

FORGOTTEN LIVES: MENTALLY DISORDERED PRISONERS IN MASSACHUSETTS

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There are at least 1.8 million people incarcerated in prisons or jails in the United States, and the number continues to increase each year.ⁱ In Massachusetts, more than 23,000 prisoners are confined in the state and county correctional systems.ⁱⁱ Despite the common misconception that mentally ill offenders will be found not guilty by reason of insanity and then hospitalized for treatment, in reality many such individuals end up in prison.ⁱⁱⁱ Indeed, the Los Angeles County Jail has been called the "largest *de facto* mental hospital in the world."^{iv}

The Prevalence of Mental Disorders in Prisons and Jails

The incidence of mental disorders among prisoners is substantially higher than it is in the community. Studies indicate that anywhere between 5 and 20 percent of prisoners suffer from a major mental illness, defined as schizophrenia, bipolar disorder, or major depression.^v In the Massachusetts Department of Correction (DOC), the incidence of major mental illness "is at least 9%, is almost certainly between 10-20%, and is best estimated at about 12-15%."^{vi} The problem may not be quite so severe in the county houses of correction, where the Department of Mental Health (DMH) recently concluded that the level of serious mental illness is about 5%.^{vii} As high as these numbers are, they may actually underestimate the need for mental health services because some inmates are likely to develop a major mental disorder during their incarceration, and many others suffer from less severe disorders that nonetheless require treatment.^{viii} Additionally, at least 1-2% of all inmates have a developmental disability.^{ix}

The reasons for the high incidence of mental illness among prisoners is somewhat unclear. It

is unlikely that incarceration itself is the cause, except in extreme circumstances such as prolonged confinement in solitary confinement. Other explanations include the lack of community support for persons with mental illness, and the large number of deinstitutionalization of mental patients who cannot control their behavior.^x

The Widespread Neglect of Prisoners with Mental Disorders

Despite the tremendous demand for mental health treatment, the available services in many, if not most, prisons and jails are woefully inadequate. Dozens of class action law suits have successfully attacked the overall quality of care in correctional institutions across the country.^{xi} *Madrid v. Gomez*, 889 F. Supp. 1146, 1280 (N.D. Calif. 1995), contains a particularly gruesome portrayal of the experiences of the mentally ill. In finding conditions at Pelican Bay -- California's state-of-the-art, "supermax" penitentiary -- to be unconstitutional, Chief Justice Henderson declared that "dry words on paper cannot adequately capture the senseless suffering and sometimes wretched misery" endured by inmates with mental illness. The litany of abuse included a schizophrenic inmate who received third degree burns when correctional officers placed him in scalding water because he had smeared himself with feces.^{xii} In the words of Stuart Grassian, the Harvard Medical School psychiatrist who has served as an expert witness in *Madrid* and other cases, "I've seen people who are horribly ill, eating their own feces, eating parts of their body, howling day and night and it's ignored, like 'who cares?' You think it belongs to some other century, but you go into the prison and you think you're back in some medieval torture chamber. The prison has become this place that's hidden and secret and it's really awful."^{xiii}

In Massachusetts the neglect and mistreatment of mentally ill prisoners received national attention after the 1996 suicide of John Salvi at MCI Cedar Junction. Although the jury that convicted Salvi of murder for killing two workers at Brookline reproduction clinics rejected his

insanity defense, it was obvious to almost everyone who encountered him that Salvi was seriously disturbed.^{xiv} Yet after he was turned over to the custody of the Massachusetts DOC, Salvi received essentially no mental health treatment, and was not even being monitored by mental health staff at the time of his suicide.^{xv}

The neglect of John Salvi unfortunately is not unique. In explaining why it ignored the pleas of Salvi's family that he be given treatment, DOC spokesman Anthony Carnevale said "We get complaints day in and day out from family members of inmates: 'He doesn't belong in prison, he belongs in a hospital,' . . . We get a dozen calls a day like that, but unless something specific happens. . . mental-health therapy is not part of the prison routine."^{xvi} Given this attitude, and the lack of resources available to treat prisoners with mental illness, it is not surprising that in the past year nine Massachusetts prisoners have committed suicide, up from a total of eight during all of the previous three years.^{xvii} And suicide is not the only risk. In 1996 an inmate with undiagnosed schizophrenia at MCI Shirley gouged out both his eyeballs and is now completely blind.^{xviii} In 1994 an inmate with a long history of mental illness bludgeoned his cellmate to death at MCI Norfolk after prison officials disregarded complaints about his mental condition.^{xix} Prisoners with untreated mental illness are also vulnerable to victimization by other inmates, may pose a threat of assault to correctional officers and staff, and can seriously disrupt the prison routine.^{xx} They are also likely to face discrimination in housing, access to rehabilitative programs, and parole.^{xxi}

Legal Rights of Prisoners with Mental Disorders

Since there is little public or political support for quality mental health care for offenders with mental illness, prisoners have been almost entirely dependent on the courts for protection of their right to treatment. The starting point for an understanding of the constitutional principles

underlying the claim of inmates to mental health services is *Estelle v. Gamble*,^{429 U.S. 97 (1996)}, where the Supreme Court held that the Eighth Amendment's prohibition against cruel and unusual punishment endows all inmates with a right to medical care. Specifically, the court ruled that prison officials may not exhibit "deliberate indifference" to the "serious medical needs" of inmates.^{xxii} Thus, an Eighth Amendment claim has two basic elements: an objective component, the existence of a "serious medical need"; and a subjective, or state-of-mind, component, namely that a prison official was "deliberately indifferent" to the need for treatment.

It is firmly established that prison officials must be equally attentive to mental as well as physical disorders.^{xxiii} The cases elaborating the constitutional requirements in this area, however, are often murky and inconsistent. For example, courts have considerable difficulty in deciding what mental health needs are "serious" enough to mandate treatment.^{xxiv} Generally, however, prisoners have a right to psychological or psychiatric treatment under the Eighth Amendment if a physician or other health care provider "concludes with reasonable medical certainty (1) that the prisoner's symptoms evidence a serious disease or injury; (2) that such disease or injury is curable or may be substantially alleviated; and (3) that the potential for harm to the prisoner by reason of delay or the denial of care would be substantial."^{xxv} Thus, mild depression and anxiety associated with the stress of the prison experience will not be regarded as a "serious," while any condition that is diagnosed by a doctor as mandating treatment must receive professional attention.^{xxvi}

Discerning whether or not prison officials have demonstrated the requisite "deliberate indifference" can be similarly confusing. It is not enough that prison officials exercised poor judgment, or that they were negligent or even grossly negligent; rather the inmate must show that the prison official was at least reckless, and reckless in the criminal sense, meaning that he or she had actual knowledge of a condition that required treatment.^{xxvii} But prison officials may not shield

themselves from liability by deliberately remaining ignorant about the need for treatment.^{xxviii} They may still be held accountable if they deliberately disregard a known risk, even if they are ignorant of the details of a particular inmate's situation.^{xxix}

Basic Components of a Prison Mental Health System

While there may be controversy about whether a specific inmate has received constitutionally acceptable care, the courts have established a clear set of minimum requirements for an adequate system of prison mental health care.^{xxx} Further, a number of professional organizations, such as the National Commission on Correctional Health Care and the American Psychiatric Association, have promulgated standards governing mental health services in prisons and jails.^{xxxi} Although courts are fond of saying that the professional standards may well exceed the constitutional floor, they often utilize such standards, both to evaluate the quality of mental health care and to devise remedies for conditions found to be unlawful.^{xxxii}

The essential components of a prison mental health system are set forth below:

1. *Screening and Evaluations*

The first requirement is that every inmate be screened upon admission in order to identify those with mental illness or developmental disabilities.^{xxxiii} This entails a standardized set of questions and observations by specially trained staff, as well as a mechanism to ensure that all potentially mentally disordered inmates are promptly referred for a comprehensive mental health evaluation and treatment.^{xxxiv} It also means that inmates must be monitored throughout their incarceration for signs and symptoms of mental illness. It is also vital that the institution have a program to identify and supervise suicidal inmates and those in crisis.^{xxxv} The threshold for referral for services must be low, both upon admission and later, since it is easy for mentally ill inmates to

escape notice in the prison environment so long as they do not engage in egregiously bizarre behavior.^{xxxvi}

2. *Treatment Modalities*

Correctional institutions must provide a range of meaningful treatment modalities to inmates identified as mentally disabled. Although many prisons and jails simply confine mentally ill inmates to segregation units where they can be closely supervised, this is not acceptable.^{xxxvii} The institution must also provide psychotropic medication if needed, but medication alone is not sufficient. It must be part of an overall program of therapy, including individual and group therapy where appropriate, as well as crisis intervention services.^{xxxviii} Each mentally disordered inmate must also have an individualized treatment plan.^{xxxix} In addition, the facility must provide qualified interpreters to ensure that non-English speaking inmates have access to mental health services.^{xi}

3. *Qualified Mental Health Staff*

It is absolutely essential that the institution have sufficient numbers of qualified and trained staff to provide treatment consistent with contemporary standards of care.^{xii} This means the facility must have an adequate number of psychiatrists, psychologists, and other mental health professionals, either on site or on call, to provide all necessary services.

4. *Special Needs Units and Inpatient Hospitalization*

Like individuals suffering from mental illness in the community, inmates may sometimes need special housing separate from the general prison population to receive more intensive treatment and supervision. This may range from a day treatment program within the prison, to a crisis unit for acutely psychotic or suicidal inmates who does not require inpatient hospitalization, to an intermediate level residential treatment unit for those whose level of functioning makes them vulnerable to abuse from other inmates, are too disruptive for placement in the general population, or

who need a considerable therapeutic services.^{xlii} Since sometimes nothing short of intensive inpatient hospitalization is adequate to handle an inmate who has decompensated, the institution must also have a procedure to transfer acutely mentally ill prisoners to a hospital setting.^{xliii}

5. *Accurate Mental Health Records and a Quality Assurance Program*

Mental health treatment records must be accurate, complete, up-to-date, and well-organized.^{xliv} Further, the institution must have a quality assurance plan to assure that inmates receive competent care.^{xlv}

6. *Discharge Planning*

Since most mentally ill inmates are eventually released back to their communities, it is vital that the facility make an effort to ensure continuity of care after release. This may mean providing the inmate with a medication prescription, as well as arranging for follow-up services in community mental health centers.^{xlvi}

The State of Mental Health Services in Massachusetts Prisons and Houses of Corrections

The Massachusetts correctional system has two parts, the state institutions, such as MCI Cedar Junction and MCI Framingham, which are run by the DOC, and the independent jails and houses of corrections operated by the county sheriffs with minimal oversight from the DOC.^{xlvii} Although the state prisons and most of the houses of correction have carefully drafted policies and procedures designed to meet their constitutional obligations regarding mental health care, there is a wide gulf between what exists on paper and the services that are actually available.

The Department of Correction

The UMass Medical Center's Salvi Report identified a broad range of systemic deficiencies in the DOC mental health services, and issued twenty-five specific recommendations, as well as an

array of supplemental suggestions. In accordance with its view that adequate staffing is by far the most important feature of an acceptable mental health system, the UMass Team focused on the dangerously low number of psychiatrists and other professional mental health staff.^{xlvi} Outside of Bridgewater State Hospital, DOC has only 4.25 psychiatrists for over 10,000 prisoners, less than half the "absolute minimum" of what is needed.^{xlvi} The number of psychologists and social workers is also far below acceptable levels.¹ As a result, DOC prisoners receive inadequate mental health evaluations and psychotherapeutic treatment, as well as inappropriate medications.^{li} One of the worst consequences of the inadequate staffing is that only those mentally ill prisoners who exhibit especially bizarre behavior, or who are assaultive and disruptive, are likely to receive any treatment at all.^{lii} Even though their illness may be equally severe, those who suffer quietly go unnoticed and unserved. This problem is exacerbated by the failure of the Department to provide sufficient training to correctional officers concerning the signs and symptoms of mental illness.^{liii}

The Report also recommended that the Department make available residential special needs units for inmates who do not require hospitalization at Bridgewater.^{liv} In 1989 the Governor's Special Advisory Panel on Forensic Mental Health, which did a comprehensive evaluation of correctional mental health services, made essentially the same recommendation.^{lv} It called for the establishment of at least three prison mental health centers, each of which would provide crisis residence, longer-term residential units that would provide day treatment in a sheltered setting, and an outpatient clinic.^{lvi} But DOC mental health providers have been advocating for these services for years, to no avail.^{lvii}

Further, the Report recommended improvements in the care afforded prisoners with developmental disabilities. Specifically, it proposed that DOC develop a relationship with the Department of Mental Retardation (DMR) regarding increased testing in the admission screening

and evaluation process. Although DMR has recently agreed to consult with the DOC about service needs and discharge planning, it has historically paid little attention to people with mental retardation in prison. For example, even though DMR regulations require that an Individual Support Plan be prepared for all its clients, this directive is routinely ignored if the individual is incarcerated.^{lviii}

The County Jails and Houses of Correction

Although, DMH has little involvement with mental health care in the state prisons, beginning in the late 1980's it has had a significant role with respect to the county jails and houses of correction. Although several counties provide their own mental health services, a number of others have arrangements with the Division of Forensic Mental Health (DFMH), whereby DFMH either provides services directly, or gives the Sheriff funds to provide services.^{lix} Further, G.L. c. 127, §§1A and 1B, requires the commissioner of correction to establish and enforce minimum standards for the county correctional facilities.^{lx}

Historically, county correctional mental health services have been seriously underfunded and this remains true today. Although DFMH spends approximately one and one-half million dollars annually on county mental health services,^{lxi} on a per capita basis this is considerably less even than the amount spent by the DOC. Thus, the central criticisms made by the Salvi Report of the DOC are also valid with respect to the counties. The only treatment most county inmates can expect is crisis intervention since ongoing individual or group therapy is largely unavailable.^{lxii}

In 1987 the legislature ordered the construction of "specialized mental health units" in the new houses of correction that were to be built in Bristol, Essex, Hampden, Suffolk, and Norfolk Counties.^{lxiii} Despite the efforts of the Division of Forensic Mental Health, the legislative mandate was ignored; today only the Hampden County House of Correction has a mental health unit.^{lxiv}

Mental health units in the other counties were never built, or were unfunded and not put into operation.^{lxv}

Bridgewater State Hospital

Bridgewater State Hospital is a psychiatric facility operated by the DOC to evaluate and treat mentally ill offenders who need maximum security confinement because of their violent or suicidal behaviors. Bridgewater serves as the inpatient psychiatric hospital for state and county prisoners, as well as for individuals who are incompetent to stand trial or not guilty by reason of mental illness.^{lxvi} It also conducts competency and criminal responsibility evaluations for the courts.^{lxvii}

Ever since the release of the 1967 film "Titticut Follies", Bridgewater has been synonymous in the public mind with abuse and mistreatment of the mentally ill. Although there have been substantial reforms in the last thirty years, it remains a deeply troubled institution.^{lxviii} The root of the problem is that DOC operates Bridgewater as a prison that offers a modicum of treatment, rather than as a genuine forensic hospital such as those that exist in other states.^{lxix} In any forensic hospital there is inevitably tension between the goals of treatment and security, but at Bridgewater DOC has tilted the balance so far in the direction of security that it has seriously compromised the quality of clinical care.^{lxx} Not only does Bridgewater have a much smaller clinical staff than equivalent hospitals in other states, and fewer options for psychological treatment, but correctional policies frequently interfere with or override the judgment of the psychiatrists and other clinical staff.^{lxxi}

DOC's overemphasis on security is epitomized by its failure even to attempt to have Bridgewater accredited by the Joint Commission on the Accreditation of HealthCare Organizations (JCAHO), the national body that customarily accredits psychiatric hospitals.^{lxxii} Instead, DOC requires only that Bridgewater be accredited by the National Commission on Correctional Health

Care, whose standards are designed for prison infirmaries, not inpatient hospitals.^{lxxiii} The lack of appropriate standards and oversight is especially problematic because, unlike any other Massachusetts hospital, Bridgewater is not licensed or inspected by either the Department of Mental Health or the Department of Public Health. Although in 1989 the Governor's Special Advisory Panel on Forensic Mental Health recommended that DMH licensure was essential to assure that forensic patients receive the same level of care as others who are hospitalized for mental illness, Bridgewater continues to operate without any outside monitoring or oversight.^{lxxiv}

The Prospects for Reform

The Department of Correction estimates that it would cost approximately \$1.7 million to implement the recommendations of the Salvi Report, an increase of approximately a 50% over what it spent last year on mental health.^{lxxv} It would probably cost a similar amount to bring services in the counties up to the same level. Although the legislature responded to the Salvi Report by appropriating an additional two million dollars for prison mental health care for fiscal year 1998, DOC has chosen to spend the extra money on other matters, claiming that inflation and other medical costs make it impossible to expand mental health services.^{lxxvi} Accordingly, the Salvi Report and its recommendations, like similar reports in the past, gathers dust with little likelihood of implementation without further legislative action or judicial intervention.

State Representative Kay Khan, a staunch advocate of mental health reform, has sponsored a comprehensive bill to improve mental health services in both county and state correctional facilities.^{lxxvii} Representative Khan's legislation mandates that prisoners receive the services recommended by the Salvi Report, and would thereby bring mental health services in Massachusetts into compliance with the Constitution. Specifically, it includes requirements that each facility provide mental health screening and assessment of all inmates, as well as a sufficient number of

mental health professionals to give inmates access to mental health services comparable to what is available in the community. It also provides that each inmate with a mental disorder must have a treatment plan, and, significantly, that the inmate be guaranteed all the services called for by that plan, including, where appropriate, group and individual therapy, or placement in a special needs unit conducive to therapy.^{lxxviii} Perhaps most importantly, Representative Khan's legislation requires regular DMH inspection of each correctional facility to ensure compliance with minimum standards of care.^{lxxix}

Representative Khan has also sponsored a bill that requires Bridgewater to seek JCAHO accreditation.^{lxxx} The Salvi Report also concluded that Bridgewater must obtain JCAHO accreditation.^{lxxxii} Although the NIC report also recommended that Bridgewater pursue JCAHO accreditation, it cautioned that Bridgewater is "not anywhere near" ready to begin the process, and that JCAHO inspection would be doomed to fail unless profound changes are made in the clinical program and organizational structure.^{lxxxiii} Although DOC now claims to be seriously considering the JCAHO process,^{lxxxiv} its commitment must be suspect, since it made similar representations in 1989 when Bridgewater was also the target of serious public scrutiny.^{lxxxv}

Although the Massachusetts Legislature deserves commendation for including the additional funds for prison mental health care in the fiscal year 1998 budget, the DOC decision to spend this money on other matters demonstrates the critical need for additional legislation, such as enactment of the bills proposed by Representative Khan, if the neglect of the mentally ill in Massachusetts prisons and jails is to come to an end. Reform is vital not only for humanitarian reasons, but also to enhance public safety by ensuring that all prisoners with mental illness receive treatment before their inevitable release back to the community.

i. According to the Bureau of Justice Statistics of Department of Justice, there were approximately 1.2 million people incarcerated in state and federal prisons as of mid-1996, and another 600,000 individuals incarcerated in local jails. Thousands of other individuals are also confined for short periods of time in police lock-ups.

ii. See Massachusetts Department of Correction, *Quarterly Report on the Status of Prison Overcrowding - Second Quarter of 1997*. As of June 30, 1997, there were 11,208 prisoners in state institutions, and 12,281 prisoners housed in the County Jails.

iii. In Massachusetts, as in many states, the insanity defense is available only to persons whose mental illness deprives them of the capacity to appreciate the wrongfulness of their conduct or to conform their conduct to the requirements of law. *Commonwealth v. McHoul*, 352 Mass. 544 (1967). This is a legal formulation that has little bearing on whether or not the individual is mentally ill in the clinical sense.

iv. See *Los Angeles Daily News*, June 13, 1996 (quoting a 1993 report compiled by a Task Force on the Mentally Ill, and noting that there are approximately 1,800 mentally ill persons in the Jail). The Department of Justice recently concluded that the treatment of mentally ill prisoners in the Jail was grossly unconstitutional. See *Los Angeles Times*, October 17, 1997.

v. See James R.P. Ogloff, et al., *Mental Health Services In Jails And Prisons: Legal, Clinical, And Policy Issues*, 18 Law & Psychol. Rev. 109 (1994).

vi. See *Report on the Psychiatric Management of John Salvi in Massachusetts Department of Correction Facilities 1995-1996*, Submitted to Massachusetts Department of Correction by the University of Massachusetts Medical Center, (January 31, 1997) ("Salvi Report") at 37. Significantly, as of September 25, 1997, there were 1,888 active prescriptions for psychotropic medications for Department of Correction prisoners. See Correctional Medical Services statistics dated September 25, 1997.

vii. See D. Smith, et al., *The Prevalence of Mental Illness in Massachusetts Jails* (1997) (unpublished Department of Mental Health Report). However, using the National Institute of Mental Health's diagnostic methodology, the DMH study concluded that 12% of the inmates had a serious mental illness.

viii. *

ix. See Leigh Ann Reynolds, *People with Mental Retardation in the Criminal Justice System* (Distributed by The ARC).

x. See T. Howard Stone, *Therapeutic Implications Of Incarceration For Persons With Severe Mental Disorders: Searching For Rational Health Policy*, 24 Am. J. Crim. L. 283, 291 (1997); Paul Benedict, *Developing Comprehensive Mental Health Services in County Jails*

(Unpublished Manuscript)(1994).

xi. See e.g. *Coleman v. Wilson*, 912 F.Supp. 1282 (E.D. Cal. 1995). (mental health treatment in virtually the entire California prison system constitutionally deficient; *Austin v. Pennsylvania Dept. of Corrections*, 876 F. Supp. 1437 (E.D. Pa. 1995)(approving consent decree in class action challenging mental health services in the entire Pennsylvania Dept. of Corrections); *Dunn v. Voinovich*, Case No. C1-93-0166 (S.D. Ohio 1995) (comprehensive consent decree entered in class action challenge to mental health care in the Ohio department of correction); *Allston v. Berman*, (D.Mass 77-3519). (consent decree governing provision of mental health treatment at MCI Walpole).

xii. *Id.* at 1166-67. A prison nurse testified, without rebuttal, that one of the officers said about the inmate, who was African-American, "that it looks like we're going to have a white boy before this is through, that his skin is so dirty and so rotten, it's all fallen off," and that "from the buttock's down, his skin had peeled off and was hanging in large clumps around his legs." *Id.*

xiii. "Mental-health Care Difficult in Prison", *Quincy Patriot Ledger*, December 4, 1996. Similarly, a leading Indiana newspaper recently characterized the treatment of that state's mentally ill inmates as "resembling 19th century psycho asylums." Editorial, *Indianapolis Star*, October 4, 1997.

xiv. See *Salvi Report* at 19-27.

xv. Salvi was only examined once by a psychiatrist, and only because the doctor was "curious about this famous new inmate." *Id.* at 1,22, 24-27.

xvi. *Providence Journal Bulletin*, December 8, 1996.

xvii. Department of Correction Death Statistics for October 1, 1993 to September 30, 1997. Significantly, these statistics do not include deaths in the county houses of correction, where suicides are even more common. Prior to 1991, when the Department of Correction eliminated the mental health program which had been put into place as a result of the consent decree in *Alston v. Berman*, *supra*, the number of mentally ill inmates who committed suicide was almost zero.

xviii. *Boston Globe*, December 4, 1996.

xix. *Slain Inmate Reportedly Feared Cellmate, had sought a transfer.* *Boston Globe*, May 10, 1995.

xx. See F. Cohen and J. Dvoskin, "Inmates with Mental Disorders: A Guide to Law and Practice," 16 *Mental and Physical Disability Law Reporter* 462, 467 (1992).

xxi . For example, only about 2.5% of the Department of Correction inmates prescribed antipsychotic medication are housed in minimum security facilities; whereas almost 20% of inmates not receiving such medication are in minimum security. *See* Correctional Medical Services Statistics on Antipsychotic Therapy, dated September 25, 1997. This may well violate the Americans with Disabilities Act, although there is some controversy about whether the ADA applies to prisons. *Compare Crawford v. Indiana Dep't of Correction*, 115 F.3d 481 (7th Cir. 1997) *with Amos v. Maryland Department of Public Safety and Correctional Services*, -- F.3d --, 1997 WL 581652 (4th Cir. 1997).

xxii . The Eighth Amendment does not apply to persons who are in jail awaiting trial. Pretrial detainees are protected instead by the Due Process clause of the Fourteenth Amendment, which provides at least the same level of protection as the Eighth Amendment. *See Bell v. Wolfish*, 444 U.S. 520 (1979). As a practical matter, it makes little difference whether mental health services are evaluated under the Eighth Amendment or the Due Process clause since the courts use the "deliberate indifference" standard in both contexts.

xxiii . As far back as 1977, the Fourth Circuit observed that "there is no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart. Modern science has rejected the notion that mental or emotional disturbances are the products of afflicted souls, hence beyond the purview of counseling, medication, and suffering." *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977). *See also Mahan v. Plymouth County House of Corrections*, 64 F.3d 14 (1st Cir. 1995); *Smith v. Jenkins*, 919 F.2d 90 (8th Cir. 1990); *Langley v. Coughlin*, 888 F.2d 252 (2d Cir. 1989); *Rogers v. Evans*, 792 F.2d 1052 (11th Cir. 1986).

xxiv . *Compare Steele v. Shah*, 87 F.3d 1266, 1267 (11th Cir. 1996), where the court found that a prisoner who "suffered from insomnia, anxiety, and various bodily pains" and "feelings of helplessness" stated a claim under the Eighth Amendment *with Doty v. County of Lassen*, 37 F.3d 540 (9th Cir. 1994), where the court declared that a female prisoner who experienced nausea, shakes, headache, sleeplessness, and depressed appetite suffered merely from "mild, stress-related ailments" and "routine discomfort," and did not have a "serious medical need" within the meaning of the Eighth Amendment.

xxv . *Bowring v. Godwin*, 551 F.2d 44 (4th Cir. 1977). *See also McGulkin v. Smith*, 974 F.2d 1050 (9th Cir. 1992) (defining a serious medical need as one which a reasonable doctor or patient would find important and worthy of comment or treatment; the presence of a medical condition that significantly affects an individual's daily activities; or the existence of chronic and substantial pain).

xxvi . *Gaudreault v. City of Salem*, 923 F.2d 203, 208 (1st Cir. 1988).

xxvii . *Farmer v. Brennan*, 511 U.S. 825, 828-829 (1994).

xxviii . *Id.*

xxxix. *Id.* But see *Mahan v. Plymouth County House of Corrections*, *supra*, 64 F.3d at 16, where the court dismissed the suit of a prisoner who had experienced severe depression and severe anxiety attacks, and who had continuously complained to prison staff that he had not received his prescribed medications, because, there was no evidence that the staff were aware that he was actually experiencing symptoms.

xxx. See *Ruiz v. Estelle*, 503 F.Supp. 1265 (S.D. Tex. 1980), *aff'd in part and rev'd in part*, 679 F.2d 1115 (5th Cir. 1982), *cert. denied*, 460 U.S. 1042 (1983); *Coleman v. Wilson*, 912 F.Supp. 1282 (E.D. Cal. 1995); *Langley v. Coughlin*, 715 F.Supp. 522 (S.D.N.Y. 1989), *aff'd* 888 F.2d 252 (2d Cir. 1989). See also *Casey v. Lewis*, 834 F.Supp. 1477 (D.Ariz. 1993); *Tillery v. Owens*, 719 F.Supp. 1256 (W.D. Pa. 1989), *aff'd*, 907 F.2d 418 (3rd Cir.1990); *Balla v. Idaho State Board of Corrections*, 595 F.Supp. 1558 (D.Idaho 1984).

xxxii. See National Comm'n on Correctional Health Care, *Standards for Health Services in Prisons* (1997); National Comm'n on Correctional Health Care, *Standards for Health Services in Jails* (1996); American Psychiatric Ass'n, *Guidelines for Psychiatric Services in Jails and Prisons, in Psychiatric Services in Jails and Prisons, Task Force Report 29* (1989). See also Center for Public Representation, *Summary of Professional Standards Governing Mental Health Services in Prisons and Jail* (1997).

xxxiii. See *Tillery v. Owens*, *supra*, 907 F.2d at 426.

xxxiiii. See *Madrid v. Gomez*, 889 F. Supp. at 1218 ("It is important that a mental health care system effectively identify those inmates in need of mental health services, both upon their arrival at the prison and during their incarceration. . . . [M]entally ill prisoners may not seek out help where the nature of their mental illness makes them unable to recognize their illness or ask for assistance."); See also *Coleman v. Wilson*, 912 F. Supp. 1282 at 1305, 1995 WL 559109, at 5 (E.D. Cal. 1995). *Langley v. Coughlin*, 715 F. Supp. at 540; *Ruiz v. Estelle*, 503 F. Supp. at 1545.

xxxv. *Id.*

xxxvi. *Madrid v. Gomez*, 889 F. Supp. at 1222.

xxxvii. See Fred Cohen and Joel Dvoskin, "Inmates with Mental Disorders: A Guide to Law and Practice." 16 *Mental & Physical Disability L. Rep.* 462, 464 (1992).

xxxviii. In *Arnold on behalf of H.B. v. Lewis*, 803 F.Supp. 246 (D.Ariz. 1992), the court characterized as "barbaric" a ten year failure to provide mental health care to a chronic paranoid schizophrenic female prisoner who was repeatedly placed in solitary confinement for periods of up to a year without psychiatric treatment.

xxxix. See *Langley v. Coughlin*, 715 F. Supp. at 540 ("failure to provide any meaningful treatment other than medication" would violate Eighth Amendment); *Madrid v. Gomez*, 889 F. Supp. at 1218 (finding constitutional violations in system where "[t]reatment for seriously ill inmates is primarily limited to medication management through use of antipsychotic or

psychotropic drugs, and intensive outpatient treatment is not available"). *See also* 103 CMR 932.15(b)(1)(requiring that "psychotropic medications are prescribed only when clinically indicated as one facet of a program of therapy").

xxxix. *See Coleman v. Wilson*, 912 F. Supp. 1282 at 1314 (Eighth Amendment violation where magistrate judge found that medical records contained incomplete or nonexistent treatment plans).

xli. *See Franklin v. District of Columbia*, -- F. Supp. -- (D.D.C. 1997) (finding grossly inadequate mental health services for Hispanic inmates because of insufficient translators)

xlii. *See Coleman v. Wilson, supra*, 912 F. Supp. at 1306; (Eighth Amendment violation where Department of Corrections "is seriously and chronically understaffed in the area of mental health care"). *See also Madrid v. Gomez*, 889 F. Supp. at 1218; *Ruiz v. Estelle*, 503 F. Supp. at 1339 (trained mental health professionals must be employed in "sufficient numbers to identify and treat in an individualized manner those treatable inmates suffering from serious mental disorders").

xliii. The consent decrees governing mental health care in the Pennsylvania and Ohio departments of correction mandate units with all three levels of care. *See Austin, supra; Dunn, supra*.

xliiii. *See Madrid v. Gomez*, 889 F. Supp. at 122021; *See also Standards for Health Services in Prisons*, National Comm'n on Correctional Health Care P-35, at 44 (1992).

xliiv. *Madrid v. Gomez*, 889 F. Supp. at 1219 (notes of mental health examinations should be substantive, documentation of monitoring should be systematic, entries should always account for prior diagnoses when making discrepant new diagnoses, and psychiatric records should include suicide watch records); *Coleman v. Wilson*, 912 F. Supp. 1282 at 1314, ("there are serious deficiencies in medical recordkeeping, including disorganized, untimely and incomplete filing of medical records, insufficient charting, and incomplete or nonexistent treatment plans.").

xlii. *Madrid v. Gomez, supra*, 889 F. Supp. at 1222; *Coleman v. Wilson, supra*, 912 F. Supp. at 1308.

xlii. *See Standards for Health Services in Prisons*, National Comm'n on Correctional Health Care P-44, at 54 (1997); American Psychiatric Ass'n, *Guidelines for Psychiatric Services in Jails and Prisons*, in *Psychiatric Services in Jails and Prisons*, Task Force Report 29, § C.4.a.

xlii. DOC contracts with a private vendor, Correctional Health Services, Inc., to provide all medical care, including mental health care, to its facilities. DMH also plays a minor role in the DOC mental health; it provides one social worker for female prisoners at MCI Framingham, and pursuant to G.L. c. 127, § 39, supervises, albeit reluctantly, psychiatric

treatment in DOC segregation units. *See Torres v. Dubois*, Suffolk C.A. No. 94-0270 at 10 (1996). Just this year, DMH also obtained funding to perform discharge planning for both state and county inmates.

xlviii. *Id* at 3, 10, 12-13, 36-38, 44.

xlix. *Id.* at 36-38, 44. As recently as 1993, DOC had over 6 FTE's of psychiatric time for a prison population that was substantially smaller. *See* "Scope of Services - Mental Health," Department of Correction (March 5, 1997). In fact, there has been a gradual deterioration in the mental health services that has occurred since 1991 when the Department of Correction eliminated the Prison Mental Health Services (PMHS) that had been put into place in response to the litigation in *Alston v. Berman*, *supra*.

l. *Id.* at 44. For example, there is literally no group therapy offered. To address such deficiencies, the Report recommended that there be a psychologist at each facility, as well as sufficient staff to visit inmates in "lockdown" at least three times per week. *Id* at 38,42.

li. *Id* at 44.

lii. *Id* at 2, 44.

liii. *Id* at 39, 44.

liv. *Id* at 42.

lv. *See* Report of Governor's Advisory Panel on Forensic Mental Health at 129 (1989).

lvi. *Id.*

lvii. *See e.g.*, Letter to Associate Commissioner for Health Services from Prison Mental Health Service Clinical Director and Executive Director (October 24, 1990). There is, however, a day treatment program at MCI Framingham.

lviii. *See* 115 CMR 6.20-25 (1997).

lix. *See Update on Mental Health Services in County Correctional Facilities*, November 1996(prepared by Paul Benedict of DFMH). Currently, DFMH funds or provides some level of services in Barnstable, Berkshire, Franklin, Hampden, Hampshire, Middlesex, Plymouth, Suffolk, and Worcester counties. The Sheriff is exclusively responsible for services only at the Essex, Bristol, and Suffolk Houses of Correction.

lx. *See also* 103 CMR 932.00, *et seq.*.

lxi. Personal Communication with Paul Benedict, Forensic Field Manager DFMH.

lxxii. Not surprisingly, class action litigation challenging the overall quality of mental health services is currently pending against Plymouth County. *See J.A. v. Forman*, Suffolk No. 96-4902.

lxxiii. St. 1987, c. 167, § 8.

lxxiv. The so-called Evaluation and Stabilization Unit at Hampden has beds for about 15 inmates and gives the facility an unprecedented capacity to deal with inmates in crisis who might otherwise require inpatient hospitalization. Paul Benedict, "Developing Comprehensive Mental Health Services in County Jails", *supra* at 20. Unfortunately, the Unit is too small to provide the intermediate level of residential treatment that is needed by many mentally ill prisoners after the crisis has abated.

lxxv. A mental health unit was constructed at the Suffolk County House of Correction, but it is used for other purposes.

lxxvi. *See* G.L. c. 123, §§ 15, 16, and 18. Pursuant to these sections, hospitalization at Bridgewater is supposed to be limited to those who need "strict security." Female prisoners who need inpatient hospitalization are generally transferred to Taunton or Worcester State Hospitals since Bridgewater has no unit for females.

lxxvii. *Id.*

lxxviii. Bridgewater received considerable national attention in 1987 when five patients died within a period of a few months. *See* Report of Governor's Special Advisory Panel on Forensic Mental Health, *supra* at 104. Unfortunately, there has been a new spate of questionable deaths at Bridgewater in the last two years. *See* "Inmate May Have Died of Asphyxiation," *Boston Globe*, March 7, 1997 at B3; "Care, Punishment Clash at Bridgewater. Recent Suicides Reveal Mixed Sense of Mission," *Boston Globe*, August 25, 1996 at A1.

lxxix. *See* Report #9601017 on Bridgewater State Hospital, National Institute of Correction Technical Assistance (June 21, 1996).

lxxx. *Id.* at 5-7.

lxxxi. *See* "Care, Punishment Clash At Bridgewater. Recent Suicides Reveal Mixed Sense Of Mission," *Boston Globe*, August 25, 1996 A1 .

lxxxii. *Id.* at 19-21.

lxxxiii. *Id.* *See also* Salvi Report at 12.

lxxxiv. *See* Report of Governor's Special Advisory Panel on Forensic Mental Health at 109.

lxxv. See Memorandum to Commissioner Michael Maloney from Deputy Commissioner Kathy M. Dennehy Re: University of Massachusetts Medical Center's Report on the Management of John Salvi in the Department of Correction, August 1, 1997. The \$1.7 million includes \$900,000 for additional psychiatrists, and about \$700,000 to hire other professional mental health staff. In 1996, DOC spent approximately \$3.2 million on mental health services, out of a total health care budget of over \$40 million .

lxxvi. See Boston Globe, July 24, 1997; The Providence Journal-Bulletin, August 12, 1997. The DOC decision did not violate the letter of the law, which provided only that DOC "is authorized to expend \$2,000,000 on mental health professionals above the expenditures for mental health professionals in fiscal year 1997."

lxxvii. See H. 4632 "An Act Relative to Mental Health Care for Inmates."

lxxviii. *Id.*

lxxix. *Id.*

lxxx. See H. 2694 "An Act Relative to Medical Services at the Bridgewater State Hospital."

lxxxii. Salvi Report at 12.

lxxxiii. *Id* at 20.

lxxxiiii. See Letter May 1, 1997 of DOC Commissioner Larry DuBois to Chairmen, Joint Committee on Human Services and Elderly Affairs .

lxxxv. See Report of Governor's Advisory Panel on Forensic Mental Health at 108 (observing that Bridgewater was making strides in achieving its goal of JCAHO accreditation).