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Substance Abuse and Mental Health Issues:

This is Us

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Personal and Professional Perspectives
Edited by Karen K. Peters

RECOVERY IN PUBLIC
BREAKFAST OR A BULLET?
BENEATH THE ROBE, A STRUGGLE WITH ADDICTION
ADDICTION, RECOVERY, COMMUNITY

LAW PRACTICE MANAGEMENT: ACCELERATING TALENT

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Mental Illness: A Prison Epidemic

Last year, a U.S. Bureau of Justice Statistics report offered a grim view of America's prisons and jails: they are filled with people who have current or past mental health problems, and they are not meeting the demand for treatment.[1] Half of the persons incarcerated in prisons and two-thirds of those in jails had either current "serious psychological distress" or a history of mental health problems. Yet only about a third of those reporting serious psychological distress was receiving treatment, according to the report.

The picture is not as grim in New York State. However, we do face profound mental health challenges in our state's prisons. Nearly 20 percent of the 50,000-plus persons incarcerated in our state's 54 correctional facilities receive mental health care.[2] It is not clear how many other inmates may need mental health care but are not receiving it. It is clear that many inmates arrive at prison with a documented history of mental illness, and others have psychological issues that were not previously diagnosed or treated. Some inmates with preexisting problems experience a downward spiral while in prison. In other cases, mental illness appears to arise during incarceration.

The use of solitary confinement as punishment for violating prison rules is particularly problematic. Prisoners are isolated in a special housing unit – that is, a small cell aptly called "the box" – for 22 hours a day, for a period of days, weeks or months. Not surprisingly, prisoners kept in the box can deteriorate psychologically. This is true for both individuals who were previously mentally healthy and for those with a history of mental illness. More than 40 percent of all suicides in New York prisons in 2014 and 2015 took place in solitary confinement, according to the Correctional Association of New York, based on data obtained from the state Office of Mental Health.

The origins of solitary confinement in the United States have been traced to a Philadelphia penitentiary in 1787.

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Back then, the belief was that if prisoners were left alone with their conscience, they would reflect on their bad deeds and reform themselves.[3] The thinking has certainly changed since then. One significant reform in New York State was a 2008 law that improved the confinement conditions and treatment of seriously mentally ill inmates.[4] As a result, now far fewer inmates with significant psychiatric issues face solitary confinement.

Problems remained, and in 2013, the State Bar's House of Delegates approved a Report of the Committee on Civil Rights, which concluded that long-term solitary confinement was harmful to prisoners and counterproductive to legitimate penological interests of prisons and public safety. The report called for a profound restriction in its use, stringent protocols, and a prohibition against imposing such confinement for more than 15 days. That time period was consistent with the Mandela Rules, adopted by the U.N. General Assembly in 2015, which provides that no person should be held in solitary confinement for more than 15 days.

While New York continues to exceed that period, our state has made real progress regarding the treatment of mentally ill inmates. There has been a dramatic expansion in mental health units and other resources at prisons,[5] as well as a reduction in the time spent in special housing units. More progress must be made. Thousands of prisoners with mental health issues do not fall within the definition of serious mental illness, they remain in the general population, and they may be subjected to long periods in solitary.

The above scenario at our state prisons presents a particularly daunting challenge to criminal defense appellate attorneys who are assigned to represent mentally ill clients serving prison sentences. The Rules of Professional Conduct offer generic guidance. Rule 1.14 states that, when clients have diminished capacity, attorneys should try to maintain conventional relationships to the extent reasonably possible. Perhaps easier said than done. It can be extremely challenging to determine how to most effectively and ethically communicate with, and represent, the mentally ill client.

Any attorney representing a client with diminished capacity faces complex issues regarding the client's ability to understand the litigation, goals, and strategies. When such a client is a criminal defendant and an inmate at a correc-

tional facility, those complexities are intensified. For one thing, the attorney-client relationship often takes place through letters, not in-person meetings. For another thing, too few attorneys know the value in having the client sign an appropriate release so that his or her mental health records can be obtained. Such records can provide invaluable insight into the client's mental condition. Another challenge is that incarcerated clients may convey distrust, hostility, and paranoia toward the assigned attorney.

But such attitude may not flow from mental illness or indicate irrationality. The client faces fundamental legal issues that could impact his or her life for years to come, and has endless time to obsess about the case. So it is quite understandable that he or she would not feel trusting and open toward an attorney who does not meet face-to-face, or even call, to discuss the case.

The answer seems simple – perhaps deceptively so. Just as other clients, the incarcerated client should have an opportunity to meet with his or her attorney. If anything, it is the mentally ill inmate who has a special need for an in-person meeting. By going to the prison, the attorney can show his or her commitment, gain the client's trust, and meaningfully discuss the case and risks posed by possible appellate strategies. The attorney can see not just the record or the issues, but the person, and can better understand the conditions of the prison and of the client's mental state.

Many appellate attorneys who do have in-person prison meetings report that they were stunned to find clients who were very disturbed mentally or had severe cognitive deficits – despite the absence of clear indications of such problems in the record on appeal. On the one hand, attorney-client meetings can help counsel identify issues to be pursued through appellate litigation, including by eliciting crucial new information to collaterally attack the conviction. On the other hand, through in-person meetings, counsel may be able to give clients a more nuanced understanding of why it makes sense to stipulate to withdraw the appeal and to gain their acceptance of such route. In addition, through meetings, counsel may discover ancillary problems that can, and should, be improved with effective advocacy. These may include health care, prison disciplinary determinations, and release from solitary confinement.

Whether or not the clients have mental health problems,[6] best practices call for visits to criminal defendants, unless not reasonably feasible. However, several forces work against such in-person meetings. Many institutional offices or individual assigned attorneys have historically lacked the time and resources to travel great distances to meet with clients at correctional facilities. Further, rules and practices have not encouraged attorneys to meet with their indigent criminal defendant clients – even in the cases in which assigned attorneys have deemed client meetings to be crucial to effective representation.

In the future, perhaps the situation will change. State funding is being dedicated to improving the quality of criminal defense representation. That includes the reduction of caseloads for attorneys providing mandated representation, resulting in more time available for any given case. Such new funding will supplement the funding historically provided by counties and the city of New York.[7] So a concern for the county fisc will not be a sound rationale for declining to compensate attorneys for meeting with indigent incarcerated clients. More intensive attorney training may also help. We can hope that a cultural shift will follow from the expanded governmental funding and from expanded attorney training that provides a vision for effective and humane representation of challenging clients.

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1. BJS, Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates 2011-12.

2. Such figures are revealed by State Office of Mental Health reports. We thank Karen Murtagh, Executive Director of Prisoners' Legal Services of New York, for information and insights provided for this article. PLSNY is a nonprofit that provides civil legal services to inmates and advocates for more a more humane prison conditions.

3. *See* Craig Haney & Mona Lynch, *Regulating Prisoners of the Future: A Psychological Analysis of Supermax and Solitary Confinement*, 23 NYU Rev L & Soc Change 477, 481-482 (1997).

4. 2008 N.Y. Laws, Ch. 1.

5. The state Department of Correctional and Community Services and the state Office of Mental Health have partnered in providing special programs for inmates with mental illness, as indicated by the brief description of program options provided here: http://www.op.nysed.gov/surveys/mhpsw/doccs-att6.pdf.

6. ILS Appellate Standards and Best Practices, Standard IX.

7. Executive Law § 832 (4).