

WHAT TO DO WITH THE SURVIVORS?



Coping With the Long-Term Effects of Isolated Confinement

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As a growing number of individuals suffering from serious mental illness are consigned to prison and selectively relegated to long-term isolated confinement, there is a newly expanded subpopulation of prisoners approaching their release from prison while exhibiting signs of mental illness and repeatedly violating rules. An attribution error and various forms of obfuscation divert attention from a cycle of longer stints in isolation and more rule-breaking behavior, until the time arrives to release the “disturbed/disruptive” prisoner. Since this subpopulation of prisoners is deemed dangerous, there is a crisis in the criminal justice system. There are attempts to solve the crisis by convicting the prisoner of additional crimes to extend prison tenure or by activating postincarceration civil commitment to a psychiatric hospital. These trends are examined, and the question is raised whether they address the core problems in the criminal justice system that result in more prisoners nearing their release dates essentially out of control behaviorally.

Keywords: prison; supermaximum security; disturbed/disruptive inmates; serious mental illness; correctional mental health; rehabilitation

There is a growing number of “disturbed/disruptive” prisoners (Toch, 1982) who, toward the end of their determinate prison sentences, remain in segregation or in intensive, high-security mental health units, where the staff are disinclined to grant them much time out of their cells or in congregate activities on account of safety concerns. These prisoners suffer from serious mental illness, and they have serious behavior problems, including rule violations and assaults. They are considered unpredictable and dangerous. These prisoners pose a difficult challenge to custody and mental health staff (Toch & Kupers, 2007). Given the fact that more than 93% of prisoners leave prison eventually, society faces a huge problem of resocializing individuals who, in prison, suffered from serious mental illness and spent an inordinate time in segregation. Sadly, many will not be successfully resocialized and will return to prison or be locked up on back wards of post-deinstitutionalization asylums (state psychiatric hospitals that are increasingly filled with forensic patients).

Some proponents of prison segregation claim we lack credible research proving there are lasting harmful effects when prisoners are consigned to isolated confinement for long periods of time (Metzner & Dvoskin, 2006). The research is not lacking. Rather, it is very clear from the research that has been done (Grassian & Friedman, 1986; Haney, 2003; Lovell, Johnson, & Cain, 2007; Rhodes, 2004; Toch, 1992)—as well as from the court-reported investigations of experts called on to assess the psychiatric effects of long-term supermaximum security confinement in the course of litigation (Kupers, 2006a, 2006b)—that for just

about all prisoners, being held in isolated confinement for longer than 3 months causes lasting emotional damage if not full-blown psychosis and functional disability. Thus, in an amicus brief in *Wilkinson v. Austin* (Amicus Brief to the Supreme Court of the United States, 2005), leading mental health experts summarized the extant literature on the effects of long-term isolated confinement:

Direct studies of solitary and solitary-like confinement reach consistent conclusions about the psychological stress that it creates for those persons subjected to it. The harm that has been measured in many published studies is serious—in some instances, serious enough to exacerbate pre-existing psychological disorders, in others contributing to the emergence of previously unrecognized or undiagnosed symptoms. Here, too, the documentation is consistent from different sources. (p. 14)

Scharff Smith (2006) provides a comprehensive review of the extant literature on the harm of prolonged isolated confinement.

AN ATTRIBUTION ERROR IN ASSESSING DISTURBED/DISRUPTIVE CAREERS

Social psychologists speak of attribution errors. Regarding the mass incarceration of people with mental illness, will we focus on the narrow question whether one or another such individual broke the law and was arrested, thus attributing the fact that so many individuals suffering from serious mental illness go to prison exclusively to bad behaviors on the part of a whole lot of individuals? Or will we ask why, at this point in history, so many people with serious mental illness wind up behind bars? As a society, we have opted to deinstitutionalize individuals with serious mental illness; we have opted to make successive cuts in public mental health and other social welfare programs; we have decimated the safety net that once provided housing and supported work opportunities for emotionally disabled people, leaving a disproportionate number of them homeless; we have declared a “war on drugs” and prolonged prison sentences for all manner of offenses. If we attribute the massive explosion of people with mental illness behind bars to individuals’ criminal inclinations, then the question we must address from a historical perspective is why we have so many disturbed criminals in our midst compared to the number in 1970, when the prison population was one tenth what it is today and the proportion with mental illness was smaller. But if we look at the successive social policy decisions and practices that led to the mass incarceration, or transinstitutionalization, of people suffering from serious mental illness, then we arrive at the ugly reality that our society has been “disappearing” psychiatrically disabled individuals into correctional settings for decades.

CREATING A PROBLEM AND BLAMING THE INDIVIDUALS HARMED BY IT

Similarly, we can explore the question of why, in prison, individuals suffering from serious mental illness spend so much time in isolation, where their behavior worsens. Are they merely expressing an innate badness that goes along with mental illness, or are they receiving

inadequate mental health care while being placed in situations where they cannot control their disturbed behavior? Why do so many prisoners with serious mental illness lose control of their behavior and wind up in long-term segregation or supermax confinement? In line with the previous argument, we could attribute the growing number of disturbed/disruptive prisoners in supermaximum security to an increased prevalence of the kind of serious mental illness that is associated with disruptive behaviors. But that is too facile. Epidemiological studies generally show that the prevalence of various forms of mental illness remains relatively constant over time, or if the prevalence rises, as in the case of bipolar disorder in the past few years, it is because our diagnostic conventions shift and we include individuals under that diagnostic rubric who would not have exhibited sufficient diagnostic criteria under previously stricter diagnostic requirements. It is simply much more logical to assume that the reason we find so many more disturbed/disruptive prisoners in long-term segregation and supermax units today is that the things we do to them in prison, including providing inadequate mental health services and locking them in isolation with no meaningful activities, worsens their mental illness and leads to their exhibiting uncontrollable behavior. In other words, the problem is, to a significant extent, iatrogenic. In the period from the 1970s to the present, we have massively overcrowded our prisons, reduced rehabilitation and education efforts, and consigned an unprecedented proportion of prisoners to long-term segregation. Furthermore, mental health treatment programs have not grown in step with the hugely increased number of prisoners with mental illness.

TWO FORMS OF OBFUSCATION

The clarity of the empirical evidence and the attribution error are often obfuscated by biased political discussions and by the tendency in correctional facilities to underdiagnose serious mental illness. I will say something about each of these two forms of obfuscation. First, consider the biased political discussions. If a male prisoner is released straight out of supermax isolated confinement into the community at the end of his prison term, and subsequently he resorts to drugs and commits a heinous crime, there are headlines and a knee-jerk response on the part of those calling for tougher sentencing. They milk the opportunity to publicly reassert their view that he is one of those incorrigible “psychopaths” or “super-predators” that should never have been released from captivity. Corrections departments wince and quickly retort that they had no choice—they had to release him because his prison sentence ran out. There is a rush to draft new sentencing legislation to keep such people behind bars. Meanwhile, little thought is given to the obvious failure of the Department of Corrections to “correct” the errant behaviors that led to this man’s long-term placement in segregation; there is no comment about the shortcomings in the provision of correctional mental health services, and there is almost no examination of the very predictable detrimental effects of releasing prisoners straight out of isolated confinement back into the community. The political discussion obfuscates the fact that long-term isolated confinement and a lack of prerelease planning cause harm. The political commentators blame the individual felon while leaving unexamined the ways the corrections system failed him and the many other ex-prisoners who may not elicit such dramatic headlines but have a very hard time adjusting to life after they are released from prison straight out of isolation.

Then, there is the underdiagnosis issue. A September 2006 report from the U.S. Bureau of Justice Statistics concludes, on the basis of questionnaires filled out by a large number of prisoners, that as many as 56% of state prisoners likely suffer from serious mental illness. In other words, their answers to questions match those by individuals known to suffer from serious mental illness. Sample questions are “Do you hear voices?” and “Do you think often of killing yourself?” (U.S. Bureau of Justice Statistics, 2006). A British team of researchers concludes that the prevalence of serious mental illness is 10 times higher in prison than in the community (Brugha et al., 2005).

If one runs the numbers, it becomes clear immediately that there are insufficient mental health services in our prisons to adequately treat even 10% to 12% of the 2.5 million prisoners in correctional facilities today. But if we make a very conservative estimate of a 30% prevalence of mental illness serious enough to require mental health treatment (remember, the Bureau of Justice Statistics pegged it at 56%), then the mental health services inside correctional systems would be overrun with disturbed patients needing treatment. In fact, in many states, in spite of a rapidly growing prison population and an expanding proportion of prisoners suffering from serious mental illness, the budget item for mental health treatment in the prisons has remained relatively flat or at least has not grown apace. The result is far too many potential patients for the oversubscribed and overworked mental health staff.

I believe that correctional mental health clinicians, on average, and without thinking about it in precisely this way, respond to the fact there is such a large number of prisoners with mental illness they cannot treat by underdiagnosing mental illness in the prisoners they see. If asked, these clinicians would express concern about malingering, or they would say they cannot get involved in deciding which of prisoners’ inappropriate behaviors and rule violations should be attributed to mental illness. But they never seem to ask themselves that if the true prevalence of significant mental illness is between 30% and 56% in the average prison, what is happening to all the prisoners in need of treatment who are not included among the 10% to 12% of the prison population who are on the mental health caseload?

UNDERSELLING MENTAL ILLNESS

Meanwhile, as a psychiatric expert in litigation and as a consultant, I see many individuals in segregation settings who are acutely psychotic, depressed, or suicidal, but they receive minimal or no mental health services, except of course those who are taking strong antipsychotic medications and those who repeatedly get transferred to suicide observation and back to their segregation cells (in other words, they recycle between segregation and observation). Often, after performing a chart review and briefly interviewing a prisoner in a supermaximum unit, I conclude that he suffers from schizophrenia, bipolar disorder, or recurrent major depressive disorder. For example, the individual may have been hospitalized two or three times in the community and repeatedly assigned a diagnosis of schizophrenia, he may have been awarded Social Security Total Disability based on that diagnosis, he may have been given that diagnosis in prison on several occasions, and he may have been prescribed antipsychotic medications with good effect. Yet when I look further in the chart, I discover that his diagnosis was inexplicably changed a year earlier, and since then he has been given a diagnosis of “no mental illness on Axis I.” If that kind of discrepancy between my review of a case and the diagnosis in the chart happened one or two times, I would write it off as “clinicians can

disagree.” But it turns out I have discovered this pattern of stark discrepancy about diagnosis in many different prisons in many different states. A large number of prisoners in segregation and supermaximum security settings in many states fit this picture to a tee. I review their charts and examine them and conclude they are suffering from serious mental illness, but the correctional mental health clinicians assigned to their unit write in the chart that they are malingering or suffering from no disorder on Axis I. Thus, the second obfuscating bias is the tendency in correctional settings for mental health clinicians to underdiagnose serious mental illness among inhabitants of isolation units. In other words, the clinicians decline to diagnose the mental disorders they lack the wherewithal to treat effectively.

I met Sam in a supermaximum segregation unit of a large prison. He had been prescribed strong antipsychotic, antidepressant, and anti-anxiety medications prior to his transfer to the segregation unit, and prior to being incarcerated he had been in a public psychiatric hospital and had been told he suffered from schizophrenia and would have to take medications for the remainder of his life. But his strong antipsychotic medications were stopped when he entered segregation. He told me that since the medications were stopped he had been hearing voices and talking to himself, and that recently a correctional officer gave him a ticket for talking to himself. He reported seeing people in the back of his cell who he knows aren't really there. He told me he believed the correctional officers put ideas in his head and made him do unspeakable things to them. He said he asked for medications over a month prior to our meeting, and the psychologist agreed he needs them, but as of our meeting he had still not seen the psychiatrist. With me, he exhibited a bizarre, flat stare, and he exhibited ideas of reference (paranoia) and strong first-rank symptoms (a set of signs indicating that an individual cannot discriminate between inner and outer reality, which is a strong indicator of active psychosis). He said he experiences command hallucinations that tell him to kill himself and to do some of the things he gets tickets for. His thin clinical chart contains the term “deferred” on the diagnosis line in one progress note, “Major Depressive Disorder” in another, and “Adjustment Disorder” in still another—in other words, his diagnoses shift, but the psychosis that is obvious to me remains undetected. But a few weeks prior to our meeting he had been noted to have suicidal ideation and was sent to an observation cell for 6 days before being returned to his supermaximum cell. There is a note in his chart that he feels hopeless and suicidal, but there is no treatment plan in the chart, and he has not been seen by a mental health clinician since being returned from an observation cell to a segregation cell.

When errors are made in diagnosis and prisoners with serious mental illness are condemned to long stints in isolated confinement with little or no mental health treatment, two things happen: Their mental condition deteriorates, and the evidence that they have been improperly assessed and treated is hidden from view. I have already commented about the first problem. Another telling and shocking statistic is that of all successful suicides in corrections, approximately half occur among the 6% to 8% of the prison population that is consigned to segregation at any given time. It is a sad reality that observation cells in prisons with supermaximum security units are usually disproportionately filled with transfers from segregation cells, and after the prisoners spend days or weeks in observation because staff are worried they might harm themselves, they are typically sent right back to their segregation cells where the stress will mount anew, and they are at risk of becoming part of the shocking statistic that as many as 50% of completed suicides occur among the much smaller proportion of prisoners in segregation at any given time.

Regarding the hiding of evidence, I am referring to the fact that if a prisoner suffering from schizophrenia is sent to segregation on account of a disciplinary ticket for breaking a

rule, and if the mental health staff erroneously determine that he does not suffer from a serious mental illness and he is denied treatment, and if his psychiatric condition deteriorates in segregation and he becomes louder and more out of control behaviorally, then his case will be viewed as a discipline problem and not a failed treatment of serious mental illness. He can hallucinate in his cell, obsess about secret plots and conspiracies to destroy him, repeatedly cut himself or smear feces, and once he has been “undiagnosed” (i.e., mental health staff have decreed that he suffers from no diagnosis on Axis I or that he is merely malingering or exhibiting a personality disorder), then all of these behaviors will be attributed to his badness, and he will not even be afforded a rigorous psychiatric assessment when his behaviors are obviously inappropriate and bizarre. Rather, on repeated 90-day segregation evaluations by mental health staff, the clinician making rounds and spending a minute or two at his cell front will not note sufficient signs and symptoms to change the diagnosis to a serious mental illness. (In a majority of states where I have reviewed required 90-day segregation evaluations, they are done at the cell front, and the mental health staff tells me custody staff are too busy to move each prisoner to an office for a confidential interview.)

Thus, there is a growing population of severely disturbed prisoners who spend inordinate time in segregation and become increasingly uncontrollable in terms of rule violations and assaultiveness. They are the “disturbed/disruptive” population that Hans Toch describes (Toch, 1992, 2008 [this issue]; Toch & Adams, 2002). How are we to explain the growth in the number of these individuals since the advent of the supermaximum security prison? Are there simply more of them in the criminal justice system? Is it a matter of more fetal alcohol syndrome, more toxic parenting, more brain-damaging drug use, more lifetimes of severe trauma, with the result being more serious and chronic mental illness and more behavior dyscontrol in a growing number of individuals? There are those who make this argument (e.g., Lykken, 2005); once they establish that there is a larger number of disturbed, incorrigible, and dangerous people, it is easy for them to blame such things as mounting prison violence, escalations in recidivism rates, and a growing rate of parole violation on the presence among us of a larger number of these very “bad” individuals. On the other hand, if it proves to be the case that, on average, the things we are doing to people in prison are making them more disturbed and more difficult to treat and rehabilitate, then the problems we are having helping ex-prisoners succeed at “going straight” after their release are caused by ill-advised practices in the criminal justice system. And if one decides to examine how what we do to people in prison makes some of them angrier and more disturbed, then the first obvious culprit is the wholesale warehousing of a growing subpopulation of prisoners in isolation.

BEWARE OF PRISONERS EXITING THE SHU

As long-term inhabitants of isolation units reach their release dates, the weaknesses in the system become apparent. There has been some research showing that supermax confinement does not reduce violence rates in prison (Briggs, Sundt, & Castellano, 2003). The unsolved problem with isolation is that, eventually, the isolated individuals have to be released. If they are released into the general prison population, there is often trouble. The anger that has been mounting during their stints in isolation causes many prisoners great difficulty controlling their tempers just after being released. The advent of supermaximum security isolation in the 1990s

was, to a large extent, a shift in policy that was motivated by the shockingly high prison violence rates of the 1980s. I have argued that a wrong turn occurred, and instead of halting prison overcrowding and the dismantling of many rehabilitation programs, correctional authorities turned instead to building more supermax isolation units for the “worst of the worst” (Kupers, 2008). The problem is always what to do with the prisoners thus designated when it comes time for them to exit the security housing unit (SHU).

In an early class action litigation (*Toussaint v. Enomoto*, 1984/1986), I toured the SHUs at San Quentin, a maximum-security prison (at that time) that contained the notorious Adjustment Center. I noted from documents provided during discovery that in the year prior to my investigation the entire prison had been locked down for 150 days—almost half the days of a year. A lockdown involves restricting all prisoners to their cells 24 hours per day and serving their meals in their cells—and this means all inhabitants of the prison, not only the ones in segregation. Meanwhile, the annual rate of violence inside San Quentin continued to be unacceptably high. But there was this pattern: During the lockdowns there was very little violence. Most of the prisoners were locked in their cells 24 hours per day, so there was little opportunity to attack anyone other than a cellmate. But then, in the days following the end of a lockdown, the violence rate shot up, eventually necessitating another lockdown.

This rather poignant phenomenon reminded me of psychiatry’s experience with suicide observation. Patients in psychiatric hospitals rarely kill themselves while they are in observation. The time to be careful about them is immediately after they are released from observation to the open psychiatric ward or just after they are discharged from the psychiatric facility. In other words, while locked in a room and while being closely observed, they do not try to harm themselves, but they think about it. Then, when they are released to the open ward or to their homes, they carry out the plans they had been quietly hatching while they were restrained from actually harming themselves. Likewise, during prison lockdowns, the prisoners think about harming someone, sometimes they even taunt and threaten their adversaries verbally while locked in their cells, but they cannot accomplish any assaults. But then, when the cell doors are opened, there is a high likelihood of bloodshed. The violence rate at San Quentin in the 1980s remained high in spite of the lockdowns because the violence rate is a matter of averaging all the assaults and deaths over a year’s time. If there are no assaults during lockdowns but the assault rate shoots up precipitously as soon as the lockdown ends, then the average violence rate remains very high.

There is an obvious parallel with the widespread utilization of long-term isolation and supermaximum confinement in modern prisons. Whether the prisoner leaves the isolation unit and gets into trouble on the yard or “maxes out of the SHU” and gets into trouble in the community, we are seeing a new population of prisoners who, on account of lengthy stints in isolation units, are not well prepared to return to a social milieu.

The advent of the supermaximum security unit is relatively recent, beginning in earnest only in the 1990s. Those early cases of recently released prisoners committing heinous crimes led to calls for debriefing prisoners in long-term segregation before they can be released. Thus, as they become “short” (nearing their fixed release date), they are transferred out of segregation to a prerelease program inside the prison so they will not max out of the SHU. Some of these prerelease programs are successful with some prisoners. The successes raise another interesting question: These prisoners are identified by corrections authorities as “the worst of the worst,” and while they are in supermax segregation they are only permitted out of their cells in cuffs and leg irons and must be accompanied by two or three officers. But then they are transferred to a prerelease program where there are no cuffs

and leg irons, and they participate in congregate activities with no officers accompanying them. Were they really not safe to be with other prisoners a day or two earlier when they were in supermax segregation? Or is there a certain amount of overkill in the supermax practice of making all inhabitants of the isolation unit wear the hardware and be escorted by beefed up security forces?

In any case, in contrast to the successful cases where a prerelease program is able to safely transition the supermax segregation inhabitant to the general population and then to the community when his release date arrives, there are a very significant number of disturbed/disruptive prisoners who do not traverse the journey as safely. They remain angry and out of control as their release dates arrive. In many jurisdictions, there are no prerelease programs to transfer them into, or recent disciplinary write-ups for one or another unacceptable behavior cause the classification staff to veto their transfer to a unit with congregate activities.

Departments of correction are very aware of this problem. Whether or not this is their stated purpose, they are responding to the problem in at least two ways: by bringing more outside cases and by seeking postrelease civil commitments. I will briefly discuss these two relatively recent developments.

A PROLIFERATION OF OUTSIDE CASES

One way to lessen the problem of releasing from their isolation cells angry prisoners who are not prepared for congregate activities is to keep them locked up for even longer terms. This happens every day in isolation units. Studies of prisoners in isolation find that the inhabitants of isolation cells must cope with mounting anger and that they often become very anxious lest they lose control of their mounting anger and receive further disciplinary sanctions, translating into longer stints in isolation. When a prisoner in isolation refuses an order, cuts himself, smears feces, or gets very angry at an officer, he is likely to receive a new disciplinary write-up and the result will be a longer stint in isolation. Since isolation itself causes anger to mount, the process becomes a vicious cycle—the prisoner becoming more angry and incapable of controlling his temper and the resulting disciplinary tickets leading to more time in the isolation setting that induces the angry behaviors.

The stint in isolation is a punishment meted out inside of prison by a hearing officer or hearing committee, and it usually does not affect the length of the prisoner's term in prison, except of course that while in isolation he does not earn "good time" and thus he does not get out of prison quite as early as he would were he in the general population earning such credits. Thus, a stint in isolation only indirectly affects the length of the sentence. But there is another procedure that directly affects the length of sentence and that is colloquially termed an "outside case." Not too long ago, officers would handle disciplinary problems inside prison by meting out punishments such as loss of privileges or time in "the hole." To get into segregation, a prisoner has to break rules inside prison. In the average case (there are variations from state to state and in the federal system), when a prisoner is being punished with a determinate sentence in segregation and his prison term runs out (he reaches his determinate release date), he will be released from segregation and from prison. In some states, if an offender is released with time remaining on his punitive segregation term, the next time he enters prison he will be returned to segregation to serve out that segregation term.

But with the advent of supermaximum security isolation, officers more often charge prisoners who "throw" (body waste) at an officer or who cause damage to an officer even in

the process of being “extracted” from a cell with a crime that will be prosecuted in court. Thus, the corrections officer files a charge against the prisoner, very often a prisoner already in isolation; the local district attorney prosecutes the new felony case; and a judge in the local court sits over the new felony trial. If the prisoner is convicted, for example, of assault on an officer, then many more years can be added to his sentence, which is all the more likely because he is a repeat offender. This is a relatively new development. More corrections staff are charging prisoners with outside cases based on violations and assaults that occur inside the prisons. As a result, prisoners in isolation are seeing their actual prison terms lengthened on account of actions they take inside isolation units. In some cases, the prisoner is correct in assuming that he will never get out of prison. This all-too-common scenario is an example of what I mean by “hiding the evidence.” I mentioned that mounting anger led the prisoner I described to swing on or throw at an officer. In fact, universally, prisoners in long-term isolated confinement report mounting anger (Grassian & Friedman, 1986; Haney, 2003; Scharff Smith, 2006).

POSTRELEASE CIVIL COMMITMENT

Another way prison authorities can avoid the problem of releasing disturbed/disruptive prisoners straight out of isolation into the community is to seek postrelease civil commitment to a psychiatric hospital, a procedure that is being instituted by new laws in many states. I will present an illustrative case:

A year ago, a distraught mother consulted me about her son, a California prisoner who was about to serve out his term but was slated for civil commitment under California’s mentally disordered offender (MDO) law. Other states also have equivalent statutes for postincarceration civil commitment. It turned out that her son, in his late 20s, had served 3 years in prison and during that time had developed a psychotic disorder. He was prescribed antipsychotic medications but often refused to take them. His inappropriate behaviors, including exposing himself to female staff, landed him in punitive segregation, where his psychiatric condition deteriorated further. The criteria for civil commitment under California’s MDO statute include (a) the prisoner has a “severe mental disorder”; (b) the mental disorder was a cause or aggravating factor in the commission of his offense; (c) the conviction was for a violent offense and the prison term was determinate; (d) the prisoner has been in treatment for the disorder for 90 days or more; and (e) psychologists or psychiatrists of the Department of Corrections and Rehabilitation and the Department of Mental Health certify that, because of the severe mental disorder, the prisoner poses a substantial danger of physical harm if released.

I reviewed the man’s clinical situation and told his mother that I did not advise challenging the MDO law and trying to have him released. I told her that he was noncompliant with treatment and was probably suffering the kinds of ill effects that individuals with serious mental illness suffer in isolated confinement, and that if she argued vociferously for his release and he then exposed himself while out in the community, he would be charged with a new felony offense. It would be better that he comply with the civil commitment proceeding for the time being, that she and the family influence him to comply with treatment in the state hospital where he would be sent, and that they work toward his speedy release once he takes part in social rehabilitation programming and attains remission. That is what she and he opted to do, and a year later he is in the community, functioning well and staying out of trouble.

I have serious qualms about postincarceration civil commitment in general (Kupers, 2007), but this man's immediate case did not provide a reasonable venue for testing my theory about the validity of the law.

Courts have not been receptive to the argument that postincarceration civil commitments constitute double jeopardy—that is, the prisoner has already served the sentence but is now to be twice punished with another term in custody, this second time on account of mental illness. The reasoning is that while civil commitment entails involuntary confinement, it is not punishment. Double jeopardy, then, is limited to “twice being punished” for the same conduct and not, shall we say, twice being confined.

There is, however, another level to the basic issue of fairness. Since more than 93% of prisoners eventually leave prison, the critical issue in corrections should be how well their prison experience prepares them to succeed at “going straight” once they are released. This is where the logic of tougher sentences falls apart, and the need for better treatment and rehabilitation programs becomes obvious.

We know from extensive research that prisoners suffering from serious mental illness fare very poorly when subjected to harsh conditions such as overcrowding or long stints in punitive segregation. They tend to suffer more serious decompensations or psychiatric breakdowns, or they tend to become suicidal. We know that individuals suffering from serious mental illness who do not receive adequate mental health treatment tend to deteriorate and have a much poorer prognosis than if they were adequately treated. We know that because of budget constraints and staff shortages, mental health care in prison is often suboptimal in many regards, in spite of conscientious efforts by many correctional clinicians to provide quality care. And we know there is a significant subpopulation of prisoners who suffer from serious mental illness but are considered “bad” and not “mad” due to clinicians' excessive concerns about malingering in prisoners seeking mental health care. Thus, many prisoners with serious mental illness do not receive adequate mental health care, suffer terribly from the effects of prison crowding, find their way into punitive segregation, and exhibit severe psychopathology as they reach a determinate date to leave prison. This is the population of disturbed/disruptive prisoners under discussion here. In this context, is it fair to de facto punish the prisoner by subjecting him or her to another sentence in a state mental hospital?

Consider the situation of a prisoner who meets criteria for postincarceration civil commitment. Assume that the system's mental health services were underfunded and lacked adequate treatment beds while he was incarcerated. Also assume that while imprisoned he spent a significant portion of his term in punitive segregation, and there the psychiatrist visited him only at the cell front. Then, if this not uncommon set of assumptions was the case, we must wonder what different outcome there could have been had he been provided higher quality mental health treatment, had the psychiatrist who prescribed his medications met with him relatively frequently in a private office setting, and instead of being relegated to segregation, had he been helped to take part in the social milieu and rehabilitation programs in the general population or in a “stepdown unit” (called residential treatment programs in some prisons, intermediate care programs in others) designed to provide more intensive mental health treatment and a modicum of safety to prisoners suffering from serious mental illness. Would he then have become noncompliant with medications? Would he have been considered “bad” and not “mad”? Would staff have consigned him to so much segregation time? And would his condition have deteriorated in a few years to the point where he became a candidate for postincarceration civil commitment?

IN CONCLUSION: AN INTERPRETATION OF POSTISOLATION MEASURES

Of course there is a subpopulation of disturbed/disruptive prisoners who, at the end of their determinate sentences, remain in segregation and pose a difficult challenge to custody and mental health staff. In my opinion, the problem is that departments of correction are relying too much on isolation as a solution to behavior problems and assaults within the prisons. The remedy, in this case isolation, is making the problem worse to the extent the harsh conditions of isolation and idleness predictably make prisoners more disturbed and disruptive, and then the failure of this foolhardy strategy for managing difficult prisoners only surfaces when the prisoners are released from isolation and get into further trouble in prison or in the community. Whether this is the conscious intention or not, the prosecution of more outside cases and the effort to secure postrelease civil commitments are designed to control the damage done by excessive isolation inside the prisons. In other words, if the prisoners who are broken by long stints in isolation and seem to pose a high risk of future turmoil remain locked up—for a longer prison term if an outside felony case has been prosecuted or for a stint in a locked psychiatric hospital if a civil commitment has been secured—then the danger of postisolation or postrelease behavior dyscontrol and aggression will appear to have been averted. But beneath the appearance, and while this strategy in a sense hides the evidence of human breakdown in isolation units, it certainly does not provide a fair, humane, or effective way to “correct” the errant path of the disturbed/disruptive offender.

NOTES

1. Litigation, including *Madrid v. Gomez* (1995) and *Jones 'El v. Berge* (2001), has resulted in the exclusion of prisoners with serious mental illness from supermaximum security confinement. But in many states, isolation units remain disproportionately filled with disturbed prisoners. And in states where death row is contained within supermaximum security settings, the prevalence of serious mental illness within segregation is alarmingly high.

2. This is called “maxing out of the SHU,” where *SHU* is the acronym for security housing unit utilized by the California Department of Corrections and Rehabilitation for its supermaximum security units.

3. Axis I is the slot in a diagnostic formulation for serious mental illness according to a convention in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (1994).

4. An exceptional situation worth noting is the instances in which male prisoners are double-celled during a lockdown or in segregation. Too often the rage that predictably mounts while the prisoners are isolated and idle leads to violence between cellmates.

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