improvement and Documentation* 149 11

Humberto Temporini, *Conducting Mental Health Assessments in Correctional Settings* 119 .... 7, 10

Allison G. Harvey, *Sleep and Circadian Rhythms in Bipolar Disorder: Seeking Synchrony, Harmony, and Regulation*, 165 Am. J. Psychiatry 820 (2008) 26

John Herbert, *Fortnightly Review: Stress, the Brain, and Mental Illness*, 315 British Med. J. 530 (1997) 26

Terry A. Kupers et al., *Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs*, Crim. Just. & Behav. OnLineFirst, July 21, 2009, at 2, *available at* http://www.aclu.org/images/asset_upload_file359_41136.pdf.................................... 17

Morven Leese et al., *An Ecological Study of Factors Associated with Rates of Self-Inflicted Death in Prisons in England and Wales*, 29 Int'l J.L. & Psychiatry 355 (2005) 27

Jeffrey L. Metzner, *An Introduction to Correctional Psychiatry*:

Part I, 25 J. Am. Acad. Psychiatry L. 375 (1997) 7, 8, 28

Part II, 25 J. Am. Acad. Psychiatry L. 571 (1997) 8

Part III, 26 J. Am. Acad. Psychiatry L. 107 (1998) 8

Peter L. Nacci et al., *Population Density and Inmate Misconduct Rates in the Federal Prison System*, 41 Fed. Probation 26 (1977) 25

National Comm'n on Correctional Health Care, *Standards for Mental Health Services in Correctional Facilities* (2008)....7, 8, 10, 11

Raymond F. Patterson & Kerry Hughes, *Review of Completed Suicides in the California Department of Corrections and Rehabilitation, 1999 to 2004*, 59 Psychiatric Services 676 (2008) 23, 24

Thomas Roth & Timothy Roehrs, *Insomnia: Epidemiology, Characteristics, and Consequences*, 5 Chronic Insomnia 5 (2003) 26

Daniel J. Taylor et al., *Insomnia as a Health Risk Factor*, 1 Behav. Sleep Med. 227 (2003) 26

John D. Wooldredge, *Inmate Experiences and Psychological Well-Being*, 26 Crim. Just. & Behav. 235 (1999) 27

INTEREST OF *AMICI CURIAE*[1]

The American Psychiatric Association, with more than 36,000 members, is the Nation's leading organization of physicians who specialize in psychiatry.

The California Psychiatric Association is a nonprofit corporation whose member psychiatrists are medical doctors specializing in the comprehensive care of adults and children with mental and emotional disorders that stem from biological and psychosocial causes, including those with drug and other addictions. The Association is dedicated to the prevention and treatment of mental disorders; to the furtherance of psychiatric education and research; and to the furtherance of psychiatric procedures for the public welfare.

The American Psychological Association is a nonprofit professional organization founded in 1892. The Association has approximately 150,000 members, including the majority of psychologists holding doctoral degrees from accredited universities in this country. Among the Association's major purposes is to increase and disseminate knowledge regarding human behavior and to foster the application of psychology to important human concerns.

The California Psychological Association ("CPA"), incorporated in 1948, has 4,000 members and is the

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[1] Pursuant to Supreme Court Rule 37.6, counsel for *amici* represent that they authored this brief in its entirety and that none of the parties or their counsel, nor any other person or entity other than *amici*, their members, or their counsel, made a monetary contribution intended to fund the preparation or submission of this brief. Counsel for *amici* also represent that all parties have consented to the filing of this brief, and a letter reflecting their blanket consent to the filing of *amicus* briefs has been filed with the Clerk.

largest state psychological association in the United States. The members of CPA represent licensed psychologists from all areas of psychology including clinical practice, public service, teaching, and research. The mission of CPA is to strengthen, promote, and sustain the discipline and practice of psychology.

The American Academy of Psychiatry and the Law, with approximately 2,000 psychiatrist members, is an organization of psychiatrists dedicated to excellence in practice, teaching, and research in forensic psychiatry, a subspecialty recognized by the Accreditation Council of Graduate Medical Education. The Academy sponsors numerous educational activities and programs and is engaged in the development of professional and ethical standards of practice for forensic psychiatrists.

The Judge David L. Bazelon Center for Mental Health Law is a national public interest organization founded in 1972 to advocate for the rights of individuals with mental disabilities. The Center has engaged in litigation, policy advocacy, and public education to preserve the civil rights of and promote equal opportunities for individuals with mental disabilities in institutional as well as community settings. It has litigated numerous cases concerning the rights of people with mental illness in correctional facilities.

The Forensic Mental Health Association of California ("FMHAC") is a non-profit membership association that provides support and education to forensic mental health and criminal justice professionals. FMHAC's objectives are to foster the provision of effective mental health services to persons in the criminal justice system; assist mental health and criminal justice professionals, as well as the public,

to understand the nature of forensic mental health services; and to enhance the quality of forensic mental health evaluation, diagnosis, and treatment.

The National Alliance on Mental Illness ("NAMI") is the Nation's largest grassroots organization dedicated to improving the lives of individuals and families affected by mental illness. NAMI has a long history of advocating for policies and programs both to prevent the unnecessary incarceration of people living with serious mental illness and to facilitate better services for persons with these illnesses during incarceration and following discharge.

NAMI-California is the largest grassroots organization of families and individuals whose lives are affected by serious mental illness in California. Comprised of 71 affiliates, NAMI-California provides leadership in advocacy, legislation, policy development, education, and support throughout the State.

These organizations have participated in numerous cases in this Court. They and their members have a strong interest in correctional mental health care and longstanding commitments to ensuring that jail and prison inmates with mental illness have access to adequate care. *See*, *e.g.*, American Psychiatric Ass'n, Position Statement, *Psychiatric Services in Jails and Prisons*, APA Doc. No. 198804 (1988), *available at* http://archive.psych.org/edu/other_res/lib_archives/archives/198804.pdf. That commitment includes a realistic recognition that severe overcrowding may render the provision of even minimally adequate care – a civil right guaranteed to inmates under the Constitution – impracticable.

SUMMARY OF ARGUMENT

The three-judge district court, applying defendants' proposed standard, found that overcrowding in California's prisons was the primary cause of the State's failure to deliver constitutionally adequate mental health care to its prison inmates and that no relief other than a reduction in overcrowding would address the constitutional violations. *See* JS1-App.[2] 78a, 168a. Those findings – which come after nearly two decades of litigation and unavailing remedial efforts – are consistent with the clinical experience of professionals with expertise in correctional mental health care and the scientific literature.

I. "A prison official's 'deliberate indifference' to a substantial risk of serious harm to an inmate violates the Eighth Amendment." *Farmer v. Brennan*, 511 U.S. 825, 828 (1994). That standard requires prison officials to "ensure that inmates receive . . . medical care," including mental health care. *Id.* at 832; *see Clark-Murphy v. Foreback*, 439 F.3d 280, 292 (6th Cir. 2006). Early in this litigation, the *Coleman* court found – without objection from defendants – that there are "six basic, essentially common sense, components of a minimally adequate prison mental health care delivery system." *Coleman v. Wilson*, 912 F. Supp. 1282, 1298, 1301 (E.D. Cal. 1995). Those components include (1) screening and evaluating inmates; (2) a treatment program; (3) adequate staffing; (4) maintenance of adequate records; (5) administration of medication only with appropriate supervision and periodic evaluation; and (6) a program for suicide prevention. *Id.* at 1298 n.10. Experts on

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[2] References to "JS1-App." are to the appendix accompanying the jurisdictional statement in No. 09-416.

correctional mental health have identified additional important or desirable components of a correctional mental health care program, but there is no dispute that inmates with mental illness are at serious risk of suffering "unnecessary and wanton infliction of pain," *Estelle v. Gamble*, 429 U.S. 97, 102-03 (1976) (internal quotation marks omitted), if those minimum requirements are not met.

II. A. The nature of what is required for minimally adequate mental health care reinforces the three-judge district court's finding that "crowding creates numerous barriers to the provision of medical and mental health care that result in the constitutional violations we consider here." JS1-App. 80a-81a. To conduct adequate initial screenings and subsequent evaluations requires sufficient staff and adequate physical space to ensure confidentiality. Provision of appropriate treatment for mentally ill inmates likewise requires staff and facilities – including a sufficient number of inpatient beds. Crowding that far outstrips the capacity of available mental health care professionals and facilities may make delivery of minimally adequate care impracticable. Management of medications and provision of other therapies – critical to ensure that mentally ill inmates do not needlessly suffer the effects of untreated illnesses – may become infeasible in a prison system characterized by overcrowding and frequent prisoner transfers. Overcrowding both increases the importance of medical records – because of frequent patient transfers and high turnover of clinical staff – and exacerbates weaknesses in medical record systems. And a prompt and effective response to indications that inmates may be at risk of suicide requires adequate crisis beds and effective staff supervision. The testi-

mony of experienced experts in correctional mental health care documented all of these impacts of overcrowding, providing the factual underpinnings for the three-judge district court's "primary cause" and "no other relief" holdings.

B. Expert testimony that overcrowding can exacerbate inmates' existing mental illness or induce mental illness in vulnerable inmates is consistent with the literature relating to the psychological and behavioral effects of overcrowding. Prison crowding is associated with negative outcomes and contributes to conditions of confinement – including high stress, sleep deprivation, and enforced idleness – that may cause or exacerbate mental illness and increase the risk of inmate suicide.

ARGUMENT

There are vast numbers of individuals with serious mental illness in correctional facilities in the United States. In 1995, when the district court in *Coleman* first determined, after five years of litigation, that the provision of mental health care in California's prisons failed to meet constitutional minimum standards, it was estimated that there were "between 13,000 and 18,000 inmates in California's prisons in need of treatment because they suffer from serious mental disorders." *Coleman v. Wilson*, 912 F. Supp. at 1299. By mid-2008, that number had approximately doubled, with the State reporting that more than 34,000 of the approximately 160,000 inmates in California's prisons suffered from serious mental illness requiring intervention.[3] The dramatic increase in mentally ill inmates in California's prisons is

[3] *See* JS1-App. 31a (citing CDCR mental health population placement reports).

paralleled by comparable increases nationwide. At mid-year 2005, more than 1.25 million individuals in custody – more than half of the total population of the Nation's prisons and jails – had a symptom of mental illness.[4] That number exceeds the total population of the Nation's prisons and jails as recently as 1990.[5] "Studies and clinical experience have consistently indicated that 8 to 19 percent of prisoners have psychiatric disorders that result in significant functional disabilities, and another 15 to 20 percent will require some form of psychiatric intervention during their incarceration."[6]

As demand for mental health care services in correctional facilities has dramatically grown, mental health professionals have developed guidelines to assist correctional officials and mental health care professionals in the provision of adequate mental health care in prisons and jails.[7] The basic elements of a

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[4] *See* Doris J. James & Lauren E. Glaze, U.S. Dep't of Justice, *Mental Health Problems of Prison and Jail Inmates* 1 (Sept. 2006), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/mhppji.pdf; *see also* Humberto Temporini, *Conducting Mental Health Assessments in Correctional Settings*, *in Handbook of Correctional Mental Health* 119, 120-28 (Charles L. Scott ed., 2d ed. 2010) ("Scott *Handbook*") (reviewing data concerning prevalence of mental illness among inmates).

[5] *See* Darrell K. Gilliard & Allen J. Beck, U.S. Dep't of Justice, *Prison and Jail Inmates at Midyear 1996*, Table 2 (Jan. 1997), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/pjimy96.pdf.

[6] Jeffrey L. Metzner, *An Introduction to Correctional Psychiatry: Part I*, 25 J. Am. Acad. Psychiatry L. 375, 375 (1997) ("Metzner, *Correctional Psychiatry: Part I*").

[7] *See*, *e.g.*, Scott *Handbook*, *supra*; National Comm'n on Correctional Health Care, *Standards for Mental Health Services in Correctional Facilities* (2008) ("NCCHC *Standards*"); American Psychiatric Ass'n, *Psychiatric Services in Jails and Prisons* (2d

minimally adequate mental health care program, as laid out in the professional literature, are consistent with lower court decisions and with the uncontested findings in this case.[8] Those sources recognize the distinction between essential requirements for minimally adequate care and those standards that are fairly characterized as important or desirable.[9] That literature and those standards thus provide an appropriate framework for evaluating, in light of the record evidence, the three-judge district court's determinations that overcrowding is the primary

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ed. 2000) ("APA *Psychiatric Services*"); Metzner, *Correctional Psychiatry: Part I*, *supra*; Jeffrey L. Metzner, *An Introduction to Correctional Psychiatry: Part II*, 25 J. Am. Acad. Psychiatry L. 571 (1997); Jeffrey L. Metzner, *An Introduction to Correctional Psychiatry: Part III*, 26 J. Am. Acad. Psychiatry L. 107 (1998) ("Metzner, *Correctional Psychiatry: Part III*").

[8] *See Coleman v. Wilson*, 912 F. Supp. at 1298 (citing *Balla v. Idaho State Bd. of Corrections*, 595 F. Supp. 1558, 1577 (D. Idaho 1984); *Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D. Tex. 1980)); *see also*, *e.g.*, *Wellman v. Faulkner*, 715 F.2d 269, 272-73 (7th Cir. 1983); *Ginest v. Board of County Comm'rs*, 333 F. Supp. 2d 1190, 1200 (D. Wyo. 2004); *Morales Feliciano v. Rosselló González*, 13 F. Supp. 2d 151, 208-12 (D.P.R. 1998); *Madrid v. Gomez*, 889 F. Supp. 1146, 1214-27 (N.D. Cal. 1995); *Tillery v. Owens*, 719 F. Supp. 1256, 1302-03 (W.D. Pa. 1989), *aff'd*, 907 F.2d 418 (3d Cir. 1990); *see also* Metzner, *Correctional Psychiatry: Part III*, 26 J. Am. Acad. Psychiatry L. at 107 (mental health care treatment in a correctional setting should "alleviate symptoms of mental disorders that significantly interfere with an inmate's ability to function in a particular criminal justice environment" and, "as in the community, should also be available for purposes of alleviating symptoms of mental disorder associated with present distress . . . or with a significantly increased risk of suffering death, pain, or significant impairment").

[9] *See generally* NCCHC *Standards*, *supra* (distinguishing between standards that are "essential" and those that are "important").

cause of the constitutional violations and that no other relief would remedy the constitutional violations.

I. THE ELEMENTS OF A MINIMALLY ADEQUATE CORRECTIONAL MENTAL HEALTH CARE PROGRAM PROVIDE THE APPROPRIATE FRAMEWORK IN WHICH TO EVALUATE THE THREE-JUDGE DISTRICT COURT'S FINDINGS

The legal standards governing the claims of the *Coleman* class are settled and are not at issue in this appeal. Nevertheless, they help to provide the framework in which the three-judge district court's findings should be reviewed.

In *Estelle v. Gamble*, this Court held that Eighth Amendment principles "establish the government's obligation to provide medical care for those whom it is punishing by incarceration." 429 U.S. at 103. That obligation "extend[s] . . . beyond the Eighth Amendment setting": the Fourteenth Amendment's Due Process Clause requires the State to provide involuntarily committed mental patients with adequate "'food, shelter, clothing, and medical care.'" *DeShaney v. Winnebago County Dep't of Soc. Servs.*, 489 U.S. 189, 199 (1989) (quoting *Youngberg v. Romeo*, 457 U.S. 307, 315 (1982)). As then-Chief Justice Rehnquist explained, "when the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs" – including "medical care" – "it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause." *DeShaney*, 489 U.S. at 200.

The constitutional obligation to provide adequate medical care includes, of course, the obligation to provide adequate mental health care. *See*, *e.g.*, *Clark-Murphy*, 439 F.3d at 292; *Greason v. Kemp*, 891 F.2d 829, 834 (11th Cir. 1990) (Tjoflat, C.J.); *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977) ("We see no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart."). The parties agreed, and the *Coleman* court held, that a minimally adequate mental health treatment program includes "six basic, essentially common sense, components." *Coleman v. Wilson*, 912 F. Supp. at 1298 & n.10. Each of these components has been the subject of standard-setting efforts by mental health care professionals and correctional experts.

"First, there must be a systematic program for screening and evaluating inmates in order to identify those who require mental health treatment." *Ruiz v. Estelle*, 503 F. Supp. at 1339. That initial screen has "multiple purposes": identifying inmates with severe mental illness who may require immediate attention; preventing inmate suicides; providing a foundation for continuation of care including, for example, existing medications; and preliminary identification of mental health problems that may require further assessment.[10] In addition, inmates may develop mental illness while in custody, which must be detected and treated. Second, there must be a program for provision of treatment to mentally ill inmates

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[10] Temporini *in* Scott *Handbook* at 130; *see* APA *Psychiatric Services* at 39-45 (reviewing "[e]ssential [s]ervices" associated with mental health screening and referral and mental health evaluations); NCCHC *Standards* at 52-57 (characterizing mental health screening and evaluation as "essential").

that "entail[s] more than segregation and close supervision." *Id.* Third, there must be a sufficient number of competent mental health care professionals – *i.e.*, adequate staffing – "to identify and treat in an individualized manner those treatable inmates suffering from serious mental disorders." *Id.*

"Fourth, accurate, complete, and confidential records of the mental health treatment process must be maintained." *Id.* The inmate's medical record should reflect current evaluation and management of an inmate's illnesses and allow the tracking of the course of an illness over time, including response to therapy.[11] An accurate and complete medical record may take on special importance in the correctional context because of frequent inmate movements and high turnover of medical and mental health professional staff. Fifth, psychotropic medication should be administered "with appropriate supervision and periodic evaluation." *Coleman v. Wilson*, 912 F. Supp. at 1298 n.10.[12] "Sixth, a basic program for the identification, treatment, and supervision of inmates with suicidal tendencies is a necessary component

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[11] *See* Amanda Ruiz, *Continuous Quality Improvement and Documentation*, *in* Scott *Handbook* 149, 158-63; NCCHC *Standards* at 89-92 (essential standards related to medical records management).

[12] *See generally* Kathryn A. Burns, *Pharmacotherapy in Correctional Settings*, *in* Scott *Handbook* 321, 321 ("Psychotropic medication is the medically accepted standard of care or treatment of choice for certain of the serious mental illnesses."). Proper administration is essential, because medications can have serious side effects; patients also may suffer harm if needed medications are withdrawn precipitously. *See*, *e.g.*, *id.* at 330-43; NCCHC *Standards* at 34.

of any mental health treatment program." *Ruiz v. Estelle*, 503 F. Supp. at 1339.[13]

The state government *amici* argue that the three-judge district court failed to rely on "objective measures of community expectations for prison health care," suggesting that the deficiencies found by the court lack constitutional significance. Louisiana et al. *Amicus* Br. 18. That claim ignores both the procedural history of the *Coleman* litigation and the established standard for minimally adequate correctional mental health care. As noted above, the standard for minimally adequate mental health care that the *Coleman* court applied was drawn from settled federal court precedent and *was not contested by the State*. *See Coleman v. Wilson*, 912 F. Supp. at 1301. The elements of a minimally adequate mental health care program are precisely those that are required to prevent "further significant injury or the 'unnecessary and wanton infliction of pain'" – as the Constitution requires. *Id.* at 1298 (quoting *McGuckin v. Smith*, 974 F.2d 1050, 1059 (9th Cir. 1992)). California's liability for failing to establish a minimally adequate mental health care program under this standard was first adjudicated 15 years ago, and the State has never moved to vacate that determination.

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[13] Consistent with national correctional standards, a comprehensive suicide prevention policy should include staff training; intake screening and assessment; communication with the inmate and among law enforcement, correctional staff, and medical personnel; appropriate housing for suicidal inmates; adequate observation; intervention when inmates attempt self-injury; reporting; and morbidity-mortality review. *See* Lindsay M. Hayes, *Toward a Better Understanding of Suicide Prevention in Correctional Facilities*, *in* Scott *Handbook* 231, 236-45; APA *Psychiatric Services* at 14-15.

The question is not and never has been what sort of mental health care program that correctional mental health experts should, ideally, put in place.[14] Rather, the issue always has been ensuring that the "basic human needs" of prison inmates are met, *DeShaney*, 489 U.S. at 200, recognizing that, while "[t]he Constitution does not mandate comfortable prisons, . . . neither does it permit inhumane ones," *Farmer v. Brennan*, 511 U.S. at 833 (internal quotation marks omitted).

II. THE THREE-JUDGE DISTRICT COURT'S DETERMINATIONS THAT CROWDING IS THE PRIMARY CAUSE OF THE DENIAL OF MINIMALLY ADEQUATE MENTAL HEALTH CARE AND THAT NO OTHER RELIEF WOULD REMEDY THE VIOLATIONS ARE CONSISTENT WITH CLINICAL EXPERIENCE

The three-judge district court determined that "crowding creates numerous barriers to the provision of medical and mental health care . . . includ[ing] severe space and other shortages"; that "[c]rowding also renders the state incapable of maintaining an adequate staff and an adequate medical records system"; and that "crowding causes prisons to rely on lockdowns, which further restrict inmates' access to care." JS1-App. 80a-81a. The court also found that overcrowding creates conditions of confinement that, themselves, "increase the incidence and severity of mental illness among prisoners." *Id.* at 81a. Applying defendants' proposed definition of "primary

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[14] *See*, *e.g.*, 1 Fred Cohen, *The Mentally Disordered Inmate and the Law* ¶ 2.6[1], [2] (2d ed. 2008) (distinguishing between minimal components and desirable components of a mental health care treatment program).

cause" – *i.e.*, "the cause that is 'first or highest in rank or importance; chief; principal,'" *id.* at 78a – the court "conclude[d] that clear and convincing evidence establishes that crowding is the primary cause of the unconstitutional denial of medical and mental health care to California's prisoners." *Id.* at 82a.

The three-judge district court had before it an extensive record documenting the effects of crowding on the provision of medical care generally and mental health care in particular. Any comprehensive review of that factual record is beyond the scope of this brief. Nevertheless, the nature of what is required to ensure the provision of minimally adequate mental health care and the scientific literature on the psychological and behavioral effects of overcrowding support the court's "primary cause" and "no other relief" determinations with regard to the *Coleman* class.

A. Overcrowding May Seriously Obstruct the Provision of Minimally Adequate Care

Clinical experience supports the conclusion that crowding may create pervasive and intractable problems for the provision of minimally adequate mental health care. To ensure that prisoners are evaluated for mental illness and afforded minimally adequate treatment, there must be sufficient clinical staff, space in which to provide treatment and perform screening and clinical evaluations, and clinical facilities to accommodate inmates requiring higher levels of care. Accordingly, where prisons are severely overcrowded, mental health care resources can be overwhelmed. There is extensive record evidence that overcrowding has had this effect in California's

prisons, with impacts on each of the six components of minimally adequate care.

Deficiencies in Screening and Evaluation: The large number of inmates entering the California prison system and rapid turnover make screening for mental illness and evaluation of new and returning inmates critical to ensuring that mentally ill inmates are appropriately housed and treated. The evidence supports the conclusion that burdens on staff and facilities have complicated initial screening and mental health evaluation. For example, there was testimony that there was inadequate office and treatment space in certain facilities – and inadequate correctional staff – to allow for initial evaluation of inmates in a confidential setting.[15]

Deficiencies in Treatment: The record indicated that, because of crowding, California's prisons could not adequately treat prisoners in need of higher levels of mental health care nor could they adequately treat inmates with less severe mental health needs who were housed in the general population.

The delivery of mental health care in California's prisons is organized around a system of classifying individuals by the severity of their mental illness.

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[15] Expert Report of Pablo Stewart, M.D., *Coleman* Docket Entry 3217, at 48 ("Stewart Report") ("[i]n my opinion, this is a dangerous practice"); *see also id.* at 32 ("Lack of adequate and appropriate space for reception center psychological screening was . . . apparent at [Deuel Vocational Institute ("DVI")]."); Expert Report of Professor Craig Haney, *Coleman* Docket Entry 3201, at 77 ("Haney Report") (describing lack of facilities for confidential screening of prisoners at Valley State Prison for Women). The insufficiency of appropriate physical space – that is, private enough to allow for confidential screening, evaluation, and treatment – cannot be addressed by hiring additional staff and may effectively limit the capacity to increase staff.

At the lowest level are Correctional Clinical Case Management Services ("CCCMS") inmates, who are housed in the general prison population. *See* JS1-App. 42a-43a & n.25. Enhanced Outpatient Program ("EOP") inmates are those who suffer "Acute Onset or Significant Decompensation of a serious mental disorder," who cannot function in the general inmate population, but who do not require round-the-clock nursing care or hospitalization. *Id.* at 43a & n.24. Mental Health Crisis Beds ("MHCBs") are for inmates who are "markedly impaired and/or dangerous to others as a result of mental illness, or who are suicidal, and who require 24-hour nursing care." *Id.* Department of Mental Health ("DMH") Inpatient Hospital Care is for inmates who cannot be treated at a lower level of care. *Id.*[16]

There is no dispute that the State lacks facilities to accommodate mentally ill inmates who require higher levels of care.[17] As a result, mentally ill inmates

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[16] *See also* Mental Health Services Delivery System Program Guide (rev. Jan. 2006), Ex. P9, at 12-1-4 to 12-1-8 ("Program Guide") (describing treatment criteria for levels of care).

[17] *See* Special Master's Response to Court's May 17, 2007 Request for Information, Ex. D1292, at 9 ("Special Master's May 31 Report") ("[N]early 12 years after the determination that mental health services in [California's prisons] were egregiously unconstitutional, hundreds certainly, and possibly thousands, of . . . inmates/patients . . . are still looking for beds at the level of treatment their mental illness requires."); Expert Report of Ira K. Packer, Ph.D., Ex. D1019, at 8 ("Packer Report") (opinion of defendants' expert: "the lack of adequate intensive mental health treatment beds . . . is the primary cause of the deficiencies in providing mental health care to mentally ill inmates in" California's prisons); Stewart Report at 25 ("[T]he level of acuity among mentally ill inmates at the EOP level of care was extraordinarily high."), 26 ("psychiatrically decompensating suicidal inmates are frequently housed in makeshift holding cells for long periods of time" because of lack of MHCBs), 35 (clinicians

cannot be transferred to appropriate levels of care in compliance with court-ordered timeframes.[18] There is evidence that, due to the lack of sufficient numbers of MHCBs, suicidal and acutely mentally ill patients are housed in administrative segregation units[19] or, during the day, in "dry cells" – that is, small upright

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at DVI reception center "are almost never able to transfer inmates needing higher levels of care to an MHCB unit or to one of the DMH inpatient programs"), 58 (noting that "the waiting list for access to DMH inpatient care programs" at one prison "is currently 111 cases"); Supplemental Expert Report of Pablo Stewart, M.D., *Coleman* Docket Entry 3221, at 35 ("Stewart Supplemental Report") ("Perhaps the most disturbing and direct result of severe overcrowding is the terrible shortage of inpatient beds for *Coleman* class members.").

[18] *See* Program Guide at 12-1-13 (setting out required transfer timeframes); Stewart Report at 64-65 ("Defendants do not appear to be meeting any of these transfer timeframes."); Haney Report at 197-200.

[19] "In administrative segregation units and supermaximum security facilities, prisoners are confined to their cells, by themselves or with cellmates, nearly 24 hours per day. They eat meals in their cells, and their out-of-cell activities are limited to solitary trips to a small yard for recreation." Terry A. Kupers et al., *Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs*, Crim. Just. & Behav. OnLineFirst, July 21, 2009, at 2, *available at* http://www.aclu.org/images/asset_upload_file359_41136.pdf.

Mental health experts who have studied the effects of administrative segregation, segregated housing unit placements, and other forms of segregation on inmates with serious mental illnesses have concluded that the social deprivation, idleness, and isolation of these facilities tend to make psychiatric conditions and prognoses worse. *See* Stuart Grassian & Nancy Friedman, *Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement*, 8 Int'l J.L. & Psychiatry 49 (1986).

cages surrounded by wire mesh.[20] More generally, plaintiffs' expert – Dr. Pablo Stewart, a clinical and forensic psychiatrist with 25 years of correctional mental health care experience – gave his opinion that "insufficient access to higher levels of care has created a system which is overwhelmed by the acuity of its patients at every level of care."[21] In his opinion, "[b]y denying prompt access to inpatient care, the State is allowing patients to become more acutely ill than they otherwise would."[22] As a result, the demand for acute care is increased, and patients require treatment for longer periods of time, further exacerbating the shortage of facilities.[23]

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[20] *See*, *e.g.*, Stewart Report at 26 (due to lack of space, "DVI often houses suicidal inmates in its administrative segregation unit"), 59-60 (describing use of "non-authorized, unlicensed 'treatment settings,'" including dry cells, in Salinas Valley State Prison); Stewart Supplemental Report at 25 (describing inmates "wearing nothing but suicide smocks" with "no mattress or blanket" housed in "small, concrete rooms" that were "completely bare aside from a small toilet and sink" at Mule Creek State Prison); *see also id.* at 24 (describing staff decision to "involuntarily medicate patients[] rather than refer them to an inpatient bed"); Packer Report at 12 (stating that use of upright cages to house mentally ill prisoners "is clearly not an acceptable standard of practice").

[21] Stewart Supplemental Report at 18; *see id.* ("EOP units house many patients in need of inpatient care, MHCB's house patients in need of inpatient hospitalization, intermediate care facility units house many patients in need of acute hospital care, and so on.").

[22] *Id.* at 4.

[23] *See* Special Master's May 31 Report at 9-10 ("The failure to stabilize [inmates requiring mental health care crisis intervention] means more of them will eventually need to be referred for inpatient care, and the unmet needs spiral higher and higher. . . . [I]ncreasing numbers of truly psychotic inmate/patients are trapped in EOPs that cannot meet their needs.").

The three-judge district court also had before it evidence that overcrowding obstructed delivery of appropriate care to CCCMS inmates housed in the general population. Individual and group therapies may be essential for the treatment of many patients with severe psychiatric disorders,[24] but such treatment cannot be delivered without adequate clinical space, qualified mental health care providers, and correctional staff to escort inmates to appointments. For example, in the California Medical Facility ("CMF"), there was evidence that, because available spaces had been converted to dorm housing, "mental health assessments, case manager contacts and psychiatrist meetings are frequently done in non-confidential settings where other staff members and even other inmates may be around."[25] Defendants' expert noted "significant problems in delivering services to CCCMS patients" in Salinas Valley State Prison where "very frequent lockdowns . . . prevent[]

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[24] *See generally* Shama B. Chaiken & Catherine Prudhomme, *Creating Wellness Through Collaborative Mental Health Interventions*, *in* Scott *Handbook* 345.

[25] Stewart Supplemental Report at 22; *see* Stewart Report at 32 ("[D]ue to space limitations, much of the treatment provided to caseload inmates in administrative segregation [at DVI] is provided at cell-front, through the cell door, which is both non-confidential and not conducive to meaningful assessments or meaningful therapy."; "Lack of adequate and appropriate space for reception center psychological screening was also apparent at DVI."), 82 ("[T]he lack of space means that case manager contacts and even therapy contacts take place in [a] public setting that affords no confidentiality."); Haney Report at 109 ("much of what goes on in the treatment area is completely visible to the prisoners in the unit").

group[] [therapy sessions] from occurring . . . [which] makes them almost useless."[26]

Staffing Problems: There was evidence before the three-judge district court that facilities throughout the California prison system have experienced chronic staffing shortages.[27] The lack of clinical and office space has exacerbated the difficulty of recruiting and retaining clinical staff.[28] Also, shortages of custodial staff likewise can impact the ability of the State to deliver adequate care: as defendants' expert explained, shortages of custodial staff – which is "primarily a function of the census," *i.e.*, overcrowding – have "more of an impact on CCCMS inmates, who are housed in General Population and may experience difficulties in movement (to yard and to appointments, as well as to groups)."[29]

Medical Record Deficiencies: Maintaining adequate medical records may become impracticable in an overcrowded facility, with potentially serious impact on clinicians' ability to deliver effective care. The inadequacies of the medical records systems in California prisons, and the deleterious effects on

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[26] Packer Report at 15; *see id.* at 16 ("It is clear . . . that the current situation does impede mental health care in this and similar settings.").

[27] *See* Haney Report at 178-79; Stewart Supplemental Report at 5 ("Until overcrowding is reduced, the State will be unable to hire and retain adequate, qualified and permanent staff.").

[28] *See* Stewart Report at 18; Haney Report at 180 ("In my opinion, the serious deficiencies in office and treatment spaces I observed throughout the system are themselves an obstacle to ever achieving appropriate clinical staffing. The working conditions are terrible and there is no space, in any event, for more clinicians.").

[29] Packer Report at 15.

care, were the subject of expert testimony and other evidence.

The *Coleman* Special Master noted concerns about management of medical records in several prisons.[30] At one prison, "staff . . . estimated that about one-third of the time when they meet with patients, they do not have access to the inmate's medical record."[31] Clinical practitioners would agree with the assertion of Dr. Stewart that "[a]ccurate and well organized medical records are a critical element of medical and mental health care" and may become "even more essential in a complex and overcrowded system . . . which is characterized by frequent transfers of patients, high turnover of clinical staff and overuse of contract clinicians who lack familiarity with the patients and the system."[32] Defendants' expert agreed, noting that "[i]n several institutions there were difficulties in clinical staff obtaining charts in a timely manner. . . . In my opinion, this is a direct effect of overcrowding."[33]

Deficiencies in Administration of Medication: Proper administration and monitoring of psycho-

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[30] 20th Special Master Report, Ex. D1112, at 68, 120, 154, 169, 176, 200-01, 221, 232, 258, 314.

[31] Stewart Report at 37; *see id.* (discussing DVI: "[t]his is a dangerous clinical situation because staff does not have access to the patient's entire medical and mental health history, including such critical information as drug allergies, prior diagnoses and treatment history"); Haney Report at 58 (noting that, at [the California Institute for Men], "although prisoners typically receive mental health and medical screening within a week of arriving at the prison, this is done without access to medical records, which may not arrive for another several weeks").

[32] Stewart Supplemental Report at 50; *see also supra* note 11.

[33] Packer Report at 19.

tropic medications is a critical element of appropriate psychiatric care.[34] When inmate populations exceed the capacity of clinical staff to administer and monitor medication, this prevents evaluation of the effectiveness of treatment, poses a danger of undetected side effects, and increases the risk of non-compliance with medication regimes.[35]

The evidence before the three-judge district court addressed deficiencies in medication administration in California prisons. Dr. Stewart concluded that "[t]he medication management system is overwhelmed and the State is therefore unable to adequately monitor both the efficacy and the side effects of prescribed medications."[36] There was evidence

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[34] *See* APA *Psychiatric Services* at 45-46.

[35] *See* Burns *in* Scott *Handbook* at 322 (for proper use of psychotropic medication, "facility [must] have appropriately trained staff in sufficient numbers to periodically monitor clinical response and potential side effects"), 325 ("Effectiveness of psychotropic medication is difficult, if not impossible, to assess unless the patient has been 100% compliant with taking all doses of the medication as prescribed.").

[36] Stewart Supplemental Report at 4; *see also* 18th Special Master Report, Ex. D1110, at 96-97 (finding deficiencies in medication practices at DVI, including low medication compliance rates), 148 (noting that Salinas Valley State Prison "did not appear to have a functioning mechanism to manage medication"); Stewart Report at 37 ("[N]o effort is currently being made on the part of the medication dispensers [at DVI] to monitor to any degree the clinical efficacy of a given medication."), 48-49 ("In light of the infrequent appointments with psychiatrists and the very brief interactions between patients and staff in the pill lines, Solano [prison] cannot adequately monitor the efficacy of medications, medication side effects, or patient compliance with medications as effectively as necessary."); Stewart Supplemental Report at 20 ("[M]edications [at CMF] were distributed very quickly by line staff who never asked about either the efficacy of the medication or potential side effects.").

that security concerns and workload burdens led correctional personnel to administer medications at cell-front through a food port, a waist-high slot in a solid door that is just large enough to slide in a food tray. When medication is dispensed through food ports, all communication happens through the door (or through the slot if both people bend down) in front of other inmates, eliminating the opportunity to monitor for side effects and the efficacy of medication, and rendering compliance more uncertain.[37]

Deficiencies in Management of Suicidality: Related to the inadequacy of treatment facilities for severely mentally ill inmates is evidence of inadequacies in suicide prevention and response. A review of suicides in California prisons during the period between 1999 and 2004 found that 60 percent of all suicides during that period were "either foreseeable or preventable, and some were both."[38] "Major contributing factors in foreseeable or preventable deaths included inadequate clinical assessments, inappropriate interventions, incomplete referrals, missed appointments

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[37] *See* Stewart Report at 61.

[38] Raymond F. Patterson & Kerry Hughes, *Review of Completed Suicides in the California Department of Corrections and Rehabilitation, 1999 to 2004*, 59 Psychiatric Services 676, 679 (2008), Ex. D1281. "The term 'foreseeable' refers to cases in which already known and reasonably available information about an inmate indicates the presence of a substantial or high risk of suicide that requires responsive clinical, custody, or administrative interventions to prevent self-harm. The term foreseeable is not to imply 'predictable,' because suicide is not predictable . . . . The term 'preventable' applies to situations where if some additional information had been gathered or some additional interventions had been undertaken, usually as required in existing policies and procedures, the likelihood of completed suicide might have been substantially reduced." *Id.* at 679-80.

and appointments that were not rescheduled, unsupported diagnoses, failure to review records, assignments to inappropriate levels of mental health care, failure to provide protective housing, and the provision of inadequate or untimely resuscitation efforts."[39] Those findings were consistent with the testimony of experts that inadequacies in treatment, including those that "appear to be the direct result of . . . severe overcrowding-related problems," had impacted suicide rates.[40]

B. Research Shows that Overcrowding May Lead to Conditions that Exacerbate Existing Mental Illness

The three-judge district court's conclusion that prison crowding exacerbated inmates' mental illness is likewise consistent with the scientific literature on the psychological effects of prison crowding.

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[39] *Id.* at 680.

[40] Haney Report at 187; *see also*, *e.g.*, Stewart Report at 34 (describing inappropriate housing of suicidal inmates as a result of the inadequate number of appropriate MHCBs and outpatient housing). A recent report of the Special Master in the *Coleman* case reported that there were at least 36 suicides in California prisons in 2008, 25 in 2009, and 26 as of September 2010. *See* Special Master's Report on Defendant's Review of Suicide Prevention Policies, Practices, and Procedures at 7, 32, *Coleman v. Schwarzenegger*, No. CIV S-90-0520 LKK JFM P (E.D. Cal. filed Sept. 27, 2010) (Docket Entry 3918). The State acknowledges that the rate of suicide in administrative segregation "remained a concern." *Id.* at 7-8. In April, the district court in the *Coleman* case found that "[t]he increase in both the inmate suicide rate and the percentage of suicide cases with 'at least some degree of inadequacy in assessment, treatment, or intervention' is deeply troubling." Order at 6, *Coleman v. Schwarzenegger*, No. 2:90-cv-0520-LKK-JFM (PC) (Apr. 14, 2010) (Docket Entry 3836).

There is evidence in the behavioral science literature that crowding is directly correlated with negative impacts on inmates' physical and mental health. Behavioral science researchers have reported that "[i]ncreases in population in prisons where facilities are not increased proportionately are associated with increased rates of death, suicide, disciplinary infraction, and psychiatric commitment."[41] A review article from 1990 found that "physiological and psychological stress responses . . . were very likely under crowded prison conditions."[42] Studies also have associated crowding with higher rates of violence and increased disciplinary infractions.[43]

In addition, there was evidence before the three-judge district court that overcrowding contributed to conditions of confinement that may contribute to or aggravate mental illness. *See* JS1-App. 100a-104a. There was testimony that overcrowding led to use of "bad beds," for example, rows of triple bunks in converted gyms.[44] Dr. Stewart gave his opinion that, "[f]or [CCCMS] inmates who are routinely triple-bunked in chaotic, overcrowded dorms, this means

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[41] Verne C. Cox et al., *Prison Crowding Research: The Relevance for Prison Housing Standards and a General Approach Regarding Crowding Phenomena*, 39 Am. Psychol. 1148, 1156 (1984).

[42] James Bonta & Paul Gendreau, *Reexamining the Cruel and Unusual Punishment of Prison Life*, 14 L. & Human Behav. 347, 351 (1990).

[43] *See* Gerald Gaes & William J. McGuire, *Prison Violence: The Contribution of Crowding Versus Other Determinants of Prison Assault Rates*, 22 J. Res. in Crime & Delinq. 41 (1985); Peter L. Nacci et al., *Population Density and Inmate Misconduct Rates in the Federal Prison System*, 41 Fed. Probation 26, 29 (1977).

[44] Stewart Supplemental Report at 27-28.

they may experience damaging levels of stress and fear of predation, as well as sleep deprivation. These conditions exacerbate mental illness and are serious barriers to the provision of minimally adequate mental health and medical care."[45]

The psychiatric literature supports Dr. Stewart's opinion regarding the impact of stressful and chaotic conditions of confinement. "Psychological stress has an important role in both the onset and course of mental illness, including schizophrenia, anxiety disorders, and depression."[46] A review of studies on sleep disturbance in patients with bipolar disorder noted a consistent relationship between insomnia and exacerbation of mood symptoms.[47] Insomnia also has been associated with anxiety and other psychological disorders,[48] including consistent association with depression.[49]

Further, there was evidence before the three-judge district court that, as a result of overcrowding,

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[45] *Id.* at 28-29; *see also id.* at 22-23 (explaining opinion that housing in multi-occupancy dorms "may exacerbate mental health conditions such as paranoia and create stressful environments for people who are otherwise vulnerable due to mental health issues, including cognitive impairments").

[46] John Herbert, *Fortnightly Review: Stress, the Brain, and Mental Illness*, 315 British Med. J. 530, 531 (1997); *see also* Cheryl Corcoran et al., *The Stress Cascade and Schizophrenia: Etiology and Onset*, 29 Schizophrenia Bull. 671 (2003).

[47] *See* Allison G. Harvey, *Sleep and Circadian Rhythms in Bipolar Disorder: Seeking Synchrony, Harmony, and Regulation*, 165 Am. J. Psychiatry 820, 822 (2008).

[48] *See* Daniel J. Taylor et al., *Insomnia as a Health Risk Factor*, 1 Behav. Sleep Med. 227 (2003).

[49] *See* Thomas Roth & Timothy Roehrs, *Insomnia: Epidemiology, Characteristics, and Consequences*, 5 Chronic Insomnia 5 (2003).

prisoners were subject to frequent lockdowns and enforced idleness because fewer facilities were available for correctional services, activities, and programming.[50] Research has shown that inmates are more depressed, anxious, and stressed when they are less involved in structured activities;[51] the lack of purposeful activity was identified in one British study on inmate suicide as the factor most strongly correlated with rates of suicide.[52] In overcrowded prisons, inmates lose opportunities for activities that can aid in adjustment to prison life. The evidence that such conditions lead to bad mental health outcomes – further aggravating the burdens on the mental health care resources in the prisons – supports the three-judge district court's findings.

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The members of the *Coleman* class have been denied constitutionally adequate mental health care – despite persistent remedial efforts – for two decades.[53] All parties agreed below that overcrowd-

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[50] *See* Haney Report at 35.

[51] *See* John D. Wooldredge, *Inmate Experiences and Psychological Well-Being*, 26 Crim. Just. & Behav. 235, 243-44, 246-47 (1999).

[52] Morven Leese et al., *An Ecological Study of Factors Associated with Rates of Self-Inflicted Death in Prisons in England and Wales*, 29 Int'l J.L. & Psychiatry 355 (2005).

[53] How the State may best comply with the district court's order is not before this Court. Many law enforcement, correctional, judicial, and mental health experts agree that diversion of individuals with mental illness from the criminal justice system in appropriate circumstances can address crowding in a manner that is cost-effective and does not compromise public safety. *See*, *e.g.*, Council of State Governments, Criminal Justice / Mental Health Consensus Project (June 2002), *available at* http://consensusproject.org/downloads/Entire_report.pdf; *Criminal Justice Responses to Offenders with Mental Illness:*

ing is a significant factor in creating the unconstitutional conditions of confinement that confront more than 34,000 mentally ill inmates in California's prisons, inflicting needless suffering on many of them. The three-judge district court's determinations that overcrowding is the primary factor and that no other relief would suffice are at bottom factual determinations – reviewed with appropriate deference on appeal. Those determinations can best be evaluated in light of the understanding of experts in correctional mental health that adequate mental health care demands adequate physical and human resources as well as adequate access for inmates to those resources in a reasonable period of time.[54] The evidence that overcrowding renders resources and access inadequate thus supports the ruling below.

CONCLUSION

The judgment of the three-judge district court should be affirmed.

Hearing Before the Subcomm. on Crime, Terrorism, and Homeland Security of the H. Comm. on the Judiciary, 110th Cong. (2007) (emphasizing the importance of pre- and post-detention diversion programs for individuals with mental illness); APA *Psychiatric Services* at 29-30.

[54] *See* Metzner, *Correctional Psychiatry: Part I*, *supra*.

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