17-3506

IN THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

MICHELET CHARLES, CAROL SMALL,
Plaintiffs-Appellants,
v.

ORANGE COUNTY, STATE OF NEW YORK, ORANGE COUNTY SHERIFF'S DEPARTMENT, ORANGE COUNTY DEPARTMENT OF MENTAL HEALTH, NICOLE KAYE, CLINIC DIRECTOR, ORANGE COUNTY CORRECTIONAL FACILITY, in her individual capacity, CARMEN ELIZONDO, FORMER CLINIC DIRECTOR, ORANGE COUNTY CORRECTIONAL FACILITY, in her individual capacity,
Defendants-Appellees.

On Appeal from a Final Judgment of the United States District Court
for the Southern District of New York (White Plains), No. 16-cv-5527-NSR

BRIEF OF AMERICAN PSYCHIATRIC ASSOCIATION, AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW, AMERICAN PSYCHOLOGICAL ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, NATIONAL ASSOCIATION OF SOCIAL WORKERS, AMERICAN PUBLIC HEALTH ASSOCIATION, AND JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLANTS AND REVERSAL

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February 20, 2018

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STATEMENT OF *AMICI CURIAE*[1]

The American Psychiatric Association, with more than 37,800 members, is the nation's leading organization of physicians who specialize in psychiatry. Members of the American Psychiatric Association are physicians engaged in treatment, research, and forensic activities, and many members regularly perform roles in the criminal justice system. In particular, the American Psychiatric Association and its members have been involved for many years in developing best practices protocols and programs for reintegrating incarcerated individuals with mental illness back into the community, including through development of discharge planning best practices protocols. The American Psychiatric Association has participated as *amicus curiae* in numerous cases in the United States Supreme Court and in the courts of appeals.

The American Academy of Psychiatry and the Law ("AAPL"), with more than 1,900 psychiatrist members, is the leading national organization of physicians who specialize in forensic psychiatry. AAPL is dedicated to excellence in practice, teaching, and research in forensic psychiatry. AAPL members evaluate defendants in all aspects of the criminal justice system and provide best practice protocols and

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[1] Pursuant to Federal Rule of Appellate Procedure 29(a)(4)(E), counsel for *amici* represent that no counsel for a party authored this brief in whole or in part and that no person or entity, other than *amici* or their counsel, made a monetary contribution to the preparation or submission of this brief. A motion for leave to file is being filed concurrently with this brief.

treatment for persons in correctional facilities. AAPL has participated as *amicus curiae* in numerous cases before the United States Supreme Court and the courts of appeals.

The American Psychological Association is the leading association of psychologists in the United States. A non-profit scientific and professional organization, the American Psychological Association has approximately 115,000 members and affiliates, including the vast majority of psychologists holding doctoral degrees from accredited universities in the United States. Among the American Psychological Association's major purposes are to increase and disseminate knowledge regarding human behavior, to advance psychology as a science and profession, and to foster the application of psychological learning to important human concerns, thereby promoting health, education, and welfare. The American Psychological Association has participated as *amicus curiae* in more than 150 cases in the United States Supreme Court and in federal and state courts of appeal nationwide.

The American Medical Association ("AMA") is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all U.S. physicians, residents, and medical students are represented in the AMA's policy-making

process. AMA members practice in every state and in every medical specialty. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these remain its core purposes.

Established in 1955, the National Association of Social Workers ("NASW") is the largest association of professional social workers in the United States with about 120,000 members in 55 chapters. The New York State Chapter has 7,200 members. The New York City Chapter has 6,000 members. In alignment with its mission to ensure the efficacy and quality of practicing social workers, NASW promulgates professional standards, provides resources, conducts research, and develops policy statements on issues of importance to the social work profession. Consistent with those statements, NASW believes incarcerated individuals should be provided full access to mental health services, including screening, assessment, medication counseling, and discharge planning.[2]

The American Public Health Association ("APHA") champions the health of all people and all communities and strengthens the profession of public health, shares the latest research and information, promotes best practices, and advocates for public health issues and policies grounded in research. APHA represents 25,000 individual members and is the only organization that combines a

[2] Nat'l Ass'n of Soc. Workers Policy Statements, *Mental Health*, *in Social Work Speaks* 217, 218 (10th ed. 2015).

140-plus-year perspective, a broad-based member community, and the ability to influence federal policy to improve the public's health. As the nation's leading public health organization, APHA is at the forefront of efforts to advance prevention, reduce health disparities, and promote wellness, including in the areas of mental health and access to quality health care and other health care delivery services.

The Judge David L. Bazelon Center for Mental Health Law is a national public interest organization founded in 1972 to advance the rights of individuals with mental disabilities. The Center advocates for laws and policies that provide people with mental illness or intellectual disability the opportunities and resources they need to participate with dignity and fully in their communities. Its litigation and policy advocacy advances rights to fair treatment, adequate mental health care, and community-based services. The Center has long worked to ensure that incarcerated individuals receive minimally adequate mental health treatment, including connections to community-based services that can meet their needs upon release.

These organizations and their members have dedicated substantial effort and resources to studying, analyzing, and developing practices to improve correctional mental health care and longstanding commitments to ensure that individuals with mental illness in correctional and detention facilities have access to adequate care.

See, *e.g.*, Am. Psychiatric Ass'n, *Position Statement on Psychiatric Services in Jails and Prisons* (1988). Part of minimally adequate mental health care – a civil right guaranteed to incarcerated individuals under the Constitution – is discharge planning to assist individuals with serious mental illness in obtaining mental health care services following release from confinement.

SUMMARY OF ARGUMENT

This case presents the question whether the government owes a duty, under the United States Constitution, to provide discharge planning – including an interim supply of needed medications and assistance in gaining access to mental health resources after release from confinement – to individuals with serious mental illness held in government custody. The district court noted that incarcerated individuals "just having been released after a stay in prison are often in no position to immediately find the alternative medical attention that they require" and that appellants "may have been owed a limited duty of protection beyond their periods of incarceration." A183-84. But the district court ruled that "the temporary deprivation" alleged in the complaint "was not sufficiently harmful to establish a constitutional violation." A187. It observed that, "[w]hile this result may seem harsh given the egregious character of the facts alleged," it could not be said that "interruption in care of the nature alleged here 'egregiously shocks' the contemporary conscience, specifically when plaintiffs are not in custody and are otherwise 'free' to seek out assistance." A187-88.

Amici do not take a position on the ultimate question whether appellants have a valid claim under applicable standards. But, to the extent the district court's judgment rests on the proposition that discharge planning for individuals with serious mental illness is not integral to minimally adequate mental health care in

the correctional setting, that proposition is incorrect. On the contrary, any evaluation of a constitutional claim in this context must give adequate weight to the consensus among mental health professionals that appropriate discharge planning is a critical part of the minimally adequate mental health care that the Constitution requires.

I. Professionals with expertise in correctional mental health care are in uniform agreement that discharge planning is an essential component of mental health care for incarcerated individuals with serious mental illness. Continuity of care is critical to effective mental health treatment. Gaps in care, including cessation of medication or periods without access to any mental health professional, can cause dangerous deterioration of a patient's condition. Accordingly, when an individual with serious mental illness is released into the community following incarceration, minimally adequate care requires that some provision be made to assist the individual in obtaining treatment during a transitional period. Failure to provide such discharge planning places released inmates at risk of serious harm, including risk of death.

II. Discharge planning is well established as part of the basic standard of care at correctional or detention facilities. Major organizations of mental health professionals include discharge planning among the requirements for adequate care. Over the past decade, a growing number of facilities have implemented

discharge planning as a standard part of their mental health services. And the Department of Justice and Immigration and Customs Enforcement require discharge planning in all their facilities and those operating under their auspices; the majority of states likewise require mental health care discharge planning in some form for correctional and detention centers.

III. Research shows that effective discharge planning can reduce rates of drug or alcohol problems, reduce recidivism, and lead to better mental health outcomes. Provision of adequate transitional services thus improves outcomes for inmates with mental illness and provides benefits to their communities as well.

ARGUMENT

Individuals with mental illness are disproportionately represented in the incarcerated population. A Bureau of Justice Statistics survey estimates that 16.2% of state prisoners have a significant mental illness, along with 7.4% of federal prisoners and 16.3% of jail inmates.[3] Other, more recent surveys have found even higher incidence.[4] The same is true for detained immigrants.[5] As a result, hundreds of thousands of individuals with mental illness are currently incarcerated in our nation's prisons, jails, and other detention facilities.

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[3] Paula M. Ditton, Bur. of Justice Stat., *Mental Health and Treatment of Inmates and Probationers* 1 (July 1999), https://www.bjs.gov/content/pub/pdf/mhtip.pdf; *see also* Doris J. James & Lauren E. Glaze, Bur. of Justice Stat., *Mental Health Problems of Prison and Jail Inmates* 1 (Sept. 2006) ("James & Glaze, *Mental Health Problems*") (finding that "more than half of all prison and jail inmates had a mental health problem").

[4] KiDeuk Kim et al., Urban Inst., *The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System* 8 (Mar. 2015); *see* Timothy Williams, *Jails Have Become Warehouses for the Poor, Ill and Addicted, a Report Says*, N.Y. Times, Feb. 11, 2015, at A19 (number of people housed in jails on any given day increased from 224,000 in 1983 to 731,000 in 2013) (citing Ram Subramanian et al., Vera Inst. of Justice, *Incarceration's Front Door: The Misuse of Jails in America* 12-13 (Feb. 2015), https://www.vera.org/publications/incarcerations-front-door-the-misuse-of-jails-in-america).

[5] Kristen C. Ochoa et al., *Disparities in Justice and Care: Persons with Severe Mental Illness in the U.S. Immigration Detention System*, 38 J. Am. Acad. Psychiatry & L. 392, 393 (2010) (finding rates of serious mental illness between 4% and 15% in the population of immigration detainees).

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.[6] Those sources recognize the distinction between essential requirements for minimally adequate care and those standards that are fairly characterized as important or desirable.[7] That literature and those standards thus provide an appropriate framework for evaluating claims that mental health care provided to incarcerated individuals meets minimal constitutional standards.

I. DISCHARGE PLANNING IS ESSENTIAL TO MINIMALLY ADEQUATE MENTAL HEALTH CARE FOR INCARCERATED INDIVIDUALS

Discharge planning for individuals with serious mental illness is part of the minimally adequate mental health care that the Constitution requires for individuals in custody of the state.

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[6] *See*, *e.g.*, Nat'l Comm'n on Corr. Health Care, *Standards for Mental Health Services in Correctional Facilities* (2008) ("*NCCHC Standards*"); Am. Psychiatric Ass'n, *Psychiatric Services in Jails and Prisons* (2d ed. 2000) ("APA, *Jails and Prisons*"); Jeffrey L. Metzner, *An Introduction to Correctional Psychiatry: Part I*, 25 J. Am. Acad. Psychiatry & L. 375 (1997); 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).

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

A. In *Estelle v. Gamble*, 429 U.S. 97 (1976), the Supreme Court held that Eighth Amendment principles "establish the government's obligation to provide medical care for those whom it is punishing by incarceration." *Id.* at 103; *see also Farmer v. Brennan*, 511 U.S. 825, 828, 832 (1994). 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 Cty. 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." *Id.* 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 v. Foreback*, 439 F.3d 280, 292 (6th Cir. 2006); *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."). And, in

Wakefield v. Thompson, 177 F.3d 1160 (9th Cir. 1999), the Ninth Circuit held that this right imposes an obligation on correctional facilities to provide inmates with a sufficient supply of interim medication to mitigate the risk of gaps in their care.

B. For individuals with serious mental illness, continuity of care is essential to effective treatment.[8] Treatment of serious mental illnesses, including psychotic disorders, major depression, and bipolar disorder – all of which are common in the correctional setting[9] – requires access to needed medications, regular interaction with a mental health professional, and the ability to access emergency mental health services when needed.

There is broad consensus that minimally adequate mental health care for those in state confinement requires a program for screening and evaluating individuals in custody at the time of intake to identify those who require mental health treatment; implementing a program for provision of treatment; ensuring adequate staffing; maintaining accurate and confidential records; administering

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[8] *See* Joint Commission, *2009 National Patient Safety Goals Behavioral Health Care Program* (2008); David A. D'Amora et al., *Achieving Positive Outcomes for Justice-Involved People with Behavioural Health Disorders*, *in Care of the Mentally Disordered Offender in the Community* 77 (Alec Buchanan & Lisa Wootton eds., 2d ed. 2017); Debra A. Pinals & Doris A. Fuller, *Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care* (Nat'l Ass'n of State Mental Health Program Directors 2017), https://nasmhpd.org/sites/default/files/TAC.Paper_.1Beyond_Beds.pdf.

[9] *See* James & Glaze, *Mental Health Problems* at 2.

necessary medications with adequate supervision and periodic evaluation; and identifying, treating, and supervising individuals with suicidal tendencies.[10] Minimally adequate care also requires implementing measures designed to assist individuals with serious mental illness to transition to needed care following release.[11]

Reentry planning, also known as discharge planning, is intended to reduce the risk that needed care will be interrupted following release and is critical in ensuring continuity of mental health care for inmates with severe mental illness.[12]

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[10] *See generally Handbook of Correctional Mental Health* (Charles L. Scott ed., 2d ed. 2010); APA, *Jails and Prisons*; *NCCHC Standards*.

[11] Henry Dlugacz, *Community Re-entry Preparation/Coordination*, *in Oxford Textbook of Correctional Psychiatry* 76 (Robert L. Trestman et al. eds., 2015) ("Dlugacz, *Community Re-entry Preparation/Coordination*").

[12] Am. Psychiatric Ass'n, *Psychiatric Services in Correctional Facilities* 35-36 (3d ed. 2016) ("APA, *Correctional Facilities*") (describing the essential services that correctional facilities must offer to detainees or inmates for community reentry and transfer planning); APA, *Jails and Prisons* at 18 ("[T]imely and effective discharge planning is essential to continuity of care and an integral part of adequate mental health treatment."); Steven K. Hoge, *Providing Transition and Outpatient Services to the Mentally Ill Released from Correctional Institutions*, *in Public Health Behind Bars: From Prisons to Communities* 461 (Robert Greifinger ed., 2007) ("Hoge, *Transition and Outpatient Services*"); Dlugacz, *Community Re-entry Preparation/Coordination* at 76 ("Re-entry planning for people with serious mental illness should be a primary focus of correctional mental health care that is integrated into the treatment function, not an afterthought to be considered only as release is imminent."); Debra A. Pinals, *Forensic Services, Public Mental Health Policy, and Financing: Charting the Course Ahead*, 42 J. Am. Acad. Psychiatry & L. 7, 13 (2014).

Providing for such continuity is not merely incidental to mental health care, but is instead integral to it. A mental health professional who must discontinue a patient's treatment has an ethical duty to ensure that some provision is made for continuing care.[13] There is an analogous duty on the part of a correctional institution to avoid an unreasonable risk that an inmate will lose access to care upon release.[14]

Discharge planning must include, at a minimum, a discharge plan for an inmate with serious mental illness that accounts for the inmate's medical needs. This includes providing a sufficient quantity of medication to allow continuous use,[15] conducting a pre-discharge assessment,[16] establishing appointments with the

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[13] *See* Am. Med. Ass'n, *Terminating a Patient Physician Relationship*, Op. 1.1.5, https://www.ama-assn.org/delivering-care/terminating-patient-physician-relationship; Faith Lagay, *Right To Choose Patients and Duty Not To Neglect*, 3 AMA J. Ethics (2001), http://journalofethics.ama-assn.org/2001/09/code1-0109.html; Am. Psychological Ass'n, *Ethical Principles of Psychologists and Code of Conduct* § 3.12 (2017), http://www.apa.org/ethics/code/index.aspx (noting that psychologists should "make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted").

[14] Henry A. Dlugacz & Erik Roskes, *Clinically Oriented Reentry Planning*, *in Handbook of Correctional Mental Health* 395, 401 (Charles L. Scott ed., 2d ed. 2010) ("Dlugacz & Roskes, *Clinically Oriented Reentry Planning*").

[15] *Id.*

[16] APA, *Correctional Facilities* at 35-36.

community providers,[17] and ensuring medical records are effectively transferred to community providers.[18]

In some circumstances, a discharge plan should also address post-release housing. Homelessness is a major and ongoing problem for those with serious mental illness.[19] Without any provision for housing in the days immediately following release, an inmate is much more likely to suffer adverse health consequences.[20] An effective discharge plan should also include an approach for

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[17] *Id.*; *see also* Am. Med. Ass'n, *Standards of Care for Inmates of Correctional Facilities*, Policy Statement H-430.997 (2012) ("AMA, *Standards of Care*"), https://policysearch.ama-assn.org/policyfinder/detail/Prisons?uri=%2FAMADoc%2FHOD.xml-0-3784.xml ("Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism."). For some inmates, connecting them with Assertive Community Treatment or peer services is essential for ensuring continuity of care.

[18] APA, *Correctional Facilities* at 35-36.

[19] Steven K. Hoge et al., Am. Psychiatric Ass'n, *Task Force Report: Outpatient Services for the Mentally Ill Involved in the Criminal Justice System* 4 (2009) ("Hoge et al., *Task Force Report*"), https://www.psychiatry.org/psychiatrists/search-directories-databases/library-and-archive/task-force-reports (highlighting the fact that mentally ill inmates in the correctional system have "roughly double" the rate of homelessness as the rest of the inmate population); *see also* Dlugacz, *Community Re-entry Preparation/Coordination* at 77 (noting that homelessness among former inmates is higher than average and that such trends are exacerbated for individuals with mental illness, substance abuse, or both).

[20] Fred Osher et al., *A Best Practice Approach to Community Reentry from Jails for Inmates with Co-Occurring Disorders: The APIC Model*, 40 Crime & Delinq. 79, 86 (2002). Osher and colleagues state that those providing discharge

reconnecting the inmate with needed safety-net programs such as Medicaid, the Social Security Supplemental Security Income program (SSI), and welfare support.[21] Most inmates with serious mental illness will only be able to access mental health services in the community through programs such as Medicaid, and are similarly likely to be able to pay for essentials such as housing only with the help of income support programs.[22]

An appropriate discharge plan must be tailored to the individual inmate or detainee, identify his or her clinical and social needs, and include coordination with community care providers to ensure that the inmate has access to medical and social service resources after release.[23] The GAINS Center for Behavioral Health

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planning must go beyond referring an inmate to a shelter and instead work with community service providers to establish supportive-housing options. *Id.* at 86-87.

[21] Joel Dvoskin & Melody C. Brown, *Jails and Prisons*, *in Oxford Textbook of Correctional Psychiatry* 31, 33-34 (Robert L. Trestman et al. eds., 2015) ("Dvoskin & Brown, *Jails and Prisons*"); *see also* Brigid K. Grabert et al., *Expedited Medicaid Enrollment, Service Use, and Recidivism at 36 Months Among Released Prisoners with Severe Mental Illness*, 68 Psychiatric Servs. 1079 (2017) (finding that providing expedited Medicaid enrollment for former inmates with serious mental illness increases the use of community mental health and other medical services); Alexandra Gates et al., Kaiser Commission on Medicaid and the Uninsured, *Health Coverage and Care for the Adult Criminal Justice-Involved Population* (2014), https://www.kff.org/uninsured/issue-brief/health-coverage-and-care-for-the-adult-criminal-justice-involved-population/.

[22] Osher et al., 40 Crime & Delinq. at 89.

[23] *See* APA, *Correctional Facilities* at 35-36; *see also*, *e.g.*, Dlugacz, *Community Re-entry Preparation/Coordination* at 79 ("The re-entry plan will be influenced by the person's illness, connection with mental health treatment while

and Justice Transformation, for example, published a best practices model for discharge planning more than a decade ago. Its pragmatic approach calls for: (1) assessing the inmate's post-release needs and public safety risks; (2) planning for the treatment and social services to address those needs, including identifying the community and correctional programs that will provide post-release services; and (4) coordinating the transition to those providers.

C. Failure to provide discharge planning can place individuals with serious mental illness at risk of grave harm. In the two weeks following discharge, former inmates' risk of death is nearly 13 times higher than that for an average person; drug overdose and suicide are the two leading causes of such deaths.[24] This is of particular concern with respect to discharged inmates suffering from serious mental illness, as they have higher rates of both drug abuse and suicidal

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incarcerated, and ability to function in the community, as well as the model of service delivery used and the size, location, and detention function of the facility."); *see also* Dvoskin & Brown, *Jails and Prisons* at 33-34; *accord* Richard A. Van Dorn et al., *Effects of Outpatient Treatment on Risk of Arrest of Adults with Serious Mental Illness and Associated Costs*, 64 Psychiatric Servs. 856, 856 (2013).

[24] Ingrid A. Binswanger et al., *Release from Prison – A High Risk of Death for Former Inmates*, 356 New Eng. J. Med. 157, 161-62 (2007); *see also* Sungwoo Lim et al., *Risks of Drug-Related Death, Suicide, and Homicide During the Immediate Post-Release Period Among People Released from New York City Jails, 2001-2005*, 175 Am. J. Epidemiol. 519 (2012).

thoughts and behaviors than average.[25] According to a recent survey by the Substance Abuse and Mental Health Services Administration, individuals with serious mental illness are almost three times as likely as the general population (23.5% vs. 8.4%) to have a substance abuse disorder.[26] Another study found that suicide risk among those with certain serious mental illnesses was more than 10 times that of the general population.[27] The coincidence of these increased risks means that recently discharged inmates with mental illness are uniquely vulnerable to rearrest, serious injury, and death during the time immediately following release.[28]

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[25] Hoge et al., *Task Force Report* at 4; *see also* Sarra L. Hedden et al., Substance Abuse and Mental Health Servs. Admin., *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health* (Sept. 2015) ("*SAMHSA Survey*"), https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf.

[26] *SAMHSA Survey* at 23, 32-33; *see also* Stephanie Hartwell et al., *Predictors of Accessing Substance Abuse Services Among Individuals with Mental Disorders Released from Correctional Custody*, 9 J. Dual Diagnosis 11 (2013) (finding that a history of substance abuse disorders is as high at 69% in the population of inmates with known mental health issues, and that 61% of ex-inmates with such mental health issues access substance abuse treatment services within 24 months of their release).

[27] Edward Chesney et al., *Risks of All-Cause Suicide Mortality in Mental Disorders: A Meta-Review*, 13 World Psychiatry 153, 158 (2014).

[28] Dlugacz, *Community Re-entry Preparation/Coordination* at 77 (noting research showing that two thirds of inmates with serious mental illness are rearrested and half are hospitalized within 18 months of release).

II. IT IS WIDELY RECOGNIZED THAT DISCHARGE PLANNING IS AN ESSENTIAL PART OF THE STANDARD OF CARE FOR CORRECTIONAL INSTITUTIONS AND DETENTION FACILITIES

Given the importance of continuity of care for individuals with serious mental illnesses, major professional organizations identify discharge planning at correctional or detention facilities as essential to the standard of care.[29] These include organizations such as the American Psychiatric Association,[30] AMA,[31] APHA,[32] the National Commission on Correctional Health Care,[33] and the Department of Veterans Affairs.[34] The American Psychiatric Association has long

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[29] *Id.* at 76.

[30] APA, *Correctional Facilities* at 35-36 (describing the essential services that correctional facilities must offer to detainees or inmates for community reentry and transfer planning).

[31] Am. Med. Ass'n, *Fundamental Elements of the Physician-Patient Relationship*, Op. E-10.01 (1990) (noting that "[t]he patient has the right to continuity of health care" and that "[t]he physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient").

[32] Am. Pub. Health Ass'n, *Standards for Health Services in Correctional Institutions* 39 (2003) ("There must be a plan for continuity of care, whether a prisoner is transferred to another correctional system or facility or returned to the community.").

[33] Nat'l Comm'n on Corr. Health Care, *Standards for Health Services in Jails* 95-96 (2014) ("*Discharge planning* is provided for inmates with serious health needs whose release is imminent.").

[34] Dep't of Veterans Aff., Veterans Health Admin., Directive 1162.06, at 3-4 (Sept. 27, 2017), https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=5473 (outlining the scope of the VA's Veterans

made clear that "timely and effective mental health discharge planning is essential to continuity of care and an integral part of adequate mental health treatment."[35] AMA has also taken the position that "correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism."[36]

Many correctional institutions or organizations have implemented policies requiring discharge planning. The Department of Justice's National Institute of Corrections states that discharge planning is both an important component of a prison's broader medical care program[37] and a critical element of a prison's mental health program.[38] "Regardless of the difficulties encountered by correctional mental health staff, it is *crucial* that every attempt be made to provide adequate discharge planning for the mentally ill."[39] "If these patients, in particular, are not

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Justice Programs, which provide "a continuum of services designed to serve justice-involved Veterans . . . re-entering the community after incarceration").

[35] APA, *Jails and Prisons* at 18.

[36] AMA, *Standards of Care*.

[37] U.S. Dep't of Justice, Nat'l Inst. of Corr., *Correctional Health Care: Guidelines for the Management of an Adequate Delivery System* 172 (2001), https://www.ncchc.org/filebin/Publications/CHC-Guidelines.pdf.

[38] *Id.* at 177-78.

[39] *Id.* at 177 (emphasis added).

provided with a supply of medications and with sufficient social services in the community, they are likely to reoffend."[40] The Bureau of Prisons is similarly "committed to helping inmates [with mental illness] prepare for reintegration into their communities."[41] It has established a network of residential reentry centers, community treatment services, social workers, and other resources to assist inmates with safely transitioning into the community.[42]

Immigration and Customs Enforcement ("ICE") likewise requires discharge planning. In its 2011 Performance-Based National Detention Standards, ICE lists the following as one of the expected outcomes of its medical care standards:

> Detainees shall receive continuity of care from time of admission to time of transfer, release or removal. Detainees, who have received medical care, released from custody or removed shall receive a discharge plan, a summary of medical records, any medically necessary medication and referrals to community based providers as medically-appropriate.[43]

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[40] *Id.*

[41] Bur. of Prisons, *Treatment and Care of Inmates with Mental Illness*, Inmate and Custody Management Policy 5310.16, at 27 (May 1, 2014), https://www.bop.gov/policy/progstat/5310_16.pdf.

[42] *Id.* at 27-31.

[43] Immigr. & Customs Enf't, *Performance-Based National Detention Standards*, pt. 4.3, at 257-58 (2011; rev. Dec. 2016), https://www.ice.gov/doclib/detention-standards/2011/4-3.pdf.

The majority of states require mental health care discharge planning for correctional and detention centers.[44] A 2008 survey of 43 states found that all 43 provided at least a limited supply of interim medications and that the vast majority (93%) work collaboratively with mental health agencies to provide discharge planning.[45] California, for instance, provides prisoners with mental illness an individualized written discharge plan, a three- to four-week supply of medication, and referrals to inpatient and outpatient services.[46] Ohio provides a reentry plan for all exiting prisoners, offering those with mental health disorders a one- to two-week supply of medication, linkage to a community social worker, and a scheduled post-release appointment.[47]

Counties also recognize the need for reentry planning. The National Association of Counties describes reentry planning as "integral" to efforts at reducing recidivism, achieving cost-savings for the government, and improving the

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[44] Mohamedu F. Jones, *Formative Case Law and Litigation*, *in Oxford Textbook of Correctional Psychiatry* 13, 15 (Robert L. Trestman et al. eds., 2015).

[45] Nancy La Vigne et al., Urban Inst., Justice Pol'y Ctr., *Release Planning for Successful Reentry: A Guide for Corrections, Service Providers, and Community Groups* 20 & App. B, at xv (2008) ("La Vigne et al., "*Release Planning*"), https://www.urban.org/sites/default/files/publication/32056/411767-Release-Planning-for-Successful-Reentry.PDF.

[46] *Id.* App. C.

[47] *Id.*

health and well-being of mentally ill individuals who have been incarcerated.[48] It also highlights model reentry programs in jails across the country.[49] Allegheny County, Pennsylvania, for example, "focuses on comprehensive reentry planning that includes family reunification, housing, substance abuse and mental health treatment, employment, and community engagement."[50] The County "begins reentry planning as soon as an individual enters the jail" and has an infrastructure of support services to facilitate reentry, aimed specifically at lowering recidivism rates.[51]

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[48] Justin Carmody, Nat'l Ass'n of Counties, *Reentry for Safer Communities: Effective County Practices in Jail to Community Transition Planning for Offenders with Mental Health and Substance Abuse Disorders* 4 (2008), https://ojp.gov/newsroom/testimony/2009/reentrysafecommunity.pdf.

[49] *Id.* at 6-14 (highlighting programs from Allegheny County, Pennsylvania, Auglaize County, Ohio; Black Hawk County, Iowa; Macomb County, Michigan; Montgomery County, Maryland; and Multnomah County, Oregon).

[50] *Id.* at 6-7.

[51] *Id.*; *see also* La Vigne et al., *Release Planning* at 28 (highlighting Allegheny County's "comprehensive, individualized release planning and case management to individuals released without community supervision who also have a mental illness").

III. RESEARCH SHOWS THAT DISCHARGE PLANNING ENHANCES POST-RELEASE OUTCOMES FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS

Research provides strong evidence that discharge planning improves outcomes for detainees and incarcerated persons with mental illness,[52] including reduced rates of recidivism,[53] and results in overall cost-savings.[54] Federal funding

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[52] *See*, *e.g.*, Jeffrey Draine & Daniel B. Herman, *Critical Time Intervention for Reentry from Prison for Persons with Mental Illness*, 58 Psychiatric Servs. 1577 (2007) (describing the benefits of Critical Time Intervention, a nine-month, staged multidisciplinary program linking individuals with serious mental illnesses with community resources in analogous contexts). Researchers have also linked discharge planning for other health care needs to improved health outcomes. *See*, *e.g.*, Emily A. Wang et al., *Discharge Planning and Continuity of Health Care: Findings from the San Francisco County Jail*, 98 Am. J. Pub. Health 2182 (2008) (finding that HIV positive inmates who received discharge planning were six times more likely to have a regular source of care in the community compared with inmates with other chronic medical conditions).

[53] Dlugacz, *Community Re-entry Preparation/Coordination* at 78 (observing that "recent studies indicate that standard mental health treatment may indeed moderate recidivism").

[54] John Roman & Aaron Chalfin, Urban Inst., Justice Pol'y Ctr., *Does It Pay To Invest in Reentry Programs for Jail Inmates?* 1 (2006), https://www.urban.org/sites/default/files/roman_chalfin.pdf (concluding that "the case for jail-based reentry programming is strong" and noting that "[m]any cost-benefit studies have found that there are large costs of crime to victims and reductions in crime yield large savings to those who are not victimized"); Ole J. Thienhaus & Melissa Piasecki, *Correctional Psychiatry: Practice Guidelines and Strategies* 12-15 (2007) (citing a New Freedom Commission report that "makes explicit the potentially positive budgetary implications of providing successful reentry services to mentally ill inmates leaving corrections"); *accord* Am. Bar Ass'n, Crim. Justice Sec., *State Policy Implementation Project* 13-17 (2011), https://www.americanbar.org/content/dam/aba/administrative/criminal_justice/spip_handouts.authcheckdam.pdf (noting that "[w]ell designed reentry programs

has encouraged models that assist individuals with co-occurring mental illness and substance abuse disorders by providing intensive in-reach and community supports as part of reentry services, using peer supports and case managers.[55] This research is of special importance in light of findings that inmates with mental illnesses are more likely to reoffend than the overall criminal justice population.[56]

California's Mentally Ill Offender Crime Reduction Grant Program conducted one such study. In 1998, California provided more than $80 million in

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can create significant savings" and citing reentry programs in Brooklyn, New York, and Michigan as examples of successful, cost-saving reentry programs). Studies have also shown that transition planning for other medical needs reduces recidivism and costs to society. One randomized trial, for example, found that linking prisoners to primary care services upon release reduced costly emergency room visits. Emily A. Wang et al., *Engaging Individuals Recently Released from Prison into Primary Care: A Randomized Trial*, 102 Am. J. Pub. Health 22 (2012) (published online). Another study found that a Michigan reentry initiative that links prisoners to a medical home, helps them access needed medications and primary and specialty care, and ensures that they obtain their medical records on release from prison, "appears to have been a contributing factor to a significant decline in recidivism rates" in the local community. Vondie Woodbury & Peter J. Sartorius, *Michigan Pathways Project Links Ex-Prisoners to Medical Services, Contributing to a Decline in Recidivism* (Agency for Healthcare Research and Quality 2009; updated 2014), https://innovations.ahrq.gov/profiles/michigan-pathways-project-links-ex-prisoners-medical-services-contributing-decline.

[55] *See generally* David A. Smelson et al., *The MISSION Treatment Manual: Maintaining Independence and Sobriety Through Systems Integration, Outreach, and Networking* (2d ed.), http://www.missionmodel.org/manuals-1/.

[56] Dlugacz & Roskes, *Clinically Oriented Reentry Planning* at 397; *see also* Jacques Baillargeon et al., *Psychiatric Disorders and Repeat Incarcerations: The Revolving Prison Door*, 166 Am. J. Psychiatry 103 (2009) (large-scale study of inmates in the Texas prison system finding that those with major psychiatric

grants to 30 programs across 26 counties to develop and assess projects to help mentally ill offenders avoid rearrest or reincarceration.[57] Grant recipients designed these projects to meet the needs of their specific offender populations. The services offered varied by county but generally included assistance in securing residential and outpatient mental health treatment; medication education, management, and support; and assistance in securing disability entitlements, housing, vocational training, and employment.[58] Grant recipients randomized offenders into two groups: one receiving enhanced reentry services, and the other receiving treatment as usual.[59] Grant recipients followed the offenders for two years post-release.[60]

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disorders "had substantially increased risks of multiple incarcerations" over six-year study period); *see also* Kamala Mallik-Kane & Christy A. Visher, Urban Inst., Justice Pol'y Ctr., *Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration* 4 (Feb. 2008), https://www.urban.org/sites/default/files/publication/31491/411617-Health-and-Prisoner-Reentry.PDF (finding that returning prisoners with mental health conditions reported poorer housing and employment outcomes, lower levels of family support, and higher levels of post-release criminal involvement).

[57] Hoge et al., *Task Force Report* at 8.

[58] Hoge, *Transition and Outpatient Services* at 472.

[59] Hoge et al., *Task Force Report* at 8.

[60] *Id.*

By the end of the study, it was clear that inmates receiving enhanced services enjoyed better outcomes.[61] From a treatment perspective, they were less likely to have drug or alcohol problems, less likely to have their conditions become more severe, and less likely to be homeless or economically insufficient.[62] And from a criminal justice perspective, they were booked, convicted, and jailed less often.[63] Although there were substantial challenges, these programs resulted in faster access to services and improved monitoring of subjects to permit quick interventions in the event of relapse, psychotic episodes, or new illegal behaviors.[64]

A study of a similar program in Maryland – the Maryland Reentry Partnership ("REP") – also found that transitional mental health programming improved criminal justice outcomes. The REP is a partnership of service providers that provide comprehensive reentry services to prisoners returning to select Baltimore neighborhoods. These services include housing assistance, substance abuse treatment, mental health counseling, education, and vocational training.[65]

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[61] *Id.*

[62] *Id.*

[63] *Id.*

[64] *Id.*

[65] John Roman et al., Urban Inst., Justice Pol'y Ctr., *Impact and Cost-Benefit Analysis of the Maryland Reentry Partnership Initiative* 1 (2007), https://www.urban.org/research/publication/impact-and-cost-benefit-analysis-maryland-reentry-partnership-initiative/view/full_report; *see also id.* at 3.

The program also matches returning prisoners to the appropriate social and medical services that can help them successfully reintegrate into the community.[66]

The Urban Institute's Justice Policy Center evaluated the impact of the REP by examining data across a cohort of prisoners released between March 2001 and December 2004, some who returned to neighborhoods participating in the REP, others who returned to neighborhoods that did not.[67] The Justice Policy Center found that the REP generally succeeded in reducing criminal offending.[68] Over the course of the study period, fewer REP participants committed new crimes, and REP participants were also arrested on fewer charges.[69] Moreover, the REP was cost-beneficial, returning approximately $3 in benefits for every dollar in new costs.[70] Overall, it yielded a total benefit to society of about $7.2 million, and a benefit to criminal justice agencies of about $3.5 million.[71]

More recently, a study of a Michigan reentry initiative – the Jail Diversion Program – has linked discharge planning with improved continuity of care and reduced rates of recidivism for released prisoners and detainees with serious

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[66] *Id.* at 1-2.

[67] *Id.*

[68] *Id.* at 18.

[69] *Id.*

[70] *Id.*

[71] *Id.*

mental illness.[72] The study, which focused on 1,267 individuals enrolled in the program across several counties between April 2015 and March 2016, concluded that individuals released from jail who were given a two-week supply of medication and instructed to see a community mental health case manager achieved greater continuity of care.[73] It also found that those counties that offered mandated treatment, intensive case management, and outreach services upon jail discharge had greater reductions in recidivism rates following implementation of the program.[74]

Other research has linked programs providing access to specific social services like Medicaid with reduced rates of recidivism, reduced costs, or both. A study of Washington and Florida county jail systems, for example, showed that released detainees with severe mental illness that had access to Medicaid and behavioral health services were less likely to be rearrested.[75] As these and other

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[72] Sheryl Kubiak et al., *Diversion Pilots: Long Term Outcomes*, *in* Mental Health Diversion Council, *Progress Report Appendices*, App. C, http://www.michigan.gov/documents/mentalhealth/Diversion_Council_Progress_2018_Appendices_611674_7.pdf.

[73] *Id.* at 11.

[74] *Id.* at 15.

[75] Joseph P. Morrissey et al., *The Role of Medicaid Enrollment and Outpatient Service Use in Jail Recidivism Among Persons with Severe Mental Illness*, 58 Psychiatric Servs. 794 (2007). The authors, however, note that the observed differences were relatively small and that further research is needed. *Id.* at 801; *see also* Grabert et al., 68 Psychiatric Servs. at 1082 (finding that providing

studies reveal,[76] discharge planning is crucial not only for individuals with serious mental illness, but it can also can play an important role in reducing crime and its costs to society.[77]

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expedited Medicaid enrollment for former inmates with serious mental illness increases the use of community mental health and other medical services); Joseph P. Morrissey et al., *Medicaid Enrollment and Mental Health Service Use Following Release of Jail Detainees with Severe Mental Illness*, 57 Psychiatric Servs. 809 (2006) (suggesting that ensuring severely mentally ill detainees' enrollment in Medicaid upon release is likely to improve access to and receipt of community-based services).

[76] Smaller or uncontrolled studies have also linked reentry planning for mentally ill detainees or prisoners with improved treatment and reduced rates of recidivism. *See*, *e.g.*, Lois A. Ventura et al., *Case Management and Recidivism of Mentally Ill Persons Released from Jail*, 49 Psychiatric Servs. 1330, 1334 (1998) (concluding that Toledo, Ohio, jail detainees who received certain case management services, including diagnostic assessment, counseling, and medications, which continued after release, "were less likely to be rearrested than subjects who received no case management").

[77] These studies also make sense in light of a growing body of literature linking outpatient treatment services or access to benefits such as supportive housing with a reduced likelihood of arrest for individuals with serious mental illnesses. For example, examining Florida Medicaid enrollees with schizophrenia or bipolar disorders between 2005 and 2012, researchers showed that "high medication possession and receipt of routine outpatient services reduced the risk of arrest" after discharge from hospitalization. Van Dorn et al., 64 Psychiatric Servs. at 860. They also found "an additional protective effect against arrest for individuals in possession of their prescribed pharmacological medications for 90 days after discharge from . . . hospitalization." *Id.*; *see also* New York City Dep't of Health and Mental Hygiene, *New York/New York III Supportive Housing Evaluation: Interim Utilization and Cost Analysis* (2013), https://shnny.org/images/uploads/NY-NY-III-Interim-Report.pdf (finding in an interim report that placement of seriously mentally ill individuals in supportive housing reduced public expenditures, with savings driven in part by reduced use of jails).

CONCLUSION

The judgment of the district court should be reversed.

Dated: February 20, 2018

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the type-volume limitation of Local Rule 29.1(c), the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5)(A), and the type-style requirements of Federal Rule of Appellate Procedure 32(a)(6). This brief was prepared using a proportionally spaced typeface (Times New Roman, 14 point). Exclusive of the portions exempted by Federal Rule of Appellate Procedure 32(f), this brief contains 6,841 words. This certificate was prepared in reliance on the word-count function of the word-processing system (Microsoft Word 2013) used to prepare this brief.

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February 20, 2018