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***391 A CORRECTIONS QUANDARY: MENTAL ILLNESS AND PRISON RULES**Jamie Fellner [\[FNa1\]](#)

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I. INTRODUCTION

The number of incarcerated men and women with severe mental illness has grown so tremendously in the last few decades that prisons may now be the largest mental health providers in the United States. Yet U.S. prisons are not designed or equipped for mentally ill prisoners. Prison conditions are hard on mental health in general, because of overcrowding, violence, lack of privacy, lack of meaningful activities, isolation from family and friends, uncertainty about life after prison, and inadequate health services. [\[FN1\]](#) The impact of these problems is worse for prisoners whose thinking and emotional responses are impaired by schizophrenia, bipolar disease, major depression, and other serious mental illnesses. The mentally ill in prison also face inadequate mental health services that leave them under-treated or mistreated. In addition, poor mental health services leave many prisoners receiving, as Thomas C. O'Bryant points out, inappropriate kinds or amounts of psychotropic medication that further impairs their ability to function. [\[FN2\]](#)

There is an inherent tension between the security mission of prisons and mental health considerations. The formal and informal rules and codes of conduct in prison reflect staff concerns about security, safety, power, and control. Coordinating the needs of the mentally ill with those rules and goals is nearly impossible.

In this Essay, I describe both the sources and effects of this tension between prisons and mental illness and propose reforms to better serve the health needs and protect the rights of the growing number of mentally ill prisoners. In Part II, I provide a brief overview of the causes of the massive increase in the population of mentally ill persons incarcerated in U.S. prisons and the basic tension between prison operations and the confinement ***392** of prisoners with mental illness. In Part III, I review the systems of discipline and segregation in U.S. prisons, and I argue in Part IV that these mechanisms violate mentally ill prisoners' constitutional and human rights. Finally, in Part V, I describe several practical steps that if adopted would help improve the treatment of mentally ill prisoners.

II. THE MENTALLY ILL AND THE PRISON SYSTEM

There are more than 200,000—perhaps as many as 300,000—men and women in U.S. jails and prisons suffering from mental disorders, including such serious illnesses as schizophrenia, bipolar disorder, and major depression. [\[FN3\]](#) The proportion of prisoners with mental illness is increasing. The high number and growing proportion of persons with mental illness in U.S. prisons are unintended and tragic consequences of inadequate community mental health services combined with punitive criminal justice policies.

Numerous studies and surveys have documented this rise in the incarceration of the mentally ill. The Bureau of Justice Statistics estimates that sixteen percent of adult inmates in state prisons and local jails are mentally ill. [\[FN4\]](#) There are three times as many mentally ill people in prisons than in mental health hospitals, and the rate of mental illness in prisons is two to four times greater than in the general public. [\[FN5\]](#)

***393** Although there is little historical data, corrections and mental health experts believe the proportion of the prison population with mental illness is increasing. Nineteen of thirty-one states responding to a 1998 survey reported a disproportionate increase in their seriously mentally ill population during the previous five years. [\[FN6\]](#) While some portion of the increase may be attributable to improved mental health screening and diagnosis of mental health problems, there is a consensus in corrections that the numbers also reflect a real change in the rate at which the mentally ill are being sent to prison. [\[FN7\]](#)

The crisis in the mental health system in the United States has undoubtedly contributed to the number of mentally ill prisoners. As a presidential advisory commission in recent years reported, the mental health system is “in disarray.” [\[FN8\]](#) It is fragmented, chronically under-funded, and rife with barriers to access, particularly in minority communities. As a result, too many people who need publicly financed mental health services cannot obtain them until they are in an acute psychotic state and are found to be a danger to themselves or others.

Left untreated and unstable, people with serious mental illnesses— particularly those who are also poor, homeless, and suffering from untreated alcoholism or drug addiction—may break the law and then enter the criminal justice system. The failure of mental health systems has led to what some have called the criminalizing of the mentally ill. As the Council of State Governments has noted:

***394** [I]f many of the people with mental illness received the services they needed, they would not end up under arrest, in jail, or facing charges in court [T]he ideal mechanism to prevent people with mental illness from entering the criminal justice system is the mental health system itself—if it can be counted on to function effectively. [\[FN9\]](#)

The nation's aggressive and punitive anti-crime policies, including its “war on drugs,” have also contributed to the number of mentally ill in prison. These tough-on-crime approaches dominant in U.S. criminal justice policy have resulted in a quadrupling of prison and jail populations in three decades. [\[FN10\]](#) Persons with mental illness are among those masses swept behind bars.

The sheer number of mentally ill inmates has transformed prisons into facilities for the mentally ill. Yet prisons cannot provide the range of services mentally ill prisoners need in the necessary quantity and quality. Seriously ill prisoners confront a paucity of qualified staff to evaluate their illness, develop and implement treatment plans, and monitor their condition. They confront treatment that often consists of little more than medication—and even that may be poorly administered and supervised, as O'Bryant notes—or no treatment at all. [\[FN11\]](#) They live without the diversity of mental health interventions they need, much less the long-term supportive and therapeutic environment that would best help many of them manage their illnesses. Without necessary care, mentally ill inmates suffer painful symptoms and their conditions can deteriorate. [\[FN12\]](#)

Apart from the mental health services that may or may not be provided, prisons typically treat prisoners with mental illness identically to all other inmates. There are no special allowances. Officials confine them in the same facilities, expect them to follow the same routines, and require them to comply with the same rules.

***395** Mentally ill prisoners, however, do not have the same capacity to comply with prison rules as do other prisoners. If they have schizophrenia or other serious “Axis I” disorders, [\[FN13\]](#) psychotic symptoms, or other serious dysfunction, inmates may suffer from delusions (false beliefs), hallucinations (erroneous perceptions of reality), chaotic thinking, or serious disruptions of consciousness, memory, and perception of the environment. [\[FN14\]](#) They may experience debilitating fears or extreme and uncontrollable mood swings. As a result of their illness, they may

huddle silently in their cells, mumble incoherently, or yell incessantly. They may hear voices or “command hallucinations,” telling them to commit violence against themselves or others. [\[FN15\]](#) They may exhibit their illness through disruptive behavior, belligerence, aggression, and violence. They may suddenly refuse to follow routine orders, such as to come out of a cell, to stand up for the count, to remove clothes from cell bars, or to take showers. They may beat their heads against cell walls, smear themselves with feces, self-mutilate, and attempt suicide (sometimes succeeding). In short, they may—and often do—behave in ways that prison systems consider punishable misconduct. [\[FN16\]](#)

III. DISCIPLINE AND SEGREGATION

The predominant goal of prison authorities is ensuring the security and safety of staff and inmates. This goal is in constant tension with the vulnerabilities of prisoners who have mental illnesses. Prisons operate according to a comprehensive and complex system of rules, policies, and procedures that regulate all aspects of inmate conduct. Compliance with those rules is paramount. Few accommodations, however, are made for prisoners whose mental illness may make it more likely they will break the rules. ^{*396} While some prison systems have begun to incorporate mental health considerations into their disciplinary systems, there is an urgent and serious need to reassess disciplinary systems in light of rising rates of mentally ill prisoners.

A. Mental Illness and Rule Violations

Like other prisoners, those with mental illness navigate the prison environment as best they can, but their illness may leave them less able to conform to the rules. Available data indicate that mentally ill prisoners have higher than average disciplinary rates. [\[FN17\]](#) A study in New York found that inmates on the mental health roster “have higher infraction rates than [other] inmates.” [\[FN18\]](#) In Washington State, “offenders with serious mental illness constitute 18.7 percent of the prison population but account for 41 percent of the infractions.” [\[FN19\]](#) According to the Federal Bureau of Justice Statistics, mentally ill prisoners in state and federal prisons as well as local jails are more likely than others to have been involved in a fight or to have been charged with breaking prison rules. [\[FN20\]](#)

Prison rules operate somewhat like the penal code in the criminal justice system, and the uniformed correctional officers (guards) function in many ways like police, trying to maintain order and charging inmates with “infractions” when they break the rules. The officers have great discretion in deciding which rule violations to write up in a formal “ticket” and how to characterize the nature of the misconduct.

Most prison systems do not provide correctional officers with more than minimal mental health training. Officers typically do not understand the nature of mental illness and its behavioral impact. They cannot distinguish—and may not even know a distinction exists—between a frustrated or disgruntled inmate who “acts out” and one whose “acting out” reflects mental illness. They assume misconduct is volitional or manipulative. When, for example, an officer gives a ticket to an inmate for banging his head against his cell wall, the officer may have little idea that the inmate is experiencing severe uncontrolled hallucinations. As the medical director of one prison system has pointed out, correctional officers all too often “refer prisoners to the disciplinary process even when the prisoners might be having behavioral problems that are a symptom of their illness.” [\[FN21\]](#)

Examples of prisoners accused of breaking rules and being punished for acts connected to mental illness are legion. Prisoners have been punished for self-mutilation because that behavior entailed the “destruction of state property”—to wit, the prisoner’s body. [\[FN22\]](#) Prisoners who tear up bed-sheets to make a rope for hanging themselves have been punished for misusing state property. [\[FN23\]](#) Prisoners who scream and kick cell doors while hearing voices have been charged with destruction of property and creating a disturbance. [\[FN24\]](#) And prisoners who smear feces in their cells have been punished for “being untidy.” [\[FN25\]](#) The findings of a federal court examining the treatment of the mentally ill in California prisons are applicable to many other state prison systems:

Mentally ill inmates who act out are typically treated with punitive measures without regard to their mental

status There is substantial evidence in the record of seriously mentally ill inmates being treated with punitive measures by the custody staff to control the inmates' behavior without regard to the cause of the behavior, the efficacy of such measures, or the impact of those measures on the inmates' mental illnesses. [\[FN26\]](#)

***398 B. Disciplinary Hearings and Mental Illness**

Mentally ill prisoners are routinely punished under prison disciplinary systems for rule infractions arising from their illness without regard to their actual culpability. Unless an infraction is minor, it will be adjudicated in a formal hearing. [\[FN27\]](#) In theory, prison disciplinary hearings can lead to a finding of “not guilty.” In practice, however, this result rarely occurs. Instead, the real purpose of the hearing is to determine punishment. [\[FN28\]](#)

Disciplinary hearings provide a modicum of due process and can be seen as functioning somewhat like a court in the criminal justice system. [\[FN29\]](#) Nevertheless, they typically do not recognize incompetence to participate in the proceedings; the hearing goes forward regardless of whether the prisoner is capable of either understanding the charge or presenting a defense. Nor do disciplinary hearings permit an insanity defense, which would excuse a prisoner from guilt for conduct that he could neither appreciate nor control. [\[FN30\]](#) Hearing officers may not even take mental illness into account as a mitigating factor in determining a sentence. They do not consider whether the prisoner's conduct reflected significant cognitive or volitional impairments. The imperative of punishment supersedes any potential recognition that a mentally ill prisoner may not have been meaningfully able to control his behavior.

Prison officials are reluctant to accept that mental illness should be given weight in disciplinary hearings. They fear that accommodating mental illness will provide excuses for prisoner misconduct, encourage others to engage in similar misconduct, and promote a general breakdown in order. [\[FN31\]](#) Particularly strong is the concern about malinger— that inmates will fake mental illness to avoid punishment for misconduct. [\[FN32\]](#) As the Director of the Ohio Department of Rehabilitation and Correction, Dr. Reginald Wilkinson, has stated, “what we cannot do is ignore the disciplinary aspect [of misconduct]. Otherwise, this would lead to faking [of mental illness] by other inmates.” [\[FN33\]](#) In addition, corrections personnel fear that incorporating *399 mental health considerations into what they see as security determinations would diminish their authority. According to one corrections expert with decades of experience, “the idea of ceding security authority to mental health personnel is pretty repugnant to most prison administrations.” [\[FN34\]](#)

University of California psychiatrist Michael Krelstein surveyed the fifty state departments of corrections and the Federal Bureau of Prisons about their disciplinary systems and the role of mental illness. [\[FN35\]](#) Many prison officials expressed concern to him that involving mental health staff in the determination of disciplinary responses would:

create a conflict of interest for the mental health teams; could encourage non-mentally ill prisoners to feign illness knowing that this illness might mitigate the prison system's responses to their misbehavior; and could place the clinicians at risk of revenge attacks from patients to whom they had assigned punishments. [\[FN36\]](#) For example, Krelstein found that:

Under Texas policy, mental health [staff] may communicate with custody [staff] regarding the disciplinary management of seriously mentally ill inmates, but are prohibited from performing forensic evaluations including sanity at the time of the alleged disciplinary infraction or competence to undergo disciplinary proceedings. [\[FN37\]](#)

According to Krelstein, Texas justified this policy on the grounds that “custody [staff] could object to the mental health [staff's] insanity determinations, which excuse an inmate's antisocial or violent behavior, further straining custodial-clinical staff relations.” [\[FN38\]](#) A number of states, however, do permit mental health staff to participate in some capacity in disciplinary hearings. [\[FN39\]](#) The roles such staff play in the hearings vary, as *400 does the willingness of disciplinary hearing officers to take mental health perspectives into consideration. [\[FN40\]](#)

A few prison systems have begun to wrestle seriously with how to incorporate mental health considerations into their disciplinary procedures. They have recognized the unfairness in having a disciplinary hearing when an inmate is too psychotic to mount any defense of his infraction, the illogic in punishing an inmate for behavior he could not meaningfully control, and the utility to the prison system of tailoring sanctions to take into account mental illness. In Ohio, the prison disciplinary system considers whether a prisoner is competent to participate in the hearing. [\[FN41\]](#) However, even if an offense is attributable to mental illness, the prisoner can still be found guilty of the infraction. The mental illness can only be factored into sanction determinations. The Ohio adjudicating body, the Rules and Infractions Board (“RIB”), consults with mental health staff about the diagnosis, treatment, and needs of prisoners who are on the mental health caseload, and mental health staff may provide input and make recommendations about suitable sanctions. [\[FN42\]](#)

The Georgia Department of Corrections requires prisoners with mental illness or mental retardation to be “screened and evaluated by mental health/mental retardation staff during the investigation phase of the disciplinary process when there is a violation of the institutional/departmental rules.” [\[FN43\]](#) For prisoners with more serious conditions, the procedures require a determination by mental health staff whether the prisoner at the time of the infraction was responsible for his conduct. Even if mental health staff determines that a prisoner can be held responsible for the rule-breaking conduct, they must also indicate whether his present mental status should preclude the use of some regular disciplinary sanctions in favor of alternative sanctions. Such alternatives may include placement in specific therapy or psycho-education groups, individual counseling or therapy, or placement in an intensive behavioral therapy unit.

***401 C. Sanctions and Mental Illness**

Unfortunately, most prison systems do not offer the possibility of tailoring sanctions to accommodate mental illness. The same sanctions are used for everyone and are dependent on the seriousness of the conduct and the prisoner's prior disciplinary history. If punishment is supposed to help deter future misconduct, that goal is clearly misplaced when individuals have no meaningful control over their conduct. Punishment is particularly counter-productive—indeed dangerous to the prisoner—when it consists of placing mentally ill prisoners in prolonged segregation. [\[FN44\]](#) The culture of corrections, however, has prevented corrections administrators from developing therapeutically sensible, productive, and change-oriented responses to infractions by the mentally ill that would contribute to the prisoner's ability to cope better, both with his illness and with prison life. [\[FN45\]](#)

Typical sanctions for misconduct range from loss of canteen privileges, to loss of prison jobs, and to disciplinary segregation. Because misconduct records can lead to loss of any accumulated “good time,” prisoners with mental illness tend to serve most or all of their maximum sentences. For example, the Pennsylvania Department of Corrections reports that prisoners with serious mental illness are three times as likely as other prisoners to serve their maximum sentence. [\[FN46\]](#) According to the Bureau of Justice Statistics, mentally ill prisoners in state prison serve more time on average than other prisoners. [\[FN47\]](#)

Because of their disciplinary records—as well as concerns about their mental illness itself—mentally ill prisoners are also at greater risk of being denied parole when brought before a parole board. According to Superintendent Donald Vaughn of Graterford Prison in Pennsylvania, parole boards “don't want to chance it on releasing them.” [\[FN48\]](#) Dr. Reginald Wilkinson, director of the Ohio Department of Rehabilitation and Corrections, pointed out in testimony to Congress that mentally ill prisoners receive parole “far less frequently” than other inmates. [\[FN49\]](#) The lack of adequate community*402 services for those with mental illness makes it difficult for the parole board to develop an effective community treatment and supervision plan. [\[FN50\]](#)

D. Segregation as Punishment

The harshest punishment in prison for misconduct is a form of solitary confinement termed segregation. Condi-

tions of confinement in segregation follow a similar pattern across the country: inmates are held at least 23 to 24 hours a day in their cells, with 3 to 5 hours for out-of-cell “recreation” and shower time a week. Recreation typically consists of solitary exercise in a space with no equipment. In most prison systems, prisoners in segregation may not have a radio or television and may not talk normally with other prisoners. [\[FN51\]](#) They are allowed at most a few books and scant personal possessions. In some prisons the cells are windowless. In many the segregation cells have solid steel doors with a slot through which food can be passed and the prisoner's hands can be placed for handcuffs, and a small window that guards can look into to check on the prisoner. The solid steel doors greatly amplify the isolation experienced by the prisoners. Prison officials dispute the characterization of segregation as “solitary confinement,” pointing out that prison staff are constantly on cell blocks. But the corrections officers who are primarily on the cell blocks are busy passing out meals, performing head counts, and escorting prisoners from one place to another. They are too busy to chat with the prisoners, and they are discouraged from doing so even if possible—such as while taking the prisoner to the showers. At least three dozen state prison systems and the Federal Bureau of Prisons use super-maximum security prisons for long-term segregation of inmates they have deemed particularly dangerous or disruptive. [\[FN52\]](#)

The mentally ill are disproportionately represented among prisoners in segregation. Whether through histories of disciplinary infractions or by exhibiting bizarre and difficult behavior that officials believe cannot be accommodated within the general prison population, they land in disciplinary*403 or administrative segregation for prolonged periods of time. [\[FN53\]](#) Data from different states reveal that the mentally ill typically account for one-quarter or more of the segregated population; in some states, they account for one-half. [\[FN54\]](#)

For many prisoners, the absence of normal social interaction, reasonable mental stimulus, exposure to the natural world, and purposeful activities is emotionally, physically, and psychologically damaging. [\[FN55\]](#) According to a federal judge, segregation “may press the outer bounds of what most humans can psychologically tolerate.” [\[FN56\]](#) Even prisoners with no prior history of mental illness who are subjected to prolonged isolation may experience depression, despair, anxiety, rage, claustrophobia, hallucinations, problems with impulse control, or an impaired ability to think, concentrate, or remember. [\[FN57\]](#)

Prisoners with preexisting psychiatric disorders are at even greater risk of suffering psychological deterioration while in segregation. [\[FN58\]](#) The stresses, social isolation, and restrictions of segregated confinement can exacerbate their illness or provoke a recurrence, immeasurably increasing their pain and suffering. [\[FN59\]](#) Placing mentally ill or psychologically vulnerable*404 people in supermax conditions “is the mental equivalent of putting an asthmatic in a place with little air to breathe.” [\[FN60\]](#)

The lack of adequate mental health treatment in segregation units aggravates the hardship mentally ill prisoners endure there. There are typically too few staff members to attend to the high proportion of mentally ill prisoners in segregation. Many are untreated or under-treated because staff dismiss their symptoms as manipulation to get out of segregation. In addition, the physical design and rules of social isolation preclude appropriate treatment measures. Mental health services typically are limited to brief cell-side conversations with mental health staff (in full earshot of corrections staff and inmates), medication, and intermittent (every one to three months) short meetings with the psychiatrist prescribing the medication. [\[FN61\]](#)

In many segregation units, mental health services are so poor that even floridly psychotic prisoners receive scant attention. Segregated confinement can provoke sufficient deterioration and exacerbation of the symptoms of mentally ill prisoners that they must be removed to in-patient psychiatric facilities for acute care. Yet once they are stabilized, they return to segregation, where the cycle continues.

Correctional authorities claim punishment and safety considerations preclude group activities and therapy for prisoners in segregation. But denying mentally ill prisoners therapy as a form of punishment is both counterproductive and needlessly cruel. Though some prisoners are so dangerous and volatile that their interaction with others must be carefully controlled, *405 “control” does not require all cessation of inter-personal interaction and mental health care

treatment other than medication.

Class action cases in recent years have challenged prolonged segregation for inmates with mental illness. In each case, evidence of harm to class members has been so powerful that the plaintiffs have secured restrictions on that confinement, either by winning the case or through settlement. [\[FN62\]](#) Correctional systems that are not bound by court orders or settlements continue, however, to confine the mentally ill in segregation.

IV. A HUMAN RIGHTS PERSPECTIVE

The failure of U.S. prisons to address adequately the special needs of prisoners with serious mental illness, including in their disciplinary systems, flies in the face of international human rights standards. While U.S. constitutional law sets low minimum standards which as a practical matter allow inhuman and degrading treatment of the mentally ill, international human rights law affirms positive obligations to treat mentally ill prisoners with dignity. Human rights law also prohibits subjecting prisoners to punishment that might be considered torture or otherwise cruel, inhuman, or degrading treatment, be it punishment for the crime that sent them to prison, or for disciplinary infractions while incarcerated. Full compliance with international human rights norms requires removing the most seriously ill prisoners from prisons altogether and placing them in mental institutions.

Under the Supreme Court's Eighth Amendment jurisprudence, the failure to provide mental health care could be held unconstitutional if it involves the “unnecessary and wanton infliction of pain” [\[FN63\]](#) and reflects corrections officials’ “deliberate indifference to serious medical needs of prisoners.” [\[FN64\]](#) To prove an Eighth Amendment violation, prisoners must show both an objective and serious injury (either physical or psychological) and a culpable subjective intent on the part of the prison authorities. Substandard quality of care, negligence, or even malpractice does not suffice to establish a constitutional violation. [\[FN65\]](#) Rather, prison officials are only liable for Eighth Amendment violations if they know “that inmates face a substantial risk of serious harm” and fail to take “reasonable measures to abate it.” [\[FN66\]](#)

***406** The “deliberate indifference” requirement has significantly limited court findings of constitutional violations with regard to mental health services and thus the courts’ ability to order improvements in those services. For example, plaintiffs’ experts in a long-running class action lawsuit against the Texas Department of Criminal Justice (“TDCJ”) found system-wide deficiencies in the mental health care system, including “not recognizing or minimizing symptoms indicative of major mental illnesses,” under-diagnosis of mental illnesses, inadequate access to psychiatric assessments, inadequate treatment of those found to be mentally ill, and “wholly inadequate” staffing. [\[FN67\]](#) However, while the federal district court concluded that the psychiatric care system of TDCJ was “grossly wanting,” it was unable to find constitutional violations due to absence of proof that TDCJ officials were “systemically and deliberately indifferent” to prisoners’ psychiatric needs. [\[FN68\]](#) The court expressed hope that the Supreme Court would eventually modify its contemporary standards for cruel and unusual punishment regarding medical treatment for prisoners: “As the law stands today, the standards permit inhumane treatment of inmates. In this court’s opinion, inhumane treatment should be found to be unconstitutional treatment.” [\[FN69\]](#)

Prisoners’ access to the courts to secure remedies for constitutional violations, including inadequate mental health services, is also limited by the restrictions imposed by the Prison Litigation Reform Act (“PLRA”). [\[FN70\]](#) The word “reform” in the statute’s title is a misleading reference to the comprehensive set of constraints on prison litigation crafted to respond to Congress’s perception that prisoners were filing too many frivolous lawsuits. The law, *inter alia*, requires that prisoners exhaust all internal administrative remedies before bringing a lawsuit, imposes filing fees, limits damages and attorney’s fees, and requires judicially enforceable consent decrees to contain findings of federal law violations. [\[FN71\]](#) O’Bryant writes that mental illness and overmedication impaired his functioning and contributed to his inability to file a timely federal petition for the writ of habeas corpus. [\[FN72\]](#) Mental illness and improper medication—too little, too much, or the wrong drug—may also prevent prisoners from complying in a timely and correct way with prison grievance procedures that typically set short deadlines for filing the initial grievance through the appeals process. While not explicitly cutting back on prisoners’ constitutionally protected rights, the PLRA creates

formidable obstacles to judicial protection and *407 enforcement of those rights by applying with equal force to meritorious as well as frivolous cases.

In contrast to U.S. constitutional law, international human rights law offers a more humane and forward-thinking framework for analyzing and responding to the treatment of mentally ill prisoners behind bars. It sets forth rights that all persons—including prisoners—possess by virtue of being human, enumerates specific protections for prisoners, and requires governments not only to protect all human rights but also to ensure remedies when those rights are violated. [FN73] The International Covenant on Civil and Political Rights (“ICCPR”), to which the United States is a party, includes provisions expressly applicable to the treatment of prisoners. Article 10 states that “[a]ll persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.” Article 10 also mandates that “[t]he penitentiary system shall comprise treatment of prisoners the essential aim of which shall be their reformation and social rehabilitation.” Unlike the U.S. Constitution, Article 10 establishes a positive goal for corrections. The injunctions to treat prisoners in a manner consistent with their humanity and inherent dignity and to promote their rehabilitation clearly distinguish Article 10 from the narrow, limited prohibitions of the Eighth Amendment.

In addition, ICCPR Article 7 states that no one “shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.” [FN74] On its face, Article 7 is broader than the Eighth Amendment, which only proscribes “cruel and unusual” treatment. Equally important, a prisoner’s right to be free of cruel treatment does not depend on the state of mind of the officials mistreating him. [FN75] Additionally, the norm of personal culpability *408 inherent in the Eighth Amendment requirement of “deliberate indifference” finds no parallel in human rights law. An official may be remiss in his obligations under Article 10 if he fails to provide decent mental health services, and the absence of services may amount to treatment prohibited by Article 7, regardless of whether he acts negligently or deliberately.

Various United Nations documents explain how governments may comply with their international legal obligations vis-a-vis the men and women incarcerated in jails and prisons. These documents include: the United Nations Standard Minimum Rules for the Treatment of Prisoners [FN76] (“Standard Minimum Rules”), adopted by the Economic and Social Council in 1957; the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, [FN77] adopted by the General Assembly in 1988; and the Basic Principles for the Treatment of Prisoners, [FN78] adopted by the General Assembly in 1990. While these instruments are not treaties, they constitute authoritative guides to the content of binding treaty standards and customary international law. All affirm the obligation of prison officials to treat prisoners humanely—including providing mental health care to those who need it. [FN79]

*409 The Standard Minimum Rules go beyond mandating proper mental health care for prisoners. They recognize that some prisoners with serious mental illness should not be confined in prisons at all. Persons found insane should be confined in mental institutions, and prisoners “who suffer from other mental diseases or abnormalities shall be observed and treated in specialized institutions under medical management.” [FN80] While such prisoners are in a prison, they “shall be placed under the special supervision of a medical officer.” [FN81]

International instruments also address disciplinary procedures, acknowledging that the rule of law and fundamental norms of justice do not stop at the prison gate. They require, for example, that the law or lawful regulations specify what conduct constitutes an offense and give the prisoner a right to be heard before disciplinary action is taken. [FN82] Human rights and corrections experts understand the rules to require that a prisoner be given time to prepare a proper defense, be present at the hearing, and receive assistance if he is incapable of defending himself. [FN83] It is wholly consistent with these principles of justice to preclude or delay disciplinary hearings and punishment for any prisoner who is incompetent to proceed in a hearing because of mental illness.

Though there is no express reference in international human rights rules to mental illness as a defense or a mitigating factor for disciplinary infractions, it is difficult to square basic principles of respect for human dignity with punishment of someone without regard to the impact of mental illness. A just and proportionate punishment must be

based on an assessment of a person's culpability as well as his conduct. Culpability determinations must consider cognitive or emotional impairments that influenced the conduct. [\[FN84\]](#)

***410** As to punishment itself, human rights law precludes the use of any punishment that may be torture or otherwise cruel, inhuman, or degrading. The Standard Minimum Rules state that no prisoner shall be subjected to any punishment “that may be prejudicial to [his] physical or mental health ... unless a medical officer has examined the prisoner and certified in writing that he is fit to sustain it.” [\[FN85\]](#) Human rights experts have concluded that prolonged solitary confinement of anyone, much less the mentally ill, is a violation of the fundamental human rights prohibition against torture and other cruel, inhuman, and degrading treatment. [\[FN86\]](#)

All too often the implicit—if not explicit—predominant goal of U.S. corrections officials is to minimize the prospect of successful constitutional litigation. They accept the minimum standards for prison conditions and the treatment of prisoners set by the Supreme Court as both a ceiling and a floor. In contrast, international human rights law sets affirmative goals for prisoner mental health that challenge prison officials to provide the best mental health services they can to mentally ill prisoners. The human rights perspective mandates that corrections officers not only be given progressive standards for prisoner care, but also the resources to do this job well.

V. CONCLUSION

Corrections officials recognize the challenge posed to their work by the large and growing number of mentally ill prisoners. They know there is much more they should do to respond to the needs of the mentally ill, to alleviate their suffering, and to prevent deterioration in their conditions. If legislatures provided sufficient financial resources as well as political support, prisons could offer effective, quality mental health care for those who need it. [\[FN87\]](#) They could hire and retain more mental health staff with appropriate qualifications and hold them to high performance standards. They could provide sufficient specialized facilities for acute care needs. They could vary the housing, supervision, and care of prisoners with mental illness according to the nature and severity of their illnesses. And they could retain independent experts to undertake careful and continuous quality of care reviews.

***411** But insufficient funding is not the only reason mentally ill prisoners do not receive the treatment they need. The culture of prisons plays an important role as well. The growing influx of mentally ill prisoners challenges corrections officials to incorporate rehabilitation and respect for human dignity into a paradigm currently circumscribed by security, safety, and discipline. If inmates' rights are to be respected, prisoners should not be punished for conduct they cannot meaningfully control. When punishment is imposed on them, it should further—or at least not undermine—the prisoners' mental health and treatment plans. Most importantly, corrections officials must develop options for responding to dangerous or disruptive individuals who are mentally ill other than simply putting them into segregation. If such individuals require extensive security precautions, they should be housed in specialized secure units where they can participate in purposeful activities, have human interaction, and receive the services that mental health professionals deem therapeutically appropriate. Corrections officials should also provide more and better mental health training to line staff and imbue them with the mission of protecting and serving inmates' needs during incarceration.

Whatever improvements are made, prisons will never be a good place for the mentally ill. As the World Health Organization (“WHO”) has recognized, imprisonment by its very nature has an adverse effect on mental health. The WHO therefore urges that incarceration “be kept to the minimum possible, consistent with the needs of the wider community to see crime punished effectively and community safety assured.” [\[FN88\]](#) In the United States, however, incarceration is not the last resort, imposed when there is no other option to protect communities. The U.S. prison population bulges with low-level nonviolent offenders for whom incarceration is not only unnecessary but also counterproductive. [\[FN89\]](#)

The most effective way to ensure that the rights of mentally ill offenders are protected is to try to keep them out of

prison in the first place. To do so, community health services need to be expanded and organized to better serve the poor, the homeless, and those who are substance abusers. Mental health courts, prosecutorial pretrial diversion, and other efforts should be expanded to divert mentally ill offenders from jails and prisons and into community-based mental health treatment programs. [FN90] Mandatory minimum sentencing laws should be reformed to ensure prison is reserved for the most serious offenders and sentences are not disproportionately harsh.

To resolve the dilemma between prison security and the needs of mentally ill offenders, we need far more commitment, compassion, and common *412 sense from public leaders, corrections officials, and the public. A serious rethinking of the purposes of incarceration is also required. Human rights principles affirm the goal of increasing the ability of the prisoner to lead a productive, law-abiding life upon return to society. Placing the mentally ill in a brutal environment that they are not equipped to navigate without the aid of robust mental health services promotes neither rehabilitation nor prison security. It smacks more of cruelty than of justice.

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[FN1]. WORLD HEALTH ORG., INFORMATION SHEET: MENTAL HEALTH AND PRISONS I, http://www.euro.who.int/Document/MNH/WHO_ICRC_InfoSht_MNH_Prisons.pdf (last visited Mar. 23, 2006); *see also* REG'L OFFICE FOR EUR., WORLD HEALTH ORG., MENTAL HEALTH PROMOTION IN PRISONS (1999), <http://www.euro.who.int/document/E64328.pdf>.

[FN2]. Thomas C. O'Bryant, *The Great Unobtainable Writ: Indigent Pro Se Litigation After the Antiterrorism and Effective Death Penalty Act of 1996*, 41 HARV. C.R.-C.L. L. REV. 299, 310-15 (2006).

[FN3]. SASHA ABRAMSKY & JAMIE FELLNER, HUMAN RIGHTS WATCH, ILL EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 17 (2003), *available at* <http://www.hrw.org/reports/2003/usa1003/usa1003.pdf> (citing Jeffrey L. Metzner et al., *Treatment in Jails and Prisons, in TREATMENT OF OFFENDERS WITH MENTAL DISORDERS* 211 (Robert M. Wittstein ed., 1998); AM. PSYCHIATRIC ASS'N, *PSYCHIATRIC SERVICES IN JAILS AND PRISONS* xix (2d ed. 2000)).

[FN4]. PAULA M. DITTON, U.S. DEPT OF JUSTICE, BUREAU OF JUSTICE STATISTICS, SPECIAL REPORT: MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS 3 (1999), *available at* <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf>. The Bureau identified prisoners as mentally ill if they met one of two criteria: they reported a current mental or emotional condition, or they reported an overnight stay in a mental hospital or treatment program. *Id.* at 2. Data from individual prison systems confirms national estimates. For example, the California Department of Corrections has estimated that over fourteen percent of its inmates were on its mental health services roster. *See* ABRAMSKY & FELLNER, *supra* note 3, at 18 (citing DATA ANALYSIS UNIT, DEPT OF CORR., STATE OF CALIFORNIA, MONTHLY REPORT OF POPULATION (July 2002)). The Pennsylvania Department of Corrections estimates that 16.5% of its prisoner population suffers from mental illness, one-quarter of which are so ill that their ability to function on a day-to-day basis has been dramatically limited. *Id.* (citing Interview by Human Rights Watch with Lance Couturier, Chief Psychologist, Pa. Dep't of Corr. (Jan. 23, 2003)).

[FN5]. NAMI (formerly known as the National Alliance for the Mentally Ill) and the Center for Mental Health Services estimate that between 2.6% and 5.4% of U.S. adults have some form of serious mental illness. *See* NAMI, *About Mental Illness*, http://www.nami.org/template.cfm?section=about_mental_illness (last visited Mar. 22, 2006). This number is based on 1998 research by R. C. Kessler. *See* Karen H. Bourdon et al., *National Prevalence and Treatment of Mental and Addictive Disorders, in MENTAL HEALTH, UNITED STATES* 22, 33 (Ronald W. Manderscheid & Marilyn J. Henderson eds., 1999). But in prisons, "studies and clinical experience indicate that 8-19 percent of prisoners have significant psychiatric or functional disabilities and another 15-20 percent will require some form of psychiatric intervention during their incarceration." *See* Metzner et al., *supra* note 3, at 211. Metzner also provides a

summary of research on the prevalence of mental disorders in jails and prisons. *Id.* at 230-33.

[FN6]. ABRAMSKY & FELLNER, *supra* note 3, at 19 (citing COLO. DEPT OF CORR., OFFENDERS WITH SERIOUS MENTAL ILLNESS (1998)).

[FN7]. The National Institute of Corrections (“NIC”) conducted a survey of prisons regarding mental health needs and services. Eighteen of twenty-five states that responded to the NIC survey reported increases in the size of prison population with mental illness. For example, in Connecticut, the number of prisoners with serious mental illness increased from 5.2% to 12.3% of the state prison population. ABRAMSKY & FELLNER, *supra* note 3, at 19 (citing U.S. DEPT OF JUSTICE, NAT’L INST. OF CORR., PROVISION OF MENTAL HEALTH CARE IN PRISONS 3 (2001), available at <http://www.nicic.org/pubs/2001/016724.pdf>). The mental health caseload in New York prisons has increased by 73% since 1991, five times the prison population increase. ABRAMSKY & FELLNER, *supra* note 3, at 19 (citing Mary Beth Pfeiffer, *Mental Care Faulted, in Six Prison Deaths*, POUGHKEEPSIE J., June 28, 2003, at A1). In Colorado, the proportion of prisoners with major mental illness was five or six times greater in 1998 than it was in 1988. *Id.* at 19 (citing COLO. DEPT OF CORR., OFFENDERS WITH SERIOUS MENTAL ILLNESS (1998)). The Colorado report includes the results of its survey of prison mental health directors regarding the proportion of prisoners with serious mental disorders. Nineteen of thirty-one states responding to the survey reported a disproportionate increase in their seriously mentally ill population during the previous five years. *Id.* For example, between 1993 and 1998, the population of seriously mentally ill prisoners in Mississippi doubled; in the District of Columbia, it rose by 30%. *Id.*

[FN8]. PRESIDENT’S NEW FREEDOM COMM’N ON MENTAL HEALTH, ACHIEVING THE PROMISE: TRANSFORMING MENTAL HEALTH CARE IN AMERICA 3 (2003), available at <http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html>.

[FN9]. COUNCIL OF STATE GOV’TS, CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT 26 (2002), available at http://consensusproject.org/downloads/Entire_report.pdf.

[FN10]. THOMAS P. BONCZAR, U.S. DEPT OF JUSTICE, BUREAU OF JUSTICE STATISTICS, PREVALENCE OF IMPRISONMENT IN THE U.S. POPULATION, 1974-2001 (2003), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/piusp01.pdf>. A good overview of the changing nature of criminal justice policies and their impact on the U.S. prison populations is provided in MARC MAUER, RACE TO INCARCERATE (1999); see also JAMIE FELLNER, HUMAN RIGHTS WATCH, PUNISHMENT AND PREJUDICE: RACIAL DISPARITIES IN THE WAR ON DRUGS (2000), available at <http://www.hrw.org/reports/2000/usa>.

[FN11]. O’Bryant, *supra* note 2, at 310-15.

[FN12]. For a comprehensive analysis of problems in mental health services in U.S. prisons, see ABRAMSKY & FELLNER, *supra* note 3; see also TERRY A. KUPERS, PRISON MADNESS: THE MENTAL HEALTH CRISIS BEHIND BARS AND WHAT WE MUST DO ABOUT IT (1999). For expert reports and complaints filed during litigation concerning prison mental health services, see Court Documents Regarding the Mistreatment of Mentally Ill Prisoners (Human Rights Watch, 22-10-2003), <http://hrw.org/english/docs/2003/10/22/usdom7148.htm> (last visited Apr. 20, 2006).

[FN13]. Axis I disorders are diagnosable mental, behavioral, or emotional disorders of sufficient duration to meet diagnostic criteria specified in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association and that result in substantial interference with or limitations on one or more major life activities. See ABRAMSKY & FELLNER, *supra* note 3, at 31.

[FN14]. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

27-28, 298-301 (4th ed. text rev. 2000). The text includes a discussion of the more serious Axis I illnesses. Whatever the diagnosis, the degree of impairment of thought, mood, and behavior can vary dramatically from individual to individual. In addition, individuals can experience great fluctuations in their symptoms, having periods of relative stability interspersed with others in which they are dramatically symptomatic. So-called Axis II disorders, or personality disorders, might also include the experience of extreme dysfunction. *See id.* at 136-37, 329, 362, 519.

[FN15]. KUPERS, *supra* note 12, at 81.

[FN16]. ABRAMSKY & FELLNER, *supra* note 3, at 59 (citing Letter from Keith R. Curry, Ph.D., to Donna Brorby, Atty. in the *Ruiz v. Johnson* litigation (Mar. 19, 2002) (The letter reads, “Once incarcerated, inmates suffering from schizophrenia, schizoaffective disorder, bipolar disorder, and major depressive disorder display predictable deficits in behavioral and emotional control, maladaptive interpersonal styles, social skills deficits, and distorted perceptions of their environments. As a result, they are less able to conform their behavior to the rigid expectations of prison life and often fall into self-defeating patterns of irrational opposition to the demands placed upon them.”)).

[FN17]. HANS TOCH & KENNETH ADAMS, AM. PSYCHOLOGICAL ASS'N, ACTING OUT: MALADAPTIVE BEHAVIOR IN CONFINEMENT 106-10, 112 (2002). Researchers have found that “more often than not periods of high disciplinary involvement overlap with symptomatic behavior for seriously disturbed inmates” and “temporal coincidence does not necessarily imply causation in the sense that disciplinary problems are always the result of emotional disorders. It does suggest, however, that at some level different manifestations of coping problems are interrelated.” *Id.* at 107, 112.

[FN18]. Kenneth Adams, *The Disciplinary Experiences of Mentally Disordered Inmates*, 13 CRIM. JUST. & BEHAV. 297, 304 (1986).

[FN19]. David Lovell & Ron Jemelka, *When Inmates Misbehave: The Costs of Discipline*, 76 PRISON J. 165, 167 (1996). An internal analysis of disciplinary data in Colorado prisons showed that offenders with serious mental illnesses were more likely than those who did not have such illnesses to receive tickets for such misconduct as disobeying a lawful order, refusing to work, sexual misconduct, threats, and verbal abuse. According to a psychiatrist who compiled the data, “it is certainly conceivable that the impairment in social skill and perception found in many mental illnesses contributes to this pattern of conduct.” ABRAMSKY & FELLNER, *supra* note 3, at 60 (citing Memorandum from John Stoner, Colo. Dep't of Corr., to Human Rights Watch (Aug. 26, 2002)).

[FN20]. For example, 35.7% of mentally ill state prison inmates have been in fights since admission, compared to 24.5% of other prisoners. Similarly, 62.2% of mentally ill state prisoners have been charged with breaking prison rules, compared to 51.9% of other prisoners. *See* DITTON, *supra* note 4, at 9.

[FN21]. ABRAMSKY & FELLNER, *supra* note 3, at 68 (citing Telephone Interview by Human Rights Watch with Harbans Deol, Med. Dir., Dep't of Corr., in Des Moines, Iowa (Apr. 2, 2003)).

[FN22]. *Id.* at 65 (citing e-mail from Tamara Serwer, Atty., S. Ctr. for Human Rights, to Human Rights Watch (Aug. 12, 2003); First Amended Complaint at 23, *Fluellen v. Wetherington*, 2003 U.S. Dist. LEXIS 21712 (N.D. Ga. 2003) (No. 1:02-cv-479-JEC)).

[FN23]. Amended Complaint, [Boyd v. Snyder](#), 44 F. Supp. 2d 966 (N.D. Ill. 1999) (No. 99 C 56).

[FN24]. ABRAMSKY & FELLNER, *supra* note 3, at 65 (citing Amended Summary Pursuant to [F.R.E. 1006](#) of Documents Relevant to Testimony of Plaintiff Mitchell, [Austin v. Wilkinson](#), 204 F. Supp. 2d 1024 (N.D. Ohio 2002) (No. 4:01-cv-71)). “Human Rights Watch does not know if he actually served this sentence.” *Id.* at 65 n.226.

[FN25]. New Jersey Prison System Report of Dr. Dennis Koson, [D.M. v. Terhune](#), 67 F. Supp. 2d 401 (D.N.J. 1996) (No. 96-1840), available at http://hrw.org/reports/2003/usa1003/New_Jersey_Expert_Report_Koson.pdf.

[FN26]. [Coleman v. Wilson](#), 912 F. Supp. 1282, 1320 (E.D. Cal. 1995) (citations omitted).

[FN27]. See WILLIAM C. COLLINS, PRACTICAL GUIDE TO INMATE DISCIPLINE IV-69, IV-70 (2d ed. 1997).

[FN28]. The author's view, developed after reviewing countless documents from disciplinary hearings and numerous conversations with corrections professionals, is also confirmed by academic studies. See ENCYCLOPEDIA OF AMERICAN PRISONS 161-64 (Marilyn D. McShane & Frank P. Williams III eds., 1996) (discussing "discipline").

[FN29]. JOHN BOSTON & DANIEL E. MANVILLE, PRISONERS' SELF-HELP LITIGATION MANUAL 243 (3d ed. 1995).

[FN30]. The courts have not required corrections to incorporate an insanity defense in their disciplinary proceedings and "prison systems would not now easily tolerate it." FRED COHEN, THE MENTALLY DISORDERED INMATE AND THE LAW 13-3 (1998).

[FN31]. ABRAMSKY & FELLNER, *supra* note 3, at 61.

[FN32]. Concern about malingering, prisoners faking mental illness or symptoms for different purposes, is pervasive among prison officials, even though serious mental illness is in fact difficult to fake. See *id.*

[FN33]. *Id.* at 63 (citing Telephone Interview by Human Rights Watch with Dr. Reginald Wilkinson, Dir., Dep't of Corr., in Columbus, Ohio (July 3, 2003)).

[FN34]. *Id.* (citing Telephone Interview by Human Rights Watch with Vincent Nathan, Expert Witness (Mar. 26, 2003)).

[FN35]. Michael S. Krelstein, *The Role of Mental Health in the Inmate Disciplinary Process: A National Survey*, 30 J. AM. ACAD. PSYCHIATRY & L. 488, 490-95 (2002).

[FN36]. ABRAMSKY & FELLNER, *supra* note 3, at 64.

[FN37]. Krelstein, *supra* note 35, at 492.

[FN38]. ABRAMSKY & FELLNER, *supra* note 3, at 64 (citing Telephone Interview by Human Rights Watch with Michael Krelstein, Senior Psychiatrist, S. Nev. Adult Mental Health Servs. (Apr. 10, 2003 & Aug. 14, 2003)). Krelstein also pointed out that mental health staff themselves are generally reluctant to go before a disciplinary committee and argue that a prisoner was insane at the time of his misbehavior. *Id.*

[FN39]. *Id.* (citing Telephone Interview by Human Rights Watch with Dr. Jeffrey Metzner (Feb. 12, 2003) ("Most states now do let mental health experts testify during disciplinary hearings.")).

[FN40]. Mental health staff's participation in hearings is no guarantee of appropriate consideration of the role of mental illness in a prisoner's offense or sanction. Mental health staff may be unwilling or unable to provide accurate diagnoses of inmates' conditions, or may not want to become involved in a conflict with custodial staff. In addition, some mental health staff "burn out" over time and come to share custodial staff's suspicions of and hostility toward prisoners. *Id.* at 63-64.

[FN41]. Ohio Department of Rehabilitation and Correction policy requires the suspension of disciplinary proceedings if an inmate is incompetent. *Id.* at 63 (citing OHIO DEP'T OF REHAB. AND CORR., Policy 206-05(D) (1999)).

[FN42]. COHEN, *supra* note 30, at 13-5.

[FN43]. ABRAMSKY & FELLNER, *supra* note 3, at 63-64 (citing STANDARD OPERATING PROCEDURES, MH/MR Discipline Procedures (Ga. Dep't of Corr. 2001)).

[FN44]. Segregation exacerbates the psychological stressors typically found in corrections, and frequently creates a counter-therapeutic atmosphere. For some prisoners, this environment causes mental deterioration to the point of necessitating psychiatric hospitalization. *Id.* at 157-58.

[FN45]. *Id.* at 162 (citing TOCH & ADAMS, *supra* note 17).

[FN46]. *Id.* at 68.

[FN47]. DITTON, *supra* note 4, at 8. Mentally ill offenders average a total of 103 months in state prisons, 15 months longer than other offenders. The largest differences in time served were among violent and property offenders. The mentally ill in state prisons serve an average of at least twelve additional months for violent and property offenses. *Id.*

[FN48]. ABRAMSKY & FELLNER, *supra* note 3, at 69 (citing Telephone Interview by Human Rights Watch with Donald Vaughn, Superintendent, Graterford Prison, Graterford, Pa. (Aug. 12, 2002)).

[FN49]. *Mentally Ill Offender Treatment and Crime Reduction Act of 2003: Hearing on S. 1194 Before the S. Comm. on the Judiciary*, 108th Cong. (2003) (statement of Dr. Reginald A. Wilkinson, Dir., Ohio Dep't of Rehab. and Corr.), available at <http://www.drc.state.oh.us/web/Articles/article77.htm>.

[FN50]. *Id.*

[FN51]. In numerous visits to segregation facilities. I have learned that segregated inmates may be able to communicate by yelling, talking through air vents, or passing messages through various means. Their ability to communicate through these or other means varies depending on the facility.

[FN52]. JAMIE FELLNER & JOANNE MARINER, HUMAN RIGHTS WATCH, COLD STORAGE: SUPER-MAXIMUM SECURITY CONFINEMENT IN INDIANA (1997), available at <http://www.hrw.org/reports/1997/usind>; JAMIE FELLNER, HUMAN RIGHTS WATCH, OUT OF SIGHT: SUPER-MAXIMUM SECURITY CONFINEMENT IN THE UNITED STATES (2000), available at <http://www.hrw.org/reports/2000/supermax>; JAMIE FELLNER, HUMAN RIGHTS WATCH, RED ONION STATE PRISON: SUPER-MAXIMUM SECURITY CONFINEMENT IN VIRGINIA (1999), available at <http://www.hrw.org/reports/1999/redonion>; see also Leena Kurki & Norval Morris, *The Purposes, Practices and Problems of Supermax Prisons*, 28 CRIME & JUST. 385 (2001); CHASE RIVELAND, NAT'L INST. OF CORR., SUPERMAX PRISONS: OVERVIEW AND GENERAL CONSIDERATIONS (1999).

[FN53]. There are two main kinds of segregation: disciplinary segregation, in which the isolation is imposed as punishment for disciplinary infractions; and administrative segregation, in which corrections officials exercise their management discretion to classify inmates as requiring confinement isolated from the general population. ABRAMSKY & FELLNER, *supra* note 3, at 145-46.

[FN54]. Prisoners with mental illness account for the following percentages of state high security or segregated units: Oregon, 28; New York, 23; California, 31.85; Indiana, between 33 and 50; Washington, 29; Iowa, 50. *Id.* at 147-49.

[FN55]. *Id.* at 149-52.

[FN56]. [Madrid v. Gomez, 889 F. Supp. 1146, 1267 \(N.D. Cal. 1995\)](#).

[FN57]. *See generally* Stuart Grassian & Nancy Friedman, *Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement*, 8 INT'L J. L. & PSYCHIATRY 49 (1986); Stuart Grassian, *Psychopathological Effects of Solitary Confinement*, 140 AM. J. PSYCHIATRY 1450 (1983); Craig Haney, *Mental Health Issues in Long-term Solitary and "Supermax" Confinement*, 49 CRIME & DELINQ. 124 (2003).

[FN58]. Some researchers have concluded, for example, that suicidal prisoners can be pushed over the edge and pathologically fearful prisoners can regress into a psychologically crippling panic reaction from being confined for prolonged periods in segregation conditions. ABRAMSKY & FELLNER, *supra* note 3, at 151 (citing HANS TOCH, *MEN IN CRISIS: HUMAN BREAKDOWN IN PRISON* (1975)). In addition, "individuals whose internal emotional life is chaotic and impulse-ridden, and individuals with central nervous system dysfunction," are particularly unable to handle supermax conditions. *Id.* (citing Declaration of Dr. Stuart Grassian, *Eng v. Coughlin*, No. CIV-80-385S (W.D.N.Y. 1989)).

[FN59]. According to psychiatrist Dr. Terry Kupers, the conditions in segregation can cause someone with a vulnerability to psychosis:

to go off the deep end. People who are vulnerable to psychosis have a relatively fragile or brittle ego. When they are made to feel very anxious, or very angry, or very distrustful, their ego tends to disintegrate—in other words, as anger or anxiety mounts, their ego falls apart. They regress, lose control, can't test reality. And this is the beginning of a psychotic decompensation If there's nobody to talk to then one is left alone to sort out one's projections, the reality-testing is more difficult—and paranoid notions build up.

ABRAMSKY & FELLNER, *supra* note 3, at 152 (citing e-mail from Dr. Terry Kupers, Psychiatrist, to Human Rights Watch (Apr. 9, 2003)). Dr. Kupers has also explained that the impact of segregation or solitary confinement depends on the nature of the illness:

Prisoners who are prone to depression and have had past depressive episodes will become very depressed in isolated confinement. People who are prone to suicide ideation and attempts will become more suicidal in that setting. People who are prone to disorders of mood, either bipolar ... or depressive will become that and will have a breakdown in that direction. And people who are psychotic in any way ... those people will tend to start losing touch with reality because of the lack of feedback and the lack of social interaction and will have another breakdown, whichever breakdown they're prone to.

Id.

[FN60]. [Madrid, 889 F. Supp. at 1265](#).

[FN61]. Depending on the nature of the illness, proper mental health treatment should provide a range of services and programs besides medication. The options should include group therapy, private individual therapy or counseling, milieu meetings, training in the skills of daily living, psychoeducation aimed at teaching prisoners about their illness and the need to comply with medication regimes, educational programs, vocational training, other forms of psychiatric rehabilitation, supervised recreation, and so forth. Some or all of these components can play a crucial part in restoring or improving mental health or, at the very least, in preventing further deterioration in the patient's psychiatric condition. The rules mandating round-the-clock confinement in a cell preclude most of these activities. *See* ABRAMSKY & FELLNER, *supra* note 3, at 154-55.

[FN62]. Restrictions on the placement of mentally ill prisoners in segregation are now in place in California, Connecticut, Ohio, Texas, and Wisconsin as a result of litigation. ABRAMSKY & FELLNER, *supra* note 3, at 164-68.

[FN63]. *Estelle v. Gamble*, 429 U.S. 97, 103 (1976) (quoting *Gregg v. Georgia*, 428 U.S. 153, 173 (1976)).

[FN64]. *Id.* at 104.

[FN65]. See generally COHEN, *supra* note 30, at 4.3-4.4 (1998) (providing a comprehensive and periodically updated analysis of legal developments, including how courts have interpreted “deliberate indifference”).

[FN66]. *Farmer v. Brennan*, 511 U.S. 825, 847 (1994).

[FN67]. *Ruiz v. Johnson*, 37 F. Supp. 2d 855, 902-07 (S.D. Tex. 1999).

[FN68]. *Id.* at 907.

[FN69]. *Id.*

[FN70]. See Pub. L. No. 104-134, §§ 801-810, 110 Stat. 1321, 1321-77 (1996) (codified at 18 U.S.C. § 3624 (2000); 28 U.S.C. §§ 1346, 1915, 1915A (2000); 42 U.S.C. §§ 1997-1997h (2000)). For a comprehensive discussion of the PLRA and its impact on prison litigation, see Margo Schlanger, *Inmate Litigation*, 116 HARV. L. REV. 1555 (2003).

[FN71]. ABRAMSKY & FELLNER, *supra* note 3, at 214-15.

[FN72]. O'Bryant, *supra* note 2, at 312-15.

[FN73]. These rights are enumerated in the Universal Declaration of Human Rights, G.A. Res. 217A (III), at 71, U.N. GAOR, 3d Sess., 1st plen. mtg., U.N. Doc. A/810 (Dec. 12, 1948), and such international treaties as the International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), at 49, U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (Dec. 16, 1966) [hereinafter ICCPR], and the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, G.A. Res. 39/46, at 197, U.N. GAOR, 39th Sess., Annex, Supp. No. 51, U.N. Doc. A/39/51 (Dec. 10, 1984) [hereinafter Convention Against Torture]. The Convention Against Torture also prohibits torture and cruel, inhuman, or degrading treatment. *Id.* at 197; see also ICCPR, *supra*, at art. 10(1). Paragraph 2(b) of article 10 also states the “essential aim” of prison systems is the “reformation and social rehabilitation” of prisoners. ICCPR, *supra*, at art. 10(2)(b). The United States, in ratifying the ICCPR, issued an understanding stating that article 10(3) “does not diminish the goals of punishment, deterrence and incapacitation as additional legitimate purposes for a penitentiary system.” U.S. Reservations, Declarations, and Understandings, International Covenant on Civil and Political Rights, 138 Cong. Rec. S4781-01 (daily ed. Apr. 2, 1992). While violations of article 7 will also constitute violations of article 10, the reverse is not necessarily the case. The criteria by which the Human Rights Committee has concluded certain prison conditions violated article 10(1) and not article 7 can be difficult to discern. See NIGEL RODLEY, *THE TREATMENT OF PRISONERS UNDER INTERNATIONAL LAW* 286-92 (2d ed. 1999).

[FN74]. The Convention Against Torture also prohibits torture, as well as cruel, inhuman, or degrading treatment. Convention Against Torture, *supra* note 73, at art. 16(1).

[FN75]. Under the Convention Against Torture, torture is defined as “any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person,” for a variety of purposes, including punishment. See Convention Against Torture, *supra* note 73, at art. 1(1). The definition also expressly excludes pain “arising only

from, inherent in or incidental to” lawful sanctions. The requirement of “intentional” precludes accidental infliction of pain. “Cruel, inhuman and degrading” treatment or punishment that does not amount to torture is also proscribed. These terms are not defined, and human rights jurisprudence indicates they reflect a continuum of treatment and consequent suffering. *See* MANFRED NOWAK, U.N. COVENANT ON CIVIL AND POLITICAL RIGHTS, CCPR COMMENTARY 126-41 (1993); *see also* ANDREW COYLE, A HUMAN RIGHTS APPROACH TO PRISON MANAGEMENT 31 (2002) (“Ill-treatment of prisoners is always legally wrong Persons who are detained or imprisoned retain all their rights as human beings with the exception of those that have been lost as a specific consequence of deprivation of liberty [T]here is, for example, a total prohibition on torture and deliberately inflicted cruel, inhuman or degrading treatment. This prohibition does not merely apply to direct physical or mental abuse. It also applies to the totality of conditions in which prisoners are held.”).

[FN76]. Standard Minimum Rules for the Treatment of Prisoners, adopted Aug. 30, 1955 by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, E.S.C. Res. 663C, Annex I, at 11, U.N. ESCOR, 24th Sess., Supp. No. 1, U.N. Doc. A/CONF/611 (July 31, 1957), amended by E.S.C. Res. 2076, at 35, U.N. ESCOR, 32nd Sess., Supp. No. 1, U.N. Doc. E/5988 (May 13, 1977) [hereinafter Standard Minimum Rules].

[FN77]. Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, G.A. Res. 43/173, Annex, at 298, U.N. GAOR, 43rd Sess., Supp. No. 49A, U.N. Doc. A/43/49 (Dec. 9, 1988) [hereinafter Body of Principles].

[FN78]. Basic Principles for the Treatment of Prisoners, G.A. Res. 45/111, Annex, at 199, U.N. GAOR, 45th Sess., Supp. No. 49A, U.N. Doc. A/RES/45 (Dec. 14, 1990) [hereinafter Basic Principles].

[FN79]. The Basic Principles establish prisoners' entitlement to health care of comparable quality to that available in the outside community. Principle 9 of the Basic Principles states that “[p]risoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.” Basic Principles, *supra* note 78, at Principle 9; *see also* EUR. COMM. FOR THE PREVENTION OF TORTURE & INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT, THE CPT STANDARDS, SUBSTANTIVE SECTIONS OF THE CPT'S GENERAL REPORTS, IV(31) (2002) [hereinafter CPT] (“[P]risoners are entitled to the same level of medical care as persons living in the community at large. This principle is inherent in the fundamental rights of the individual.”). Principle 24 of the Body of Principles establishes the obligation of authorities to ensure prisoners are given medical screening upon admission and provided appropriate medical care and treatment as necessary and free of charge. Body of Principles, *supra* note 77, at Principle 24. “The medical services ... shall seek to detect and shall treat any ... mental illnesses or defects which may hamper a prisoner's rehabilitation. All necessary ... psychiatric services shall be provided to that end.” Standard Minimum Rules, *supra* note 76, at Rule 62.

[FN80]. Standard Minimum Rules, *supra* note 76, at Rule 82.

[FN81]. *Id.*

[FN82]. *See, e.g.,* Body of Principles, *supra* note 77, at Principle 30; Standard Minimum Rules, *supra* note 76, at Rules 29, 30, and 35.

[FN83]. COYLE, *supra* note 75, at 77.

[FN84]. *See id.* (emphasizing requirement of proportional punishment). For discussions of the human rights requirement of proportional punishment that takes into account culpability as influenced by mental impairments or cognitive and emotional limitations, see ROSA EHRENREICH & JAMIE FELLNER, HUMAN RIGHTS WATCH, BEYOND REASON: THE DEATH PENALTY AND OFFENDERS WITH MENTAL RETARDATION (2001), available at <http://www.hrw.org/reports/2001/ustat>; *see also* ALISON PARKER, HUMAN RIGHTS WATCH, THE

REST OF THEIR LIVES: LIFE WITHOUT PAROLE FOR CHILD OFFENDERS IN THE UNITED STATES (2005), *available at* [http:// hrw.org/reports/2005/us1005](http://hrw.org/reports/2005/us1005).

[FN85]. Standard Minimum Rules, *supra* note 76, at Rule 32.

[FN86]. Krocher & Miller v. Switzerland, App. No. 8463/78, 26 Eur. Comm'n H.R. Dec. & Rep 52 (1982); EUR. COMM. FOR THE PREVENTION OF TORTURE & INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT (CPT), REPORT TO THE FINNISH GOVERNMENT ON THE VISIT TO FINLAND, ¶ 67, CPT/Inf (93) 8 (Apr. 1, 1993), *available at* [http:// www.cpt.coe.int/documents/fin/1993-08-inf-eng.pdf](http://www.cpt.coe.int/documents/fin/1993-08-inf-eng.pdf); CPT, REPORT TO THE ICELANDIC GOVERNMENT ON THE VISIT TO ICELAND, ¶ 59, CPT/Inf (94) 8 (June 28, 1994), *available at* <http://www.cpt.coe.int/documents/isl/1994-08-inf-eng.pdf>.

[FN87]. “The basic components of what is needed for correctional mental health services to pass constitutional muster were outlined in Ruiz v. Estelle.” ABRAMSKY & FELLNER, *supra* note 3, at 213.

[FN88]. REG'L OFFICE FOR EUR., WORLD HEALTH ORG., *supra* note 1, at Appendix 1.2.

[FN89]. *See supra* notes 1, 12, 43, and accompanying text.

[FN90]. *See* COUNCIL OF STATE GOV'TS, *supra* note 9, at 26-125 for a comprehensive and sensible analysis of why people with mental illness are landing in the criminal justice system, the improvements needed in mental health systems, and changes that should be made in law enforcement and court systems to address offenders with mental illness.

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