



**The American Civil Liberties Union**

Written Statement  
For a Joint Hearing on

**Human Rights at Home: Mental Illness in U.S. Prisons and Jails**

Submitted to the U.S. Senate

Committee on the Judiciary  
Subcommittee on Human Rights and the Law

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## I. Introduction

The American Civil Liberties Union (ACLU) commends the Senate Judiciary Committee Subcommittee on Human Rights and the Law for holding a hearing on mental illness in U.S. prisons and jails. This hearing was the Subcommittee's first hearing examining a U.S. domestic human rights issue.

The ACLU is a nationwide, non-partisan organization of more than 500,000 members dedicated to enforcing the fundamental rights of the Constitution and United States laws. The ACLU's National Prison Project ("NPP") is the only national litigation program on behalf of prisoners. Since 1972, the NPP has represented more than 100,000 men, women and children. Through litigation, community outreach, advocacy, and public education, the ACLU's Women's Rights Project ("WRP") empowers poor women, women of color, and immigrant women who have been victimized by gender bias and face pervasive barriers to equality. WRP advocates on behalf of and its clients have included incarcerated women and girls.

This statement addresses the problem of deplorable treatment of several populations of mentally ill prisoners including women, juveniles, and immigration detainees. This statement also details the successful reforms instituted at Unit 32 at Mississippi State Penitentiary (Parchman) – a model for all state and federal prisons that has produced better outcomes in terms of mental health, prison discipline, and ability to integrate back into society upon release. The ACLU urges Congress to fund Parchman-like models on the federal level and to create incentives for states to adopt Parchman-like models.

## II. Rise of Mental Health Inmates in U.S. Prisons and Jails Nationwide

Between the 1970's and 1990's the U.S. prison population multiplied several times over. During that same period, the states emptied their psychiatric hospitals with the promise that patients with serious mental illness would receive better and more humane treatment in community-based treatment facilities and supported housing. Those community resources did not, however, materialize, and many thousands of people suffering from serious mental illness found themselves on the streets – and eventually in jails and prisons. As the prison population swelled around the nation, the proportion of the prison population with serious mental illness ("SMI") increased. Empirical studies across custodial settings have found that mentally disabled detainees and inmates are held for longer periods of time than persons without mental disabilities, despite the fact that providing mental health treatment services in a custodial setting is the most costly and least effective form of mental health care.<sup>1</sup>

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<sup>1</sup> See, e.g., Eve Bender, *Data Confirm MH Crisis Growing in U.S. Prisons*, 41 PSYCHIATRY NEWS 6 (2006), available at <http://pn.psychiatryonline.org/cgi/content/full/41/20/6> ("[P]rison inmates who had a mental health problem were incarcerated for an average of five months longer than were prisoners without such a problem."); M.J. Stephey, *De-Criminalizing Mental Illness*, TIME MAG. Aug. 8, 2007, available at <http://www.time.com/time/health/article/0,8599,1651002,00.html> ("[S]tudies show that people with mental illness stay in jail eight times longer than other inmates, at seven times the cost."); *Mentally Ill Offender Treatment and Crime Reduction Act of 2003: Hearings on S. 1194 Before the S. Judiciary Comm.*, 108th Cong. (2003) (testimony of Dr. Reginald Wilkinson, director, Ohio Department of Rehabilitation and Correction), available at [http://judiciary.senate.gov/hearings/testimony.cfm?id=882&wit\\_id=2485](http://judiciary.senate.gov/hearings/testimony.cfm?id=882&wit_id=2485) ("Pennsylvania estimates that an average prison inmate 1 It costs \$80 per day to incarcerate, while the added costs of mental health services, medications, and additional correctional staff means that it costs approximately \$140 per day to incarcerate an inmate with mental illness"); Ken Jenne and Donald F.

### III. Disproportionate Impact on Incarcerated Women With Mental Illness

Women prisoners suffer especially high rates of mental illness. In many jurisdictions, rates of mental illness among women prisoners range from one quarter to one half of the population, roughly two to three times the rate seen in male prisoners.<sup>2</sup> Estimates of the rate of post-traumatic stress disorder among women prisoners due to sexual or physical abuse suffered prior to incarceration range from 48 percent to 88 percent.<sup>3</sup>

Despite the soaring rates of women's incarceration and women inmate's mental health needs, most prisons lack adequate facilities, services, and programming for women prisoners. Therapeutic counseling is rarely available.<sup>4</sup> As a consequence, women attempting to access mental health services are often denied care, or administered psychotropic medication without being offered psychotherapeutic treatment.<sup>5</sup>

### IV. Effect on Juveniles with Mental Illness

About two thirds of child prisoners have at least one mental illness.<sup>6</sup> In its investigations of juvenile correctional institutions, the ACLU has found that this mental illness often stems from severe – often horrific – childhood sexual or physical abuse.<sup>7</sup> Despite high rates of mental illness, including post-traumatic stress disorder, major depression, borderline personality disorder, and bipolar disorder, children in custody are subjected to a range of abuses. For example:

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Eslinger, Op-Ed., *Without reforms, problems mount*, S. FLORIDA SUN-SENTINEL, Apr. 21, 2003, available at <http://www.psychlaws.org/GeneralResources/article122.htm> (“It costs Broward County taxpayers \$78 per day to house a general population inmate, but it costs \$125 per day to house an inmate with a mental illness.”); cf., Edward Cohen & Jane Pfeifer, COSTS OF INCARCERATING YOUTH WITH MENTAL ILLNESS – FINAL REPORT, PREPARED FOR THE CHIEF PROBATION OFFICERS OF CALIFORNIA AND THE CALIFORNIA MENTAL HEALTH DIRECTORS ASSOCIATION, at vi (2008) (finding that incarcerating “a youth with mental illness can cost at least \$18,800 more than other youth....”).

<sup>2</sup>Human Rights Watch, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, 38 (2003).

“In New York, for example, 26 percent of incarcerated women are on the active mental health caseload (compared to 11 percent of men).[99] In Pennsylvania, 37.7 percent of female prisoners are on that state's mental health caseload.[100] In the late 1990s, the Colorado Department of Corrections estimated that 27.9 percent of the women in the Colorado Women's Correctional Facility had severe mental health needs.[101] While women made up only 5.7 percent of the state's total number of prisoners, they made up a startling 16.3 percent of the correctional system's most seriously mentally ill prisoners.[102] Georgia estimates that 33 percent of its female prisoners are mentally ill.[103] In Vermont, of the forty-five prisoners at Dale Women's Correctional Center, thirty-six were on the mental health roster as of September 2002.[104] Arkansas's deputy director of Health and Correctional Programs, Max Mobley, estimates twice as high a percentage of female prisoners are seriously mentally ill as are males.[105] In Oregon, 47 to 49 percent of female prisoners are on the mental health caseload.[106]”

<sup>3</sup> Amnesty International, *Women in Prison: A Fact Sheet*, <http://www.amnestyusa.org/women/womeninprison.html> (accessed Sept. 9, 2009).

<sup>4</sup> *Ill-Equipped*, 39; *Women in Prison Fact Sheet*.

<sup>5</sup> *Women in Prison Fact Sheet*.

<sup>6</sup> New York Times, *Mentally Ill Offenders Strain Juvenile System*, Aug. 9, 2009.

<sup>7</sup> ACLU, *A Blueprint for Meeting the Needs of Girls in TYC Custody: Report and Recommendations to the Texas Youth Commission*, <http://www.aclu.org/womensrights/crimjustice/29875pub20070524.html> (accessed Sept. 9, 2009), 4.

- *Children are subjected to solitary confinement and sensory deprivation for breaking prison rules, even when their mental illness or mental retardation makes it impossible for them to comply with rules.* Almost all juvenile prisons in the U.S. still implement outdated “behavior modification” programs which attempt to mold children’s behavior through punishment. The high rate of mental illness among the child prisoner population renders such programs largely ineffective. Moreover, punishing children for behavior they cannot control amounts to abuse.



- *Mentally ill children, especially girls, are subjected to solitary confinement for committing self-harm or confessing their wish to hurt themselves.*<sup>8</sup> Adhering to a punitive culture, and lacking counseling and other mental health resources, many youth prisons punish self-harm and other manifestations of mental illness. The ACLU found the isolation of girls in crisis to be rampant in Texas youth prisons. Girls subjected to such re-traumatization commit further self-mutilation, including self-cutting, banging their head and limbs against cell walls, and self-strangling with pieces of clothing.



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<sup>8</sup> ACLU/Human Rights Watch, *Custody and Control: Conditions of Confinement in New York’s Juvenile Prisons for Girls*, (2006), 100-01; *TYC Blueprint*, 10-11.

- *Mentally ill children are overmedicated, wrongly medicated, and prescribed drugs to sedate rather than treat them.*<sup>9</sup> Even when youth prisons attempt to address the mental health needs of incarcerated children, they do so by administering powerful psychotropic medications, often in lieu of therapeutic counseling. Medication is often administered when unnecessary, and their effectiveness and side effects are insufficiently monitored. At other times, multiple medications are used without attention to their potential interaction. Children are frequently medicated without the informed consent of the children or their guardians. And in some instances, medication is administered to make the child compliant; thus constituting a “chemical restraint” in violation of domestic and international law.



## **V. The Particular Plight of Immigrants Facing Detention and Deportation**

68 percent of immigration detainees are held in U.S. prisons and jails that contract with ICE,<sup>10</sup> and in 2008 the Division of Immigration Health Services (“DIHS”) estimated that 15 percent of immigration detainees are mentally ill and that the percentage of mentally ill detainees is rising.<sup>11</sup> This is likely a low estimate because many detainees decline to report mental health symptoms for fear of being placed in segregation.<sup>12</sup> The relatively high proportion of mentally ill immigration detainees should come as no surprise given that the detained immigrant population

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9 *TYC Blueprint*, 6; US Department of Justice, Civil Rights Division, Special Litigation Unit, letter of Aug. 14, 2009 to New York Governor David Patterson, 19-23.

10 Kerwin, Donald and Serena Yi-Ying Lin. “Immigration Detention: Can ICE Meet Its Legal Imperatives and Case Management Responsibilities?” *Migration Policy Institute*. September 2009, p. 9.  
<http://www.migrationpolicy.org/pubs/detentionreportSept1009.pdf>.

11 “Careless Detention, Suicides Point to Gaps in Treatment: Errors in Psychiatric Diagnoses and Drugs Plague Strained Immigration System,” Dana Priest and Amy Goldstein, May 13, 2008, available at  
[http://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc\\_d3p1.html](http://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc_d3p1.html).

12 Testimony of Homer D. Venters, M.D., Attending Physician, Bellevue/NYU Program for Survivors of Torture, Public Health Fellow, New York University, House Judiciary Committee’s Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law, Hearing on Problems with Immigration Detainee Medical Care, June 4, 2008, available at <http://judiciary.house.gov/hearings/pdf/Venters080604.pdf>.

contains survivors of trauma and torture awaiting credible fear interviews, who, according to a 2003 study by Physicians for Human Rights and the Bellevue/NYU Program for Survivors of Torture, face “extremely high symptom levels of anxiety, depression and post-traumatic stress disorder (PTSD),”<sup>13</sup> as well as long-term permanent residents and other non-citizens who end up in the criminal justice system because of chronic psychiatric illnesses, from where they are transferred to immigration custody.

The Department of Homeland Security Immigration and Customs Enforcement (“ICE”)’s current policies and practices lack adequate safeguards for non-citizens suffering from mental disabilities or other mental health conditions. First, initial decisions by ICE to detain mentally ill immigrants vary immensely and are seemingly arbitrary. Insufficient screening of detainees for mental health concerns leads to inappropriate and often prolonged detention and mental deterioration of detainees with psychiatric illnesses and other mental health conditions. Although reliable and cost-effective alternatives to detention exist, they are too rarely utilized for those with mental health concerns. Detention facilities, including prisons and jails, lack the adequate personnel and accommodations to properly care for detainees with mental health concerns. As a result, detainees are often provided with erratic, inappropriate or insufficient medicine, diagnoses, and treatment.

As Dana Priest and Amy Goldstein noted in their 2008 Pulitzer Prize-nominated *Washington Post* piece, “Suicidal detainees can go undetected or unmonitored. Psychological problems are mistaken for physical maladies or a lack of coping skills . . . Some get help only when cellmates force guards and medical staff to pay attention. And some are labeled psychotic when they are not; all they need are interpreters so they can explain themselves.”<sup>14</sup> According to numerous reports, the already fragile psychological health of immigrant detainees worsens with continued detention.<sup>15</sup> For example, in some cases, the mental health of several non-citizen detainees has deteriorated to the point of creating a danger, forcing facility custodians to get state court orders for involuntary treatment of 90 days each. The ACLU joins advocates in encouraging a DHS Office of Inspector General audit regarding ICE detainees with mental health concerns.<sup>16</sup> Unlike criminal defendants facing incarceration, immigrants facing detention and deportation are not afforded the right to government-appointed counsel. Mentally ill detainees who are unable to find or afford to retain their own attorneys, are particularly vulnerable. The lack of counsel for mentally incompetent immigration detainees serves to prolong their confinement in situations where they receive inadequate mental health attention. Immigration judges do not have adequate

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13 “From Persecution to Prison: The Health Consequences of Detention for Asylum Seekers,” Physicians for Human Rights and The Bellevue/NYU Program for Survivors of Torture, June 2003, see footnote 3, Executive Summary pg. 2.

14 “Careless Detention, Suicides Point to Gaps in Treatment: Errors in Psychiatric Diagnoses and Drugs Plague Strained Immigration System,” Dana Priest and Amy Goldstein, May 13, 2008, available at [http://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc\\_d3p1.html](http://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc_d3p1.html).

15 “From Persecution to Prison: The Health Consequences of Detention for Asylum Seekers,” Physicians for Human Rights and The Bellevue/NYU Program for Survivors of Torture, June 2003, at 56, available at <http://physiciansforhumanrights.org/library/documents/reports/report-perstoprison-2003.pdf>; “Mental health implications of detaining asylum seekers: systematic review,” *The British Journal of Psychiatry*, 2009, Katy Robjant, Rita Hassan and Cornelius Katona, 194: 306–312, (Finding high levels of mental health problems among detained asylum seekers and refugees and a suggested independent adverse effect of detention on mental health).

16 For more information, see Appendix A, *OIG Audit Request Mental Health, June 18, 2009*, available at [http://www.aclu.org/images/asset\\_upload\\_file666\\_41134.pdf](http://www.aclu.org/images/asset_upload_file666_41134.pdf).

guidance on how to handle unrepresented immigrants with mental disabilities. This has led to inconsistent decisions, protracted litigation, and prolonged detention. Unrepresented and mentally incompetent immigrants can languish in detention for many months while their cases are on hold because immigration judges may not accept admissions of removability from mentally incompetent individuals who proceed without representation. For these reasons, the ACLU recommends both appointing counsel and guardians *ad litem* for mentally incompetent individuals, as well as rewriting regulations providing for the protection of for immigration detainees with mental disabilities.<sup>17</sup>

In addition to their mistreatment and neglect during confinement, mentally ill immigration detainees also face the risk of illegal deportation. Due to their reduced capacity, U.S. citizens with mental disabilities have been illegally detained and even deported. In at least one case, a mentally disabled U.S. citizen was illegally deported to Mexico. Pedro Guzman, a U.S. citizen born in California, who is cognitively impaired and was living with his mother prior to being deported, ended up dumped in Mexico – a country where he had never lived – forced to eat out of trash cans and bathe in rivers. His mother, also a U.S. citizen, took leave from her job to travel to Mexico in search of her son. She combed the jails and morgues of northern Mexico in search of her son. After he was located and allowed to reenter the U.S., Mr. Guzman was so traumatized that he could not speak for some time. To vindicate Mr. Guzman’s rights and to prevent future DHS errors and abuses, the ACLU and the law firm of Morrison & Foerster filed a damages lawsuit against ICE and Los Angeles County in 2007.<sup>18</sup>

## **VI. The Results of Supermax Confinement and Mentally Ill Prisoners: Lessons to Be Learned from Mississippi’s Far-Reaching Reforms**

State prisons all over the country are facing crisis levels of mentally ill inmates. Large populations of mentally ill inmates, along with fiscal challenges and inadequate community resources, have created population management difficulties for prisons. More and more, Departments of Correction are turning to administrative segregation as the solution. In supermaximum security (“supermax”) prisons, inmates are typically confined to their cells alone or with a cellmate nearly 24 hours a day.

Long-term administrative segregation tends to exacerbate psychiatric dysfunction and misconduct. Research has shown that a very high percentage of prisoners suffering from SMI are consigned to long-term administrative segregation – where extreme isolation and idleness makes their psychiatric conditions and prognoses worse.

In Mississippi, beginning in 2002, prisoners' rights advocates brought litigation aimed at improving the plight of prisoners in the state’s supermax, Unit 32 at Mississippi State Penitentiary (“Parchman”). The 1,000 men housed in Unit 32 were all permanently locked down in administrative segregation, in horrific conditions. Psychosis was rampant among the population, and use of force to control the unit was routine.

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<sup>17</sup> See Appendix B, *Letter to Attorney General Holder July 24, 2009*, for more information, available at [http://www.aclu.org/images/asset\\_upload\\_file893\\_41135.pdf](http://www.aclu.org/images/asset_upload_file893_41135.pdf).

<sup>18</sup> Esquivel, Paloma. “Suit Filed Over Disabled U.S. Citizen’s Deportation Ordeal.” *Los Angeles Times*. February 28, 2008.

In contrast to some states where litigation over such conditions has led to endless court battles and little change, in Mississippi the adversarial relationship shifted after a few years of intensive litigation to a mostly collaborative and extremely productive relationship, ushering in far-reaching reforms in classification and mental health programming. These changes have resulted in significant, documented decreases in rates of violence, disciplinary infractions and use of force.

Mississippi's experience contradicts some widespread assumptions about administrative segregation. The popularity of the supermax unit is premised on the assumption that violence and misconduct in the prisons cannot be controlled without keeping a growing number of very dangerous prisoners in long-term administrative segregation. According to this assumption, releasing the majority of these prisoners from administrative segregation to general population would result in increased rates of violence, serious disciplinary incidents, and use of force. In Mississippi, however, these rates declined dramatically following the transfer of a majority of prisoners out of administrative segregation at Unit 32.

In 2002 the ACLU National Prison Project, the Mississippi ACLU and the law firm of Holland & Knight filed suit on behalf of the Death Row prisoners. In 2003 the U.S. District Court for the Northern District of Mississippi, the Hon. Jerry Davis, entered an injunction granting the relief plaintiffs had requested.<sup>19</sup> The U.S. Court of Appeals for the Fifth Circuit largely upheld the injunction.<sup>20</sup>

In 2005 the prisoners filed a new lawsuit to extend the remedies ordered in the Death Row case to all of Unit 32.<sup>21</sup> The new case also challenged the classification system, which permanently consigned the thousand-man population in Unit 32 to administrative segregation. A negotiated consent decree in Presley v. Epps incorporated all of the relief upheld by the Fifth Circuit in the Death Row case, excluded prisoners suffering from SMI from administrative segregation, and provided that prisoners could earn their way out of administrative segregation through good behavior.

To implement the consent decree, Plaintiffs retained a classification expert, Dr. James Austin, to carry out an objective analysis of the Unit 32 population. His analysis showed that 80 percent of the 1,000 men did not belong in administrative segregation and should be transferred to general population. In 2006 the parties met and agreed to collaborate to reform the classification system within a 12-month period. MDOC Commissioner Christopher Epps promptly established a Classification Task Force that included Dr. Austin and key DOC officials.

Addressing the mental health issues was essential to fully addressing the classification issues. Prisoners with untreated mental illness became more disturbed in administrative segregation; their illness led them to misbehave; security staff sprayed them with chemicals, and their mental health deteriorated further. This cycle put severe pressure on everyone who lived or worked in Unit 32.

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19 *Russell v. Johnson*, 2003 WL 22208029 (5/21/03)

20 *Gates v. Cook*, 385 F.3d 503 (5<sup>th</sup> Cir. 2004)

21 *Presley v. Epps*, (N.D. Miss. Nov. 18, 2007) (No. 4:05 Civ. 148)

In 2007 Judge Davis held an evidentiary hearing on the mental health issues. At the end of six hours of testimony the Judge called the lawyers into chambers and advised them in the most urgent terms to come up with a joint plan to remedy the situation. He said that he feared Unit 32 was a tinder box about to explode. Unfortunately a few weeks later Unit 32 did explode. Beginning at the end of May 2007 and continuing into August, there was an outburst of gang warfare in which many inmates were stabbed and some died. Even in the face of this deep crisis in security, Commissioner Epps made the remarkably bold decision to go forward with implementing the recommendations of the Classification Task Force. Deputy Commissioner Sparkman left his home in Jackson to live at Parchman for months, overseeing the release of several hundred carefully selected men into general population, walking among them, speaking and interacting with them, getting to know their histories, and showing his staff at the prison that these men were not so dangerous that they needed to be in administrative segregation.

These remarkable acts of courage worked. Within a very few months, a striking transformation of Unit 32 had taken place. Nearly 80 percent of the unit's population had been reclassified from administrative segregation to general population. Program and recreation areas were constructed, and prisoners were allowed for the first time to play basketball and recreate together. General population housing areas were created, and prisoners were allowed to spend several hours per day out of their cells. A classroom was constructed, and for the first time classes were offered. A dining hall was constructed, and prisoners were allowed to eat meals together. In November 2007 the parties entered into a far-reaching supplemental consent decree on classification, mental health and use of force (Presley v. Epps).

As required by the consent decree, mental health staff now works in close collaboration with custody staff to develop an intermediate level treatment program, or step-down unit, for prisoners with serious mental illness. Prisoners who require inpatient psychiatric services are transferred to an inpatient psychiatric unit at another facility. Prisoners who require an intermediate level of mental health treatment, equivalent to halfway house or day treatment in the community, are candidates for the step-down unit, which provides for many prisoners the portal for leaving administrative segregation.

A comprehensive mental health training curriculum was expressly designed for correctional officers. Any officer working on the Step-Down Unit must undergo training on mental health issues. Completion of the mental health training is considered an honor, and is celebrated in a ceremony where officer graduates are given a special uniform patch and awarded the title of Correctional Mental Health Manager.

Prisoners remain in the step-down unit an average of three to six months. They are considered ready for discharge from the program when their treatment plan has been accomplished and their condition has stabilized. After being discharged, a prisoner may be readmitted if he experiences another relapse. If he is discharged for lack of compliance or behavioral issues, he may be considered for readmission following intensive individual treatment with mental health staff.

After a large proportion of prisoners were transferred to general population within Unit 32, the number of incidents requiring use of force plummeted. Monthly statistics showed a drop of

almost 70 percent in serious incidents, both prisoner-on-staff and prisoner-on-prisoner incidents. Prisoners with SMI had been heavily over-represented in the earlier serious disciplinary incidents, and participation in the step-down unit has helped to keep this group out of trouble.

The program has proven to be an effective point of entry into mental health treatment for previously non-compliant prisoners with SMI. Prisoners in the program report they expect to be treated with respect and not to be inappropriately punished or otherwise abused. Recently the Step-Down program successfully graduated most of the Security Threat Group (“STG”) leadership who were participants. One former STG leader has been granted Open C custody (essentially general population privileges). Two other STG leaders graduated with honors.

As the classification system was revised to permit prisoners in administrative segregation to earn their way to general population, and as MDOC administration focused greater attention on the professionalism of custody staff, the prisoners felt that they were being treated more fairly and could hope to gain their freedom. This helped them control their tempers and their behavior. These changes, plus the reduction in crowding as the population of Unit 32 declined, all promoted a greater calm and sense of fairness within the facility. The overall result is far fewer prisoners in need of administrative segregation.

The fact that there was a sharp decrease in the number of disciplinary offenses accumulated by prisoners with SMI after they were transferred to the step-down unit strongly supports a conclusion that prisoners with SMI tend to suffer psychiatric deterioration and get into disciplinary trouble in supermax administrative segregation, and that they fare much better in treatment programs. The changed management of prisoners with serious mental illness has also played a part in reducing the number of serious incidents and use of force at Unit 32.

The developments described here also illustrate something about the effect of litigation on corrections. In Mississippi, the Department of Corrections eventually welcomed the changes urged by Plaintiffs in a series of class action lawsuits, and this cleared the way for the changes to be put into effect in an atmosphere of collaboration, including collaboration between custody and mental health staff. In this kind of process, it becomes possible to devise management and treatment strategies for prisoners who might otherwise be considered incorrigible.

In fact, the assumption that a large number of prisoners are beyond help and will never change their unacceptable behaviors, and the practice of locking them away in segregation and punishing them harshly, predictably leads to worse behavior problems. In contrast, when custody and mental health work together to devise creative approaches to the management and treatment of some of the most difficult cases, and give prisoners clear and incremental requirements to win greater freedom, the prisoners’ behavior usually improves significantly. Of course, problems and tough issues remain, and monitoring continues, but the problems encountered are less serious, and a collaborative approach to their resolution is becoming the norm.<sup>22</sup>

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<sup>22</sup> The history of these far-reaching reforms and of the changing dynamic between Mississippi Department of Corrections officials and the prisoners’ litigation team is recounted in a journal article jointly authored by those officials and Plaintiffs’ team: “*Beyond Supermax Administrative Segregation: Mississippi’s Experience Rethinking Classification and Creating Alternative Mental Health Programs* (Criminal Justice and Behavior, August 2009) (see Appendix C, available at [http://www.aclu.org/images/asset\\_upload\\_file359\\_41136.pdf](http://www.aclu.org/images/asset_upload_file359_41136.pdf)). An account of the

## VII. Conclusion

While many prisons, jails, juvenile detention facilities persist in the deplorable practice of isolating, punishing, and neglecting to appropriately treat incarcerated and detained individuals with mental illness, the experience of Mississippi State Penitentiary (Parchman)'s Unit 32 indicates that there are significantly more effective and humane ways to handle the mentally ill population. The ACLU urges Congress to fund Parchman-like models on the federal level and to create incentives for states to adopt Parchman-like models.

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experience by Plaintiffs' counsel also appeared in the Fall 2008 issue of *Litigation*, the quarterly journal of the American Bar Association, "*Parchman Farm Blues: Pushing for Reforms at Mississippi State Penitentiary*" (Fall 2008) (see Appendix D, available at [http://www.aclu.org/images/asset\\_upload\\_file829\\_41138.pdf](http://www.aclu.org/images/asset_upload_file829_41138.pdf)).