

A COMMUNITY MENTAL HEALTH MODEL IN CORRECTIONS

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The jail and prison population in the United States has been multiplying exponentially for four decades. We now have almost two-and-a-half million people behind bars, and during the same years the proportion of prisoners with serious mental illness has also grown.¹ The Treatment Advocacy Center and the National Sheriff's Association recently released a study showing that there are ten times as many individuals with serious mental illness in our jails and prisons as there are in our state psychiatric hospitals.² Mental health services behind bars have not grown apace, and as a result a large number of prisoners with serious mental illness are subject to victimization in the jails and prisons, receive inadequate mental health treatment, and are subjected to harsh conditions of confinement that exacerbate their mental illness and make their prognosis dire.³ There is a mental health crisis behind bars, and correctional mental health treatment requires urgent attention.

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1. See DORRIS J. JAMES & LAUREN E. GLAZE, BUREAU OF JUSTICE STATISTICS, NCJ 213600, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 10 (2006), available at <http://www.bjs.gov/content/pub/pdf/mhppji.pdf>.

2. E. FULLER TORREY ET AL., THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN PRISONS AND JAILS: A STATE SURVEY 6 (2014), available at <http://www.tacreports.org/treatment-behind-bars>.

3. See TERRY A. KUPERS, PRISON MADNESS: THE MENTAL HEALTH CRISIS BEHIND BARS AND WHAT WE MUST DO ABOUT IT (1999).

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INTRODUCTION: PUBLIC MENTAL HEALTH POLICY

Some social policies are carefully designed, vigorously debated, and then put into practice through legislation. Medicare is an example; the federal law culminates public debate and establishes a strong social policy regarding medical care for seniors. Other policies are not as clearly formulated and ultimately prove foolhardy, but they are similarly effected through legislation. The imprisonment binge of the past several decades is an example. Legislation, presumably mirroring public opinion, shapes ever longer prison sentences for a growing number of charges. The designers of that social policy, however, failed to see the long range costs in higher recidivism rates, decimation of inner city communities, and mandated medical care for a huge population of older prisoners. Then there are social policies that are never actually articulated, are not guided by specific legislation, and seem to have no champions. The incarceration of people with serious mental illness is like that, and even though unplanned, it has been accelerating for decades. There really are no advocates for incarcerating people with serious mental illness. Sheriffs and wardens universally complain that it should not be their job to take care of people with mental illness, and they certainly were not trained for the task.

There are a number of historic events that combined to send so many people with serious mental illness to jail and prison, including de-institutionalization, “The War on Drugs,” and changes in the criteria for a psychiatric defense. De-institutionalization involves the downsizing and closing of state and Veterans Affairs mental hospitals with the expectation that former patients (or, today, individuals who would have been candidates for state hospitals until the 1960s) would receive quality mental health care in the community.⁴ But community mental health care, after an infusion of federal funds with President Kennedy’s 1963 Community Mental Health Centers Act, would experience successive budget cuts and eventually, by the 1990s, prove vastly inadequate for the task of providing public mental health services.⁵

4. E. FULLER TORREY, *OUT OF THE SHADOWS: CONFRONTING AMERICA’S MENTAL ILLNESS CRISIS* 8-11 (1997).

5. Hunter L. McQuiston et al., *Challenges for Psychiatry in Serving Homeless People With Psychiatric Disorders*, 54 *PSYCHIATRIC SERVS.* 669, 673-74 (2003); E. Fuller Torrey et al., *Documenting the Failure of Deinstitutionalization*, 73 *PSYCHIATRY: INTERPERSONAL & BIOLOGICAL PROCESSES* 122, 122-24 (2010).

In the same period, there was the “War on Drugs” with attendant sentencing guidelines that sent an unprecedented number of low-level drug offenders to prison for longer terms. Of course, since “dual diagnosis,” that is, psychiatric disorder plus substance abuse, is very prevalent, the War on Drugs landed a huge number of individuals with serious mental illness in our jails and prisons.

Meanwhile, the criteria for determining that a defendant is insane have changed. The “third prong” of many states’ statutes on insanity, the criterion whereby a defendant, on account of a mental illness or defect, is unable to control himself and refrain from the criminal act, was taken off the books.⁶ This change made it more difficult to prove a defendant is not guilty by reason of insanity (NGRI), resulting in more individuals with mental illness going to prison.

The growing proportion of prisoners with serious mental illness created a huge over-subscription for correctional mental health services and a glaring crisis in correctional mental health care today. For example, many prisoners with serious mental illness are warehoused in prison segregation units, where isolation and idleness exacerbate their mental illness. Others are consigned to general population units where mental health treatment is very thin, and they are too often victimized. Even when the prisoner in crisis is identified, and, for instance placed in an “observation cell” while he presents an imminent risk of suicide, on average there is too little actual treatment going on in the observation cells. Then, because correctional mental health services are relatively underfunded and oversubscribed, the prisoner in crisis is moved out too fast, often transferred back to a segregation cell from where he came, and receives inadequate follow-up treatment. This is why a disproportionate number of prison suicides occur in isolation cells, with prisoners who have cycled through the prison’s observation unit.⁷

The high rate of suicide in prison is only one of many indicators that prison mental health services are far from adequate. There is a widely held but erroneous assumption that correctional mental health is relatively adequate, that the best place for the indigent individual with serious mental illness to receive treatment is behind bars. This assumption can actually serve to rationalize the consignment of even more individuals with serious mental illness to prison. Thus, in many states the law provides for a finding in criminal trials that the defendant is “guilty but insane.” The jury can find the defendant guilty, not guilty, not guilty by reason of insanity (NGRI), or “guilty but insane.”⁸

6. GRAY B. MELTON ET AL., *PSYCHOLOGICAL EVALUATIONS FOR THE COURTS* 190-93 (2d ed. 1997).

7. Raymond F. Patterson & Kerry Hughes, *Review of Completed Suicides in the California Department of Corrections and Rehabilitation, 1999 to 2004*, 59 *PSYCHIATRIC SERVS.* 676, 677 (2008).

8. THOMAS GRISSO ET AL., *EVALUATING COMPETENCIES: FORENSIC ASSESSMENTS AND INSTRUMENTS* 193-98 (2d ed. 2003).

Because many jurors actually believe that prison is the best place for a severely disturbed individual to receive needed mental health treatment, when given the choice, they opt for “guilty and insane.”⁹ Perhaps they also fear that a “NGRI” finding would result in the defendant eventually being released when the defendant seems too dangerous for that. But in the several states where I have investigated correctional mental health care and where “guilty but insane” is provided in the jury instructions at trial, prisoners who have been found “guilty but insane” do not receive any different mental health care than do other prisoners, and for the most part that care is quite substandard.

While the prison population has grown exponentially and the proportion of prisoners with serious mental illness also has expanded, mental health services in corrections have simply not grown apace. There are too many individuals with serious mental illness for the mental health staff to treat them adequately.¹⁰ The oversubscribed mental health staff try to fulfill their professional duty. They may try focusing their energies on the “major mental illnesses,” including schizophrenia, bipolar disorder, and major depressive disorder. Or in some states a decision is made to provide a larger “case load” psychotropic medications only. Or there is a tendency, neither articulated nor advocated by anyone in particular, to lock up the most seriously disturbed prisoners in some form of isolative confinement, usually punitive segregation but occasionally protective custody (which too often also happens to be an isolative confinement unit). In any case, prisoners with serious mental illness tend to go untreated, undertreated, or treated with medications and little else, and a disproportionate number wind up in isolative confinement.¹¹ Then the isolated prisoners with mental illness complete their prison term and need to return to the community. But the many years of inadequate treatment and harsh conditions, including prison crowding and long-term isolative confinement, have exacerbated their mental disorder and made them more disabled.¹² Then we read about prisoners with mental illness being released straight out of isolative confinement and perpetrating horrible crimes in the community. A very high profile and tragic example is the 2012 murder of Tom Clements, the Executive Director of the Colorado Department of Corrections, by a man who had recently been released from prison after spending years in solitary

9. See John Q. La Fond, *U.S. Mental Health Law and Policy: Future Trends Affecting Forensic Psychiatrists*, 11 AM. J. FORENSIC PSYCHIATRY 5 (1990).

10. See KUPERS, *supra* note 3; TORREY, *supra* note 2.

11. ACLU OF COLO., *OUT OF SIGHT, OUT OF MIND: COLORADO’S CONTINUED WAREHOUSING OF MENTALLY ILL PRISONERS IN SOLITARY CONFINEMENT* (2013); TORREY, *supra* note 2; Fred Cohen, *Denial of Needed Mental Health Care, Excessive Segregation and Predictable Tragedy: The Nebraska Ombudsman Report*, 16 CORRECTIONAL MENTAL HEALTH REP. 3 (2014).

12. Terry A. Kupers, *What to Do with the Survivors?: Coping with the Long-Term Effects of Isolated Confinement*, 35 CRIM. JUST. & BEHAV. 1005, 1014 (2008).

confinement.¹³ The irony was that Director Clements had been advocating the downsizing of solitary confinement in the Colorado D.O.C.

Departments of correction cannot effectively address the mental health crisis behind bars in isolation from community groups and government agencies. The mental health crisis behind bars is not of correctional professionals' doing. It is a matter of poorly planned social policies—i.e., de-institutionalization, incrementally diminished funding for public mental health services, a War on Drugs that captured many individuals with serious mental illness in its dragnet, changes in criteria for a psychiatric defense in court, and so forth—, so the social policies designed to address the mental health crisis behind bars must include consideration of such things as public mental health resources in the community, services available to ex-prisoners when they return to the community, low-income housing, jobs, and substance abuse treatment in the community.

In effect, our society needs to decide how we want to deal with serious mental illness and whether dreadful and harmful prison conditions and deprivations are acceptable in our democracy. It is no longer possible for politicians and the public to ignore the problem and leave individuals with serious mental illness to be arrested and sent to prison, where their fate is mostly invisible to the public. Mental illness can no longer be swept under the carpet. Media coverage of the ill effects of isolative confinement, as well as correctional officers' excessively violent measures with prisoners who suffer from mental illness, opens the discussion to a larger public. The relegation to jails and prisons of a large proportion of people suffering from mental illness was not a well-considered policy, but the remedy will require careful deliberations about our social priorities.

I. THE COMMUNITY MENTAL HEALTH MODEL

I trained as a community psychiatrist out of commitment to the principle that mental health services should be available to all, according to their needs and regardless of their ability to pay. That was the vision underlying President Kennedy's Community Mental Health Centers Act of 1963. Federal grants to support local governments in building community mental health centers lasted for five years, with a possible three-year extension.¹⁴ By the time I completed a fellowship in social and community psychiatry in 1974, the incremental defunding of public mental health services was already underway, and a growing

13. *Colorado Department of Corrections Director Murdered*, CBS DENVER (Mar. 20, 2013, 5:50 AM), <http://denver.cbslocal.com/2013/03/20/colorado-department-of-corrections-director-murdered>.

14. Benjamin G. Druss et al., *Trends in Mental Health and Substance Abuse Services at the Nation's Community Health Centers, 1998-2003*, 96 AM. J. PUBLIC HEALTH 1779 (2006); Rebecca Wells et al., *Trends in Behavioral Health Care Service Provision by Community Health Centers, 1998-2007*, 61 PSYCHIATRIC SERVS. 759 (2010).

number of individuals with serious mental illness were finding their way into jails and prisons.

Originally, in the 1960s and early 70s, community mental health services included not only direct treatment in the community, but also prevention and consultation to schools, churches, and other community agencies and institutions (including jails) to best support individuals prone to mental illness living in the community.¹⁵ The model was sound, even visionary, but eventually community mental health was decimated by cuts in public budgets until we reached the point where, in many clinics, the main therapeutic modality would be medication with very little in the way of talking therapy, and even case managers would find their caseloads so large that they could not provide optimal care or even adequate monitoring.¹⁶ Meanwhile, the social safety net was cut as drastically as public mental health services, and a large number of those suffering from mental illness found their way into homelessness, and then jails and prisons.

Community mental health begins with the idea that it is far better to treat individuals suffering from mental illness in the community than it is to warehouse them in state psychiatric hospitals, where they become passive, overweight, and numbed out on strong tranquilizers.¹⁷ The array of required clinical services at community mental health centers (CMHCs) would change over the years. At first the list included adult outpatient and crisis intervention services, inpatient services, services for children, day treatment (also known as intermediate care or partial hospital), vocational training, consultation to community agencies, and so forth.¹⁸ Halfway houses, supported living programs, self-help groups, substance abuse treatment programs, case management, services for individuals with developmental disabilities, psychiatric or psychosocial rehabilitation services, and other worthy programs would eventually be added to the list of required services.¹⁹ The CMHCs were encouraged to establish collaborations with local colleges, vocational training facilities, and low-income housing agencies to provide wrap-around services to individuals with serious mental illness. Meanwhile, community psychiatrists and psychologists would consult with schools, governmental agencies, and local businesses to foster improvements in the general quality of mental health

15. Wells et al., *supra* note 14.

16. McQuiston et al., *supra* note 5, at 374.

17. COMMUNITY PSYCHOLOGY: IN PURSUIT OF LIBERATION AND WELL-BEING (Geoffrey Nelson & Isaac Prilleltensky eds., 2010); GERALD N. GROB, FROM ASYLUM TO COMMUNITY: MENTAL HEALTH POLICY IN AMERICA (1991).

18. William R. Breakey, *The Rise and Fall of the State Hospital*, in INTEGRATED MENTAL HEALTH SERVICES: MODERN COMMUNITY PSYCHIATRY 15, 34 (William R. Breakey ed., 1996).

19. See Gale Bataille, *Psychotherapy and Community Support: Community Mental Health Systems in Transition*, 46 NEW DIRECTIONS FOR MENTAL HEALTH SERVS. 9, 10-11 (1990).

in the community. As part of their preventive work, community psychiatrists advocate quality schools, full employment, low-income housing, vocational training, and access by disabled individuals to work sites as well as education programs. “Safety-net” programs are the underpinning of a sound community mental health program.²⁰ After all, clients need a place to live and a job or job-training opportunity if the clinical treatment is to be effective, no matter how targeted and powerful the prescribed medications are. The emphasis of community mental health is on prevention: attacking the social problems that are believed to cause mental illness. The reason that advocating for quality public schools is so important to community psychiatrists is that a good primary education serves as a foundation for a lifetime of sound mental health, whereas early and serious failure in school too often leads to substance abuse, failure in the job market, and then psychiatric disability and the risk of criminal involvement.²¹ The addition of Psychiatric Rehabilitation or Psychosocial Rehabilitation since the 1980s enlarges community mental health practitioners’ methods for helping individuals with serious mental illness live the best quality lives they can, given their disability.²² Analogously, rehabilitation programs in prison support post-release success, while social isolation and idleness during a prison term lead to subsequent disability.²³

In Part IV, I will outline twelve components of a contemporary community mental health model for the delivery of mental health services that I believe should be available in a correctional mental health treatment program. They include (1) screening mental health assessment; (2) a method for prisoners to access mental health treatment; (3) confidentiality and privacy; (4) adequate staffing; (5) inpatient, outpatient, crisis intervention, and intermediate levels of care; (6) proper documentation; (7) a variety of therapeutic modalities; (8) communication and collaboration among mental health, medical, and custody staff; (9) adequate staff training; (10) informed consent; (11) case management; and (12) a variety of psychiatric rehabilitation programs.

20. See Jenny Gold, *Mental Health Cops Help Reweave Social Safety Net in San Antonio*, NAT’L PUB. RADIO (Aug. 19, 2014, 3:34 AM), <http://www.npr.org/blogs/health/2014/08/19/338895262/mental-health-cops-help-reweave-social-safety-net-in-san-antonio>.

21. William P. Erchul, *Gerald Caplan: A Tribute to the Originator of Mental Health Consultation*, J. EDUC. & PSYCHOL. CONSULTATION 95, 101-02 (2009).

22. William Anthony, *Psychiatric Rehabilitation Leadership*, 33 PSYCHIATRIC REHABILITATION J. 7, 7-8 (2009); see also LeRoy Spaniol et al., *The Role of the Family in Psychiatric Rehabilitation*, in AN INTRODUCTION TO PSYCHIATRIC REHABILITATION 153 (1994).

23. David Lovell et al., *Recidivism of Supermax Prisoners in Washington State*, 53 CRIME & DELINQ. 633, 649-50 (2007) (discussing how direct release from extended solitary confinement may significantly impact recidivism because such confinement exacerbates certain unstable mental states).

II. ALTERNATIVES TO INCARCERATION

Before exploring what would constitute adequate mental health care in prison, I must mention alternatives to providing mental health care in prison. In other words, the community mental health (CMH) model for public mental health emphasizes “prevention,” and one important way to prevent the incarceration of individuals with serious mental illness is to provide alternatives to incarceration that include mental health and substance abuse treatment in the community.

To be effective, a remedy for the current crisis in correctional mental health must include a drastic reduction in the prison population, such as sentencing reform aimed at sending fewer people to prison and on average for shorter terms, plus widespread “diversion.” Diversion is occurring in many states today.²⁴ In a diversion program, a behavioral health court usually administers a program where a criminal defendant is offered an opportunity to avoid jail or prison if he or she is willing to participate in a drug treatment or mental health treatment program in the community under the court’s supervision.²⁵ Often the court’s authority is just what the defendant needs to motivate full participation in the treatment program, and behavioral health courts boast of impressive success rates, as measured in eventual compliance with mental health treatment and/or recovery from substance abuse.²⁶

In many localities there is robust debate about building “mental health jails” or “mental health prisons” as opposed to diverting a significant number of offenders with mental illness to treatment programs in the community. In Los Angeles County, the Board of Supervisors recently voted to demolish the dilapidated and unsafe Men’s Central Jail and to carry out a little of both strategies: build a new “mental health jail” and expand behavioral health courts and diversion mental health programs in the community.²⁷ I concur with the

24. BRIAN STETTIN ET AL., TREATMENT ADVOCACY CTR., MENTAL HEALTH DIVERSION PRACTICES: A SURVEY OF THE STATES 8-9 (2013).

25. See, e.g., *Developing a Mental Health Court: An Interdisciplinary Curriculum*, COUNCIL OF STATE GOV’TS JUST. CENTER (2012), <http://learning.csgjusticecenter.org>.

26. See, e.g., ARLEY LINDBERG, SAN FRANCISCO SUPERIOR COURT, COSTS AND BENEFITS OF BEHAVIORAL HEALTH COURT: FINDINGS FROM “EXAMINING PROGRAM COSTS AND OUTCOMES OF SAN FRANCISCO’S BEHAVIORAL HEALTH COURT” (2009); Rafael A. Rivas-Vazquez et al., *A Relationship-Based Care Model for Jail Diversion*, 60 PSYCHIATRIC SERVS. 766 (2009); Henry J. Steadman et al., *A SAMHSA Research Initiative Assessing the Effectiveness of Jail Diversion Programs for Mentally Ill Persons*, 50 PSYCHIATRIC SERVS. 1620 (1999); Henry J. Steadman et al., *Effect of Mental Health Courts on Arrests and Jail Days*, 68 ARCHIVES GEN. PSYCHIATRY 167 (2011). But see, e.g., David Loveland & Michael Boyle, *Intensive Case Management as a Jail Diversion Program for People with a Serious Mental Illness: A Review of the Literature*, 51 INT’L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 130 (2007).

27. See SARAH LIEBOWITZ ET AL., ACLU OF S. CAL., A WAY FORWARD: DIVERTING PEOPLE WITH MENTAL ILLNESS FROM INHUMANE AND EXPENSIVE JAILS INTO COMMUNITY-

Southern California ACLU and the Bazelon Center for Mental Health Law in strongly advocating sentencing reforms to bring down the jail and prison population and in choosing the diversion option over the “mental health jail.” Research shows that the outcome of community mental health and substance abuse programs is far superior to the outcomes when individuals suffering from serious mental illness are incarcerated, as demonstrated by higher recidivism and parole-violation rates among this population in recent years.²⁸ It is simply too easy, and too likely, that a mental health jail, several years down the line when there are further budget cuts for correctional mental health programs, will become a human warehouse where inmates with serious mental illness merely sit in a cell or jail dormitory and take strong psychotropic medications with no real treatment or rehabilitation opportunities. But sentencing and diversion are not the topics at hand.

The first step toward applying CMH principles in correctional mental health care is to expand prevention and diversion. Today, this requires rebuilding the social safety net that helps disabled individuals remain functional in the community and expanding upon very widespread and encouraging efforts to “divert” individuals with mental illness and substance abuse problems through behavioral health and drug courts. Placing low-level offenders in community programs that target their areas of disability has proven to help keep them out of jail and prison. Anything that can be done to strengthen education, help youngsters who get into trouble at school straighten out and succeed in their studies, and resurrect the social safety net—including low-income housing and meaningful job placement—will provide important prevention vis a vis mental illness, psychiatric disability, future substance abuse, and criminal behavior. Prevention and diversion are very important issues in any discussion of the problem of mental illness behind bars—the best remedy is to prevent the incarceration of individuals with mental illness or provide alternative treatment in the community—, but since this Article is about prison mental health per se, prevention and diversion are left to another day.

III. THE COMMUNITY MENTAL HEALTH MODEL IN CORRECTIONS

Inside correctional facilities, community mental health provides a model for comprehensive mental health treatment. When in the 1960s and 1970s we worked to reintegrate individuals with mental illness into the community, we relied on community resources (e.g., churches, schools, youth centers,

BASED TREATMENT THAT WORKS 2-3, 9 (2014), *available at* <https://www.aclusocal.org/wp-content/uploads/2014/07/JAILS-REPORT.pdf>.

28. *See generally* Bureau of Justice Statistics, *RECIDIVISM*, <http://www.bjs.gov/index.cfm?ty=tp&tid=17> (last visited Nov. 15, 2014) (providing data on the recidivism patterns of a variety of offenders, including persons on probation or released from prison).

community colleges, and job-training agencies) to help them succeed in the community.²⁹ Ninety-five percent of prisoners will eventually be released.³⁰ The focus of mental health programs in corrections must be the successful post-release re-integration of prisoners with mental illness. And we know, from years of work in community mental health, what that requires.

Individuals suffering from mental illness who receive adequate treatment and spend their time in peaceful and encouraging circumstances (for example, a loving home or a halfway house where they are encouraged to study, form healthy relationships, and accomplish the steps they need to traverse if they are ever to enjoy meaningful employment) have a fighting chance of being able to keep their illness under control and do relatively well. On the other hand, the equivalent individual (i.e., someone who suffers from the same mental illness) who is repeatedly traumatized, maybe raped, has neither stable residence nor gainful pursuits, and is shuffled from one relatively uncaring service provider to another will suffer a worsening mental disability and will have a much bleaker future (likely including incarceration).³¹ The take-away message is that prisoners with mental illness must be provided a safe place to serve their sentences (they need to be safe from victimization, from the unrestrained expression of their own most troubling proclivities, and from damaging conditions such as crowding and solitary confinement) and need to be provided an adequate level of mental health treatment and rehabilitation so that they are prepared to succeed in the community after they are released. I will offer a definition of “mental health” in correctional settings; outline the array of services that are needed to support the mental health of prisoners; expand a little on two components that I believe are critical if mental health services are to be effective: intermediate treatment and suicide prevention; and end this Part with a note about the issue of trauma.

A. *A Definition of Mental Health in Corrections*

How do we define “mental health” in the context of corrections? Traditionally, mental health has been defined as the absence of mental illness,³² but that definition is limited in its usefulness in correctional contexts. I have come to the conclusion that the definition of what we consider “healthy” must

29. See Breakey, *supra* note 18.

30. TIMOTHY HUGHES & DORIS JAMES WILSON, BUREAU OF JUSTICE STATISTICS, REENTRY TRENDS IN THE UNITED STATES 7 (2004), available at <http://www.bjs.gov/content/pub/pdf/reentry.pdf>.

31. See, e.g., WERNER M. MENDEL, TREATING SCHIZOPHRENIA (1989).

32. See Patricia Woods, *Mental Health: More Than the Absence of Mental Illness*, ROCHESTER HEALTH HEALTHCARE RESOURCE GUIDE (Nov. 2011), <http://www.rochesterhealth.com/healthnotes/articles/mental-health-more-than-the-absence-of-mental-illness> (“When mental health is brought up in a conversation, most people’s initial reaction is to think of it as the absence of a mental illness.”).

begin with the set of human capacities we believe are required to succeed in the community after one's release from prison (in other words, modifying a very old quote from Freud, the capacity "to love, work and play" without resorting to illicit substances and running afoul of the law). I believe this definition is superior to definitions based on, for example, the absence of a psychiatric disorder, because the most important consideration in treating prisoners with mental illness is the likelihood of their success at "going straight" after they are released. Then, in the process of developing individual treatment plans, correctional mental health staff need to assess patients on the caseload for the capacities that need to be strengthened if he or she is to succeed after being released. Of course, to be healthy one's mental illness must be under control, and thus compliance with mental health treatment and the ability to make basic efforts to take care of oneself (one's diet, dress, and ability to regulate sleep and wake cycles) would head the list of capacities associated with mental health. We would want to add the capacity to be on time for appointments, to act in disciplined fashion, to be reliable and trustworthy, to set and work on goals, to modulate emotions and do some reality-testing when irrational thoughts emerge, to settle differences peacefully, to be able to follow through and complete tasks, and so forth. The list of healthy capacities would become the core aims of treatment throughout the mental health programs, and frequent rewards, including expanded privileges and freedoms, would be granted when prisoners reach a new level of emerging healthy capacities. In other words, we would build into all prison mental health programs the learned capacities we consider prerequisites for success at going straight after release.

B. *The Requisite Components of Mental Health in Corrections*

As in the community, a community mental health model in corrections requires a spectrum of treatment modalities at different levels of intensity. There needs to be sufficient screening, assessment, outpatient, inpatient, crisis intervention, intermediate care, and case management for the population being served. Clinicians need to form trusting therapeutic relationships with prisoners suffering from mental illness. This is not so easy to accomplish in corrections. Research shows that the more trusting and caring the therapeutic relationship, and the more continuous it is over time, the more likely the patient is to comply fully with treatment and function the best he or she can, given the level of psychiatric disorder.³³ This is the rationale for the continuous treatment team and the assertive community treatment model in CMH, where a subpopulation of the mental health caseload in the community is assigned to a team of

33. Gregory B. Teague et al., *Evaluating Use of Continuous Treatment Teams for Persons with Mental Illness and Substance Abuse*, 46 PSYCHIATRIC SERVS. 689, 691-92 (1995) (indicating that "continuous treatment teams" were more effective than standard case management programs at implementing substance abuse treatment).

clinicians who have continuing responsibility for them (e.g., the clinicians will visit patients at home if they fail appointments).³⁴

Too often in correctional settings, because of relative budget shortfalls and a resulting excessive caseload for clinicians, there is no time to establish an adequate therapeutic relationship, or the prisoner is seen in episodic fashion and shifted from one clinician to another each time he or she asks to be seen. Instead, continuous therapeutic relationships must be formed. A related requirement is “through care.” Provisions need to be made so that prisoners entering the system are able to continue the mental health care they had been receiving prior to incarceration, and prisoners being released need to have post-release community care arranged in advance of their release. Likewise, when prisoners are transferred from one correctional facility to another, including jail to prison, or from one location to another within a facility, continuity of care must be a high priority. For example, many departments of corrections provide automatic continuation of previously prescribed psychotropic medications (a “bridge prescription”) until the prisoner has an opportunity to meet with a psychiatrist after being transferred to a different facility.

With these potential shortfalls in mind, and utilizing the standard of care in the community as a reference, I will outline the components of a correctional mental health program.³⁵ As in the community, not all the components need to be available in any particular location. For example, prisoners in need of inpatient psychiatric treatment can be transferred to a hospital within the department of corrections or to an outside hospital per prior arrangement. But inpatient care needs to be available, and it is not acceptable to simply isolate an acutely psychotic or suicidal prisoner in a segregation cell, perhaps with psychotropic medications, when inpatient care is required. Required components include:

- There must be a mental health screening assessment, including rigorous suicide risk assessment, upon admission of a prisoner to the Department of Corrections, upon transfer to a prison, and upon admission to segregation; then there must be periodic mental health assessments from that time onward or as needed (for example, when the prisoner evidences a heightened risk of decompensation (breakdown) or suicide). Suicide risk assessments must be rigorous and not superficial. If staff ask prisoners, “Are you suicidal?” most prisoners will answer, “no,” simply because they do not know the staff

34. See AM. PSYCHIATRIC ASS'N, *Practice Guidelines for the Treatment of Patients with Schizophrenia*, in PRACTICE GUIDELINES FOR THE TREATMENT OF PSYCHIATRIC DISORDERS: COMPENDIUM 299 (2000).

35. See NAT'L COMM'N ON CORR. HEALTH CARE, STANDARDS FOR HEALTH SERVICES IN PRISONS (2008); see also AM. PSYCHIATRIC ASS'N, PSYCHIATRIC SERVICES IN JAILS AND PRISONS (2d ed. 2000); FRED COHEN, PRACTICAL GUIDE TO CORRECTIONAL MENTAL HEALTH AND THE LAW (2011); CORRECTIONAL PSYCHIATRY: PRACTICE GUIDELINES AND STRATEGIES (Ole J. Thienhaus & Melissa Piasecki eds., 2007).

member and do not want to be stigmatized as weak in the prison setting. But if the screening staff member is well-trained to recognize clues of suicide risk, and asks the prisoner a longer series of questions—such as “Do you ever feel like nobody would care if you were dead,” “Do you ever feel that life is not worth living,” “Have you ever thought about ending your life?”—then the prisoner begins to get a sense that this staff member is concerned and can be trusted to a certain extent. There then is a good chance he will drop his guard and start responding candidly to the questions.³⁶ In other words, instead of limiting the mental health assessment to one or two questions about whether the prisoner is feeling suicidal, the screening instrument must include ten or twenty questions related to self harm. Then, while the staff member spends the time necessary to garner answers to the multiple questions, there is an opportunity for sufficient trust to evolve so that the prisoner becomes more forthcoming.

- Prisoners must have a way to access mental health care when they feel they need it. Thus, prisoners must be oriented about the mental health services available, and there must be forms they can fill out to request mental health care (even when they are in segregation); the confidentiality of the process must be guaranteed so that the prisoner seeking mental health services does not fall prey to stigma related to being a mental patient; and there must be a timely and adequate response to prisoners’ requests for mental health care.
- Prisoners must be provided confidential and private meetings with mental health staff. This means that when the prisoner is in segregated housing, the intervention cannot occur “at cell-front.” It is not acceptable for a mental health clinician to stand in front of a prisoner’s segregation cell and conduct an interview about very sensitive matters such as hallucinations and suicidal ideation. Prisoners in neighboring cells and officers passing by too easily overhear the dialogue, and in prison there can be very intense stigma toward prisoners with mental health problems.³⁷ In fact, in my experience, when mental health staff interview prisoners on segregation units at cell-front, the prisoner tends not to be forthcoming with responses and merely wants the mental health staff member to go away so that there will be no negative repercussions. In other words, the cell-front interview is unlikely to uncover the information that is needed (e.g., that the prisoner is acutely psychotic or suicidal). False negatives abound when assessment occurs at cell-front, absent a private and confidential interview. The prisoner

36. Ole J. Thienhaus, *Suicide Risk Management in the Correctional Setting*, in *CORRECTIONAL PSYCHIATRY*, *supra* note 35.

37. See KUPERS, *supra* note 3.

also is entitled to private and confidential contact with mental health providers.

- There must be sufficient staff at every level of care so that prisoners in need of mental health services are evaluated and treated in a reasonable time and with a comprehensive treatment plan. There are staffing ratios available; for example, the American Psychiatric Association recommends that a full-time psychiatrist not be responsible for prescribing psychotropic medications to more than 150 prisoners.³⁸ But more important than any ratio of staff to patients is the adequacy of the treatment being provided. In prisons where there are insufficient numbers of mental health staff of all disciplines, typically the prisoners on the mental health caseload are prescribed medications and receive little or no psychotherapy of any kind or other psychiatric rehabilitation programming.³⁹ In other words, overreliance on psychotropic medication is a clear sign of inadequate staffing levels and inadequate staff training.
- There must be a psychiatric inpatient hospital within the Department of Corrections or available by contract for transfer of prisoners requiring inpatient level of care. There must be an outpatient mental health treatment program. There must be a crisis intervention program, including suicide prevention and intervention. There must be an intermediate level of care, a program in between the inpatient and outpatient levels of care where prisoners suffering from mental illness can be safely housed and can participate in a variety of mental health treatment, psychiatric rehabilitation and case management services. Intermediate care will be discussed in the next Part. Outpatient care must be available to prisoners housed anywhere in the department of corrections.
- Documentation in the form of paper charts or electronic medical records must meet the standard of care in the community. There must be adequate medical records that include accurate and thorough histories, mental status examinations, case formulations, diagnoses, treatment plans that outline each phase of the treatment, explanations of rationales for treatment interventions and changes in treatment, medication monitoring, and continuity of care.
- Inpatient crisis intervention, intermediate treatment, and outpatient treatment must all include a variety of therapeutic modalities as well as

38. See AM. PSYCHIATRIC ASS'N, *supra* note 35, at 8.

39. WESLEY K. SOWERS ET AL., MENTAL HEALTH IN CORRECTIONS 49-50 (1999) (“Currently, there are three major approaches to treating mental illness: (1) the use of medications and other ‘biological’ interventions; (2) psychotherapy or ‘talking’ treatment, and (3) rehabilitation Like the illnesses involved, treatment is complex, and usually involves all three of these methods.”).

case management (see #11 below). The prescription of psychotropic medications alone is not, in itself, adequate mental health treatment at any of these levels of care. Medications are often part of the needed treatment but do not substitute for staff taking time to talk to prisoners as part of multiple treatment and rehabilitation modalities. That is clearly the standard of care in the community and is reflected in all standards in the field of correctional mental health. For example, the Task Force on Correctional Mental Health Care of the American Psychiatric Association arrived at this formulation: “Mental health treatment in the correctional setting, like that in any setting, is defined as the use of a variety of mental health therapies, including biological, psychological, and social. In the correctional setting the goal of treatment is to alleviate symptoms of mental disorders that significantly interfere with an inmate’s ability to function in the particular criminal justice environment in which the inmate is located. It is obvious, therefore, that mental health treatment is more than the mere prescribing of psychotropic medication, and psychiatrists should resist being limited to this role.”⁴⁰

- There must be meaningful communication and collaboration between mental health disciplines, including multi-disciplinary team meetings, and between mental health, medical, and custody staff.
- There must be adequate training for both mental health and custody staff working in areas where mental health treatment is occurring.
- Informed consent must be in place for all treatments, including documented discussion of the patient’s right to refuse treatment, including medications. Informed consent is a fundamental ethical consideration in the practice of medicine, including psychiatry. Patients have a right to accept or reject any recommended treatment, and that right cannot be meaningfully exercised unless the decision is informed: that is, the physician must explain to the patient the material facts about the nature, consequences, and risks of the proposed treatment, examination, or procedure; the alternatives to it; and the prognosis if the proposed treatment is not undertaken. This fundamental principle of the requirement of informed consent applies in prisons just as it does in the community. The National Commission on Correctional Health Care (NCCHC) articulates the requirement of informed consent as follows: “Informed consent is the agreement by a patient to a treatment, examination, or procedure after the patient receives the material facts about the nature, consequences, and risks of the proposed treatment, examination or procedure; the alternatives to it; and the prognosis of the proposed treatment is not undertaken” Further, “If at any point the patient indicates refusal, the medication

40. AM. PSYCHIATRIC ASS’N, *supra* note 35, at 15-16.

must not be forced: the right to refuse treatment “is inherent in the notion of informed consent”⁴¹

- Case management, where the case manager tracks the progress of the prisoner on the mental health caseload and meets with him or her at regular intervals, is also a crucial component of mental health services, but case management does not substitute for needed individual and group psychotherapy.
- Psychiatric rehabilitation programs are needed, including education and vocational training programs as well as social skills training, anger management, and substance abuse treatment. For example, a prisoner suffering from schizophrenia needs quality contact with mental health clinicians. In addition to individual and group psychotherapy, psycho-education is an important component of treatment. The afflicted individual must understand the nature and probable life course of the illness, the benefits and side effects of medications, the dangers of non-compliance, ways to recognize early or “prodromal” symptoms of an impending psychotic episode or suicidal crisis, the value in seeking help early when an episode seems to be evolving, the dangers of using illicit substances, and ways to cope with the depression and suicidal ideation that tend to accompany schizophrenia. In addition, the patient needs help navigating the ordinary events of life, the activities of daily living (ADL). All of this takes a certain amount of staff time, and there must be an adequate amount of face-to-face talk at all levels of treatment.

C. *Intermediate Care: A Crucial Component of Mental Health Services*

The importance of intermediate care, including what is generally called in corrections a “stepdown mental health unit” or “residential treatment program,” cannot be stressed too much. These are locations and programs within the prisons where an intermediate level of mental health care is provided, intermediate between inpatient and outpatient care. Intermediate care, or residential treatment programs within the prisons, are equivalent to halfway houses and day treatment or partial hospitalization programs in the community. They are not staffed with round-the-clock nurses as inpatient units are, yet there are psychologists, social workers, case managers, and nurses available on a nearly daily basis. There are group therapy, milieu meetings, and case management. Usually these are general population units, and the prisoners go out from the unit to mingle with other prisoners on the yard and in the cafeteria. But they have support from the mental health staff on the unit as well as counseling when they experience troubling interactions with other prisoners off the unit. In the best of cases, there are Correction Officers dedicated to work on

41. See NAT'L COMM'N ON CORR. HEALTH CARE, *supra* note 35.

the intermediate care units. In other words, all officers on the intermediate care unit have received special mental health training and elected to work on the unit.

If enough intermediate care beds are provided to serve the population in need, then many prisoners with mental illness will be provided a safe enough environment and sufficient continuous mental health treatment to avoid victimization and stay out of disciplinary trouble, and thus will not wind up as often in punitive isolation units, nor as likely require protective custody.⁴² This kind of intermediate care is relatively inexpensive; the cost of the mental health staffing necessary to run such a program is far less than what is required for an inpatient psychiatric ward or than the cost of security on a supermax solitary confinement unit.⁴³

Too many prisoners with serious mental illness get robbed, beaten, raped, and eventually sent to long-term segregation. In segregation they suffer terribly, often developing an exaggerated version of their already familiar pattern of emotional breakdown.⁴⁴ In the New York litigation *Disability Advocates, Inc. v. Office of Mental Health*, we found too many very disturbed prisoners warehoused in segregation cells, and as just one of several possible remedies for that problem, the negotiated settlement included dedicating 305 additional intermediate care beds.⁴⁵ And indeed, prisoners with serious mental illness who are fortunate enough to be admitted to an intermediate care unit in prison are much less likely to be written a rule violation ticket and much less likely to be sent to segregation.⁴⁶

D. *Suicide and Self-Harm*

Suicide is a very big problem in jails and prisons. The rate of suicide behind bars is much greater than in the community. It has been known for decades that suicide is approximately twice as prevalent in prison as in the community. Long-term consignment to segregation is a major factor in the high

42. See David Lovell, *Evaluating the Effectiveness of Residential Treatment for Prisoners with Mental Illness*, 28 CRIM. JUST. & BEHAV. 83 (2001).

43. See Terry A. Kupers, *Treating Those Excluded from the SHU*, 12 CORRECTIONAL MENTAL HEALTH REP. 49 (2010).

44. See Stuart Grassian & Nancy Friedman, *Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement*, 8 INT'L J.L. & PSYCHIATRY 49 (1986); see also Craig Haney, *Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement*, 49 CRIME & DELINQ. 124 (2003); Peter Scharff-Smith, *The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature*, 34 CRIME & JUST. 441 (2006).

45. Private Settlement Agreement at 7, *Disability Advocates, Inc. v. N.Y. State Office of Mental Health* (S.D.N.Y. Apr. 27, 2007) (No. 02 Civ. 4002 (GEL)).

46. See Kupers, *supra* note 43; Lovell, *supra* note 42.

suicide rate among prisoners.⁴⁷ Recent research confirms that of all successful suicides that occur in a correctional system, approximately fifty percent involve the three to eight percent of prisoners who are in some form of isolated confinement at any given time.⁴⁸

Crisis intervention and suicide prevention must include a number of components. The standards of the National Commission on Correctional Health Care⁴⁹ provide this list: Training of mental health and custody staff on recognition and intervention regarding prisoners at risk; identification (i.e., screening at admission to the prison or the segregation unit as well as ongoing suicide risk assessment as clinically appropriate); referral (to the appropriate mental health practitioners and programs); evaluation (comprehensive mental health examination including past suicidal and self-harm crises and incidents as well as current stressors); housing (for example, transfer to an observation cell, or after a period of observation, to a location where the patient will be safe and appropriately monitored); monitoring (this means not only intensive observation during the immediate crisis, but also ongoing monitoring at incrementally less frequent intervals as the prisoner demonstrates diminishing risk of self-harm); communication (between custody and mental health staff and also between the various mental health and medical providers); intervention (including but not limited to observation and monitoring since meaningful talking psychotherapy must occur if the staff are to get to the issues driving the prisoner to despair and contemplate or attempt suicide); notification (of family members, and so forth); reporting (in the electronic medical record according to widely accepted standards in the medical and mental health fields); review (peer review, quality assurance, etc., with the assumption that where programmatic deficiencies or lapses in staff interventions are discovered they will be corrected); and critical incident debriefing (which are essential if flaws in the mental health program are to be addressed).

Continuity of care is absolutely essential. Because fifty percent of prison suicides involve the three to eight percent of prisoners in segregation or isolative confinement, let us consider the case of a prisoner in segregation who complains to an officer that he is suicidal. The officer refers him to mental health staff, and he is transferred to an “observation cell,” often in the infirmary. The observation cell typically has a large interior window to the

47. See Daniel P Mears & Jamie Watson, *Towards a Fair and Balanced Assessment of Supermax Prisons*, 23 JUST. Q. 232 (2006); see also Patterson & Hughes, *supra* note 7; Bruce Way et al., *Factors Related to Suicide in New York State Prisons*, 28 INT'L J.L. & PSYCHIATRY 207 (2005).

48. Patterson & Hughes, *supra* note 7; Rusty Reeves & Anthony Tamburello, *Single Cells, Segregated Housing, and Suicide in the New Jersey Department of Corrections*, 42 AM. ACAD. PSYCHIATRY & L. 484-88 (2014).

49. See NAT'L COMM'N ON CORR. HEALTH CARE, *supra* note 35. While accreditation by the National Commission on Correctional Health Care (NCCHC) is not required, the standards of the NCCHC do reflect a national consensus on what the standard of care in the community requires as adapted to the correctional environment.

hallway, or a transparent wall (usually constructed of lexan or indestructible plastic). Typically, the prisoner's clothes are removed, and he is given a suicide-proof gown and blanket. Usually there are no other amenities or possessions in his observation cell, and he is not permitted out for recreation while on observation. There is nothing to do all day. He is even more isolated, idle, and uncomfortable in the observation cell than he would be in a segregation cell. The prisoner eventually tells staff he is no longer suicidal. I have spoken with many prisoners who have been in this situation, and most tell me the boredom and discomfort in the observation cell is worse than what they experience in their segregation cell, and mental health staff do not really talk to them while they are in observation. So they eventually tell staff they are not suicidal in order to effect a move back to their ordinary cell. And when suicides actually happen in prison, they quite likely occur in the period of time after the prisoner is transferred out of observation.⁵⁰ Many successful suicides in prison occur in segregation cells, where prisoners who have been released from observation are returned. Then they are not closely enough monitored, staff do not talk to them about the quality or causes of their despair, and when I examine their medical record I do not find an adequate treatment plan that covers the frequency of observation or the kind of treatment that is planned subsequent to their release from observation.

An effective crisis intervention and suicide prevention plan would not in most cases permit sending a prisoner back to a segregation cell after he is discharged from observation but would require a detailed treatment plan that includes recommendations on housing, the frequency of monitoring and the kind of ongoing mental health treatment he will receive. This might include medications and must include some talking psychotherapy so the mental health staff can assess ongoing suicide risk and the prisoner can be helped to become more functional.⁵¹

Sometimes self-harm involves suicidal intent; sometimes it does not. Both kinds of self-harm are urgent problems in a correctional setting. I have very rarely seen grown men cut themselves for non-suicidal reasons anywhere except in a prison isolation unit. "Cutting" is a symptom usually seen in adolescent girls and rarely occurs in adult males.⁵² But non-suicidal self-harm, especially cutting of some part of the body, is very commonplace in prison segregation units, and in my experience the worse the conditions of confinement and the less the officers attend to prisoners' urgent needs, the more often prisoners cut themselves for non-suicidal reasons.

50. See Henry Schmidt III & Andre Ivanoff, *Behavioral Prescriptions for Treating Self Injurious and Suicidal Behaviors*, in CORRECTIONAL PSYCHIATRY: PRACTICE GUIDELINES AND STRATEGIES, *supra* note 35.

51. *Id.* at 6-1 to 7-23.

52. See Milton Z. Brown et al., *Reasons for Suicide Attempts and Nonsuicidal Self-Injury in Women with Borderline Personality Disorder*, 11 J. ABNORMAL PSYCHOL. 198 (2002).

Often correctional mental health staff, viewing non-suicidal self-harm as manipulative, pay little or no attention to the prisoners' despair, anxiety, and needs that are expressed in the self-harm. That is a deadly mistake. Non-suicidal self-harm can be as dangerous as self-harm with suicidal intent. Non-suicidal self-harm, a well-studied psychiatric phenomenon, is usually related to a high degree of anxiety, often secondary to past or current traumas and exacerbated by isolation and idleness, and it can result in unintended fatalities. For example, many prisoners I have interviewed subsequent to a serious episode of self-harm in a segregation setting report that they despair of ever being released from their unbearable segregation cell, and often there is an objective reality to their fear of never leaving segregation. That reality-based despair drives many acts of self-harm. When a prisoner decides out of despair to take his own life, the situation can be dire, and much clinical energy and competence need to be expended on providing crisis intervention.

E. *A Note About Trauma*

In many correctional systems, because there are inadequate resources to provide all the prisoners who need it with mental health treatment, the mental health staff concentrate their limited resources on the "major mental illnesses," including schizophrenia, bipolar disorder, and major depressive disorder. Prisoners suffering from those conditions do require mental health treatment. But so do a lot of others suffering from diagnosed conditions that do not appear on the short-list of "major mental disorders." I mentioned non-suicidal self-harm in Part III.D. Often it is anxiety more than depression that drives acts of non-suicidal self-harm. This means that a condition such as "anxiety disorder" can lead to as much disability as can a condition such as bipolar disorder. In other words, correctional mental health treatment needs to be available to all prisoners who need help, not just to those whose diagnosis happens to fit a short-list that qualifies for services.

Posttraumatic stress disorder is one of the conditions that is not among the "major mental illnesses" but can cause severe disability, even suicide. A large majority of prisoners have suffered multiple traumas throughout their life prior to incarceration.⁵³ Very often they require mental health treatment. In addition, the traumas of prison life can add to their emotional troubles, too often serving as a "reenactment" of earlier traumas or "retraumatization."⁵⁴ If adequate treatment for PTSD were offered to prisoners, there would be far fewer incidents of self-harm, and many of the treated prisoners would more

53. See Terry A. Kupers, *Posttraumatic Stress Disorder in Prisoners*, in *MANAGING SPECIAL POPULATIONS IN JAILS AND PRISONS* (Stan Stojkovic ed., 2005).

54. See Louise Bill, *The Victimization and Re-Victimization of Female Offenders*, *CORRECTIONS TODAY* 107 (1998); see also Angela Browne et al., *Prevalence and Severity of Lifetime Physical and Sexual Victimization Among Incarcerated Women*, 22 *INT'L J.L. & PSYCHIATRY* 301 (1999); Kupers, *supra* note 53.

effectively participate in rehabilitation programs and stay out of trouble while incarcerated, and then would more likely succeed at “going straight” after being released from prison.⁵⁵

IV. SOME ISSUES UNIQUE TO CORRECTIONAL SETTINGS

Certain situations unique to correctional settings require further comment. These include the mental health hazards of isolative confinement, the prescription of medications and medication-over-objection, the “disturbed/disruptive” prisoner, use of force, “therapeutic cubicles” or what the prisoners call “cages” for therapy sessions, and the issue of malingering.

Before I move on to those topics, a comment about general principles is in order. Quality correctional mental healthcare is not only about an adequate array of services or a complete list of conditions that require treatment. It also is about more general principles for the provision of care: the conditions of confinement need to be humane; the prisoners need to be treated with respect at every turn; there need to be multiple modalities of treatment so that individualized treatment plans can be created for each patient; in general, rewards for positive behaviors are more effective than negative punishments; at each level of security, and there need to be incremental phases wherein a prisoner who successfully works on his or her program can be advanced to higher levels of freedom and more amenities. There needs to be close collaboration between mental health and custody staff, and discipline must be handled in the context of that collaboration; in other words discipline must be handled in the context of a treatment plan that emerges from the collaboration of mental health and custody staff. Keeping these general principles in mind throughout the discussion that follows, I will return to a fuller discussion of general principles in Part VI, below.

A. *Isolative Confinement and Supermax Security*

One huge obstacle to the application of a community mental health model in corrections is the widespread practice of long-term segregation and supermaximum isolative confinement. Too often the prisoner who is involved in mental health treatment, or who should be in treatment, acts inappropriately or breaks rules and finds his or her way into the “SHU” (acronym for long-term segregation or supermaximum security). Litigation in quite a few states has, to a varying extent, succeeded in barring prisoners with serious mental illness from long-term solitary confinement because of the known destructive effects of forced isolation and idleness on individuals prone to mental illness.⁵⁶ State

55. See Kupers, *supra* note 53.

56. Presley v. Epps, No. 4:05CV148-JAD, 2014 WL 1468087 (N.D. Miss. 2005); Jones ‘El v. Berge, 164 F. Supp. 2d 1096 (W.D. Wis. 2001); Madrid v. Gomez, 889 F. Supp.

legislatures have enacted or are considering legislation barring the department of corrections from placing prisoners with serious mental illness in long-term isolative confinement.⁵⁷ I have written about the treatment programs that are subsequently needed for the population thus excluded from isolated confinement.⁵⁸

Long-term confinement (three months or longer) in an isolated confinement unit is well-known to cause severe psychiatric morbidity, disability, suffering, and mortality.⁵⁹ It has been known for as long as solitary confinement has been practiced that human beings suffer a great deal of pain and mental deterioration when they remain in solitary confinement for a significant length of time. Prisoners who are relatively stable when they enter solitary confinement experience symptoms including anxiety, thinking disorders, possibly paranoia, insomnia, mounting anger, and problems with concentration and memory. Prisoners with pre-existing mental disorders, and those with any proclivity to suffer from mental illness, tend to experience exacerbations of their mental illness or experience despair and become suicidal.⁶⁰ These effects tend to be long-lasting or permanent. The recidivism and parole violation rates for prisoners who “max out” their sentences in isolated confinement, as well as for those who spent considerable time in isolation, are extremely dire.⁶¹

If the community mental health model is to succeed in corrections, there needs to be a comprehensive re-thinking about isolated confinement.⁶² The entire notion of “worst of the worst” prisoners, who have to be locked up for long periods in near 24/7 solitary cell confinement, is relatively new, having caught on in American corrections in the 1990s. Of course there was always “the hole,” usually a dark dungeon-like area of a prison where a prisoner would be consigned for ten days or a few weeks for fighting or contraband. But never before the advent of the supermax prison at the end of the twentieth century had

1146, 1265 (N.D. Cal. 1995); see also Erica Goode, *Prisons Rethink Isolation, Saving Money, Lives and Sanity*, N.Y. TIMES (Mar. 10, 2012), <http://www.nytimes.com/2012/03/11/us/rethinking-solitaryconfinement>.

57. Colorado, New York, Maine, and New Mexico have passed laws limiting admission of prisoners with mental illness to solitary confinement, and Illinois, Nevada, and Texas are considering comparable legislation. See Joe Palazzolo, *Colorado Becomes Latest to Back Ban on Solitary Confinement of Mentally Ill*, WALL ST. J. (June 6, 2014, 3:55 PM), <http://blogs.wsj.com/law/2014/06/06/colorado-becomes-latest-to-back-ban-on-solitary-confinement-of-mentally-ill>.

58. See Kupers, *supra* note 43.

59. For reviews of this research, see Bruce Arrigo & Jennifer Leslie Bullock, *The Psychological Effects of Solitary Confinement on Prisoners in Supermax Units: Reviewing What We Know and Recommending What We Should Change*, 52 INT'L J. OFFENDER THERAPY COMP. CRIMINOL. 622 (2008); Scharff-Smith, *supra* note 44, at 488-90.

60. See Scharff-Smith, *supra* note 44.

61. Lovell et al., *supra* note 23.

62. CRAIG HANEY, REFORMING PUNISHMENT: PSYCHOLOGICAL LIMITS TO THE PAINS OF IMPRISONMENT (2006).

so many prisoners been consigned to segregation for such extended periods.⁶³ Whenever prison violence spikes and mayhem in the prisons seems imminent, there are calls for more punitive measures, including deep-freeze segregation.⁶⁴

There are a disproportionate number of prisoners with serious mental illness in segregation units and supermax prisons.⁶⁵ As soon as a significant proportion of prisoners are consigned to long-term segregation, there are issues about individual prisoners' mental status. Did a mental disorder either cause the unacceptable behavior that led to segregation as punishment, or are the conditions in segregation damaging the prisoner with mental illness to the point where he or she needs to be removed from solitary confinement? The mental health clinician is tasked with separating prisoners with bona fide mental illness who should be excluded from supermax isolation from those who are "malingering" or "merely Axis II."⁶⁶ In states that bar consignment of prisoners with serious mental illness from isolative confinement, the prisoners deemed authentically "disturbed" are removed from isolation and, one hopes, transferred to the level of mental health treatment their condition requires, be it inpatient, outpatient, or intermediate care. Those whose mental disorders are considered inauthentic are left to the punishments meted by custody staff.

Of course, once a prisoner with mental illness is consigned to isolative confinement, providing that prisoner with mental health treatment becomes very problematic. On the one hand, staff believe the isolation and control are warranted because, according to an old adage in institutional psychiatry, one cannot conduct psychotherapy or psychiatric treatment if the situation is not safe, and it is not safe if either the clinician or the patient has valid reality-based reasons for feeling unsafe during the encounter. On the other hand, isolation is well-known to exacerbate mental illness. Mental health clinicians err when they emphasize the need to keep patients in isolation to provide safety, and they give too little attention to the mental damage caused by the isolation. Clinicians must venture into discussions of security issues, if only to better guarantee a safe place to practice and a safe place for their patients to serve their time while minimizing the negative effects of penal isolation.⁶⁷ In order to address this dilemma in an effective and humane way, mental health clinicians need to

63. LORNA RHODES, *TOTAL CONFINEMENT: MADNESS AND REASON IN THE MAXIMUM SECURITY PRISON* (2004); SHARON SHALEV, *SUPERMAX: CONTROLLING RISK THROUGH SOLITARY CONFINEMENT* (2009).

64. Corey Weinstein, *Even Dogs Confined to Cages for Long Periods of Time Go Berserk*, in *BUILDING VIOLENCE: HOW AMERICA'S RUSH TO INCARCERATE CREATES MORE VIOLENCE* 118-23 (John P. May & Khalid R. Pitts eds., 2000); HUMAN RIGHTS WATCH, *COLD STORAGE: SUPER-MAXIMUM SECURITY CONFINEMENT IN INDIANA* 18-20 (1997).

65. HUMAN RIGHTS WATCH, *supra* note 64.

66. Terry A. Kupers, *Malingering in Correctional Settings*, 5 *CORRECTIONAL MENTAL HEALTH REP.* 6 (2004).

67. Fred Cohen provides a lucid forum on the topic in a Special Issue of *Correctional Law Reporter*. See Fred Cohen et al., *Long-Term Penal Isolation: A Problem Solving Symposium*, 26 *CORRECTIONAL L. REP.* 1 (2014).

advocate for close collaboration between custody and mental health staff. There needs to be cross-training and cross-thinking. Clinicians need to know about security issues, and officers who work with prisoners suffering from mental illness need to know a certain amount about mental illness and suicide.⁶⁸

Research is beginning to prove that supermaximum isolation units do not achieve the end of reduced prison violence.⁶⁹ In fact, the collaborative Mississippi study I participated in concludes that downsizing supermax and segregated confinement actually reduces violence in the prisons.⁷⁰ The punishment society has meted through the courts for felonies is captivity in a penal institution.⁷¹ The punishment includes loss of one's family, one's work, and one's freedom. Solitary confinement is not part of a prison sentence; it is an additional punishment and restriction mandated by the administration of the prisons and jails. Today, if a correctional system elects to warehouse a significant number of prisoners in solitary confinement for long periods, then, in the opinion of a growing number of courts and state legislatures, at the very least that system must exclude prisoners with serious mental illness.⁷² There also is a duty to offer effective programming at the end of a stint in solitary confinement to help the prisoner isolated and idle for so long to learn or re-learn the social skills and personal capacities that long-term isolated confinement tends to destroy or weaken.

Instead of simply modifying long-term isolation by excluding prisoners with mental illness and providing transitions back to the general population or to the community, I strongly advocate, and include in my list of remedies during trial testimony, that there be much less solitary confinement altogether.⁷³ Of course there are certain prisoners who need to be in isolation for a limited period for the purpose of quarantine—they present a clear danger of violence and chaos if they are permitted to mix with others in general population. Even there, though, with professional classification officers doing their job and keeping enemies apart, there are not many individuals who really need to be isolated for long periods of time. I believe the current population

68. As I enter collaborative discussions about security and safety, I have to disclose early on that I believe there is excessive punishment going on in the jails and prisons, punishment for punishment's sake, with no valid "penological objective."

69. See Chad S. Briggs et al., *The Effect of Supermaximum Security Prisons on Aggregate Levels of Institutional Violence*, 41 CRIMINOLOGY 1341 (2003).

70. See Terry A. Kupers et al., *Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs*, 36 CRIM. JUST. & BEHAV. 1037 (2009).

71. Thanks to Henry W. "Hank" Skinner for pointing out this fact to me.

72. *Presley v. Epps*, No. 4:05CV148-JAD, 2014 WL 1468087 (N.D. Miss. 2005); *Jones 'El v. Berge*, 164 F. Supp. 2d 1096 (W.D. Wis. 2001); *Madrid v. Gomez*, 889 F. Supp. 1146, 1265 (N.D. Cal. 1995).

73. See Expert Report of Terry Kupers, *Dockery v. Epps*, No. 3:13-cv-326 TSL-JCG (S.D. Miss. 2013), available at <https://www.aclu.org/prisoners-rights/dockery-v-epps-expert-report-terry-kupers>.

consigned to solitary confinement in prisons and jails could be greatly reduced with no negative outcome in terms of the safe functioning of the institutions.

One of the main reasons I would greatly reduce the use of isolative confinement is that the warehousing of prisoners in segregation cells further undermines the quality of relationships that are possible between prisoners and staff. When an officer's main contact with prisoners occurs during the passage of a food tray through a slot in the cell door, there is not much opportunity to talk about much. One officer is exchangeable with another; the passing of a food tray is something any officer can do. So the staff move around, and prisoners have less and less opportunity to talk to the officers who are charged with providing for their wellbeing. A widening gap opens between the officers and the prisoners. I truly believe that many of the assaults on officers that occur in supermax prisons are a thin veil over a prisoner's compelling need to have human contact, even if it has to be negative. I am afraid the quality of relationships between officers and prisoners has deteriorated in recent decades precisely because so many prisoners are in isolation. Newer officers express fear when they walk among prisoners; they prefer having the prisoners "locked down." But mental health treatment requires a trusting therapeutic relationship that deepens over time. To my knowledge, nobody has found a way to do that when the prisoner is experiencing near total isolation and idleness in a segregation cell. This problem is another important reason why mental illness becomes so florid in isolation units—there can be no mental health treatment involving a deepening therapeutic relationship.

The most obvious risks of long-term isolative confinement are suicides and repetitive self-harm. But in addition, as a general rule, the longer an acute episode of mental illness goes untreated—in other words the longer the individual is left to be irrational and emotionally out of control—the worse the prognosis. Thus, placing prisoners prone to serious mental illness in isolation, where their disorder is exacerbated, and failing to provide them with adequate mental health treatment are quite likely to result in permanent psychiatric injury.

For the purpose of illustration, think of schizophrenia. Generally the illness follows a waxing and waning course over a lifetime; that is, there are decompensations ("break-downs") and remissions. As a general rule, the longer the period of decompensation lasts, and the less functional the patient is during the remission phase, the worse the prognosis. If the acutely psychotic individual can quickly undergo effective mental health treatment in a safe and health-sustaining setting, a remission is likely. The shorter the psychotic episode and the longer and more complete the inter-episodic remission, the better the prognosis. On the other hand, for the individual who never really attains remission, or is left in harsh conditions to experience acute psychosis for a lengthy period, the eventual prognosis is much more dire.

Thus, when a prisoner in long-term segregation suffers a psychotic episode and receives little or no treatment except for psychotropic medications, the isolation and idleness to which he is subjected exacerbate his mental illness.

Isolation and idleness, especially when accompanied by staff neglect, excessive use of force, and other harsh conditions of confinement, exacerbate mental illness and make the disability and prognosis much more severe. Often such an individual remains in a psychotic state for months or even years. The fact that he does not experience remission in a relatively short time means that his prognosis is going to be much worse than if he had been removed from isolation and provided adequate mental health treatment. The most severe and disabling cases of psychosis, mania, and depression that I have ever encountered in over forty years of psychiatric practice are in prisoners who have been held in long-term segregation.

In some departments of correction, prisoners with serious mental illness are left in isolative confinement in supermax units, but their treatment program is supplemented with two or more hours out of their cell, often in “therapeutic cubicles,” during which time they are involved in group activities or psycho-educational classes. It is my considered opinion that this kind of mental health treatment does not ameliorate the very damaging effects of isolative confinement. In addition, the use of “therapeutic cubicles,” which I discuss more in depth below, is problematic.

B. *Medications and Medication-over-Objection*

It is very dangerous to give medications when no other treatment modalities are available. Quite often, when medications are the sole form of psychiatric treatment, the dosages of the medications have to be incrementally increased to control the patient’s behavior if not to resolve the worst symptoms. This is because there is no therapeutic process in effect that might relieve the target symptoms of mental illness. In general, medications alone will not resolve many of the symptoms, nor will they improve functioning and prognoses. On the other hand, when medications are administered in the context of a full treatment program (i.e., along with individual and group psychotherapy and therapeutic programs such as vocational rehabilitation or art therapy), then the medications play an important role as part of the treatment.

When medications are given in the absence of other mental health treatment modalities, they can have the effect of merely tranquilizing or sedating the patients, and then long-term prognoses worsen. This was a big problem in the state hospitals of the 1940s and 1950s, which were termed “asylums” and “snakepits.” Many patients were merely turned into chronic patients or “zombies” in the state hospitals through the administration of high doses of anti-psychotic medications.⁷⁴ It was the public’s outrage about the warehousing and ill-treatment of mental patients in the asylums that brought on

74. See ERVING GOFFMAN, *ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES* (1962).

“de-institutionalization” and the down-sizing of state mental hospitals since the 1960s.⁷⁵

Medications must be prescribed carefully, and there must be close monitoring by the psychiatrist to gauge effectiveness and tolerance and to prevent negative side effects, including excessive sedation. There must be informed consent, and of course this means patients must have a right to refuse the treatment. There are instances where the patient must be involuntarily treated, or prescribed and administered medications over the patient’s objections.

The National Commission on Correctional Health Care (NCCHC) publishes standards for the involuntary administration of medications in non-hospital settings. The NCCHC standards reflect the standard of medical care in the community. The NCCHC Standard on Forced Psychotropic Medication requires that before administering medication involuntarily, “[a]ll less restrictive or intrusive measures have been employed or have been judged by the treating physician or psychiatrist to be inadequate. . . . The physician or psychiatrist clearly documents in the medical record the inmate’s condition, the threat posed, and the reason for the proposed forcing of medication, including other treatments attempted.”⁷⁶ The Code of Federal Regulations, while controlling practices in the Federal Bureau of Prisons and not binding on state corrections systems, also reflects the community standard of care. It provides that “[d]uring a psychiatric emergency, psychotropic medication may be administered when the medication constitutes an appropriate treatment for the mental illness and less restrictive alternatives (e.g., seclusion or physical restraint) are not available or indicated, or would not be effective.”⁷⁷

Physicians are permitted to order involuntary medications on an emergency basis for a certain number of hours; depending on the state or jurisdiction, that might be 24, 48, or 72 hours.⁷⁸ If there is not an emergency, or after 72 hours elapse, due process is required, including an “involuntary medication hearing,” with the prisoner notified in writing twenty-four hours prior to the hearing.⁷⁹ *Harper v. Washington* is the controlling legal precedent for non-emergency involuntary medication in prison.⁸⁰ *Harper* requires a due process hearing before an impartial hearing committee that does not include members of the

75. Walid Fakhoury & Stefan Priebe, *Deinstitutionalization and Reinstitutionalization: Major Changes in the Provision of Mental Healthcare*, 6 PSYCHIATRY 313 (2007).

76. NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE, CORRECTIONAL MENTAL HEALTH CARE: STANDARDS & GUIDELINES FOR DELIVERING SERVICES 146 (2003).

77. 28 C.F.R. § 549.46 (West, Westlaw through Aug. 12, 2011).

78. NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE, *supra* note 76, at 146.

79. *Id.* (“For guidance in forcing psychotropic medications on a more frequent basis or as part of an ongoing treatment plan, staff are referred to current case law”) (citing *Harper v. Washington*, 494 U.S. 210 (1990)).

80. *Harper v. Washington*, 494 U.S. 210 (1990).

treatment team, advance notice to the prisoner of the hearing, and the prisoner's right to argue against involuntary medications.

Of course, policies and law do not permit the administration of medications that act for longer than two weeks such as antidepressants or Haldol Decanoate, because the time limit on emergency administration is seventy-two hours, and the time limit on an order for medication-over-objection from the Special Hearing Committee is fourteen days. Involuntary medications are not permitted merely because a prisoner refuses to take his prescribed medications (remember that according to guidelines for informed consent, the prisoner has the right to refuse treatment), and involuntary medications are never to be administered as punishment.

In a prison where psychotropic medications are the only mental health intervention—that is, facilities where there are no other treatment modalities— involuntary medications should be barred precisely because no less restrictive interventions are available, so they cannot have been tried and found to fail. In fact, clinical research shows that where there is a good therapeutic relationship between the patient and mental health staff, involuntary medications are very rarely needed.⁸¹ According to the American Psychiatric Association's 1999 "Mandatory Outpatient Treatment Resource Document," "[e]mpirical studies of mandatory outpatient treatment tend to indicate that outcomes would not be significantly improved by allowing forcible administration of medication, and that, even if available, forced medication will rarely be necessary in clinical practice."⁸² In the vast majority of cases, by developing a therapeutic

81. See, e.g., Jennifer C. Day et al., *Attitudes Toward Antipsychotic Medication: The Impact of Clinical Variables and Relationships with Health Professionals*, 62 ARCHIVES GEN. PSYCHIATRY 717 (2005); Brandon A. Gaudiano & Ivan W. Miller, *Patients' Expectancies, the Alliance in Pharmacotherapy, and Treatment Outcomes in Bipolar Disorder*, 74 J. CONSULTING & CLINICAL PSYCHOL. 671 (2006); Margaret Weiss et al., *The Role of the Alliance in the Pharmacologic Treatment of Depression*, 58 J. CLINICAL PSYCHIATRY 196 (1997); Rosemarie McCabe et al., *The Therapeutic Relationship and Adherence to Antipsychotic Medication in Schizophrenia*, PLOS ONE (Apr. 27, 2012), <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0036080>.

82. AM. PSYCHIATRIC ASS'N, MANDATORY OUTPATIENT TREATMENT RESOURCE DOCUMENT 8 (1999). The American Psychiatric Association, in its 1999 Mandatory Outpatient Treatment Resource Document, states: "Studies have shown that mandatory outpatient treatment is most effective when it includes services equivalent to the intensity of those provided in the assertive community treatment or intensive case management models. States adopting mandatory outpatient treatment statutes must assure that adequate resources are available to provide effective treatment." *Id.* at 1. For example, California Welfare and Institutions Code §§ 5325-5337 permits assisted outpatient treatment and involuntary medications with due process only in counties that prove they supply a variety of mental health treatment modalities and services—including multiple modalities of psychotherapy, case management, home visits and so forth—available to the population being involuntarily treated, and then only after all less restrictive interventions have been exhausted. Cal. Welf. & Inst. §§ 5325-5337 (West, Westlaw through 2014 Reg. Sess.); see John Menninger, INVOLUNTARY TREATMENT: HOSPITALIZATION AND MEDICATIONS 3, http://www.brown.edu/Courses/BI_278/Other/Clerkship/Didactics/Readings/INVOLUNTARY%20TREATMENT.

relationship with the patient while engaged in individual and group psychotherapy and other modalities of treatment and psychiatric rehabilitation, the staff are in a position to influence her and motivate her to comply with treatment, even in emergency situations, so very little or no involuntary actions are needed.⁸³

The converse also is definitely true. When involuntary medications are utilized more often than on rare occasions, it is almost certain that there are staff shortages and a lack of adequate training on the part of mental health staff, leading to inadequate treatment and the inability of mental health staff to foster patients' compliance with treatment. In states where involuntary medications are permitted outside of psychiatric hospital settings, there is a requirement that comprehensive mental health services be available.⁸⁴

C. *The Disturbed/Disruptive Prisoner*

It is the responsibility of custody as well as mental health staff to write disciplinary tickets or RVRs (rule violation reports). This sometimes puts mental health staff in the difficult position of deciding which inappropriate behaviors on the part of prisoners with serious mental illness are related to their mental illness—for example, a command hallucination or voice commanding the prisoner to break the rule or hit someone, or an irresistible, anxiety-driven impulse to cut oneself—as opposed to willful acts deserving of punishment. I believe this is a useless distinction. In previous eras (before the 1990s), a distinction was typically made between “the bad and the mad.” The bad were prisoners with behavior problems deserving of punishment, and the mad were those with a serious mental illness, whose misbehaviors were to be viewed as symptoms. There were many problems with that dichotomy, including the fact that the consignment of individual prisoners either to punitive segregation or a more intensive level of mental health treatment often played out along racial lines; that is, too often the prisoner of color was sent to punitive segregation while the white prisoner was referred to mental health treatment. Meanwhile, the same individuals could be mad and act bad. Were their bad acts symptoms of their mental illness, or were they simply individuals with mental illness who would act inappropriately? Hans Toch pioneered the contemporary consensus in corrections that prisoners with serious mental illness can be both mad and bad, and the distinction is not actually very important because it is the entirety of the person, the mad and the bad, that needs to be taken into account as we proceed to devise a combined treatment and management plan that integrates

pdf (last visited Nov. 13, 2014) (“Emergency medications should work acutely (e.g., neuroleptics and benzodiazepines as opposed to antidepressants and mood stabilizers) and must target the serious presenting symptoms.”).

83. See AM. PSYCHIATRIC ASS'N, *supra* note 82.

84. *Id.*

custody staff's concerns about security with mental health staff's concerns about treatment issues. Toch coined the term "disturbed/disruptive" and provided treatment and management recommendations for mental health staff as well as security staff.⁸⁵

When prisoners with serious mental illness break rules, especially if they assault staff, they tend to be "flunked out" or ejected from treatment programs such as intermediate mental health care programs. Then they are once again at very high risk of running into disciplinary problems and winding up in long-term punitive isolation. Long-term punitive isolation, however, is banned by court order for prisoners with serious mental illness in many jurisdictions.⁸⁶ In my view, intermediate care and other treatment programs fail to the extent they eject "disturbed/disruptive" prisoners, thereby leaving them to be punished for their unacceptable actions and eventually consigned to isolative confinement. Instead, prisoners with mental illness who are in step-down mental health programs or intermediate care and subsequently break rules and assault staff need to be retained within the mental health program, where the consequences for their disruptive or assaultive behaviors can be handled in the context of a mental health treatment plan—again, utilizing a collaborative approach by custody and mental health staff. This means that there must be, in each department of correction, a step-down mental health treatment unit that can operate at a high level of security.

With Toch's help, we now know how to provide mental health treatment for "disturbed/disruptive" prisoners. There need to be incremental rewards for appropriate behaviors and a lot of encouragement as the patient traverses the incremental steps or phases of the program toward greater freedoms and amenities. For example, if custody staff believe the patient poses a security risk in congregate activities, he or she can be released from a cell with staff supervision and permitted to go alone down the hallway to a day room or library. Next, after he succeeds at that level or phase of treatment, he can be offered the opportunity to be in the day room or library or on the recreation yard with one or two other inmates, as long as he can prove over a certain length of time that he can refrain from self-harm, angry verbalizations toward staff and others, and threats of violence. The best option, to the extent possible, is to offer positive rewards for appropriate behavior rather than negative consequences and punishments for unacceptable behavior. More time in the day room, recreation, and so forth can be among the rewards, as can more possessions including art materials, more commissary, participation in activities

85. See Hans Toch, *The Disturbed Disruptive Inmate: Where Does the Bus Stop?*, 10 J. PSYCHIATRY & L. 37 (1982).

86. *Presley v. Epps*, No. 4:05CV148-JAD, 2014 WL 1468087 (N.D. Miss. 2005); *Jones 'El v. Berge*, 164 F. Supp. 2d 1096 (W.D. Wis. 2001); *Madrid v. Gomez*, 889 F. Supp. 1146, 1265 (N.D. Cal. 1995).

and programs the prisoner likes, and opportunities to participate in congregative activities.

Of course, there needs to be close collaboration between mental health and custody staff to arrive at a collaborative treatment plan and management plan for difficult-to-manage prisoners. Toch and Adams explain that the more difficult the prisoner is to manage and treat, the more collaborative meetings need to occur to devise a workable treatment and management plan.⁸⁷ It is important to assign one or a few mental health staff and custody staff to work consistently with the prisoner; then, in the context of a deepening, trusting therapeutic relationship, even the most recalcitrant prisoner can be encouraged to cooperate with the psychopharmacological component of treatment. Dialectical behavior therapy, a modality that has proven effective with difficult “disturbed/disruptive” prisoners, requires frequent and thorough case discussions across multiple disciplines precisely because this kind of collaboration is needed to help staff cope with the difficult feelings treatment of these patients evokes.⁸⁸

D. *Use of Force*

Prisoners suffering from serious mental illness are, on average, subject to a disproportionate amount of use force on the part of custody staff. The term “use of force” denotes physical restraint, shooting with pepper spray or mace, or otherwise subduing a prisoner. Often this has something to do with the fact that custody staff, especially if they have not been trained adequately in working with prisoners on the mental health caseload, become impatient with disturbed prisoners and relatively insensitive to their psychiatric disabilities. Such prisoners’ rule-breaking and recalcitrant behavior angers the officers, and too often officers lose any objective sense of the “penological objective” involved in their use of force and go overboard. Excessive force is that which goes beyond the penological objective, such as resorting to force before talking has been tried, kicking a prisoner after he has already been subdued, or shooting a prisoner with a second round of immobilizing gas before the prior round has had time to take effect.

I will illustrate the notion of “excessive force” with incidents where a jail prisoner with serious mental illness is sprayed with immobilizing gas as part of

87. HANS TOCH & KENNETH ADAMS, *ACTING OUT: MALADAPTIVE BEHAVIOR IN CONFINEMENT* (2002).

88. See MATTHEW MCKAY ET AL., *DIALECTICAL BEHAVIOR THERAPY WORKBOOK: PRACTICAL DBT EXERCISES FOR LEARNING MINDFULNESS, INTERPERSONAL EFFECTIVENESS, EMOTION REGULATION & DISTRESS TOLERANCE* (2007); Marsha M. Linehan et al., *Dialectical Behavior Therapy for Patients with Borderline Personality Disorder and Drug-Dependence*, 8 AM. J. ADDICTIONS 279 (1999); Marsha M. Linehan et al., *Interpersonal Outcome of Cognitive Behavioral Treatment for Chronically Suicidal Borderline Patients*, 151 AM. J. PSYCHIATRY 1771 (1994).

a procedure known as a “cell extraction.” Several correction officers are going to rush into an uncooperative prisoner’s cell and perform a “take-down.” As in mental hospitals, when a ward needs to be subdued, several staff members team up to accomplish the “take-down.” But in jail, before officers will perform a forcible “take-down,” they spray the prisoner with immobilizing gas in his cell. The hope is that the prisoner who has been sprayed will give up and submit to “cuffing” or “returning the food tray,” and further physical force will not be needed. But the spraying of immobilizing gas can in itself constitute “excessive force.” I have been in litigation involving excessive force allegations and discovered that, indeed, officers shoot the prisoner with two or even three bursts of immobilizing gas, without even waiting enough time between bursts to determine if the previous spraying has been effective. I have seen videos of prisoners with serious mental illness being sprayed so many times with immobilizing gas that they lay motionless on the floor between gasps for breath.

Use of immobilizing gas in this fashion is an entirely unacceptable practice; it runs a very high risk of negative medical consequences, including death, and very serious and long-lasting psychiatric consequences, including exacerbation of mental illness and the likely development of posttraumatic stress disorder (PTSD) or other trauma-related psychiatric disorders and disabilities. Sheriff departments need to write policies that require officers intent on using force against prisoners with mental illness to first do their best to reason with the recalcitrant prisoner, then to summon the shift commander and a mental health clinician, to each talk with the prisoner to see if a solution to the impasse other than the use of force can be negotiated. At the very least, this type of policy provision mandates a “cooling off period,” and, one hopes, in very many cases the use of force can be averted.

Custody staff too often attempt to manage the use of force against a prisoner with serious mental illness with very little participation by mental health staff. This is an unacceptable practice. Inmates with serious mental illness often do not comprehend orders. Their delusions, hallucinations, and oppositional behavior can be symptoms of their mental illness and preclude their ability to follow orders. Their symptoms need to be managed as a mental health treatment issue, and absent a dire emergency requiring the urgent use of force, these prisoners’ recalcitrant stand should not trigger the use of force. It is quite likely that some of the inmates did not even entirely understand that they were being subjected to immobilizing gas in order to influence them to “cuff up.” It is simply cruel to administer repeated doses of the gas.

Not only is the use of force unlikely to improve inmate behavior, but it also is very likely to be extremely harmful. The use of immobilizing gas, or actually any form of force, on inmates with mental illness is likely to have very

damaging effects on their psychiatric condition, disability, and prognosis.⁸⁹ A delusional inmate will likely incorporate into his delusional system the intrusion into his cell of deputies wearing padding and gas masks; for example, he will believe that the same external enemies who he already knew were out to harm him are now responsible for his being attacked and sprayed with gas. And just about any inmate who is subjected to multiple sprayings with immobilizing gas and other uses of force will be traumatized by the incidents. Since prisoners as a group have suffered many more prior traumas than the general population, they are very vulnerable to “retraumatization” and even the emergence of PTSD following a new trauma such as a cell extraction with the use of immobilizing gas.

Of course the best way to ward off incidents of excessive force is to have in place adequate mental health treatment, and then, in the immediate prelude to officers’ use of force, mental health staff should be called upon to interact with the prisoner. In too many cases, the prisoner who is eventually the target of use of force had not been receiving adequate mental health treatment in the period just prior to the use-of-force incident. Had the prisoner been receiving adequate treatment, he likely would have been taking prescribed medications that would lessen the severity of symptoms and would have previously formed a therapeutic relationship with mental health staff who would then be in a better position to talk him into complying with the order to cuff up. In fact, when officers are considering the use of force with prisoners who are suffering from serious mental illness or are enrolled in mental health treatment, mental health staff should be asked to talk to the prisoner first. Their specialized training makes them better-equipped than officers are to handle inmates suffering from mental illness. Where possible, the mental health staff assigned to the particular jail module should be tasked with talking to the prisoner, as individuals with severe mental illnesses are more likely to cooperate with mental health staff members with whom they have a pre-existing relationship.

The general principle that underlies the standard of care in the community as well as correctional health care standards, including those of the National Commission on Correctional Health Care (NCCCHC), is that the use of force must be a last resort, and it should happen only very rarely when all other, less restrictive options have been attempted and failed. The first option, always, is to talk, perhaps to negotiate, compromise—whatever it takes to avoid violence.

E. *Therapeutic Cubicles*

In quite a few state departments of correction, “programming cubicles” are used in isolative confinement units to restrain prisoners while they participate

89. See Steve Martin, *Sanctioned Violence in American Prisons*, in BUILDING VIOLENCE: HOW AMERICA’S RUSH TO INCARCERATE CREATES MORE VIOLENCE 113-17 (John P. May & Khalid R. Pitts eds., 2000).

in group therapy or classes.⁹⁰ The cubicles are approximately the shape of a telephone booth, but they are made of indestructible metal and lexsan (unbreakable plexiglass). Four or five of these booths are bolted to the floor in a group therapy room. Prisoners are brought from their segregation cells one at a time in shackles and locked into a booth. When the booths are all occupied, the counselor or teacher comes into the room and conducts the session. Prisoners call these booths “cages” and tell me that when they are placed inside of them, they feel they are being treated like animals.

Often correctional mental health staff arrive at the point where it seems to them that all prisoners in segregation units need to be severely restrained because their classification level shows they pose an imminent risk of harm to staff. Some do, but I find that most of the prisoners currently confined in supermax units are actually perfectly capable of having “contact visits” with clinicians and acting appropriately. I report that conclusion after investigating dozens of such units in many states and finding that only very rarely do I encounter a prisoner with whom I cannot safely sit down with for a face-to-face interview.

Security staff are very good at identifying that rare prisoner who poses a danger of assault during a contact visit, and they advise me not to meet with those few prisoners without officers present. In other words, one-size security does not fit all. When across-the-board security measures are designed to restrain the most disturbed, assaultive prisoner, then inevitably a large number of prisoners (all prisoners in the supermax who qualify for congregate programs) will be forced to endure what essentially constitutes excessive restraint for most of them. This has led some departments of corrections to construct a large number of therapeutic cubicles, which then led automatically to restraining all supermax prisoners in them whenever they are scheduled to see a clinician, individually or in group.

When prisoners are treated as if they are out of control (i.e., they are saddled with severe restraints, including programming cubicles), they feel demeaned and become angry about the way they are being treated. A self-fulfilling prophecy is thereby activated whereby they actually may become more disruptive and assaultive.⁹¹

Programming cells, as currently utilized in average practice, worsen two compelling problems with supermaximum, long-term isolative confinement: the “dead time” phenomenon, where the prisoner despairs of ever winning greater freedom and amenities, and the growing distance and alienation between prisoners and staff. As for the first of these problems, I advocate

90. Jeffrey Metzner, *The Use of Programming Cells in the Treatment of Seriously Mentally Ill Inmates in Supermax Prisons*, 13 CORRECTIONAL MENTAL HEALTH REP. 90 (2012).

91. Kate King et al., *Violence in the Supermax: A Self-Fulfilling Prophecy*, 88 PRISON J. 144, 161-63 (2008).

multiple, relatively short phases within any SHU term, wherein the prisoner can achieve incremental behavioral objectives and advance steadily in the quest to return to general population. “Dead time” is the opposite of this approach, a lengthy course of isolation and idleness with no opportunity for the prisoner to improve his plight. The resulting despair, of course, plays a major part in the shockingly high rate of suicide in segregation units. Programming cells have a less obvious but still highly destructive impact on staff perceptions, confirming the view that these are very dangerous prisoners who need to be handled very forcefully.

In the psychiatric literature on seclusion and restraint, guidelines require that all alternatives to more severe forms of restraint first must be tried and exhausted, and that the patient then needs to be placed in the least restrictive environment for the shortest time that will accomplish the maintenance of safety and permit the treatment to proceed.⁹² Of course adjustments need to be made for correctional milieus, but the psychiatric guidelines remain relevant. If this kind of restraint were possible in corrections, I would have no objection to the use of programming cubicles in very rare circumstances as a time-limited means to help a prisoner advance in the phase program toward greater freedom and amenities. In practice, I have not seen any department of corrections where use of programming cubicles is rare or short-term.

I find that the use of therapeutic modules or programming cubicles tends to exacerbate the distance and alienation between prisoners and staff in contemporary corrections.⁹³ Over several decades there has been a diminution of everyday interactions between prisoners and staff. At every level of security, compared to just a few decades ago, prisoners spend less time interacting with staff out of their cells and in public spaces within the facilities. For example, in the 1970s, even in a maximum-security prison, general population prisoners would exit their cells in the morning, spend most of their day at work or on the yard or in a dayroom, and would need to return to their cells only for count and to sleep. Today, many maximum-security general population cellblocks permit only four or five hours per day of non-work, out-of-cell time. At the same time, “lockdowns” have become commonplace, where cellblocks or entire prisons are locked down for months at a time. In that context, contact between prisoners and officers is relatively limited, often consisting only of officers

92. 104 MASS. CODE REG. 27.12 (LexisNexis, Lexis Advance through Nov. 21, 2014) (“Medication restraint, mechanical restraint, physical restraint or seclusion may be used only after the failure of less restrictive alternatives, including strategies identified in the individual crisis prevention plan, or after a determination that such alternatives would be inappropriate or ineffective under the circumstances, and may be used only for the purpose of preventing the continuation or renewal of such emergency condition.”); *see also* AM. PSYCHIATRIC ASS’N ET AL., VERMONT STATEWIDE STANDARDS: LEARNING FROM EACH OTHER, *available at* http://mentalhealth.vermont.gov/sites/dmh/files/CommitteesWorkgroups/Statewide_Standards/Learning_from_Each_Other.pdf.

93. Terry A. Kupers, *Programming Cells Are Neither the Problem nor the Solution*, 13 CORRECTIONAL MENTAL HEALTH REP. 83 (2012).

passing out food trays and ushering prisoners in restraints to and from activities. In many settings, officers have essentially forgotten (or never learned or practiced) how to interact with prisoners informally, and in too many cases they are actually frightened of interacting with prisoners. Is it any wonder that staff who once “walked the line” and chatted with their wards are now afraid to be in a room with prisoners who are not in total restraints? Unfortunately, when programming cubicles become a routine, across-the-board requirement, they serve to further distance staff from prisoners and worsen the growing problem of alienation.

F. *Malingering*

One of the obstacles to supplying adequate mental health treatment to many prisoners with serious illness, especially those who fit the description of “disturbed/disruptive,” is that clinical staff deem them malingerers or otherwise not bona fide psychiatric patients. Malingering, the exaggeration or feigning of symptoms for secondary gain, does occur.⁹⁴ But I also have seen in quite a large number of prisoners, whom I diagnosed with confidence, a very serious mental illness when local correctional mental health staff insisted they were “merely malingering” or that their behavior problems stemmed from an antisocial personality disorder. It is likely there are errors in both directions. It is possible I occasionally diagnose serious mental illness where the prisoner is merely malingering, and I am taken in.

It also is possible that correctional mental health staff, in their rush to diagnose malingering, miss cases of bona fide mental illness. The difference is extremely important in a courtroom context; whether a prisoner is incompetent to stand trial or merely malingering is a critical question. In the context of assessing potential admissions to a step-down mental health unit, I will make a bald assertion: We can mostly trump the entire issue of malingering by creating mental health programs where prisoners are required to learn precisely the things we think any prisoner would need to know in order to succeed at going straight after being released. In other words, we do not have to worry so much if prisoners exaggerate symptoms to some extent to get into the program (but remember, an individual with mental illness can also exaggerate symptoms or be manipulative, so it is usually not an either/or consideration); we want them to benefit from what the program offers even while they are trying to fool us about having a bona fide mental illness.

Of course correctional mental health staff do not want to let themselves be manipulated too much, or they will lose the respect of prisoners. It also is important to have a reasonable policy on prescribing medications with a “street value” in prison. Thus, malingering to get drugs must be carefully controlled.

94. CLINICAL ASSESSMENT OF MALINGERING AND DECEPTION (Richard Rogers ed., 1997); Kupers, *supra* note 66, at 81.

The most important aim of correctional programming, however, is to rehabilitate prisoners so they have a better chance at succeeding in non-criminal roles after release. If, hypothetically, a prisoner tries some version of faking to get out of a prison punishment and succeeds at the manipulation to the extent he is admitted to the step-down mental health treatment unit, then the upshot is that he has to learn to relate to other prisoners more peacefully in group therapy, has to take a class on being a good parent, or has to take part in some kind of educational or vocational preparatory program. Everyone wins. Even though victory is achieved with a little deception, the deceiver actually is playing ball with us in our plan to help him go straight. In other words, the more we make the aims of the step-down unit synonymous with the aims we have for “correcting” the unacceptable and self-destructive behaviors of prisoners, the less we need to worry that the wrong prisoners will be admitted as a result of their fakery.

I do not want to push this point too far. Of course there needs to be a rational disciplinary process in prisons, and we do not want to make the mental health step-down unit a haven for fakers. Within limits, however, I am suggesting that, by bringing the step-down unit interventions in line with the general aims of prison rehabilitation, we diminish the dangers of staff being fooled by prisoners who merely want to gain an easier housing and program situation.

I do not believe there are too many prisoners in mental health treatment (but probably there are some wrong prisoners in treatment). The mental health portion of the corrections budget is far too meager, on average. We know that a very large proportion of prisoners suffer from significant mental illness (a nuance: “significant” means requiring treatment, in contrast to the more specific “serious” mental illness). Thus, while it is the case that certain “inauthentic” patients get treatment that unfairly taxes the mental health budget, it also is the case that many prisoners with mental health issues justifying treatment do not receive any treatment at all or receive inadequate treatment. The difficult hat trick is to get the right prisoners into the right slots, and it requires clinician hours and competence to perform proper diagnosing and treatment planning. My idea is to reconfigure mental health budgeting so that rehabilitative programs that would accomplish positive purposes have less stringent admission mechanisms and thus, were an “inauthentic” prisoner to gain admission and in the process learn some skills that would prepare him better for post-release success, we would all say that the mental health bucks have been well-spent.

V. SOME GUIDING PRINCIPLES⁹⁵

As mentioned in Part V, I can offer eight guiding principles that inform the work of correctional mental health.

- Confine the prisoners in humane surroundings that would not be held unconstitutional in the face of competent legal challenge. In other words, improve conditions so they are humane and end all abuses that violate prisoners' Eighth Amendment right to remain free of "cruel and unusual punishment."
- Treat the prisoners with respect, and in a meaningful dialogue, both in and out of treatment, communicate to the prisoners that they will do better and be better people if they likewise treat the staff with respect. After all, a quality therapeutic relationship is the key to success in mental health treatment and for successful rehabilitation in corrections.
- Provide multi-modality therapeutic interventions. Individual psychotherapy is important wherein a trusting therapeutic relationship is fostered. Group therapy also is important, as are meaningful educational and vocational programs. The principles of modern psychiatric rehabilitation need to be applied robustly, and prisoners with and without mental illness need help preparing to succeed at "going straight."
- Emphasize rewards over punishments. This is such a long-established principle in psychology that it should need no explication. I often find it shocking how intent some (but certainly not all) custody staff and even mental health staff are about punishing prisoners for every infraction and how little need they feel to reward prisoners' positive behaviors and accomplishments. If the punitive attitude I too often discover on prison units were described to social psychologists studying therapeutic milieus, they would conclude that the punitive prison milieu is entirely counter-therapeutic. What all parties need to remind themselves of constantly is that prisoners are serving their sentence in prison as their punishment. They are deprived of their freedom, contact with loved ones, a life in the community, and so forth. They do not need to be further punished with inhumane conditions and brutal abuse. In the case of prisoners with serious mental illness residing in a mental health treatment unit, it is especially the case that a relative emphasis on rewards over punishments is a prerequisite to therapeutic success.
- When the prisoner with mental illness is in segregation or at a classification level that is restrictive in terms of freedoms and amenities, create very short and incremental phases whereby the prisoner can rapidly and continually earn increasing freedoms and

95. See Kupers, *supra* note 43.

amenities. The best of the correctional step-down mental health units I have toured contain many phases, each relatively brief, with advancement to the next phase very attainable with a change in behavior or attitude. The result, and the variable to measure in assessing success at behavior change, is the proportion of prisoners who are able to achieve each goal and move briskly through the stages of the program. A corollary is that long-term static conditions of deprivation should not be imposed on prisoners. Even prisoners consigned to segregation on account of unacceptable or assaultive behaviors should be given attainable goals to reach if they want to increase their freedom and amenities. Having no way to attain more freedom will almost certainly lead to despair and desperate acts; this is a major reason why disciplinary infractions occur so often in supermaximum segregation units and staff so frequently resort to the use of force. It also has much to do with the extraordinarily high rate of suicide in segregated housing units.

- Foster very close collaboration between custody and mental health staff. There is a very strong consensus in corrections about the need to foster cross-discipline custody and mental health staff collaboration. This is not easy to accomplish. It requires quite a lot of cross-training—security training for mental health staff and mental health training for custody staff. In some states, it runs afoul of civil service labor arrangements; for example, some union contracts make it difficult for custody staff with an interest in working with prisoners suffering from mental illness to successfully bid for jobs in the mental health unit. And there are concerns about confidentiality: should custody staff be permitted to know about prisoners' psychiatric issues, and how will their vow to maintain patient confidentiality float in an officer culture that frowns on special agreements involving select prisoners? These very reasonable debates need to be joined and resolved in the process of establishing step-down mental health units.
- Pay close attention to, and target in treatment plans, the context in which each individual prisoner is prone to get into disciplinary trouble. It also is important to identify the events that typically lead up to the trouble. Having studied the context and history of the disruptive behavior, the custody and mental health collaborative team can best design management and treatment plans that take into account this unique analysis in each prisoner's case. This is a strategy proposed by Hans Toch for the "disturbed/disruptive" prisoner.⁹⁶
- Discipline is handled in the context of a treatment plan by a collaborative treatment team. Many correctional systems require that hearing officers check with mental health staff prior to ruling on disciplinary infractions to make certain the unacceptable behavior is not driven by mental illness. Too often that process involves nothing

96. HANS TOCH & KEN ADAMS, *THE DISTURBED, VIOLENT OFFENDER* (1989).

more than a “rubber stamp,” with the mental health team responding that there is no reason this prisoner cannot be fully punished. The issue is not whether the behavior at issue is part of the individual’s mental illness or merely a “bad behavior.” I find that distinction very difficult to make when the prisoner suffers from schizophrenia, for example. Rather, the question needs to be how to manage the disruptive prisoner in a treatment context with a collaborative (mental health and custody staff) treatment team. Punishments can be meted, of course, but the disciplinary process occurs in a treatment context, where the entire team works with the prisoner to improve behavior and foster compliance with and continuity of treatment.

CONCLUSION

When it comes to the treatment of individuals with mental illness in correctional facilities, the central question is: “Who is the prisoner?” Is he or she a human being with feelings and rights? Or is the prisoner an animal who should be kept in a cage with no social interactions nor productive activities, and then sprayed with immobilizing gas as punishment for behaviors the prisoner with serious mental illness cannot control? The breakdown in policy is society-wide and involves more than funding for psychiatric hospitals and mental health clinics. I have written about society’s need to “disappear” prisoners behind bars and “lock them up and throw away the key” so that the average citizen does not have to see every day on the streets the harmful effects of dismantling the social welfare safety net.⁹⁷ But when prisoners with serious mental illness are warehoused in segregation cells, dosed with immobilizing gas, put into cages before they can meet with their counselor, and otherwise abused, their mental illness worsens, as does their prognosis and potential recidivism rate. I have summarized some approaches to mental health treatment that I believe would improve the situation. I have offered eight guiding principles for thinking about prisoners plagued with mental illness. But there has to be a larger change in attitude on the part of custody staff and mental health staff, as well as on the part of legislators and the public.

97. Kupers, *supra* note 12; see also Terry A. Kupers, *Isolated Confinement: Effective Method for Behavior Change or Punishment for Punishment’s Sake?*, in THE ROUTLEDGE HANDBOOK OF INTERNATIONAL CRIME AND JUSTICE STUDIES 213-32 (Bruce Arrigo & Heather Bersot eds., 2014).