

“Madness” and penal confinement: Some observations on mental illness and prison pain

Craig Haney

University of California Santa Cruz, USA

Punishment & Society

2017, Vol. 19(3) 310–326

© The Author(s) 2017

Reprints and permissions:

sagepub.co.uk/journalsPermissions.nav

DOI: 10.1177/1462474517705389

journals.sagepub.com/home/pun



Abstract

Unprecedented numbers of mentally ill persons are now housed in prisons and jails in the United States and elsewhere in the world. In many jurisdictions penal institutions have become the default placement for the mentally ill, in lieu of more humane and appropriate facilities in which to treat them. This article briefly reviews some of the causes of the unprecedented influx of the mentally ill into prisons and jails, examines the characteristics of these environments that render them singularly inappropriate placements in these cases, and discusses the various ways that the pains of imprisonment can exacerbate rather than alleviate various forms of mental illness and psychological vulnerability.

Keywords

mental illness, pains of imprisonment, prison overcrowding, solitary confinement

This article discusses a set of interrelated issues that pertain to the treatment of mentally ill persons housed in prisons throughout the United States and elsewhere in the world. I approach this topic from the perspective of someone who has been studying how people are changed and affected by prisons and prison-like environments for many years (e.g. Haney et al., 1973), including the degree to which certain conditions of confinement constitute violations of the prisoners' constitutional rights (*Brown v. Plata*, 2011; *Madrid v. Gomez*, 1995; *Ruiz v. Johnson*, 1999). I have necessarily focused over the years on the plight of the mentally ill in prison and on the nature and quality of mental health care provided in various prisons

Corresponding author:

Craig Haney, Social Sciences II, University of California Santa Cruz, Santa Cruz, CA 95064, USA.

Email: psylaw@ucsc.edu

and prison systems (e.g. Haney, 2006; Haney and Specter, 2001). The reason for this specialized focus is perhaps all too obvious. Correctional institutions have become the default placement for the mentally ill in the United States and many other parts of the world; it would be impossible (and irresponsible) to attempt to study the nature and consequences of prison life without acknowledging that a very large percentage of prisoners suffer from one or another form of what is commonly called “mental illness.”

The fact that there are presently about 10 times more identified mentally ill persons in prisons and jails in the United States than in mental hospitals (Torrey et al., 2014) is tragic for a number of reasons. But to get to the tragic crux of the matter, let me simply say that, if any one of us were challenged to devise an environment that was uniquely *ill suited* to address the needs of psychologically vulnerable persons—those formally diagnosed with mentally illness as well as the broader group of emotionally fragile persons or those who are especially prone to unstable behavior (perhaps as the result of an extensive history of trauma, severe forms of material or economic deprivation, or other background “risk factors” from which they have suffered)—we would be hard pressed to come up with anything worse than the modern American prison. Prisons are fraught with danger, dehumanization, and deprivation, and pervaded by all of the negative emotions that those things engender. They are the very antithesis of a treatment-oriented milieu that promotes openness, caring, and mutual concern.

Of course, there are better and worse prisons, and commentators are ill advised to discuss them as if they were all the same. In this article, however, I will address some of the core psychological dynamics that I have witnessed inside many prisons in the United States, ones that are relatively more common and generic because they inhere in the very structure and in the standard operating procedures of the institutions themselves. Prisons that have managed to avoid or minimize these dysfunctional and destructive dynamics have done so because their staff have acknowledged and taken effective steps to neutralize them but the malevolent forces remain dormant and ready to be activated whenever concerted efforts to oppose or hold them in abeyance them wane. Moreover, although I will concentrate my observations on conditions and practices that I have directly witnessed and analyzed in the United States, there is good reason to believe that the problems and issues that I will discuss are not limited to any one country (e.g. Almanzar et al., 2015; Andersen, 2004; Blaauw et al., 2000; Edgar and Rickford, 2009; Vandeveldt et al., 2011).

I believe that the combination of the sheer number of psychologically vulnerable prisoners who continue to be confined in penal institutions, the potential for adverse conditions of confinement to exacerbate their preexisting vulnerabilities, and the substandard mental health treatment that many of them receive while incarcerated represent a modern prison crisis. Although others have very thoughtfully discussed many aspects of this crisis (e.g. Fellner, 2006; Kupers, 1999), its magnitude still greatly exceeds the amount of public attention and critical scholarly commentary that it has received. Unless and until the plight of mentally ill

prisoners is adequately addressed, meaningful criminal justice reform—in the United States and elsewhere—will not be possible. In fact, these two systems—the prison and mental health systems—have become inextricably intertwined. As one commentator recently noted, “no discussion of community mental health in the United States is complete without consideration of the prevalence of mental illness within prisons and the policies that contribute to it” (Prins, 2014: 870).

The problem of the high concentration of the mentally ill in prison and the desperate circumstances that many of them confront once there is the product of a number of very problematic legal, social, and political trends that have developed over the last four decades, a period that has been termed the era of “mass incarceration” (e.g. Simon, 2012) and that I have characterized more evocatively as a “War on Prisoners” (Haney, 2012). Those trends include the decontextualization of criminality, which has greatly expanded the reach of the criminal justice system and removed consideration of what were once called “social factors” (including mental illness) from the sentencing calculus (e.g. Christie, 2000). A closely related trend has involved the increased criminalizing and punishing of deviance per se, which resulted in the deemphasis on and defunding of more benign alternatives to a whole range of social problems, including mental illness. The abandonment of the core rehabilitative function of “correctional” institutions in the 1970s, which legitimized the “warehousing” of prisoners and committed prisons unself-consciously to what Feeley and Simon (1992) called “waste management,” collectively meant that, among many other regrettable things, unprecedented numbers of mentally ill prisoners were confined in facilities that too often lacked the mandate or the resources with which to humanely address their needs. Tens of thousands of them are still there.

The consequences of these problematic trends are visible in cellblocks throughout the United States. In the worst prison systems in the country, mentally ill prisoners languish in squalor and in pain. This, despite the fact that the seriousness of the problems from which many mentally ill prisoners suffer cannot be overstated. Mentally ill prisoners typically have extensive trauma histories that include chronic poverty and deprivation, severe forms of emotional, physical, and sexual abuse, and abject neglect. A number of them have been hospitalized for mental health problems dating back to early childhood and been administered numerous psychotropic drugs throughout their lifetime. Many suffer from so-called co-occurring substance abuse disorders (e.g. Peters et al., 2015) that complicate their response to what prison systems commonly use as their default (indeed, often their only) form of mental health “treatment”—psychiatric medication. Some mentally ill prisoners have suffered the aftereffects of substandard, abusive care by shoddy mental health practitioners long before they entered prison or during prior incarcerations, and they are understandably wary and suspicious of even well-intentioned staff members.

Despite the complex treatment challenges they pose—as complex as any that clinicians face anywhere in free society—the mental health care they receive in prison is often marginal or even nonexistent. Rather than receiving treatment

from the most competent mental health professionals—persons with the very best training, the most sophisticated skills, and extensive experience commensurate with the complexity of the problems they will be expected to address in prison—mentally ill prisoners are still too often treated by understaffed, overworked, inexperienced, and insufficiently skilled mental health staff (many of whom lack the training and credentials to be employed in similar capacities *anywhere else but in prison*). Of course, this is not true of every prison system or correctional facility. Even in the worst facilities, there are notable, noble exceptions that include dedicated, highly skilled staff members. But the generalization about the overall quality of care in far too many prisons and jails remains unfortunately accurate. Moreover, even well-trained and dedicated mental health staff must work in and against punitive prison norms, counter-therapeutically structured environments, and long-standing correctional practices that undermine their ability to provide caring and effective treatment.

The prevalence and overlay of prison pain

There are a few caveats that should be made about my focus on mentally ill prisoners and assertion that their plight is at the center of a modern prison crisis. For one, no one should equate the prevalence of mental illness among prisoners—however high and unsettling those figures are—with the extent of mental suffering or harm that is being inflicted in or by a particular prison housing unit, prison facility, or prison system. The distinguished Norwegian criminologist Nils Christie (1981) once observed that the “core phenomena” within penal law—the penalties themselves—are easily forgotten by scholars, legal decision-makers, and members of the public. They are forgotten, in part, because compared to the “enormous wealth of detail and subtle distinctions” contained in books about criminal law and legal procedure, there is a “remarkable reservation” among authors against discussing what is at the very heart of the criminal justice system—the true nature of the *punishments* that the prison system imposes. That is, we are loath to describe “[h]ow the punishment hurts, how it feels, the suffering and the sorrow...” (p. 15). Thus, my focus on the plight of the mentally ill in prison should not be misinterpreted to suggest that the “suffering and the sorrow” of the great many other, nonmentally ill prisoners is not worthy of concern. Of course, it is.

In fact, I believe that a narrow legal view that only those prison conditions or forms of mistreatment that “cause” diagnosable forms of “mental illness” are sufficient to justify public outcry, scholarly commentary, or court intervention intended to alleviate the cruel and unusual punishment that results—has hampered attempts to address the full range and depth of damage that extremely harsh and severe or badly mismanaged prison environments can and do inflict. To take just one example, in an otherwise extremely thoughtful and detailed opinion that was highly critical of the conditions of solitary confinement and other abusive practices at the notorious “supermax” facility at California’s Pelican Bay State Prison, highly respected federal judge Thelton Henderson concluded that “*if* the particular conditions of segregation

being challenged are such that they inflict a serious mental illness, greatly exacerbate mental illness, or deprive inmates of their sanity, *then* defendants have deprived inmates of a basic necessity of human existence” (*Madrid v. Gomez*, 1995, at p. 1264, my emphasis). Later in the opinion, Judge Henderson tied the threshold of an Eighth Amendment or “cruel and unusual punishment” violation directly to this implicit “serious mental illness” standard, writing that

while the conditions in the SHU may press the outer bounds of what most humans can psychologically tolerate, the record does not satisfactorily demonstrate that there is *a sufficiently high risk to all inmates of incurring a serious mental illness* from exposure to conditions in the SHU to find that the conditions constitute a *per se* deprivation of a basic necessity of life. (*Madrid v. Gomez*, 1995, p. 1267, emphasis added)¹

In fact, as I will suggest, although diagnosable “mental illness” is an important and distinctive category of psychological vulnerability in prison, it is a more fluid category than often depicted and does not begin to encompass the extent of psychic pain and harm that adverse conditions of confinement can inflict. Like all of us, prisoners range along a continuum of psychological vulnerability, which sometimes manifests itself as diagnosable mental illness and sometimes not. Certain adverse conditions of confinement and forms of mistreatment nonetheless place prisoners at significant risk of serious harm—“risk” that represents a reasonable (not merely “remote”) possibility, and “harm” that entails not only pain but psychological damage (which includes but is not limited to the development or exacerbation of mental illness).

Estimating mental illness in U.S. prisons

Despite the inappropriateness of housing mentally ill persons in prisons, we know that there are unprecedented numbers of them confined there. Unfortunately, estimates of their *exact* number vary widely. In fact, the task of determining precisely how many mentally ill prisoners are housed in any given correctional facility or prison system is more challenging than it first appears. Although the examples that I will cite are based on data and studies from the United States, here, too, there is no reason that the issues and problems identified in this and the subsequent section of this article are uniquely American.

For example, in 2006 I summarized the then existing studies on the prevalence of mental illness in various prison and determined that, depending on how “mental illness” was defined and assessed, the estimates actually ranged from 12 to 43% (Haney, 2006: 250). The most recent Bureau of Justice Statistics report on the topic, published the same year that I summarized the range of estimates from individual studies, yielded a much higher figure. Specifically, James and Glaze (2006) relied on interviews conducted with a sample of more than 20,000 prisoners in state and federal prisons and local jails around the country. They found that an estimated 56% of state prisoners nationally reported suffering from “mental health

problems.”² This included nearly a quarter who were suffering from major depression and one in six (15.4%) with symptoms of psychosis (James and Glaze, 2006).

All other things being equal, proactive, direct assessments like the one James and Glaze oversaw, conducted with a properly drawn representative sample of prisoners, are likely to produce more accurate estimates of the prevalence of mental illness than official reports from correctional systems or facilities. There are several reasons why this is true. For one, there are general and long-standing concerns about the poor quality and reliability of the data collection undertaken by prison systems in general (e.g. National Research Council, 2014: 164–166). In addition, it is difficult to imagine a plausible scenario in which prison systems would be motivated to “over-detect” mental illness among their prisoner populations. Thus, prevalence estimates based primarily or exclusively on system-generated data are likely to consistently understate the magnitude of the problem. More importantly, mental health data in particular are susceptible to an obvious structural bias: their reliability varies as a function of the quality of the mental health care system that produces them. Poor prison mental health care systems typically lack adequate personnel and procedures with which to reliably detect mental illness among prisoners. Hence, the very worst systems are likely to significantly *undercount* their mentally ill prisoners.

With these things in mind, within the range of estimates based entirely on data sources coming from U.S. correctional systems themselves, those from California may be among the most reliable. This is because the groundwork for the litigation that resulted in the United States Supreme Court’s landmark decision in *Brown v. Plata* (2011) began decades ago, when the state legislature funded an especially careful system-wide study—a proactive, direct assessment with a representative sample of prisoners—intended to more accurately estimate the number of mentally ill prisoners who were housed in California’s prisons (Haney and Specter, 2001). When researchers returned with estimates that were not only significantly greater than had been previously thought but also far in excess of the prison system’s capacity to address the needs of this population, statewide litigation over unconstitutional levels of care soon followed (see *Coleman v. Gomez*, 1995).

Decades later, this litigation is still ongoing, even after the 2011 United States Supreme Court *Plata* decision acknowledged that the state’s mentally ill prisoners continued to suffer from a lack of constitutionally adequate care and ordered a drastic reduction in the overall prison population, so that the system could better meet their needs (*Brown v. Plata*, 2011). In the course of this decades-long litigation process, the reform of the prison mental health care system has been overseen by a federal district court, which implemented elaborate monitoring procedures to evaluate the quality of mental health care that is being delivered throughout the state’s very large prison system (that, at one time in this process, held nearly 200,000 prisoners). Thus, the recent report from the California system that more than 30% of its inmates are now on the mental health caseload (California Department of Corrections and Rehabilitation, 2016) appears to be as reliable an estimate of the number of state prisoners who are actually mentally ill as

exists, at least among those that are based on correctional system data alone. Yet, for reasons that I will discuss in the next section of this article, it too may be an underestimate.

The contested nature of “mental illness” in prison

The term “mental illness” denotes a complicated and contested set of concepts and categories. Broadly conceived, mental illness is not “disease” in any conventional sense. Instead, it encompasses an extremely wide range of disparate signs and symptoms of cognitive, emotional, and behavior disorder and dysfunction, most of which do not appear to have any precisely identifiable physical causes. This means that no definitive medical tests exist for the overwhelming majority of mental illnesses. Perhaps in part as a result, there is not always a high degree of reliability in specific diagnoses. Of course, none of that means that mental illness does not exist. Anyone who has encountered someone in the throes a serious mental illness such as schizophrenia or clinical depression knows better. Persons who experience mental illness suffer greatly as a result of their conditions. Their overall health and well-being are profoundly compromised, and their current and future social and psychological functioning can be severely undermined and impaired.

However, the complicated and contested nature of mental illness creates a number of special problems and challenges inside prisons, given the unique characteristics of most correctional settings where large numbers of prisoners who suffer from some form of mental illness must be accurately identified, effectively treated, and their conditions continuously monitored. There are several ways in which the unique nature of mental illness interacts with the special nature and norms of prison life to make reliable identification, the provision of caring treatment, and the implementation of conscientious, ongoing monitoring especially difficult.

For one, the diagnostic process in the case of mental illness entails more elements of social construction than most traditional forms of medical diagnosis. It is therefore more subject to influence by whatever powerful social forces may be operating in the social context in which it is conducted. In this instance, the process of applying an already contested set of categories in the highly contested space of prison is ripe for abuse. Diagnostic decisions in prison are freighted with implications about where prisoners can be housed, what kind of treatment services the prison is obligated to provide them, how frequently their psychiatric conditions must be formally monitored, and so on. Judgments about the acuity of a prisoner’s mental health problems carry enormous implications for the allocation of resources, and prison systems with too few treatment beds and inadequate mental health staff present clinical decision-makers with ethical dilemmas and built-in conflicts of interest. Those dilemmas and conflicts of interest include the fact that reaching particular psychiatric diagnoses, applying prison-specific codes that ostensibly reflect the seriousness or degree of prisoner’s mental health

impairment, or articulating (and documenting) treatment plans that set out clinically indicated courses of action may obligate mental health staff (and the prison systems for which they work) to a host of things they cannot provide.

At a different level, the fact that many of the signs and symptoms of mental illness are *nonobvious* has especially important consequences in the interpersonally fragmented, physically divided, and procedurally overcontrolled world of prison. Contrary to popular opinion (and contrary to beliefs I have heard widely expressed by many prison staff members) it is typically impossible to reliably tell whether or not someone is suffering from mental illness merely by looking at them. In fact, the most obvious signs—personal dishevelment, odd overt behavior or inappropriate emotional reactions, and incoherent speech—are manifested by only a portion of the persons who are in the throes of some (even serious) form of mental illness. Nonetheless, the dangerously incorrect inference abounds among prison staff (and even some mental health workers) that unless someone is outwardly manifesting one or another obvious sign, they are not suffering from mental illness or serious emotional distress. It is part of what allows correctional and mental health staff in some prisons to routinely conduct “cell-front monitoring” rounds in cellblocks in which they merely pass by prisoners’ cells and look in, or perfunctorily ask a superficial question or two, as if this constitutes a meaningful mental health observation, assessment, or contact.

This problem is compounded in places where there is little or no close or meaningful personal interaction between inmates and custody and other staff on a day-to-day basis. What little interaction does occur is typically mediated by bars and other physical barriers that limit the nature and quality of information conveyed. A lack of intimacy or authentic contact between the groups means that staff members are less likely to sense prisoner suffering or observe its subtler behavior manifestations. Indeed, the conditions and norms under which many correctional and mental health staff members must work are incompatible with or outwardly hostile toward any truly conscientious, sensitive mental health monitoring or treatment.

For correctional officers, the problem may begin with their expectations about the job for which they are being recruited. For example, here is the statement of “minimum qualifications” for the job of correctional officer posted on the Department of Corrections website in a Western state in the United States:

Willingness to: work unarmed among unrestricted offenders; work in a high-stress, hostile environment; withstand offender harassment, threats, and verbal abuse; deal with violence and break up fights; conduct body searches of offenders and visitors for contraband and weapons; work in confined spaces such as guard towers for entire shift; fire a weapon at an individual if necessary; physically restrain offenders; work in a disciplined, law enforcement environment and carry out orders; work shifts, weekends, holidays, and overtime.

Prison officials would face enormous difficulties training beginning correctional officers who originally applied to perform in such a job to ever function in

caring and effective ways around vulnerable mentally ill prisoners. The initial training that correctional officers in many jurisdictions receive does very little to remedy these problems (e.g. Conover, 2001; Jacobs and Cooperman, 2012; SpearIt, 2009).

Once on the job, the separation between prisoners and correctional staff is created and maintained by a host of practices and procedures, many of which “morally disengage” staff from the persons with whom they interact (Bandura, 2016; Haney, 2016). In extreme cases, these practices and procedures help to create what I have called “an ecology of cruelty” that engenders a “culture of harm” (Haney, 2008). Among other things, there is little or no genuine interpersonal trust or closeness that is or can be created inside many correctional facilities that are structured and run in these ways.

I am reminded of this every time I visit the supermax prison, SMU II, at Florence, Arizona. Everyone—including every correctional staff member, mental health worker, and visitor—who enters this high security prison, where many mentally ill prisoners are still housed, passes through a small building where their credentials are checked and they and their belongings scanned. However, the very last thing each of them sees before he or she moves inside the security perimeter of the prison is a very large, approximately 2' × 3' sign adjacent to the door that leads into the prison, that reads:

Staff/Inmate
Maintain Professional Distance
Do Not Cross the Line

Once inside, everyone—again, including every correctional officer and mental health staff worker—who actually goes into any of the housing units is required to wear a heavy protective vest and helmet with a full Plexiglas face shield, even though all of the prisoners are either safely locked inside their cells, or in shackles and overseen by several correctional officer escorts at all times.

These are stark and unmistakable reminders—verbal communications backed up by procedures and practices—of the rigid division that exists between staff and inmates (a division so important that staff must be reminded of it each day, as they enter the institution). The consistently and intensely enforced message is instilled into the correctional culture and undermines the development of empathy across groups.

Especially inside segregation, isolation, or “supermax” units, the staff’s limited insight into the mental health status of prisoners is compounded by the fact that prisoners are permitted to engage in so little actual behavior outside their cells that correctional and mental health staff members have few opportunities to clearly observe them or to identify changes in their normative or established day-to-day patterns. Unless a prisoner does something dramatic—stops eating or showering, refuses to come out of her cell for recreation, soils himself, or begins to flagrantly act out—the signs of a worsening mental health condition are likely to go

unnoticed. More subtle but more common symptoms of decompensation may be overlooked and thus recognized and responded to only after it is too late.

In addition, many persons who suffer from mental illness—both in prison and elsewhere—are unable to recognize that they are. Of course, this means that someone who is experiencing the signs and symptoms of mental illness often cannot “self-identify,” even if they wanted to. This obvious fact underscores the wrongheadedness of putting the onus on prisoners to ask for help or to proactively seek out mental health staff, and also why having mental health staff engage in a process of “monitoring” that entails merely asking prisoners, in a routine or pro forma way, “how are you feeling?” or “are you having any problems?” is unlikely to identify all but a small percentage of those prisoners who are suffering from even very serious symptoms of mentally illness. Yet, especially in badly run correctional mental health systems, this is the primary if not only form of detection and monitoring that occurs. Sadly, in a number of correctional facilities, these ill-conceived practices are employed not only by custody staff (if and when they engage in mental health monitoring at all), but also by mental health workers. Mental health rounds are notorious in such places—dubbed “drive-bys” by prisoners—because they entail staff briskly walking through a cellblock, barely stopping long enough for more than a cursory cell-front glance at those prisoners who are easily visible (and none at all for those who are not).

Moreover, given the strong disincentives that exist for prisoners to acknowledge weakness or vulnerability of any kind, there is perhaps no worse place to be labeled “mentally ill” than in prison. It diminishes prisoners in the eyes of their fellow inmates because, among other things, it is taken to imply that they are weak, cannot be relied on, or are necessarily allied with and overly dependent on the prison staff (from whom they now need treatment). In many prisons, mentally ill prisoners—sometimes because of their odd or annoying behavior, or because mental illness is interpreted as a sign of weakness, or sometimes simply as a result of their derogated status—become the targets of derision, exploitation, and abuse. This means that even when persons who are suffering from mental illness *do* become aware of their worsening condition—realize that they are in emotional pain, are losing control of themselves, or are becoming disoriented and unstable—they may still be reluctant to seek help, and suffer silently instead. Of course, conscientious and caring programs of mental health outreach and periodic assessments may help overcome the impediments that thwart the accurate identification of mentally ill prisoners. However, even when these programs are in place, estimates of the magnitude of prisoners’ mental health needs depend on self-report in an environment where there are strong disincentives against being forthcoming, mentally ill prisoners are very likely undercounted by prison staff.

It is also important to recognize that, as I noted earlier, the signs and symptoms of “mental illness” should be understood as being suffered and manifested variably, along a continuum. Although there are degrees of apparent psychiatric instability and disability, and persons who do not appear to be seriously mentally ill may still be suffering, such suffering may be a precursor to more serious forms of psychiatric

harm. In addition, people vary significantly not only in the degree to which they manifest symptoms of mental illness but also in the degree to which they are susceptible or “at risk” of suffering psychiatric disorders. In fact, especially given the extraordinarily stressful and counter-therapeutic nature of prison life, mildly or moderately emotionally distressed prisoners are always at risk of becoming more seriously disabled.

Thus, a prisoner’s mental health status can and does typically *vary over time*. Someone who is not currently seriously mentally ill may have been in the past—indeed, may have been hospitalized for their illness, been prescribed psychotropic medications over a long period of time, or may have suffered serious bouts of suicidality. They are at especially high risk, even if they do not currently present as such. Given the fact that there is such a strong disincentive against self-identifying as mentally ill in prison, it is critical that information about a prisoner’s psychiatric history be carefully documented and taken seriously by correctional and mental health staff—for example, factoring critically into decisions about in-prison housing assignments (such as isolation) and the kinds of mental health monitoring and treatment that each prisoner should be afforded.

Finally, it is important to recognize that “mental illness” is an *intrinsically psychological malady* and, for this reason, is especially sensitive to surrounding psychological and environmental conditions. People’s mental health status can deteriorate rapidly in stressful, hostile, or psychologically abusive settings. Especially adverse conditions of confinement and forms mistreatment in prison place all prisoners at risk, but particularly those who are or have been deemed mentally ill as well as those with a broader range of preexisting psychological and other vulnerabilities.

Punitive prisons, mentally ill prisoners, and isolation

The era of mass incarceration not only led to the unprecedented influx of prisoners—disproportionate numbers of whom were mentally ill—but also to increasingly negative forms of institutional control. As population pressures mounted, the use of harsh discipline and punishment escalated. In fact, the reliance on harsh mechanisms of institutional control, especially the overuse of segregation or solitary confinement, is still characteristic of many chronically overcrowded and understaffed prison systems. The apparent short-term expediency of punitive and administrative segregation comes at the expense of long-term negative consequences, especially for mentally ill prisoners.

Once the use of harsh and punitive policies and practices became the normative approach to maintaining order and control, custody staff became increasingly dependent on punishment and little else to attempt to manage prisoner behavior. As a result, correctional officers’ interpersonal skills atrophied in prison systems where it became customary for problems and conflicts to be met reflexively by “locking up” or “locking down” problematic or challenging prisoners (or doing the same with the entire housing units in which they resided). The severe “culture of

harm” (Haney, 2008) that is created in the worst of these places has an especially damaging effect on the mentally ill.

These practices can result in large number of mentally ill prisoners cycling back and forth between mainline prison housing and various forms of isolated confinement, a pattern that poses especially significant risks to their well-being. In many instances their long-term mental health is placed in grave jeopardy as a result. For some of them, their deterioration, decompensation, and even more serious consequences (in the form of self-harm and suicide) may prove irreversible (e.g. Kaba et al., 2014). As one commentator put it, “[p]erhaps no factor has been more tragically associated with jail and prison suicides” than placement inside “isolated/segregated housing of the jail or prison environment” (Bonner, 2000: 374). And yet, underscoring the degree to which a punitive mind-set now dominates over therapeutic perspectives in many correctional settings, note that acts of attempted suicide and self-harm are themselves often treated as disciplinary infractions, resulting in the placement (or retention) of suicidal inmates in segregated confinement as punishment for their “offense.” Prisoners who become suicidal while in segregation, because they cannot tolerate the painful suffering they experience there, are likely to find their term of isolation extended as a result.

There are several reasons why mentally ill prisoners who are placed in isolated confinement are particularly at risk. For one, these environments subject prisoners to significantly more stress and psychological pain on a day-to-day basis than other forms of imprisonment. Mentally ill prisoners are generally more sensitive and reactive to psychological stressors and emotional pain. In many ways, the harshness and severe levels of deprivation that are imposed on them in isolation are antithetical to the kind of benign and socially supportive atmosphere that mental health workers seek to create within genuinely therapeutic environments. Not surprisingly, mentally ill prisoners are more likely to deteriorate and decompensate when they are subjected to the punitive harshness and callousness that prevails inside the typical prison isolation unit.

Some of the deterioration and decompensation that mentally ill prisoners suffer in isolation results from the critically important role that social contact and social interaction play in maintaining psychological equilibrium. Social contact and social interaction are essential components in the creation and maintenance of normal social identity and social reality. Isolated prisoners have few if any opportunities to receive feedback about their feelings and beliefs, which become increasingly untethered from any normal social context. The absence of meaningful contacts with significant others and the lack of social comparison deprives prisoners of opportunities to evaluate the reasonableness of their thoughts, feelings, and actions. Thus, the experience of isolation is psychologically destabilizing because it undermines a person’s sense of self or social identity and erodes his connection to a shared social reality. As Cooke and Goldstein (1989) put it, social isolation allows persons to “confuse reality with their idiosyncratic beliefs and fantasies” and become more “likely to act upon such fantasies . . .” (p. 288). In extreme cases, a related pattern can emerge: isolated confinement becomes so painful, so bizarre,

and so impossible to make sense of that some prisoners create their own reality—they live in a world of fantasy instead of the intolerable one that surrounds them.

Finally, many of the direct negative psychological effects of isolation mimic or parallel specific symptoms of mental illness. Thus, the direct effects of isolation that are experienced in reaction to adverse conditions of confinement can add to and compound a mentally ill prisoner's outward manifestation of symptoms of their diagnosed mental illness, as well as the internal experience of their disorder. For example, many studies have documented the degree to which isolated confinement contributes to feelings of lethargy, hopelessness, and depression (e.g. Grassian, 1983; Haney, 2003; Kupers, 2008; Smith, 2006). For already clinically depressed prisoners, these acute situational effects are likely to exacerbate their preexisting chronic condition and lead to worsening of their depressed state. Similarly, the mood swings that some prisoners report experiencing in isolation can amplify the preexisting emotional instability that prisoners diagnosed with bipolar disorder suffer. Prisoners who suffer from disorders of impulse control likely find their preexisting condition aggravated by the frustration, irritability, and anger that many isolated prisoners in general report experiencing. And prisoners prone to psychotic breaks may suffer more in isolated confinement because they are denied the stabilizing influence of social feedback and opportunities to ground their internal reality in a stable and meaningful social world.

Not surprisingly, perhaps, courts in the United States that have actually seen and considered evidence that directly addresses the significant risk of serious harm that solitary confinement represents for mentally ill prisoners have all reached essentially the same conclusions about the impermissible dangers it poses. For example, Judge Thelton Henderson, whose landmark opinion in the *Madrid* case I quoted from earlier, noted that the category of prisoners for whom the psychological risks of isolated confinement were “particularly”—and unacceptably—high included anyone suffering from “overt paranoia, psychotic breaks with reality, or massive exacerbations of existing mental illness as a result of the conditions in [solitary confinement]” (*Madrid v. Gomez*, 1995: 1265). The judge elaborated, noting that the group of prisoners to be *excluded* from isolation should include:

[T]he already mentally ill, as well as persons with borderline personality disorders, brain damage or mental retardation, impulse-ridden personalities, or a history of prior psychiatric problems or chronic depression. For these inmates, placing them in [isolated confinement] is the mental equivalent of putting an asthmatic in a place with little air to breathe. The risk is high enough, and the consequences serious enough, that we have no hesitancy in finding that the risk is plainly “unreasonable.” (*Madrid v. Gomez*, 1995: 1265)

And yet, there are still a number of prison systems in the United States, and in some other countries, such as Canada (e.g. Office of the Correctional Investigator,

2015) where the ill-advised use of segregated confinement for mentally ill prisoners persists, sometimes with truly tragic consequences (e.g. Associated Press, 2016; Editorial, 2014).

Conclusion

In many parts of the world, and certainly in the United States, unprecedented numbers of mentally ill persons are housed in correctional institutions rather than in dedicated mental health facilities. In the still very overcrowded U.S. prison system, estimates of the percentage of prisoners who suffer from mental illness translate into somewhere between just under a half million to over three-quarters of a million.³ The potential for prison in general and for especially adverse conditions of confinement in particular to exacerbate preexisting psychological vulnerabilities, such as mental illness, is well known. The sheer number of mentally ill and otherwise vulnerable prisoners who are subjected to these conditions and the substandard mental health treatment that many of them continue to receive constitute what I have characterized as a modern prison crisis. I have suggested further that unless and until the plight of mentally ill prisoners is adequately addressed, meaningful criminal justice reform will not be possible.

The tendency to continue to confine mentally ill prisoners in solitary confinement is an especially problematic aspect of this crisis, at least in certain prison systems in the United States and elsewhere. When persons are deprived of normal social contact for extended periods of time they experience mental pain and suffering. They are also more susceptible to severe stress-related maladies and disorders and are subject to deterioration and dysfunction along a number of mental, emotional, and physical dimensions. In some instances, they are placed risk of even more serious harm, including the loss of their sanity and even their lives. The broad range of adverse effects that derive from social deprivation underscores the fundamental importance of meaningful social contact and interaction and, in essence, establishes them as identifiable human needs. Indeed, over the long term, meaningful social contact and interaction may be as essential to a person's psychological well-being as adequate food, clothing, and shelter are to his or her physical well-being. This appears to be true for prisoners in general, but, as I have said, it is especially true for mentally ill prisoners who are particularly vulnerable to the pains of isolated confinement and susceptible to its harmful effects.

Large numbers of seriously mentally ill prisoners continue languish for very long periods of time in prisons that are unsuited to house and treat them, including in extremely harsh segregation units that expose them to significant risk of serious psychological harm. Mentally ill inmates, especially, endure significant psychological stress and pain, and are placed in jeopardy of further deterioration and decompensation. The adverse psychological consequences of prison confinement can be severe, long lasting, even permanent and, in the case of the many mentally ill prisoners for whom the risk of suicide is intensified in isolation, fatal.

These are compelling reasons to drastically reduce the number of mentally ill persons sentenced to prison, to commit significant resources to the development of alternative and more benign approaches to the treatment of mental illness in society at large, to ensure that those mentally ill persons who are sentenced to prison receive adequate and even enhanced treatment during and after their incarceration (to compensate for the harsh and unhealthy conditions to which they are subjected), and to completely end the still too widespread practice of placing mentally ill prisoners in segregation.

Notes

1. Courts in the United States appear to be evolving on this issue. For example, see *Johnson v. Wetzel* [Civil Action No. 1:16-CV-893, United States District Court, Middle District of Pennsylvania, September 20, 2016] to the effect that “[t]he court rejects defendants’ contention that Mr. Johnson cannot attain relief until his condition devolves below some arbitrary threshold of mental illness” (p. 18).
2. “Mental health problems” were defined by James and Glaze (2006) as having—anytime within 12 months prior to being interviewed—either been given a clinical mental health diagnosis or received mental health treatment by a mental health professional or having suffered from DSM IV symptoms of a mental disorder.
3. According to the most recent BJS figures, there are 1,561,500 prisoners incarcerated in prisons in the United States (Carson, 2015). Although I have focused on prisons not jails, there are approximately three-quarters of a million persons housed in local U.S. jails (Minton and Zeng, 2015), many of which facilities are also overcrowded and, if anything, even more lacking in mental health resources. In addition, the prevalence rates for mental illness among jail inmates are, if anything, higher than in U.S. prisons (James and Glaze, 2006).

References

- Almanzar S, Katz C and Harry B (2015) Treatment of mentally ill offenders in nine developing Latin American countries. *Journal of the American Academy of Psychiatry and Law* 43: 340–349.
- Andersen H (2004) Mental health in prison populations: A review—with special emphasis on a study of Danish prisoners on remand. *Acta Psychiatrica Scandinavica* 110: 5–59.
- Associated Press (2016) DOC: Arizona prison inmate found unresponsive in cell dies. *Washington Times*, 20 July. Available at: <http://www.washingtontimes.com/news/2016/jul/20/doc-arizona-prison-inmate-found-unresponsive-in-ce/> (accessed 10 March 2017).
- Bandura A (2016) *Moral Disengagement: How People do Harm and Live with Themselves*. New York: Worth Publishers.
- Blaauw E, Roesch R and Kerkhof A (2000) Mental disorders in European prisons: Arrangements for mentally disordered prisoners in the prison systems of 13 European countries. *International Journal of Law and Psychiatry* 23: 649–663.

- Bonner R (2000) Correctional suicide prevention in the year 2000 and beyond. *Suicide and Life-Threatening Behavior* 30: 370–376.
- Brown v. Plata*, 131 S.Ct. 1910 (2011).
- California Department of Corrections and Rehabilitation (2016) *Reports, Monthly Archive; Coleman Monthly Reports (HC-POP-and MIS)*. Sacramento: California Department of Corrections and Rehabilitation.
- Carson E (2015) *Prisoners in 2014*. Bureau of Justice Statistics Special Report NCJ 248955. Washington, DC: Department of Justice.
- Christie N (1981) *Limits to Pain*. Oxford: Martin Robertson.
- Christie N (2000) *Crime Control as Industry*. 3rd edn. New York: Routledge.
- Coleman v. Gomez*, 912 F. Supp. 1282 (1995).
- Conover T (2001) *Newjack: Guarding Sing Sing*. New York: Random House Inc.
- Cooke M and Goldstein J (1989) Social isolation and violent behavior. *Forensic Reports* 2: 287–294.
- Edgar K and Rickford D (2009) Neglecting the mental health of prisoners. *International Journal of Prisoner Health* 5: 166–170.
- Editorial, Canada's overuse of solitary confinement shames us all, *Toronto Star*, 14 December 2014. Available at: https://www.thestar.com/opinion/editorials/2014/12/14/canadas_overuse_of_solitary_confinement_shames_us_all_editorial.html (accessed 10 March 2017).
- Feeley M and Simon J (1992) The new penology. *Criminology* 30: 449–473.
- Fellner J (2006) A conundrum for corrections, a tragedy for prisoners: Prisons as facilities for the mentally ill. *Washington University Journal of Law and Policy* 22: 135–144.
- Grassian S (1983) Psychopathological effects of solitary confinement. *American Journal of Psychiatry* 140: 1450–1454.
- Haney C (2003) Mental health issues in long-term solitary and 'supermax' confinement. *Crime and Delinquency* 49: 124–156.
- Haney C (2006) *Reforming Punishment: Psychological Limits to the Pains of Imprisonment*. Washington, DC: American Psychological Association Books.
- Haney C (2008) A culture of harm: Taming the dynamics of cruelty in supermax prisons. *Criminal Justice and Behavior* 35: 956–984.
- Haney C (2012) Politicizing crime and punishment: Redefining "justice" to fight the "war on prisoners.". *West Virginia Law Review* 114: 373–414.
- Haney C (2016) On structural evil: Disengaging from our moral selves. *PsycCRITIQUES* 61(8). Available at: <https://www.apa.org/pubs/highlights/psyccritiques-spotlight/PSQ-a0040160.pdf> (accessed 21 April 2017).
- Haney C, Banks C and Zimbardo P (1973) Interpersonal dynamics in a simulated prison. *International Journal of Criminology and Penology* 1: 69–97.
- Haney C and Specter D (2001) Vulnerable offenders and the law: Treatment rights in uncertain legal times. In: Ashford J, Sales B and Reid W (eds) *Treating Adult and Juvenile Offenders with Special Needs*. Washington, DC: American Psychological Association, pp. 51–79.

- Jacobs J and Cooperman K (2012) A proposed national corrections college. *New England Journal on Criminal and Civil Confinement* 38: 57–91.
- James D and Glaze L (2006) *Mental Health Problems of Prison and Jail Inmates*. Bureau of Justice Statistics Special Report NCJ 213600. Washington, DC: U.S. Department of Justice.
- Kaba F, Lewis A, Glowa-Kollisch S et al. (2014) Solitary confinement and risk of self-harm among jail inmates. *American Journal of Public Health* 104: 442–447.
- Kupers T (1999) *Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It*. New York: Jossey Bass.
- Kupers T (2008) What to do with the survivors? Coping with the long-term effects of isolated confinement. *Criminal Justice and Behavior* 35: 1005–1016.
- Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995).
- Minton T and Zeng Z (2015) *Jail Inmates at Midyear 2014*. Bureau of Justice Statistics Special Report. Washington, DC: Bureau of Justice Statistics.
- National Research Council (2014) *The Growth of Incarceration in the United States: Exploring Causes and Consequences*. Washington, DC: National Academies Press.
- Office of the Correctional Investigator (2015) *Administrative Segregation in Federal Corrections: 10 Year Trends*. Canada: Office of the Correctional Investigator.
- Peters R, Wexler H and Lurigio A (2015) Co-occurring substance use and mental disorders in the criminal justice system: A new frontier of clinical practice and research. *Psychiatric Rehabilitation Journal* 38: 1–6.
- Prins S (2014) Prevalence of mental illness in U.S. prisons: A systematic review. *Psychiatric Services* 65: 862–872.
- Ruiz v. Johnson*, 37 F. Supp. 2d 855 (S.D. Texas 1999).
- Simon J (2012) Mass incarceration: From social policy to social problem. In: Reitz K and Petersilia J (eds) *The Oxford Handbook of Sentencing and Corrections*. New York: Oxford University Press, pp. 23–52.
- Smith P (2006) The effects of solitary confinement on prison inmates: A brief history and review of the literature. In: Tonry M (ed.) *Crime and Justice*. Vol 34, Chicago, IL: University of Chicago Press, pp. 441–528.
- SpearIt (2009) Mental illness in prison: Inmate rehabilitation & correctional officers in crisis. *Berkeley Journal of Criminal Law* 14: 277–299.
- Torrey E, Zdanowicz M, Kennard A, et al. (2014) *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey*. Arlington, VA: Treatment Advocacy Center. Available at: <http://tacreports.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf> (accessed 10 March 2017).
- Vandeveld S, Soye V, Vander Beken T, et al. (2011) Mentally ill offenders in prison: The Belgian case. *International Journal of Law and Psychiatry* 34: 71–78.

Craig Haney, is Distinguished Professor of Psychology and VC Presidential Chair, 2015–2018, at the University of California, Santa Cruz.