Solitary Confinement and Mentally Ill Offenders

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The discovery of antipsychotic medicines in the 1950s has led to a paradigm shift in the world of mental health. The idea that treatment would be more effective if based within the community as opposed to within an institution (Barker, 2013), in addition to changes in funding, legislation, and police response models, lead to mass releases from psychiatric facilities (Reyes, 2014). As a result, law enforcement is now the first line of response in mental health situations (Reyes, 2014), as is evidenced by the fact that the nation’s top three mental health institutions are jails (Cook County Jail, Rikers Island, and Los Angeles County Jail). These facilities reflect the reality that approximately 10% of inmates in jail, 18% of inmates in state prison, and 16% of federal inmates experience symptoms of severe mental illness (Barker, 2013).

Prisons operate with safety as a main priority. They maintain the safety of society by incarcerating offenders. They have rules within the institutions meant to protect employees and inmates. Johnston (2013) asserts that inmates with severe mental illness are less able to adapt to life in prison and to conform to its rules, which results in more frequent and severe punishments. This is due to the nature of mental illness. An inmate suffering from a distorted perception of reality or behavioral control deficits as a result of mental illness cannot be held to the same standard of conduct as other inmates. Of the 80,000 members of the nation’s inmate population currently being held in some form of solitary confinement, a common form of punishment for rule infractions in prisons (Landau, 2014), it is estimated that 20% to 50% are mentally ill. This suggests that special considerations must be made to accommodate inmates with mental illness whose symptoms may be exacerbated by safety infractions.
We must look at how solitary confinement affects inmates who do not suffer from mental illness. Then, we will discuss the vulnerabilities of inmates who do suffer from mental illness when they are placed in solitary confinement. Lastly, we will examine the constitutionality of placing mentally ill offenders in solitary confinement.

Jack Henry Abbott, author of *In the Belly of the Beast*, recounts what solitary confinement is like for an inmate in prison:

A man is taken away from his experience of society, taken away from the experience of a living planet of living things, when he is sent to prison.

A man is taken away from other prisoners, from his experience of other people, when he is locked away in solitary confinement in the hole.

Every step of the way removes him from experience and narrows it down to only the experience of himself.

There is a *thing* called death and we have all seen it. It brings to an end a life, an individual living thing. When life ends, the living thing ceases to experience.

The *concept* of death is simple: it is when a living thing no longer entertains experience.

So when a man is taken farther and farther away from experience, he is being taken to his death.

(Abbot, 1981, p52-53)

Jack H. Abbott compares solitary confinement to a slow death. Human beings are social creatures and thrive when interacting with other human beings. When deprived of human interaction, the human psyche begins to break down. Many inmates who do not suffer from mental illness develop psychological symptoms from extended periods in solitary confinement (Landau, 2014; Kaba, et al, 2014; Johnston, 2013; Hafemeister and George, 2012). Inmates may experience hallucinations, depression, anxiety, confusion, loss of
sense of reality, heart palpitations, oversensitivity to stimuli, impaired concentration, dizziness, loss of appetite and weight, the development of personality disorders, and brain atrophy (Landau, 2014). Prisoners who have been in solitary confinement as little as one time are 6.9 times more likely to self-harm than other inmates (Kaba, et al, 2014).

Many of the psychological symptoms brought on by solitary confinement are regularly experienced by the mentally ill. It stands to reason that prolonged solitary confinement can exacerbate symptoms for the mentally ill offender. Johnston (2013) explains how those suffering from certain preexisting mental illnesses (schizophrenia, depression, borderline personality disorder, bipolar disorder) will be more vulnerable to the symptoms of their disorders without the protective factors offered by social interaction. One could theorize that an inmate with a history of psychotic episodes is placed in solitary confinement for an extended period of time with little to no social interaction. The inmate could lose touch with reality again due to lack of genuine environmental stimuli. The protective factors that encouraged accurate perception of reality (e.g. other people who verified or discredited the inmate’s perceptions) are no longer there.

With these factors in mind, is it unethical to place a mentally ill inmate in solitary confinement? Glidden and Rovner (2012) suggest that confining a mentally ill inmate in solitary confinement is a violation of disability rights statutes. Hafemeister and George (2012) suggest it is a violation of the inmate’s eighth amendment rights. The Americans with Disabilities Act prohibits “discrimination by public entities on the basis of disability” (Glidden & Rovner, 2012, p. 66) and the Rehabilitation Act prohibits “such discrimination by recipients of federal funding” (Glidden & Rovner, 2012, p. 66). A
disabled person is defined as someone having a “physical or mental impairment that substantially limits one or more…major life activities, has a record of such impairment, or is regarded as having such an impairment” (Glidden & Rovner, 2012, p. 66). A major life activity includes “learning, concentrating, thinking, and communicating, as well as the operation of neurological and brain functions” (Glidden & Rovner, 2012, p. 66). This means that an inmate with severe ADHD would qualify as having a disability, although behaviors that are symptoms of his disorder could be the instigating factors that lead to his isolation. Similarly, an inmate with violent hallucinations may be placed in isolation to protect him or other inmates from harm. So the disability he or she is experiencing is, in many cases, the leading cause of their isolation or their safety and the safety of others.

Discrimination constitutes the denial of any “services, programs, or activities that [an inmate] is qualified to receive” (Glidden & Rovner, 2012, p. 67); where the denial of such services is based on a disability. If a disability is the reason for isolation, then that isolation can be considered discriminatory because services are being denied to the inmate while in isolation. Hafemeister and George (2012) argue that the placement of a mentally ill inmate in solitary confinement is tantamount to cruel and unusual punishment under the eighth amendment “because this setting poses a significant risk to their basic level of mental health, a need as essential to human existence as other basic physical demands” (p. 35). In addition, solitary confinement “subjects them [mentally ill inmates] as a class to a substantial present and known risk of serious harm and constitutes deliberate indifference to their needs…” (Hafemeister and George 2012, p. 40).

As a result of recent class-action suits against several state and county jails and prisons across the nation, as well as the recent annual meeting of the American
Association for the Advancement of Science, renewed attention has been brought to the damaging effects of solitary confinement on all inmates but mentally ill inmates in particular (Landau, 2014). Several States including New York are reforming disciplining programs for special populations (Landau, 2014).
References


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