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## CALLOUS AND CRUEL

Use of Force against Inmates with Mental Disabilities  
in US Jails and Prisons



# **Callous and Cruel**

**Use of Force against Inmates with Mental Disabilities  
in US Jails and Prisons**

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Printed in the United States of America

ISBN: 978-1-6231-32415

Cover design by Rafael Jimenez

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MAY 2015

ISBN: 978-1-6231-32415

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## Summary

Across the United States, staff working in jails and prisons have used unnecessary, excessive, and even malicious force on prisoners with mental disabilities such as schizophrenia and bipolar disorder.

Corrections officials at times needlessly and punitively deluge them with chemical sprays; shock them with electric stun devices; strap them to chairs and beds for days on end; break their jaws, noses, ribs; or leave them with lacerations, second degree burns, deep bruises, and damaged internal organs. The violence can traumatize already vulnerable men and women, aggravating their symptoms and making future mental health treatment more difficult. In some cases, including several documented in this report, the use of force has caused or contributed to prisoners' deaths.

Prisons can be dangerous places, and staff are authorized to use force to protect safety and security. But under the US constitution and international human rights law, force against any prisoner (with mental disabilities or not) may be used only when—and to the extent—necessary as a last resort, and never as punishment.

As detailed in this report, staff at times have responded with violence when prisoners engage in behavior that is symptomatic of their mental health problems, even if it is minor and non-threatening misconduct such as urinating on the floor, using profane language, or banging on a cell door. They have used such force in the absence of any emergency, and without first making serious attempts to secure the inmate's compliance through other means. Force is also used when there is an immediate security need to control the inmate, but the amount of force used is excessive to the need, or continues after the inmate has been brought under control. When used in these ways, force constitutes abuse that cannot be squared with the fundamental human rights prohibition against torture or other cruel, inhuman, or degrading treatment or punishment. Unwarranted force also reflects the failure of correctional authorities to accommodate the needs of persons with mental disabilities.

There is no national data on the prevalence of staff use of force in the more than 5,000 jails and prisons in the United States. Experts consulted for this report say that the misuse of force against prisoners with mental health problems is widespread and may be

increasing. Among the reasons they cite are deficient mental health treatment in corrections facilities, inadequate policies to protect prisoners from unnecessary force, insufficient staff training and supervision, a lack of accountability for the misuse of force, and poor leadership.

It is well known that US prisons and jails have taken on the role of mental health facilities. This new role for them reflects, to a great extent, the limited availability of community-based outpatient and residential mental health programs and resources, and the lack of alternatives to incarceration for men and women with mental disabilities who have engaged in minor offenses.

According to one recent estimate, correctional facilities confine at least 360,000 men and women with serious conditions such as schizophrenia, bipolar disorder, and major depression. In a federal survey, 15 percent of state prisoners and 24 percent of jail inmates acknowledged symptoms of psychosis such as hallucinations or delusions.

What is less well known is that persons with mental disabilities who are behind bars are at heightened risk of physical mistreatment by staff. This report is the first examination of the use of force against inmates with mental disabilities in jails and prisons across the United States. It identifies policies and practices that lead to unwarranted force and includes recommendations for changes to end it.

### **Mental Disability and Misconduct**

Most jails and prisons are bleak and stressful places in which few prisoners are able to engage in productive, meaningful activities. Staff seek to ensure institutional safety and smooth operations through regimentation, control, and an insistence—backed up by discipline and force—on unquestioned, immediate prisoner obedience to rules and orders. Prison is challenging for everyone, but prisoners with mental disabilities may struggle more than others to adjust to the extraordinary stresses of incarceration, to follow the rules governing every aspect of life, and to respond promptly to staff orders. In the trenchant words of Professor Hans Toch, people with mental health problems behind bars can be “disturbed and disruptive,” “very troubled and extremely troublesome.”<sup>1</sup>

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<sup>1</sup> Hans Toch, “Humpty Dumpty in the Prison,” *Correctional Mental Health Report*, vol. 16, no. 4 (November/December 2014), p. 51.

Prisoners with mental disabilities misbehave and are sanctioned for disciplinary infractions at higher rates than other prisoners. Nationwide, among state prisoners, 58 percent of those who had a mental health problem had been charged with rule violations, compared to 43 percent of those without such problems.<sup>2</sup> In New York City, for example, inmates with mental health problems represent 40 percent of the jail population but are involved in 60 percent of all incidents of misconduct.<sup>3</sup>

Some prisoners with mental health conditions engage in symptomatic behavior that corrections staff find annoying, frightening, and provocative, or which, in some cases, can be dangerous. For example, they may refuse to follow orders to sit down, to come out of a cell, to stop screaming, to change their clothes, to take a shower, or to return a food tray. They may smear feces on themselves or engage in serious self-injury—slicing their arms, necks, bodies; swallowing razor blades, inserting pencils, paper clips, or other objects into their penises. Sometimes prisoners refuse to follow orders because hallucinations and delusions have impaired their connection with reality. An inmate may resist being taken from his cell because, for example, he thinks the officers want to harvest his organs or because she cannot distinguish the officer’s commands from what other voices in her head are telling her.

Correctional officers and jail deputies (also referred to as “security staff” or “custody staff” in this report) are rarely taught how to recognize the symptoms of mental illness and to understand how they can affect behavior. Custody staff are also rarely trained in and required to use verbal de-escalation techniques or to seek the intervention of mental health staff before resorting to force against inmates with mental disabilities. Force can be the staff response to misconduct even when it is symptomatic of a mental health condition, even when that condition prevents the prisoner from being able to comply with staff orders, and even when skilled verbal interventions might obviate the need for force.

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<sup>2</sup> Doris J. James and Lauren E. Glaze, Bureau of Justice Statistics, US Department of Justice, “Mental Health Problems of Prison and Jail Inmates,” September 2006, <http://www.bjs.gov/content/pub/pdf/mhppji.pdf> (accessed February 9, 2015), p. 10.

<sup>3</sup> Michael Winerip and Michael Schwartz, “Rikers: Where Mental Illness Meets Brutality in Jail,” *New York Times*, July 14, 2014, <http://www.nytimes.com/2014/07/14/nyregion/rikers-study-finds-prisoners-injured-by-employees.html> (accessed February 15, 2015).



## **Mental Health Services**

Many prisoners with mental disabilities are not receiving mental health treatment that could promote recovery, ameliorate distressing symptoms, and increase their skills and coping strategies to better handle the demands of life behind bars as well as, once they are released, life in the community. Deficiencies in correctional mental health services are pervasive across the country. Because of funding shortages and lack of political support, corrections agencies lack sufficient numbers of properly qualified mental health professionals.

Inmates are often not properly diagnosed, do not have timely access to mental health professionals, and do not receive care based on individualized treatment plans. Treatment is often limited to medication and typically does not include other effective therapeutic mental health interventions and psychiatric rehabilitation programs. In the absence of robust mental health services, some corrections agencies use solitary confinement and force as the default response to the behavioral symptoms of mental illness.

Inmates diagnosed with mental illness are disproportionately represented in the isolation units to which prison officials send their more difficult inmates. The harsh conditions of being held alone in a cell 23 hours or more a day with little or nothing to do, coupled with the paucity of mental health treatment characteristic of such units, can lead to an increase in symptoms, more episodes of psychosis, and further misconduct. Experts say that use of force is more common in solitary confinement units than elsewhere in correctional facilities.

## **Use of Force Policy and Practice**

Prison and jail staff interact with prisoners on a daily basis and around the clock. Some respond professionally and even with compassion and sensitivity to prisoners who have mental health problems, including when they are behaving erratically or breaking the rules. They may try to calm an agitated prisoner locked in his cell or give him time to “cool down.” They refrain from force unless there is no alternative.

Such responses, however, are unlikely absent carefully constructed and effective use of force policies, training programs, and supervisory and accountability systems. Even when policies clearly limit the use of force to situations in which serious danger is imminent or a significant disruption must be addressed, staff may turn much too quickly to force, use

more than is needed, or use it for punitive purposes. As evidenced in recent class-action litigation challenging the constitutionality of excessive use of force against prisoners with mental illness and Department of Justice investigations, patterns of unwarranted and abusive force, including against prisoners with mental health problems, arise from serious deficiencies in use of force policy and practice. Experts consulted for this report believe such deficiencies are widespread.

In jails and prisons across the country officials fail to ensure one or more of the following: sound and comprehensive use of force policies; effective training for and supervision of staff on the proper use of force; special provisions to protect prisoners with mental disabilities from unnecessary force; strict compliance with reporting policies; effective supervisory review of all use of force reports; thorough investigations of questionable use of force incidents; and meaningful disciplinary measures for staff who violate policies and procedures.

### **Abuse is Not Inevitable**

Corrections facilities differ significantly in their conditions of confinement and the degree to which inmates are treated with respect. The misuse of force is more likely in facilities that are overcrowded, have abysmal physical conditions, and lack educational, rehabilitative, and vocational programs for inmate. Force is also more likely where custody staff are too few in number relative to the number of prisoners, are poorly paid, are poorly trained in inter-personal skills and conflict resolution, or are poorly supervised.

In some facilities—for example the New York City jail on Rikers Island—a culture of violence has taken hold and persisted for decades. Staff have used force to assert their power and to punish prisoners who displeased, provoked, or annoyed them, and they have done so with impunity. The malicious infliction of pain became an affirmative strategy of control. In such facilities, even if senior officials did not condone the abuse, they took few steps to end it. They abdicated their responsibility to enforce use of force policies and to hold accountable staff who violate them.

Our research leaves no doubt that unwarranted or malicious use of force against men and women with mental disabilities is more prevalent in more violent facilities in which all prisoners are at heightened risk of abuse. It is more prevalent in facilities which rely on

force instead of mental health treatment to respond to rule-violating behavior that is symptomatic of a clinical condition. And it is more prevalent in poorly managed facilities: a badly run jail or prison will almost always have more instances of force against inmates, including those with mental disabilities, than one which is well-run.

An isolated instance of unnecessary force can occur in any correctional facility. But when corrections officials fail to establish and enforce a commitment to minimize the use of force, patterns of abuse can emerge. Good use of force policies in and of themselves are not enough to prevent such abuse. Effective leadership is required to ensure policies are reflected in practice. Leadership is essential in any institution, but is particularly important in jails and prisons because they are operated as hierarchical organizations subject to a quasi-militaristic chain of command and there is little external pressure for the humane treatment of prisoners. Without leadership determined to minimize the use of force and to promote prisoner well-being, the best use of force policies can be a dead letter.

Litigation cannot be counted on to ensure appropriate use of force policies and practices. When individual prisoners sue corrections agencies because of staff abuse, they typically seek monetary damages or protection for themselves as individuals and not facility-wide remedies that would require agencies to change their policies and practices. While a class action case may result in court ordered or court-approved protections for prisoners, such cases are enormously expensive, time-consuming, and rare. Moreover, even when the plaintiffs in a class action prevail or secure a desirable settlement agreement, it may take years and even decades before the mandated changes are fully implemented.

In addition to private litigation, the Department of Justice can also mount investigations and bring cases to protect prisoners from abuse. Pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997a, the Special Litigation Section of the Civil Rights Division of the US Department of Justice (Special Litigation Section) reviews conditions and practices in facilities, including but not limited to jails and prisons, in which people are institutionalized. It uses expert consultants to undertake comprehensive investigations, including onsite inspections, document reviews, and interviews with officials and prisoners. According to the Department of Justice website, if there are systematic civil rights violations, “we may send the state or local government a letter that describes the problems and that says what steps they must take to fix them. We will try to

reach an agreement with the state or local government on how to fix the problems. If we cannot agree, then the Attorney General may file a lawsuit in federal court.”<sup>4</sup>

The Department of Justice currently has 30 pending CRIPA matters involving practices in state or local correctional facilities (almost all of the cases address a single facility), some but not all of which involve the use of force. Important as the work of the Special Litigation Section is, it does not have the resources to address rights violations in even a tiny fraction of the thousands of local jails and state prisons in the country.

While private litigation and the Department of Justice have important roles to play to protect US prisoners, it is ultimately the responsibility of public officials to ensure that the men and women they confine, including those with mental disabilities, are treated humanely and with respect for their fundamental human rights. And it is the responsibility of elected officials to ensure that corrections agencies have the resources and political support they need to fulfill that mandate. The evidence marshaled in this report suggests that those responsibilities are too often ignored: prisoners with mental disabilities continue to suffer grievously and unnecessarily from the unwarranted and punitive use of force.

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<sup>4</sup> The United States Department of Justice, “Rights of Persons Confined to Jails and Prisons,” <http://www.justice.gov/crt/about/spl/corrections.php> (accessed April 1, 2015).

## Key Recommendations

At the end of this report we provide detailed recommendations. In brief, we urge federal, state, and local executive branch and legislative officials to:

- 1) Enact the Comprehensive Justice and Mental Health Act of 2015 in the U.S. Senate and House of Representatives (S. 993 in the Senate, HR 1854 in the House), and similar state and local legislation to increase collaboration among the criminal justice, juvenile justice, mental health treatment, and substance abuse systems. Such legislation should also support and authorize funding for programs and strategies to ensure appropriate interventions for persons with mental health problems at every stage of the criminal justice system.
- 2) Reduce the number of persons confined in prisons and jails who have mental disabilities including by increasing the availability of community mental health resources and access to criminal justice diversion programs.
- 3) Improve conditions in prisons and jails to provide all inmates with more humane and safe conditions of confinement.
- 4) End solitary confinement for persons with mental disabilities confined in jails and prisons.
- 5) Improve mental health services in prisons and jails by ensuring that there are sufficient numbers of qualified mental health professionals, adequate treatment resources, and levels of care that meet community standards.
- 6) Ensure that prisons and jails have sound use of force policies that are enforced through training, supervision, reviews, investigations, and holding staff accountable for violating the policies. Use of force policies should include provisions specifically addressing the unique needs and vulnerabilities of prisoners with mental disabilities.
- 7) Ensure that corrections agencies are led by officials committed to operating safe facilities in which all inmates, including those with mental disabilities, are treated with respect and in which unnecessary, excessive, or punitive use of force is not tolerated.

## Methodology

This report is based primarily on Human Rights Watch interviews, filings and judgments from recent court cases from across the United States and reports of investigations or complaints filed by the Special Litigation Section of the Civil Rights Division of the Department of Justice.

Beginning in March, 2014, we conducted interviews in person, by telephone, and by email with more than 125 current and former prison and jail officials, current and former correctional mental health professionals, use of force and mental health experts, lawyers, disability rights advocates and academics with relevant expertise. Many of the people we interviewed have firsthand knowledge of conditions in a large number of jurisdictions because they have served as monitors or experts in many federal, state and local facilities and agencies. Some of our interviews occurred during visits in July 2014 to the Washington State Department of Corrections headquarters and one of its prisons and to the Ada county jail in Boise Idaho.

The interviews provided invaluable information and insights into the nature, causes, and consequences of the use of force against prisoners with mental disabilities, and illuminated the difficult set of interrelated problems that play out in jails and prisons across the country. They also pointed toward necessary components of reform.

This report also draws on detailed information about the use of force against particular individuals or classes of individuals and about facility- or agency-wide use of force policies and practices that are revealed in documents filed and evidence presented during litigation. We reviewed thousands of pages of pleadings by plaintiffs and defendants, and evidence they have submitted to the courts (for example, deposition transcripts and expert reports), hearing transcripts, court decisions, and settlement agreements from recent cases. We present information from some of those cases to demonstrate the nature of the problems that our research suggests exist in many facilities across the country. The documents filed in federal cases to which we refer are publicly available on Public Access to Court Electronic Records (PACER), an electronic public access service that allows users to obtain case and docket information online (<https://www.pacer.gov>).

The report also draws on facts documented by the Special Litigation Section in recent investigations into patterns and practices of unnecessary, excessive, or malicious use of force in state prisons and local jails. The findings of and complaints filed by the Special Litigation Section are publically available on the Department of Justice website, <http://www.justice.gov/crt/about/spl/findsettle.php>.

Prisons and jails do not operate transparently. Most corrections agencies surround their operations with a wall of silence and, citing prisoners' privacy interests, refuse to discuss incidents involving individual prisoners. Information from court cases and detailed investigations by the Special Litigation Section offer invaluable descriptions and analyses of individual incidents and more widespread practices that would otherwise remain hidden to the public.

## **A Note on Terminology**

Although the term mental disability can embrace a wide range of conditions, including cognitive disabilities, in this report we use it solely to refer to mental health conditions such as bipolar disorder, schizophrenia, and depression that may cause intense distress, be accompanied by psychosis, or substantially interfere with or limit one or more major life activities.

The Convention on the Rights of Persons with Disabilities recognizes that disability is an evolving concept and that it results from the interaction between persons with impairments and social, cultural, attitudinal and environmental barriers that prevent their full and effective participation in society on an equal basis with others. The mental impairments that can lead to mental disabilities include psychological conditions commonly referred to in the United States—particularly by mental health professionals, courts, lawyers, corrections officials and the media—as mental illness or mental disorders. International disability rights advocates increasingly use the term “psycho-social disability” to emphasize that the disability reflects the interaction between an individual's psychological characteristics and society's response to them.

# I. Background

We have replaced the hospital bed with the jail cell, the homeless shelter and the coffin.

—Rep. Tim Murphy, R-PA<sup>5</sup>

## Disproportionate Representation of Individuals with Mental Disabilities in Jails and Prisons

Persons with mental disabilities are heavily and disproportionately represented in US jails and prisons. In 2003, Human Rights Watch estimated there were 300,000 men and women with mental illness in US jails and prisons.<sup>6</sup> The Treatment Advocacy Center recently estimated there were 356,000 persons with mental illness behind bars.<sup>7</sup> Jails and prisons in the United States are *de facto* mental health facilities, housing three times as many individuals with mental health problems as do state mental hospitals.<sup>8</sup>

An estimated 4.1 percent of adults aged 18 or older in the United States has a “serious mental illness.”<sup>9</sup> By contrast, “studies and clinical experience indicate that somewhere between 8 and 19 percent of prisoners have significant psychiatric or functional disabilities and another 15 to 20 percent will require some form of psychiatric intervention during their incarceration.”<sup>10</sup> In a federal survey conducted in 2011-2012, an estimated

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<sup>5</sup> Liz Szabo, “Cost of not caring: Nowhere to go,” *USA Today*, May 12, 2014, <http://www.usatoday.com/longform/news/nation/2014/05/12/mental-health-system-crisis/7746535/> (accessed February 10, 2015).

<sup>6</sup> Human Rights Watch, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, October 22, 2003, <http://www.hrw.org/reports/2003/usa1003/usa1003.pdf>.

<sup>7</sup> E. Fuller Torrey et al., Treatment Advocacy Center, “More Mentally Ill Persons are in Jails and Prisons than Hospitals: A Survey of the States,” May 2010, [http://www.treatmentadvocacycenter.org/storage/documents/final\\_jails\\_v\\_hospitals\\_study.pdf](http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf) (accessed February 10, 2015); Human Rights Watch, *Ill-Equipped*, <http://www.hrw.org/reports/2003/usa1003/usa1003.pdf>, pp.16-19.

<sup>8</sup> *Ibid.*

<sup>9</sup> National Institute of Mental Health, “Any Mental Illness (AMI) Among Adults,” <http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml> (accessed February 10, 2015) (serious mental illness defined as a mental disorder with serious functional impairment which substantially interferes with and limits one or more major life activities). See also, National Alliance on Mental Illness (NAMI), “Mental Illness Facts and Numbers,” [http://www.nami.org/factsheets/mentalillness\\_factsheet.pdf](http://www.nami.org/factsheets/mentalillness_factsheet.pdf) (accessed February 15, 2015).

<sup>10</sup> Jeffrey L. Metzner et al., “Treatment in Jails and Prisons,” in Robert M. Wittstein, ed., *Treatment of Offenders with Mental Disorders* (New York: The Guilford Press, 1998), p. 211. See also David Lovell et al., “Evaluating the Effectiveness of Residential Treatment for prisoners with Mental Illness,” *Criminal Justice and Behavior*, vol. 28 (February 2011), p. 83-104 (reviews of clinical studies indicate 10-15 percent of inmates in state prisons have serious mental illness).



36.6 percent of prison inmates and 43.7 percent of jail inmates reported they had been told by a mental health professional they had a mental health disorder, and 8.9 percent of prisoners and 12.8 percent of jail inmates reported an overnight stay in a hospital or other mental health facility prior to their current incarceration.<sup>11</sup> In an earlier federal survey, over a third of state and jail prisoners reported major depressive or mania symptoms and approximately 24 percent of state inmates, 15 percent of federal inmates, and 24 percent of jail inmates reported symptoms of psychosis, (delusions or hallucinations).<sup>12</sup>

The National Commission on Correctional Health Care has estimated that on any given day “between 2.3 and 3.9 percent of inmates in State prisons are estimated to have schizophrenia or other psychotic disorder, between 13.1 and 18.6 percent major depression, and between 2.1 and 4.3 percent bipolar disorder (manic episode.)”<sup>13</sup> The American Psychiatric Association has estimated that up to 5 percent of prisoners are actively psychotic at any given moment.<sup>14</sup>

In specific correctional systems the proportion of individuals in the jail or prison population diagnosed with a mental illness or who are on the mental health caseload may range from 20 to nearly 40 percent.<sup>15</sup> Among jails, for example, the proportion in New York City’s Rikers Island is 40 percent;<sup>16</sup> in Dallas County, 20 percent;<sup>17</sup> and in California’s jails,

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<sup>11</sup> Allen J. Beck et al., Bureau of Justice Statistics, US Department of Justice, “Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-2012,” Table 14, May 2013, <http://www.bjs.gov/content/pub/pdf/svpjri1112.pdf> (accessed March 25, 2015), p. 24. Nearly 15 percent of state and federal prisoners and 26 percent of jail inmates had symptoms of serious psychological distress. *Ibid.*, p. 25.

<sup>12</sup> Doris J. James and Lauren E. Glaze, Bureau of Justice Statistics, US Department of Justice, “Mental Health Problems of Prison and Jail Inmates,” September 2006, <http://www.bjs.gov/content/pub/pdf/mhppji.pdf> (accessed February 9, 2015).

<sup>13</sup> National Commission on Correctional Health Care, “The Health Status of Soon-to-be Released Inmates, A Report to Congress,” March 2002, <https://www.ncjrs.gov/pdffiles1/nij/grants/189735.pdf> (accessed March 11, 2015), vol. 1, p. 22.

<sup>14</sup> American Psychiatric Association, *Psychiatric Services in Jails and Prisons*, 2nd Ed. (Washington, DC: American Psychiatric Association, 2000), p. xix.

<sup>15</sup> The prevalence of mental illness within individual facilities or agencies will vary depending on a variety of factors, including the quality of the community mental health system, police practices, the degree of poverty in the community, and the availability of beds in mental health hospitals. Caution should be exercised in comparing prevalence across facilities or states: the accuracy of the prevalence data depends greatly on the thoroughness, frequency, and accuracy of mental health screening and diagnoses in individual facilities and agencies.

<sup>16</sup> Michael Winerip and Michael Schwartz, “Rikers: Where Mental Illness Meets Brutality in Jail,” *New York Times*, July 14, 2014, <http://www.nytimes.com/2014/07/14/nyregion/rikers-study-finds-prisoners-injured-by-employees.html> (accessed February 15, 2015).

<sup>17</sup> Human Rights Watch telephone interview with Waseem Ahmed, M.D. and Medical Director, Dallas County Correctional Health Services, Dallas, Texas, April 27, 2014.

23 percent.<sup>18</sup> Among state prison systems, in Indiana the figure is 22 percent; in Iowa, 41 percent;<sup>19</sup> in South Carolina, 17 percent;<sup>20</sup> and in California, 28 percent.<sup>21</sup>

The reasons for the disproportionate incarceration of persons with mental disabilities include: the closure of so many public psychiatric hospitals following de-institutionalization—the movement of persons with mental illness out of the hospitals in which they had been involuntarily confined—that some communities now lack sufficient beds for voluntary inpatient treatment; the lack of sufficient community-based voluntary outpatient and residential treatment programs; aggressive policing of minor crimes, including drug crimes; and the lack of programs to divert people with mental disabilities who commit minor offenses from the criminal justice system.<sup>22</sup> States continue to reduce the number of mental hospital beds and cut funding for inpatient and outpatient mental health care.<sup>23</sup>

Unless they have significant personal or family financial resources or comprehensive health insurance policies, people with psycho-social disabilities in the United States may

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<sup>18</sup> Email from David Lovell, Board of State and Community Corrections, Sacramento, California, to Human Rights Watch, July 29, 2014, on file at Human Rights Watch.

<sup>19</sup> Iowa Department of Corrections, “Seriousness/Acuity of Mentally Ill Offenders in Prison, Data Download,” July 2009, <http://www.doc.state.ia.us/UploadedDocument/475> (accessed March 2, 2015).

<sup>20</sup> *T.R. et al. v. South Carolina Department of Corrections*, case no. 2005-40-2925, slip op. (S. Car. Court of Common Pleas, Jan. 8, 2014).

<sup>21</sup> *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Order, filed April 10, 2014, p.4.

<sup>22</sup> See Human Rights Watch, *Ill-Equipped*, <http://www.hrw.org/reports/2003/usa1003/usa1003.pdf>, for a more detailed overview of the reasons for high rates of incarceration of persons living with mental illness. For discussion of diversion, see generally, Substance Abuse and Mental Health Services Administration GAINS Center for Behavioral Health and Justice Transformation, “Jail Diversion,” [http://gainscenter.samhsa.gov/topical\\_resources/jail.asp](http://gainscenter.samhsa.gov/topical_resources/jail.asp) (accessed March 25, 2015); Bazelon Center for Mental Health Law, “Diversion from Incarceration and Re-entry,” <http://www.bazelon.org/Where-We-Stand/Access-to-Services/Diversion-from-Incarceration-and-Reentry-.aspx> (accessed March 25, 2015).

<sup>23</sup> From 2009-2012, states cut \$5 billion in mental health services and eliminated 4,500 public psychiatric hospital beds. Szabo, “Cost of not caring: nowhere to go,” *USA Today*, <http://www.usatoday.com/longform/news/nation/2014/05/12/mental-health-system-crisis/7746535/>. Individual states have had dramatic cuts: for example, between 1987 and 2003, Michigan closed three quarters of its 16 state psychiatric hospitals. Jeff Gerritt, “Mentally ill get punishment instead of treatment,” *Detroit Free Press*, February 5, 2012, <http://archive.freep.com/article/20120205/OPINION02/202050442/PUNISHMENT-INSTEAD-OF-TREATMENT-Hundreds-of-Michigan-s-mentally-ill-inmates-languish-in-solitary-confinement-lost-in-a-prison-system-ill-equipped-to-treat-them> (accessed March 11, 2015). Illinois closed 6 of its 12 community health centers in 2012. Adults without insurance can turn to one of the six remaining clinics, but may have to travel long distances and face high out of pocket costs. Even with private insurance, individuals may have to wait many weeks or months to see a psychiatrist. Bridget Kuehn, “Criminal Justice Becomes Front Line for Mental Health Care,” *JAMA: The Journal of the American Medical Association*, vol. 311, no. 19 (2014), p. 1953.

get little or no care.<sup>24</sup> Some use drugs, and end up arrested for buying or selling them.<sup>25</sup> Untreated or undertreated, some end up in a mental health crisis and engage in disorderly or unlawful behavior that leads to police intervention. Unless police have the skills and training to identify psychiatric crises, and have alternatives to incarceration in their jurisdiction such as access to emergency care facilities or criminal justice diversion programs, officers may simply arrest and book these individuals in jail, unaware of or ignoring the role that mental illness played in the suspects' conduct.

## Mental Disabilities

People in US jails and prisons have the full range of mental health conditions present in the community. Some have mental disorders, defined by the American Psychiatric Association as “a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities.”<sup>26</sup>

In this report we use the term mental disability to refer to mental disorders or illnesses (the terms are used interchangeably in the United States) such as such as bipolar disorder, schizophrenia, and depression that may cause intense distress, be accompanied by psychosis, or substantially interfere with or limit one or more major life

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<sup>24</sup> Nearly 40 percent of adults with severe mental illness such as schizophrenia or bipolar disorder received no treatment in the previous year. Data from 2012 National Survey on Drug Use and Health, cited in Johnson, “Mental Illness Cases Swamp Criminal Justice System,” *USA Today*, <http://www.usatoday.com/story/news/nation/2014/07/21/mental-illness-law-enforcement-cost-of-not-caring/9951239/>.

<sup>25</sup> Individuals with mental health problems often have co-occurring substance abuse problems. See generally, Substance Abuse and Mental Health Services Administration, “Co-Occurring Disorders,” <http://www.samhsa.gov/co-occurring> (accessed March 25, 2015).

<sup>26</sup> American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Washington, DC: American Psychiatric Association, 2013), p. 20. The latest Diagnostic and Statistical Manual of Mental Disorders, commonly referred to as the DSM-5, presents diagnostic criteria for 28 categories of mental disorders, many of which have subcategories. Categories include neurodevelopmental disorders, schizophrenia spectrum and other psychotic disorders, bipolar and related disorders, depressive disorders, personality disorders, and neurocognitive disorders. Individuals can have symptoms that cross different categories and subcategories. According to the DSM-5, “The symptoms contained in the respective diagnostic criteria sets do not constitute comprehensive definitions of underlying disorders, which encompass cognitive, emotional, behavioral and physiological processes... Rather, they are intended to summarize characteristic syndromes of signs and symptoms that point to an underlying disorder with a characteristic developmental history, biological and environmental risk factors, neuropsychological and physiological correlates, and typical clinical course.” *Ibid.*, p. 19. The DSM-5 is used by mental health professionals to diagnose, understand and treat mental health problems.

activities. The Convention on the Rights of persons with Disabilities (discussed at greater length in Chapter VI), which the United States has signed but not yet ratified, recognizes that disability results from the interaction between persons with impairments and the social and cultural attitudes that lead to social disadvantage, discrimination and stigma. The ability of an individual with a mental illness to participate fully and equally in society depends on biological and genetic factors, the individual's socio-economic circumstances, the support received from family and community, access to treatment and support services, and the presence or absence of abusive, discriminatory, or marginalizing social, economic, and institutional dynamics.<sup>27</sup> Many of the people behind bars with mental health conditions have experienced forms of poverty, inequality, homelessness, or discrimination that no doubt have contributed to, or even decisively shaped their mental disability.<sup>28</sup>

In prison as in the community, the symptoms of some individuals with mental health conditions may be subtle, discernible only to clinicians. Prisoners with serious depression, for example, may appear merely withdrawn and unsociable. The conditions of others may be readily evident: they are agitated, cannot talk coherently, bite themselves aggressively, repeatedly bang their heads against walls, or call out for help against unseen persecutors. Some live in a world constructed around their delusions.

The diagnosis of a mental disorder is not the same as a decision that treatment is needed, and similarly, an individual may not meet all the criteria for a mental disorder but nonetheless may want treatment.<sup>29</sup> In prison as in the community, the degree of disturbance, dysfunction, and distress can vary dramatically from individual to individual, and within the same individual at different times. Some individuals with clinical conditions have periods of relative stability during which symptoms are minimal,

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<sup>27</sup> "In terms of mental disabilities, impairment cannot be understood as a fixed structural or mechanical 'abnormality'... Innate or acquired genetic or biological factors associated with the origins of serious mental disabilities are ... 'vulnerability factors' – rendering the individual susceptible to psychosocial and environmental factors within society." Jonathan Kenneth Burns, "Mental health and inequity: A human rights approach to inequality, discrimination, and mental disability," *Health and Human Rights Journal*, vol. 11, no. 2 (2009), p. 22. Burns provides extensive citations to research in the United States and elsewhere on the impact of social, economic and political factors on the prevalence of mental disability and access to mental health services.

<sup>28</sup> Doris J. James and Lauren E. Glaze, Bureau of Justice Statistics, US Department of Justice, "Mental Health Problems of Prison and Jail Inmates," September 2006, <http://www.bjs.gov/content/pub/pdf/mhppji.pdf> (accessed February 9, 2015), p. 4.

<sup>29</sup> From a clinical perspective, the need for treatment takes into consideration many factors, including the nature and severity of the symptoms, the person's distress and pain associated with the symptoms, impairments in life activities associated with the symptoms and the risks and benefits of different types of available treatments. DSM-5, p. 20.

interspersed with periods of psychiatric crisis. Some recover. Some adjust to life with their symptoms with relatively little impairment in their ability to have strong family connections and successful work. Others are profoundly impaired in their ability to undertake ordinary life activities for prolonged periods. An individual with bipolar disorder, for example, may at different times be able to live in the community and at other times may benefit from the care provided in a hospital.

## II. Life Behind Bars for Persons with Mental Disabilities

Life behind bars is difficult for everyone, but it is particularly difficult for individuals with mental health problems that impair their thinking, emotional responses, impulse control, and ability to cope.

Prisoners with mental disabilities, like all prisoners, struggle to maintain their self-respect and emotional equilibrium in correctional environments commonly marked by rigid rules; the often aggressive and hostile attitudes of officers and other inmates; violence; lack of privacy; stark limitations on family and community contacts; and a paucity of opportunities for education, meaningful work, or other productive, purposeful activity.<sup>30</sup> Inmates with mental health conditions are more likely to be victimized by other inmates.<sup>31</sup> Physical conditions in some facilities are abysmal—filthy, beastly hot or frigid, infested with vermin.<sup>32</sup>

As one study put it, the:

absence of privacy adds tension and stress to the daily existence of each inmate. Inmates with serious mental illness have fewer resources with which to cope with added turmoil. Anxious, depressed, psychotic and

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<sup>30</sup> For a description of conditions under which such prisoners commonly live, see Human Rights Watch, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, October 22, 2003, <http://www.hrw.org/reports/2003/usa1003/usa1003.pdf>.

<sup>31</sup> Prison and jail inmates with mental health problems are between two and three times more likely to be injured in a fight with other prisoners. Doris J. James and Lauren E. Glaze, Bureau of Justice Statistics, US Department of Justice, “Mental Health Problems of Prison and Jail Inmates,” Table 16, September 2006, <http://www.bjs.gov/content/pub/pdf/mhppji.pdf> (accessed February 9, 2015), p. 10. Individuals in prison with mental health problems are more likely to be victimized by other prisoners, and that victimization includes rape. Prisoners with mental illnesses were sexually abused at significantly higher rates than other inmates: in a recent survey, an estimated 6.3 percent of state and federal prisoners identified with serious psychological distress reported that they were sexually victimized by another inmate compared to 0.7 percent of prisoners with no indication of mental illness. Allen J. Beck et al., Bureau of Justice Statistics, US Department of Justice, “Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-2012,” May 2013, <http://www.bjs.gov/content/pub/pdf/svpjri1112.pdf> (accessed March 25, 2015), p. 7.

<sup>32</sup> See, for example, the descriptions of conditions of the Orleans Parish Prison in *Jones v. Gusman*, United States District Court for the Eastern District of Louisiana, case no. 2:12-cv-00859, Order Approving Consent Judgment and Certifying Settlement Class, filed on June 6, 2013 (cells covered with crusted fecal matter, urine, old food, and prisoners plagued by deaths, suicides, rapes, stabbings, and severe beatings.); South Carolina prisons in *T.R. et al. v. South Carolina Department of Corrections*, case no. 2005-40-2925, slip op. (S. Car. Court of Common Pleas, Jan. 8, 2014 (cold, filthy special management cells with trash, blood and feces scattered about; inmates without blankets or mattresses sleeping on cold steel or concrete slab.); East Mississippi Correctional Facility in *Dockery v. Epps*, United States District Court for the Southern District of Mississippi, case no. 3:13-cv-326, Class Action Complaint, filed on May 30, 2013 (floors and walls caked with dirt, excrement, blood; broken toilets so inmates defecate in plastic buckets; broken ventilation systems, vermin infestations, dark cells because of non-existent or broken light bulbs).

suicidal inmates are at increased risk of deteriorating emotionally and of having impaired judgment in such settings.<sup>33</sup>

Many prisoners with mental health conditions are incarcerated in correctional environments and subject to rules and regimes that are, at best, counter-therapeutic, at worst, dangerous to their mental as well as physical well-being. Many inmates with mental disabilities deteriorate behind bars, their symptoms worsening, their suffering increasing.

There are competent and committed professionals working in corrections who struggle to improve the conditions of confinement for such prisoners, including providing them with medical and mental health treatment. Nevertheless, as Judge William Wayne Justice observed in a case that arose in Texas, “whether because of a lack of resources, a misconception of the reality of psychological pain, the inherent callousness of the bureaucracy, or officials’ blind faith in their own policies,” many officials have been insufficiently attentive to the unique needs of individuals with mental illness when they are confined in correctional facilities.<sup>34</sup>

Mental health professionals have little say over prison rules, even when they compromise or prevent therapeutic efforts. Indeed, mental health treatment is almost always subordinated to custodial and security concerns. Prison policies may permit practices such as solitary confinement and the use of force that directly threaten prisoners’ mental health, above and beyond the toxic prison environment itself. The institutional culture within many corrections facilities is antithetical to—indeed hostile to—accommodating the needs of prisoners with mental disabilities.

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<sup>33</sup> Cheryl D. Wills, M.D., “The Impact of Conditions of Confinement on the Mental Health of Female Inmates Remanded to Alabama Department of Corrections,” prepared for *Laube v. Haley*, United States District Court for the Middle District of Alabama, case no. 02-T-957-N, on file at Human Rights Watch. On December 12, 2002, the court granted plaintiffs’ motion for a preliminary injunction finding that inmates at the Julia Tutwiler Prison for Women were at a substantial risk of serious harm caused by the facility’s “greatly overcrowded and significantly understaffed open dorms.... [T]he unsafe conditions are so severe and widespread today that they are essentially a time bomb ready to explode facility-wide at any unexpected moment in the near future.” *Laube v. Haley*, 234 F. Supp. 2d 1227, 1252 (M.D. Ala. 2002).

<sup>34</sup> *Ruiz v. Johnson*, 37 F. Supp. 2d 855, 914 (S.D. Texas, 1999). The quote is as apt today as when written by Judge William Wayne Justice.

## Neglect

There have been shocking recent cases of staff neglect, mistreatment, and even cavalier disregard of the wellbeing of prisoners with mental health problems. In some cases, including two described below, prisoners have become gravely ill and died because staff allegedly failed to attend to their basic needs for food, water, or medical care.

### **ANTHONY MCMANUS**

Anthony McManus died in a Michigan prison shortly after his 38th birthday in September, 2005. His estate filed a lawsuit against officials and staff of the Michigan Department of Corrections. The following account of McManus' death is based on the court's ruling denying certain defendants' motions for summary judgment.

According to the court, at the time of his death McManus weighed 75 pounds, having dropped from 140 pounds in five months. A nurse observed that he looked like a concentration camp prisoner.

McManus had arrived in the Michigan prison system eight years earlier to serve a sentence for indecent exposure. Although he had a history of schizophrenia and bipolar disorder for which he had previously received treatment, he was confined in a prison which did not have a psychiatry department.

In the year preceding his death, McManus' mental health deteriorated. He became more difficult to manage and was placed in segregation. He behaved strangely, was frequently irritable, profane, and by turns up-beat or depressed. During the last six months of his life, he was constantly disruptive and noisy, was difficult to communicate with, talked about the devil, and would cover his body with food he had chewed up. He would also spread feces and urine around his cell and on himself and even mixed it with his food. Although he would not eat, he begged for food. McManus' estate asserted in the lawsuit that during the final weeks of McManus' life, officials sometimes turned off the water in his cell and restricted his access to food in order to control his behavior. The court notes that when McManus received food, he often smeared it over his cell or rolled it into little balls to keep in his pocket.

According to the court, three days before McManus died, he flooded his cell and pushed a mixture of feces, urine, and water under his door into the hallway. The unit manager who came to the cell said McManus was incoherent and "babbling." He ordered McManus to come to the door but McManus did not comply. The officer subsequently ordered McManus to remove his clothes to show he had no weapons. When McManus refused, the officer pepper sprayed him. McManus then removed his clothes and officers entered the cell and escorted him out. The officer who sprayed him observed, "What's going on with this man? He's dying." A video of the pepper spaying was



introduced as evidence in the case, and the court stated that the video revealed a “very emaciated, naked individual who appears to be in great discomfort, who is verbalizing in an incoherent manner and who eventually makes repeated clear requests for water and help.” During the taped footage, no one provides him with water.

Three days after the pepper spraying, on September 8, 2005, McManus was found dead in his cell. His cell floor was covered with an inch of standing water, toilet paper, feces, and other debris. The autopsy identified the causes of death as myocarditis (heart disease), emaciation, and clinical history of polysubstance abuse and mental disorder.

The court noted that while the various expert opinion reports submitted by the plaintiff regarding the care McManus received, “all generally agreed that various individuals could have done more to prevent Mr. McManus’ unfortunate death, one line from an expert prison official...stands out, ‘[a]nimals in animals shelters are generally given more attention and better care than was afforded to McManus.’” The court also pointed out that “even the inmate across the hall, an obvious layperson...could tell that Mr. McManus was suffering,” testifying in his deposition that “you could see that his eyes was [sic] turning yellow. His cheeks were sunken in, the skin on his frame was just hanging off his bones like clothes on a hanger.” According to the court, the warden agreed in his deposition that it was “obvious to him” and “it should have been obvious to anyone that Mr. McManus needed medical attention.” The court also noted that the internal affairs investigation by the Michigan Department of Corrections concluded that health care and custody staff failed to provide basic medical/psychological care to McManus, and this failure led to his death.

The court concludes that McManus received so little food and water that he finally succumbed to death. It states that although McManus clearly had “serious psychological issues,” he was confined in a facility that “did not provide its inmates with psychiatric treatment or medications to treat mental illness” and “not a single defendant made a serious attempt to have him transferred to a facility that could treat his obvious mental illness.”

## CHRISTOPHER LOPEZ

According to a lawsuit brought by his estate, Christopher Lopez was a 35-year-old man who died in a Colorado prison on March 17, 2013 because of staff negligence and mistreatment. This account of the final hours of his life comes from the complaint filed in his case and a video filmed by prison staff.<sup>35</sup>

Lopez had been diagnosed with schizophrenia and had been involuntarily committed a dozen times to a mental health hospital because of psychotic episodes. In 2010, he began serving a four year sentence for having kicked a correctional officer during an earlier incarceration. Because of hallucinations and delusions, Lopez was sent twice to the San Carlos Correctional Facility in Colorado, a facility operated by the Colorado Department of Corrections to provide treatment for prisoners with mental illness. His second tenure at SCCF began in May 2012 and he remained there until his death. According to the complaint in his lawsuit, he was kept isolated in his cell 22-24 hours a day. Although Lopez was given antipsychotic medication, he was placed on frequent mental health watches due to increasing suicidal thoughts and his mental health continued to deteriorate.

On March 17, 2013, at approximately 3:30 a.m., correctional officers found Lopez lying on his stomach on the floor of his cell. Lopez was barely able to lift his head in response to officer commands. Staff started a video recording of Lopez which tracked the following six hours until his death.

When Lopez continued to remain unresponsive to commands to move and to cuff up, to “show some cooperation,” a cell extraction was authorized to forcibly extract Lopez from his cell and place him on “special controls” status.<sup>36</sup> According to the complaint, the shift commander in his use of force report described Lopez as “psychologically intimidating” because staff did not know why he was refusing orders, because of his past history, and that Lopez engaged in “passive resistance” because he “refused to acknowledge staff directives” and just lay on the floor.

The events depicted in the video are summarized below. Officers suited up in riot gear with helmets, face masks, and pads enter Lopez’s cell, strip him to his underwear, place his wrists in handcuffs attached to a stomach chain, chain his ankles together, and tie him to a restraint chair. They also

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<sup>35</sup> Our description of Lopez’ death is based on *Lopez v. Waska*, United States District Court for the District of Colorado, case no. 1:14-cv-01705, Complaint, filed June 19, 2014; which in turn draws heavily from a six-hour video made by the Department of Corrections pursuant to policies requiring staff to film certain types of prison incidents. Plaintiff’s law firm Killmer, Lane & Newman law firm edited the film to a 45 minute version available on YouTube at <https://www.youtube.com/watch?v=LqdLDLiywQ> (accessed March 11, 2015). We also talked with the attorney for the estate, Human Rights Watch telephone interview with David Lane, attorney for plaintiff, Denver, Colorado, February 3, 2015; and from Tom McGhee, “Colorado gives \$3 million in case of inmate who died as guards laughed,” *The Denver Post*, December 18, 2014, [http://www.denverpost.com/news/ci\\_27162848/colorado-gives-3-million-case-inmate-who-died](http://www.denverpost.com/news/ci_27162848/colorado-gives-3-million-case-inmate-who-died) (accessed March 30, 2015).

<sup>36</sup> Under Colorado Department of Corrections regulations, special controls status is to be used only to house prisoners who have become violent or destructive to themselves or others. According to the complaint, the shift commander allegedly described Lopez as “psychologically intimidating” and justified the extraction because Lopez refused to acknowledge staff directives and just lay on the floor.

place a spit mask over his face. Lopez is limp, semi-conscious and breathing loudly and rapidly during this procedure. Lopez is then taken to another cell for observation. He appears to have a seizure and slumps sideways in the restraint chair. Later, officers remove Lopez from the restraint chair and placed him on the floor of the cell, still shackled in ankle restraints with handcuffs attached to a belly chain. He turns over onto his stomach, and lying prone he begins to groan intermittently and his breathing becomes even more labored.

Shortly before 8:00 a.m., a nurse gives Lopez an injection of psychotropic drugs. According to the complaint, neither she nor anyone else ever took Lopez' vital signs, performed any sort of medical assessment or took any steps to address his medical crisis. The edited video does not show any medical treatment being provided to Lopez. Just prior to 9:00 a.m., Lopez appears to have another seizure. At 9:10, he appears to stop breathing. None of the staff ostensibly watching him seemed to notice, and the video indicates they continued to talk among themselves and tell jokes. A mental health nurse arrives soon after Lopez has seemed to stop breathing, opens the food tray slot of the cell door and yells, "what are you doing," "what is going on," and "why are you acting this way." She then says, "I can see you breathing" and tells him to open his eyes. She then closes the food tray slot and begins laughing and talking with other staff in the area.

As the video shows, approximately 20 minutes after he seems to have stopped breathing, custody staff enter the cell to take him back to his cell. Only after they lift his body off the floor and place it in the restraint chair do they indicate that Lopez may not be breathing. They call for medical back-up, but it is too late.

An autopsy revealed Lopez had died of severe hyponatremia, a condition that can occur when too much psychotropic medication leads to an abnormally low level of sodium in a person's blood. It is a condition that is easily diagnosed with a blood test and easily treatable with prompt and adequate medical attention.

The lawsuit brought by Lopez' family resulted in a settlement from the Colorado Department of Corrections. The department acknowledged the settlement in a brief statement. "We wish to reiterate that Department does not condone the actions or omissions of the employees involved. Their actions were well outside of the Department's established training, policies, and practices."<sup>37</sup> The Department also fired three staff involved in the case, including the mental health nurse who had "talked" to Lopez after he had died, and disciplined five others.<sup>38</sup>

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<sup>37</sup> Tom McGhee, *The Denver Post*, "Colorado gives \$3 million in case of inmate who died while guards laughed," December 18, 2014, [http://www.denverpost.com/news/ci\\_27162848/colorado-gives-3-million-case-inmate-who-died](http://www.denverpost.com/news/ci_27162848/colorado-gives-3-million-case-inmate-who-died) (accessed March 30, 2015). The fact of a settlement agreement is not an indication or admission by a defendant of guilt or liability.

<sup>38</sup> Associated Press, "\$3M settlement reached in Colorado inmate's death," December 18, 2014, <http://coloradosprings.com/3m-settlement-reached-in-colorado-inmates-death/article/1543323> (accessed March 30, 2015). Defendants' willingness to settle a case is not an admission of legal wrongdoing.

## Inadequate Mental Health Treatment

“[H]aving stripped [prisoners] of virtually every means of self-protection and foreclosed their access to outside aid, [society may not look away and let] the state of nature take its course.” – *Farmer v. Brennan*, 511 U.S. 825 (1994)

Mental health treatment can alleviate painful symptoms, facilitate recovery, and help prisoners with mental disabilities strengthen or develop the resilience and coping skills needed to handle incarceration and to have the lives they want once they are back in the community. The nature and the level of mental health services that are helpful to any given individual depend on the specific nature of the individual’s condition, the duration and degree of functional impairment, and the amount of suffering and distress the individual experiences.<sup>39</sup> Mental health services not only can help improve the quality of individual prisoners’ lives, but they also promote safety and order within the prison by reducing rule-breaking and decreasing the need for custody staff to use force.

Prisoners have a constitutional right to treatment for serious mental illness.<sup>40</sup> Depriving prisoners of needed mental health care “is incompatible with the concept of human dignity and has no place in civilized society.”<sup>41</sup> Prisons and jails are constitutionally required to make treatment available to inmates, but the basic components of an adequate mental health system are poorly implemented or functionally non-existent in many facilities.<sup>42</sup> Gains that may have been made in mental health staffing, programs, and

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<sup>39</sup> Frederica W O’Connor, David Lovell, and Linda Brown, “Implementing Residential Treatment for Prison Inmates with Mental Illness,” *Archives of Psychiatric Nursing*, vol. 16, no. 5 (October 2002), p. 232. See generally, Fred Cohen, *The Mentally Disordered Inmate and the Law*, vol. 1, 2nd edition, (Kingston, NJ: Civil. Research Institute, 2008), sections 2.3 and 4.5.

<sup>40</sup> The right to treatment is limited to serious conditions and the avoidance of deliberate indifference that results in the unnecessary and wanton infliction of pain. Although there is no explicit mention of a right to health care in the US constitution, the right of prisoners to receive medical and mental health treatment was established by the US Supreme Court in *Estelle v. Gamble*, 429 U.S. 97 (1976) and *Farmer v. Brennan*, 511 U.S. 825 (1994) as emerging from the Eighth Amendment’s prohibition on cruel or unusual punishment. Although there is extensive jurisprudence on the meaning and application of the deliberate indifference standard, the courts have rarely addressed what constitutes a “serious” condition and no clear definition emerges from the cases. Email from Fred Cohen to Human Rights Watch, January 30, 2015. See generally, Fred Cohen, “Correctional Mental Health Law: Origins, Status, Future,” *Criminal Law Bulletin*, vol. 49, no. 5 (2013); Human Rights Watch, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, <http://www.hrw.org/reports/2003/10/21/ill-equipped-o>, p. 209-213.

<sup>41</sup> *Brown v. Plata*, 131 S. Ct. 1910, 1923 (2011).

<sup>42</sup> The basic components of prison mental health services are well established. Prisons must have procedures for screening and identifying prisoners with mental health problems; a range of mental health treatment services, including appropriate medication and other therapeutic interventions; a sufficient number of mental health professionals to provide adequate services to all prisoners with serious mental disorders; adequate and confidential clinical records; protocols for identifying and treating suicidal prisoners; procedures to ensure timely access by prisoners to necessary mental health services; and

physical resources have often ended up swamped by a tsunami of prisoners with serious mental health needs.<sup>43</sup> Many prisoners cannot obtain mental health services and support, much less services provided in an atmosphere of empathy by qualified staff who respect their dignity.<sup>44</sup> Mental health interventions are often limited to medication oriented to responding to immediate crises and not tailored to the individual prisoner's needs, strengths, and goals for recovery.<sup>45</sup>

Impossibly large caseloads often frustrate the ability of mental health professionals to provide appropriate, individually tailored services to prisoners who want them. Mental health staff often fail to discuss with prisoners the nature, purpose, risks, and benefits of different types of treatment so that the prisoners can make informed decisions on whether or not to consent to the treatment. The effectiveness of their work is also often impeded by antagonistic relations between prisoners and custody staff which “destroy trust and create an atmosphere of fear, frustration, helplessness, and anger.”<sup>46</sup>

Mindful of budget constraints and scant public support for investments in services beneficial to prisoners, elected officials have been reluctant to provide the funds needed to ensure that prisons and jails have mental health resources commensurate with the size of the inmate

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different levels of care, e.g. emergency psychiatric services, acute inpatient wards with intermediate levels of care, and outpatient services. The minimally necessary components to pass constitutional muster were first articulated in *Ruiz v. Estelle*, 503 F. Supp. 1265 (S.D. Tex. 1980). Additional components have subsequently been identified as desirable for effective and comprehensive correctional mental health services. See Cohen, *The Mentally Disordered Inmate and the Law*, section 2.6, Components of a Treatment Program; National Commission on Correctional Health Care, *Standards of Mental Health Services in Correctional Facilities* (Chicago: NCCHC, 2008). Human Rights Watch, *Ill-Equipped*, <http://www.hrw.org/reports/2003/10/21/ill-equipped-o>, Chapter IX.

<sup>43</sup> For example, when the California prison system was at double capacity, the inability of medical and mental health staff to provide sufficient care to the prisoners yielded needless suffering and death, as evidenced by a suicide rate in California prisons 80 percent higher than the national prison average. The United States Supreme Court upheld lower court rulings that required a reduction in the prison population to remedy unconstitutionally deficient medical and mental health care. *Brown v. Plata*, 131 S. Ct. 1910 (E.D. Cal) 2011.

<sup>44</sup> According to a 2006 report based on a survey of inmates in a national sample of prisons and jails, among prisoners and inmates with mental health problems, only 34 percent of state prisoners, 24 percent of federal prisoners, and 17 percent of jail inmates received mental health treatment following admission. Doris J. James and Lauren E. Glaze, Bureau of Justice Statistics, Department of Justice, “Mental Health Problems of Prison and Jail Inmates,” September 2006, <http://www.bjs.gov/content/pub/pdf/mhppji.pdf> (accessed February 9, 2015), p.9, table 14.

<sup>45</sup> The extent to which correctional mental health professionals provide mental health services that respect the dignity, autonomy, and rights of prisoners with mental disabilities, including their rights not to be subjected to involuntary medication or to prolonged seclusion and restraint for treatment purposes, is a critically important question, but one beyond the scope of this report, which focuses on unnecessary, excessive, and punitive use of force by correctional staff.

<sup>46</sup> *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Expert Declaration of Edward Kaufman, M.D., filed March 14, 2013, p. 55.

population that could benefit from them.<sup>47</sup> As a result, correctional mental health services are often inadequately staffed and resourced.<sup>48</sup> Three recent examples follow:

- A medical expert reported that mental health care is “grossly sub-standard” with “extreme and unacceptable deficiencies in essentially every aspect of the mental health care system” in the Eastern Mississippi Correctional Facility, a prison with the ostensible mission of housing prisoners with serious mental illness.<sup>49</sup>
- In South Carolina, a court recently concluded that “inmates have died in the South Carolina Department of Corrections for lack of basic mental health care, and hundreds more remain substantially at risk for serious physical injury, mental decompensation, and profound, permanent mental illness.” The mental health program was “inherently flawed and systematically deficient in all major areas.” There were far too few psychiatrists, clinical psychologists, and counselors, and many of the counselors were not qualified. Inadequate staffing created deficiencies in screening, treatment programs, access to higher levels of care, and administration of medication.<sup>50</sup>
- An expert concluded that because of profoundly inadequate staffing levels at the Orleans Parish Prison in New Orleans, “[n]umerous prisoners receive no treatment whatsoever, resulting in worsening of their condition and making future treatment less likely to succeed. Failure to treat also increases acting out resulting in harm and increased risk of harm to both self and others.”<sup>51</sup>

Adverse working conditions can leave correctional mental health staff burned out, feeling “exhausted, cynical, ineffective, and wish[ing] they could find work elsewhere. The more

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<sup>47</sup> Cece Hill, “Inmate mental health care,” *Corrections Compendium*, vol. 29, no. 5 (2004), p. 15-31.

<sup>48</sup> Jeffrey L. Metzner and Jamie Fellner, “Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics,” *The Journal of the American Academy of Psychiatry and the Law*, vol. 38, no. 1 (201), <http://www.hrw.org/news/2010/03/22/solitary-confinement-and-mental-illness-us-prisons> (accessed February 11, 2015).

<sup>49</sup> *Dockery v. Epps*, United States District Court for the Southern District of Mississippi, case no. 3:13-cv-00326, Expert Report of Terry A. Kupers, M.D., on Eastern Mississippi Correctional Facility, filed September 25, 2014. See also the Class Action Complaint in that case, filed May 30, 2013.

<sup>50</sup> *T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, slip op., filed Jan. 8, 2014.

<sup>51</sup> Bruce C. Gage, M.D., “Expert Evaluation: Mental Health Care at the Orleans Parish Prison,” March 3, 2013, p. 52, on file at Human Rights Watch. Decades of inadequate mental health care, among other problems, led to the filing of *Jones v. Gusman*, United States District Court for the Eastern District of Louisiana, case no. 2:12-cv-00859, Class Action for Declaratory and Injunctive Relief, filed April 2, 2012. The United States intervened in the case a few months later. In September 2013, the parties reached a settlement agreement. Ongoing monitoring pursuant to that agreement reveals progress implementing its term has been slow. An August 2014 monitors report revealed that mental health care remains “virtually non-existent.” *Jones v. Gusman*, Monitors’ Report No.2, filed August 26, 2014.

burned out staff become, the harder it is to be caring and conscientious.”<sup>52</sup> Some correctional mental health staff become quick to see malingering or manipulation among prisoners and to overlook mental illness.<sup>53</sup>

The US Department of Justice found that in one Pennsylvania prison, there was a “disturbing tendency by many of the [prison] clinicians to describe almost all disruptive conduct as purely willful and behavioral, and to overlook the role of the prisoner’s mental instability in causing the conduct. Our consultants found cases of maladaptive behavior rooted in mental instability that ... the mental health staff members incorrectly characterized as ‘manipulative’ or ‘malingering’ behavior.”<sup>54</sup> In New Orleans’ jails, mental health staff often dismissed self-harm as manipulative efforts by prisoners to change their housing assignments and failed to provide mental health services to prisoners who engaged in it.<sup>55</sup>

Few corrections agencies have established mental health interventions programs designed for people with personality disorders.<sup>56</sup> Correctional mental health staff typically provide little or no mental health services to prisoners they have diagnosed with personality disorders such as anti-personality disorder and borderline personality disorder.<sup>57</sup> Indeed, even though

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<sup>52</sup> Terry Kupers, M.D., *Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It* (San Francisco, California, Jossey-Bass Publishers: 1999), pp. 84-85. See also, Jeffrey L. Metzner, et al., “Treatment in Jails and Prisons,” in *Treatment of Offenders with Mental Disorders*, ed. Robert M. Wittstein (New York: The Guilford press, 1998), p. 229. (Continuing education and training of prison mental health in addition to the use of part-time consultants can help prevent burnout.)

<sup>53</sup> Prisoners can, of course, be manipulative, feigning mental illness for numerous reasons— to gain a transfer, change housing assignments, seek attention, or to improve their legal situation. But manipulation is not inconsistent with mental illness. For example, behavior such as self-mutilation can be manipulative. But it can also—and simultaneously—be a symptom of a major psychiatric disorder or a self-reinforcing behavior that requires a psychiatric response. See Human Rights Watch, *Ill-Equipped*, p. 106-109.

<sup>54</sup> U.S. Department of Justice, “Investigation of the Pennsylvania Department of Corrections’ Use of Solitary Confinement on Prisoners with Serious Mental Illness and/or Intellectual Disabilities,” February 24, 2014, [http://www.prisonpolicy.org/scans/DOJ\\_Findings\\_Letter\\_Issued\\_by\\_DOJ\\_2\\_24\\_2014.pdf](http://www.prisonpolicy.org/scans/DOJ_Findings_Letter_Issued_by_DOJ_2_24_2014.pdf) (accessed February 9, 2015), p. 15.

<sup>55</sup> “[Such labeling] demonstrates gross inattention to the underlying reasons for engaging in or talking about self-harm, resulting in lack of appropriate treatment and intervention.” It also ignores the fact that most prisoners who are unhappy with their housing do not engage in or threaten self-harm. Bruce C. Gage, M.D., “Expert Evaluation: Mental Health Care at the Orleans Parish Prison,” March 3, 2013, p. 51, on file at Human Rights Watch.

<sup>56</sup> Promising programs for prisoners with personality disorders have been developed in some state correctional agencies, e.g. Massachusetts and Washington. Because the origins of personality disorders are rooted in life histories, e.g. childhood traumas and perhaps genetics, psychotropic medication developed to address brain chemistry and other organic problems that may play a role in mental illness has limited utility in addressing personality disorders.

<sup>57</sup> According to the DSM-5, a “ personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.” DSM-5, p. 645. The DMS-5 identifies 10 specific personality disorders, with numerous subcategories. Anti-personality disorder is described as “a pattern of disregard for, and violation of, the rights of others,” and borderline personality disorder is “a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity.” DSM-5, p. 645.

those prisoners may be deeply distressed and impaired in their ability to function, staff may dismiss their symptoms and concerns as manipulative or malingering.<sup>58</sup> The diagnosis of a personality disorder often reflects a character judgement under the guise of a clinical one. Faced with particularly difficult or troublesome inmates who may not respond to standard treatment protocols, clinicians may dismiss them, in essence, as “bad, not mad.”<sup>59</sup>

## Rule-Breaking by Prisoners with Mental Disabilities

Treatment works. Mental health and custody staff need to work together. It reduces aberrant behavior, improves staff lives, improves inmates’ lives.

—Steve Cambra, former warden, California Department of Corrections and Rehabilitation.<sup>60</sup>

Prisoners with mental health problems may act out and break rules more frequently than other prisoners, but the behavioral manifestation of their illness will decline as the quantity and quality of mental health treatment increases.

—Bruce Gage, M.D. Chief of Psychiatry, Washington State Department of Corrections.<sup>61</sup>

Many prisoners with mental disabilities pose difficult management challenges for correctional staff. Their mental health problems can make it difficult for them to adapt to an extremely regimented life in an unsupportive, hostile and frequently violent environments.<sup>62</sup> Especially when not receiving appropriate mental health services, they

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<sup>58</sup> Mental health staff are likely make a diagnosis of a personality disorder, in the words of one doctor, if “an inmate does not appear to have bona fide depressive or psychotic illness at the moment he is being examined. This implies that the individual should be treated less like a patient and more like an antisocial person who needs greater control.” Letter from Seymour L. Halleck, M.D. to Randall C. Berg, Florida Institute of Justice, Miami, Florida, “Evaluation of Conditions of Close Management,” December 30, 2001, on file at Human Rights Watch

<sup>59</sup> Terry Kupers, “What to do with the Survivors? Coping with the Long-Term Effects of Isolated Confinement,” *Criminal Justice and Behavior*, vol. 35, no. 8 (August 2008).

[http://www.nrcat.org/storage/documents/usp\\_kupers\\_what\\_do\\_with\\_survivors.pdf](http://www.nrcat.org/storage/documents/usp_kupers_what_do_with_survivors.pdf) (accessed April 20, 2015), p. 1014. See also Jamie Fellner, “Afterwords: A Few Reflections,” *Criminal Justice and Behavior*, vol. 35, no. 8, August 2008, 1079-1087.

<sup>60</sup> Human Rights Watch telephone interview with Steve Cambra, former warden, California Department of Corrections and Rehabilitation, Elk Grove, California, April 16, 2014.

<sup>61</sup> Human Rights Watch interview with Bruce Gage, M.D. Chief of Psychiatry, Washington State Department of Corrections, Olympia, Washington, July 14, 2014.

<sup>62</sup> A high percentage of prisoners diagnosed with mental illness also have co-occurring substance use disorders and those prisoners “may be more likely to have difficulty managing the stresses and expectations within corrections settings and incur



may engage in violent or disruptive conduct, act out in ways staff consider bizarre, frightening or challenging, and engage in dangerous behavior such as self-injury or striking out at staff.<sup>63</sup> Persons with schizophrenia may experience prison as a particularly frightening, threatening environment and as a consequence some behave dangerously towards themselves, staff, or other prisoners.<sup>64</sup> Persons with bipolar disorder in a manic phase can be disruptive, quick to anger, provocative, and dangerous.<sup>65</sup> Some prisoners can become extremely violent. According to a detailed study by the *New York Times*, for example, Michael Megginson, a 25 year old who has been in and out a psychiatric hospitals since he was 6 and is at times severely psychotic, is one of the most violent inmates at New York City's jail on Rikers Island:

In his 18 months there, he was constantly involved in some kind of disturbance, his records show. He fought with other inmates and officers; spit and threw urine at them; smashed windows and furniture and once stabbed an officer in the back of the head with a piece of glass.... He also repeatedly hurt himself, cutting his body all over, banging his head against walls and tying sheets and clothing around his neck in apparent suicide attempts.... He had 70 physical confrontations with officers.<sup>66</sup>

Prisoners with psychotic disorders such as schizophrenia may find it next-to-impossible to abide by, or even to understand, prison regulations when delusions and hallucinations distort their understanding of reality. According to correctional mental health expert Dr. Jeffrey Metzner:

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disciplinary problems at higher rates than those without behavioral health issues. Some may have difficulty understanding directions or controlling impulses while in custody as well." Fred Osher et al., Council of State Governments Justice Center, "Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery," 2012, [https://www.bja.gov/Publications/CSG\\_Behavioral\\_Framework.pdf](https://www.bja.gov/Publications/CSG_Behavioral_Framework.pdf) (accessed March 11, 2015), p.7.

<sup>63</sup> Kupers, *Prison Madness*, p. 81; Martin Drapkin, *Management and Supervision of Jail Inmates with Mental Disorders* (New Jersey: Civic Research Institute, 2003), ch. 4.

<sup>64</sup> Schizophrenia is a complex disease which may include disordered thinking or speech, delusions (fixed, rigid beliefs that have no basis in reality), hallucinations (hearing or seeing things that are not real), inappropriate emotions, confusion, withdrawal, and inattention to any personal grooming. Among the subtypes of schizophrenia is "paranoid schizophrenia" with characteristics of delusions of persecution and extreme suspiciousness.

<sup>65</sup> Bipolar disorder (previously called manic-depressive disorder) is characterized by frequently dramatic mood swings from depression to mania. During manic phases some people may be psychotic and experience delusions or hallucinations. See Martin Drapkin, *Management and Supervision of Jail Inmates with Mental Disorders* (New Jersey: Civic Research Institute, 2003), ch. 4, for an overview of the nature of and correctional implications of various mental diseases and disorders.

<sup>66</sup> Michael Winerip and Michael Schwartz, "For Mentally Ill Inmates at Rikers Island, A Cycle of Jail and Hospitals," *New York Times*, April 10, 2015, [http://www.nytimes.com/2015/04/12/nyregion/for-mentally-ill-inmates-at-rikers-a-cycle-of-jail-and-hospitals.html?\\_r=0](http://www.nytimes.com/2015/04/12/nyregion/for-mentally-ill-inmates-at-rikers-a-cycle-of-jail-and-hospitals.html?_r=0) (accessed April 22, 2015).

A small percentage [of prisoners] don't understand the rules. They're the ones who are psychotic. Prison rules don't mean much to someone hearing voices. A person with paranoid schizophrenia may, on a literal level, understand a rule but nevertheless view a request to abide by that rule as being part of a conspiracy directed against him. It's less of not understanding and more of acting on distortions.<sup>67</sup>

Use of force expert Steve J. Martin points out that some “inmates don't really understand what's going on, they don't really know what they are being asked to do. They often perceive the officers' orders as threats, as an attempt by some force to do something bad to them, so they retreat, and they refuse to comply.”<sup>68</sup>

The available data indicates that nationwide, inmates with mental illness commit from one-and-a-half to five times more infractions (violations of the rules) than other inmates.<sup>69</sup> A national survey found that among state prisoners, 58 percent of those who had a mental health problem had been charged with rule violations, compared to 43 percent of those without such problems.<sup>70</sup> According to that survey, an estimated 24 percent of state prisoners with mental health problems had been charged with physically or verbally assaulting correctional staff or other inmates compared to 10.4 percent of state prisoners without such problems.<sup>71</sup> In New York City, prisoners with mental health problems in 2013 represented 38 percent of the jail population but were involved in 60 percent of all “incidents;” and the “acutely mentally ill” constituted 6 percent of the jail population but were involved in 16 percent of all misconduct incidents.<sup>72</sup> In one California prison, 99 percent of the rules violations were issued to inmates with mental disorders who comprised

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<sup>67</sup> Human Rights Watch telephone interview with Dr. Jeffrey Metzner, clinical professor of psychiatry, University of Colorado Health Sciences Center, Denver, Colorado April 2, 2003.

<sup>68</sup> Human Rights Watch interview with Steve J. Martin, New York, New York March 9, 2015.

<sup>69</sup> Frederica W O'Connor, David Lovell and Linda Brown, “Implementing residential treatment for prison prisoners with mental illness,” *Archives of Psychiatric Nursing*, vol. 16, no. 5 (2002), p 232. See Human Rights Watch, *Ill-Equipped*, for references to other studies.

<sup>70</sup> Doris J. James and Lauren E. Glaze, Bureau of Justice Statistics, “Mental health Problems of Prison and Jail Inmates,” September 2006, <http://www.bjs.gov/content/pub/pdf/mhppji.pdf> (accessed February 9, 2015), p. 10.

<sup>71</sup> *Ibid.* Among jail inmates, 8.2 percent with mental health problems were charged with assault compared to 2.4 percent of other inmates.

<sup>72</sup> Dora B. Schriro, commissioner, NYC Department of Correction, “Statement to the New York City Council, Committee on Fire and Criminal Justice Services,” March 7, 2013, <http://www.docstoc.com/docs/153297337/Statement-to-the-New-York-City-Council-Committee-on-NYC-gov#> (accessed March 20, 2015), p. 11. Schriro did not define “acutely mentally ill.”

only 34 percent of the population; in another facility, 84 percent of the violations were issued to inmates with mental disorders who comprised 43 percent of the population.<sup>73</sup>

## Institutional Responses to Rule Breaking

The assumption that prisoners make rational choices infuses the culture of corrections. If an inmate refuses to come out of his cell when ordered to do so or swears at an officer, staff are likely to assume he is deliberately breaking the rules. They also are likely to assume that failure to force the inmate to comply or to punish him for doing so would be tantamount to sanctioning defiance, would encourage others to engage in similar misconduct, and would promote a general breakdown in order. They find it difficult to understand—or to accept—the role mental illness can play in prisoners’ ability to follow the rules behind bars.

Our research suggests the typical correctional response to difficult, disruptive, or dangerous behavior by prisoners with mental illness differs little from the response to any other inmate who breaks the rules—punishment, solitary confinement, and the use of force. In some facilities, these responses are the default mechanisms for responding to the inadequacies of mental health services for prisoners in the United States.

## Disciplinary Systems

In many prisons and jails, custody staff issue a “ticket” to inmates for disciplinary infractions, and officers then hold a disciplinary hearing to determine the sanction to be imposed.<sup>74</sup> The sanctions for prisoners with mental disabilities are usually the same as those imposed on other prisoners, and typically include restrictions on visits or telephone calls for a period of time, or confinement in disciplinary segregation. These measures are usually imposed without regard to the cause of the behavior, the efficacy of the measures, or the impact of the measures on particular mental conditions.<sup>75</sup>

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<sup>73</sup> *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Expert Declaration of Eldon Vail in Support of Motion for Enforcement of Court Orders and Affirmative Relief Related to Use of Force and Disciplinary Measures, filed May 29, 2013, para 47; and Expert Declaration of Eldon Vail, filed on March 14, 2013, para 78.

<sup>74</sup> The de facto purpose of the disciplinary hearing is to determine the appropriate sanction. Guilt is all but a foregone conclusion. Jamie Fellner, “A Corrections Quandary,” *Harvard Civil Rights-Civil Liberties Law Review*, vol. 41 (2006), p. 391-412.

<sup>75</sup> *Ibid.* Prison officials—and mental health staff—are concerned that having mental health staff involved in the disciplinary process, even if solely regarding possible mitigation of the punishment, can encourage prisoners to feign illness as an excuse to soften the punishment and could also expose clinicians to retaliation from patients. Human Rights Watch, *Ill-Equipped*, p. 64.

In some places, mental health professionals provide information to hearing officers about misconduct by one of their patients and may recommend that it be treated as a mental health problem and not a cause for discipline. They may also urge that sanctions be tailored to take into consideration the individual needs and vulnerabilities of the prisoner. But being able to present views is no guarantee they will be listened to.<sup>76</sup> The California Department of Corrections and Rehabilitation, for example, refused to divert prisoners from the disciplinary process even when their behavior— such as disobeying an order to be handcuffed—reflected psychosis rather than willful disobedience.<sup>77</sup> The punishment imposed on them for breaking the rules was, in effect, punishment for their illness.

An approach that more successfully accommodates mental illness is reflected in a recent agreement by the Department of Justice concerning polices at the Muscogee County Jail in Georgia, which requires that a qualified mental health professional should review disciplinary charges against inmates with serious mental illness to ensure that such illness “is used as a mitigating factor, as appropriate, when punishment is imposed and to determine whether placement into segregation is appropriate.”<sup>78</sup> In addition, jail staff are to “consider suggestions by mental health staff for minimizing the deleterious effect of disciplinary measures on the mental health status of the inmate. Any punishment must work within the inmate’s mental health treatment plan.”<sup>79</sup>

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<sup>76</sup> For refusing orders to cuff up, the California inmate described in the summary of this report was punished with a 30-day loss of privileges, including use of the dayroom, TV, radio, telephone calls, and family visits. The punishment deprived him “of virtually all of his opportunities for external stimuli, which further isolates him and increases his paranoia and anxiety, and contradicts every recommendation made by the clinician in the Mental Health Assessment.” *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Supplemental Expert Declaration of Edward Kaufman, M.D., In Support of Plaintiffs’ Motion for Enforcement of Court Orders and Affirmative Relief Related to Use of Force and Disciplinary Measures, filed September 23, 2013, p.8. In South Carolina, inmates may be found “guilty but not accountable” in disciplinary proceedings but this finding typically had scant effect on the sanctions imposed. *T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, slip op, filed Jan. 8, 2014, p. 12.

<sup>77</sup> *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Plaintiffs’ Post-Trial Brief Regarding Use of Force and Disciplinary Practices and Provision of Inpatient Mental Health Treatment to Condemned Class Members, filed November 15, 2013, p. 10. In every single instance of a cell extraction of a class member for which defendants produced documentation, CDCR charged the prisoner with a rule violation and found the prisoner guilty. The court ordered the CDCR to implement a plan that had been agreed upon in 2011 that would ensure appropriate use of mental health assessments in the disciplinary process.

<sup>78</sup> Memorandum of Agreement Between the United States Department of Justice and the Consolidated Government of Columbus, Georgia Regarding the Muscogee County Jail, 2015, [http://www.justice.gov/crt/about/spl/documents/muscogee\\_moa\\_1-16-15.pdf](http://www.justice.gov/crt/about/spl/documents/muscogee_moa_1-16-15.pdf) (accessed April 28, 2015), p. 6. “A person with serious mental illness is a person with a mental, behavioral, or emotional disorder of mood, thought, or anxiety; diagnosable currently or within the last year; that significantly impairs judgment, behavior, capacity to recognize reality, and the ability to cope with the demands of life in the general population facilities of the Jail.”

<sup>79</sup> *Ibid.* p. 15.

## Solitary Confinement

According to the Department of Justice, a prisoner it identified as Prisoner AA, had a mood disorder, an IQ of 66, was on the Pennsylvania Department of Corrections' mental health roster, and had been subjected to prolonged solitary confinement in Pennsylvania prisons. He attempted to hang himself after more than five months in solitary confinement. He was removed from solitary for a day and then returned for another five months, after which he again attempted to hang himself. Prisoner AA said that while in solitary he became hypersensitive to sights and sounds, became extremely depressed, and his feelings of hopelessness made him want to kill himself and act out against the guards. He also experienced visual hallucinations. For instance, he recalled sometimes seeing his deceased brother encouraging him to cut himself and to "come join me."<sup>80</sup>

Corrections officials across the country rely on solitary confinement—which they usually call "segregation"—to punish prisoners who have broken the rules and to isolate those whom they deem difficult, disruptive, or dangerous, regardless of whether the behavior reflects mental health problems.<sup>81</sup>

Because they are more likely to break the rules and more likely to develop reputations of being unable to function in the general prison population, significant proportions of prisoners with mental disabilities are held in solitary confinement.<sup>82</sup> Indeed, compared to other prisoners, they are disproportionately at risk of being confined in solitary. In Pennsylvania, for example, prisoners with mental illness are placed in solitary at twice the rate of other prisoners.<sup>83</sup> Similarly, in South Carolina, an inmate with mental illness is twice as likely to be

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<sup>80</sup> U.S. Department of Justice, "Investigation of the Pennsylvania Department of Corrections' Use of Solitary Confinement on Prisoners with Serious Mental Illness and/or Intellectual Disabilities," February 24, 2014, [http://www.justice.gov/crt/about/spl/documents/pdoc\\_finding\\_2-24-14.pdf](http://www.justice.gov/crt/about/spl/documents/pdoc_finding_2-24-14.pdf) (accessed February 16, 2015), p. 12.

<sup>81</sup> When segregation is imposed as punishment after a disciplinary hearing, officials refer to it as disciplinary segregation. Prisoners can also be segregated from general population as housing or classification decision made administratively. Disciplinary segregation is imposed for a specified period of time, although it can be extended if the prisoner continues to engage in misconduct. Administrative segregation can be and often is indefinite.

<sup>82</sup> For example, in Indiana, 33 percent of prisoners with mental illness are in segregation. *Indiana Protection and Advocacy Services Commission v. Commissioner*, United States District Court for the Southern District of Indiana, case no. 1:08-cv-01317, Entry Following Bench Trial, filed on December 31, 2012, p. 16. In the Washington State Department of Corrections, 30.5 percent of prisoners in the intensive management units have a mental illness. Vera Institute of Justice, Segregation Reduction Project, Vera/DRW Project Update, "Washington State Department of Corrections," October 2012, on file at Human Rights Watch.

<sup>83</sup> U.S. Department of Justice, "Investigation of the Pennsylvania Department of Corrections' Use of Solitary Confinement on Prisoners with Serious Mental Illness and/or Intellectual Disabilities," February 24, 2014, [http://www.justice.gov/crt/about/spl/documents/pdoc\\_finding\\_2-24-14.pdf](http://www.justice.gov/crt/about/spl/documents/pdoc_finding_2-24-14.pdf) (accessed March 11, 2015), p. 3. In a settlement agreement in a lawsuit filed by Disability Rights Network on behalf of Pennsylvania inmates with serious mental illness, the

placed in segregation as other inmates, and more than three times as likely to be assigned to security detention, the most restrictive form of segregation in that prison system.<sup>84</sup>

High rates of isolation of prisoners with mental illness often reflect the failure of correctional agencies to provide them with adequate mental health treatment. After an investigation that documented systemic deficiencies in the Pennsylvania Department of Corrections' mental health services, the US Department of Justice concluded that if the department were able to provide better mental health care to its prisoners, fewer would deteriorate to the point of having to be placed in isolation. "Too often, instead of providing appropriate mental health care, [the Pennsylvania Department of Correction's] response to mental illness is to warehouse vulnerable prisoners in solitary confinement cells."<sup>85</sup> In South Carolina, a court concluded prisoners were placed in segregation and subjected to use of force "in lieu" of treatment.<sup>86</sup>

Prisoners placed in solitary either for disciplinary or administrative reasons can spend months, years, and even decades locked up 23 to 24 hours a day in small cells that frequently have solid steel doors. They live with extensive surveillance and security controls, the absence of ordinary social interaction, abnormal environmental stimuli, often only three to five hours a week of recreation alone in caged enclosures, and little, if any, educational, vocational, or other purposeful activity.<sup>87</sup> The stress, lack of meaningful social contact, and lack of activity in isolation can be psychologically harmful to any prisoner, with the nature and severity of the impact depending on the individual, the duration, and particular conditions.<sup>88</sup> But the adverse psychological effects of isolation are especially

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state agreed to stop housing those inmates in its segregated housing units. Inmates with serious mental illness who require restricted housing because they pose safety and security threats are to be housed in special secure treatment units in which they receive at least 20 hours a week of unstructured and therapeutic out of cell time. *Disability Rights Network of Pennsylvania v. Wetzel*, United States District Court for the Middle District of Pennsylvania, case no. 1:13-cv-00635 Settlement Agreement, p.46, January 5, 2015.

<sup>84</sup> *T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, slip op, filed Jan. 8, 2014, p.10-11. See Human Rights Watch, *Ill-Equipped*, p. 147-149, for other examples of disproportionate confinement of inmates with mental illness in solitary confinement.

<sup>85</sup> U.S. Department of Justice, "Investigation of the Pennsylvania Department of Corrections' Use of Solitary Confinement on Prisoners with Serious Mental Illness and/or Intellectual Disabilities," February 24, 2014, [http://www.justice.gov/crt/about/spl/documents/pdoc\\_finding\\_2-24-14.pdf](http://www.justice.gov/crt/about/spl/documents/pdoc_finding_2-24-14.pdf) (accessed March 11, 2015) p. 3.

<sup>86</sup> *T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, slip op, filed Jan. 8, 2014,

<sup>87</sup> For a graphic description of especially harsh isolation units, see *Parsons v. Ryan*, United States District Court for the District of Arizona, case no. 12-cv-00601, Expert Report of Craig Haney, filed November 7, 2014

<sup>88</sup> Psychological effects can include anxiety, depression, anger, cognitive disturbances, perceptual distortions, obsessive thoughts, paranoia, and psychosis. Jeffrey L. Metzner and Jamie Fellner, "Solitary Confinement and Mental Illness in U.S. Prisons:

significant for persons with mental conditions characterized by psychotic symptoms and/or significant functional impairments.<sup>89</sup>

Prisoners are also harmed by the grossly inadequate mental health care typical in isolation units. Mental health services in such units are frequently limited to psychotropic medication, a mental health staff person periodically stopping at the cell front to ask how the prisoner is doing (often derisively called “walk-bys”), and occasional meetings in private with a clinician. Because of prison rules requiring prisoners to remain in their cells and the limited numbers of custody staff available to escort prisoners out of their cells, individual or group therapy and structured educational, recreational, and life-skill enhancing activities are usually not available.<sup>90</sup>

All too frequently, the deprivations of solitary confinement exacerbate symptoms of mental illness or provoke a recurrence. Prisoners with mental illness may decompensate so markedly—their symptoms may become so severe and their ability to function become so impaired—that they require crisis care or hospitalization. Many simply will not get better as long as they are isolated.<sup>91</sup>

According to International treaty bodies and human rights experts, including the Human Rights Committee, the Committee against Torture, and the UN special rapporteur on torture,

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A Challenge for Medical Ethics,” *The Journal of the American Academy of Psychiatry and the Law*, vol. 38, no. 1 (2010). Craig Haney, “Mental Health Issues in Long Term Solitary and ‘Supermax’ Confinement,” *Crime & Delinquency*, vol. 49, no. 1 (2003), <http://www.supermaxed.com/NewSupermaxMaterials/Haney-MentalHealthIssues.pdf> (accessed March 11, 2015).

<sup>89</sup> *T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, slip op, filed Jan. 8, 2014, p.6 (“Prolonged segregation of inmates with serious mental illness, particularly those in crisis, exposes them to a substantial risk of serious harm by limiting their access to mental health counselors and psychiatrists, disturbing their eating and sleeping cycles, disrupting the administration of medications, and deepening their mental illnesses. These conditions have contributed to the deaths of multiple inmates in segregation, while placing other inmates and staff at risk.”) US Department of Justice, “Investigation of the Pennsylvania Department of Corrections’ Use of Solitary Confinement on Prisoners with Serious Mental Illness and/or Intellectual Disabilities,” February 24, 2014, [http://www.justice.gov/crt/about/spl/documents/pdoc\\_finding\\_2-24-14.pdf](http://www.justice.gov/crt/about/spl/documents/pdoc_finding_2-24-14.pdf) (accessed February 25, 2015) (noting that the manner in which the department isolates prisoners with serious mental illness “exacerbates their mental illness and leads to serious psychological and physiological harms including severe mental deterioration, psychotic decompensation, and acts of self-harm. [M]ore than 70 percent of the documented suicides occurred in the solitary confinement units”). See generally, Jamie Fellner, “Correctional Psychiatry and Human Rights: An Unfulfilled Vision,” Robert Trestman, Kenneth Appelbaum and Jeffrey Metzner, eds, *The Oxford Textbook of Correctional Psychiatry* (forthcoming 2015).

<sup>90</sup> Metzner and Fellner, “Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics,” *The Journal of the American Academy of Psychiatry and the Law*.

<sup>91</sup> Maureen L. O’Keefe, et al., “One Year Longitudinal Study of the Psychological Effects of Administrative Segregation,” submitted to the National Institute of Justice, October 31, 2010, <https://www.ncjrs.gov/pdffiles1/nij/grants/232973.pdf> (accessed February 9, 2015).

prolonged solitary confinement may amount to torture or cruel, inhuman, or degrading treatment prohibited by international human rights treaties.<sup>92</sup> Because solitary confinement may severely exacerbate previously existing mental health conditions, the special rapporteur on torture believes that imposition of solitary confinement on persons with mental disabilities of any duration is cruel, inhuman, or degrading treatment.<sup>93</sup>

Since the ground-breaking 1995 case of *Madrid v. Gomez*, US federal courts in class action cases have consistently rejected as unconstitutionally cruel the prolonged round the clock isolation of prisoners with serious mental illness.<sup>94</sup> The potential for grave psychological harm has also prompted health associations to call for changes in the use and conditions of segregation for inmates with mental illness.<sup>95</sup> In what the Department of Justice calls “landmark restrictions on the use of solitary confinement,” an agreement signed January 16, 2015 between it and the Columbus Consolidated Government of Columbus, Georgia, which operates the Muscogee County Jail in Georgia, provides that segregation “shall be presumed contraindicated” for inmates with serious mental illness. If an inmate has a “serious mental illness” or other acute mental health contraindications to segregation, that inmate shall not remain in segregation absent extraordinary and exceptional circumstances.”<sup>96</sup>

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<sup>92</sup> United Nations Human Rights Committee, “Consideration of reports submitted by States parties under Article 40 of the Covenant: Concluding observations of the Human Rights Committee,” UNHRC, UN Doc. CCPR/C/USA/CO/3, December 18, 2006; United Nations Committee Against Torture, “Consideration of reports submitted by States parties under Article 19 of the Convention, Conclusions and Recommendations of the Committee Against Torture, United States of America,” UN Doc. CAT/C/USA/CO/2, 2006; United Nations General Assembly, “Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,” UN Doc. A/66/ 268, August 5, 2011.

<sup>93</sup> UNGA, “Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,” August 5, 2011, p. 21.

<sup>94</sup> *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal 1995). According to the Department of Justice, isolating prisoners on the basis of their mental illness constitutes impermissible discrimination under the Americans with Disabilities Act “where it unjustifiably denies those prisoners access to services and programs provided to most other prisoners.” US Department of Justice, “Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation,” May 31, 2013 (internal citations omitted), [http://www.justice.gov/crt/about/spl/documents/cresson\\_findings\\_5-31-13.pdf](http://www.justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf) (accessed March 13, 2015).

<sup>95</sup> The American Psychiatric Association issued the following position statement in 2012: “Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates. If an inmate with serious mental illness is placed in segregation, out of cell structured therapeutic activities (i.e., mental health/psychiatric treatment) in appropriate programming space and adequate unstructured out of cell time should be permitted. Correctional mental health authorities should work closely with administrative custody staff to maximize access to clinically indicated programming and recreation for these individuals.” American Psychiatric Association, “Position Statement on Segregation of Prisoners with Mental Illness,” December 2012, [http://www.dhcs.ca.gov/services/MH/Documents/2013\\_04\\_AC\\_06c\\_APA\\_ps2012\\_PrizSeg.pdf](http://www.dhcs.ca.gov/services/MH/Documents/2013_04_AC_06c_APA_ps2012_PrizSeg.pdf) (accessed March 12, 2015); The Society for Correctional Physicians issued a similar position statement: Society of Correctional Physicians, “Restricted Housing of Mentally Ill Inmates, Position Statement,” July 9, 2013, <http://societyofcorrectionalphysicians.org/resources/position-statements/restricted-housing-of-mentally-ill-inmates> (accessed February 6, 2015).

<sup>96</sup> Memorandum of Agreement Between the United States Department of Justice and the Consolidated Government of Columbus, Georgia Regarding the Muscogee County Jail, 2015,



Housing inmates with mental disabilities in isolation can be counterproductive to the goals of safety and security: as their mental health deteriorates they can become more difficult to manage.<sup>97</sup> Rather than ending misconduct by persons with mental disabilities, solitary confinement may prompt more. For example, according to his lawyer, Jerry Williams is a 58-year-old schizophrenic, developmentally disabled man serving a 28-year term for low level crimes who has spent more than eight years in solitary confinement in North Carolina state prisons. Because he constantly receives:

disciplinary infractions for misbehavior related to the symptoms of his mental illness, he remains in solitary confinement year after year. Any psychological professional would be unsurprised to hear that a schizophrenic patient, locked within a small, dim, concrete box, might resort to shouting, using profane language, banging on the cell door, or throwing food and liquid. Yet, when Jerry does so, he is consistently disciplined with yet new extended terms of solitary confinement.<sup>98</sup>

Since isolation can have the perverse effect of making inmates with mental disabilities more likely to engage in rule violations, it also increases the likelihood of staff use of force. Indeed, the use of force may be more common in isolation units than elsewhere in correctional facilities.<sup>99</sup> As summarized by correctional expert Steve J. Martin, when a prisoner with a mental disability is placed in solitary confinement, “you have placed that offender in a situation in which he simply cannot cope on a daily basis without decompensating, without struggling more and more, which again leads to efforts to manage the offender with force.”<sup>100</sup>

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[http://www.justice.gov/crt/about/spl/documents/muscogee\\_moa\\_1-16-15.pdf](http://www.justice.gov/crt/about/spl/documents/muscogee_moa_1-16-15.pdf) (accessed April 28, 2015), p. 13. A person with serious mental illness is defined in the agreement as “a person with a mental, behavioral, or emotional disorder of mood, thought, or anxiety; diagnosable currently or within the last year; that significantly impairs judgment, behavior, capacity to recognize reality, and the ability to cope with the demands of life in the general population facilities of the Jail.”

<sup>97</sup> When lawsuits challenging the isolation of prisoners with mental illness are brought, courts almost always order correctional agencies to eliminate solitary confinement of such prisoners or to modify the length of time they are isolated in their cells and to increase their access to mental health services and programming.

<sup>98</sup> Elizabeth Simpson, North Carolina Prisoner Legal Services, Inc., “Reassessing Solitary Confinement II: the Human Rights, Fiscal, and Public Safety consequences,” Hearing before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights, February 24, 2014, <http://solitarywatch.com/wp-content/uploads/2014/02/Jerry-Williams-testimony-for-hearing-on-solitary-confinement.pdf> (accessed April 22, 2015), p. 1.

<sup>99</sup> Human Rights Watch interview with Jeffrey L. Metzner, M.D., Denver, Colorado March 16, 2015.

<sup>100</sup> *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Testimony of Steve Martin, Evidentiary Hearing, November 5, 2013, transcript, p. 1857-1858. The Department of Justice has described the cycle of isolation, misconduct and force this way: “[A] prisoner with serious mental illness is placed in isolation with

As part of the 2012 settlement ending five years of litigation, the Massachusetts Department of Correction agreed to maintain two maximum security mental health treatment units as alternatives to segregation.<sup>101</sup> One of the special units is for prisoners with serious mental illnesses such as schizophrenia or bipolar disorder, and the other is for prisoners with severe personality disorders.<sup>102</sup> Prisoners in either unit receive a total of at least 25 hours weekly of time out of cell for structured and unstructured programming and recreation. An array of mental health interventions are offered to promote recovery, help inmates manage the symptoms of their illness, and help inmates develop the social skills and behaviors needed to transition successfully back to the general population or to the community after their sentences have been served. Custody staff volunteer for and are individually selected for work on the units. They receive mental health training that includes information on the nature and symptoms of mental illness as well as on techniques for defusing and de-escalating volatile situations.

As an incentive to good conduct, prisoners can rapidly earn additional privileges (e.g., more yard time or access to television); the consequence for misconduct is the brief loss of privileges. Disciplinary reports, assaults on staff, and suicide watch placements for prisoners on these units have reportedly dropped significantly from what they were previously. The use of force has reportedly dropped 60 percent.

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inadequate mental health care, causing him to decompensate and behave negatively; staff respond by subjecting the prisoner to harsher living conditions, denying him stimuli, and/or using excessive force against him; the prisoner's mental health continues to deteriorate, and he begins to engage in self-injurious conduct (e.g., banging his head hard and repeatedly against a concrete wall, ingesting objects, or hurling himself against the metal furnishings of his room) or attempts to kill himself; staff eventually respond by placing him in [a mental health unit] where a limited amount of treatment is provided; as soon as the prisoner begins to stabilize, he is returned to isolation, and the prisoner's mental health again spirals downward." US Department of Justice, Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation, May 31, 2013 (internal citations omitted), [http://www.justice.gov/crt/about/spl/documents/cresson\\_findings\\_5-31-13.pdf](http://www.justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf) (accessed February 8, 2015).

<sup>101</sup> *Disability Law Center, Inc. v. Massachusetts Department of Correction*, United States District Court for the Court of Massachusetts, case no. 1:07-cv-10463, Memorandum and Order, filed on April 12, 2012.

<sup>102</sup> Information in this section based on Human Rights Watch telephone interviews and email communications in 2014 and January 2015 with Joel Andrade, Program Manager and Director of Clinical Programs, Massachusetts Partnership for Correctional Health Care, Westborough, Massachusetts, and Leslie Walker, Executive Director, Prisoner Legal Services, Boston, Massachusetts.

## JEROME LAUDMAN

*"That shouldn't be part of his punishment to say hey, you gonna lay back here and die in your own feces and starve to death. That's beyond punishment."*<sup>103</sup>

Jerome Laudman died in 2008 at age 44 after 10 years in South Carolina prisons. His estate filed a lawsuit alleging cruel and unusual punishment, excessive use of force and failure to provide medical care.<sup>104</sup>

Because of mental illness, including bipolar disorder and paranoid schizophrenia, Laudman had been in psychiatric hospitals 13 times in the five years before his death. Each time, however, he was returned to South Carolina prisons. In 2014, a South Carolina state judge ruled the state's prisons provided grossly deficient mental health care.<sup>105</sup>

According to the estate's complaint, Laudman was placed in a crisis intervention cell in the Special Management Unit (SMU), a solitary confinement unit, at Lee Correctional Institution on December 7, 2007 because he was displaying severe emotional problems and had been refusing medications, screaming, experiencing visual hallucinations and he appeared psychotic. In January a psychiatrist observed Laudman exhibiting unusual behavior and talking to himself, with his cell in disarray. The psychiatrist prescribed various antipsychotic medications and ordered a follow-up visit in two weeks. The follow-up allegedly never occurred.

On February 7, Laudman was transferred to the special Supermax (segregation) unit within the SMU, which the complaint characterized as a unit designed to punish and provide intensive supervision to assaultive inmates.<sup>106</sup> According to the administrator of the Supermax, Laudman

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<sup>103</sup> Arthur Laudman, Jerome Laudman's uncle, quoted in "Family: Corrections Treatment of Nephew Was Inhumane," WLTX News – CBS Affiliate, January 20, 2014, <http://www.wltx.com/story/news/2014/02/12/1694012/> (accessed March 12, 2015).

<sup>104</sup> Unless otherwise noted, information about Jerome Laudman is drawn from *Laudman v. Padula*, United States District Court for the District of South Carolina, case no. 8:12-cv-02382, Amended Complaint, filed September 7, 2012. Relying primarily on the evidence in the complaint, the court granted defendants' motions for summary judgment as to some claims and denied them as to others, *Laudman v. Padula*, Report and Recommendation, filed August 22, 2013. The court addressed defendant's asserted legal defenses to liability, e.g. that the statute of limitations had expired, Eleventh Amendment immunity from monetary damages, and whether defendants could be sued in their official or individual capacities. The circumstances leading to Laudman's death are also summarized in *T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, slip op, filed January 8, 2014, a class action case that successfully challenged the deficient treatment of inmates with mental illness in South Carolina prison.

<sup>105</sup> *T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, slip op, filed Jan. 8, 2014.

<sup>106</sup> According to Drs. Jeffrey Metzner and Raymond Patterson, who inspected the unit as plaintiffs' experts in *T.R. v. South Carolina Department of Corrections*, the Supermax section of the SMU was especially inappropriate as housing for inmates with mental illness because the harsh conditions of confinement were likely to exacerbate their symptoms. Prisoners in the Supermax confronted scant time out of cell, limited access to showers, filthy and unhygienic cells, and extreme social isolation. Psychiatric staffing was inadequate, and mental health services consisted primarily of short, infrequent meetings at the inmates' cell fronts, *T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, slip op, filed January 8, 2014.

had been transferred because he had been “trashing” his room, was uncooperative, and was parading around naked.<sup>107</sup> After he refused to back up to his cell door to be handcuffed for the transfer to the new cell, Laudman was gassed with chemical spray.<sup>108</sup>

Plaintiff alleges that Laudman’s physical and mental health rapidly deteriorated after he was transferred to the Supermax because he did not receive necessary medical attention or care there. According to the complaint, Laudman refused to take his medication, refused meals, ingested fecal matter, and smeared feces on himself. A sergeant at the facility told the investigator with the South Carolina Department of Corrections that on February 11 he looked in on Laudman and “he was sitting and stopped over like he was real weak or sick.”<sup>109</sup> The officer also stated he saw food trays piled up, that Laudman was naked, and his room was bare. The investigator’s review of prison medical records revealed that there were only five medical entries from January 1, 2008 until his death.<sup>110</sup> According to the complaint, Laudman had been stripped of his clothing and bedding and for a week, between February 11 to February 18, and lay naked on the cold concrete floor. By February 18, Laudman had lost a lot of weight, and had numerous sores, cuts, and bruises on his body.

The complaint continues that on February 18 a nurse received a call from a correctional officer reporting that Laudman “was down.” She went to his cell and found Laudman lying naked on the floor in feces, urine, and vomit, still alive but breathing shallowly. There were 15-20 food trays with decaying food in the cell and the stench was terrible. Laudman was transported to the prison medical center alive but unresponsive, and he was then taken to a hospital. Medical notes from the hospital indicated Laudman was covered in dirt, urine, and feces when he was brought to the emergency room, and his core body temperature was 80.6 degrees, indicating hypothermia.<sup>111</sup> He went into cardiac arrest and died a few hours later.<sup>112</sup>

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<sup>107</sup> Lloyd R. Greer, Investigative Report, Office of Inspector General, South Carolina Department of Corrections, June 8, 2008, p. 5. (hereinafter “Greer Report”). Greer conducted an investigation into the circumstances surrounding Laudman’s death. He reviewed prison and medical records and interviewed numerous prison security and medical staff as well as inmates. His report was originally filed in court under seal but the confidentiality order was subsequently lifted and the report was attached to the Plaintiffs’ Opposition to Defendants’ Motion for Summary Judgment, filed August 2, 2013.

<sup>108</sup> Greer Report, p. 4.

<sup>109</sup> Greer Report, p. 7.

<sup>110</sup> Greer Report, p. 13

<sup>111</sup> Greer Report, p. 12.

<sup>112</sup> According to the complaint, the death certificate reported the cause of death as “cardiac arrhythmia and cardiomegaly.” The case was settled in 2015 for \$1.2 million. Tim Smith, “State pays \$1.2 million in lawsuit over mentally ill inmate who died,” *Greenville Online*, January 9, 2015. <http://www.greenvilleonline.com/story/news/politics/2015/01/09/state-pays-million-lawsuit-mentally-inmate-died/21525039/> (accessed February 11, 2015). The fact of a settlement agreement is not an indication or admission by a defendant of guilt or liability.

## The Case of Jermaine Padilla

In early 2012, Jermaine Padilla began serving a 10-month prison term in California for a parole violation. According to a lawsuit Padilla filed,<sup>113</sup> he had a lengthy history of mental illness and periods of hospitalization for inpatient mental health treatment. In May 2012 he was housed in the administrative segregation unit of Corcoran State Prison designated for prisoners who are considered unable to function in the general prison population because of “acute onset or significant decompensation of a serious mental disorder.”<sup>114</sup> Shortly after being transferred to CSP-Corcoran, mental health staff noted he manifested auditory hallucinations, his thought process became illogical, he began to refuse medication, and his mental state declined. The complaint states that mental health notes for the first two weeks of June indicate Padilla expressed paranoia, appeared psychotic, delusional, illogical and was responding to internal stimuli. On July 1 he was transferred to the prison’s Mental Health Crisis Bed (MHCB) unit. When a psychiatrist in the MHCB unit began treating Padilla, he considered Padilla to be “gravely disabled,” according to testimony he provided in court.<sup>115</sup> Padilla’s complaint indicates MCHB treatment team records showed he had diagnoses of schizoaffective disorder, bipolar disorder, and depression.

Over the course of the next three weeks, Padilla’s mental health continued to deteriorate. The complaint alleges that treatment notes over this period indicated that Padilla took off his clothes and stayed naked, talked as if he were responding to internal stimuli, and sometimes screamed. He urinated on his mattress and on the floor of his cell, smeared feces, peanut butter and food remains upon a dried puddle of urine. According to the psychiatrist, Padilla was completely unresponsive to any treatment efforts. Padilla also refused to eat. On July 24, he smeared himself with feces. The psychiatrist testified in court

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<sup>113</sup> Unless otherwise noted, information about Jermaine Padilla is drawn from *Padilla v. Beard*, United States District Court for the Eastern District of California, case no. 2:14-cv-01118, Amended Complaint, filed December 2, 2014. Evidence about Padilla was also presented in the class action case *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, including a video of the cell extraction of Padilla and the following expert reports: Supplemental Expert Declaration of Edward Kaufman, M.D., in support of plaintiffs’ Motion for Enforcement of Court Orders and Affirmative Relief Related to Use of Force and Disciplinary Measures, filed September 23, 2013; Declaration of Eldon Vail, filed March 14, 2013; and Expert Declaration of Eldon Vail, filed March 14, 2013.

<sup>114</sup> In the mental health context, the term “decompensation” is a clinical term referring to a deterioration in the condition of a person with mental illness, e.g. a worsening of symptoms and a loss of ability to function. Email communication from Pablo Stewart, M.D., to Human Rights Watch, March 30, 2015.

<sup>115</sup> All quotes from the psychiatrist, Dr. Ernest Wagner and statements about his views and conduct with regard to Padilla are from the transcript of his examination and cross-examination during the court hearings are from the transcript of his examination during the court hearings in *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Evidentiary hearing, October 22, 2013.

that he decided that Padilla presented an emergency situation and he asked custody staff to remove Padilla from his cell so that he could be involuntarily medicated. He stated that he believed Padilla would have died without the involuntary medication.<sup>116</sup>

As seen in a video that plaintiffs introduced as evidence in the class action case *Coleman v. Brown*, a mental health staff member spoke to Padilla briefly—for about half a minute—trying to get him to voluntarily “cuff up” (voluntarily submit to being restrained in handcuffs) so that he could be escorted from his cell.<sup>117</sup> When that effort failed, a member of the prison medical staff cleared the use of chemical agents against Padilla, that is, she indicated he had no medical conditions such as asthma that should preclude the use of the agents. A cell extraction team assembled in front of Padilla’s cell wearing gas masks, suited head to toe in biohazard suits, and armed with handcuffs, leg irons, batons, a full-length plastic body shield, and fire-extinguisher-sized canisters of pepper spray. The extraction team leader read Padilla a warning that if he did not cuff up he would be forcibly extracted as well as disciplined. Padilla refused.

The video shows that custody staff proceeded to spray Padilla with OC (oleoresin capsicum) six times over a period of approximately six-and-a-half minutes. A psychiatrist working as an expert for plaintiffs in the class action case *Coleman v. Brown* who watched the video of Padilla’s cell extraction said that although it appeared that Padilla could “not understand or comply with such orders, each failure by [him] to ‘cuff up’ [was] met by another injection of OC spray into the cell. Even as [Padilla] [was] repeatedly crying for help, there [was] no further attempt by officers or clinicians to engage him. Rather, they administer[ed] more OC spray.”<sup>118</sup> The video shows Padilla screaming in pain, yelling for help, and sometimes

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<sup>116</sup> Under international human rights law, the forced administration of psychiatric medication to individuals with psychosocial disabilities may amount to torture or other prohibited ill treatment. See United Nations General Assembly, “Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Mendez,” A/HRC/22/53, February 1, 2013, available at [http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53\\_English.pdf](http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf) (accessed March 17, 2015); United Nations General Assembly, “Torture and other cruel, inhuman or degrading treatment or punishment, Note by the Secretary-General,” A/63/175, July 28, 2008, <http://www.refworld.org/docid/48db99e82.html> (accessed February 17, 2015). Assessing whether the forced medication of Padilla constitutes torture or prohibited ill treatment is, however, beyond the scope of this report.

<sup>117</sup> Following prison policies, prison staff made a video of Padilla’s cell extraction which was introduced as evidence in *Coleman v. Brown*. Human Rights Watch obtained a copy of the video from the court hearing that case.

<sup>118</sup> *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, including a video of the cell extraction of Padilla and the following expert reports: Supplemental Expert Declaration of Edward Kaufman, M.D., in support of plaintiffs’ Motion for Enforcement of Court Orders and Affirmative Relief Related to Use of Force and Disciplinary Measures, filed September 23, 2013.

crawling on the floor of his cell. A use of force expert for plaintiffs in *Coleman v. Brown* who watched the video stated that Padilla “was not lucid or coherent enough to be able to follow the officer’s orders to back up to the cell and ‘cuff up’. He turned in circles near the cell door but did not get the concept that relief might come if he could back up to the cell door and then manage to place his hands through the cuff port in the door.”<sup>119</sup>

His complaint alleges that Padilla believed the extraction team was “there to harvest his organs or turn him into a cyborg.” According to an incident report subsequently filed by a captain who authorized the cell extraction and observed it, during the extraction Padilla was “very confused and disoriented” and was “observed in a mental state where he could not follow the simplest [sic] instruction.”<sup>120</sup>

When the use of spray did not succeed in making Padilla agree to cuff up, a supervising officer decided the team should enter Padilla’s cell and physically extract him.<sup>121</sup> As shown on the video, an extraction team entered his cell, used the full-length shield to pin him down, and then put arm and leg restraints on him while he continued to scream and resist. He was placed on a gurney, naked, with his genitals exposed, and taken to a restraint bed where he was fully immobilized. On the video, as Padilla is being wheeled into the room and put in restraints, he can be heard making statements such as “Why is this happening,” “I didn’t do nothing wrong ... I don’t want to decapitate nobody ... Why is my skin falling off?” and “I don’t want to be executed.” His complaint alleges that Padilla was “scared that Defendants were going to cut off his limbs with a chainsaw, put a fake heart in his chest, or do experiments on him. It seemed to him that everything he feared from his hallucinations was coming true.”

Padilla was involuntarily medicated by injection and kept immobilized in restraints for about three days. The complaint alleges that he was not allowed out of restraints to use the bathroom; he urinated on himself, the bed, and the floor. The psychiatrist treating him testified that Padilla’s “combativeness when psychotic” warranted great caution before

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<sup>119</sup> *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Expert Declaration of Eldon Vail, filed March 14, 2013, p. 19.

<sup>120</sup> Crime/Incident Report by Captain Jenna Castro, incident log number COR-HCO-12-07-0431, dated July 24, 2012, p. 2, on file at Human Rights Watch.

<sup>121</sup> *Ibid.*, p.3. “After approximately 10 minutes when the controlled use of force was initiated I decided based on the circumstances (i.e., attached lanyard, inmate distance from the food port, mental state of the inmate, OC pepper spray not having the desired effect), the best option was to ...send the cell extraction team inside of the cell to subdue the inmate.”

removing the restraints, and he thought Padilla should remain restrained until he agreed to take his medications orally, was likely to take medications voluntarily in the future, and had a “demonstrated ability to acknowledge and state the reason he’s restrained.” According to the complaint, after Padilla had been restrained for 72 hours, another psychiatrist ordered him released from the restraints. The complaint in his case states that he was subsequently transferred to an inpatient mental health hospital within Salinas Valley State Prison. He was released from prison on February 14, 2013.<sup>122</sup>

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<sup>122</sup> Human Rights Watch telephone interview with Lori Rifkin, attorney for Padilla, February 4, 2015.



### III. Approaches to Use of Force

[U]se of force incidents with the mentally ill can exacerbate and worsen their mental health illness. [A]voidance of use of force needs to be a primary value of the organization when you're dealing with mentally ill inmates.

—Eldon Vail, former Secretary, Washington State Department of Corrections.<sup>123</sup>

Justin Monroy, a 22-year-old with paranoid schizophrenia and bipolar disorder who lived with his parents, sister, and three younger brothers in Michigan, was arrested after he threatened his sister with a knife in an argument over cigarettes and was held at the Jackson County Jail. According to information Monroy and his family provided to the press, Monroy's mental health deteriorated in jail where he did not receive his medication. According to the *Detroit Free Press*, after he kicked, punched, and banged his head against a cell door, officers sprayed Monroy with a chemical agent. Still concerned that Monroy might continue to hurt himself, officers reportedly also shocked him with an electric stun device and shackled him in a restraint chair with ankle chains. According to a psychiatric evaluation, Monroy believed government agents were out to kill him. He was subsequently transferred to a psychiatric hospital.<sup>124</sup>

There are no national statistics on the prevalence of staff use of force against inmates in general, or inmates with mental disabilities in particular, in the more than 5,100 jails and prisons in the United States.<sup>125</sup> Experts we consulted for this report said that force is used

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<sup>123</sup> *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Deposition of Eldon Vail, filed October 2, 2013, p. 139

<sup>124</sup> Gerritt, "When jails must be mental clinics," *Detroit Free Press*. Gerritt interviewed Monroy and his family for the story. Human rights Watch was not able to talk with Monroy, but we did interview the reporter of the story, Jeff Gerritt, now a deputy editor with the Toledo Blade. Gerritt told us that to report the story, in addition to talking with Monroy and his family, he also talked with jail staff and read a copy of Monroy's psychiatric evaluation. He said that no complaints were made about the accuracy of his account after the story ran. Human Rights Watch telephone interview with Jeff Gerritt, Toledo, Ohio, April 30, 2015.

<sup>125</sup> Some agencies do not track uses of force; those that keep data rarely make it public. Moreover, where use of force data is kept, it is difficult to make comparisons among agencies because of different reporting criteria and reliability. According to correctional use of force expert Jeffrey Schwartz, "In badly run facilities where there is a significant amount of excessive force, any data that exists are also likely underestimates, because many uses of force in such facilities go unreported." Human Rights Watch email correspondence with Jeffrey A. Schwartz, February 23, 2015.

disproportionately against prisoners with mental illness.<sup>126</sup> This disproportion is reflected in the statistics we have been able to gather<sup>127</sup>:

- In Colorado, 3 percent of the prison population was diagnosed with mental illness but those inmates were the targets of force in 36 percent of the use of force incidents. Cell extractions involving pepper spray occurred at a rate of 44.4 per 1,000 inmates with mental illness compared to 3.8 per 1,000 other inmates.<sup>128</sup>
- In South Carolina, inmates diagnosed with mental illness were subjected to use of force at a rate two-and-a-half times that of other inmates.<sup>129</sup>
- In 12 California prisons, use of force incidents against inmates with mental illness were reported at a rate more than double their representation in the prison population. In four of the 12 facilities, force against prisoners with mental illness constituted 87-94 percent of use of force incidents, even though those prisoners constituted only 30-55 percent of the population of the four facilities.<sup>130</sup>
- In Washington state prisons, out of a total of 636 reported uses of force in calendar year 2013, 101 involved offenders in the mental health unit.<sup>131</sup>
- In Los Angeles County jails, roughly a third of the use of force cases in 2011 involved inmates with mental health histories, although they constituted 15 percent of the jail population.<sup>132</sup>

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<sup>126</sup> For example, Steve J. Martin, an independent corrections consultant, has visited, investigated or monitored hundreds of facilities in 35 states. He told Human Rights Watch that everywhere he has looked at use of force data, force has been used disproportionately against prisoners with mental illness. Human Rights Watch telephone with Steve J. Martin, Austin, Texas, April 29, 2014.

<sup>127</sup> The data presented here should not be used to make comparisons among jurisdictions because different agencies use different definitions regarding what constitutes use of force and how prisoners are identified as having mental disorders. We offer the data simply to show that some agencies do have data that indicates prisoners with mental illness within their jurisdiction are subjected to force more frequently than other inmates. We found no data that indicates prisoners with mental illness are less likely to be subjected to use of force.

<sup>128</sup> Data based on number of cell extractions, forced cell entry, restraint chair, and four or five point restraints at San Carlos and Centennial, the Colorado prison facilities devoted primarily to custody of prisoners with mental illness, from March, 2013 through February 2014. There may also be prisoners with mental illness confined in other facilities. Data provided to Human Rights Watch by Colorado Department of Corrections, on file at Human Rights Watch.

<sup>129</sup> In some individual prisons the disparity was even higher. At Perry Correctional institution for example, 44 percent of the mentally ill were subjected to at least one use of force compared to 16 percent of those without mental illness. Incidents involving the use of force were measured from January 2008 through September 2011. *T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, slip op, filed Jan. 8, 2014, p. 16.

<sup>130</sup> *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Deposition of Eldon Vail, para. 9-11.

<sup>131</sup> Data provided to Human Rights Watch by Dan J. Pacholke, Deputy Secretary, Washington State Department of Corrections, June 25, 2014. Data was not available that indicated how many prisoners with mental illness who were not in the mental health unit had force used against them.

## Prison and Jail Policy and Practice

The use of force is inherent in the idea of involuntary confinement and is a fact of life in prisons and jails across the country.<sup>133</sup> Custody staff are permitted by law and policy to use force to protect themselves or others, prevent crimes and escapes, maintain safety and security, and enforce lawful orders.<sup>134</sup>

Agency policies establish the types of force staff may use, when force may be used, and rules for reporting on and investigating incidents in which force is used. Even with “excellent policy, training, equipment, practices and procedures, and the best of intentions, a use-of-force situation may produce serious injury or death.”<sup>135</sup> When any one of those components is lacking—as is common in many facilities—unnecessary and excessive force causing injury or death becomes far more likely.

Staff reliance on force to manage or control inmates is diminished in agencies which are well managed, emphasize respect for inmates, provide them decent conditions of confinement, and provide mental health services to inmates who need them. Bernard Warner, Secretary of the Washington Department of Corrections, told Human Rights Watch, “If you have a well-run prison with good programming and mental health treatment, there will be less use of force.”<sup>136</sup> According to Major Ron Freeman of the Ada County Jail in Idaho, “We teach inmate behavioral management instead of physical containment. We set expectations, use incentives and disincentives and hold inmates accountable to get the behavior we want. Force begets force. Officers are safer here if there is less force; the facility is calmer and less tense.”<sup>137</sup> Staff who are trained and expected to defuse potentially volatile situations will also have less need to resort to force.

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<sup>132</sup> Jack Leonard and Robert Faturechi, “L.A. County jailers more likely to use force on mentally ill inmates,” *Los Angeles Times*, January 11, 2012, <http://articles.latimes.com/2012/jan/11/local/la-me-sheriff-jails-20120111> (accessed March 12, 2015)

<sup>133</sup> In the corrections context, force “means offensive or defensive physical contact with a prisoner.” American Bar Association, Standard 23-5.6(a), “Force does not include a firm hold, or use of hand or leg restraints, or fitting of a stun belt, on an unresisting prisoner,” in American Bar Association, *ABA Standards of Criminal Justice (3rd ed.): Treatment of Prisoners*, June 2011, [http://www.americanbar.org/content/dam/aba/publications/criminal\\_justice\\_standards/Treatment\\_of\\_Prisoners.authcheckdam.pdf](http://www.americanbar.org/content/dam/aba/publications/criminal_justice_standards/Treatment_of_Prisoners.authcheckdam.pdf) (accessed March 12, 2015), p. 132.

<sup>134</sup> Constitutional and international legal standards governing use of force are discussed later in this report.

<sup>135</sup> Jeffrey A. Schwartz, “Come and Get Me! The Best and Worst in Cell Extractions,” *American Jails*, July/August, 2009.

<sup>136</sup> Human Rights Watch interview with Bernard Warner, Secretary, Washington State Department of Corrections, Olympia, Washington, July 14, 2014.

<sup>137</sup> Human Rights Watch interview with Major Ron Freeman, Ada County Sheriff’s Office, Boise, Idaho, July 17, 2014.

US court rulings, human rights standards, and corrections experts agree that staff should use force only when necessary, should use only the minimum amount of force necessary, and should use force only for so long as is necessary to attain a legitimate objective. The legitimacy and legality of the use of force depends on such factors as the reason for the force, the relationship between that reason and the amount of force used, and efforts made to avoid force or to temper its severity. Even if force is required initially, staff may not continue to use it once a prisoner is subdued or secured, is no longer resisting, or has complied with staff orders. Force should never be used as punishment or reprisal against a prisoner or solely for the purpose of causing physical or psychological pain.<sup>138</sup>

The immediate use of force is unnecessary if the officers “could have waited without risking harm before using force.”<sup>139</sup> Force is also not a necessary response to “every inmate who fails to follow a prison rule or order [absent] an immediate necessity to incapacitate, immobilize or neutralize threatening behavior.”<sup>140</sup> When there is a recalcitrant or disruptive inmate who does not pose an imminent threat, sometimes the best option is to do nothing. “We’re not here to punish. If an inmate is kicking and banging on his cell door and not hurting himself, we just let him stay there unless [he is] seriously disrupting the rest of the unit for a long time.”<sup>141</sup> A “cooling off” period may succeed in obviating the need for force to be used at all.

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<sup>138</sup> For a good summary of the basic precepts governing the use of force, see *Shreve v. Franklin County*, United States District Court for the Southern District of Ohio, case no. 2:10-cv-00644, Report of Plaintiffs’ Expert Steve J. Martin, filed July 23, 2010. The American Bar Association standard on the use of force provides that: “Correctional authorities should use force against a prisoner only: (b) (i) to protect and ensure the safety of staff, prisoners, and others; to prevent serious property damage; or to prevent escape;(ii) if correctional authorities reasonably believe the benefits of force outweigh the risks to prisoners and staff; and(iii) as a last alternative after other reasonable efforts to resolve the situation have failed. (c) In no case should correctional authorities use force against a prisoner:(i) to enforce an institutional rule or an order unless the disciplinary process is inadequate to address an immediate security need;(ii) to gratuitously inflict pain or suffering, punish past or present conduct, deter future conduct, intimidate, or gain information; or (iii) after the risk that justified the use of force has passed.” American Bar Association, *ABA Standards of Criminal Justice (3rd ed.): Treatment of Prisoners*, June 2011, p. 132. The American Correctional Association’s use of force policy calls on correctional authorities to seek to reduce or prevent the necessity of the use of force, to authorize force only when no reasonable alternative is possible, to permit only the minimum force necessary, and to prohibit the use of force as a retaliatory or disciplinary measure. American Correctional Association’s (ACA) public correctional policy on use of force as published in Craig Hemmens and Eugene Atherton, *Use of Force: Current Practice and Policy*, American Correctional Association, (Upper Marlboro, MD: Graphic Communications, 1999), p. vi-vii. Specific standards governing the use of force in corrections are contained in the *Standards for Adult Correctional Institutions*, American Correctional Association, (Lanham, MD: American Correctional Association, 2003); and *Standards of Adult Local Detention Facilities* (4<sup>th</sup> ed), American Correctional Association, (Lanham, MD: American Correctional Association, 2004).

<sup>139</sup> *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Order, filed April 10, 2014, p. 21 (quoting defendants’ use of force expert Steve J. Martin).

<sup>140</sup> *T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, slip op, filed Jan. 8, 2014, p. 21.

<sup>141</sup> Human Rights Watch interview with Major Ron Freeman, Ada County Sheriff’s Office, Boise, Idaho, July 17, 2014.

When some level of force is warranted, the force should not be disproportionate to the risk of harm posed by the prisoner. For example, if an unarmed prisoner is sitting passively on a bed in a securely locked cell and refuses to return a food tray, the use of an electronic stun device to force him to return the tray would be disproportionately harsh. Because it would exceed what is needed to resolve the situation, it could not be considered necessary.<sup>142</sup>

While the exact language varies somewhat, good policies for the use of force echoing the principles outlined above are reflected in recent settlements of lawsuits bringing claims against corrections facilities and personnel for unconstitutional and abusive use of force. One such settlement, for example, requires the Los Angeles Sheriff's Department, which runs the Los Angeles County jails, to establish policies under which force:

- (a) must be used as a last resort;
- (b) must be the minimal amount of force that is necessary and objectively reasonable to overcome the resistance;
- (c) must be terminated as soon as possible consistent with maintaining control of the situation and must be de-escalated if resistance decreases: "force may not be used as discipline or corporal punishment."<sup>143</sup>

The injunction to avoid unnecessary force is also spelled out in a settlement of litigation over the rampant misuse of force in Orleans Parish Prison in New Orleans. The sheriff of New Orleans is required to adopt policies that prohibit, for example:

- (1) Use of force as a response to verbal insults or prisoner threats where there is no immediate threat to the safety or security of the institution, prisoners, staff or visitors;
- (2) Use of force as a response to prisoners'

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<sup>142</sup> Indeed, any use of force in this situation might be excessive. Staff could simply tell the inmate that he will not receive more food until he is willing to return the tray. California regulations previously authorized immediate use of force if an inmate refused to return a food tray. Under the new policy adopted in 2014, the inmate will be told he will not get another meal until he returns the food tray. After 24 hours, the manager will decide if force should be used to retrieve the tray. Also, if the goal is simply to retrieve the tray, and the tray can be retrieved without the use of a cell extraction team and force, staff may enter the cell, retrieve the tray and exit. *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Defendants' Plans and policies Submitted in Response to April 10, 2014 and May 13, 2014 orders, Policy 51020.12.5, filed August 1, 2014.

<sup>143</sup> *Rosas v. Baca*, United States District Court for the Central District of California, case no. 2:12-cv-00428, Implementation Plan, 2.2 and 2.6., filed December 17, 2014. The settlement also requires policies prohibiting striking inmates in the head or kicking them on the ground absent a situation of imminent danger of serious injury.

failure to follow instructions where there is no immediate threat to the safety or security of the institution, prisoners, staff or visitors.<sup>144</sup>

## Special Policies for Inmates with Mental Disabilities

Careful adherence to the principle of necessity would preclude the use of force in many instances in which it is currently used against prisoners whose behavior is symptomatic of mental health problems. But it also helps if use of force policies expressly require special steps, such as having mental health staff talk to the prisoner, before force can be used on such prisoners.<sup>145</sup>

Recent settlements and court orders in lawsuits alleging excessive use of force against inmates with mental illness require prisons and jails to adopt policies ensuring that mental health staff or other staff skilled in defusing volatile situations are called in to intervene with the inmate before force is authorized in non-emergency situations. Thus, for example, the settlement agreement in a case brought on behalf of Pennsylvania prison inmates with mental illness provides in relevant part:

If an inmate with [mental illness] presents a non-emergency security threat, a [mental health professional], a person who is appropriately trained in Crisis Intervention, or a member of the Hostage Negotiation Team will be notified and that person will attempt to de-escalate the situation so that use of force is not necessary and/or to reduce the level of force required.<sup>146</sup>

As experts we consulted emphasized, to be effective at preventing the need for force, de-escalation or crisis interventions cannot be brief pro forma visits to the inmate's cell front. Mental health staff or other negotiators must be given the time and have the determination to connect with the individual to determine what is prompting his distress, what he is seeking, and how the situation can be resolved without violence. Correctional mental

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<sup>144</sup> *Lashawn Jones, et al., v. Marlin Gusman*, United States District Court for the Eastern District of Louisiana, case no. 2:12-cv-00859-LMA-ALC, filed December 12, 2012, p. 11.

<sup>145</sup> "When a prisoner has a history of mental illness or is exhibiting behaviors consistent with mental illness, the advice and intervention of a qualified mental health professional should be sought before taking action, or, if that is not possible, as soon as is feasible." American Bar Association, *ABA Standards of Criminal Justice (3rd ed.): Treatment of Prisoners*, June 2011, p. 132.

<sup>146</sup> *Disability Rights Network of Pennsylvania v. Wetzel*, United States District Court for the Middle District of Pennsylvania, case no. 1:13-cv-00635, Settlement Agreement, filed on January 5, 2015, p.46.

health expert Dr. Terry Kupers, for example, believes such interventions ideally should be without time limits, but should last at a minimum 30 minutes before force is initiated.<sup>147</sup>

The best use of force policies take into account the possibility that because of mental illness an inmate may not understand or be able to comply with an order. The case of Jermaine Padilla, featured in Chapter II above, illustrates how an inmate who is experiencing psychosis may not be able to comply with orders. A psychiatrist who testified for plaintiffs in the California case of *Coleman v. Brown* described how a cell extraction and the use of chemical agents (e.g. pepper spray) may be perceived by and affect individuals with mental disorders:

[T]he ‘cell extraction teams’ (consisting of approximately five to seven custody officers) gear up in head-to-toe protective gear and gas masks or helmets, rendering them a bizarre and frightening team of figures as experienced by the inmate-patient. They then approach the inmate-patient’s cell with various weapons at the ready including a range of sizes of OC canisters, expandable batons, and full-body shields. The officers proceed by speaking or shouting at the patient through a closed door and a helmet or mask, and deploying OC spray, grenades, and/or Barricade Removal Devices (“cell-busters”) into the cells. For a psychiatric patient who may already be responding to delusions or internal stimuli such as voices, or who has impaired reality testing, or paranoia or anxiety about people picking on, physically hurting, sexually assaulting, poisoning, or attacking him or her, [forced cell extractions with pepper spray] can ...appear to be his delusions come-to-life...<sup>148</sup>

Because of the *Coleman v. Brown* litigation, the California Department of Corrections and Rehabilitation recently adopted use of force policies to reduce the pepper spraying of inmates with mental illness. Absent an emergency or special authorization by senior facility officials, the policy prohibits the use of chemical agents against inmates in specialized mental health housing or against inmates who “do not possess the ability to

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<sup>147</sup> Email to Human Rights Watch from Terry Kupers, M.D, Oakland, California, April 21, 2015.

<sup>148</sup> *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Supplemental Expert Declaration of Edward Kaufman, M.D. in Support of Plaintiffs’ Motion for Enforcement of Court Orders and Affirmative Relief Related to the Use of Force and Disciplinary measures, filed September 23, 2013, p. 5.

understand orders, have difficulty complying with orders due to mental health issues, or are at increased risk of decompensation resulting from such use of force. For inmates who do not possess the ability to understand orders, the Warden ... may only authorize the use of chemical agents where serious circumstances exist calling for extreme measures to protect staff or inmates.”<sup>149</sup>

## Putting Policies into Practice

Good policies by themselves are not enough.<sup>150</sup> Training, supervision, and accountability mechanisms are crucial to ensuring staff refrain from misusing force. Sheriff Gary Raney in Ada County, Idaho, told Human Rights Watch:

Agencies focus too much on finding the words to write in policy and hope that makes things better.... I’ve seen many jails that have good policies—that are ignored. When other jail administrators come here, they look for the policy and training, but I always tell them that while policy is important, it’s not a significant factor of our success. Training is—so long as it is reinforced by effective supervision. That’s the real key—policy, training and supervision—but I’ll take supervision every time over the other two.<sup>151</sup>

Use of force training for correctional officers in the academy as well as in-service training often fail to give correctional officers the knowledge and skills to make sound judgments as to when force is necessary in any given situation and, if so, how much force should be used. It typically prioritizes physical containment over inmate management through non-forceful means, including verbal negotiation and de-escalation strategies, being responsive to inmate concerns, and the judicious use of cooling off periods. The training

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<sup>149</sup> *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Defendants’ Plans and Policies Submitted in Response to April 10, 2014 and May 13, 2014 Orders, *Coleman v. Brown*, filed August 1, 2014, p. 5.

<sup>150</sup> Thus, for example, the Arizona Department of Corrections policies instructed staff to employ chemical sprays to prevent suicide or serious self-inflicted injury only after attempts at verbal intervention failed. But in practice, custody staff routinely and immediately sprayed inmates who made even the slightest move towards self-harm without notifying or seeking intervention by mental health staff, *Parsons v. Ryan*, United States District Court for the District of Arizona, case no. 12-00601, Expert Report of Eldon Vail, filed November 8, 2013, p. 33.

<sup>151</sup> Email to Human Rights Watch from Sheriff Gary Raney, Ada County Sheriff’s Office, Boise, Idaho, July 9, 2014.



does not give officers the skills “to anticipate, stabilize and diffuse situations that might give rise to conflict...”<sup>152</sup>

Training and then supervision after training can help custody staff understand that force alone cannot keep a facility safe and secure, that unnecessary and excessive force creates the need for more force. Supervisors must constantly impress upon front-line staff the message that inmate violence and misconduct decline and facilities are safer when staff establish rapport with prisoners, are respectful to them, and are responsive to their legitimate questions and concerns.

Deputy-on-inmate violence, including needless and malicious force against inmates with mental disabilities, persisted for years in the Los Angeles County jails. According to a class action complaint, deputies were able to engage in such abuse because the sheriff and the jail’s senior leadership turned a blind eye to evidence of it, tolerated a code of silence by front-line staff as well as supervisors, and failed to ensure accountability through timely and thorough investigations and discipline.<sup>153</sup> The settlement of the lawsuit and new leadership may lead to improved conditions in the jails, but the lawsuit put a spotlight on serious problems that the new jail leadership needs to act vigorously and effectively to address.<sup>154</sup> The role of leadership in staff violence at the jails was succinctly summarized by the Citizens Commission on Jail Violence in Los Angeles County:

Over the years, some deputies have viewed force as a way to signal their authority over inmates and to establish “who is running the jails,” rather than as a last resort in response to problematic inmate behavior. These deputies have adopted a confrontational approach in their interactions

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<sup>152</sup> ABA Standard 23-5.6(b)(iii); The American Bar Association’s Standards on the Treatment of Prisoners, reflect “constitutional and statutory law, a variety of relevant correctional policies and professional standards, the deep expertise of the many people who assisted with the drafting, and the extensive contributions and comments of dozens of additional experts and groups, they set out principles and functional parameters to guide the operation of American jails and prisons...” American Bar Association, *ABA Standards of Criminal Justice (3rd ed.): Treatment of Prisoners*, June 2011, p. 132.

<sup>153</sup> *Rosas v. Baca*, United States District Court for the Central District of California, case no. 00:12-CV-00428, Complaint for Injunctive Relief Class Action, filed January 18, 2012. The parties reached a settlement agreement three years later. *Rosas v. Baca*, United States District Court for the Central District of California, case no. 00:12-CV-00428, Preliminary Order Approving Parties Proposed Settlement, filed January 23, 2015. The fact of a settlement agreement is not an indication or admission by a defendant of guilt or liability.

<sup>154</sup> Editorial, “Can L.A. County Jails end the culture of violence against inmates,” *Los Angeles Times*, December 16, 2014 <http://www.latimes.com/opinion/editorials/la-ed-rosas-settlement-los-angeles-county-jails-20141217-story.html> (accessed May 1, 2015).

with inmates, thereby heightening disrespect among deputies and inmates and increasing tension in the jails. Management, in turn, has sent the wrong message by failing to address excessive force and a deputy culture resistant to supervision.

[W]idespread use of excessive force is both indicative of, and often precipitated by, a problematic organizational culture.... [A] lasting transformation of the culture in custody will not be easy. It will require capable and committed supervisors; strong and clear communication of policies and Core Values; timely and strict enforcement action evidencing zero tolerance for misconduct and dishonesty; and engaged and visible leadership in regard to these issues at the highest level of the department.”<sup>155</sup>

### *Mental Health Training for Staff*

The front-line custodial staff who manage prisoners on a daily basis have a difficult job. Often working in insufficient numbers, they are asked to maintain control over prisoners in tense, overcrowded, and often physically unpleasant facilities. Before being hired, custody staff are rarely screened to determine whether they have the maturity and temperament needed to manage prisoners calmly and professionally, including prisoners who engage in erratic or disruptive behavior because of mental health problems.<sup>156</sup> Although “many officers do their best to provide compassionate supervision.... it is also unfortunately true that a few officers behave with a style, and sometimes an intent, that can only be described as harmful to the emotional well-being of any inmate and toxic to inmates with serious mental illness.”<sup>157</sup>

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<sup>155</sup> Citizen’s Commission on Jail Violence, Report, September 28, 2012, <http://ccjv.lacounty.gov/wp-content/uploads/2012/09/CCJV-Report.pdf> (accessed February 11, 2015), p. 96.

<sup>156</sup> Human Rights Watch telephone interview with Eldon Vail, former Secretary, Washington State Department of Corrections and corrections consultant, Olympia, Washington, February 10, 2015. See Human Rights Watch, *Ill-Equipped*, p. 76-78.

<sup>157</sup> Kenneth L. Appelbaum, “Commentary: The Use of Restraint and Seclusion in Correctional Mental Health,” *Journal of the American Academy of Psychiatry and the Law*, vol. 35, no. 4 (2007), p. 432.

Custody staff commonly receive little or no training in managing inmates with mental disabilities.<sup>158</sup> They are not given information on the nature of different mental health problems and the symptoms that may episodically or chronically result from them. Even officers who work on units with high proportions of, or dedicated to the confinement of, inmates diagnosed with mental illness may have scant understanding of what the inmates are living with and how it may affect their conduct. They do not understand that, for example, prisoners who are “hearing voices, [are] manic or severely depressed... may lack the capacity to regulate their behavior with the same speed and responsiveness as someone who is not suffering such distress.”<sup>159</sup> They are not given the training that would help them distinguish between erratic behavior that is symptomatic of mental illness and genuine aggression.<sup>160</sup> Custodial staff are also rarely trained in verbal de-escalation and crisis intervention techniques that can be useful when confronting an agitated or violent prisoner whose mental condition is deteriorating and who is experiencing an increase in symptoms and a loss of function.<sup>161</sup> The importance of such training is increasingly recognized. Thus, for example, in a recent agreement with the Department of Justice, officials for Muscogee County, Georgia, agreed to provide correctional staff with “Crisis Intervention Team training that includes training on (i) understanding and recognizing psychiatric signs and symptoms to identify inmates who have or may have [serious mental illness], (2) using de-escalation techniques to calm and reassure inmates who have or may

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<sup>158</sup> Although training for both prison and jail staff is inadequate, training for the latter is particularly deficient. During the hiring process, there is also typically less screening of jail staff than for prison staff to ascertain their ability to work with inmates who have mental health conditions. Email to Human Rights Watch from Fred Cohen, March 24, 2015.

<sup>159</sup> *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Expert Declaration of Eldon Vail, filed March 14, 2013, p. 41.

<sup>160</sup> Peter Eliasberg, legal director of the ACLU of Southern California, which successfully sued the Los Angeles County jails for excessive use of force, has pointed out: “You have to be on guard that some [inmates] behave differently and they often do things that if they didn’t have mental illness, it would be a real true sign of aggression. But if you’re sensitive that this is an inmate with mental illness, you realize it’s not a deliberate attempt to incite.” Leonard and Faturechi, “L.A. County jailers more likely to use force on mentally ill inmates,” *Los Angeles Times*.

<sup>161</sup> New policies and practices required after class action litigation by plaintiffs alleging excessive force against mentally ill prisoners often include requirements for special mental health training for custody staff. See, e.g., *Disability Rights Network of Pennsylvania v. Wetzel*, United States District Court for the Middle District of Pennsylvania, case no. 1:13-cv-00635, Settlement Agreement, filed on January 5, 2015, (requiring staff to receive training in “Mental Health First Aid Training” and crisis intervention training); *Rosas v. Baca*, United States District Court for the Central District of California, case no. 00:12-CV-00428, Implementation Plan, filed on December 17, 2014 (requiring “custody specific, scenario based, skill development training” for staff to enable them to identify and work with inmates who have a mental illness as well as such training in crisis intervention and conflict resolution. .)

have [serious mental illness] before resorting to use of force, discipline, or isolation, and (3) making appropriate referrals of such inmates to mental health staff.”<sup>162</sup>

Absent such training, correctional officers may act on the same misconceptions, fears, and biases about mental illness common among members of the general public and which fuel discriminatory and hostile reactions. They may be hostile or disrespectful to inmates with mental health problems. They may believe “crazy” people are scary and dangerous.<sup>163</sup> They may not understand that their own conduct and attitudes about the prisoners’ mental health conditions can influence how those prisoners behave. Lack of training, ignorance, and a correctional culture predicated on command and control all increase the likelihood that force will be the default response to disruption or disobedience by inmates with mental disabilities.<sup>164</sup>

### *Collaboration between Custody Staff and Mental Health Staff*

Mental health training for correctional officers helps them better understand the contributions mental health staff can make to a safer facility and to overcome stereotypes that often impede effective responses to inmates with mental disabilities.<sup>165</sup> It is not uncommon for custody staff to view mental health staff with distrust, failing to understand that mental health staff can make their jobs easier. This view is reinforced when, as is usually the case, matters of safety and security are deemed the sole prerogative of custody staff, and mental health staff do not play a direct role in the daily operation and supervision of living units in which prisoners with mental disabilities are housed. Too

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<sup>162</sup> Memorandum of Agreement Between the United States Department of Justice and the Consolidated Government of Columbus, Georgia Regarding the Muscogee County Jail, 2015, [http://www.justice.gov/crt/about/spl/documents/muscogee\\_moa\\_1-16-15.pdf](http://www.justice.gov/crt/about/spl/documents/muscogee_moa_1-16-15.pdf) (accessed April 28, 2015).

<sup>163</sup> Fear of persons with mental illness can combine with the adrenaline rush that can occur in a volatile situation to cause correctional officers to react more violently than necessary. David A. Rembert and Howard Henderson, “Correctional Officer Excessive Use of Force: Civil Liability under Section 1983,” *The Prison Journal*, vol. 94, February 2014, p. 204.

<sup>164</sup> Human Rights Watch telephone interview with Lorna Rhodes, PhD, Orcas Island, Washington, June 26, 2014. Rhodes, an Emeritus Professor of Anthropology at the University of Washington, is author of *Total Confinement: Madness and Reason in the Maximum Security Prison* (2004).

<sup>165</sup> Correctional officers often believe mental health professionals coddle their patients, are duped by manipulative prisoners, and do not sufficiently appreciate security needs. They may see mental health treatment as a lot of “mumbo jumbo.” On the other hand, mental health professionals may view correctional officers as averse to and unfit for anything but regimentation, control, and force. Working together can help dismantle such stereotypes, redounding to the benefit of the inmates and creating a safer prison.

often, mental health staff members “are treated as visitors in the units, not as co-workers who belong and share the work load of managing inmate behavior.”<sup>166</sup>

In facilities in which mental health and corrections staff establish strong working relationships based on mutual respect, they can cooperate to minimize the use of force on inmates with mental health problems.<sup>167</sup> Indeed, the prevalence and extent of the use of force against inmates with mental disabilities may be inversely related to the extent to which custody and mental health staff work as partners in managing inmates. Officials with the Washington State Department of Corrections and the Ada County Sheriff’s Office (which runs the county jail in Boise, Idaho), told Human Rights watch that their policies require mental health consultation wherever possible prior to the use of force on prisoners with mental health problems, and that, importantly, the institutional culture in their facilities has evolved into one in which mental health staff are respected and relied upon by custody staff—and vice versa, with a resulting diminution in the use of force.<sup>168</sup>

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<sup>166</sup> *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Expert Declaration of Eldon Vail, filed March 14, 2013, p. 36.

<sup>167</sup> Since correctional officers typically have the most contact with prisoners on a day to day basis, they may notice unusual behavior or changes that suggest the need for attention by mental health staff. Understanding the nature and symptoms of mental illness enhances the ability of officers to know when mental health staff should be called. If officers view acting out as deliberate volitional misbehavior, if they do not realize a prisoner who is mumbling to himself may be hallucinating, if they do not realize huddling in the corner of a cell and refusing to heat may be a sign of crippling depression, they will not call on mental health staff. Human Rights Watch, *Ill-Equipped*, p. 75.

<sup>168</sup> Human Rights Watch made a site visit to the Washington State Department of Corrections, July 14-15, 2014, and spoke with senior agency officials, including the secretary, at headquarters in Olympia as well as senior officials at the Monroe Correctional Complex in Monroe, Washington. Human Rights Watch also made a site visit to the Ada County Jail, Boise, Idaho, July 17, 2014 and spoke with senior officials there as well as custody and mental health staff.

## IV. Types of Force Used and their Harms for Prisoners with Mental Disabilities

Custody staff have a range of options for bringing disruptive or dangerous prisoners under control and getting them to comply with orders. Absent an imminent serious danger, the first option is to “do nothing,” i.e., to talk to the inmate and try to defuse the situation, including by just letting time pass. When staff do use force, agency policies specify what types of physical force and weaponry may be used. As the permitted force against an inmate escalates in severity, so does the likelihood of pain and injury—both physical and psychological.

Force is undertaken with and without weaponry, but the use by corrections staff of weaponry, such as chemical agents (e.g., pepper spray) and electronic stun devices such as Tasers and stun shields, appears to be growing.<sup>169</sup> Full body restraints such as special restraint chairs or four- or five-point restraints on a bed are used to fully immobilize inmates. Use of deadly force, such as firearms, is rare in correctional settings and is not discussed in this report.

In this chapter we describe certain commonly use types of force and the physical as well as psychological impact they can have on inmates with mental disabilities. Absent litigation, it is rare for use of force policies to restrict the use of types of force according to an inmate’s mental status.<sup>170</sup>

### Physical Force & Cell Extractions

Officers sometimes use just their hands and bodies to control an inmate. Physical force can be either “soft” or “hard.” Soft technique includes applying pressure to specific points,

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<sup>169</sup> Chemical agents and stun devices are commonly called either “non-lethal” or “less-lethal” weapons. The federal Bureau of Prison’s basic requirement for a “less-lethal weapon is that it must serve as an effective deterrent to an inmate by inducing a high degree of discomfort or pain, but remain a weapon that cannot cause an inmate’s death under any conditions.” Department of Justice, Office of the Inspector General, “Review of the Department of Justice’s Use of Less-Lethal Weapons,” May 2009, p. 56. See Appendix One of the report for photos and descriptions of many types of weaponry.

<sup>170</sup> Prisoners who are in inpatient units in correctional facilities may face a lower risk of pepper spray and Tasers than prisoners in general population, because the use of force standards in such units may be more restrictive. Thus, for example, some prison inpatient units do not permit chemical spraying except when necessary to subdue an inmate engaged in conduct likely to result in serious injury or death.

takedowns, joint locks, or simply grabbing on to the person. Hard technique entails striking, punching, and kicking.<sup>171</sup> The injury that may occur depends on the nature of the force, how long it lasts, and how many people participate in inflicting it. Punches, kicks, or blows to the head, neck, face, or groin carry a high risk of injury.<sup>172</sup> Staff may couple physical force with other forms of force such as non-lethal weapons and restraint chairs.

When an inmate in a cell does not agree to leave the cell voluntarily, staff may decide to forcibly extract him. The decision to forcibly extract an inmate might follow a prisoner's refusal to agree to a routine effort to move him to a new cell or it might be a response to misconduct, such as when an individual will not stop making a loud ruckus in his cell and staff decide he should be brought to the mental health unit.

Forced extractions are typically undertaken by a special tactical team resembling a SWAT team—team members are suited up in Kevlar vests, knee pads, helmets with visors and carry a range of weapons, such as batons, chemical spray, and electronic stun devices.<sup>173</sup> Chemical spray and Tasers may be used prior to the extraction in an effort to inflict enough pain to convince the individual to let himself be handcuffed and removed from the cell. The weapons may also be used once the officers enter the cell if the inmate continues to resist. With or without weaponry, forced cell extractions can be violent, as the team of officers grapples with the inmate and tries to place restraints on his arms and legs.

When the prisoner in his cell is not threatening imminent harm himself, that is, when there is no emergency, a forced extraction can often be avoided by talking for a while with the individual, or by giving him time to cool down. As one correctional mental health expert told us, when the inmate has a mental illness, “If you have a therapeutic, clinically informed

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<sup>171</sup> National Institute of Justice, “The Use of Force Continuum,” August 4, 2009, <http://www.nij.gov/topics/law-enforcement/officer-safety/use-of-force/Pages/continuum.aspx> (accessed February 10, 2015).

<sup>172</sup> According to the American Bar Association these types of force should not be used except in highly unusual circumstances in which a prisoner poses an imminent threat of serious bodily harm. American Bar Association, *ABA Standards of Criminal Justice (3rd ed.): Treatment of Prisoners*, June 2011, p. 132. Recent settlements of lawsuits restrict the use of such types of force. For example, part of the settlement of a lawsuit alleging widespread inmate abuse, the Los Angeles Sheriff's Department must develop use of force policies whereby “striking an inmate in the head or kicking an inmate who is on the ground, or kicking an inmate who is not on the ground anywhere above the knees is prohibited unless the inmate is assaultive and presents an imminent danger of serious injury...” See, e.g. *Rosas v. Baca*, United States District Court for the Central District of California, case no. 00:12-CV-00428, Implementation Plan, 2.6., filed on December 17, 2014.

<sup>173</sup> Human Rights Watch, *Cruel and Degrading: The Use of Dogs for Cell Extractions in U.S. Prisons*, October 2006, <http://www.hrw.org/reports/2006/us1006/us1006webwcover.pdf>.

approach, you often do not need a forced extraction.”<sup>174</sup> Too often, however, extractions are initiated without meaningful efforts to avoid them. Worse, if staff are so inclined, a cell extraction easily can be used to physically punish an uncooperative prisoner.<sup>175</sup>

When a confrontation with an inmate in his cell reaches a certain point and tempers have risen, there will be staff in some jails and prisons who do not want to see the situation resolved without force. Even when good faith efforts have been made to avoid a cell extraction, but unsuccessfully, staff may still use more force during the extraction than is necessary just to teach the inmate a lesson.<sup>176</sup>

### *Harm from Physical Force*

Physical force used during cell extractions has resulted in serious injury and death for inmates with mental disabilities.<sup>177</sup> In many such cases physical force was accompanied by the use of chemical spray and/or electronic stun devices.

**Gregory Maurice Kitchen** died in the Dallas County Jail in January 2010 while he was in pretrial detention. His estate filed a lawsuit alleging excessive force to extract Kitchen from his cell resulted in his asphyxiation and death.<sup>178</sup>

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<sup>174</sup> Human Rights Watch telephone interview Dr. Kenneth Appelbaum, M.D., Shrewsbury, Massachusetts, April 22, 2014. Dr. Appelbaum, a psychiatrist, is director of the Correctional Mental Health Policy and Research, and was previously the director of mental health at the UMass Medical School’s mental health program in the Massachusetts Department of Correction.

<sup>175</sup> As use of force expert Steve J. Martin has observed, a cell extraction “can move from a proper tactical exercise to a punitive and retaliatory exercise.” Erica Goode, “When Cell Door Opens, Tough Tactics and Risk,” *New York Times*, July 28, 2014, <http://www.nytimes.com/2014/07/29/us/when-cell-door-opens-tough-tactics-and-risk.html> (accessed March 12, 2015).

<sup>176</sup> Email from Jeffrey Schwartz, corrections consultant, to Human Rights Watch, February 5, 2015.

<sup>177</sup> In one case, for example, the medical examiner listed the probable cause of death as a “beating” which left the prisoner with “[m]ultiple blunt traumatic injuries including contusions, abrasions and lacerations of face and scalp, fracture of mandible; patterned and unpatterned abrasions and contusions on anterior and posterior trunk, multiple serial rib fractures of right and left halves of rib-cage, fracture of sternum, right and left hemothoraces, and subcutaneous emphysema extending from lower face to scrotum; lacerations and hemorrhage of gut mesenteries and liver capsule; hemorrhage within and around right adrenal gland; abrasions of right and left legs from knee to ankle level and linear abrasions on right and left wrists.” *Valdes v. Crosby*, 450 F.3d 1231, 1237 (11th Cir. 2006).

<sup>178</sup> Information on Gregory Maurice Kitchen and the incidents leading up to his death are taken from the summary of facts in *Kitchen v. Dallas County*, case no. 13-10545 (Fifth Cir.) July 17, 2014. The trial court granted defendants’ motion for summary judgment as to all of plaintiff’s claims, concluding the record before it, which concluded evidence presented by both plaintiff and the defendants contained insufficient evidence to create a genuine issue of material fact. On appeal, the court of appeals reversed the grant of summary judgment ruling that there were genuine issues of material fact as to whether officers had used excessive force. The appellate court noted that, with a “few critical exceptions,” most of the facts were not in dispute. The case is still pending.



According to the court, the evidence before it showed Kitchen had been observed digging through other detainees' property, mumbling, walking backwards, and avoiding eye contact and had been placed in the facility's West Tower for psychiatric evaluation. During interviews with mental health staff, he urinated on himself, cried, stated he could hear his mother's voice, and admitted to suicidal thoughts. Just before midnight on January 21, 2010, staff observed Kitchen hitting his head on the cell door and walls, and Kitchen was sent to a nursing station for evaluation. He then broke free from the guards, started screaming, and grabbed a nurse. Officers subdued him and placed him in a restraint chair for five hours, after which he was transferred to another cell. The next afternoon, while officers were attending to another inmate, Kitchen began to scream obscenities, and cry out for his mother, and he resumed banging his head against the bars. One of the officers told him to have a seat and stop banging his head. Kitchen showed the officers his middle finger and urinated on the floor. At this point, several officers talked to him for seven to eight minutes, during which he was not causing any harm to himself. No one called medical or mental health staff. An officer then entered Kitchen's cell and a physical altercation ensued. It ended, ultimately, when a group of officers used pepper spray on Kitchen, took him out of the cell, and placed him in cuffs and leg irons.

What happened next was disputed by the parties. Four inmates provided affidavits asserting that officers kicked, choked, and stomped on Kitchen and applied pepper spray even after he had been restrained and was not resisting. Jail authorities denied staff these accounts or that engaged in malicious or excessive force.

Shortly after being restrained, Kitchen stopped breathing and died. According to the autopsy, which the court quotes, the death was a homicide caused by "complications of physical restraint including mechanical asphyxia due to neck restraint during struggle and the fact that one officer was kneeling on the decedent's back during restraint." Other factors included "physiological stress, morbid obesity and cardiomegaly, and exposure to oleoresin capsicum" (the chemical in pepper spray).<sup>179</sup>

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<sup>179</sup> Asphyxia—a condition of severely deficient supply of oxygen that can happen when someone is not able to breathe normally—is a risk anytime officers kneel, sit or stand on a prisoner's chest or back while attempting to restrain him or after the person is secured. It is particularly likely when prisoners have been placed in a prone position, with the arms behind the back, making it impossible for the respiratory muscles to work properly. The inability to breathe is aggravated and a fatal outcome likely, when the prisoner is overweight or obese and one or more officers then put weight on him. See generally, "Restraint Ties and Asphyxia, Part Two – Compressional Asphyxia," *AELE Monthly Law Journal*, vol. 101, January 2009.

The court of appeals noted that the record contained evidence creating a genuine dispute as to “the need for application of force, the relationship between that need and the amount of force used, the threat reasonably perceived by the responsible officials, and any efforts made to temper the severity of a forceful response.” A reasonable jury could believe, it noted, that the officers may have engaged in the actions described by the inmate witnesses, and may conclude they did so to cause harm or because of an unreasonable perception that Kitchen still posed a threat after he had been restrained and subdued. The case is apparently still pending.

**Charles Agee** was a 47-year-old state prisoner at Alabama’s William A. Donaldson Correctional Facility when he died in a prison infirmary.<sup>180</sup> Agee’s estate brought a lawsuit against the Alabama Department of Corrections alleging excessive force, among other claims, and the account below is drawn from the court’s order on the defendants’ motion for summary judgment.

Agee had been diagnosed in 1995 with acute paranoid schizophrenic disorder and was housed in a residential treatment unit at Donaldson with other inmates with diagnoses of mental illness. He sometimes had periods of severe psychosis marked by agitation, belligerence, auditory and visual hallucinations, and delusions. He had a long disciplinary history in prison, including incidents of violence.

According to the court order, after lunch on January 21, 2005, a prison officer instructed Agee and other inmates in his cell block to return to their cells or join in a group counseling session. Agee wanted to return to his cell but he also wanted to take with him a chair on which he had marked his name. A scuffle ensued. According to the testimony related to the use of force on Agee that day, Agee swung the chair at an officer, and the officer immediately sprayed Agee in the face with Freeze+P, a chemical agent. The officer lost his footing and fell, and two other officers quickly came to his assistance.

One of the officers hit Agee several times with a baton, although there is conflicting evidence as to whether he hit Agee with it on the knees or his head and shoulders. The

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<sup>180</sup> Information on the incidents of January 21, 2005 and the use of force against Charles Agee is taken from *Bogus v. Alabama Department of Corrections*, United States District Court for the Northern District of Alabama, case no. 7:06-cv-01667, Memorandum Opinion, filed August 21, 2009. Drawing on extensive testimony and exhibits submitted by plaintiff and the defendants, the court denied defendants’ motion for summary judgment because certain material facts remained in dispute.

officer who sprayed Agee got up from the floor and allegedly punched Agee at least twice in the abdomen with his fist. Agee was then subdued and handcuffed. Another officer placed his knee on Agee's back to gain control. Some of the testimony presented to the court indicates that once Agee was on the ground and cuffed, the officers then "repeatedly hit, kicked, or stomped" on him. All three officers denied doing so.

Agee was taken to the infirmary. The court pointed out in its ruling that although Agee was conscious and able to walk out of the cell block area, by the time he arrived at the infirmary he was being carried by the officers, was barely conscious, and bloody drool was coming out of his mouth. At the infirmary, Agee began vomiting, appeared to have a seizure and became unresponsive. Infirmary staff were unable to resuscitate him. The autopsy concluded Agee died of internal bleeding because broken ribs had lacerated his spleen.

What caused Agee's injuries was disputed. The first officer who sprayed and punched Agee denied that he inflicted any injuries that could have led to Agee's death while they were in the cell block. The officer who placed his knee on Agee's back testified he neither placed his knee in a position to break Agee's ribs nor did he apply enough pressure to do so. Although a nurse and an administrative assistant heard loud noises and/or a scuffle as officers brought Agee from the hallway into the infirmary, the officers who transported Agee to the infirmary denied beating him. The court refused to grant summary judgment for the officers, because the question of who applied the force that led to Agee's death was a material issue of fact that would have to be resolved by a jury.<sup>181</sup>

The use of violent physical force against persons with mental disabilities can also cause psychiatric harm.

What is little recognized is that if someone has mental illness, the trauma from a use of force can aggravate the pre-existing condition. It can trigger a psychotic episode or increase hallucinations. For a person with a pre-existing condition their symptoms can be exacerbated. For someone who is

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<sup>181</sup> The case was settled for an undisclosed sum shortly after the court's summary judgment ruling. The fact of a settlement agreement is not an indication or admission by a defendant of guilt or liability.

depressed, it can cause more depression; if bipolar, more depression or mania; schizophrenia, more hallucinations and delusions.<sup>182</sup>

The actual impact of the use of force on a given individual will differ depending on that individual's history and diagnosis.<sup>183</sup> But, "since many inmates have already experienced trauma in their lives, they are already particularly vulnerable to the psychological impact of another trauma."<sup>184</sup> Even if a cell extraction is done well, for example, "it can deepen paranoia and distrust and aggravate symptoms."<sup>185</sup>

## Chemical Agents

Proponents of chemical agents and electronic stun devices (described in the section below) say these weapons minimize injuries to inmates and staff because they make it less likely that direct physical force will be used and they enable staff to undertake a more graduated response to disruptive or dangerous situations. However, the very nature of these weapons makes it easy for staff to use them unnecessarily and punitively. A single officer can use them quickly and easily without risk to himself even when there is no immediate need for force, such as in response to verbal insolence or other minor misconduct that poses no physical threat.<sup>186</sup>

Although they can be highly effective at inflicting pain, neither chemical sprays nor electronic stun devices guarantee a prisoner will become compliant. Psychosis may render a prisoner incapable of understanding that compliance with an order is the fastest way to avoid the pain of pepper spray or electric shocks. In fact, the infliction of pain may strengthen paranoid delusions. One California inmate, for example, thought officers who

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<sup>182</sup> Human Rights Watch telephone interview with Terry Kupers, M.D., psychiatrist and correctional mental health expert, Berkeley, California, April 18, 2014.

<sup>183</sup> Human Rights Watch telephone interview with Dr. Kenneth Appelbaum, M.D., psychiatrist, and former director of mental health at the UMass Medical School's mental health program in the Massachusetts Department of Correction.

<sup>184</sup> Human Rights Watch telephone interview, Pablo Stewart M.D., psychiatrist and consultant in correctional mental health care, San Francisco, California, April 21, 2014.

<sup>185</sup> Human Rights Watch telephone interview with Jeffrey Metzner, M.D., psychiatrist and correctional mental health expert, Denver, Colorado, March 24, 2014. See also, *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Deposition of Ernest Wagner, M.D., filed on October 22, 2013, p. 681-682 (subjecting a flagrantly psychotic patient to a violent cell extraction can exacerbate symptoms of mental illness, and if the inmate was paranoid the extraction could "exacerbate paranoid ideation").

<sup>186</sup> See Human Rights Watch, *Red Onion State Prison: Super-Maximum Security Confinement in Virginia*, April 1999, <http://www.hrw.org/reports/1999/redonion>, for an early description of the misuse of electronic stun devices.

ordered him to cuff up wanted to harvest his organs, and he resisted even when being deluged with pepper spray. Some individuals continue being combative despite repeated electric shocks.

Chemical agents are widely used in correctional agencies.<sup>187</sup> According to a former commissioner of New York City Department of Corrections, “The least force, indeed no force, is always preferable but when force is necessary to regain or to maintain order, utilization of a chemical agent yields the optimal outcome under the circumstances—order without injury.”<sup>188</sup>

Oleoresin capsicum (OC) is the chemical agent most frequently sprayed on prisoners.<sup>189</sup> It is commonly referred to as pepper spray, because its active agent is extracted from hot peppers. OC can be dispersed in different ways—personal size aerosol cans, pepper balls, crowd size canisters, grenades—and the effectiveness and the rapidity of onset of its effect varies according to the delivery method. While the manufacturers typically provide instructions on the safe and effective use of their products, custody staff do not always adhere to them.<sup>190</sup>

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<sup>187</sup> In California prisons, chemical agents are used in approximately half of use of force incidents. Office of the Inspector General, State of California, “Use-of-Force within the California Department of Corrections and Rehabilitation January-June 2012,” October 2012, <http://www.oig.ca.gov/media/reports/SAR/2012/Use-of-Force%20within%20CDCR%20January-June%202012.pdf> (accessed April 28, 2015).

<sup>188</sup> Dr. Dora B. Schiro, Commissioner, NYC Department of Correction, “Statement to the New York City Council, Committee on Fire and Criminal Justice Services,” March 7, 2013, <http://www.docstoc.com/docs/153297337/Statement-to-the-New-York-City-Council-Committee-on-NYC-gov#> (accessed March 20, 2015), p. 6-7.

<sup>189</sup> The other commonly used chemical agents are chloroacetophenone (CN) and chlorobenzalmalononitrile (CS). OC is putatively less toxic than CN and CS, though there has been a paucity of research on the acute or long-term effects of any of the compounds. See Hu H, Fine J, et al., “Tear gas—harassing agent or toxic chemical weapon?” *Journal of the American Medical Association*, vol. 262 (5), August 1989, p.660-3; Graham Chambers, ed., *Crowd Control Technologies*, OMEGA Foundation (European Parliament: Luxembourg 2000), p. xxi. [http://www.europarl.europa.eu/RegData/etudes/etudes/stoa/2000/168394/DG-4-STOA\\_ET\(2000\)168394\\_EN\(PAR02\).pdf](http://www.europarl.europa.eu/RegData/etudes/etudes/stoa/2000/168394/DG-4-STOA_ET(2000)168394_EN(PAR02).pdf) (accessed March 12, 2015).

<sup>190</sup> For example, in South Carolina, “officers routinely gas inmates with OC spray in amounts that exceed manufacturer instructions and at closer distances than the manufacturer directs...[They also use] MK-9, crowd control fogger devices in large disbursements in individual closed cells, again contrary to manufacturer instructions and [agency] policy.” *T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, slip op, filed Jan. 8, 2014, p. 18.

Exposure to chemical agents is painful.<sup>191</sup> Jerry Williams, a North Carolina prisoner with mental disabilities described the experience as follows: “[Y]ou feel blind. You ain’t going to be able to see no more. And it burns real bad. Burns like you’re on fire.”<sup>192</sup> Pepper spray:

inflames the tissues. It burns the eyes, the throat, the skin. It frequently causes temporary blindness as the eyes dilate. It makes breathing difficult because of that, and sometimes people will panic... Depending on how much you are hit with, it lasts at least 30 to 45 minutes, sometimes as much as four hours. In some people it causes headaches. It makes the skin—people describe it as it feels like your skin is burning off. The eyes feel like they’re bubbling and burning. Some people cough convulsively. It brings them to their knees.<sup>193</sup>

An advertisement by the manufacturer of a new form of pepper spray leaves no doubt as to its intended effect: “Two years of research has produced an OC aerosol which delivers immediate effectiveness ... [It] inflames the mucous membranes and upper respiratory tract, resulting in an intense burning sensation and a dramatic cough reaction. Unlike stream delivery products, OC Vapor affects the respiratory tract and any exposed skin, diminishing a person’s ability to continue violent actions. Onset is immediate and extreme. Regardless of whether exposure is in an open area or in a confined space, the targets immediately focus on their own discomfort.”<sup>194</sup>

Many use of force experts agree with Eldon Vail, former secretary of corrections in Washington state, that the use of chemical agents against prisoners with mental health

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<sup>191</sup> Office of Justice Programs, Department of Justice, “Oleoresin Capsicum: Pepper Spray as a Force Alternative,” March 1994. <https://www.ncjrs.gov/pdffiles1/nij/grants/181655.pdf> (accessed April 3, 2015).

<sup>192</sup> Elizabeth Simpson, North Carolina Prisoner Legal Services, Inc., “Reassessing Solitary Confinement II: the Human Rights, Fiscal, and Public Safety consequences,” Hearing before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights, February 24, 2014, <http://solitarywatch.com/wp-content/uploads/2014/02/Jerry-Williams-testimony-for-hearing-on-solitary-confinement.pdf> (accessed April 22, 2015), p. 5.

<sup>193</sup> *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Deposition of Eldon Vail, October 2, 2013, p. 125. Manufacturer instructions and agency policies call for prompt decontamination with soap and cold water of anyone who has been subjected to pepper spray. Failure to provide proper decontamination procedures can prolong the pain from the agents and puts prisoners at risk of skin burns. Numerous cases we have reviewed involving allegations or findings of misuse of pepper spray also included complaints that the inmates were denied opportunity to decontaminate or that decontamination was deliberately delayed as “punishment.”

<sup>194</sup> “OC Vapor,” Defense Technology promotional pamphlet, 2014, <https://www.safariland.com/on/demandware.static/Sites-tsg-Site/Sites-tsg-Library/default/v1412382183860/resources/def-tech-pdfs/MK-9SOCVaporFlier-Web.pdf> (accessed February 16, 2015).

problems should be avoided whenever possible.<sup>195</sup> But absent clear policies and diligent supervision, chemical sprays against those inmates can become the routine first response to perceived problems. For example, in Arizona isolation units confining many inmates diagnosed with mental illness, pepper spray was:

routinely deployed with little or no apparent justification on inmates for such reasons as failing to return his food tray, covering his light fixture with a blanket, refusing to relinquish a blanket s/he had placed over her head, refusing to surrender a suicide smock, tampering with his colostomy bag, refusing to come out from under his bunk, refusing to take court ordered medication and tearing his suicide mattress. In none of these cases was the inmate or the spraying officer at risk of imminent or serious harm. Rather ... officers seemingly sprayed inmates—solely because they refused to obey the officers' command.<sup>196</sup>

In litigation successfully challenging the constitutionality of the treatment of inmates with mental illness in South Carolina prisons, plaintiff's use of force expert Steve J. Martin testified that prison staff used chemical sprays against individuals with mental health problems who masturbated while locked in their cells; verbally threatened officers while locked securely in a cell; complained about not receiving an evening meal; used profane language; kept banging on the cell door and let the sink overflow; and refused to sit on the cell stool.<sup>197</sup> Indeed, officers used crowd-control canisters of chemical spray against inmates with mental health problems, including, for example, an asthmatic inmate who refused to return his inhaler; an inmate who urinated inside a holding cell; and an inmate who had been placed on crisis intervention status and refused to surrender his boxer shorts.

Martin concluded on the basis of his examination of use of force practices, that South Carolina prison staff:

routinely deploy chemical agents on mentally ill inmates in the absence of any objective and immediate enforcement necessity to incapacitate,

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<sup>195</sup> *Parsons v. Ryan*, United States District Court for the District of Arizona, Expert Report of Eldon Vail, filed November 8, 2013.

<sup>196</sup> *Ibid.*, p. 35 (internal citations omitted).

<sup>197</sup> *Ibid.*, p. 13-15.

neutralize or immobilize the subject inmates; routinely apply levels of force disproportionate to the levels of resistance presented by mentally ill inmates; routinely deploy dangerous and unnecessary quantities of chemical agents on mentally ill inmates who are locked securely in their cells, are not armed, and not barricaded; routinely fail to consider alternative measures to use of force and very often immediately resort to the use of chemical agents notwithstanding time and opportunity to consider/attempt alternative measures.<sup>198</sup>

The logic of pepper spray is that the pain it causes and the desire to avoid more such pain lead inmates to comply with orders. But this logic may not work with prisoners with mental illness. “It’s like a shot across the bow—cuff up or we’ll do more or worse. But it is an impaired logic. With a psychotic prisoner it doesn’t register. He does not get the causal relationship between gas and the next step in extraction, or why the gas.”<sup>199</sup>

For example, when a prisoner diagnosed with schizophrenia housed in administrative segregation at California’s Kern Valley State prison became increasingly paranoid, delusional, and persisted in playing with his feces, he was extracted from his cell so that he could be transferred to a mental health crisis bed. During the cell extraction the inmate was pepper sprayed several times in less than six minutes. During the spraying he yelled, “You’re trying to kill me” and “don’t treat me like a dog” and he called several times for medical staff. A victim of sexual abuse during childhood, the inmate became increasingly anxious that staff were going to rape him anally. Correctional officers used a device with a long metal tube to send OC gas into the cell and the inmate apparently feared the tube would be inserted in his anus, which caused him to resist even more vigorously officer orders to cuff up.<sup>200</sup>

Staff sometimes keep spraying even after the initial application of chemical does not have the desired effect.<sup>201</sup> An internal memorandum by a manufacturer of OC spray cautioned that

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<sup>198</sup> *T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, Report of Plaintiffs’ Expert Steve J. Martin, filed March 11, 2011.

<sup>199</sup> Human Rights Watch telephone interview with Terry Kupers, M.D., Berkeley, California, April 18, 2014.

<sup>200</sup> The videotape of the cell extraction of the prisoner, referred to as “Inmate B,” was introduced as evidence in *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-005201. The incident is discussed by plaintiffs’ experts, Testimony of Edward Kaufman, M.D., Evidentiary Hearings, October 2, 2013, transcript, p. 207-211; Expert Declaration of Eldon Vail, filed May 29, 2013, p.9.

<sup>201</sup> Agency policies that authorize the use of chemical sprays often fail to provide guidance as to the amount that should be used, whether there should be multiple applications and, if so, how much time should lapse between each application and



persons who are mentally disturbed and/or extremely agitated are less likely to react to the pain of pepper spray and may not become immediately compliant with officers' commands. The memo states that law enforcement officers who mistakenly rely on OC to incapacitate someone might be inclined to administer repeated doses when the first dose does not have the desired effect. The memo concludes "[t]his obviously would be an overexposure, which may cause added health risks" and "raises the concern of excessive use of force."<sup>202</sup>

Incidents of repeated doses abound. For example, a naked prisoner in California on the mental health caseload was yelling that he was "the Creator" and threatening to kill himself. Custody staff decided that they need to remove him from his cell. In an effort to get the inmate to agree to be handcuffed, they sprayed him with pepper spray approximately 40 times, and entered his cell to handcuff the inmate and remove him. Plaintiff's corrections expert Eldon Vail testified during litigation that the "volume of spray used in this incident astounds me... [It] is excessive to the point of abuse."<sup>203</sup> As plaintiffs' expert in Arizona litigation, Vail testified that the use of pepper spray on prisoners who are disconnected from reality because of psychosis can feed into the inmates' delusions and hallucinations and exacerbate their condition. It yields only psychological harm and physical pain, "akin to corporal punishment."<sup>204</sup>

In a Florida case involving the repeated use of chemical agents against prisoners diagnosed with mental illness, an appellate court concluded "when the [Department of Corrections] fails to account for an inmate's decompensation, with the result that he is gassed when he cannot control his actions due to his mental illness, then the force no longer has a necessary penological purpose and becomes brutality."<sup>205</sup>

Following recent litigation, several corrections agencies have developed or are developing new policies restricting the use of chemical agents against prisoners with mental disabilities. The Arizona Department of Corrections, for example, has agreed to establish

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how and when to decide that additional spraying would be futile. Agencies also often fail to measure how much spray has been used and to record how much spray is used in each incident.

<sup>202</sup> *Vandehey v. Vallario*, United States District Court for the District of Colorado, case no. 1:06-cv-01405, First Amended Class Action Complaint, filed August 1, 2006, p. 13 (citing corporate memorandum obtained published by the ACLU of California in the mid-1990s).

<sup>203</sup> *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Expert Declaration of Eldon Vail, filed May 29, 2013, p.12. Vail also noted that correctional officers sometimes applied chemical spray repeatedly without giving it a chance to work before the next application.

<sup>204</sup> *Parsons v. Ryan*, United States District Court for the District of Arizona, Expert Report of Eldon Vail, p. 35.

<sup>205</sup> *Thomas v. Bryant*, 614 F.3d 1288, 1311 (11th Cir. 2010), (internal citations omitted).

new policies that chemical agents can be used against prisoners with serious mental illness held in certain prison complexes:

only in case of imminent threat.... If the inmate has not responded to staff for an extended period of time, and it appears that the inmate does not present an imminent physical threat, additional consideration and evaluation should occur before the use of chemical agents is authorized.... If it is determined the inmate does not have the ability to understand orders, chemical agents shall not be used without authorization from the Warden, or if the Warden is unavailable, the administrative duty officer.... If it is determined an inmate has the ability to understand orders but has difficulty complying due to mental health issues, or when a mental health clinician believes the inmate's mental health issues are such that the controlled use of force could lead to a substantial risk of decompensation, a mental health clinician shall propose reasonable strategies to employ in an effort to gain compliance...<sup>206</sup>

In California, new prison regulations adopted pursuant to a recent court order, prohibits the use of chemical agents on inmates who do not possess the ability to understand orders, have difficulty complying with orders, or are at increased risk of decompensation resulting from use of force unless there is an emergency or the warden or other designated senior officials authorize their use because "serious circumstances exist calling for extreme measures to protect staff or inmates."<sup>207</sup> The policy also bans the use of chemical agents in controlled use of force situations within mental health treatment facilities absent high level authorization.

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<sup>206</sup> *Parsons v. Ryan*, United States District Court for the District of Arizona, case no. 12-cv-00601, Stipulation, filed on October 14, 2014, par.27 (a)-(d).

<sup>207</sup> *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Defendants' Plans and Policies Submitted in Response to April 10, 2014 and May 13, 2014 Orders, filed August 1, 2014, p.5.

## RAMIREZ V. FERGUSON

Larry Ramirez was a 32-year-old welder diagnosed with schizophrenia, bipolar disorder with psychotic features, and panic disorder. Ramirez was brought into the Benton County Detention Center in Arkansas on July 7, 2007 after an arrest for fraudulent use of a credit card, public intoxication, resisting arrest, and possession of a controlled substance. He filed a lawsuit alleging jail deputies used excessive force against him on his first day of detention, and a judge ruled in his favor after trial.<sup>208</sup>

As summarized by the court, the jail's use of force policy provided that staff should only use the force and restraint necessary to control an inmate who displays violent or threatening behavior. If verbal persuasion and warnings are not effective, a deputy should call for back up and if necessary, attempt to use physical holds to control the inmate. With regard to the use of pepper spray, the policy prohibited its use on an inmate who has not demonstrated an intention to use violence or force. The court found that these policies were not followed with regard to Ramirez.

According to the court, jail deputies pepper sprayed Ramirez twice, including once after they had restrained him. The first spraying occurred after Ramirez had been taken to the holding cell. The deputy who sprayed Ramirez testified that, "Ramirez wasn't aggressive as in trying to fight us. [He] wasn't swinging, wasn't using force. He just was not complying with us." After he refused orders to stop banging his cell door and go to the back of the cell, the deputy sprayed him. The court noted, did not credit the deputy's testimony that he believed Ramirez posed a physical threat to him and that he could not use control holds or call for back-up to subdue Ramirez as required by jail policy. The court found that the deputy pepper sprayed Ramirez for non-compliance with orders, which constituted unjustified and excessive force.

About one hour after the first pepper spray incident, the deputy re-entered the cell with two other deputies. The court credited Ramirez' testimony that the deputies "entered his cell and, without giving him any commands, forcefully took him to the ground, restrained his arms and legs behind his back, sprayed him with OC spray again, and lifted him by his restraints and dropped him two or three times." Photographs taken after the incident showed bruising, abrasions and blood on Ramirez' head and face, and swollen eyes. The medical observation form states that Ramirez was in obvious pain. The court ruled this force was excessive and not reasonable to quiet someone from banging a door. According to the court, Ramirez could not identify which deputies lifted and dropped him from his shackles or sprayed him the second time, although he did hear all three laughing and commenting "you're not so tough now." The court nonetheless held all three liable for the use of unnecessary and excessive force, because even if an officer does not participate in such force, he has a duty to prevent it.

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<sup>208</sup> Information and quotes about case of Larry Ramirez from *Ramirez v. Ferguson*, United States District Court for the Western District of Arkansas, case no. 08-cv-5038, Order, filed on March 29, 2011, following a bench trial..

The court found that the three deputies “acted willfully and maliciously in using excessive force” against Ramirez. The Court stated that it “respects the fact that jail deputies have a difficult job and must make split-second decisions in situations where their safety or the security of the jail is at risk. However, that is not what occurred here. What occurred here was an abuse of the deputies power over an inmate.” The court awarded Ramirez \$5,500 in compensatory damages for pain and suffering and \$15,000 in punitive damages (\$5,000 per deputy) “to punish the three deputies and to deter them, as well as other deputies, from abusive conduct in the future.”

### *Harm from Chemical Agents*

“With inmates [who] are not able to adequately process information and who are already in an agitated state, the use of and then repeated use of pepper spray would only exacerbate [their symptoms].”<sup>209</sup>

In most cases, chemical agents cause acute but temporary pain. Individuals with asthma or chronic obstructive pulmonary disease, however, are more sensitive to the irritation effects of pepper spray.<sup>210</sup> The chemical agents chloroacetophenone (CN) and chlorobenzalmalonitrile (CS) also cause tearing and respiratory effects, but do not cause the temporary blindness and inflammation that pepper spray causes.

Repeated applications of any of the chemical sprays without appropriate decontamination can cause second degree burns, as evident in the case of Jeremiah Thomas, discussed below. There can be even more serious consequences. If an inmate is exposed to chemical agents and then placed on his stomach, it can aggravate the risk of positional asphyxia and death.<sup>211</sup> When used on someone taking antipsychotic medication or illegal drugs such as cocaine, pepper spray may be the precipitating agent that contributes to death.<sup>212</sup>

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<sup>209</sup> *Christie v. Scott*, United States District Court for the Middle District of Florida, case no. 2:10-cv-00420, Expert Report by Sally Johnson, M.D., filed on July 3, 2012.

<sup>210</sup> C. Gregory Smith and Woodhall Stopford, “Health Hazards of pepper spray,” *North Carolina Medical Journal*, vol. 60, no. 5, September/October 1999, p. 268-274. See also, Michael Cohen, “The Human Health Effects of Pepper Spray: A Review of the Literature and Commentary,” *Journal of Correctional Health Care*, vol. 4, issue 1, spring 1997, p. 73.

<sup>211</sup> Positional asphyxia occurs when an individual’s body position interferes with respiration, resulting in death. See *Parsons v. Ryan*, United States District Court for the District of Arizona, case no. 12-cv-00601, Supplemental Report of Eldon Vail, p.4, describing the apparently routine but dangerous practice in Arizona prisons of cuffing inmates behind their back after they have been pepper sprayed and placing them on a gurney face down for transportation to decontamination and placement in another cell.

<sup>212</sup> Cohen, “The Human Health Effects of Pepper Spray: A Review of the Literature and Commentary,” *Journal of Correctional Health Care*, p. 77.

According to mental health experts, the use of pepper spray can have severe mental health consequences for prisoners who are already psychologically vulnerable because of mental illness. Pepper spray can leave someone temporarily unable to breathe, which can be a terrifying experience for anyone. But the impact can be even more terrifying and traumatic for someone whose experience is colored by mental illness.

Psychiatrist Dr. Edward Kaufman says that pepper spray can have immediate as well as long term consequences:

[I]n the short term there is a real escalation of fear and anxiety. And in the longer term there is ... a destruction of trust in the mental health staff. And in many of the cases there occur prolonged psychotic episodes, when the inmate recovers, there are recurrent psychotic episodes. Some inmates have almost a posttraumatic stress disorder in which they become very frightened of even seeing custody [staff]. They have dreams and nightmares about custody.... And then with each succeeding psychosis there is potentially brain damage and definitely vulnerability to future psychotic episodes.<sup>213</sup>

In 1998, the Florida Department of Corrections Office of Health Services alerted prison officials that pepper spray should not be used on inmates with serious mental illness or who were in mental health patient units.<sup>214</sup> But custody staff nonetheless sprayed such prisoners when they created minor disturbances such as when they kicked their cell doors and yelled. During litigation challenging the constitutionality of this use of chemical agents, mental health professionals testified that chemical sprays could exacerbate the very conditions that mental health staff were trying to treat, leading to a vicious cycle of behavior that required further intervention with chemical agents to address the inmates' rapidly destabilizing behavior. According to one of plaintiffs' experts, gassing the inmates "makes them more paranoid, frightened and fearful, and it makes them less trusting and more angry which is detrimental to the mental health services attempting to be provided to them."<sup>215</sup> Another of

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<sup>213</sup> *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. 2:90-cv-00520, Testimony of Edward Kaufman, M.D. (E.D. Cal.) Oct. 2, 2013, p. 177-178.

<sup>214</sup> *Thomas v. McDonough*, United States District Court for the Middle District of Florida, case no. 3:04-cv-917, Plaintiffs Omnibus Response in Opposition to Defendants' Motions for Summary Judgment, filed September 27, 2007, p.45.

<sup>215</sup> *Ibid.*, p. 46 (quoting Dr. Donald Gibbs).

plaintiffs' experts testified that it could also cause "intense physical and psychological pain" and give the inmates a "fear of dying ... and intense helplessness."<sup>216</sup>

It is unclear whether mental health staff are typically aware of, much less communicate with custody staff about, the potential psychiatric injury from pepper spray. Even in facilities in which mental health staff collaborate with custody staff to avoid the use of force, our research does not indicate that they are attentive to the possibility of trauma from cell extractions in which pepper spray is used. Unless the inmate has a physical condition such as asthma, medical staff routinely "clear" inmates for cell extractions, i.e., they indicate there is no medical reason to preclude the use of force. This assessment apparently looks only at physical, and not psychological, concerns.

### NICK CHRISTIE

Nick Christie died two days after repeatedly being pepper sprayed and placed in a restraint chair with a spit mask in a Florida jail. His wife filed a lawsuit alleging he died from excessive force, among other claims.<sup>217</sup> The account below of the last days of his life is taken from the court order responding to defendants' motion for summary judgement.

In March, 2009, the 62-year-old left his home in Ohio to visit his brother in Florida. Christie had chronic obstructive pulmonary disease, morbid obesity, and asthma. He had stopped taking his antidepressant and anti-anxiety medication and his mental health was on a downward spiral. On March 25, he was arrested for public intoxication, briefly detained and released. On March 27 he was again arrested again, this time at an Arby's restaurant where he was trying to give money to passers-by. He was held at the Lee County Jail in Fort Meyers, Florida, where he was placed in the unit for detainees with mental health concerns.

According to the court, while detained Christie was apparently "loud and belligerent" and confused (for example, he asked for his keys so he could return home) but there was little evidence that he was physically violent with staff. Nevertheless, over the course of about 36 hours at the jail, Christie

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<sup>216</sup> Ibid., p. 39 (quoting Dr. Kathryn Burns).

<sup>217</sup> Information on Nick Christie taken from the court's Memorandum and Order, in *Christie ex rel. Estate of Christie v. Scott* 923 F.Supp.2d 1308 (M.D. Fla), Jan. 9, 2013. Christie's widow brought a lawsuit alleging excessive force and deliberate indifference to Christie's serious medical and mental health needs against the contract provider for medical and mental health services at the jail, medical staff employees, the Sheriff and his employees who worked at the jail. *Christie v. Scott*, The United States District Court for the Middle District of Florida, case no. 2:10-cv-420, Motion for Summary Judgment, filed June 11, 2012. After reviewing the record, including evidence submitted by both plaintiff and defendants, the court granted in part and denied in part defendants' motions for summary judgment, with many of plaintiff's claims against the Sheriff and the officers who participated in the pepper-spraying surviving the defendants' motions.

was sprayed more than 12 times with pepper spray (OC spray) and was decontaminated only once. He was held naked in a restraint chair for more than five hours, was sprayed with OC while restrained, was not decontaminated after the spraying, and had a spit mask placed over his nose and mouth while in the restraint chair and after being sprayed. Apart from evidence that Christie was sprayed once because he was yelling, the court's opinion does not provide explanations for why Christie was sprayed on the other occasions. The court's opinion noted, however, that plaintiff's evidence suggested "deputies in the Jail were using pepper spray nearly indiscriminately to enforce the rules of the Jail."

On March 29, Christie's health deteriorated. He was taken to the hospital and he died there two days later. The emergency room physician who examined Christie testified that he was "entirely covered" in pepper spray. The coroner determined Christie died due to OC poisoning.

Plaintiff's claims against the Sheriff centered on the lack of policies with regard to pepper-spraying. As the court pointed out, when Christie was incarcerated at the jail, there was clear legal precedent that pepper spraying a detainee unable to conform his behavior in response to the spraying violates the detainee's constitutional rights. Nevertheless, the jail did not have any policy regarding whether, and if so, when, detainees with mental illness could be sprayed. As the court stated:

The Jail had no mechanism to determine whether an inmate's mental health rendered him incapable of following a corrections officer's commands, and thus should not be pepper-sprayed for refusing to follow those commands. Rather, the Jail's policy was that inmates who yelled or banged on their cells were pepper-sprayed—spray first, ask questions later. And there is no dispute that the unit on which Christie was housed...was regarded by staff as the unit in which mentally ill inmates were held, so that staff knew or should have known that inmates in that unit were likely suffering from sort of mental health issue.<sup>218</sup>

The jail also lacked policies regarding the number of times an inmate could be sprayed with pepper spray, whether an inmate held in a restraint chair could be pepper sprayed, or requiring immediate decontamination after pepper-spraying.

In a motion for summary judgment the moving party has the burden of establishing there are no contested issues of material fact and that the party is entitled to judgment as a matter of law. In reviewing motions for summary judgment, courts interpret facts in the light most favorable to the non-moving party. In this case, considering the defendants' motions, the court found that "the absence of any policy regarding whether the use of pepper spray is appropriate on an individual who is fully restrained" should have put the Sheriff on notice that a detainee's constitutional rights might

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<sup>218</sup> *Christie v. Scott*, 923 F. Supp. 2d at 1323.

be violated. It also observed, “[E]ven assuming that Christie continued to yell or that he spat in the direction of an officer after he was restrained does not necessarily justify the pepper spraying that occurred. Rather, there is at least a question of fact as to whether there was any penological justification for the custom of allowing the use of pepper spray on restrained individuals.” The court also ruled that there was a genuine issue of fact as to whether some of the defendant jail staff were deliberately indifferent to Christie’s physical and mental needs. The “corrections defendants had to be aware of the serious side effects multiple pepper-sprays posed to even healthy inmates. At least one employee testified that on Sunday morning the air in the unit was so permeated with pepper spray that everyone in the unit was having difficulty breathing, ‘even the nurses.’” With regard to the officers who participated in or ratified the pepper-spraying of Christie, the court ruled there was evidence from which a jury could conclude that the Corrections Defendants were not attempting to maintain or restore discipline but rather were simply attempting to harm Christie.<sup>219</sup>

## JEREMIAH THOMAS

*Being sprayed with a chemical agent would “eat me up on the inside...it burn me real bad and it harmed me.”<sup>220</sup>*

Jeremiah Thomas was one of several plaintiffs with mental health problems who joined a lawsuit against Florida State Prison for repeatedly spraying inmates with chemical agents when they caused disturbances in their cells in the close management (solitary confinement) wings of the prison.<sup>221</sup> A federal district court ruled that Thomas and another plaintiff were sprayed with chemical agents in non-emergency situations at times when they were unable to conform their behavior to prison

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<sup>219</sup> A month after the court’s decision, the sheriff’s office signed a \$4 million dollar settlement with Christie’s wife, Aisling Swift, “Widow receives \$4M settlement in Lee jail pepper-spray death,” *Naples Daily News*, July 2, 2013. The fact of a settlement agreement is not an indication or admission by a defendant of guilt or liability.

<sup>220</sup> *Thomas v. McDonough*, United States District Court for the Middle District of Florida, case no. 3:04-cv-917, Plaintiffs Omnibus Response in Opposition to Defendants’ Motions for Summary Judgment, filed on September 27, 2007, p. 14.

<sup>221</sup> Unless otherwise noted, all information about Jeremiah Thomas comes from *Thomas v. McNeil*, United States District Court for the Middle District of Florida, case no. 3:04-cv-917-2009, Findings of Fact and Conclusions of Law, filed January 9, 2009 (2009 WL 64616; 2009 US Dist. LEXIS 1208), aff’d. *Thomas v. Bryant*, 614 F. 3d 1288 (11th Cir. 2010). Plaintiffs sought an injunction to prevent the Florida Department of Corrections from spraying them while housed in close management at the Florida State prison without first conducting a mental health consultation to evaluate whether they possessed the mental faculties to understand and follow instructions. Plaintiffs’ contended such decisions to spray them constituted cruel and unusual punishment in violation of the Eighth Amendment. The trial court made its findings based on its evaluation of the evidence in the record, including facts jointly stipulated to by the parties and the testimony and exhibits admitted at the bench trial. Where the evidence to support a relevant finding was in dispute, the court weighed the evidence to determine which facts were more “likely true than not.”



standards due to their mental illness, a practice which amounted to unconstitutionally cruel and unusual punishment.<sup>222</sup>

Thomas was serving a 30-year sentence for second degree murder and other charges. He had diagnoses of schizoaffective disorder, bi-polar type, and antisocial personality disorder with severe borderline features. According to the court, during 15 years of incarceration, Thomas would be periodically non-compliant with his medications and would subsequently decompensate. His symptoms included auditory hallucinations, impaired thought processes and paranoid delusions, and his behavior while incarcerated included acute agitation, banging on his cell door, eating his feces, pouring urine on his hands, exhibitionistic masturbation, urinating on his mattress, attempting to cut his penis, and repeated suicide attempts. He was frequently sprayed with different chemicals, including OC, CN and CS gas, despite the fact that custody staff observed this had no effect on his compliance with staff orders to stop.

In a 21-day period between July 20 and August 3, 2000, Thomas was sprayed with chemical agents eight times for simply yelling in his cell or banging on his cell door. He was then sprayed six times in seven days between September 20 and September 26, 2000. He consistently refused to take showers to decontaminate after being sprayed. After the September 26 incident, Thomas was taken to the prison infirmary where “medical staff reported he had first to third degree burns on his back, abdomen, arms, elbows, and buttocks.” The severity of his burns prompted medical staff to consider sending him to a special burn treatment facility.<sup>223</sup> Thomas was then transferred to Union Correctional Institution (UCI), a prison providing inpatient psychiatric care, where he remained for three years. According to a psychiatrist who treated Thomas at UCI, it took her six months to stabilize him. Department policy prohibited the use of chemical agents at UCI.

Thomas was returned to FSP in June 2003. He resumed kicking his cell door and cursing staff, and custody staff resumed spraying him, according to the district court’s decision. Thomas’ mental health again deteriorated and in July 2003, he was sent back to the UCI inpatient unit where he remained until his death from natural causes.

The use of pepper spray was not permitted at UCI. The trial court noted testimony from senior department officials that facilities such as UCI that provide inpatient treatment have greater resources which permit closer supervision and monitoring of inmates. It pointed out that when there are disturbances such as an inmate banging on a cell door or yelling, the first response is with

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<sup>222</sup> The case was not a class action. By the time of trial, four of the original ten plaintiffs had been dismissed from the suit. The district court entered judgment in favor of two of the remaining plaintiffs, ruling that the Florida prison policies as applied to them were unconstitutionally cruel. Thomas died in prison while the Department of Corrections’ appeal of the district court’s decision was pending.

<sup>223</sup> *Thomas v. McNeil*, United States District Court for the Middle District of Florida, case no. 3:04-cv-917- 2009, Findings of Fact and Conclusions of Law, filed January 9, 2009 (2009 WL 64616; 2009 US Dist. LEXIS 1208), p. 33

“mental health intervention instead of with security measures.” According to the court, the department has recognized that, “it is possible that the symptoms of their mental illness have exacerbated to the extent that they cannot control their actions or that their reactions or particular situations are disproportionately magnified due to the exacerbation of their mental illness symptoms, and not due to recalcitrance.” The court also referred to the testimony of a psychiatrist who worked at UCI that “mental health and security staff work together as a team” and that inmates could usually be counseled into cooperating when mental health staff intervene.<sup>224</sup>

## Electronic Stun Devices

Officers in some prisons and jails are equipped with weapons that administer electric shocks—referred to variously as stun guns, electroshock guns, or conducted emergency devices, among other terms.<sup>225</sup> The most commonly used stun weapons are Tasers, made by Taser International. Because of the pain from the shocks and their dangerousness, it is generally agreed that if electronic stun devices are used at all, it should only be when necessary to control dangerous or violent subjects when other tactics have been or would be ineffective.<sup>226</sup>

Officers can administer electric shocks to prisoners in one of two ways—either by placing the weapon directly against the body of the person in so-called drive-stun mode—or by sending dart-like projectiles which administer a shock to a person located at a distance. The “drive-stun” or contact mode of applying shocks does not cause muscular incapacitation. It is used to inflict pain on inmates to convince them to comply with orders

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<sup>224</sup> *Ibid.*, p. 16.

<sup>225</sup> Many police agencies also arm law enforcement officers with electronic shock devices. According to the National Institute of Justice, as of spring 2010, conducted energy devices (CEDs) have been procured by more than 12,000 law enforcement agencies in the United States. According to the New York Civil Liberties Union, in 2011, Tasers were in use by 16,000 law enforcement agencies. New York Civil Liberties Union, “Taking Tasers Seriously: The Need for Better Regulation of Stun Guns in New York,” 2011, [http://www.nyclu.org/files/publications/nyclu\\_TaserFinal.pdf](http://www.nyclu.org/files/publications/nyclu_TaserFinal.pdf), (accessed March 13, 2015), p. 1. The number of agencies equipping officers with these weapons has soared in recent years. According to a spokesperson for the Taser, 576,000 devices were used by more than 16,500 organizations, mostly in the United States in 2012, compared to only 500 or so agencies using them in 2000. Dan Hinkel, “Doubts surface as police sharply increase Taser use,” *Chicago Tribune*, January 1, 2012, [http://articles.chicagotribune.com/2012-01-01/news/ct-met-taser-use-increases-20120101\\_1\\_tasers-electroshock-weapons-doubts-surface](http://articles.chicagotribune.com/2012-01-01/news/ct-met-taser-use-increases-20120101_1_tasers-electroshock-weapons-doubts-surface) (accessed March 13, 2015). We do not know of data that indicates how many Tasers have been purchased or issued to staff working in jails or prisons.

<sup>226</sup> For a description of the history and functioning of Tasers, see *Thomas v. Nugent*, on petition for writ of certiorari to the United State Court of Appeals for the Fifth Circuit, case no. 13-682, Brief of Former Law Enforcement, Prosecutors, Judges, Corrections Officials, and Experts on Police Accountability and Use of Force as Amici Curiae in support of the Petitioner, filed on February 21, 2014. (The case concerned the use of Tasers by the police to secure compliance by handcuffed non-threatening persons).

in order to avoid further pain. When the darts are used, the electrical charge “overrides the subject’s central nervous system, causing uncontrollable contraction of the muscle tissue and instant collapse.”<sup>227</sup> That collapse then enables staff to restrain the inmate.

It is easy for staff who routinely carry stun devices to deploy them unnecessarily.<sup>228</sup> Indeed, “by their very nature, [these weapons] lend themselves to misuse.”<sup>229</sup> Officers have stunned inmates with mental disabilities who are not acting aggressively or posing an imminent threat of danger. They have used them to make inmates comply with verbal commands even absent a threat, and they have used them punitively.<sup>230</sup> For example:

- According to newspaper accounts, Marie Franks, a 58-year-old woman with bipolar disorder, was jailed in Muscatine, Iowa, in September, 2013 after she made multiple non-emergency calls to 911 and resisted arrest.<sup>231</sup> She was not taking her prescription medications while incarcerated and her mental health deteriorated.<sup>232</sup> On October 7, according to a news story, jail staff wanted Franks to change her jumpsuit. A videotape of the incident was obtained by the *Des Moines Register* and can be viewed on its website.<sup>233</sup> As shown in the video,

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<sup>227</sup> Stanford Criminal Justice Center, “Use of Tasers by Law Enforcement Agencies: Guidelines and Recommendations,” 2005, <http://www.law.stanford.edu/academic/programs/criminaljustice> (accessed February 16, 2015), p. 4.

<sup>228</sup> We have not found documentation of patterns of electronic stun device use in correctional agencies. More attention has been paid to how police use—and misuse—them. The New York Civil Liberties Union found, for example, that New York police frequently used them even in the absence of active aggression or risk of physical injury, shocking people when they were merely passively or verbally noncompliant with a police order. New York Civil Liberties Union, “Taking Tasers Seriously: The Need for Better Regulation of Stun Guns in New York.”

<sup>229</sup> Council of Europe, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, “CPT Standards,” CPT/Inf/E (2002) 1 - Rev. 2011, March 8, 2011, p. 100.

<sup>230</sup> For multiple examples of the unnecessary and punitive use of electric stun devices, see *Rosas v. Baca*, United States District Court for the Central District of California, case no. 00:12-CV-00428, Complaint for Injunctive Relief Class Action, filed on January 28, 2012.

<sup>231</sup> See Jason Clayworth, “Tasered woman: I’d hate to see anyone else go through this,” *Des Moines Register*, November 23, 2013, <http://archive.desmoinesregister.com/article/20131124/NEWS01/311230057/Tasered-woman-d-hate-see-anyone-else-go-through-this> (accessed February 27, 2015); and Jason Clayworth, “Register Investigation: Muscatine County Democrats call for probe of Taser use in jail,” *Des Moines Register*, January 24, 2014, <http://archive.desmoinesregister.com/article/20140125/NEWS14/301250059/Register-Investigation-Muscatine-County-Democrats-call-probe-Taser-use-jail> (accessed February 15, 2015). Human Rights Watch was not able to contact Franks or her father, with whom she lived at the time. The newspaper accounts are based on the reporters’ interviews with Franks, her father, county officials and a records review.

<sup>232</sup> There was some disagreement as to whether the jail failed to provide Franks with her medications or she refused to take them. Jason Clayworth, “Tasered woman: I’d hate to see anyone else go through this,” *Des Moines Register*, November 23, 2013, <http://archive.desmoinesregister.com/article/20131124/NEWS01/311230057/Tasered-woman-d-hate-see-anyone-else-go-through-this> (accessed February 27, 2015).

<sup>233</sup> *Ibid.*

when a group of several officers enter Franks' cell, she begins screaming and shouting profanities, which she continues to do for most of the next 20 minutes. She resists being handcuffed, and she resists having her jumpsuit changed. But the video does not show she posed a direct threat to the officers or assaulted them. Nevertheless, as shown in the video, over an eight-minute period, an officer shocked her with a Taser once while the officers were trying to cuff her, and two or three times after she was cuffed.<sup>234</sup> An unidentified guard can be heard to say at the end of the video, "Good job, everybody. I tell you what, that is one psychotic woman."<sup>235</sup>

- According to report by Jim Mustian in the *Ledger Enquirer*, James C. Williams, who had a history of mental health problems, was arrested on drug and obstruction of justice charges and held in the Muscogee County Jail in Georgia.<sup>236</sup> While in his cell, he reportedly masturbated in front of officers distributing the laundry. A sergeant ordered him to put on his shirt and exit the cell. A video filmed by jail staff shows that Williams put on his shirt and then begin to walk in the corridors.<sup>237</sup> A sergeant ordered him to stop, but he kept walking and then refused to cooperate in being handcuffed. The video does not show Williams acting aggressively. According to Mustian's report, the sergeant used a Taser on him 11 times. On the video one can hear the sound of the Taser being fired and Williams yelling in pain.

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<sup>234</sup> The news accounts all say Franks had a Taser used on her four times. On the video, however, an officer states he had used a Taser on her three times.

<sup>235</sup> Disability Rights Iowa filed a lawsuit against the Muscatine County Sheriff's Department, *Disability Rights Iowa v. David White*, United States District Court for the Southern District of Iowa, case no. 4:14-cv-00092, Complaint for Injunctive and Declaratory Relief, filed March 12, 2014; the Parties settled, and the case was dismissed, Dismissal With Prejudice, filed July 1, 2014. The fact of a settlement agreement is not an indication or admission by a defendant of guilt or liability. The *Des Moines Register* reported that under the settlement, the sheriff's department agreed, among other things, to prohibit the use of Tasers under the following new provisions: "Use of Tasers on pregnant women, individuals with mental or physical impairments and inmates impaired by drugs or alcohol will be prohibited unless they individuals threaten officials' safety, act aggressively or attempt to flee or escape; in addition, Sheriff's staff must seek a mental health consultation before using a Taser or other 'electronic control device' on a person with a mental illness." Jason Noble, "Muscatine County to revise Taser policy," *Des Moines Register*, July 21, 2014, <http://www.desmoinesregister.com/story/news/investigations/2014/07/07/muscatine-county-revise-taser-policy/12279619/> (accessed February 16, 2015).

<sup>236</sup> Information on James C. Williams comes from Jim Mustian, "Muscogee County Jail officials changed guidelines after questionable tasings," *Ledger Enquirer*, June 9, 2012, <http://www.tmcnet.com/submit/2012/06/09/6359353.htm> (accessed May 5, 2015). Mustian said his article is based on interviews and his review of internal documents.

<sup>237</sup> A video of the incident is posted on <https://www.youtube.com/watch?v=JCD1fH2aPW4> (accessed March 23, 2015).

Experts who reviewed the footage and related documents at the request of the *Ledger Enquirer* differed as to the reasonableness of the use of the Taser.<sup>238</sup> The newspaper reported that the use of the Taser on Williams and another inmate prompted a reworking of the jail's use of force policy. The new policy reportedly clarifies that Tasers should not be used as punishment or to "gain compliance from inmates that are non-compliant by passively resisting verbal commands."<sup>239</sup>

### *Harm from Stun Devices*

Electronic stun devices can have serious and even lethal consequences.<sup>240</sup> The company that makes Tasers recognizes their use may increase the risk of death or serious injury because of physiologic and/or metabolic effects such as: "changes in blood chemistry, blood pressure, respiration, heart rate and rhythm, and adrenaline and stress hormones, among others.... Some individuals may be particularly susceptible to the effects.... Repeated shocks can have cumulative effects and increases the risks of injury."<sup>241</sup>

According to Amnesty International, by 2012 more than 500 people in the United States had died after being shocked with Tasers either during their arrest or while in jail.<sup>242</sup> A study for the federal National Institute of Justice concluded individuals who are mentally

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<sup>238</sup> Mustian, "Muscookee County Jail officials changed guidelines after questionable tasings," *Ledger Enquirer*. One former police officer and criminology professor who reviewed the video thought Williams was not engaged in active resistance. He is quoted in the article as saying, "He's just being a pain in the neck." He also stated, "Let's assume it was OK to tase him the first time. He goes to the floor eventually. At that point, that's where physical control and restraint – handcuffs – should have been applied in my opinion." Another police practices consultant said, "The number of uses of the Taser was just astounding" and that some of the later stuns appeared to be "gratuitous." But another expert, a police department sergeant, said the tasings were not out of line given the "number of warnings" the sergeant gave Williams. He said, "Sometimes the only thing – because of the size of the person and how violent they can get—that's allowing you to keep the status quo in the situation is to keep applying the Taser, because that's how nasty these fights get."

<sup>239</sup> Mustian, "Muscookee County Jail officials changed guidelines after questionable tasings," *Ledger Enquirer*.

<sup>240</sup> US Department of Justice, Office of the Inspector General, "Review of the Department of Justice's Use of Less-Lethal Weapons," May 2009, <http://www.justice.gov/oig/reports/plus/eo903/final.pdf> (accessed February 17, 2015). The report reviews studies on the effect of Tasers. The New York Civil Liberties Union reported that more than a dozen New Yorkers have died after Taser shocks. New York Civil Liberties Union, "Taking Tasers Seriously: The Need for Better Regulation of Stun Guns in New York."

<sup>241</sup> Taser International, Product Warnings for Law Enforcement, <https://www.taser.com/images/resources-and-legal/product-warnings/downloads/law-enforcement-warnings.pdf> (accessed February 17, 2015).

<sup>242</sup> Amnesty International, "Amnesty International Urges Stricter Limits on Police Taser Use as U.S. Death Toll reaches 500," press release, February 15, 2012, <http://www.amnestyusa.org/news/press-releases/amnesty-international-urges-stricter-limits-on-police-taser-use-as-us-death-toll-reaches-500> (accessed February 17, 2015). Amnesty does not indicate the number of cases in which medical examiners concluded the shock devices contributed to or caused the fatalities. In a 2008 report, Amnesty said examiners had done so in 50 out of 334 deaths following use of stun devices. Amnesty International, "'Less than lethal'? The use of stun weapons in US law enforcement," 2008, <http://www.amnesty.org/en/news-and-updates/report/tasers-potentially-lethal-and-easy-abuse-20081216> (accessed February 16, 2015).

ill, drug-intoxicated, or have serious underlying medical conditions are at higher risk than other people for serious complications and even death from being stunned. The study also found that death is more likely when there has been continuous or repeated discharge of the stun device.<sup>243</sup>

### SHREVE V. FRANKLIN COUNTY

In 2010, the Department of Justice (DOJ) intervened in a civil rights case filed by inmates at the Franklin County Jail in Ohio alleging jail staff had engaged in a pervasive pattern of unnecessary and excessive use of Tasers. The Justice Department's Complaint in Intervention alleged that the Franklin County Sheriff's Office engaged in an unconstitutional pattern and practice of using Tasers in an abusive manner, failed to adequately investigate their use, and failed to adequately train corrections deputies in their use. In February 2011, these claims were resolved by a court-enforceable settlement agreement.<sup>244</sup>

The policy of the Franklin Country Jail at the time authorized the use of Tasers "to gain control of a violent or dangerous inmate...when attempts to subdue the inmate by conventional tactics have been or are likely to be ineffective or there is a reasonable expectation that it will be unsafe for deputies to approach within contact range of the inmate." Nevertheless, the DOJ claimed, jail deputies frequently and gratuitously used Tasers to inflict pain, fear, corporal punishment, and humiliation, and they used Tasers on individuals even when sufficient numbers of deputies were present to easily physically control an individual, while individuals were in mechanical restraints, and even when they were fully immobilized in restraint chairs. They used Tasers on people whose only offenses were minor rule violations that did not pose any threat to anyone, people who showed verbal or passive resistance to being stripped or otherwise showed lack of cooperation during the booking process, and people who used profanity or made derogatory remarks to deputies. However, staff officials who reviewed use of force reports and videotapes routinely found such uses of Tasers to be "justified."

In one case described in the DOJ's complaint, deputies used a Taser on an inmate who was fully immobilized in a four point restraint chair. "In another cases, deputies came to a cell ostensibly to

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<sup>243</sup> National Institute of Justice, "Study of Deaths Following Electro-Muscular Disruption," May 2011, <https://www.ncjrs.gov/pdffiles1/nij/233432.pdf>, (accessed February 17, 2015). National Institute of Justice, "In-Custody Death Study: The Impact of Use of Conducted Energy Devices," <http://www.nij.gov/topics/technology/less-lethal/pages/incustody-deaths.aspx> (accessed February 17, 2015), p. 3. The study looked at the police use of stun devices in the field, not in correctional settings

<sup>244</sup> Information in this section from *Shreve v. Franklin County*, United States District Court for the Southern District of Ohio, case no. 2:10-cv-644, United States' Complaint in Intervention Pursuant to 42 U.S.C. §14141, filed on November 3, 2010; Agreement between the United States of America and the Sheriff of Franklin county Ohio, [http://www.justice.gov/crt/about/spl/documents/franklin\\_settle\\_2-4-11.pdf](http://www.justice.gov/crt/about/spl/documents/franklin_settle_2-4-11.pdf). See also *Shreve v. Franklin County*, United States District Court for the Southern District of Ohio, case no.2:10-cv-644, Individual and Class Action Complaint, filed on July 16, 2010.

assist a mentally ill inmate who was banging his head against his bed. Instead of entering the cell to remove the inmate, a team of deputies stood around outside the cell while a sergeant repeatedly tased this inmate a total of fourteen times because he would not slide out of the cell by himself.”

The class action complaint provides numerous other examples. In one incident, deputies came to the cell of an inmate with mental health problems to move him to another location. When deputies opened the cell door the inmate was holding a mat in front of him and speaking unintelligibly. According to the class action complaint, a deputy used a Taser on this inmate “for not standing up and tased him again for moving his arms and legs, stating, ‘I’m tired of playing with you.’” When the inmate tried to crawl under the bed, the officer continued to use a Taser on him. The inmate was finally pulled out of the cell, still clutching his mat. He was put in leg irons and allegedly had a Taser used on him again when he would not let go of the mat.<sup>245</sup>

In the settlement agreement, the sheriff agreed, inter alia, to limit the use of conducted energy devices:

Absent exigent and exceptional circumstances, [conducted energy devices] shall not be deployed against any person who is not reasonably perceived to pose a threat to the safety of the deputy or others and is not resisting by use of physical force or by displaying Active Aggression against the deputy or others, or who questions a deputy’s commands in a non-violent manner, or who remains in a limp or prone position. When such exigent and exceptional circumstances exist, [interpersonal communication skills] and alternative forms of force or control techniques shall be considered first and rejected only if there is an objectively reasonable basis that alternative forms of force or control techniques would be unsafe.

The Agreement also specifically provides additional protection of persons with mental disabilities.

[The jail] [s]hall prohibit the deployment of the CED, except when there is an objectively reasonable threat to an individual’s safety, a display of active aggression, or an attempt to flee or escape, against the following.... subjects who have a mental or physical impairment or are intoxicated due to drugs or alcohol such that it is reasonably perceived to be impossible or impracticable to comply with an order. A deputy shall consider any known or apparent mental or physical impairment or intoxication due to drugs or alcohol in determining whether there is an objectively reasonable basis to deploy the CED.

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<sup>245</sup> *Shreve v. Franklin County*, United States District Court for the Southern District of Ohio, case no.2:10-cv-644, Individual and Class Action Complaint, filed on July 16, 2010. p.12.

## Full Body Restraints

When an inmate is out of control and unable or unwilling to stop acutely dangerous behavior, correctional policies typically permit custody staff to temporarily immobilize his arms, legs, and sometimes head in special chairs or outfitted beds.<sup>246</sup> Such full body restraints should only be used in extreme and exigent circumstances and as a last resort when other types of control are ineffective.<sup>247</sup>

Custody staff have used full body restraints for prisoners with mental health problems in non-emergency situations without attempting less restrictive means of control. They have used them for their own convenience to manage inmates who may be annoying or engaging in misconduct, but who are not a grave danger to themselves or others. Even when custody staff have used restraints because of an imminent threat of serious self-harm, they have continued to apply the restraints after they are no longer necessary.<sup>248</sup> In South Carolina, for example, a court concluded that staff used restraints unnecessarily and excessively.<sup>249</sup> The court noted, among other misuses of restraints, that staff routinely left

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<sup>246</sup> Correctional agencies add ankle, wrist and sometimes chest straps to turn beds into vehicles for immobilization. Restraint chairs are specifically designed by their manufacturers for use in restraining an inmate, although sometimes agencies will restrain prisoners in an ordinary chair. While restraint chairs have the advantage of mobility, permitting the restraint to occur in different settings, such chairs are often used in housing units where “the environment is not supportive and staff are not trained or experienced with the use of restraint... Proper procedures are less likely to be followed in such circumstances, which increases the likelihood of an adverse outcome.” Jeffrey L. Metzner et al., “Resources Document on the Use of Restraint and Seclusion in Correctional Mental Health Care,” *Journal of the American Academy of Psychiatry and the Law*, vol. 35:4, 2007. p. 420. When custody staff have placed an inmate in restraints for security reasons, medical staff should review the inmate’s health record for contraindications or need for accommodations, monitor the inmate’s health at designated intervals and if the inmate’s health is or becomes at risk, communicate immediately with custody staff. National Commission on Correctional Health Care, “Standards for Health Services in Prisons,” Standard P-1-01, National Commission on Correctional Health Care, 2014.

<sup>247</sup> *Standards for Adult Correctional Institutions* (4<sup>th</sup> ed.), American Correctional Association, (Lanham, MD: American Correctional Association, 2003). According to the US Department of Justice, “Because of the dangers associated with using full-body restraints, professional standards have been developed to delineate the scope of their use. These standards require staff to only use full-body restraints in exigent circumstances, and only for the briefest time necessary to ensure the safety of the subject prisoner or those around him. As with all uses of force, staff have an obligation to explore alternatives to the use of full-body restraints as a means for controlling a prisoner’s behaviors. Those alternatives include engaging in de-escalation techniques, giving the prisoner medicine, and/or providing additional mental health treatment.” US Department of Justice, “Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation,” May 31, 2013, [http://www.justice.gov/crt/about/spl/documents/cresson\\_findings\\_5-31-13.pdf](http://www.justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf) (accessed March 13, 2015). (internal citations omitted).

<sup>248</sup> “Sometimes a prisoner’s ability to control his behavior can be ascertained by observation while he is restrained. In others, staff must assess the prisoner’s behavior, every time they observe or interact with the restrained prisoners, looking for clues about his impulse control and emotional status.” Metzner et al., “Resources Document on the Use of Restraint and Seclusion in Correctional Mental Health Care,” *Journal of the American Academy of Psychiatry and the Law*, pp. 420, 424.

<sup>249</sup> *T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, Order, filed Jan. 8, 2014, p. 18.



inmates in restraints for specified increments of time, regardless of whether such immobilization continued to be necessary.<sup>250</sup>

Plaintiffs' use of force expert testified that South Carolina prison staff, "routinely utilize the restraint chair as a means of imposing summary and corporal punishment on mentally ill inmates who are not engaged in active or combative resistance, and in the absence of an objective and immediate need to fully immobilize the subject inmates."<sup>251</sup> According to Martin, custody staff placed inmates in restraints as deliberate punishment for prior misconduct and as a warning not to engage in it again. He testified that staff continued restraints after they were no longer necessary. For example, they returned inmates to restraint chairs for additional periods of time after the inmates had been released from restraints for a meal or a hygiene break and were calm and compliant.<sup>252</sup>

When a prisoner with mental disabilities is acting in ways that are extremely dangerous to themselves or others, mental health staff should if possible be involved in any decision as to whether full body restraint is necessary as an emergency measure.<sup>253</sup> If restraints have already been authorized by custody staff, the restraints should not be continued unless a licensed mental health practitioner, preferably a physician, has assessed the situation and decided whether the restraints are still necessary or whether the prisoner should be released and, for example, transferred to a mental health setting. Although prisoners are often held restrained in ordinary cells or other security settings, mental health experts maintain that if prisoners with mental health conditions require emergency restraint, it should be "in the prison or jail infirmary, which generally have 24-hour coverage by mental health staff who can provide health care assessments and treatment for inmates."<sup>254</sup>

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<sup>250</sup> Ibid.

<sup>251</sup> *T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, Report of Plaintiffs' Expert Steve J. Martin, filed March 11, 2011, p. 10.

<sup>252</sup> Ibid., p. 28. In one incident described by Martin, an inmate was placed in a restraint chair in the nude to prevent self-harm and was allowed out after four hours for an evening meal. He was thereafter returned to the chair, released again after four hours for a hygiene break and then again returned to the chair. Even though he was compliant each time he was released from the chair, he was kept there for a total of twelve hours.

<sup>253</sup> Email communication with Human Rights Watch on January 30, 2015 from Terry Kupers, M.D.; Human Rights Watch telephone interview with Jeffrey Metzner, M.D. Denver, Colorado, February 9, 2015. Professional standards permit mental health staff to authorize restraints "as an emergency measure to prevent imminent harm when other means of control are not effective or appropriate." Metzner et al., "Resources Document on the Use of Restraint and Seclusion in Correctional Mental Health Care," *Journal of the American Academy of Psychiatry and the Law*, p. 417.

<sup>254</sup> Metzner et al., "Resources Document on the Use of Restraint and Seclusion in Correctional Mental Health Care," *Journal of the American Academy of Psychiatry and the Law*, p. 419.

Some correctional mental health experts argue that the use of restraints for mental health purposes in correctional facilities should be limited to the stabilization of unsafe situations until the inmate can be transferred to a psychiatric hospital.

Jails and prisons are inherently nontherapeutic environments and are not adequate settings for managing mental health emergencies, such as those that require the use of restraints. Correctional conditions often contribute to the onset, and impede the resolution, of the underlying mental health crisis. Attempts to contain mental health emergencies in a correctional setting with an expanded use of restraints can compromise clinical care, overlook the root cause of many crises, impair the role of mental health professionals by blurring the distinction between mental health and security staff, and can lead to a deterioration in the standards of care.<sup>255</sup>

### **Use of Restraints at Pennsylvania State Correctional Institution, Cresson, Pennsylvania**

A Department of Justice (DOJ) investigation into the use of isolation for prisoners with mental illness at the Pennsylvania State Correctional Institution at Cresson (“Cresson”) revealed—among many other problems—the excessive and punitive use of full-body restraints on those prisoners.<sup>256</sup> According to the DOJ, officers used full-body restraints on them not only to prevent imminent harm, but also to discipline or punish prisoners by using the restraints to cause discomfort or pain. Prisoners were kept in restraints for an average of 10.5 hours. When restrained, “the prisoners typically were held in one fixed position in a windowless cement cell, were sometimes required to urinate while still in restraints, and wore only light smocks that left most of their bodies bare and exposed to the cold.” Mental health staff were not consulted about the use of restraints nor did they monitor restrained inmates. The DOJ also identified instances in which officers used additional force such as electronic stun devices against inmates who were already fully immobilized.

Quoted below from the DOJ’s findings letter are two examples that illustrate the misuse of restraints at Cresson:

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<sup>255</sup> Kenneth L. Appelbaum, M.D., “Commentary: The Use of Restraint and Seclusion in Correctional Mental Health,” *Journal of the American Academy of Psychiatry and the Law*, vol. 35, No.4 (2007) p. 431.

<sup>256</sup> US Department of Justice, “Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation,” May 31, 2013 (internal citations omitted), [http://www.justice.gov/crt/about/spl/documents/cresson\\_findings\\_5-31-13.pdf](http://www.justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf) (accessed March 13, 2015).

On July 21, 2010, prisoner KK, who had an extensive history of self-injury and was diagnosed with a depressive disorder, ran headfirst into his cell door.... Officers found KK unresponsive and lying on his back. After a brief medical evaluation, officers placed him into a restraint chair and deploying [sic] an EBID [an electronic stun device] twice during the placement. While restraining him in the restraint chair, officers “exercised” KK—a process during which one limb at a time is removed from restraints. When KK’s left leg was exercised, he began kicking. Officers responded by twice applying a handheld EBID. Later, during another exercise, a handheld EBID was applied again when he had only one limb removed. A third time, during exercise, officers applied a handheld EBID four times and deployed pepper spray on his face twice while he had only one limb removed. It appears KK’s total time in the restraint chair neared 24 straight hours.

Prisoner CC had been diagnosed with schizophrenia, had a history of psychiatric hospitalization starting at age eight, and had a low IQ. During periods of confinement in isolation he would decompensate; be transferred to inpatient mental health treatment units and then once stabilized be returned to isolation where the cycle would begin again. He ingested objects such as sandwich bags and spoons. He cut his wrists and tied a sheet around his neck. Cresson staff dismissed his serious acts of self-injury as “behavioral issue[s]” and malingering. On five occasions, between February and March 2011, he was placed in a restraint chair for periods lasting between 7 and 15 hours. On July 4, 2011, he was placed into a restraint chair for more than 19 hours after banging his head against the wall.

The Department of Justice described such uses of force as:

cruel and unnecessary. Instead of increasing compliance with prison rules, Cresson’s use of excessive force on prisoners with serious mental illness without any meaningful mental health supervision or intervention has the effect of further traumatizing the prisoners, intensifying their psychotic episodes, and exacerbating their mental illness.

After its investigation at Cresson, the Department of Justice initiated a system-wide investigation into the use of solitary confinement in Pennsylvania Department of Corrections facilities, an investigation that also found unnecessary and excessive use of full-body restraints for prisoners with serious mental illness in other facilities.<sup>257</sup> It concluded that across the state “corrections officers routinely

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<sup>257</sup> US Department of Justice, “Investigation of the Pennsylvania Department of Corrections’ Use of Solitary Confinement on Prisoners with Serious Mental Illness and/or Intellectual Disabilities,” February 24, 2014, [http://www.prisonpolicy.org/scans/DOJ\\_Findings\\_Letter\\_Issued\\_by\\_DOJ\\_2\\_24\\_2014.pdf](http://www.prisonpolicy.org/scans/DOJ_Findings_Letter_Issued_by_DOJ_2_24_2014.pdf) (accessed February 9, 2015), p. 15.

use full-body restraints for far longer than is needed to avoid harm. Instead, they often appear interested in using the restraints as a means to discipline prisoners by causing discomfort or pain.”<sup>258</sup> It proposed as a remedial measure that the Pennsylvania Department of Corrections ensure that: “The restraint chair, and other uses of force, are not used as punishment or as a substitute for mental health interventions and are instead used only in instances where a prisoner poses a physical threat.”<sup>259</sup>

### *Harm from Full-body Restraints*

Custody staff may fail to follow proper procedures to care for an inmate while restrained, increasing the likelihood of injury and prolonging physical as well as psychological pain. They may fail to give the restrained inmate sufficient feeding and hydration, or not provide bathroom opportunities, leaving the inmate to defecate and urinate on himself.<sup>260</sup> They may not move inmates’ arms and legs periodically, which is necessary to avoid the formation of potentially deadly blood-clots.<sup>261</sup> Inmates who have experienced the restraint chair for several hours or more complain of limbs going numb, swelling limbs, and varying degrees of pain and extreme discomfort.<sup>262</sup>

As with other types of force, full body restraints can produce unique harm for persons with mental disabilities. Prolonged use of restraints on inmates with certain clinical conditions, including some paranoid conditions, anxiety syndromes, and post-traumatic stress disorder, can be extremely difficult for them to tolerate.<sup>263</sup> The Department of Justice concluded that subjecting prisoners with mental illness to harsh treatment such as prolonged restraint “in response to behaviors derivative of their illness does nothing but accelerate their mental deterioration and intensify their mental torment and anguish.”<sup>264</sup>

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<sup>258</sup> *Ibid.* p. 11.

<sup>259</sup> *Ibid.*, p. 24

<sup>260</sup> While a prisoner is in restraints, adequate nutrition, hydration, and toileting are necessary, and a health care official should perform frequent periodic assessments every 15 minutes, including a range of motion checks and complete in-person evaluations. US Department of Justice, “Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation,” May 31, 2013, (internal citations omitted).

<sup>261</sup> Michael Valent, a Utah prisoner with schizophrenia, died in 1997 when blood clots formed in his legs broke loose and lodged in his lungs after he had spent 16 hours strapped in a restraint chair.

<sup>262</sup> *T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, Report of Plaintiffs’ Expert Steve J. Martin, filed March 11, 2011, p. 27

<sup>263</sup> Metzner et al., “Resources Document on the Use of Restraint and Seclusion in Correctional Mental Health Care,” *Journal of the American Academy of Psychiatry and the Law*, p. 421.

<sup>264</sup> US Department of Justice, “Investigation of the State Correctional Institution at Cresson and Notice of

When proper procedures are not followed, full-body restraints can be lethal, with death resulting from cardiac difficulties, aspiration (breathing in of vomit), pulmonary embolisms, and positional asphyxia (death by respiratory obstruction).<sup>265</sup> The danger of injury and death is even more acute when staff also use pepper spray or electric stun devices on the inmate immediately preceding the restraint or while he or she is in the restraint. In addition to the case of Nick Christie, presented above, the lethal danger of these restraints is revealed in the following cases.

**Daniel Linsinbigler** was 19 years old when he died in the Clay County Jail in Florida. His estate filed a lawsuit alleging the death was the result of excessive force.<sup>266</sup> Linsinbigler was incarcerated on March 2, 2013 after a misdemeanor arrest for trespassing and indecent exposure. According to news accounts, the police said he had entered two apartments naked and without permission and, “yelling bible scriptures and proclaiming he was Jesus.”<sup>267</sup> He was kept on suicide watch in the jail. After he had been detained for a week, Linsinbigler asked staff to give him a pencil. According to the account an inmate housed in the cell next to Linsinbigler gave investigators with the Clay County Sheriff’s office, the staff refused to give Linsinbigler a pencil. Instead they teased and mocked him about his religious beliefs.<sup>268</sup> Linsinbigler reportedly grew agitated and kicked and punched his door. The next morning when Linsinbigler began yelling again and throwing

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Expanded Investigation,” May 31, 2013, p. 19.

<sup>265</sup> A recent review of deaths at county jails around the country found more than three dozen restraint chair deaths since the late 1990s. Anne Schindler, “Controversial restraint chair linked to jail deaths,” *First Coast News*, May 7, 2014, <http://www.firstcoastnews.com/story/news/crime/2014/05/07/restraint-chair-jail-deaths-controversial/8769607/90s> (accessed March 15, 2015). Deborah Dorfman, Sara Fawk and Bob Fleischner, “Restraint Chairs and People with Disabilities,” Center for Public Representation, Northampton Mass, May 2012. See Amnesty International, “United States of America: The restraint chair. How many more deaths?” February 2002, <http://www.refworld.org/pdfid/3c8c81f36.pdf> (accessed March 13, 2015); see also Sue Burrell, “Moving Away from Hardware: The JDAI Standards on Fixed Restraint,” Youth Law Center, prepared for the Annie E. Casey Foundation Juvenile Detention Alternative Initiative, February 2009, <http://ylc.org/wp/wp-content/uploads/MovingAwayFromHardware-Final.pdf> (accessed March 13, 2015); William P. Angrick, II, “Investigation of Restraint Device Use in Iowa’s County Jails.” Iowa Citizens’ Aide/Ombudsman, February 2009, <https://www.legis.iowa.gov/docs/publications/CI/9966.pdf> (accessed March 13, 2015).

<sup>266</sup> *Curtis v. Beseler*, The United States District Court for the Middle District of Florida, case no 3:13-cv-01352, Complaint and Demand for Jury Trial, filed on November 11, 2013.

<sup>267</sup> Unless otherwise noted, information on Daniel Linsinbigler is from Anne Schindler, “Strapped In: Local teen dies in police custody,” *First Coast News*, June 16, 2014, <http://www.firstcoastnews.com/story/news/local/orange-park/2014/05/07/restraint-chair-death-daniel-linsinbigler/8768079/> (accessed March 13, 2015).

<sup>268</sup> An audio of inmate Linus Farr describing officers taunting Linsinbigler is available at [http://download.gannet.edgesuite.net/wtlv/mp3/farr\\_taunting.mp3](http://download.gannet.edgesuite.net/wtlv/mp3/farr_taunting.mp3) (accessed March 30, 2015). This audio was embedded in Anne Schindler, “Strapped In: Local teen dies in police custody,” *First Coast News*, June 16, 2014. The audio was made while Farr was speaking with the Sheriff’s internal affairs investigators.

himself against his cell, a nurse recommended he be removed from his cell because she feared he would injure himself. Officers entered the cell around 8:30 a.m., subdued him with pepper spray, strapped him into a restraint chair, and then placed a spit hood over his head. According to an audio recording of statements by the officer who sprayed Linsinbigler, he realized Linsinbigler had mental health problems.<sup>269</sup> The officer was ordered to spray him, but he did not want to. As can be heard on the audio recording, he states: “I didn't need to. I'm a big guy, controlling this guy was not going to be an issue for me at all. He was a fragile guy as it was.”

Three inmates claim to have heard Linsinbigler complaining that he could not breathe and pleading for help. The officers said they did not hear any such requests for help and that they monitored him every 15 minutes as required by jail policy. Nevertheless, sometime shortly after 9:00 a.m., Linsinbigler was discovered without a pulse and not breathing. He was taken to a hospital where he was declared dead. According to the complaint filed by his estate, the state medical examiner identified the cause of his death as asphyxiation.<sup>270</sup>

**Timothy Souder** died at age 21 in the Southern Michigan Correctional Facility at Jackson, Michigan, while serving a sentence for resisting arrest and destroying police property.<sup>271</sup> He had a history including bipolar disorder, depression, hyperactivity, and suicide attempts. In 2006 he was transferred from general population to administrative segregation for

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<sup>269</sup> Audio recording of Deputy Rodney Houldson, [http://download.gannett.edgesuite.net/wtlv/mp3/houldson\\_pepperspray.mp3](http://download.gannett.edgesuite.net/wtlv/mp3/houldson_pepperspray.mp3) (accessed March 30, 2015). This audio is embedded in Anne Schindler, “Strapped In: Local teen dies in police custody,” *First Coast News*, June 16, 2014, <http://www.firstcoastnews.com/story/news/local/orange-park/2014/05/07/restraint-chair-death-daniel-linsinbigler/8768079/> (accessed March 13, 2015). The audio was made while Houldson was speaking with the Sheriff's internal affairs investigators.

<sup>270</sup> *Curtis v. Beseler*, The United States District Court for the Middle District of Florida, case no 3:13-cv-01352, Complaint and Demand for Jury Trial, filed on November 11, 2013. The case settled for \$2.2 million. Susan Cooper Eastman, “Clay County Puts A Price Tag on Daniel Linsinbigler's Life: \$2.2 million,” *Folio Weekly*, November 17, 2014, <http://folioweekly.com/CLAY-COUNTY-PUTS-A-PRICE-TAG-ON-DANIEL-LINSINBIGLERS-LIFE-22-MILLION,11511> (accessed March 31, 2015). The fact of a settlement agreement is not an indication or admission by a defendant of guilt or liability.

<sup>271</sup> Information about Timothy Souder taken from *Hadix v. Caruso*, case 4:92-cv-00110, Opinion, filed November 13, 2006. Plaintiffs in *Hadix*, a class action case filed in 1980 regarding unconstitutional conditions in Michigan prisons, including inadequate mental health care. In 2001, the court granted defendants' request to terminate enforcement of the mental health provision of the consent decree in the case. The death of Souder along with other deaths attributable to deficient mental health care prompted a motion in 2006 by the *Hadix* plaintiffs to reopen the terminated provisions and for a preliminary injunction pertaining to mental healthcare. The court granted the motion and, among other things, ordered the Michigan Department of Corrections to stop using any form of punitive mechanical restraints in the facilities covered by *Hadix*. In that opinion, the court discussed the facts surrounding the death of Souder (identified as T.S.). Souder's estate filed a lawsuit, *Souder v. Burt*, United States District Court for the Eastern District of Michigan, 2:06-cv-14353, on October 3, 2006. The case was settled for \$3,250,000 on June 18, 2008.

disobeying orders, and his continued disobedience led to his being placed on August 2, 2006 in “top of the bed restraints,” what the court called “ a euphemism for chaining an inmate’s hands and feet to a concrete slab.” Restrained prisoners were to be observed every 15 minutes and offered bathroom and water drinking breaks every two hours. An outpatient social worker determined that Souter was “floridly psychotic” and referred him for transfer to a prison psychiatric hospital, but the transfer never took place. Because the staff psychiatrist was on an extended leave, there was no on-site psychiatric coverage at the prison. According to the court, the “immediate consequence of the failure to transfer was that a psychotic man with apparent delusions and screaming incoherently was let in chains on a concrete bed over an extended period of time with no effective access to medical or psychiatric care and with custody staff telling him that he would be kept in four-point restraints until he was cooperative.”<sup>272</sup> Souder was taking several psychotropic medications which increase the risks of dehydration and can interfere with temperature regulation. During the period Souter was restrained, conditions at the prison were hot and humid, with heat index reading around 100 degrees on two of the days. Although Souter’s medical condition needed careful medical monitoring because of the heat, no such monitoring occurred.

The court found it “striking” that neither custody staff, who checked on Souter at regular intervals, nor psychological and nursing staff, who saw him in a state of decline, “took any action to summon emergency care,” even though it was apparent that Souter was experiencing mental and physical deterioration. When he was released from the restraints on August 6, he was unable to stand and fell face first onto the floor. He died shortly thereafter of dehydration and arrhythmia.

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<sup>272</sup> Hadix v. Caruso, 461 F. Supp. 2<sup>nd</sup> 574, W.D. Mich (2006).

## V. Retaliatory and Gratuitous Use of Force

In early 2014, according to a mental health clinician who witnessed the incident, a homeless man, who the psychiatrist thought was psychotic, was held in pretrial detention in the mental health unit of an upstate New York jail. An officer had a sandwich and put it on top of the counter in the common area of the unit. The detainee, who apparently was hungry, picked up the sandwich. The officer responded by spraying him with a chemical agent. When the clinician asked the officer why he had sprayed the inmate, the officer said, “because he looked at me funny.”<sup>273</sup>

### Corporal Punishment

Use of force by correctional staff for purposes of punishment or retaliation—corporal punishment—is prohibited by constitutional jurisprudence, professional standards, and agency policies.<sup>274</sup> Despite this prohibition, it takes place across the country, including against inmates with mental disabilities. Sometimes corporal punishment consists of prolonged vicious beatings by one or more officers in which there is not even a pretense of necessity. Sometimes chemical agents and the restraint chair are used “as a means of imposing summary and corporal punishment on mentally ill inmates who are not engaged in active or combative resistance, and in the absence of an objective and immediate enforcement necessity to incapacitate, neutralize or immobilize” them.<sup>275</sup>

There is also “the more insidious pattern or practice of unlawful staff use of force that is cloaked with, or protected by, an air of legitimacy or facial validity. It is not uncommon for ostensibly lawful applications of physical force to mask the intentional infliction of punishment, retaliation or reprisal on prisoners.”<sup>276</sup> The initial use of force may have been appropriate, but the force is continued long after it is no longer needed, such that it

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<sup>273</sup> Human Rights Watch telephone interview with a forensic psychiatrist [name withheld on request], New York, April 29, 2014.

<sup>274</sup> Retaliation can take forms other than brutality such as writing false disciplinary reports, trashing mail, denying meals or commissary access, or transferring prisoners to less desirable cells or work details. See, e.g., David A. Rembert and Howard Henderson, “Correctional Officer Excessive Use of Force: Civil Liability under Section 1983,” *The Prison Journal*, vol. 94, no. 2, February 2014, p. 207.

<sup>275</sup> *T.R. et al. v. South Carolina Department of Corrections*, Court of Common Pleas, South Carolina, case no. 2005-CP-40-2925, Report of Plaintiffs’ Expert Steve J. Martin, filed March 11, 2011, p. 10.

<sup>276</sup> Steve J. Martin, “Staff Use of Force in U.S. Confinement Settings: Lawful Control Tactics Versus Corporal Punishment,” *Social Justice*, vol. 33, no. 4, 2006, p. 183.



becomes punitive. The use of force must stop when the need for it to maintain or restore discipline no longer exists. Force should not be continued once the prisoner is incapacitated and no longer able to pose a threat to staff's ability to maintain order, resist orders, or engage in disruptive behavior. Using force at that point has no object other than to inflict pain.

Some custody staff have also deliberately used disproportionately severe force for the purpose of inflicting pain as punishment for misconduct. When “unnecessary or disproportionate force is applied for the primary purpose of inflicting punishment, retaliation or reprisal rather than control, [it constitutes] de facto corporal punishment.... Often, the subjects of such force are mentally ill offenders whose behavior as viewed by inadequately trained officers, is to be punished rather than treated.”<sup>277</sup>

Officers often use force immediately after an incident of misconduct has ended. In a not uncommon example, an inmate securely locked in a cell throws urine or feces on an officer but then retreats to the back of his cell and makes no further threatening gestures. He has broken rules, but he does not pose an ongoing danger that requires him to be controlled. If the officer nonetheless responds immediately by spraying the inmate with pepper spray, he has engaged in retaliation or punishment, not a reasonable good faith effort to gain control. The disciplinary system exists to impose sanctions for rule breaking, but some officers nonetheless believe such conduct calls for the immediate infliction of pain.

Thorough reviews of use of force incidents and, where appropriate, full-fledged investigations by senior agency staff outside the facility chain of command are vital to determine whether the force was legitimate and proportionate or constituted corporal punishment. The facts must be reviewed to ascertain, for example, whether the staff manufactured or exaggerated the need to physically control a prisoner or legitimately initiated the force and then unnecessarily but deliberately escalated it—both examples of corporal punishment that remain hidden absent a closer look by senior staff who report directly to the head of the agency.

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<sup>277</sup> Martin, “Staff Use of Force in U.S. Confinement Settings: Lawful Control Tactics Versus Corporal Punishment, *Social Justice*, p. 183.

Court decisions and Department of Justice reports include a plethora of cases of punitive violence against inmates with mental health problems. We detail some illustrative cases below, and in the following chapter we describe agencies and facilities in which punitive force has become widespread and systemic.

**Jerry Williams**, a prison inmate in North Carolina, filed a lawsuit alleging unconstitutionally excessive use of force.<sup>278</sup> The 57 year-old Williams has been diagnosed with paranoid schizophrenia, and according to press accounts spent much of his adult life in state psychiatric hospitals and prisons. He received a 28-year sentence in 2002 following a lengthy record of convictions for trespassing, assault and burglary.<sup>279</sup> Since then, he has cycled between the solitary confinement unit of the Central Prison and an inpatient mental health ward. According to press accounts, his prison record lists 142 infractions over ten years, many for disobeying orders or throwing cups filled with bodily waste.<sup>280</sup> Williams' response to defendants' motion for summary judgment, alleges that some of the primary symptoms of his illness—agitation, yelling, kicking and throwing things—have been responded to as “pure behavior problems that must be punished with the intentional infliction of pain.”<sup>281</sup> For example, between June 5, 2008 and September 17, 2009, he was allegedly sprayed with pepper spray at least eight times for nonviolent conduct such as kicking on his cell door, profane language, and throwing liquids.

Williams contended that on September 17, 2009, his dinner tray did not include bread or a spoon. Williams kicked the door of his cell to complain and later, when a correctional officer returned to collect the food tray, refused to return it. Two officers subsequently returned to his cell and ordered him to return the tray. According to the court in its ruling on defendants' motion for summary judgment, the parties disputed what happened next. Williams claimed the tray slipped from his hands and fell through the food port to the floor outside his cell. One of the officers then deployed a single burst of pepper spray, and after he did so, Williams retaliated by throwing a cup of water at him. According to the officer,

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<sup>278</sup> Unless otherwise noted, information on Williams is drawn primarily from *Williams v. Wellman*, United States District Court for the Eastern District of North Carolina, case no 5:12-ct-03055, Order on Motion for Summary Judgment, filed July 17, 2014 (granting defendants' motions for summary judgement on grounds of qualified immunity based on evidence submitted by plaintiffs and defendants).

<sup>279</sup> Michael Biesecker, “Suit: Mentally Ill NC Inmate Often Pepper Sprayed,” Associated Press, October 27, 2013, <http://hamptonroads.com/2013/10/suit-nc-inmate-was-repeatedly-pepper-sprayed> (accessed March 13, 2015).

<sup>280</sup> *Ibid.*

<sup>281</sup> *Williams v. Wellman*, United States District Court for the Eastern District of North Carolina, case no 5:12-ct-03055, Plaintiff's Response in Opposition to Defendants' Motion for Summary Judgment, filed on October 17, 2013, p. 1.

however, Williams threw the food tray out of the food port, picked up a cup of liquid as if to throw it at the officer, and refused an order to put it down. The officer then pepper sprayed Williams in an unsuccessful effort to deter him from throwing the liquid.

According to the court's recounting of the events, the officer subsequently ordered Williams to submit to handcuffs to be taken out of his cell but Williams refused. Officers then tried to forcibly remove Williams from his cell, efforts which included the repeated use of pepper spray, before they succeeded the second time. Defendants contended that Williams had jammed his cell door and used his mattress to prevent it from fully opening. They also claimed Williams attempted to assault them by throwing more liquid on them and by swinging a sock with a bar of soap in it at them. Williams denied hitting any of the officers. According to the officers, after they entered his cell Williams refused to submit to handcuffs; Williams said that he complied. After he was out of his cell, officers placed him in full restraints.

The parties' accounts of what happened next diverge markedly. According to the court, Williams alleged that after he was handcuffed, officers proceeded to beat him, stomp him, kick him and stand on his back, chest, head and neck and that one of the officers grabbed and twisted his hands, allegedly breaking three of his fingers. Defendant officers denied such a beating occurred.<sup>282</sup>

**Robert Sweeper** was booked into the Alvin S. Glenn Detention Center, the county jail in Richland County, South Carolina, on February 7, 2013. While detained in the jail, Sweeper was assaulted by staff, causing serious injuries. The US Attorney brought a criminal case against a jail officer, and Sweeper brought civil complaints against Richland County and against the jail's medical care providers.<sup>283</sup>

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<sup>282</sup> The trial court, construing disputed issues of fact in the light most favorable to plaintiff, granted the defendants' motion for summary judgment. It ruled that even assuming the officer pepper sprayed Williams in his cell solely to cause him harm, Williams had failed to show that any injury from a single burst of pepper spray was more than *de minimis* or that even he had suffered harm from the use of pepper spray during the effort to extract him from his cell. The court also ruled that even if Williams did sustain fractures to three of his fingers during the alleged beating, such injuries were also *de minimis*. At the time in the Fourth Circuit, absent extraordinary circumstances, a plaintiff with *de minimis* injuries could not prevail on an excessive force claim even if the injuries were caused by officers using force maliciously and sadistically. In 2010, the Supreme Court ruled that the proper focus in an excessive force case was on the nature of and reason for the force not the extent of the injury caused. *Wilkins v. Gaddy*, 130 S. Ct. 1175 (2010).

<sup>283</sup> Information on Sweeper is compiled from the felony information filed by the US Attorney, *United States v. Smith*, United States District Court for the District of South Carolina, case no. 3:13-995; the complaint Sweeper filed against the jail's medical contractor and staff, alleging unconstitutionally deficient medical care, *Sweeper v. Correct Care Solutions*, United

Sweeper was charged with trespassing after University of South Carolina campus police found him sleeping in a classroom building doorway on a cold night and took him to the jail. He was behaving erratically, was uncooperative, combative, and incoherent.<sup>284</sup> Staff recognized Sweeper had mental health problems and assigned him to suicide watch, but they did not send him to a hospital where he could receive psychiatric care. Over the following days he was disoriented, rambling, illogical, refused food, and showed poor hygiene.

On February 11, corrections officers were searching cells that housed inmates with mental illness and those on suicide watch to look for weapons or tools inmates could use to hurt themselves. According to the felony information filed by the US Attorney, Officer Robin Smith, “while acting under color of law, did willfully kick R.S. multiple times, causing bodily injury.”<sup>285</sup> Smith pleaded guilty to a criminal civil rights violation. The plea agreement stated:

On or about February 11, 2012, Defendant Robin Smith was employed as a corrections officer at the Alvin S. Glenn Detention Center (“ASGDC”) in Richland County, South Carolina, in the District of South Carolina. At approximately 6:30 am, Defendant Smith entered the suicide watch cell assigned to Robert Sweeper, a pre-trial detainee. Sweeper was assigned to suicide watch because, while non-violent, he was mentally ill and generally incoherent. During the course of a routine search of Mr. Sweeper's cell, Defendant Smith twisted Sweeper's wrist and arm, and kicked Sweeper in the upper body. During the assault, Sweeper was lying on the floor of the cell with one hand cuffed. Mr. Sweeper was not combative and posed no threat to Defendant Smith. There was no legitimate law enforcement purpose for Defendant's level of use of force. As a result of Defendant

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States District court for the District of South Carolina, case no. 2:14-cv-1950, Complaint, filed May 9, 2014; John Monk, “Richland County pays 750,000 to settle inmate beating suit,” *The State*, July 16, 2014, <http://www.thestate.com/news/local/crime/article13868816.html> (accessed March 13, 2015); and Noelle Phillips, “Former Jail Guard Sentenced to 2 years in Beating of Homeless Columbia man,” *The State*, April 9, 2014 <http://www.thestate.com/news/local/crime/article13846913.html> (accessed March 30, 2015); John Monk, “Former Richland County jail guard to be sentenced Wednesday for beating mentally-ill homeless prisoner,” *The State*, April 8, 2014, <http://www.thestate.com/news/local/crime/article13846580.html#storylink=cpy> (accessed May 5, 2015)

<sup>284</sup> Monk, “Former Richland County jail guard to be sentenced Wednesday for beating mentally-ill homeless prisoner,” *The State*.

<sup>285</sup> *United States v. Smith*, United States District Court for the District of South Carolina, case no. 3:13-995, Information, filed November 12, 2013.

Smith's unjustified and excessive use of force, Mr. Sweeper sustained bodily injury.<sup>286</sup>

According to the assistant US attorney who handled the case against Smith, “Smith lost his temper, and when you are a correctional officer you can’t do that, and the system will not tolerate it.”

Sweeper ended up with three broken ribs, a punctured lung, and two fractured vertebrae.<sup>287</sup> Four days passed before Sweeper was taken to a hospital, where he remained eight days.<sup>288</sup> Smith was sentenced to two years in prison. Six other guards were fired for not reporting the beating.<sup>289</sup>

**Darren Rainey**, a 50-year-old man with a diagnosis of schizophrenia, was housed in the inpatient mental health unit at Florida’s Dade Correctional Institution while serving two years on a cocaine charge.<sup>290</sup> According to a lawsuit filed by his estate, Rainey’s mental health problems sometimes led him to smear feces on himself and his cell, and he did so on the evening of June 23, 2012. Under normal procedures, the custody staff would have taken Rainey to the closest shower to be washed. Instead, it is alleged they took him to a more distant shower that was either altered or broken in such a way that correctional officers could set the temperature to scalding and Rainey could not shut the water off, control its

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<sup>286</sup> *United States v. Smith*, United States District Court for the District of South Carolina, case no. 3:13-995 Amended Plea Agreement, filed April 7, 2014.

<sup>287</sup> Monk, “Richland County pays 750,000 to settle inmate beating suit,” *The State*.

<sup>288</sup> The delay before Sweeper was taken to a hospital may have aggravated his injuries. The pre-sentencing report noted that “While the victim required a great deal of medical care as a result of his significant injuries, the government conceded the evidence collected during the investigation does not conclusively prove the full array of injuries Sweeper sustained resulted directly from the specific assault by acts committed by Smith. Indeed, the Government represented Smith’s acts started a chain of events, in combination with other concurrent causes, which proximately resulted in Sweeper’s deteriorated health and required hospitalization.” *United States v. Smith*, United States District Court for the District of South Carolina, case no. 3:13-995, Sentencing Memorandum, filed December 18, 2013.

<sup>289</sup> Richland County agreed to pay \$750,000 to settle Sweeper’s lawsuit. John Monk, “Richland County pays \$750,000 to settle inmate beating suit,” *The State*, July 16, 2014, <http://www.thestate.com/news/local/crime/article13868816.html> (accessed March 13, 2015). The fact of a settlement agreement is not an indication or admission by a defendant of guilt or liability. In January 2015, Sweeper’s case against the medical care provider was dismissed pursuant to plaintiff’s stipulation.

<sup>290</sup> Unless otherwise noted, information on Darren Rainey is taken from the lawsuit seeking damages that were filed by Rainey’s estate, *Chapman v. Florida Department of Corrections*, United States District Court for the Southern District of Florida, case no. 1:14-cv-23323, Amended Complaint, filed on December 18, 2014. This case was consolidated with a civil rights lawsuit filed seeking injunctive relief by Disability Rights Florida claiming that Florida prison staff at the Dade Correctional Institution subjected other inmates, all with serious mental illnesses, to scalding showers in retaliation for behaviors that correctional officers did not like, *Disability Rights Florida v. Jones*, United States District Court for the Southern District of Florida, case no. 1-14-cv-23323, Amended Complaint, filed on January 23, 2015.

temperature, or leave the shower until staff opened the door.<sup>291</sup> A related lawsuit brought by Disability Rights Florida alleged in its complaint that staff at this institution had previously placed another inmate with mental health problems in the scalding shower to punish him.<sup>292</sup>

Nearly two hours later, according to the Rainey complaint, when the officers went to retrieve Rainey, he was lying unresponsive on the floor of the shower. They called a nurse who discovered Rainey had no pulse and was not breathing. He had burns over 90 percent of his body, and his skin was hot/warm to the touch and slipped off when touched. Inmates told journalists that Rainey had angered corrections officers by defecating in his cell and refusing to clean up the mess. A psychotherapist who worked at the prison between 2008 and 2011 told the press that guards at the prison “taunted, tormented, abused, beat and tortured chronically mentally ill inmates on a regular basis.”<sup>293</sup>

Two years after Rainey’s death the police investigation remains pending and there is no report from the medical examiner. Settlement discussions are ongoing in consolidated lawsuits filed by Rainey’s estate for damages and by Disability Rights Florida for injunctive relief.<sup>294</sup>

**Paul Schlosser III**, age 27, an inmate at the Maine Correctional Center diagnosed with bipolar disorder and depression and serving a sentence for robbery, returned from a hospital in June 2012 where he had been treated for deep self-inflicted cuts on his arm. According to news stories, after returning to the prison, he removed the dressing from his cuts and reopened them, but refused to go to the medical unit to be treated. Officers placed him in a restraint chair with his ankles and waist strapped to the chair and took him to another cell where a nurse could take care of his arm.<sup>295</sup> As shown in a 17-minute video recorded by

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<sup>291</sup> Julie K. Brown, “Staff at a Miami-Dade prison tormented, abused mentally ill inmates, former worker says,” *Miami Herald*, May 20, 2014, <http://www.miamiherald.com/news/local/community/miami-dade/article1964709.html> (accessed February 16, 2015).

<sup>292</sup> See *Disability Rights Florida v. Jones*, United States District Court for the Southern District of Florida, case no. 1-14-cv-23323, Amended Complaint, filed on January 23, 2015, p. 11.

<sup>293</sup> Julie K. Brown, “Behind Bars, a brutal and unexplained death,” *Miami Herald*, May 18, 2014, <http://www.miamiherald.com/news/local/community/miami-dade/article1964620.html> (accessed March 13, 2015).

<sup>294</sup> Human Rights Watch telephone interview with Peter Sleasman, attorney, Florida, February 17, 2015.

<sup>295</sup> Information on Paul Schlosser comes from David Hench, “Prison captain fired, but later reinstated, after pepper spraying inmate,” *Portland Press Herald*, March 16, 2013, [http://www.pressherald.com/2013/03/16/prison-captain-fired-but-later-reinstated-after-pepper-spraying-inmate\\_\\_2013-03-17/](http://www.pressherald.com/2013/03/16/prison-captain-fired-but-later-reinstated-after-pepper-spraying-inmate__2013-03-17/) (accessed March 2015); David Hench, “Maine prisoner files claim over pepper-spray incident,” *Portland Press Herald*, December, 2013, [http://www.pressherald.com/2013/12/05/maine\\_inmate\\_may\\_file\\_lawsuit\\_over\\_restraint\\_\\_pepper-spraying/](http://www.pressherald.com/2013/12/05/maine_inmate_may_file_lawsuit_over_restraint__pepper-spraying/) (accessed March 13, 2015); and 17-minute video of the pepper spraying recorded by prison staff which can be seen at <https://www.youtube.com/watch?v=oMN4ngibpHs> (accessed March 31, 2015).

prison staff, Schlosser was quiet and compliant while the officers took the cuffs off of his wrists so they could fasten his arms to the chair until one of the officers pinned back his head. He then started to struggle and spit at one of the officers. A captain with the officers immediately then sprayed Schlosser in the face with a short blast of pepper spray.

The video shows that after Schlosser was pepper sprayed, he gagged, choked, and gasped for breath, and pleaded not to have his head restrained. The captain then ordered a spit guard put on Schlosser without decontaminating him first, which trapped the pepper spray against Schlosser's face. Schlosser kept saying he was unable to breathe, begged to have the spit guard removed, and promised not to spit again. As can be heard on the video, the captain's response was to keep repeating, "If you can talk you can breathe." The captain also berated Schlosser, saying, for example, "Why did you remove the dressing, why did you spit on an officer?" and asking if Schlosser was "done playing games." The captain also told Schlosser that if he refused to cooperate, "This will happen all over again... You're not going to win... we win every time." At the end of the video, following an order from the captain, officers remove the spit mask.

According to the news stories, a prison investigator who looked into the incident said, "[T]he situation went from a security situation to a punishment one." The captain reportedly told the investigator that the use of pepper spray was appropriate because Schlosser, who has hepatitis C, spit on one of the officers and was not being cooperative. The captain was fired but Corrections Commissioner Joseph Ponte reinstated him with a 30-day suspension because of his otherwise clean work record.

## A Culture of Abuse

Prisons don't have to be as dangerous and as violent as they are. The culture of our prisons virtually dictates the level of violence you will have in them. And if you change that culture, you will reduce the violence.

—Donald Specter, Prison Law Office, Testimony to Commission on Safety and Abuse in America's Prisons<sup>296</sup>

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<sup>296</sup> "Confronting Confinement: A Report of the Commission on Safety and Abuse in America's Prisons," Vera Institute, June 8, 2006, [http://www.vera.org/sites/default/files/resources/downloads/Confronting\\_Confinement.pdf](http://www.vera.org/sites/default/files/resources/downloads/Confronting_Confinement.pdf) (accessed March 13, 2015).

In some correctional facilities, a culture of violence develops in which staff routinely, maliciously, and even savagely abuse inmates, including inmates with mental health problems, using force, fear, reprisal, and retaliation to control them. All levels of staff become complicit, actively or passively, in the widespread physical abuse. Force is used but not reported; if reported it is reported inaccurately with key facts omitted; staff who witness an incident say nothing; supervisors do not carefully scrutinize use of force reports, incidents are not referred for investigation or, if they are, the investigation is cursory. Impunity for abuse is the norm. As Steve J. Martin notes, where such practices exist they operate to say, in effect, “This is the way we do business here.... We use force on our own terms, not the terms of what the law requires or what sound corrections practice requires, but on our terms.”<sup>297</sup>

### *New York City Department of Corrections: Rikers Island*

Andre Lane was locked in solitary confinement in a Rikers cellblock reserved for inmates with mental illnesses when he became angry at the guards for not giving him his dinner and splashed them with either water or urine. Correction officers handcuffed him to a gurney and transported him to a clinic examination room beyond the range of video cameras where, witnesses say, several guards beat him as members of the medical staff begged for them to stop. The next morning, the walls and cabinets of the examination room were still stained with Mr. Lane’s blood.

—Michael Winerip and Michael Schwartz, “Rikers: Where Mental Illness Meets Brutality in Jail,” *New York Times*<sup>298</sup>

Staff brutality has been pervasive for decades in New York City’s main jail complex on Rikers Island. Rikers Island houses 10 facilities (nine operational currently), holding about 11,000 inmates daily, 85 percent of which are pretrial detainees.<sup>299</sup> Over a period of 25 years, five separate class action lawsuits were brought to end staff abuse. Each of the lawsuits was successful in obtaining changed policies and practices to end staff violence,

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<sup>297</sup> Human Rights Watch interview with Steve J. Martin, New York, New York March 9, 2015.

<sup>298</sup> Michael Winerip and Michael Schwartz, “Rikers: Where Mental Illness Meets Brutality in Jail,” *New York Times*, July 14, 2014, [http://www.nytimes.com/2014/07/14/nyregion/rikers-study-finds-prisoners-injured-by-employees.html?\\_r=0](http://www.nytimes.com/2014/07/14/nyregion/rikers-study-finds-prisoners-injured-by-employees.html?_r=0) (accessed March 13, 2015).

<sup>299</sup> Editorial, “What is Happening at Rikers Island,” *New York Times*, December 15, 2015, <http://www.nytimes.com/2014/12/16/nyregion/what-is-happening-at-rikers-island.html> (accessed April 22, 2015).



including video monitoring, staff training, and unbiased and thorough investigations. But the injunctive relief was often limited to the particular facilities subject to the lawsuits, and the city failed to keep all the measures in place once the court orders expired.

A new system-wide class action lawsuit was filed in 2012 replete with harrowing allegations of staff violence against inmates. The complaint claims Rikers Island is “pervaded by a culture of routine and institutionalized staff violence against inmates, by a failure of accountability at every level, and by supervisors’ deliberate and even calculated indifference to, and tolerance and encouragement of, the Constitutional violations that occur on their watch.”<sup>300</sup>

On December 18, 2014, the United States intervened in that lawsuit, following release of a federal report that documented a “deep-seated culture of violence” at Rikers and highlighted the slow pace of negotiations to secure needed reforms.<sup>301</sup> The complaint by the United States alleges systemic use of unnecessary and excessive force against inmates to control them and to punish disobedience or disrespect. Even when some level of force is necessary, staff often use force that is disproportionate to the risk posed by inmates.

The federal report focuses on the force used against youthful inmates (most of whom are pretrial detainees) held at Rikers. It identifies a “staggering” number of injuries: nearly 44 percent of the adolescent male population in custody as of October 2012 had been subjected to use of force by correctional staff. Many of the incidents involved adolescents with significant mental health problems who have limited impulse control. An unpublished internal study by the city’s Department of Health and Mental Hygiene found that over an 11 month period in 2013, 129 inmates suffered serious injuries—fractures, wounds requiring stitches, head injuries in one case, even a perforated bowel—at the hands of corrections officers. According to the *New York Times*, which obtained a copy of the study, the report lays “bare the culture of brutality [at Rikers] and makes clear that it is inmates with mental

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<sup>300</sup> *Nunez v. City of New York*, United States District Court for the Southern District of New York, case no. 11-cv-5845, Amended Complaint, filed on May 24, 2012, p. 2-3.

<sup>301</sup> *Nunez v. City of New York*, United States District Court for the Southern District of New York, case no. 11-cv-5845, United States’ Motion to Intervene Pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997, United States’ Proposed Complaint-In-Intervention, filed on December 18, 2014; U.S. Department of Justice, “CRIPA Investigation of the New York City Department of Correction Jails on Rikers Island,” August 4, 2014, <http://www.justice.gov/usao/nys/pressreleases/August14/RikersReportPR/SDNY%20Rikers%20Report.pdf> (accessed February 17, 2015).

illnesses who absorb the overwhelming brunt of the violence.”<sup>302</sup> Inmates with mental illness, who make up 40 percent of the jail population, suffered more than three-quarters of the injuries from staff use of force documented in the study.

According to the federal report, youth are in constant danger of physical harm even when they present no risk to the system or safety of the staff. Inmates are beaten and battered for minor infractions. Force is routinely used not so much to keep order but for the express purpose of “inflicting injuries and pain.... Inmates are beaten as a form of punishment, sometimes in apparent retribution for some perceived disrespectful conduct.” The report includes, for example, a December 2012 incident in which two inmates with mental disabilities who were in the Mental Health Assessment Unit for Infracted Inmates (MAUII) facility were forcibly extracted from their cells, taken to the clinic at the George R. Vierno Center and beaten in front of medical staff. The New York City Department of Investigation (DOI) conducted an investigation and concluded that staff had assaulted both inmates “to punish and/or retaliate against the inmates for throwing urine on them and for their overall refusal to comply with earlier search procedures.” The federal report provides the following lengthy description of the incident:

Based on inmate statements and clinic staff accounts, a Captain and multiple officers took turns punching the inmates in the face and body while they were restrained. One clinician reported that she observed one inmate being punched in the head while handcuffed to a gurney for what she believed to be five minutes. Another clinician reported that she observed DOC staff striking the other inmate with closed fists while he screamed for them to stop hurting him. A physician reported that when he asked what was happening, correction officers falsely told him that the inmates were banging their heads against the wall. A Captain later approached a senior [mental health] official and stated, in substance, that it was good the clinical staff were present “so that they could witness and corroborate the inmates banging their own heads into the wall.” The correction officers’ reports did not refer to any use of force in the clinic, and each report concluded by stating: “The inmate was escorted to the clinic without further incident or force used.” The involved Captain did not submit

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<sup>302</sup> Winerip and Schwartz, “Rikers: Where Mental Illness Meets Brutality in Jail,” *New York Times*.

any use of force report at all. One inmate sustained a contusion to his left shoulder and tenderness to his ribcage, and the other inmate reported suffering several contusions and soreness to his ribs and chest. One of the inmates told our consultant that he was still spitting up blood due to the incident when interviewed more than a month later.<sup>303</sup>

In its complaint, the Department of Justice summarizes the failure of the top management of the New York City Department of Correction, which operates Rikers island, to take meaningful steps to correct the excessive violence against inmates by staff as well as inmate-on-inmate violence. It alleges officials have failed to meaningfully address an organizational culture that tolerated unnecessary and excessive force; to ensure the use of force is properly reported and investigated; to appropriately discipline correction officers who utilize unnecessary and excessive force, as well as those who supervise such officers; and to implement measures to ensure inmates are appropriately supervised by experienced, qualified, and well-trained staff.<sup>304</sup>

While the lawsuit continues, steps are being taken to improve conditions at Rikers, including steps to improve the jail's ability to care for inmates with mental illness. For example, Mayor Bill de Blasio has appropriated funds to create specialized therapeutic units that reward improvements in behavior.<sup>305</sup> On December 17, 2014, Mayor de Blasio and Joseph Ponte, Commissioner for New York City's Department of Correction, announced the end of punitive segregation for adolescents in New York City jails. "By ending the use of punitive segregation for adolescents, we are shifting away from a jail system that punishes its youngest inmates, to one that is focused on rehabilitation with the goal of helping put these young New Yorkers on the path to better outcomes," said Mayor de Blasio. "Commissioner Ponte is a proven change agent and today's announcement is one of a

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<sup>303</sup> U.S. Department of Justice, "CRIPA Investigation of the New York City Department of Correction Jails on Rikers Island," August 4, 2014, <http://www.justice.gov/usao/nys/pressreleases/August14/RikersReportPR/SDNY%20Rikers%20Report.pdf> (accessed March 17, 2015), p. 15. The complaint in *Nunez v. City of New York* provides numerous and sickening examples of staff force against inmates, but does not specify which of the inmates has a serious mental illness.

<sup>304</sup> *Nunez v. City of New York*, United States District Court for the Southern District of New York, case no. 1:11-cv-05845, United States' Proposed Complaint-In-Intervention, filed December 18, 2014, p.2. See also U.S. Department of Justice, "CRIPA Investigation of the New York City Department of Correction Jails on Rikers Island," August 4, 2014, p. 44.

<sup>305</sup> Michael Winerip and Michael Schwartz, "For Mentally Ill Inmates at Rikers Island, A Cycle of Jail and Hospitals," *New York Times*, April 10, 2015, [http://www.nytimes.com/2015/04/12/nyregion/for-mentally-ill-inmates-at-rikers-a-cycle-of-jail-and-hospitals.html?\\_r=0](http://www.nytimes.com/2015/04/12/nyregion/for-mentally-ill-inmates-at-rikers-a-cycle-of-jail-and-hospitals.html?_r=0) (accessed April 22, 2015).

series of reforms under his leadership that will begin to stabilize the situation and unwind the decades of neglect that have led to unacceptable levels of violence on Rikers Island.”<sup>306</sup>

### *Orleans Parish Prison*

In 2012, prisoners at the Orleans Parish Prison (OPP), the city jail for New Orleans run by the New Orleans Sheriff’s department, filed a class action lawsuit alleging unconstitutional jail conditions, including staff violence against inmates, inmate-on-inmate violence, and terrible medical and mental health care.<sup>307</sup> The Department of Justice joined the lawsuit after its investigations revealed OPP to be a “violent and dangerous institution, with shockingly high rates of serious prisoner-on-prisoner violence and officer misconduct.... The violence, sexual assaults, and pervasive atmosphere of fear are the direct result of such failures in jail management as adequate staffing, poor staff training, failed systems of accountability.”<sup>308</sup> According to the Department of Justice, OPP also lacked appropriate mechanisms to identify prisoners with mental illness and too few treatment staff to address their urgent and chronic conditions.<sup>309</sup>

The complaint provided examples of detainees with mental disabilities alleged to have been physically abused by jail officers. For example, LaShawn Jones, one of the named plaintiffs, has been diagnosed with bipolar disorder and schizophrenia.<sup>310</sup> She was arrested and placed in OPP on March 21, 2012 after she refused to leave a mental health center (her family was informed later that the facility could not take care of her due to budget cuts). The complaint alleges that a deputy brought her to the psychiatric floor of one of the OPP facilities and said, “You wanna fucking fight me one on one? You want to

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<sup>306</sup> New York City Press Release, “De Blasio Administration Ends use of Punitive Segregation for Adolescent Inmates on Rikers Island,” December 17, 2014, <http://www1.nyc.gov/office-of-the-mayor/news/566-14/de-blasio-administration-ends-use-punitive-segregation-adolescent-inmates-rikers-island#/o> (accessed April 22, 2015).

<sup>307</sup> *Jones v. Gusman*, United States District Court for the Eastern District of Louisiana, case no. 2:12-cv-00859, Complaint, filed April 2, 2012.

<sup>308</sup> Civil Rights Division, U.S. Department of Justice, “Update to Letter of Findings, United States’ Civil Rights Investigation of the Orleans Parish Prison System,” April 23, 2012, [http://www.justice.gov/crt/about/spl/documents/parish\\_update\\_4-23-12.pdf](http://www.justice.gov/crt/about/spl/documents/parish_update_4-23-12.pdf) (accessed April 29, 2015), p. 2. It also concluded that the Orleans Parish Prison (OPP) had done little to prevent or correct the “pattern or practice of unnecessary and inappropriate uses of force by OPP correctional officers” that the DOJ had identified in Civil Rights Division, U.S. Department of Justice, “Orleans Parish Prison System, New Orleans, Louisiana,” September 11, 2009, [http://www.justice.gov/crt/about/spl/documents/parish\\_findlet.pdf](http://www.justice.gov/crt/about/spl/documents/parish_findlet.pdf) (accessed February 17, 2015).

<sup>309</sup> Civil Rights Division, U.S. Department of Justice, “Update to Letter of Findings, United States’ Civil Rights Investigation of the Orleans Parish Prison System,” April 23, 2012, [http://www.justice.gov/crt/about/spl/documents/parish\\_update\\_4-23-12.pdf](http://www.justice.gov/crt/about/spl/documents/parish_update_4-23-12.pdf) (accessed February 17, 2015), p. 3.

<sup>310</sup> *Jones v. Gusman*, United States District Court for the Eastern District of Louisiana, case no. 2:12-cv-00859, Complaint, filed April 2, 2012, p. 18.

fucking play with me?” The deputy then allegedly beat Jones, leaving her with lacerations, bruises, and a blackened and bloody eye. Defendants denied the allegation.<sup>311</sup>

Mark Walker, another named plaintiff in the lawsuit, has been diagnosed with bipolar disorder and is legally blind. He has allegedly been attacked multiple times by inmates and beaten by staff. According to the complaint:

One night, Mark was packing up his items to move to another facility. When he grabbed his mat, the deputy said that Mark had hit him with it. The deputy took Mark, to the back of [the facility] and beat him, while he was handcuffed. A female deputy witnessed this incident and initially laughed while Mark endured the beating, but eventually, after the deputy continued to beat Mark for an extended period of time, she told him to stop.<sup>312</sup>

Defendants also denied this allegation.<sup>313</sup>

The parties entered into settlement negotiations. Before approving their proposed settlement and certifying the proposed class, the court reviewed the evidence in the record. It concluded the record showed brutal beatings of inmates by inmates and staff, stark and shocking deficiencies in mental health and medical care, and deplorable living conditions.<sup>314</sup> The court also said the evidence showed OPP had “deeply ingrained problems with respect to staff members’ uncontrolled use of force on inmates.”<sup>315</sup> Existing use of force policy was routinely ignored. Staff members were not familiar with it, supervisors did not hold them accountable for failing to comply with it, and the jail lacked a system to track uses of force or staff misconduct.<sup>316</sup>

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<sup>311</sup> *Jones v. Gusman*, United States District Court for the Eastern District of Louisiana, case no. 2:12-cv-00859, Answer and Defenses, filed May 17, 2012.

<sup>312</sup> *Jones v. Gusman*, United States District Court for the Eastern District of Louisiana, case no. 2:12-cv-00859, Complaint, filed April 2, 2012, p. 31.

<sup>313</sup> *Jones v. Gusman*, United States District Court for the Eastern District of Louisiana, case no. 2:12-cv-00859, Answer and Defenses, filed May 17, 2012.

<sup>314</sup> *Jones v. Gusman*, United States District Court for the Eastern District of Louisiana, case no. 2:12-cv-00859, Order Approving Consent Judgment and Certifying Settlement Class, filed June 6, 2013 (noting that the facilities are in a “state of disrepair, many toilets, sinks and showers are not functional, sewage seeps into cells.... Mental health units smell strongly of feces, urine, and rotting organic matter. Several inmates had floors and walls smeared with feces”).

<sup>315</sup> *Jones v. Gusman*, United States District Court for the Eastern District of Louisiana, case no. 2:12-cv-00859, Order Approving Consent Judgment and Certifying Settlement Class, filed June 6, 2013, p. 38.

<sup>316</sup> *Ibid.*

The detailed June 2013 consent decree, “seeks to overhaul decades of unsafe conditions, lack of basic medical and mental health care for inmates, underfunding, insufficient staffing, and the absence of a professional corrections experience.”<sup>317</sup> Progress at fulfilling the requirements of consent decree has been slow. Budget and political disputes between the city and the sheriff’s office, disagreements among the parties, a lack of experience in professional jail management in New Orleans, and poor coordination of compliance have hampered efforts to remedy the unconstitutional conditions.

Compliance with the consent decree is monitored by a court appointed monitor. The most recent report by the monitor, issued in August 2014, found that inmates and staff “continue to face grave harm.”<sup>318</sup> The jail remains “dangerous, there is an overreliance on use force (sic) to control inmate behavior,” and it is unclear if the full extent of incidents is reported. The monitor also found, “There have not been a sufficient number of corrections deputies hired, trained, and/or deployed to allow for sufficient staffing to properly supervise inmates. [N]o policies on use of force that comply with the language of the Consent Judgment have been completed and implemented, nor staff trained.”<sup>319</sup> The monitor further concluded that use of force reports were not timely reviewed in many cases and the reports that supervisors signed off on “were often inadequate and/or incomplete, and contained boilerplate and conclusory language that does not allow the reader to make an evaluation of the level of resistance, the level of force used, and/or the appropriateness of the force.” The use of force reports do not detail “what type of behavior prompted the use of force, de-escalation efforts, and the type of force used”<sup>320</sup> The monitor also found that inmates with mental health problems are still held “in deplorable conditions” and that “[m]ental health care is virtually non-existent.”<sup>321</sup>

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<sup>317</sup> *Jones v. Gusman*, United States District Court for the Eastern District of Louisiana, case no. 2:12-cv-00859, Monitors’ report No.2, filed August 26, 2014, p. 1.

<sup>318</sup> *Ibid.*

<sup>319</sup> *Ibid.*, p. 29. According to Katie M. Schwartzmann, lead counsel for plaintiffs in the lawsuit and co-director of the MacArthur Justice Center’s office in New Orleans, “The lack of progress outlined in the monitor’s second report to the court reflects the grave and deadly continuing crisis facing the men, women and youth in Orleans Parish Prison. Medical care, mental health care and violence have continued to worsen, jeopardizing the lives of everyone who is held at the jail, as well as the staff.” MacArthur Justice Center, “Orleans Parish Prison Lawsuit: Lack of Progress in Improving Conditions at Orleans Parish Prison ‘Inexcusable,’” August 27, 2014, <http://neworleans.macarthurjusticecenter.org/Projects/Motion-Granted-to-Enroll-MacArthur-Justice-Center-in-Orleans-Parish-Prison-Lawsuit.html> (accessed March 17, 2015).

<sup>320</sup> *Ibid.*, p. 36.

<sup>321</sup> *Ibid.*, p. 6.

The monitor’s report ends with the recognition that “years of neglect, lack of leadership, and inadequate funding” can only be remedied in the long term, but that, meanwhile, “the health and safety of more than 2,000 inmates are in peril today.” Recognizing the need for leadership to solve the problems, the report calls on the sheriff and the city to “never lose track during debates and arguments about funding (or whatever issues arise) that there are Parish citizens incarcerated who require basic care and protection.”<sup>322</sup>

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<sup>322</sup> *Ibid.*, p. 128.

## VI. Applicable Constitutional and International Human Rights Law

Prisoners retain the essence of human dignity inherent in all persons.

—*Brown v. Plata*<sup>323</sup>

All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

—International Covenant on Civil and Political Rights, Article 10(1)<sup>324</sup>

All prisoners have the right, under the US Constitution as well as international human rights law, to be treated with respect for their humanity. Unnecessary, gratuitous, or punitive force violates that right. It can constitute cruel and unusual punishment prohibited by the Eighth Amendment to the US Constitution, and “torture or other cruel, inhuman or degrading treatment or punishment” prohibited by international human rights treaties.

### The Eighth Amendment

The Eighth Amendment of the US Constitution prohibits “cruel or unusual punishments,” a prohibition the courts interpret to reflect evolving standards of decency.<sup>325</sup> In cases centered on allegations that officers used prohibited force against specific individuals, courts consider whether the use of force was undertaken “maliciously and sadistically for the very purpose of causing harm,” rather than “in a good faith effort to maintain or restore discipline.”<sup>326</sup> The key inquiry for a court is whether officers’ actions are “objectively reasonable” from the perspective of a reasonable officer on the scene in uncertain, rapidly

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<sup>323</sup> *Brown v. Plata*, 131 S. Ct. 1910, 1928 (2011).

<sup>324</sup> International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, ratified by the United States on June 8, 1992, art. 10(1).

<sup>325</sup> U.S. Const., 8th Amendment. The Fourteenth Amendment’s substantive due process protections have been similarly interpreted to protect pre-trial detainees, affording them somewhat greater protections because legally they are merely being held, not punished. *Bell v. Wolfish*, 441 U.S. 520, 545, n.16 (1979) (“Due process requires that a pretrial detainee not be punished. A sentenced inmate, on the other hand, may be punished, although that punishment may not be ‘cruel and unusual’ under the Eighth Amendment.”); see also *Whitley v. Albers*, 475 U.S. 312, 327 (1986) (indicating that Fourteenth Amendment standards for use of force are at least as stringent as Eighth Amendment standards, and may not require intentional conduct like the Eighth Amendment does).

<sup>326</sup> *Whitley v. Albers*, 475 U.S. 312, 320-21 (1986) (quoting *Johnson v. Glick*, 481 F.2d 1028, 1033 (2d. Cir. 1973)); see also *Hudson v. McMillian*, 503 U.S. 1, 7 (1992).



evolving circumstances. Factors the courts consider include the need for the application of force, the extent of the injury suffered by the inmate, and the relationship between that need and the amount of force used.<sup>327</sup> Officers may not use gratuitous force against a prisoner who is already subdued or restrained, and the court must decide whether any force was necessary and, if some force was justified, whether the amount of force used was reasonable.

The courts recognize that officers must make difficult judgments and therefore the “infliction of pain in the course of a prison security measure ... does not amount to cruel and unusual punishment simply because it may appear in retrospect that the degree of force authorized or applied for security purposes was unreasonable, and hence unnecessary in the strict sense.”<sup>328</sup>

When courts confront claims that use of force policies and practices create unconstitutional conditions of confinement, they consider whether officials have engaged in the “unnecessary and wanton infliction of pain” and whether they have been “deliberately indifferent” to the unnecessary suffering they cause.<sup>329</sup>

The mental health status of the prisoners is taken into account in determining whether use of force policies and practices are constitutional. In a significant and recent case, *Coleman v. Brown*, a federal district court confronted allegations that pepper spray was used unnecessarily and excessively against prisoners who because of their mental illness either could not understand the orders being given them or could not comply. The court noted that a violation of the Eighth Amendment with respect to use of force “arises from policies and practices that permit use of force against seriously mentally ill prisoners without regard to (1) whether their behavior was caused by mental illness and (2) the substantial and known psychiatric harm and risks thereof caused by such application of force.”<sup>330</sup> The

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<sup>327</sup> *Hudson v. McMillan*, 403 U.S. 1, 7 (1992); *Johnson v. Glick*, 481 F.2d 1028, 1033 (2d Cir. 1973).

<sup>328</sup> *Whitley v. Albers*, 475 U.S. 312, 319 (1986).

<sup>329</sup> E.g., *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. civ. S-90-520, Order, April 10, 2014. The two different approaches are often blended or muddled in practice. Human Rights Watch telephone interview with Fred Cohen, Tucson, Arizona, January 28, 2015.

<sup>330</sup> *Coleman v. Brown*, United States District Court for the Eastern District of California, case no. S-90-520, Order, April 10, 2014. Precedent firmly established that the use of pepper spray was subject to restrictions under the Eighth Amendment. In *Williams v. Benjamin*, 77 F. 3d 756, 763 (4th Cir 1996), cited by the *Coleman* court, the court ruled “it is a violation of the Eighth Amendment for prison officials to use mace, tear gas or other chemical agents in quantities greater than necessary...” because of their inherently dangerous characteristics.

court concluded that for pepper spray to be used consistent with the Eighth Amendment, prison policies must establish “clear and adequate constraints on the amount, if any, of pepper spray that may be used on mentally ill inmates generally and more particularly when such inmates are confined in a space such as a cell or a hold cage.” In addition, policy must establish “significant constraints, if not a total ban, on the use of pepper spray on mentally ill inmates who because of their mental illness are unable to comply with official directives.”<sup>331</sup>

## Human Rights Law

The touchstone of human rights is the dignity of all persons. Human rights treaties to which the United States is a party, including the International Covenant on Civil and Political Rights (ICCPR) and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture) codify some of the rights that derive from this dignity and which must be respected and protected by public officials.<sup>332</sup> Because people involuntarily confined are particularly vulnerable to violations of their rights, both the ICCPR and the Convention against Torture give special attention to their treatment.<sup>333</sup> Corrections officials must treat all prisoners with humanity and respect for their inherent dignity.<sup>334</sup> In addition, the treaties expressly forbid subjecting a prisoner to torture or to cruel, inhuman or degrading treatment or punishment.<sup>335</sup>

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<sup>331</sup> *Coleman v. Brown*, p. 14.

<sup>332</sup> ICCPR, adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, ratified by the United States on June 8, 1992; Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture), adopted December 10, 1984, G.A. res. 39/46, annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984), entered into force June 26, 1987, ratified by the United States on October 21, 1994. See generally, Jamie Fellner, “Correctional Psychiatry and Human Rights: An Unfulfilled Vision,” in Robert Trestman, Kenneth Appelbaum, and Jeffrey Metzner, eds., *The Oxford Textbook of Correctional Psychiatry* (Oxford: Oxford University Press, March 2015).

<sup>333</sup> See generally, Jamie Fellner, “Correctional Psychiatry and Human Rights: An Unfulfilled Vision,” in Robert Trestman, Kenneth Appelbaum, and Jeffrey Metzner, eds., *The Oxford Textbook of Correctional Psychiatry* (Oxford: Oxford University Press, forthcoming 2015).

<sup>334</sup> International Covenant on Civil and Political Rights (ICCPR) Article 10 (states that “[a]ll persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.” Paragraph 3 of article 10 continues, “[t]he penitentiary system shall comprise treatment of prisoners the essential aim of which shall be their reformation and social rehabilitation.” Ibid. The obligation to respect the dignity of prisoners is also contained in UN documents developed to provide more detailed guidance to officials on how to apply treaty provisions with regard to prisoners and other persons subject to the authority of law enforcement officials. See, e.g., Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, G.A. res. 43/173, annex, 43 U.N. GAOR Supp. (no. 49) at 298, U.N. Doc. A/43/49 (1988), prin. 1 (“All persons under any form of detention or imprisonment shall be treated in a humane manner and with respect for the inherent dignity of the human person”); Basic Principles for the Treatment of Prisoners, adopted December 14, 1990, G.A. Res. 45/111, annex, 45 U.N. GAOR Supp. (No. 49A) at 200, U.N. Doc. A/45/49 (1990), prin. 1 (“All prisoners shall be treated with the respect due to their inherent dignity and value as human beings”); and Code of Conduct for Law Enforcement Officials, G.A. res. 34/169, annex, 34 U.N. GAOR Supp. (No. 46) at 186, U.N. Doc.

Torture and other prohibited cruel, inhuman, or degrading treatment are not subject to precise delineation but exist on a continuum of acts by public officials (or others acting at their direction or instigation) that inflict pain or suffering, be it physical or mental.<sup>336</sup> The prohibition against ill-treatment should be interpreted to provide the widest possible protection against physical or mental abuse.<sup>337</sup> Practices by prison staff that cause acute physical or mental suffering beyond that inherent in incarceration may be impermissible regardless of their ostensible justification.<sup>338</sup>

This does not mean that prison officials are prohibited from ever using force that may be painful.<sup>339</sup> But to be consistent with human rights, the use of force must be subject to basic principles of necessity, proportionality and non-punitiveness.<sup>340</sup>

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A/34/46 (1979) (Code of Conduct for Law Enforcement Officials), art. 2 (“[i]n the performance of their duty, law enforcement officials shall respect and protect human dignity and maintain and uphold the human rights of all persons”).

<sup>335</sup> ICCPR, art. 7, states “[n]o one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.” The Convention against Torture, in Article 2, prohibits torture, and requires parties to take effective measures to prevent it in any territory under their jurisdiction. This prohibition is absolute and non-derogable. Article 16 of the Convention against Torture requires parties to prevent “other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture.” Because it is often difficult to distinguish between cruel, inhuman, or degrading treatment or punishment and torture, the Committee against Torture, the body of human rights experts that monitors implementation of the Convention against Torture by State parties considers Article 16’s prohibition to be as absolute and non-derogable as the prohibition in Article 2. See UN Committee against Torture, General Comment No. 2. Implementation of article 2 by States Parties, U.N. Doc. CAT/C/GC/2/CRP. 1/Rev.4 (2007), para. 3.

<sup>336</sup> For a thorough analysis of current international law on what constitutes torture and other ill-treatment, see Nigel Rodley and Matt Pollard, *The Treatment of Prisoners under International Law* (3<sup>rd</sup> ed.), (Oxford: Oxford University Press, 2009), chapter 3.

<sup>337</sup> To qualify as torture, severe suffering must be intentionally inflicted for a specific purpose such as punishment. Treatment can constitute prohibited “cruel, inhuman, or degrading treatment,” however, without such a specific purpose and without the same degree of pain.

<sup>338</sup> Insufficient, inappropriate, or untimely mental health treatment can also constitute cruel, inhuman, or degrading treatment. Such treatment can be deliberate or the result of negligence, oversight, or ignorance. As the European Committee for the Prevention of Torture has noted, inadequate health care can “lead rapidly to situations falling within the scope of the term ‘inhuman and degrading treatment,’” Council of Europe, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, “CPT Standards,” CPT/Inf/E (2002) 1 - Rev. 2011, March 8, 2011, p. 100. The touchstone is the suffering endured by the prisoner and whether staff conduct caused or aggravated that suffering. For example, if prisoners’ mental health deteriorates and they endure serious suffering due to insufficient clinical staff to treat them, their right to be free of cruel or inhuman treatment may have been violated, regardless of the reason for the staff shortage.

<sup>339</sup> The U.N. Open-ended Intergovernmental Expert Group on the Standard Minimum Rules for the Treatment of Prisoners. “Second Report of Essex Expert Group on the Review of the Standard Minimum Rules For The Treatment Of Prisoners,” U.N. Doc. CCPCJ/EG/6/2014/NGO.7 (Mar. 20, 2014), para. 42; observed that “international law recognizes certain legitimate reasons for using force or restraints such as to protect prisoners or staff, to prevent escape, to prevent harm and suicide and in self-defense.”

<sup>340</sup> Various documents developed within the United Nations provide authoritative guidance on how governments may use force without engaging in torture or other cruel, inhuman or degrading treatment or punishment. See, e.g.

United Nations Standard Minimum Rules for the Treatment of Prisoners (Standard Minimum Rules), adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolution 663 C (XXIV) of July 31, 1957, and 2076 (LXII) of May 13, 1977.; Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, adopted by the General Assembly in 1988; G.A. res. 43/173, annex, 43 U.N. GAOR Supp. (no. 49) at 298, U.N. Doc. A/43/49 (1988); Basic Principles for the Treatment of Prisoners, G.A. res. 45/111, annex, 45 U.N. GAOR Supp. (no. 49A) at 200, U.N. Doc. A/45/49 (1990). Additionally

*Necessity:* Force, including measures of control and restraint, should only be used when it is necessary and is the least intrusive or restrictive option available to ensure the safety of inmates, staff or visitors, or the security of the facility.<sup>341</sup> Implicit in the concept of necessity is that force is only permissible as a last resort.<sup>342</sup> Prison authorities must prioritize non-violent means of carrying out their duties, and can only use force if those non-violent means prove ineffective or have no possibility of success.<sup>343</sup>

*Proportionality:* In the narrow circumstances when force may be appropriate, the use of force must be kept to a minimum to achieve a legitimate objective.<sup>344</sup> Prison authorities may not use force greater than is necessary nor for longer than necessary.<sup>345</sup> Whenever the use

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there are documents directing the conduct of law enforcement officials (including prison officials) directly, such as the Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, Havana, 27 August to 7 September 1990, U.N. Doc. A/CONF.144/28/Rev.1 at 112 (1990) (Basic Principles on the Use of Force and Firearms by Law Enforcement), and the Code of Conduct for Law Enforcement Officials, G.A. res. 34/169, annex, 34 U.N. GAOR Supp. (No. 46) at 186, U.N. Doc. A/34/46 (1979).

<sup>341</sup> According to the U.N. Open-ended Intergovernmental Expert Group on the Standard Minimum Rules for the Treatment of Prisoners: “international law only permits the use of force and restraints in very narrow and exceptional circumstances, in line with the principles of legality, necessity and proportionality and when all other methods have been exhausted and no alternatives remain.” U.N. Open-ended Intergovernmental Expert Group on the Standard Minimum Rules for the Treatment of Prisoners. “Second Report of Essex Expert Group on the Review of the Standard Minimum Rules for The Treatment Of Prisoners,” March 20, 2014. These principles are also delineated by other international authorities and in authoritative documents: Principle XXIII, which states Inter-American Commission on Human Rights, “Principles and Best Practices on the Protection of Persons Deprived of their Liberty in the Americas,” approved by the Commission during its 131st regular period of sessions, March 3-14, 2008. (“[t]he personnel of places of deprivation of liberty shall not use force and other coercive means, save exceptionally and proportionally, in serious, urgent and necessary cases as a last resort after having previously exhausted all other options, and for the time and to the extent strictly necessary in order to ensure security, internal order, the protection of the fundamental rights of persons deprived of liberty, the personnel, or the visitors.”); Code of Conduct for Law Enforcement Officials, art. 3, (“[l]aw enforcement officials may use force only when strictly necessary”); Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, para. 15 (“[l]aw enforcement officials, in their relations with persons in custody or detention, shall not use force, except when strictly necessary for the maintenance of security and order within the institution, or when personal safety is threatened). See also, Report of the U.N. Special Rapporteur Theo van Boven on torture and other cruel, inhuman or degrading treatment or punishment, “Civil and political rights, including the questions of torture and detention,” Commission on Human Rights, U.N. Doc. E/CN.4/2004/56 (Dec. 23, 2003). (“use of physical force which is not genuinely justified by the conduct of the detainee may amount to torture or another form of ill-treatment.”)

<sup>342</sup> “Workshop 2: Survey of United Nations and other best practices in the treatment of prisoners in the criminal justice system,” Twelfth United Nations Congress on Crime Prevention and Criminal Justice, Salvador, Brazil, April 12-19, 2010, U.N. Doc. A/CONF.213/13 (January 28, 2010), para. 46. (“The use of force must be the last resort in controlling detainees or prisoner if good order breaks down.”)

<sup>343</sup> Basic Principles on the Use of Force and Firearms by Law Enforcement, para. 4. states, “Law enforcement officials, in carrying out their duty, shall, as far as possible, apply non-violent means before resorting to the use of force and firearms. They may use force and firearms only if other means remain ineffective or without any promise of achieving the intended result.”

<sup>344</sup> Basic Principles on the Use of Force and Firearms by Law Enforcement, para. 5 states, “[w]hen the lawful use of force and firearms is unavoidable, law enforcement officials shall: (a) Exercise restraint in such use and act in proportion to the seriousness of the offence and the legitimate objective to be achieved.”

<sup>345</sup> Standard Minimum Rules, Rule 54(1) states, “Officers who have recourse to force must use no more than is strictly necessary.” Code of Conduct for Law Enforcement Officials, art. 3 states, “Law enforcement officials may use force only when strictly necessary and to the extent required for the performance of their duty.” With regard to instruments of restraint, the

of force is unavoidable, officials shall “exercise restraint in such use and act in proportion to the seriousness of the offence and the legitimate objectives to be achieved.”<sup>346</sup> They must also “minimize damage and injury, and respect and preserve human life.”<sup>347</sup>

*Prohibition on force as punishment:* Prison officials may not use corporal punishment as punishment for rule breaking by prisoners.<sup>348</sup> To protect against the ill treatment of prisoners, even in the pursuit of legitimate goals of safety and security, prison officers should be trained in the techniques to restrain aggressive prisoners, without unnecessarily endangering either the life of the prisoner or the life of the officer.<sup>349</sup> Further, prison officials must be trained to recognize situations when these techniques are necessary. For example, non-lethal incapacitating weapons, such as pepper spray, should be deployed only after the officer carefully evaluates the risk of endangering uninvolved persons and should be carefully controlled.<sup>350</sup> In order to prevent abuses and ensure accountability, use of force incidents must be adequately recorded. Immediately after a use of force incident, the officer must report the incident to the director of the institution.<sup>351</sup> When an injury or death has been caused by the use of force, an independent authority such as a prosecutor must conduct an investigation.<sup>352</sup>

While standards regarding the use of force for reasons of safety and security are more likely to apply to the actions of custodial staff, mental health staff have responsibilities to

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Standard Minimum Rules, Rule 34 states, “Such instruments must not be applied for any longer time than is strictly necessary.” U.N. Open-ended Intergovernmental Expert Group on the Standard Minimum Rules for the Treatment of Prisoners. “Second Report of Essex Expert Group on the Review of the Standard Minimum Rules for the Treatment of Prisoners,” March 20, 2014.

<sup>346</sup> Basic Principles on the Use of Force and Firearms, 5(a).

<sup>347</sup> Basic Principles on the Use of Force and Firearms, 5(b).

<sup>348</sup> Standard Minimum Rules, Rule 31. (“Corporal punishment, punishment by placing in a dark cell, and all cruel, inhuman or degrading punishments shall be completely prohibited as punishments for disciplinary offences.”) Corporal punishment may constitute cruel, inhuman and degrading punishment. Nigel Rodley and Matt Pollard, *The Treatment of Prisoners under International Law* (3<sup>rd</sup> ed.), (Oxford: Oxford University Press, 2009), p.436. See chapter 10 in Rodley and Pollard’s book for an extensive discussion of international jurisprudence on corporal punishment.

<sup>349</sup> Standard Minimum Rules, Rule 54(2). The European Prison Rules provide that “staff who deal directly with prisoners shall be trained in techniques that enable the minimal use of force in the restraint of prisoners who are aggressive. “Council of Europe: Committee of Ministers, Recommendation Rec(2006)2 of the Committee of Ministers to Member States on the European Prison Rules, January 11, 2006, Rule 66. (European Prison Rules). They also provide that staff who work with specific groups of prisoners, such as mentally ill prisoners, shall be given specific training for their specialized work. *Ibid.*, Rule 81.3.

<sup>350</sup> Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, Principle 3,

<sup>351</sup> Standard Minimum Rules, Rule 54.

<sup>352</sup> Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, Principles 6, 22.

safeguard their patients from use of force practices that constitute ill-treatment. According to the Standard Minimum Rules for the Protection of Prisoners, which are not legally binding but provide authoritative and internationally accepted guidance on good principle and practice in the treatment of prisoners and management of penal institutions, a facility's medical director shall report to the head of the facility "whenever he considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment."<sup>353</sup> The head of the facility is required either to act on the medical officer's concerns or to send his own report and the medical officer's to a higher authority.<sup>354</sup>

### *Rights of Persons with Mental Disabilities*

The Convention on the Rights of Persons with Disabilities (CRPD), which the United States has signed, seeks to "promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities."<sup>355</sup> Announcing the decision to sign the convention, President Obama stated, "Disability rights aren't just civil rights to be enforced here at home; they're universal rights to be recognized and promoted around the world."<sup>356</sup> To promote equality and eliminate discrimination on the

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<sup>353</sup> Standard Minimum Rules, 25(2). See also the European Prison Rules, 43.3; "The medical practitioner shall report to the director whenever it is considered that a prisoner's physical or mental health is being put seriously at risk by continued imprisonment or by any condition of imprisonment, including conditions of solitary confinement."

<sup>354</sup> Standard Minimum Rules, Rule 26(2). The director is required to "take into consideration the reports and advice that the medical officer submits according to rules 25(2) and 26 and, in case he concurs with the recommendations made, shall take immediate steps to give effect to those recommendations; if they are not within his competence or if he does not concur with them, he shall immediately submit his own report and the advice of the medical officer to higher authority."

<sup>355</sup> United Nations General Assembly, Convention on the Rights of Persons with Disabilities (CRPD), adopted January 24, 2007, A/RES/61/106, entered into force May 3, 2008, signed by the United States on July 30, 2009, <http://www.unhcr.org/refworld/docid/45f973632.html> (accessed September 17, 2009). The United States has not yet ratified the constitution, but as a signatory, may not take actions inconsistent with it. According to the convention, "persons with disabilities include those who have long-term physical, mental intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others." The principles reflected in and measures required under the convention are similar to those contained in domestic legislation protecting persons with disabilities from discrimination. *Ibid.*, art. 1, the goals and requirements of the convention are similar to those established under section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794(a), and by Title II of the Americans with Disabilities Act, (ADA) 42 U.S.C. § 12131.

<sup>356</sup> "Remarks by the President on the Signing of the Convention on the Rights of Persons with Disabilities Proclamation," White House Press Release, July 24, 2009, <https://www.whitehouse.gov/the-press-office/remarks-president-rights-persons-with-disabilities-proclamation-signing> (accessed April 29, 2015).

<sup>356</sup> *Ibid.*

basis of disability, public officials must ensure reasonable accommodation for persons with disabilities.<sup>357</sup>

The UN Special Rapporteur on Torture has pointed out that persons with disabilities are often segregated from society in prisons as well as in other institutions. Inside these institutions, persons with disabilities “are frequently subjected to unspeakable indignities, neglect, severe forms of restraint and seclusion, as well as physical, mental and sexual violence.”<sup>358</sup> Under the CRPD, states have the obligation to ensure that persons deprived of their liberty are entitled to provision of reasonable accommodation.<sup>359</sup> “This implies an obligation to make appropriate modifications in the procedures and physical facilities of detention centres ... to ensure that persons with disabilities enjoy the same rights and fundamental freedoms as others, when such adjustments do not impose a disproportionate or undue burden. The denial or lack of reasonable accommodations for persons with disabilities may create detention and living conditions that amount to ill-treatment and torture.”<sup>360</sup>

In a September 2014 statement, the CRPD Committee, which monitors implementation of the treaty, explained: “The committee is of the view that persons with disabilities who are sentenced to imprisonment for committing a crime should be entitled to reasonable accommodation in order not to aggravate incarceration conditions based on disability.”<sup>361</sup> As elaborated by the UN Special Rapporteur on Torture, the CRPD affirms the right of persons with disabilities not to be subjected to torture or other cruel, inhuman or

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<sup>357</sup> “In order to promote equality and eliminate discrimination, States parties shall take all appropriate steps to ensure that reasonable accommodation is provided.” CRPD, art. 5(3).

<sup>358</sup> United Nations General Assembly, “Torture and other cruel, inhuman or degrading treatment or punishment, Note by the Secretary-General,” A/63/175, July 28, 2008, available at <http://www.refworld.org/docid/48db99e82.html> (accessed February 17, 2015).

<sup>359</sup> CRPD, art. 14(2): “States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation.”

<sup>360</sup> United Nations General Assembly, “Torture and other cruel, inhuman or degrading treatment or punishment, Note by the Secretary-General,” A/63/175, July 28, 2008, <http://www.refworld.org/docid/48db99e82.html> (accessed February 17, 2015), p.12.

<sup>361</sup> Committee on the Rights of the Persons with Disabilities, “Statement on article 14 of the Convention on the Rights of Persons with Disabilities,” September 2014, <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=15183&LangID=E#sthash.LaofXcOB.dpuf> (accessed April 23, 2015).

degrading treatment by corrections agencies.<sup>362</sup> If pain is inflicted unnecessarily or punitively on prisoners for conduct that reflects mental disability or, even more egregiously, in situations in which the prisoner cannot understand or comply with staff orders because of mental disability, it could constitute a violation of the CRPD as well as a violation on the universal prohibitions on ill treatment contained in the ICCPR, discussed above.

Prison officials are not required to tolerate uncontrolled misconduct by prisoners with mental disabilities. But they are required to take steps to ensure persons with mental disabilities are not discriminated against with regard to the use of force. If US jails and prisons offered prisoners with mental disabilities adequate mental health treatment, less stressful and difficult conditions of confinement and access to productive and rehabilitative programs, and services, the putative need for force would undoubtedly be significantly reduced. Similarly, ensuring custody staff engage in de-escalation techniques and seek the intervention of mental health staff to help defuse volatile situations before resorting to force can also be considered reasonable accommodation to prevent the discriminatory use of unnecessary or punitive force against persons with mental illness.

It is important to note that conduct justified for “the good of” the inmate or for another benign or beneficial purpose, such as protecting facility safety and security, may still amount to cruel, inhuman, or degrading treatment or even torture: Officials also have a different albeit interrelated obligation to prevent discriminatory mistreatment of persons with mental disabilities whether inflicted deliberately or negligently and regardless of an ostensible good purpose.<sup>363</sup>

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<sup>362</sup> Persons with disabilities are entitled to freedom from torture or cruel, inhuman, or degrading treatment or punishment. Officials must take effective measures to “prevent persons with disabilities, on an equal basis with others” from being subjected to such treatment or punishment. CRPD, art. 15(2).

<sup>363</sup> The Special Rapporteur on torture has noted that that prohibited torture or other ill-treatment of persons with mental disabilities can occur even in health care settings. Authorities have sought to defend certain cruel practices in health care facilities on the grounds of efficiency, behavior modification, or medical necessity, but such good intentions may not be sufficient. Indeed, in some cases of impermissible abuse “the explicit or implicit aim of inflicting punishment, or the objective of intimidation, often exist alongside ostensibly therapeutic ones.” United Nations General Assembly, “Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Mendez,” A/HRC/22/53, February 1, 2013, [http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53\\_English.pdf](http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf) (accessed March 17, 2015), p. 6.



## Non-Lethal Weapons and Restraints

Human rights treaty bodies and experts have noted the special potential for prohibited ill-treatment to arise from the use of chemical sprays, electronic stun devices, and restraints. For example, the UN Special Rapporteur on torture has observed the possibility that misuse of restraints, chemical sprays, and electronic shock devices, particularly applied in a “degrading or painful manner,” may amount to torture.<sup>364</sup> The UN Special Rapporteur on torture has also noted that these types of force can be misused—sometimes due to a lack of proper training—or intentionally used to inflict torture and other forms of ill treatment.<sup>365</sup> The Committee against Torture has expressed concern about allegations of ill-treatment of vulnerable groups by US law enforcement officers.<sup>366</sup>

### *Electronic Stun Devices*

Numerous human rights bodies have criticized the use of electronic stun devices in light of international standards on use of force. The Committee against Torture has expressed concerns that electrical discharge weapons can cause “severe pain constituting a form of torture,” and has recommended that at least one state party relinquish their use because the impact on the prisoners’ mental and physical state appears to violate international law.<sup>367</sup> Confirming that the use of these weapons “should be subject to principles of necessity and proportionality,” the Committee has stated that extensive use of them by law-enforcement personnel raises “serious issues of compatibility” with the Convention against Torture.<sup>368</sup> The Human Rights Committee has expressed concern that electronic stun devices are being used against vulnerable people, including persons with mental disabilities.<sup>369</sup>

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<sup>364</sup> Report of the Special Rapporteur Theo van Boven on torture and other cruel, inhuman or degrading treatment or punishment, civil and political rights, including the question of torture and detention, “Study on the situation of trade in and production of equipment which is specifically designed to inflict torture or other cruel, inhuman or degrading treatment, its origin, destination and forms,” Commission on Human Rights, U.N. Doc. E/CN.4/2003/69 (January 13, 2003).

<sup>365</sup> *Ibid.*

<sup>366</sup> “The Committee is concerned about reports of brutality and use of excessive force by the State party’s law-enforcement personnel, and the numerous allegations of their ill-treatment of vulnerable groups...which have not been adequately investigated.” U.N. Committee Against Torture, “Consideration of Reports Submitted By States Parties Under Article 19 of the Convention, Conclusions and Recommendations of the Committee Against Torture,” U.N. Doc. CAT/C/USA/CO/2 (2006), para. 27.

<sup>367</sup> “The State party should consider relinquishing the use of electric ‘TaserX26’ weapons, the impact of which on the physical and mental state of targeted persons would appear to violate articles 1 and 16 of the Convention,” United Nations Committee against Torture, “Consideration of Reports Submitted By States Parties Under Article 19 of the Convention, Conclusions and recommendations of the Committee against Torture, Portugal,” CAT/C/PRT/CO/4, February 19, 2008, [http://www1.umn.edu/humanrts/cat/general\\_comments/portugal2008.html](http://www1.umn.edu/humanrts/cat/general_comments/portugal2008.html) (accessed March 17, 2015), para. 14.

<sup>368</sup> “The Committee is of the view that the use of electrical discharge weapons should be subject to the principles of necessity and proportionality...” United Nations Committee against Torture, “Concluding observations on the fifth periodic report of the United Kingdom, adopted by the Committee at its fiftieth session,” CAT/C/GBR/CO/R/5, May 2013, para. 26;

In 2006, the Human Rights Committee spoke directly to the use of stun devices in the United States and registered concern that they were being used in situations where such force is not necessary.<sup>370</sup> The Committee suggested that US policies on the use of these weapons use do not comply with the UN Basic Principles on the Use of Firearms by Law Enforcement Officials.<sup>371</sup> In 2014, the Committee again raised concerns about “excessive use of force by certain law enforcement officers, including the deadly use of tasers” and suggested that the United States remained non-compliant with the Basic Principles.<sup>372</sup>

The European Committee for the Prevention of Torture (the CPT) has addressed the proper use of electronic stun devices (which it calls electronic discharge weapons) so as to avoid their use in ways that constitute torture or other prohibited ill-treatment.<sup>373</sup> In its view, any use of these devices:

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Discussing practices in U.S. prisons: “The Committee remains concerned about the extensive use by the State party’s law-enforcement personnel of electroshock devices, which have caused several deaths. The Committee is concerned that this practice raises serious issues of compatibility with article 16 of the Convention,” UN Committee against Torture, “Consideration of Reports Submitted By States Parties Under Article 19 of the Convention, Conclusions and Recommendations of the Committee Against Torture,” CAT/C/USA/CO/2, July 25, 2006, para. 35.

<sup>369</sup> “The Committee is concerned in particular by the use of so-called less lethal restraint devices, such as electro-muscular disruption devices (EMDs), in situations where lethal or other serious force would not otherwise have been used. It is concerned about information according to which police have used tasers against unruly schoolchildren; mentally disabled ...without in most cases the responsible officers being found to have violated their departments’ policies,” U.N. Human Rights Committee, “Committee observations of the Human Rights Committee: United States of America,” U.N. Doc. CCPR/C/USA/CO/3 (2006), para. 30. The recommendation continues: “The State party should ensure that EMDs and other restraint devices are only used in situations where greater or lethal force would otherwise have been justified, and in particular that they are never used against vulnerable persons.”

<sup>370</sup> “The Committee is concerned in particular by the use of so-called less lethal restraint devices, such as electro-muscular disruption devices (EMDs), in situations where lethal or other serious force would not otherwise have been used” and “[t]he State party should ensure that EMDs and other restraint devices are only used in situations where greater or lethal force would otherwise have been justified...” United Nations Human Rights Committee, “Consideration of Reports Submitted by States Parties under Article 40 of the Covenant, Concluding observations of the Human Rights Committee: United States of America,” CCPR/C/USA/CO/3, December 18, 2006.

<sup>371</sup> *Ibid.*, “The State party should bring its policies into line with the United Nations Basic Principles on the Use of Force and Firearms by Law Enforcement Officials.”

<sup>372</sup> “The Committee is concerned about ... reports of excessive use of force by certain law enforcement officers including the deadly use of tasers.... The State Party should (a) step up its efforts to prevent the excessive use of force by law enforcement officers by ensuring compliance with the 1990 UN Basic Principles on the Use of Force and Firearms by Law Enforcement Officers; ... and (c) improve reporting of excessive use of force violations and ensure that reported cases of excessive use of force are effectively investigated, alleged perpetrators are prosecuted and, if convicted, punished with appropriate sanctions, that investigations are re-opened when new evidence becomes available, and that victims or their families are provided with adequate compensation,” United Nations Human Rights Committee, “Concluding observations on the fourth report of the United States of America,” CCPR/C/USA/CO/4, April 23, 2014, para. 11.

<sup>373</sup> The CPT was set up under the 1987 Council of Europe Convention of the same name (hereinafter “the Convention”) with a mandate of examining the conditions under which persons are deprived of their liberty with a view to strengthening their protection from torture and from inhuman or degrading treatment or punishment. It is one of the most informed and authoritative analysts of conditions of confinement and their compliance with human rights standards.

[S]hould be subject to the principles of necessity, subsidiarity, proportionality, advance warning (where feasible) and precaution.... [Their use] should be limited to situations where there is a real and immediate threat to life or risk of serious injury. Recourse to such weapons for the sole purpose of securing compliance with an order is inadmissible. Furthermore, recourse to such weapons should only be authorised when other less coercive methods (negotiation and persuasion, manual control techniques, etc.) have failed or are impracticable and where it is the only possible alternative to the use of a method presenting a greater risk of injury or death.<sup>374</sup>

Applying these principles to the use of these weapons in prisons, the CPT has concluded that:

Only very exceptional circumstances (e.g. a hostage-taking situation) might justify the resort to [electrical discharge weapons] in such a secure setting, and this subject to the strict condition that the weapons concerned are used only by specially trained staff. There should be no question of any form of EDW being standard issue for staff working in direct contact with persons held in prisons or any other place of deprivation of liberty.<sup>375</sup>

### *Restraints*

Under the current Standard Minimum Rules for the Treatment of Prisoners, Rule 33, instruments of restraint, such as four-point restraints, may only be used “(a) as a precaution against escape during a transfer, (b) On medical grounds by direction of the medical officer; (c) by order of the director, if other methods of control fail, in order to prevent a prisoner from injuring himself or others or from damaging property; in such instances the director shall at once consult the medical officer and report to the higher administrative authority.”<sup>376</sup> Restraints should not be applied for longer than strictly necessary.<sup>377</sup> At a recent meeting of experts convened to consider changes to the Standard

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<sup>374</sup> European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), “CPT Standards,” CPT/Inf/E (2002) 1 - Rev. 2015, Strasbourg, January 2015, <http://www.cpt.coe.int/en/documents/eng-standards.pdf> (accessed March 17, 2015), paras. 69-70.

<sup>375</sup> *Ibid.*, para. 71.

<sup>376</sup> Standard Minimum Rules, Rule 33.

<sup>377</sup> Standard Minimum Rules, Rule 34.

Minimum Rules, consensus was reached that the provision permitting restraints on medical grounds by direction of the medical officer should be deleted.<sup>378</sup> The experts also agreed the following principles should apply when restraints are authorized:

- (a) Restraints are to be imposed only when no lesser form of control would be effective to address the risks posed by unrestricted movement;
- (b) The method of restraint shall be the least intrusive necessary that is reasonably available to control the prisoner's movement, based on the level and nature of the risks posed;
- (c) Restraints should only be imposed for the period required, and are to be removed as soon as possible once the risks posed by unrestricted movement are no longer present.

European human rights jurisprudence affirms that restraints may only be used to avoid self-harm or serious danger to others, may never be used for punishment, and that their use for periods of time beyond what is strictly necessary can constitute inhuman or degrading treatment or punishment.<sup>379</sup> For example, the European Human Rights Court found that placing an individual in a restraint bed constituted inhuman and degrading treatment when the prisoner was restrained because he had been banging on the door of a cell.<sup>380</sup>

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<sup>378</sup> Report of the open-ended intergovernmental Expert Group on the Standard Minimum Rules for the Treatment of Prisoners at its Fourth Meeting, United Nations Office of Drugs and Crime, <http://www.unodc.org/unodc/en/justice-and-prison-reform/expert-group-meetings-8.html> (accessed April 3, 2015). The recommended revisions will be considered at the 13th UN Congress on Crime Prevention and Criminal Justice (Doha, 12-19 April 2015) and may be adopted at the 24th session of the Commission on Crime Prevention and Criminal Justice (Vienna, 18-22 May 2015).

<sup>379</sup> European Court of Human Rights, *Tali v. Estonia*, Judgment of February 13, 2014, no. 66393/10, <http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-140785> (accessed April 2, 2015). Paragraphs 81-82 of the judgment read in relevant part as follows: "The Court reiterates, however, that means of restraint should never be used as a means of punishment, but rather in order to avoid self-harm or serious danger to other individuals or to prison.... In the present case, the Court considers that it has not been convincingly shown that after the end of the confrontation with the prison officers the applicant—who had been locked in a single-occupancy disciplinary cell—posed a threat to himself or others that would have justified applying such a measure. Furthermore, the period for which he was strapped to the restraint bed was by no means negligible and the applicant's prolonged immobilization must have caused him distress and physical discomfort. In view of the above and considering the cumulative effect of the measures used in respect of the applicant on 4 July 2009, the Court finds that the applicant was subjected to inhuman and degrading treatment in violation of Article 3 of the Convention."

<sup>380</sup> European Court of Human Rights, *Julin v. Estonia*, Judgment of May 29, 2012, nos. 16563/08, 40841/08, 8192/10 and 18656/10, <http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-110949> (accessed April 2, 2015). Paragraph 127 of the judgment reads in relevant part as follows: "Even assuming that his banging on the door of the cell had severely disturbed peace and order in the prison, the Court doubts that confinement in the restraint bed can have been the least intrusive measure available in this context. There is no indication that before the applicant's placement in the restraint bed, or in the course of the application of this measure, alternatives such as confinement to a high-security cell were considered."

According to the Committee for the Prevention of Torture, “In those rare cases when resort to instruments of physical restraint is required, the prisoner concerned should be kept under constant and adequate supervision. Further, instruments of restraint should be removed at the earliest possible opportunity; they should never be applied, or their application prolonged, as a punishment.”<sup>381</sup>

### *Chemical Spray*

The European Court of Human Rights has held that, in certain circumstances, the use of chemical spray on a prisoner can constitute inhuman and degrading treatment.<sup>382</sup> Stressing the dangers of chemical spray, the court has emphasized that it should be used only in exceptional circumstances and not in confined spaces. The court was unequivocal that chemical spray “should never be deployed against a prisoner who has been brought under control.”<sup>383</sup>

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<sup>381</sup> CPT Standards, para. 53.

<sup>382</sup> ECHR, *Tali v. Estonia*, para. 78 and 82. Paragraph 78 of the judgment emphasize that “pepper spray is a potentially dangerous substance and should not be used in confined spaces; even when used in open spaces, there should be clearly defined safeguards in place.... Having regard to these potentially serious effects of the use of pepper spray in a confined space on the one hand and the alternative equipment at the disposal of the prison guards, such as flak jackets, helmets and shields on the other, the Court finds that the circumstances did not justify the use of pepper spray.”

<sup>383</sup> *Ibid.*

## **Detailed Recommendations**

### **To Federal, State and Local Officials**

- Enact the Comprehensive Justice and Mental Health Act of 2015 in the U.S. Senate and House of Representatives (S. 993 in the Senate, HR 1854 in the House), and similar state and local legislation to increase collaboration among the criminal justice, juvenile justice, mental health treatment, and substance abuse systems. Such legislation should also support and authorize funding for programs and strategies to ensure appropriate interventions for persons with mental health problems at every stage of the criminal justice system, reduce their confinement in jails and prisons, and improve treatment and rehabilitation programs for the behind bars in and in the community.

### **To Federal, State, and Local Officials with Responsibilities over who is Jailed or Sent to Prison**

- Reduce the number of individuals with mental disabilities who have committed low-level non-violent offenses who are confined in jails or prisons, including by increasing access to criminal justice diversion programs, and by increasing the availability of low cost or free voluntary community-based mental health services. Reducing the number of individuals with mental health problems sent to jails and prison will diminish the number who are unnecessarily confined in environments that are not likely to respond appropriately to their mental health needs, and will free up correctional resources to ensure appropriate mental health treatment for those men and women who must be incarcerated for reasons of public safety, whether pre-trial or following a criminal conviction.

### **To Federal, State, and Local Public Officials with Responsibilities for the Allocation of Resources for Jails and Prisons**

- Ensure there are enough qualified mental health professionals and treatment resources in jails and prisons to provide appropriate mental health care to prisoners with mental disabilities. Mental health treatment can help individual prisoners and increases the likelihood they will be able to return successfully to their communities

following release. It can also improve facility safety and security by reducing disruptions and rule violations by such prisoners and reducing the number of instances in which use of force against prisoners with mental disabilities is deemed necessary.

### **To Federal, State, and Local Public Officials Who Determine or Administer Policies Governing Use of Solitary Confinement:**

- End the prolonged solitary confinement of any prisoner.
- End solitary confinement for prisoners with mental disabilities. When such prisoners must be segregated from the general population as a disciplinary sanction or to protect institutional safety and security, they should receive at least 20 hours a week of out-of-cell time for structured and unstructured activities, including mental health programs.

### **To Federal, State, and Local Public Officials Involved in Hiring Heads of Corrections Agencies**

- Select as heads of corrections agencies professionals who have the skills, experience, and determination to be effective leaders and who are committed to operating safe and secure facilities in which the wellbeing and dignity of all inmates are protected. Officials should also give correctional leaders the financial resources needed to pursue humane conditions of confinement, eliminate unnecessary or excessive use of force, and respond appropriately to the unique vulnerabilities and needs of prisoners with mental disabilities. Officials should pay close attention to prison and jail conditions through effective oversight mechanisms and hold accountable, including by removing them from their positions, those leaders who fail to protect the wellbeing and dignity of those held in their facilities.

### **To Federal, State, and Local Public Officials Who Determine, Administer or Oversee Use of Force Policies and Practices**

- Ensure that use of force policies include the following provisions:
  - A clear statement of the agency's commitment to minimize the use of force, to authorize force in non-emergency situations only when no reasonable alternative is possible or all less restrictive measures have been tried and

exhausted, and then to permit only the minimum force necessary to regain control of inmates or secure inmate compliance with an order.

- An unequivocal prohibition on the use of force as punishment or as retaliation, and on the continued use of force after a prisoner has ceased to offer resistance or is under control.
  - Except in emergencies when immediate action is required to prevent serious injury or escapes, a requirement that staff make every reasonable effort to avoid the use of force, including through the use of “cooling off” periods and verbal persuasion and negotiation strategies to defuse and de-escalate volatile situations. If an inmate is in his cell and there is no emergency, policy should also establish a presumption that force not be used unless all less restrictive measures have been tried and exhausted and securing compliance with the order is imperative for prison safety and security.
  - A prohibition on the use of chemical sprays, electronic stun devices, or forced cell extractions against inmates with mental disabilities unless: 1) there is an emergency (i.e. imminent threat of serious injury or death to a person, serious damage to property, or an escape) or 2) custody or mental health staff have taken the time needed to make a meaningful effort, using verbal persuasion and negotiation strategies and “cooling off” time, to try to talk the inmate into complying with orders; mental health staff have determined that the individual is not experiencing psychosis and is capable of understanding and conforming his behavior to the order; and custody and mental health staff have jointly decided that on balance the risks of physical or psychological harm to the inmate from the use of force are outweighed by the importance of ensuring compliance with an order or restoring control.
- Ensure enforcement of policies and careful review of use of force incidents:
    - Senior officials at corrections facilities should review every use of force incident, including video where available, to ascertain whether the use of force was appropriate, including whether the timing, reasons for, and nature of the force used were consistent with policy. The review should determine what precipitated the incident and consider whether there were reasonable steps staff could have taken to avoid the use of force and to provide reasonable accommodations for persons with mental disabilities. Any use of force that involved the use of chemical sprays or electronic stun devices or other



weaponry or caused more than minor injuries to the prisoner should be sent to headquarters for further review. The purpose of that review should include identifying cases that warrant further investigation by an entity outside the facility chain of command that reports directly to the head of the agency. Such cases should include, at a minimum, those which result in serious injury, involve blows to the head of the inmate or the use of electronic stun devices or impact weapons, and failures to promptly, fully, and truthfully report on the incidents.

- Officials at agency headquarters should randomly review individual use of force incidents to assess compliance with policies and to ensure the quality of investigations and reviews. Headquarters officials should undertake special in-depth analyses where the nature or prevalence of uses of force suggests the need for changed policies or practices, additional staff training, or changes in programming available to or conditions of confinement for inmates.
- Staff who do not comply with use of force policies should be subject to appropriate disciplinary sanctions up to and including dismissal and referral for criminal prosecution where appropriate.
- Staff should be required to fully and honestly answer questions concerning the use of force, the “code of silence” should not be tolerated, and staff who fail to forthrightly answer questions regarding use of force should be sanctioned.
- Headquarters officials should ensure the creation of and regularly review comprehensive data on the use of force in their facilities. The data should include identification of the specific reasons for the use of force, what alternatives to use of force were tried or considered, what type of force was used, whether the force was used against a person on the mental health caseload, the names of staff and inmates involved in the incident, and the nature of any injuries sustained by inmates or staff. Based on the data and trends, officials should look more closely at use of force practices in individual facilities, look more closely at individual staff or inmate records, and take appropriate action, including disciplinary action against individuals and revision of applicable policies or practices.
- Senior mental health staff at each facility should review each use of force against inmates on the mental health caseload to determine what precipitated the incident, whether mental health staff undertook efforts to prevent the use

of force, whether a proper determination was made that the prisoner was able to understand and comply with orders prior to the use of force, and to consider what mental health staff might have done differently to avoid the incident. The mental health review should be incorporated in the facility's use of force review and sent to agency headquarters. Senior mental health staff should also notify the senior officials at the facility and at agency headquarters if they believe either custody or mental health staff have violated agency use of force policies.

- Custody and mental health staff at both the facility level and at headquarters should periodically meet to review use of force incidents involving inmates on the mental health caseload, and to assess whether changes in policies or practices would better meet needs of patients and the safety and security of the facility.
- Ensure appropriate staff are hired, trained, and retained:
  - Correctional officers should be screened before hiring to make sure they have the character and personality to work in a professional and respectful manner with all inmates, including those who may be disruptive or difficult because of mental disabilities. Performance reviews should include consideration of whether staff interact with inmates in a respectful manner, comply with use of force policies, and provide truthful, complete responses during use of force reviews and investigations. Individuals who violate use of force policies should be held accountable through appropriate sanctions.
  - Custody staff should receive training in the academy and on an ongoing basis on the signs and symptoms of mental health conditions. Custody staff on units designated for or with high proportions of inmates with mental disabilities should receive additional mental health training.
  - Custody and mental health staff should be trained in the use of verbal negotiation and de-escalation techniques, in how to manage assaultive behavior, and in other means of responding to disruptive or assaultive inmates without recourse to use of force. Trainings should include role playing and scenario-based exercises. In-service training should ensure that staff remain familiar and comfortable with techniques to avoid use of force and have the opportunity to learn new ones.
  - Custody staff should be given positive incentives and rewards, including recognition and merit awards, for avoiding unnecessary or excessive force.

- Increase transparency and promote better understanding of use of force patterns, practices, and trends:
  - Conduct periodic audits of use of force practices with the results reported to senior facility and headquarters officials, to executive and legislative officials who oversee or have funding responsibility for prison or jail operations, and to the public. To ensure thorough and impartial review, the audits should be conducted by experienced professionals who are not employed by the correctional agency unless they are part of an inspector general's office.
  - Compile summary data on incidents involving the use of force (with names and identifying information deleted to protect privacy interests); such data should be periodically made available to the public for free and without special request, for example, by posting it on the agency website. The data should provide information on the most recently concluded period as well as trends over time.

## Acknowledgments

This report was researched and written by Jamie Fellner, senior advisor in the US Program of Human Rights Watch. Alison Parker, US Program co-director, Shantha Rau Barriga, Disability Rights Program director, and Joe Saunders, deputy program director, edited the report. Dinah PoKempner, Human Rights Watch general counsel, provided legal review. Samantha Reiser and W. Paul Smith, associates for the US Program, provided research and production assistance. Production was coordinated by Kathy Mills, publications specialist, and Fitzroy Hepkins, administrative manager.

Human Rights Watch would like to thank Rebecca Riddell and Cassandra Kildow, law students and Human Rights Watch interns, for their valuable research assistance. We are indebted to the many corrections and mental health professionals, lawyers, and academics who took time from their busy schedules to answer countless questions and provide expert insights and advice. We are grateful to the Washington State Department of Corrections and the Ada County Jail for letting us observe their operations and interview officials.

We would like to give special thanks to Jeffrey L. Metzner, Terry Kupers, Steve J. Martin, Eldon Vail, Jeffrey Schwartz, and Fred Cohen for their guidance and support as our research proceeded and for reviewing a draft of the report. Human Rights Watch is, of course, solely responsible for the conclusions we have drawn from our interviews and other research.

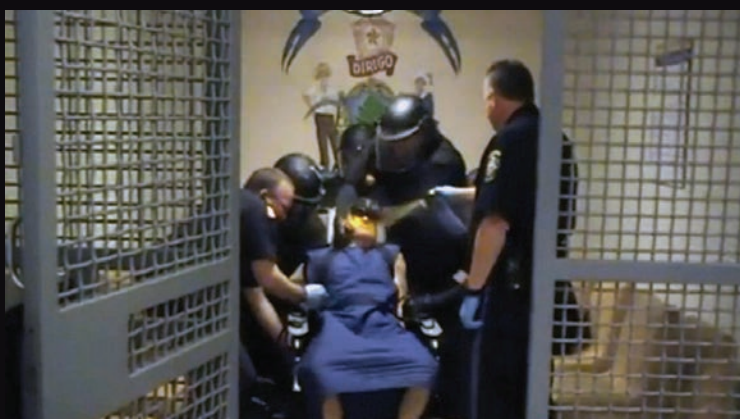
# CALLOUS AND CRUEL

## Use of Force against Inmates with Mental Disabilities in US Jails and Prisons

Staff in US correctional facilities are authorized to use force when necessary to control dangerous or highly disruptive prisoners. But officials have used violence needlessly against prisoners diagnosed with mental illness.

*Callous and Cruel*—based on Human Rights Watch’s review of several hundred individual and class action court cases and interviews with 125 current and former prison and jail officials, mental health professionals, lawyers, advocates and academics—documents a pattern of unnecessary, excessive, and even malicious force against such prisoners in US prisons and jails. It details incidents in which correctional staff have deluged prisoners with mental disabilities with painful chemical sprays, shocked them with powerful electric stun weapons, and strapped them for days in restraining chairs or beds. Such abuses have taken place in response to minor misconduct such as urinating on the floor, masturbating, complaining about not receiving a meal, refusing to come out of a cell, using profane language, or banging repeatedly on a door. Force is used against prisoners even when their misconduct is symptomatic of their mental health problems and even when those problems prevent them from being able to understand or comply with staff orders.

The report concludes with recommendations on ending the abuses, including through improved mental health services in prisons and jails and use of force policies that address the unique needs and vulnerabilities of prisoners with mental disabilities, enforced through proper training, supervision, and accountability mechanisms.



*Image of Paul Schlosser III, who is diagnosed with bipolar disorder and depression, being pepper sprayed on June 10, 2012 by a correctional officer at the Maine Correctional Center in Windham, Maine. The image is a screengrab of a video of the incident which was taken by officers at the prison, and which is posted on YouTube at <https://www.youtube.com/watch?v=oMN4ngibpHs>*