

NOTES

RAISING THE BARS: A COMPARATIVE LOOK AT TREATMENT STANDARDS FOR MENTALLY ILL PRISONERS IN THE UNITED STATES, UNITED KINGDOM, AND AUSTRALIA

*Kim P. Turner**

I.	INTRODUCTION	410	R
II.	THE UNITED STATES, THE UNITED KINGDOM, AND AUSTRALIA: STATISTICS, JURISPRUDENCE, AND STATUTES	414	R
A.	<i>United States</i>	415	R
1.	<i>U.S.—Snapshot: The Incarcerated Mentally Ill</i> .	415	R
a.	Sub-Standard Care and the Revolving Door of Incarceration	416	R
b.	Inappropriate Rehabilitation Environments	418	R
2.	<i>U.S. – Jurisprudence</i>	419	R
a.	Prisoner Medical Treatment Under the Eighth Amendment	419	R
b.	The Eighth Amendment: Encompassing Mental Health	420	R
c.	Defining Deliberate Indifference In Effort to Challenge Treatment Conditions	421	R
d.	Articulating More Detailed Treatment Standards	423	R
3.	<i>U.S. – Statutory Approach</i>	424	R
B.	<i>United Kingdom</i>	426	R
1.	<i>U.K. – Snapshot: The Incarcerated, Mentally Ill</i>	426	R
2.	<i>U.K. – Jurisprudence</i>	427	R
a.	General Duties to Mentally Ill Prisoners .	428	R

* Executive Editor, *Cardozo Journal of International and Comparative Law*, 2007-2008. J.D., Benjamin N. Cardozo School of Law, May 2008. I dedicate this Note to my brother, James, and to my parents.

410 CARDOZO J. OF INT'L & COMP. LAW [Vol. 16:409

- b. Diversion Policy Precluding Litigation 429 R
 - 3. U.K. – Statutory Approach 430 R
 - C. Australia 431 R
 - 1. Australia – Snapshot: The Incarcerated Mentally Ill 431 R
 - 2. Australia – Jurisprudence 432 R
 - 3. Australia – Statutory Approach 433 R
 - a. Recent Reforms 433 R
 - b. Statutorily-Based Rights for Mentally Ill Prisoners 433 R
- III. INTERNATIONAL STANDARDS FOR TREATING THE INCARCERATED MENTALLY ILL 435 R
 - A. Generally-Applicable International Human Rights Standards 435 R
 - B. International Instruments Speaking Directly to Prisoners’ Rights 436 R
 - C. Lack of Independent Standards Regarding the Rights of Mentally Ill Prisoners 436 R
 - D. International Standards Speaking Directly to Correctional Mental Health Treatment 437 R
 - 1. Standard Minimum Rules Provisions Affording Mentally Ill Prisoners Important Treatment Rights 438 R
 - E. Compliance Issues in Individual Countries 439 R
 - F. Additional International Instruments Articulating Standards for Correctional Mental Health 440 R
- IV. U.S., U.K., AND AUSTRALIAN INCORPORATION OF INTERNATIONAL STANDARDS REGARDING THE TREATMENT OF MENTALLY ILL INMATES: EXAMPLES, LESSONS, AND WORK TO BE DONE 442 R
 - A. U.S. on International Standards 442 R
 - B. The United Kingdom on International Standards 444 R
 - C. Australia on International Standards 449 R
- V. CONCLUSION 455 R

I. INTRODUCTION

Prisoner 1 is a 25-year-old who was transferred to [Wisconsin’s] Supermax [prison] in February 2001. He has a history of serious mental illness beginning at age 11 . . . [and] was diagnosed with Paranoid Schizophrenia. Prisoner 1 experiences command hallucinations, which are voices that tell him to do bad things. . . .

2008] STANDARDS FOR MENTALLY ILL PRISONERS 411

[His] charts list medication orders dating back to 1995 that include the antipsychotic medications Thorazine, Haldol, Quetiapine, Seroquel, Loxitane, Risperdal and Olanzapine. . . . Prisoner 1 told Dr. Kupers . . . that he hears voices constantly that command him to kill himself or hurt others. . . . [H]e cannot sleep because he “sees things,” including “demons moving around the floor and climbing on my bed” all night.¹

Prisoner 1 is representative of the enormous number of mentally ill inmates imprisoned throughout the world. The rate of mental illness among prisoners in the United States, the United Kingdom, and Australia is dramatically higher than the rate of mental illness found among each country’s general population, indicating that prisons have become a primary mental health provider for hundreds of thousands of inmates across the globe.² In the United States, due to the closing of state-sponsored psychiatric institutions, a lack of community-based resources, health insurance restrictions, and the commonly poverty-stricken and unpredictable lifestyles of the mentally ill, these individuals are increasingly entangled with police—thus, prison officials are becoming de facto “caretakers.”³ Mental health experts view prisons as toxic environments for the seriously mentally ill because of prison overcrowd-

¹ HUMAN RIGHTS WATCH, *ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS* 34 (2003) [hereinafter *ILL-EQUIPPED*] (quoting a correctional psychiatric report in *Jones ‘El v. Berge*, 164 F. Supp.2d 1096, 1108 (W.D. Wis., 2001)).

² The International Centre for Prison Studies reports that there are 2,186,230 prisoners in the United States, 79,861 in the U.K. (England and Wales), and 25,353 in Australia. INTERNATIONAL CENTRE FOR PRISON STUDIES, *WORLD PRISON POPULATION LIST* (7th ed., King’s College London) (information current through Oct. 2006), <http://www.kcl.ac.uk/depsta/rel/icps/world-prison-pop-seventh.pdf> (last visited Mar. 25, 2008). At mid-year 2005 in the United States, 705,600 inmates (56 percent of State prisoners), 78,800 (45 percent of Federal prisoners), and 479,900 (64 percent of jail mates) reported a mental illness of some kind. Doris J. James & Lauren E. Glaze, U.S. DEP’T OF JUST., OFFICE OF JUST. PROGRAMS, *SPECIAL REPORT: MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1* (Sept. 2006, rev. Dec. 14, 2006) [hereinafter 2006 OJP REPORT]. In the U.K., a 1997 study revealed that “90% of prisoners have at least one mental health disorder, including personality disorder, psychosis, neurosis, alcohol misuse and drug dependence.” HOUSE OF COMMONS, ALL-PARTY PARLIAMENTARY GROUP ON MENTAL HEALTH, *THE MENTAL HEALTH PROBLEM IN UK HM PRISONS: A REPORT FROM THE ALL-PARTY PARLIAMENTARY GROUP ON PRISON HEALTH 2* (Nov. 2006). In Australia, a recent study revealed the presence of psychiatric illness in 80 percent of prisoners, over a one-year period, versus 31 percent in the community. Tony Butler et al., *Mental Disorder in the New South Wales Prisoner Population*, 39 *AUST. N. Z. J. PSYCHIATRY*, 407, 407–13 (2005).

³ See U.S. DEP’T OF JUST., NAT’L INST. OF CORRECTIONS, *EFFECTIVE PRISON MENTAL HEALTH SERVICES: GUIDELINES TO EXPAND AND IMPROVE TREATMENT 1* (2004), <http://www.nicic.org/pubs/2004/018604.pdf> (last visited Mar. 25, 2008) (noting the factors causing the “enormous influx of persons with mental illness” and describing the legal and constitu-

ing, violence, lack of privacy, limited community contact, and scarce opportunities for meaningful activity.⁴ Many scholars have chronicled the alarming number of mentally ill inmates living in and passing through prisons.⁵ However, this Note aims to evaluate the legal and legislative standards endemic to the United States, United Kingdom, and Australia, which dictate the quantity and quality of treatment received by mentally ill inmates, while using international treatment standards as a baseline for comparing each country's approach.

The U.S., U.K., and Australia have employed a range of tactics to handle the incarcerated mentally ill, with some measures garnering greater clinical, legal, and legislative support than others. Despite calls from various international governmental bodies, particularly the United Nations (U.N.), to provide mentally ill prisoners with fundamental human rights in the form of comprehensive services and treatment,⁶ correctional systems worldwide continue to mismanage and even exacerbate inmates' symptoms of mental illness,⁷ further stunting rehabilitation. Assurances by corrections officials that prisons furnish adequate inmate mental health care are often uncorroborated by the evidence, particularly in the United States where independent monitoring is not mandatorily conducted.⁸ Moreover, underserving mentally ill of-

tional requirement that prison officials "handle" these inmates despite inadequate training).

⁴ ILL-EQUIPPED, *supra* note 1, at 53.

⁵ See *supra* note 2.

⁶ See *infra* Part III for discussion of the international standards applicable to treating mentally ill prisoners.

⁷ "Where a prison or prison system is believed to be providing inadequate mental health care, one of the first places to be studied is the prison's segregation (isolation or lockdown) units. This is where an untreated prisoner likely will be hidden [for disciplinary or suicide watch reasons] along with all of his psychiatrically driven disturbing behavior; it is where he is likely to deteriorate as well." FRED COHEN, THE MENTALLY DISORDERED INMATE AND THE LAW 11.2 (1998) [hereinafter 1998 COHEN].

⁸ For example, the U.S. Department of Justice (DOJ), Bureau of Justice Statistics (BJS) states that "[a]ll Federal prisons and most State prisons and jail jurisdictions, as a matter of policy, provide mental health services to inmates, including screening inmates at intake for mental health problems, providing therapy or counseling by trained mental health professionals, and distributing psychotropic medication." 2006 OJP REPORT, *supra* note 2, at 9. However, the Human Rights Watch states that according to the National Commission on Correctional Health Care (NCCHC) "only 231 of the nation's approximately 1,400 prisons have received NCCHC accreditation, meaning that they adhere to NCCHC guidelines [such as effectively screening inmates for mental illness upon admission] and submit themselves to monitoring by the organization." ILL-EQUIPPED, *supra* note 1, at 94. "Most state correctional systems [in the United States] do not have proce-

R
R

R

R

2008] *STANDARDS FOR MENTALLY ILL PRISONERS* 413

fenders creates additional costs and complications for correctional institutions and society as a whole.⁹

The United States, United Kingdom, and Australia can learn from one another in managing mentally ill prisoners given the nations' common history, shared democratic traditions, comparable legal and penal systems (based on the English common law), and similar economic standings.¹⁰ The proportion of inmates suffering from mental illness in these countries is only growing¹¹ and providing better-coordinated, lasting treatment can significantly stem the tide of an overwhelming correctional, mental health epidemic.

Given the dearth of legal literature comparing these similarly situated countries' in terms of the legal and legislative standards governing the correctional treatment of mentally ill inmates, Part II provides a snapshot of the incarcerated, mentally ill population in each nation, the jurisprudence guiding treatment standards, and the relevant statutes in the United States, United Kingdom, and Australia. Part III outlines the framework, developed by various international governing bodies, of rights, values, and obligations relating to mentally ill prisoners. An examination of each nation's efforts to integrate such international guidelines into their own cor-

dures for independent review of the quality of the mental health services they provide." *Id.* In contrast, in the U.K., "[e]very [prison] establishment in England and Wales has its own Independent Monitoring Board." HM Prison Service, *How Prisons are Regulated*, <http://www.hmprisonservice.gov.uk/prisoninformation/howprisonsareregulated> (last visited Mar. 25, 2008). The Minister appoints members of the local community to these Independent Monitoring Boards to serve as independent "watchdogs" to oversee, through unrestricted access, the wellbeing of both prisoners and staff. *Id.*

⁹ "[R]esearch has found jail-diversion programs for suspects with serious mental illness and co-occurring substance use conditions reduce the time they spend incarcerated without increasing the public-safety risk." Rich Daly, *Prison Mental Health Crisis Continues to Grow*, 41 *PSYCHIATRIC NEWS* no. 20, 1 (Oct. 20, 2006), available at <http://pn.psychiatryonline.org/cgi/content/full/41/20/1>. "[C]osts for jail diversion are no higher than those for imprisonment of those with mental illness, who often languish in jail on minor charges because they lack the understanding or funds to fight their incarceration." *Id.*

¹⁰ Despite these three nations' discrepant populations (U.S. population: 301,139,947 (2007 est.); U.K. population: 60,776,238 (2007 est.); Austl. population: 20,434,176), each country's Gross Domestic Product Per Capita is relatively similar: \$46,000 (U.S. 2007 est.); \$35,300 (U.K. 2007 est.); \$37,500 (Austl. 2007 est.). CENTRAL INTELLIGENCE AGENCY, *THE WORLD FACTBOOK*, available at <https://www.cia.gov/cia/publications/factbook/> (use drop-down menu to choose country) (last visited Mar. 12, 2008).

¹¹ For example, in the United States "[a]mong jail inmates, in 2002 around 30% said they had received treatment for a mental health problem in the past, up from 25% in 1996." 2006 OJP REPORT, *supra* note 2, at 10.

rectional mental health care laws and policies is provided in Part IV.¹²

Throughout, this Note makes suggestions for increasing each nation's adherence to international standards based on the best practices taking place in the United States, the United Kingdom, and Australia, keeping in mind the political, economic, and legal limitations present in each national context. International human rights standards provide a universal platform for assessing the quality and quantity of treatment afforded to mentally ill prisoners in each country. Most critically, given the unparalleled number of prisoners in the United States, and the sky-rocketing number of incarcerated, mentally ill individuals, this Note argues that the United States must reevaluate the current Eighth Amendment jurisprudence, which offers a narrow litigative avenue for mentally ill prisoners to challenge the inadequacies of correctional psychiatric treatment. In stark contrast to the United States' bare-boned Eighth Amendment framework, which provides relatively meager safeguards for prisoners, international standards call on nations to *affirmatively* provide comprehensive mental health treatment for prisoners—an outlook better embraced by the U.K. and Australia, where legislators have actualized such higher standards even when the courts have been reluctant to do so.

II. THE UNITED STATES, THE UNITED KINGDOM, AND AUSTRALIA: STATISTICS, JURISPRUDENCE, AND STATUTES

The United States, United Kingdom, and Australia have taken divergent approaches in handling the growing number of mentally ill inmates brimming over in their jails and prisons. Indeed, in each country, population and demographics vary¹³ and each nation is comprised of a “patchwork quilt” of states and territories with varying local legal and statutory guidelines.¹⁴ Nonetheless, through a

¹² No such comparative analysis has been conducted to date. Yet, irreconcilable variations in demographics, prison system structure, and governmental hierarchy exist among the United States, United Kingdom, and Australia, and therefore, this review and comparison of each country's legal and statutory approach toward the incarcerated mentally ill is conducted at a more general level, in order to highlight broader trends and areas for further development and research.

¹³ See *supra* note 10.

¹⁴ The U.S. corrections system is comprised of both federal and state prisons operating throughout the 50 states (there are 180 Bureau of Prisons facilities and fourteen privately-managed federal facilities, and hundreds of state-run prisons). FEDERAL BUREAU OF PRIS-

2008] STANDARDS FOR MENTALLY ILL PRISONERS 415

generalized comparison, lessons emerge when examining the conditions, case law, statutes, and policies governing mentally ill inmates in the three countries.

A. United States

1. U.S.—Snapshot: *The Incarcerated Mentally Ill*

The U.S. prison population is the highest in the world at 2,186,230 (738 per 100,000 people) while the U.K. prison population stands at 79,861 (148 per 100,000), and the prison population of Australia is 25,353 (126 per 100,000).¹⁵ The United States' infamy for being the world's largest incarcerator is *forcing* corrections administrators, legislators, agencies, and the courts to address mental illness in prisons so as to maintain basic order in an overloaded system.

In terms of the mentally ill within the U.S. prison population, “[s]omewhere between two and three hundred thousand men and women in U.S. prisons suffer from mental disorders, including such serious illnesses as schizophrenia, bipolar disorder, and major depression,”¹⁶ and roughly seventy thousand are psychotic on any particular day.¹⁷ In mid-2005, over half of all prison and jail inmates suffered from a mental health problem,¹⁸ in contrast to the

ONS, WEEKLY POPULATION REPORT, available at http://www.bop.gov/locations/weekly_report.jsp#bop (last visited Feb. 7, 2008). The U.K. prison system encompasses correctional facilities in England and Wales, which are overseen by one central authority, Her Majesty's (HM) Prison Service. (Prisons in Scotland and Northern Ireland are run separately and not covered in this Note.). H.M. Prison Service, *Statement of Purpose*, <http://www.hmprisonservice.gov.uk/abouttheservice/statementofpurpose> (last visited Oct. 29, 2007). Australia's prison system operates more like that of the U.S., on both a federal and state level, in the following states and territories: New South Wales, Victoria, Tasmania, Queensland, South Australia, Northern Territory, Western Australia, and the Australian Capital Territory. In each nation's states or territories the system of mental health within prisons is shaped, in part, by the laws, customs, and agency practices within each local jurisdiction.

¹⁵ WORLD PRISON POPULATION LIST, *supra* note 2, at 3, 5–6. The U.S. Department of Justice (DOJ) estimated in mid-2000 that 1,931,859 people were incarcerated in U.S. prisons and jails, demonstrating that statistics can fluctuate based on the year in which data was collected and particular survey methods used. Allen J. Beck & Jennifer C. Karberg, U.S. DEP'T OF JUST., OFFICE OF JUST. PROGRAMS, BUREAU OF JUST. STATISTICS BULLETIN: PRISON AND JAIL INMATES AT MIDYEAR 2000 1 (Mar. 1, 2001), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/pjim00.pdf> (last visited Mar. 25, 2008) (this reflects the most recent data available from the DOJ).

¹⁶ ILL-EQUIPPED, *supra* note 1, at 1.

¹⁷ *Id.*

¹⁸ 2006 OJP REPORT, *supra* note 2, at 1. Mental health problems were defined by a recent history of psychiatric symptoms or a mental health problem, such as a clinical diag-

R

R

R

general population where roughly “1 in 10 persons age 18 or older in the U.S. general population met DSM-IV criteria for symptoms of a mental health disorder.”¹⁹ The absolute percentage of mentally ill inmates within the prison system has increased since the 1990s.²⁰

a. Sub-Standard Care and the Revolving Door of Incarceration

In terms of care, more than one third of those state prisoners categorized as having a mental health problem reportedly receive treatment after correctional admission.²¹ Thus, roughly two thirds of eligible state prisoners *do not* receive mental health treatment after their admission. Furthermore, untreated inmates are often haphazardly released in the same or worse condition than the state in which they arrived.²² The mentally ill are often caught up in a

nosis or treatment by a mental health professional, occurring in the 12 months preceding the interview. *Id.*

¹⁹ 2006 OJP REPORT, *supra* note 2, at 3. The DSM-IV or DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS is a compendium of information about mental health disorders, used commonly by mental health professionals and published by the American Psychiatric Association. R

²⁰ According to the U.S. Department of Justice, National Institute of Corrections, the steep increase in the number of mentally ill persons in the prison system is due to: the downsizing or closure of state psychiatric facilities; a lack of community support programs; the underfunding of public services; inadequate insurance and managed care policies (which restrict access to appropriate mental health services); the impoverished and transient lifestyles of the mentally ill (thereby exposing the population to police interaction); and the interplay between serious mental illness and co-occurring substance disorders. US DEPT. OF JUST., NAT'L INST. OF CORRECTIONS, EFFECTIVE PRISON MENTAL HEALTH SERVICES, GUIDELINES TO EXPAND AND IMPROVE TREATMENT 1 (May 2004), *available at* <http://www.nicic.org/pubs/2004/018604.pdf> (last visited Mar. 25, 2008). Due to the massive closing of mental hospitals in the 1960s, “[p]atients ended up in jail, [and] prisons became the new asylums. ‘They became de facto mental hospitals and the prisons are ill equipped to handle it,’ says Robert Walsh, a clinical psychologist working inside Michigan prisons for the past 25 years.” *60 Minutes, The Death of Timothy Souders* (CBS television broadcast, Feb. 11, 2007) (reporting on the death of a 21 year-old mentally ill prisoner who died from dehydration in solitary confinement after refusing water and sustenance as a result of non-treated psychotic symptoms), *available at* <http://www.cbsnews.com/stories/2007/02/08/60minutes/main2448074.shtml> (last visited Mar. 25, 2008). “Walsh did an extensive study of Michigan prisons and found that the staff often tries to punish psychotic inmates into better behavior.” *Id.*

²¹ 2006 OJP REPORT, *supra* note 2, at 1. R

²² In the class action lawsuit, *Brad H. v. City of New York*, mentally ill inmates sued New York City and other defendants and the plaintiffs challenged the city jail’s practice of releasing mentally ill inmates at “the desolate Queens Plaza between the hours of 2 and 6 a.m. with \$1.50 in cash and \$3 Metrocard.” FRED COHEN, THE MENTALLY DISORDERED INMATE AND THE LAW: 2005 TRENDS AND DEVELOPMENTS UPDATE 7.2 (2005) (describing the history of the *Brad H.* case). In *Brad H.*, plaintiffs argued that the release policy not

2008] STANDARDS FOR MENTALLY ILL PRISONERS 417

“revolving door” cycle with the corrections system—the National Alliance for the Mentally Ill reports that up to 40 percent of adults who suffer from serious mental illness will come into contact with the U.S. criminal justice system at some point in their lives,²³ and their records present many more previous arrests when compared with non-mentally ill inmates.²⁴ These repeat arrests of under-treated individuals cost taxpayer dollars. The health care system in U.S. federal prisons, which includes the provision of mental health services, is funded, implemented, and overseen by the federal government.²⁵ State-run prison health care systems, funded by state taxes, vary in their spending on individual prisoners, which leads to the uneven provision of correctional mental health care across the country.²⁶ The economical inefficiencies, resulting from the “revolving door” effects of incarcerating the mentally ill, may be alleviated by providing better clinical treatment for inmates.

only violated state regulations and the inmates’ rights under New York State law, but also resulted in many inmates’ return to “the cycle of likely harm,” through “substance abuse, mental and physical health deterioration, homelessness, indigence, crime, re-arrest, and re-incarceration,” because they were released in an unstable condition, without any psychotropic medication, temporary housing, or treatment planning. *Brad H. v. City of New York*, 712 N.Y.S.2d 336, 345 (2000), *aff’d*, 716 N.Y.S.2d 852, 852 (2000).

²³ Mentally Ill Offender Treatment and Crime Reduction Act of 2004, 42 U.S.C.A. § 3711 (2007), Congressional Findings, Section 2(3).

²⁴ 2006 OJP REPORT, *supra* note 2, at 8 (internal citations omitted) (“A larger proportion of inmates who had a mental health problem had served more prior sentences than inmates without a mental problem. An estimated 47% of state prisoners who had a mental health problem, compared to 39% of those without, had served 3 or more prior sentences to probation or incarceration.”).

²⁵ *Federal Prisons, Containing Health Care Costs for an Increasing Inmate Population, Hearing Before the Subcomm. on Criminal Justice Oversight of the S. Comm. on the Judiciary*, 106th Cong. 4 (Apr. 6, 2000) (statement of Richard M. Stana, Associate Director, Administration of Justice Issues, General Government Division), available at <http://www.gao.gov/archive/2000/gg00112t.pdf> (last visited Mar. 25, 2008) [hereinafter *Health Care Hearing*]. “According to BOP’s Health Services Manual, the health care mission of BOP is to provide the necessary medical, dental, and mental health services to inmates by a professional staff, consistent with acceptable community standards.” *Id.*

²⁶ See Mark Taylor, *Prisoners of the System*, 37 MODERN HEALTHCARE 25 (Feb. 19, 2007) (describing variances in spending and stating that, according to a 2001 study, California spent \$3,000 per prisoner, whereas \$1,000 per prisoner is apportioned in North Dakota, with states generally allocating roughly 12 percent of their total corrections budget to prison healthcare). “Mentally ill inmates are more expensive to house, and they are generally confined for longer periods than other inmates because their illness complicates their release.” H.R. REP. NO. 108-732, at 8 (2005). However, the high short-term cost of providing inmates with adequate mental health care during their initial interactions with the correctional system may be less than the long-run cost of handling a mentally ill offender who repeatedly lands in jail and prison over the course of his life.

R

b. Inappropriate Rehabilitation Environments

Unlike the United Kingdom and Australia,²⁷ mentally ill prisoners in the United States are often treated *within* prisons rather than being transferred to external facilities, such as secure hospitals with staffs that are more competent and knowledgeable in the handling of mental illness matters than prison guards and administrators.²⁸ *Vitek v. Jones*²⁹ governs the procedural requirements related to transferring an inmate from a prison to a mental health treatment facility.³⁰ The procedural safeguards set forth in *Vitek* include: written notice to the prisoner that officials are considering a transfer to the mental hospital; a hearing with sufficient notice; an opportunity for defensive evidence to be presented; the involvement of an independent decision-maker; a written statement regarding the evidence and reasons related to transfer; assistance to the inmate in preparing and presenting his defense; and effective and timely notice of rights.³¹

Ironically, *Vitek* does not speak to the more prevalent problem, where an inmate actually *desires* a transfer to more appropriate mental health facilities but cannot be admitted.³² Exemplifying a positive trend in this area, a study of psychiatric prison transfers

²⁷ See *infra* Part IV regarding transfer and diversion policies in the U.K. and Australia. Note the difference between transfer (moving an inmate from a prison to a secure psychiatric facility) and diversion (directing a mentally ill criminal offender to a non-correctional or alternative program or facility) at various stages in the proceedings.

²⁸ Space limitations in psychiatric facilities marks one reason prisoners aren't transferred, even when such a decision to transfer is made. ILL-EQUIPPED, *supra* note 1, at 162. For example, in Mississippi, "it can take several weeks for a prisoner to be removed to an inpatient unit . . . [d]ue to lack of staff and lack of space, and sometimes a lethargic bureaucracy plays a part. Also, the hospitals are simply reluctant to accept disruptive prisoners, even if they are acutely ill." *Id.* Even in the U.K. where diversion policies are better developed, "[a]dmission criteria to secure facilities vary and procedures may depend upon central legal or administrative issues. They are more often matters of local policy and clinical judgment." Martin Humphreys, *Aspects of Basic Management of Offenders with Mental Disorders*, 6 *ADVANCES IN PSYCHIATRIC TREATMENT* 22, 28 (2000) (internal citation omitted).

²⁹ *Vitek v. Jones*, 445 U.S. 480, 493–95 (1980) (holding that a prisoner convicted and incarcerated in a State prison is entitled to certain procedural protections before being involuntarily transferred to a state mental hospital for treatment of his mental illness).

³⁰ See 1998 COHEN, *supra* note 7, at 17.2 ("*Vitek v. Jones* . . . now governs the procedural requirements that apply to transfers from prisons to mental treatment facilities").

³¹ *Id.* at 17.6.

³² "[I]nmates rarely resist such transfers; indeed, the contrary is true. Many inmates, it can be argued, prefer the relative comfort, security . . . and frequently better treatment available in a mental hospital. Thus, *Vitek* is simply an arm-chair libertarian's decision solving presently nonexistent problems." *Id.* at 17.7.

R

R

2008] *STANDARDS FOR MENTALLY ILL PRISONERS* 419

in six states revealed that “five of six states transferred nearly all (86 percent) of their mentally disordered inmates to mental health facilities within corrections, that three of these states had changed to this pattern since 1978, and that the mental health facilities in corrections were not drastically different from their mental-health-operated counterparts.”³³ Despite such official commitments to the policy of transferal, courts continually note, “prisoners in need of commitment to a mental hospital have experienced prolonged delays in being transferred to a state hospital.”³⁴

2. U.S. – Jurisprudence

Understanding the U.S. approach toward mentally ill inmates presents myriad challenges given the fifty different state models and the parallel federal system of corrections. Furthermore, historically, executive and legislative officials have underutilized their respective powers to ensure that prison officials provide adequate mental health care or meet basic constitutional standards,³⁵ rendering litigation especially necessary to incite change.³⁶

a. Prisoner Medical Treatment Under the Eighth Amendment

The Eighth Amendment dictates the quality of treatment for all prisoners whether or not an inmate suffers from mental illness.³⁷

³³ *Id.* at 17.9.

³⁴ *Casey v. Lewis*, 834 F. Supp. 1477, 1527 (D. Ariz. 1993). *Casey* held that defendants who were deliberately indifferent to prisoners’ serious medical and mental health care needs violated the Eighth Amendment rights of a class of inmates. *See id.*

Prisoners in need of commitment to a mental hospital have experienced prolonged delays in being transferred to a state hospital . . . [T]he staff indicated [on March 8, 1989] that there was a plan to transfer the patient as an involuntary admission to the Arizona State Hospital . . . [T]he patient was not transferred but two months later placed in lockdown for eleven and one-half months. She was not admitted to the hospital until April 27, 1990.

Id.

³⁵ *See ILL-EQUIPPED*, *supra* note 1, at 203 (“Constitutional standards are primarily enforced through prisoner litigation—litigation which faces enormous procedural as well as substantive obstacles.”).

³⁶ *See ILL-EQUIPPED*, *supra* note 1, at 46.

While it should not take the threat of a lawsuit to get correctional systems to improve their mental health services, in practice, litigation or the threat of it, has been the cause of systematic improvements in mental health services. The earlier lawsuits challenged the utter lack of mental health services in prisons. More recently, litigation has sought improvements in existing systems.

Id.

³⁷ “The Constitution ‘does not mandate comfortable prisons,’ but neither does it permit inhumane ones, and it is now settled that ‘the treatment a prisoner receives in prison and

R

R

In *Estelle v. Gamble*³⁸ the U.S. Supreme Court established the legal standard for evaluating general medical claims under the Eighth Amendment. For a claim to be recognized, “a prisoner must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs.”³⁹ The Court added that “[i]t is only such indifference that can offend ‘evolving standards of decency’ in violation of the Eighth Amendment.”⁴⁰ *Estelle* declared that “deliberate indifference to [the] serious medical needs of prisoners constitutes the ‘unnecessary and wanton infliction of pain,’ proscribed by the Eighth Amendment . . .” whether by prison doctors who are indifferent to an inmate’s needs or by prison guards who purposefully delay or deny medical care access or interfere with treatment plans.⁴¹ Practically, “[*Estelle v. Gamble* shook up the national correctional establishment [as] [i]t ‘became quickly apparent that most systems operated well below standards set by the Supreme Court.’”⁴²

b. The Eighth Amendment: Encompassing Mental Health

One year after *Estelle*, the Court of Appeals for the Fourth Circuit, in *Bowring v. Godwin*,⁴³ extended the *Estelle* standard to the treatment of mental illness. The *Bowring* Court announced, in unprecedented detail, that the plaintiff (or any other prisoner), is “entitled to psychological or psychiatric treatment” if the health

the conditions under which he is confined are subject to scrutiny under the Eighth Amendment.” *Farmer v. Brennan*, 511 U.S. 825, 832 (1994) (internal citations omitted). See U.S. CONST. amend. VIII (“Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.”) (emphasis added).

³⁸ *Estelle v. Gamble*, 429 U.S. 97 (1976) (Inmate plaintiff was injured while performing a prison work assignment, initiated a suit regarding inadequate prison treatment of the injury, and the case was remanded to re-consider plaintiff’s cause of action against prison officials in light of a new treatment standard).

³⁹ *Id.* at 106.

⁴⁰ *Id.*

⁴¹ *Id.* at 104–05 (internal citations and notes omitted). *Estelle* firmly established that inadequate medical care for prisoners violated the Cruel and Unusual Punishments Clause of the Eighth Amendment and made the distinction between “deliberate indifference to serious medical needs of prisoners” and “negligen[ce] in diagnosing or treating a medical condition.” Only the former violates the Clause. *Id.* at 104, 106.

⁴² Taylor, *supra* note 26. After *Estelle*, litigation swept the country, and the courts became overseers of prison health care programs for years beyond the initiation and settlement of lawsuits. See *id.* “Standards improved, and correctional healthcare began to resemble the care someone on the outside would receive if that person happened to be well-insured.” *Id.*

⁴³ *Bowring v. Godwin*, 551 F.2d 44 (4th Cir. 1977) (petitioner, incarcerated under state law, sought psychiatric treatment which would make him eligible for parole).

2008] *STANDARDS FOR MENTALLY ILL PRISONERS* 421

care provider reasonably concludes that the prisoner's symptoms indicate serious injury or disease, that such an ailment may be cured or improved, and delay or denial of treatment could cause substantial harm.⁴⁴ The Court qualified its holding by stating that cost and time were to be considered with regard to treatment and "the essential test is one of medical necessity and not simply that which may be considered merely desirable."⁴⁵ Critically, the *Bowring* Court recognized that an inmate's right to medical care for physical issues is co-extensive with the right to care for mental health matters.⁴⁶

c. Defining Deliberate Indifference In Effort to Challenge Treatment Conditions

Farmer v. Brennan,⁴⁷ the most recent, leading U.S. Supreme Court decision, which "provided an authoritative and reasonably clear answer to the question of just how to define deliberate indifference,"⁴⁸ involved a mentally ill prisoner's challenge to treatment standards. The plaintiff, identifying as a transsexual,⁴⁹ brought a Bivens action⁵⁰ alleging an Eighth Amendment violation by prison officials. Specifically, the plaintiff argued that officials were deliberately indifferent to his health and well-being in their act of placing him within the general prison population, thereby failing to protect the plaintiff from harm inflicted on him by other prisoners.⁵¹ The Court responded by stating: "[t]he [Eighth] Amendment also imposes duties on these officials, who must provide humane conditions of confinement; prison officials must ensure that inmates receive adequate food, clothing, shelter, and medical care,

⁴⁴ *Id.* at 47.

⁴⁵ *Id.* at 48.

⁴⁶ *Id.* at 47 ("We see no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart.")

⁴⁷ *Farmer v. Brennan*, 511 U.S. 825 (1994).

⁴⁸ 1998 COHEN, *supra* note 7, at 4–6.

⁴⁹ "[A] transsexual, one who has '[a] rare psychiatric disorder in which a person feels persistently uncomfortable about his or her anatomical sex,' and who typically seeks medical treatment, including hormonal therapy and surgery, to bring about a permanent sex change. American Medical Association, *Encyclopedia of Medicine* 1006 (1989)." *Farmer*, 511 U.S. at 829.

⁵⁰ "Bivens action" is a phrase commonly used to describe a judicially-created remedy which allows individuals to seek damages for conduct by federal officials alleged to be unconstitutional. See *Bivens v. Six Unknown Named Agents of Federal Bureau of Narcotics*, 403 U.S. 388 (1971).

⁵¹ See *Farmer*, 511 U.S. at 829–31.

and must ‘take reasonable measures to guarantee the safety of the inmates.’”⁵² The Court spoke of the two requirements to be met in making an Eighth Amendment claim. The first requirement echoed the “serious harm” language announced in *Estelle*:

[T]he deprivation alleged must be, objectively, “sufficiently serious,” [and] a prison official’s act or omission must result in the denial of the minimal civilized measure of life’s necessities. For a claim (like the one here) based on a failure to prevent harm, the inmate must show that he is incarcerated under conditions posing a substantial risk of serious harm.⁵³

The second requirement also affirmed the *Estelle* threshold for liability in that “only the unnecessary and wanton infliction of pain implicates the Eighth Amendment.”⁵⁴ To violate the Eighth Amendment, the “prison official must have a ‘sufficiently culpable state of mind’”⁵⁵ meaning, in prison cases, “[o]ne of ‘deliberate indifference’ to inmate health or safety”⁵⁶ Inmates must, therefore, show that they face a substantial risk of serious harm and that prison officials failed to abate such harm.⁵⁷ Although *Farmer* involved the question of prison officials’ liability in dangerously placing a psychiatrically disordered inmate within the general prison population, it is possible to extrapolate from *Farmer* a more generally-applicable standard for evaluating prison officials’ treatment (or non-treatment) of mentally ill inmates based on these announced guidelines.

In sum, to successfully claim an Eighth Amendment violation, U.S. prisoners need to demonstrate both an objectively serious physical or psychological injury and a culpable, subjective intent by prison authorities.⁵⁸ However, a constitutional violation cannot be raised merely based on inadequate standards of care, negligence, or malpractice.⁵⁹ The U.S. Supreme Court has affirmed that “[E]ighth Amendment liability requires ‘more than ordinary lack of due care for the prisoner’s interests or safety.’”⁶⁰ Applying this

⁵² *Id.* at 832 (internal citations omitted).

⁵³ *Id.* at 834 (internal citations omitted).

⁵⁴ *Id.* (internal citations omitted).

⁵⁵ *Id.* (internal citations omitted).

⁵⁶ *Farmer*, 511 U.S. at 834. (internal citations omitted).

⁵⁷ *See id.* at 847.

⁵⁸ *See* Jamie Fellner, *A Corrections Quandary: Mental Illness and Prison Rules*, 41 HARV. C.R.-C.L. L. REV. 391, 405 (2006).

⁵⁹ *See id.* at 406.

⁶⁰ *Farmer*, 511 U.S. at 835 (quoting *Whitley v. Albers*, 475 U.S. 312, 319 (1986)).

2008] STANDARDS FOR MENTALLY ILL PRISONERS 423

deliberate indifference test, the Court in *Farmer* held that prison officials could be held liable under the Eighth Amendment for denying humane conditions of confinement, but only if the officials *knew* that an inmate faced a substantial risk of serious harm and disregarded that risk by failing to take reasonable measures to address such harm.⁶¹ The Court concluded, “[u]nder the test we adopt today, an Eighth Amendment claimant need not show that a prison official acted or failed to act believing that harm actually would befall an inmate; it is enough that the official acted or failed to act despite his knowledge of a substantial risk of serious harm.”⁶²

d. Articulating More Detailed Treatment Standards

The Court in *Ruiz v. Estelle*⁶³ took a step beyond most courts by articulating a highly detailed and comprehensive framework for the adequate treatment of mentally ill prisoners. In response to a class action challenging the generally pernicious conditions and severely under-resourced mental health services provided to prisoners in the Texas Department of Corrections, the District Court announced a specific set of guidelines including: a systematic screening program for evaluating the mental health of inmates, treatment beyond segregation and supervision, the participation of trained mental health professionals in adequate numbers, individualized treatment, accurate and confidential record-keeping, proper administration of medications, and identification of inmates at risk of suicide.⁶⁴ The Court concluded that the Texas Department of Correction’s mental health program violated the Eighth Amendment in failing to reach even a minimal level of adequacy with regard to the aforementioned components.⁶⁵

⁶¹ *Id.* at 825.

⁶² *Id.* at 842.

⁶³ *Ruiz v. Estelle*, 503 F.Supp. 1265 (S.D. Tex. 1980). The Court described the prison’s method of handling mentally ill inmates: “[e]ssentially, an inmate with a mental disorder is ignored by unit officers until his condition becomes serious. When this occurs, he is medicated excessively.” *Id.* at 1332.

If his condition becomes acute, he is deposited at TDC’s Treatment Center, a facility exclusively for inmates with mental disorders. Located at the Huntsville Unit, the Treatment Center has only limited professional staffing, and inmates who are sent there are the recipients of little more than medication and what amounts to warehousing.

Id.

⁶⁴ *Ruiz*, 503 F.Supp. at 1339.

⁶⁵ *Id.*

To assess the adequacy of mental health services within their own prisons, certain courts and organization have applied the criteria announced in *Ruiz*.⁶⁶ Case law is still developing the concrete standards regarding access to the services necessary for effectively diagnosing and treating mental illness among the incarcerated.⁶⁷ *Estelle* was decided in 1976 and several evolutionary steps in prison mental health treatment have been taken since then. Today, however, the burden of proof for inmates to assert Eighth Amendment violations regarding inadequate mental health care remains exceptionally high⁶⁸ in contrast to the proactive policy approaches of the United Kingdom and Australia. There, prison systems have more successfully incorporated the affirmative treatment expectations commanded by international human rights standards, albeit through legislative means more than through the courts.

3. U.S. – Statutory Approach

Regardless of the slow-moving litigative progress made in correctional mental health, the U.S. Congress has recently taken more radical steps by enacting The Mentally Ill Offender Treatment and Crime Reduction Act of 2004 (MIOTCRA),⁶⁹ aimed generally at reducing the number of prisoners while increasing public safety. As a heretofore unseen effort toward coordinating federal, state, and local entities, MIOTCRA was passed to “provide grant funding to state and local government agencies to implement programs and strategies aimed at solving the modern problems that such

⁶⁶ The National Commission on Correctional Health Care, the non-profit organization that accredits and monitors the correctional health care systems, issued a 1992 *Position Statement, Mental Health Services in Correctional Settings*, based on the requirements outlined in *Ruiz*. *Bryant v. State*, 393 Md. 196, 207 (Md. 2006).

⁶⁷ See *ILL-EQUIPPED*, *supra* note 1, at 214 (citing 1998 *COHEN*, *supra* note 7, at 7.7).

⁶⁸ “*Ferola v. Moran* [622 F. Supp. 814 (D.R.I. 1985)] is an interesting example of how a system that is not in compliance with an order entered nine years previously on mental health care can successfully defend an individual complainant’s suit for money damages.” 1998 *COHEN*, *supra* note 7, at 7–55. “The court found that the doctor did all that was possible” to treat a 25-year-old inmate with anti-social personality disorder, who injured himself 60 times and set fire to his cell. *Id.*

⁶⁹ Mentally Ill Offender Treatment and Crime Reduction Act of 2004, 42 U.S.C.A. § 3711 (2004) (“An Act To foster local collaborations which will ensure that resources are effectively and efficiently used within the criminal and juvenile justice systems.”). Provision (7) of the Act states: “Collaborative programs between mental health, substance abuse, and criminal or juvenile justice systems that ensure the provision of services for those with mental illness or co-occurring mental illness and substance abuse disorders can reduce the number of such individuals in adult and juvenile corrections facilities, while providing improved public safety.”

R

R

2008] *STANDARDS FOR MENTALLY ILL PRISONERS* 425

agencies deal with concerning criminals, mental health illnesses, and substance abuse problems.”⁷⁰ Although the bill was signed into law in 2004, only now are grant requests starting to be filed, approved, and realized in the establishment of training programs and special mental health courts.⁷¹ Federal money has been made available for states and municipalities to develop and implement a range of “programs designed to improve outcomes for individuals with mental illness involved in the criminal justice system. . . . [T]o establish mental health courts, provide in-jail treatment and transitional services, as well as provide additional training for mental health personnel, police, judges, prosecutors, and corrections officials.”⁷²

Time will tell whether these funds will tangibly improve outcomes for mentally ill offenders, since only a handful of MIOT-CRA grant-based programs have thus far been instituted. However, MIOTCRA represents an unprecedented commitment by the federal government to: promote the constructive diversion of offenders (whose rate of rehabilitation is likely to be improved in non-jail settings); train corrections personnel to more adeptly handle mentally ill inmates; and fully fund the coordination efforts between agencies and various levels of government in cooperatively addressing the issue. Congressional hearings to assess progress are already underway and lawmakers and practitioners are arguing for the reauthorization of MIOTCRA based on initially successful results.⁷³

⁷⁰ Ralph M. Rivera, *The Mentally Ill Offender: A Brighter Tomorrow Through the Eyes of the Mentally Ill Offender Treatment and Crime Reduction Act of 2004*, 19 J. L. HEALTH 107, 133 (2005). “The bill directs the Attorney General and the Secretary of Health and Human Services to develop a list of ‘best practices’ for criminal justice personnel to use when diverting mentally ill offenders from incarceration into treatment.” Press Release, Sen. Patrick Leahy, *Mentally Ill Offender Treatment And Crime Reduction Act Of 2003 Fact Sheet* (June 5, 2003), available at <http://leahy.senate.gov/press/200306/060503a.html> (In terms of financial support, “[t]he bill authorizes \$100 million per year for fiscal years 2004 and 2005 for the grant program and ‘such sums as may be necessary for fiscal years 2006 through 2008.’”).

⁷¹ One example includes the “Mansfield Municipal Mental Health Court [which was granted] \$199,981 to accept referrals from entities in which potential participants meet the criteria of severe mental illness and have exhibited criminal behavior problems which are manageable in an outpatient, non-jail setting.” *Three Ohio Courts Receive Mentally Ill Offenders Grants Through Sen. DeWine Bill*, U.S. FED. NEWS, Sept. 1, 2006.

⁷² *Sen. Dewine Announces Grants Available to Help Mentally Ill Offenders*, U.S. FED. NEWS SERVICE, Apr. 28, 2006.

⁷³ *Criminal Justice Responses to Offenders with Mental Illness: Hearing Before the Subcomm. on Crime, Terrorism, and Homeland Security of the Comm. on the Judiciary*, 110th

B. *United Kingdom*

1. *U.K. – Snapshot: The Incarcerated, Mentally Ill*

Among the 61,944 prisoners in 131 penal establishments throughout England and Wales,⁷⁴ inmates with mental disorders are significantly overrepresented. “One in five prisoners have four of the five major mental health disorders” and many present a history of self harm.⁷⁵ The Department of Health reports that in 2002 there were 39,000 admissions to prison health care centers; 30 percent of admissions were based on mental health reasons.⁷⁶ In terms of the availability and quality of treatment, the U.K. maintains comparatively high standards, yet more progress needs to be made in fully addressing the needs of mentally ill prisoners. Inadequate care is evidenced by research showing that twenty eight percent of male prisoners with psychotic symptoms report being forced to spend twenty three hours or more per day in their cells—twice the proportion of those not suffering from mental illness.⁷⁷

Unlike the United States and most of Australia, in the United Kingdom, Her Majesty’s Inspectorate of Prisons in England, Wales, and Northern Ireland, is charged with the duty to inspect the prisons and report annually to Parliament about the treatment of prisoners and prison conditions—an effort led by a Chief Inspec-

Cong. 11 (2007) (statement of Judge Steve Leifman, Criminal Division of Miami-Dade County Court, 11th Judicial District, Miami, FL). Judge Leifman addressed the committee to discuss the importance of continued funding for MIOTCRA, stating the legislation has been “crucial to facilitating collaborative community-wide solutions to people with mental illnesses in the criminal justice system.” *Id.*

⁷⁴ See NICOLA SINGLETON ET. AL, PSYCHIATRIC MORBIDITY AMONG PRISONERS—SUMMARY REPORT 5 (Social Survey Division of Office of National Statistics, on Behalf of the Dep’t of Health) (1997) (The Under-Secretary of State for the Home Department stated in 2006 that the 1997 Office for National Statistics Report provided the most thorough assessment of mental illness within prisons.). “It is well known that [in the U.K.] we currently have around 75,000 people in our prisons: more *per capita* than any other western European country.” Anne Owers, HM Chief Inspector of Prisons Speech, Address at the London School of Economics, *Rights Behind Bars: The Conditions and Treatment of Those in Detention* 1 (Dec. 9, 2004), available at http://www.lse.ac.uk/collections/humanRights/articlesAndTranscripts/Rights_behind_bars.pdf (last visited Mar. 25, 2008).

⁷⁵ PRISON REFORM TRUST, BROMLEY BRIEFINGS: PRISON FACTFILE 27 (Apr. 2006, Bromley Trust) [hereinafter PRISON REFORM TRUST], available at http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/03_04_06_prisons.pdf (last visited Mar. 28, 2008). “72,000 people in prison at any given time . . . hav[e] some kind of mental disorder.” C. BROOKER ET. AL., PRISON HEALTH, DEPARTMENT OF HEALTH, MENTAL HEALTH SERVICES AND PRISONERS: A REVIEW (Dec. 2002), available at <http://www.phrn.nhs.uk/workstreams/mentalhealth/MHReview.pdf> (last visited Mar. 28, 2008).

⁷⁶ PRISON REFORM TRUST, *supra* note 75, at 27.

⁷⁷ PRISON REFORM TRUST, *supra* note 75, at 28.

R
R

2008] *STANDARDS FOR MENTALLY ILL PRISONERS* 427

tor unaffiliated with the Prison Service.⁷⁸ U.K. prisons are both overseen by the Prison Service Inspectorate and monitored by independent boards.⁷⁹ Despite such monitoring measures, problems still plague the U.K. system. Anne Owers, former Chief Inspector recognizes these problems: “We have built overcrowding into the system—just as surely as we have built in suicides, self-harm and mental illness: and the four are indeed closely inter-connected.”⁸⁰ Owers further noted, “things that would be unacceptable in any other context can become accepted and even built in to the system.”⁸¹

In terms of the structure and management of prison health care, the United Kingdom has coordinated an unprecedented partnership between the Bureau of Prison Services and the National Health Service (NHS) to improve mental health care in prisons by integrating the two systems as of 2005.⁸² Thus, responsibility for prison health care funding has been transferred from the Prison Service to the Department of Health.⁸³ Local prisons’ health care budgets are gradually transferring to local NHS Primary Care trusts to assume full financial responsibility for prison health care.⁸⁴ Such progress has been lauded as a major step toward better tailoring mental health care to the needs of the incarcerated mentally ill. The U.K. state-sponsored health care system makes this arrangement more feasible than in the United States, where the model of privatized health care impedes this kind of reorganization.

2. U.K. – Jurisprudence

Unlike those in the United States, mentally ill prisoners in the U.K. have not needed to rely as heavily on litigative strategies as a means of improving treatment standards. The U.K. government’s more proactive approach to implementing effective policies and

⁷⁸ Pat Carlen, *Prisongate: The Shocking State of Britain’s Prisons and the Need for Visionary Change*, BRIT. J. CRIMINOLOGY 1000 (Nov. 2004) (reviewing DAVID RAMSBOTHAM, *PRISONGATE*, (2005) (“Only Western Australia has a similar Inspectorate.”).

⁷⁹ Independent Monitoring Boards, <http://www.imb.gov.uk/> (last visited Mar. 17, 2008).

⁸⁰ Owers, *supra* note 74.

⁸¹ *Id.*

⁸² Jean McHale, *Standards, Quality and Accountability—the NHS and Mental Health: A Case for Joined-Up Thinking?* 25(4) J. SOC. WELFARE & FAM. L. 369, 372 (2003).

⁸³ HM PRISON SERVICE, PRISON SERVICE ORDER, CLINICAL GOVERNANCE—QUALITY IN PRISON SERVICE HEALTHCARE (Jan. 16, 2003), *available at* http://pso.hmprisonservice.gov.uk/PSO_3100_clinical_governance_quality_in_prison_healthcare.doc (last visited Mar. 28, 2008).

⁸⁴ *Id.*

practices, took shape in the form of the Mental Health Act of 1983 (MHA),⁸⁵ for example, to alleviate problems and potential causes of action *before* they arise.⁸⁶ Nonetheless, neither the U.K. nor the U.S. courts have set high treatment standards with regard to the baseline duty of care toward prisoners. This is because the relevant “Prisons Act 1952, the Prison Rules 1964 and the common law do not generally impose duties on prison authorities [with respect to the] conditions under which prisoners are confined and the regimes to which they are subject.”⁸⁷

a. General Duties to Mentally Ill Prisoners

In *R. v. Deputy Governor of Parkhurst Prison, ex p. Hague*,⁸⁸ the House of Lords held that prison officials owe a duty of care to those they imprison, but the duty is to *avoid* imposing conditions on prisoners that would foreseeably mentally or physically harm them, rather than a duty to uphold affirmative standards of human dignity.⁸⁹ This standard is not unlike the Eighth Amendment framework guiding prison practices in the United States.⁹⁰ U.K. courts have gone so far as to say that “[a] prisoner with a mental disorder is entitled to receive treatment for his or her condition, on an informal basis.”⁹¹

⁸⁵ Mental Health Act, 1983 (Eng.).

⁸⁶ One reason for this policy paradigm of governmental problem-solving, as opposed to the litigious U.S. model, lies in the American system of federalism, in which fifty different states run their own prisons systems in addition to the federal prison system. Neither state nor federal prisons are operating under one main statute. In the U.K., the Mental Health Act universally governs the treatment of mentally ill inmates in hospital settings, rendering the system comparatively easier to manage. “For prisoners who are regarded as requiring treatment in hospital for mental disorder, arrangements will be made to transfer them to hospital under the provisions of sections 47 and 48 of the Mental Health Act 1983.” HOME OFFICE AND THE DEPARTMENT OF HEALTH, *MENTALLY DISORDERED OFFENDERS: INTER-AGENCY WORKING 22* (1995), available at <http://www.homeoffice.gov.uk/documents/disorder-offender-inter-agency?view=binary> (last visited Mar. 28, 2008).

⁸⁷ David Feldman, *Human Dignity as a Legal Value: Part 2*, 5 PUB. L. 61, 65 (2000).

⁸⁸ [1992] 1 A.C. 58, 102.

⁸⁹ See Feldman, *supra* note 87, at 65 (“Their Lordships held that a prisoner may bring an action for false imprisonment against a person who limits the prisoner’s freedom of movement more closely than has been authorised by lawful decisions, but this was thought to apply mainly to action by other prisoners and was not seen as a remedy for poor conditions of imprisonment.”).

⁹⁰ See *supra* notes 39 and 40 and accompanying text for an articulation of the U.S. Eighth Amendment standard.

⁹¹ Humphreys, *supra* note 28, at 27.

R

R

R

b. Diversion Policy Precluding Litigation

In 1990, the U.K. Home Office⁹² began mandating the “diversion” of mentally disordered defendants from the criminal justice system into the health and social services sector whenever possible,⁹³ an aggressive response to “the growing number of mentally ill offenders inappropriately placed in prison.”⁹⁴ The policy aimed to spur individual agencies to implement diversion strategies by highlighting the police and court power, on the basis on of the MHA, to direct offenders to appropriate mental health care facilities, thereby precluding the need for protracted litigation over the diversion decision.⁹⁵ As of 1999, almost 200 diversion schemes in various forms were in operation at police stations and in courts across the U.K.,⁹⁶ successfully addressing the health care needs of mentally disordered offenders before the full litigation process ever commences.⁹⁷ Additionally, when possible, the MHA allows for informal psychiatric evaluation referrals of individuals who have not yet been charged.⁹⁸ However, once charges have been levied, an individual may remain in custody even when mental illness is detected, revealing the lingering imperfections of the diversion system.⁹⁹ Mentally ill offenders can be diverted from the criminal justice system “at the point of arrest, at the police station, at the time of first appearance in court, while on bail, by transfer to hospital, while on remand, through a psychiatric disposal from court, [or] by transfer to hospital while serving a sentence of imprisonment.”¹⁰⁰ The crimes committed by this group of diverted disordered offenders are often minor disturbances (largely sum-

⁹² See Home Office, *Provision for Mentally Disordered Offenders*, Circular 66/90, London: HMSO (1990).

⁹³ See Judith M. Laing, *Diversion of Mentally Disordered Offenders: Victim and Offender Perspectives*, Oct. CRIM. L. REV. 805, 805 (1999) (“Essentially, ‘diversion’ is used to describe a process of decision-making, at various stages of the criminal justice system, whereby certain offenders are not prosecuted, or not imprisoned or not punished, but are identified and treated in a different way.”).

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *Id.* at 807.

⁹⁷ *Id.* “Research studies have shown that the establishment of diversionary initiatives has increased the opportunities for mental health assessments and enhanced the quality of disposal.” *Id.* at 807-08. Thus, such interventions preclude the need for protracted litigation.

⁹⁸ See Humphreys, *supra* note 28, at 23.

⁹⁹ *Id.*

¹⁰⁰ *Id.*

mary offences not serious violent crimes)¹⁰¹ further justifying the establishment of alternative methods for managing mentally ill offenders.

3. U.K. – Statutory Approach

In the U.K., the MHA¹⁰² was originally passed to provide a “consistent and comprehensive approach to psychiatric care in England and Wales.”¹⁰³ Since then, the “mental health service provision has radically changed involving widespread hospital closures and the introduction of care in the community,” necessitating a wholesale update of the legislation.¹⁰⁴ U.K. officials have long been working on a new version of the bill to coordinate the nation’s mental health care at all levels of service, including in prisons.¹⁰⁵ In response to criticism that the MHA is out of synch with current needs, the government wrestled with mental health campaigners and psychiatrists over the bill’s language for several years¹⁰⁶ before finally updating the legislation in July of 2007.¹⁰⁷

The Act contains certain provisions that are clearly constructive in effectively treating mentally ill prisoners. Section 48 “authorizes the transfer of remand prisoners who are diagnosed as suffering from either mental illness or severe mental impairment and are deemed in urgent need of psychiatric treatment, from custody into hospital.”¹⁰⁸ Although this power is not historically novel, “the phenomenal increase in the number of such transfers”

¹⁰¹ See Laing, *supra* note 93, at 812.

¹⁰² Mental Health Act, 1983, c. 20 (Eng.).

¹⁰³ RACHEL CHURCHILL ET. AL., A SYSTEMATIC REVIEW OF RESEARCH RELATING TO THE MENTAL HEALTH ACT (1999) 5, available at http://www.health.wa.gov.au/mhareview/resources/documents/Systematic_Review_of_MH_Legislation.pdf (last visited Mar. 28, 2008).

¹⁰⁴ *Id.*

¹⁰⁵ See David Batty, *The Mental Health Bill*, THE GUARDIAN, Nov. 17, 2006, available at <http://society.guardian.co.uk/qa/story/0,,1300759,00.html> (describing the U.K. government’s many attempts over eight years to reform mental health law).

¹⁰⁶ *Id.*; see also Devika Bhat, *Lords Considers Controversial Mental Health Law*, TIMES ONLINE (London), Jan. 8, 2007, available at <http://www.timesonline.co.uk/tol/news/article1290610.ece> (“Previous attempts to change the Act were thwarted by opposition from campaigners and doctors.”).

¹⁰⁷ See David Brindle, *A New Act, but Mental Health Battles Remain*, THE GUARDIAN, July 11, 2007, available at <http://www.guardian.co.uk/society/2007/jul/11/mentalhealth.socialcare> (“And so, almost nine years after it embarked upon the exercise, the government has a new mental health legislation.”).

¹⁰⁸ R.D. Mackay & David Machin, *The operation of section 48 of the Mental Health Act of 1983*, 40 BRIT. J. CRIMINOLOGY, 727, 728 (2000).

2008] *STANDARDS FOR MENTALLY ILL PRISONERS* 431

is a newer phenomenon in recent years.¹⁰⁹ The expanded use of section 48 has been regarded as “beneficial” in that mentally ill prisoners are “more readily identified” in the prison system and thus, transferred to an appropriate hospital environment capable of addressing such an inmate’s needs.¹¹⁰

The 1992 Reed Report, from the Home Office’s Department of Health, “emphasized that ‘wherever possible, mentally disordered offenders should receive care and treatment from health and social services, rather than the criminal justice system.’”¹¹¹ This governmental commitment and practice of treating mentally ill offenders within the health care system rather than the prison system is reflective of the U.K.’s overall acceptance that mentally ill prisoners cannot be properly managed and rehabilitated in a traditional corrections environment.

C. *Australia*

1. *Australia – Snapshot: The Incarcerated Mentally Ill*

Australia is not unlike the United States and the United Kingdom in that many of its prisoners, numbering approximately 25,000,¹¹² are suffering from one or more mental illnesses. A 2006 study comparing Australian prisoners with the general community revealed “[t]he 12-month prevalence of any psychiatric illness in the last year was 80% in prisons” compared to only “31% in the community.”¹¹³

¹⁰⁹ *Id.*

¹¹⁰ *Id.* at 729.

¹¹¹ *Id.*

It is the Government’s policy that those suffering from mental disorder who require specialist medical treatment or social support should receive it from the health and social services. . . . [M]entally disordered people should not be drawn into the criminal justice system unnecessarily, for example in the hope of securing treatment in prison. Detention in prison is likely to be damaging to the mental health of a mentally disordered person, and the Prison Service is not equipped to provide treatment equivalent to that available in hospital.

HOME OFFICE AND THE DEPARTMENT OF HEALTH, *supra* note 86, at 4.

¹¹² See *Crime and Justice: Women in Prison*, 4102.0 AUSTRALIAN SOCIAL TRENDS (Austl. Bureau of Stat., June 15, 2004), available at <http://www.abs.gov.au/ausstats/abs@.nsf/7d12b0f6763c78caca257061001cc588/781c132ae9185bedca256e9e002975fc!OpenDocument#>.

¹¹³ Tony Butler, et al, *Mental Disorders in Australian Prisoners: A Comparison with a Community Sample*, 40 AUSTRALIAN & N. Z. J. PSYCH. 272, 272 (2006).

2. Australia – Jurisprudence

Because Australian mentally ill prisoners are often transferred to suitable mental health facilities before adequacy of care becomes an issue, there has been little, if any, litigation contesting the level and quality of mental health care afforded to such offenders. Nonetheless, the U.K. decision *Raymond v. Honey*¹¹⁴ marked a critical shift, implicating Britons and Australians alike, in the judicial approach to the interpretation of domestic legislation governing prisoners' rights. The House of Lords affirmed the conviction of a prison governor after he interfered with the correspondence of a prisoner,¹¹⁵ stating the proposition that "[u]nder English law, a convicted prisoner, in spite of his imprisonment, retains all civil rights which are not taken away expressly or by necessary implication."¹¹⁶ The House of Lords asserted that the Home Secretary's regulation-making power to discipline and control prisoners through legislation does not allow for the curtailment of prisoner court access.¹¹⁷ Thus, legislation seeking to abrogate prisoner rights will be strictly scrutinized by Australian courts which have continued to cite the *Raymond* principle of interpretation approvingly.¹¹⁸ On the other hand, *Raymond* has had limited practical effects because recent Australian judicial decisions regarding the treatment of prisoners show great deference for the judgment of prison officials.¹¹⁹ For example, determinations of prison officials such as the chief administrative officers will not be reviewed on grounds of unreasonableness; furthermore, harsh prison methods, such as placing prisoners in administrative segregation, have not been closely questioned by the courts.¹²⁰

¹¹⁴ *Raymond v. Honey*, [1983] 1 A.C. 1.

¹¹⁵ Matthew Groves, *International Law and Australian Prisoners*, 24 U. NEW SOUTH WALES L. J. 17, 19 (2001).

¹¹⁶ *Raymond*, 1 A.C. at 10.

¹¹⁷ See Groves, *supra* note 115, at 20.

¹¹⁸ See *id.*; see, e.g., Kuczynski (1994) R., 72 A. Crim. R. 568, 583 (where the Supreme Court of Western Australia held that the status of being a prisoner "affects his ability to enjoy certain of the rights that are guaranteed to citizens in our society but it does not abrogate those rights except to the extent that Parliament has decreed and except also to the extent necessary to reflect the prison environment.").

¹¹⁹ See Groves, *supra* note 115, at 20.

¹²⁰ See *id.*

R

R

3. *Australia – Statutory Approach*

a. Recent Reforms

Australia witnessed many mental health care reforms in the 1990s as the movement for helping mentally ill prisoners gained momentum. More recently, in 2006 the Council of Australian Governments (“COAG”) unveiled a plan to comprehensively overhaul mental health services throughout the country, including a four billion dollar, five-year, coordinated commitment by the federal, state, and territory governments.¹²¹ With respect to the four billion dollar budget, commentators have called for the expansion and improvement of prison mental health services, court diversion programs, inpatient and community services, and a strengthening of connections between the mental health, correctional and judicial systems.¹²² The importance of diverting mentally ill people, who have committed minor offenses, away from the criminal justice system as a means for “community-based prevention,” has also been stressed,¹²³ as has the necessity of “adequate training” of relevant court and police personnel.¹²⁴ COAG’s announcement to commit an unprecedented amount of money and attention to national mental health programs for treating and diverting mentally ill offenders in Australia suggests that resources for these issues were previously under-allocated and disorganized. Only recently have Australian citizens, service-providers, and legislators called for more concrete services and protections for the incarcerated mentally ill.¹²⁵

b. Statutorily-Based Rights for Mentally Ill Prisoners

The management and treatment of Australian prisoners is governed, in great part, by the laws of the state or territory in which the prisoner is detained; an approach similar to the U.S. state-

¹²¹ See Paul White & Harvey Whiteford, *Prisons: Mental Health Institutions of the 21st Century?*, 185(6) *MED. J. AUSTRAL.* 302, 303 (2006) (the authors, who are psychiatrists working for the Australian government, recommend a course of action with respect to the COAG’s plan and budget).

¹²² *Id.*

¹²³ *Id.*

¹²⁴ *Id.*

¹²⁵ In 2005 the South Australian Health Minister announced the doubling of forensic liaison workers in the territory’s prison system, recognizing “mental illness is more prevalent among prison populations than the rest of the community and that’s why we’re delivering more services.” Press Release, Department of Health, Government of South Australia, More Mental Health Support in Prisons (Oct. 12, 2005).

driven system.¹²⁶ Correctional legislation has been reviewed by the Australian courts, for example, in suits brought by prisoners challenging the administrative decisions made by prison officials regarding disciplinary issues.¹²⁷ The Corrections Act of 1986,¹²⁸ created by the Australian territory of Victoria, included an express grant of prisoners' rights. The grant marked "the first statutory recognition of prisoners' rights within correctional legislation in Australia . . ."¹²⁹ The only other territory to include such a statutory provision is Tasmania.¹³⁰ Specifically, Section 56AB of Victoria's Corrections Act of 1986, concerning "[l]egal custody of prisoners and detainees transferred to institutions and approved mental health services," speaks directly to the mental health treatment rights of prisoners, with regard to transfer.¹³¹ Notably, although the rights provisions of the Corrections Act of 1986 are generally framed and not specifically enumerated,¹³² they are actually "part of the law of Victoria and Tasmania."¹³³ However, both the Tasmanian and Victorian charters lack the means or a remedy, such as a cause of action for damages, to enforce the rights granted to prisoners, suggesting that official recognition of such harms needs further development.¹³⁴ Furthermore, "the Victorian charter of prisoners' rights, which has been in operation for well over a decade, has not been invoked successfully in any legal action by a prisoner,"¹³⁵ reflecting the difficulty of bringing such a challenge.

¹²⁶ See Groves, *supra* note 115, at 17. The statute that created the office of the Ombudsman, and the legislation regarding Freedom of Information (which provides access to prison records) together dictate standards of prisoner management and treatment and the means to voice dissatisfaction with administrative agency practices. See *id.* at 17, n.1.

R

¹²⁷ See *id.* at 17 (citing Matthew Groves, *Proceedings for Prison Disciplinary Offences*, 24 *MONASH U. L. REV.* 338 (1998)).

¹²⁸ Corrections Act, 1986 (Victoria, Austl.) (as amended Oct. 11, 2006), available at [http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubLawToday.nsf/a12f6f60fbd56800ca256de500201e54/F700FF234143AB10CA25720200161DEC/\\$FILE/86-117a064.pdf](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubLawToday.nsf/a12f6f60fbd56800ca256de500201e54/F700FF234143AB10CA25720200161DEC/$FILE/86-117a064.pdf).

¹²⁹ Groves, *supra* note 115, at 21.

R

¹³⁰ See *id.*

¹³¹ Corrections Act, 1986, *supra* note 127. "(1) This section applies if a prisoner in a prison or a person detained in a police gaol is transferred from the prison or police gaol to— (a) an approved mental health service within the meaning of the Mental Health Act 1986 in accordance with that Act." *Id.*

¹³² See Groves, *supra* note 115, at 21 (describing the provisions as "vague").

R

¹³³ *Id.*

¹³⁴ See *id.* (stating that both charters lack enforcement mechanisms). Prisoners in the U.K. face similar procedural obstacles. See Feldman, *infra* note 253.

R

¹³⁵ Groves, *supra* note 115, at 23.

R

III. INTERNATIONAL STANDARDS FOR TREATING THE INCARCERATED MENTALLY ILL

A. *Generally-Applicable International Human Rights Standards*

Through a handful of resolutions and principles, articulating basic standards necessary to adequately treat the needs of mentally ill prisoners, in the last half-century international human rights law has evolved to more squarely address the needs of this disadvantaged population. The Universal Declaration of Human Rights (UDHR),¹³⁶ the International Covenant on Civil and Political Rights (ICCPR),¹³⁷ the Covenant on Economic, Social and Cultural Rights (CESCR),¹³⁸ and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture)¹³⁹ all generally speak of the rights extended to mentally ill prisoners.¹⁴⁰ Yet, the degree to which these instruments have been integrated and synthesized with the domestic laws and policies in their party countries, including the United States, United Kingdom, and Australia, is the subject of constant debate and controversy.¹⁴¹

¹³⁶ The Universal Declaration of Human Rights, G.A. Res. 217A, U.N. GAOR, 3d Sess., 1st plen. mtg., U.N. Doc. A/810 (Dec. 12, 1948) [hereinafter UDHR], available at <http://www.un.org/Overview/rights.html> (e.g., “Article 1: All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.”).

¹³⁷ International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), at 51, U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (Mar. 23, 1976), 999 U.N.T.S. 171 [hereinafter ICCPR], available at <http://www1.umn.edu/humanrts/instate/b3ccpr.htm> (e.g., “Art. 1(1) 1. All peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.”).

¹³⁸ Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), at 49, 21 U.N.GAOR Supp. No.16., U.N. Doc. A/6316 (Jan. 3, 1976), available at http://www.unhchr.ch/html/menu3/b/a_ceschr.htm (CESCR generally concerns the right to work and earn a decent living and states in Part 1, Art. 1: “All peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.”).

¹³⁹ Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, G.A. Res. 39/46, at 197, Annex, 39 U.N. GAOR Supp. No. 51), U.N. Doc. A/39/51 (June 26, 1987), available at <http://www.ohchr.org/english/law/cat.htm>.

¹⁴⁰ ILL-EQUIPPED, *supra* note 1, at 204.

¹⁴¹ See, e.g., Yuval Shany, *How Supreme is the Supreme Law of the Land, Comparative Analysis of the Influence of International Human Rights Treaties Upon the Interpretation of Constitutional Texts by Domestic Courts*, 31 BROOK. J. INT’L L. 341, 347 (2006). The extent to which countries have a duty to integrate international human rights norms into their own domestic laws based on a resolution such as the ICCPR has been considered widely. *Id.* Conservative scholars and human rights entities have expounded that “the treaties do

B. *International Instruments Speaking Directly to Prisoners' Rights*

The UDHR first established baseline rights for the incarcerated, regardless of mental health status, by resolving that “[n]o one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.”¹⁴² The ICCPR, ratified by the United States in 1988 with limiting reservations, affirms this UDHR principle and presents an especially thorough framework for protecting prisoners from mistreatment and abuse by dealing with issues such as the right to a fair trial and the right to be free from arbitrary detention.¹⁴³ Article 7 of the ICCPR, which is specifically applicable to prison officials’ interactions with individual prisoners and the general conditions of incarceration, echoes the values espoused in the UDHR in that, “[n]o one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.”¹⁴⁴ ICCPR, Article 10, also imposes *affirmative* obligations on prison authorities by stating in Section 1 that “[a]ll persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.”¹⁴⁵ Article 10, Section 3 further asserts that “[t]he penitentiary system shall comprise treatment of prisoners the essential aim of which shall be their reformation and social rehabilitation.”¹⁴⁶

C. *Lack of Independent Standards Regarding the Rights of Mentally Ill Prisoners*

Unfortunately, no *independent* international treaty specifically articulates the rights and specific treatment obligations owed to prisoners.¹⁴⁷ Also, the main documents regarding prisoner treatment and prison management “are not treaties, and are therefore

not introduce a duty to incorporate human rights by way of specific legislation, and that states have a wide margin of discretion in determining how to give effect to their treaty obligations in this area.” *Id.*

¹⁴² UDHR, *supra* note 136, at art. 5; *see also*, Danielle Drissel, *Massachusetts Prison Mental Health Services: History, Policy and Recommendations*, MASS. L. REV. 107, 107 (2003) (describing the UDHR’s general protection for the incarcerated).

¹⁴³ ILL-EQUIPPED, *supra* note 1, at 204; *see* ICCPR, *supra* note 137.

¹⁴⁴ ILL-EQUIPPED, *supra* note 1, at 204.

¹⁴⁵ ICCPR, *supra* note 137, at art. 10(1).

¹⁴⁶ *Id.* at art. 10(3).

¹⁴⁷ *See* Groves, *supra* note 115, at 24 (“[T]here is no international treaty that deals solely, or in great detail, with the rights or treatment of prisoners.”).

R

R

R

R

R

2008] *STANDARDS FOR MENTALLY ILL PRISONERS* 437

not binding in international law.”¹⁴⁸ Scholars acknowledge that enforcing human rights norms in domestic courts is relatively more effective than enforcement through the less-forceful compliance mechanisms available at the more abstract international level, such as “through treaty bodies such as United Nations (UN) Committees, or inter-state communications, which are less accessible to individual victims and less likely to generate compliance by the state in question.”¹⁴⁹ Nonetheless, this Note attempts to enumerate the international standards in order to furnish a cross-section of the most influential and detailed sources of guidance on treatment standards for prisons and prisoners.¹⁵⁰ Countries may invoke these international standards to “raise the bar(s)” in correctional mental health care.

D. *International Standards Speaking Directly to
Correctional Mental Health Treatment*

The United Nations has elaborated on the rights of those deprived of liberty to guide governments on how they may fulfill their international human rights obligations in treating mentally ill inmates.¹⁵¹ These documents include the United Nations Standard Minimum Rules for the Treatment of Prisoners (Standard Minimum Rules),¹⁵² adopted by the Economic and Social Council in 1957, the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (BPPAP),¹⁵³

¹⁴⁸ *Id.* (Hence, the term “instruments” or “standards” are used).

¹⁴⁹ Shany, *supra* note 141, at 349. Furthermore, “note that the decisions of UN treaty bodies are not even legally binding.” *Id.* at 349–50.

¹⁵⁰ The “various model rules and guidelines provide the most detailed and influential source of international guidance on prisons and prisoners.” Groves, *supra* note 115, at 24.

¹⁵¹ ILL-EQUIPPED, *supra* note 1, at 205.

¹⁵² Standard Minimum Rules for the Treatment of Prisoners, U.N. Doc. A/CONF/611, Annex I (Aug. 30, 1955), E.S.C. Res. 663C, 24 U.N. ESCOR Supp. (no. 1) at 11, U.N. Doc. E/3048 (1957), amended E.S.C. Res. 2076, 62 U.N. ESCOR Supp. (no. 1) at 35, U.N. Doc. E/5988 (1977) [hereinafter Standard Minimum Rules], available at http://www.unhchr.ch/html/menu3/b/h_comp34.htm; see *Estelle*, 429 U.S. at 104 (1976) (citing the Standard Minimum Rules 22–26 in the context of discussing prisoner rights).

¹⁵³ 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) [hereinafter Body of Principles], available at http://www.unhchr.ch/html/menu3/b/h_comp36.htm. The Body of Principles is not a convention or treaty as it lacks the binding force of international law, but it does declare that “Member States should attempt to make ‘all efforts’ to ensure that the principles become ‘generally known and respected.’” Groves, *supra* note 115, at 28. The Body of Principles has been articulated in relatively general terms, in contrast to the Standard Minimum Rules, which contains far

R

R

R

R

adopted by the U.N. General Assembly in 1988, and the Basic Principles for the Treatment of Prisoners (BPTP),¹⁵⁴ adopted by the U.N. General Assembly in 1990.¹⁵⁵ Principle 9 of the BPTP declares that “[p]risoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.”¹⁵⁶ Furthermore, under BPPAP prison officials are required to provide inmates with a medical screening, free medical care, and treatment.¹⁵⁷

The Standard Minimum Rules more specifically outline the rights of prisoners with regard to their mental health¹⁵⁸ and are considered the most widely known U.N. declaration concerning the treatment of prisoners, “drafted primarily to provide standards that could be incorporated into the national penal codes of individual nations, with adaptations as required by the [respective country’s] political, social and legal circumstances.”¹⁵⁹

1. *Standard Minimum Rules Provisions Affording Mentally Ill Prisoners Important Treatment Rights*

Paragraph 49, Section 1 of the Standard Minimum Rules addresses the issue of adequacy of mental health correctional staff, regarding expertise and numbers, by stating that “[s]o far as possible, the personnel shall include a sufficient number of specialists such as psychiatrists, psychologists, social workers, teachers and trade instructors.”¹⁶⁰ Paragraph 62 also states that “[t]he medical services of the institution shall seek to detect and shall treat any

more specific provisions, so as to apply in a wider variety of circumstances such as juvenile detentions or the detaining of an inmate based on a psychiatric diagnosis. *See id.*

¹⁵⁴ 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) [hereinafter Basic Principles], available at <http://www1.umn.edu/humanrts/instree/g2bpt.htm>.

¹⁵⁵ Compiled in ILL-EQUIPPED, *supra* note 1, at 204–05 (“While these instruments are not treaties, they constitute authoritative guides to the content of binding treaty standards and customary international law.”).

¹⁵⁶ Basic Principles, *supra* note 154, principle 9.

¹⁵⁷ Body of Principles, *supra* note 153, principle 24.

¹⁵⁸ ILL-EQUIPPED, *supra* note 1, at 205.

¹⁵⁹ Groves, *supra* note 115, at 24.

¹⁶⁰ Standard Minimum Rules, *supra* note 152, para. 49(1). Exemplifying a violation of the UNSMR standard, *Coleman v. Wilson*, 912 F. Supp. 1282 (E.D. Cal. 1995), was “perhaps the blockbuster decision of the last decade; [Coleman] is to the 90s what *Ruiz* in Texas was for the 70s.” 1998 COHEN, *supra* note 7, at 7.3[1]. The court held that the California Department of Corrections chronically understaffed prison mental health units maintaining one half of the necessary personnel while running a 25 percent staff vacancy rate. *Id.*

R
R
R
R
R
R

2008] *STANDARDS FOR MENTALLY ILL PRISONERS* 439

physical or mental illnesses or defects which may hamper a prisoner's rehabilitation. All necessary medical, surgical and psychiatric services shall be provided to that end."¹⁶¹ Paragraph 63 speaks to the need for individualized treatment;¹⁶² paragraphs 82 and 83 of section B, titled "Insane and Mentally Abnormal Prisoners," expressly advise that mentally ill prisoners should be removed to mental health facilities, observed and treated by specialized medical management, while being placed under the supervision of a medical officer.¹⁶³ Paragraph 83 goes so far as to prescribe that measures should be taken, through coordination with various agencies, to continue psychiatric treatment for mentally ill inmates *after release* along with the "provision of social-psychiatric after-care."¹⁶⁴ Paragraph 22, section 1 calls for institutions to maintain at least one qualified medical officer with basic knowledge of psychiatry.¹⁶⁵ Finally, "medical services should be organized in close relationship to the general health administration of the community or nation,"¹⁶⁶ further demonstrating the values embodied in the Standard Minimum Rules that prisoners deserve comprehensive, quality mental health care on par with general standards.

E. *Compliance Issues in Individual Countries*

Early reports suggested that many U.N. member states were not complying with major portions of the Standard Minimum Rules by either delaying their reports or failing to report on com-

¹⁶¹ Standard Minimum Rules, *supra* note 152, para. 62.

¹⁶² *Id.* para. 63(1) ("The fulfillment of these principles requires individualization of treatment and for this purpose a flexible system of classifying prisoners in groups; it is therefore desirable that such groups should be distributed in separate institutions suitable for the treatment of each group.").

¹⁶³ *Id.* at para. 82.

¹⁶⁴ *Id.* at para. 83 (emphasis added).

¹⁶⁵ *Id.* at para. 22(1).

¹⁶⁶ *Id.* "Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standards as is afforded to those who are not imprisoned or detained." The Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, G.A. Res. 37/194, Annex, 37 U.N. GAOR Supp. (No. 51) at 211, U.N. Doc. A/37/51 (Dec. 18, 1982), available at <http://www1.umn.edu/humanrts/instree/h3pmerhp.htm>. The United States has also noted the importance of parity between community and correctional mental health care services, yet not with direct reference to U.N. standards. See *Health Care Hearing*, *supra* note 25.

R

R

pliance altogether.¹⁶⁷ In order to increase implementation, in 1984 the U.N. Economic and Social Council (ECOSOC) adopted the Procedures for the Effective Implementation of the Standard Minimum Rules for the Treatment of Prisoners, providing that “[s]tates whose standards for the protection of all persons subjected to any form of detention or imprisonment fall short of the Standard Minimum Rules for the Treatment of Prisoners shall adopt the Rules.”¹⁶⁸ According to surveys conducted regarding such implementation, by 1999, states had responded to questionnaires from the U.N. on the status of their implementation of the Standard Minimum Rules, reporting that they had integrated them into domestic legislation—such assertions of compliance, however, have been practically impossible to substantiate without directly observing prison practices.¹⁶⁹

F. *Additional International Instruments Articulating Standards for Correctional Mental Health*

Yet another relevant international instrument, the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles),¹⁷⁰ adopted by the U.N. General Assembly in 1991, have been recognized as “the most complete standards for the protection of the rights of persons with mental disability at the international level.”¹⁷¹ These principles evolved in response to growing international concern about the essential human rights of those suffering from mental illness.¹⁷²

¹⁶⁷ Groves, *supra* note 115, at 25–26.

¹⁶⁸ *Id.* at 26.

¹⁶⁹ *Id.*

¹⁷⁰ Principles for the Protection of Persons with Mental Illnesses and the Improvement of Mental Health Care, G.A. Res. 46/119, 46 U.N. GAOR Supp. (No. 49) at 189, U.N. Doc. A/46/49 (1991) [hereinafter MI Principles], available at <http://www1.umn.edu/humanrts/instree/t2pppmii.htm> (last visited Mar. 17, 2008).

¹⁷¹ Victor Rosario Congo v. Ecuador, Case 11.427, Inter-Am. C.H.R., Report No. 63/99, OEA/Ser.L/V/II.95, doc. 7 rev. at 475, para. 54 n.8 (1998), available at <http://www.law.wits.ac.za/humanrts/cases/1998/ecuador63-99.html>. “These Principles serve as a guide to States in the design and/or reform of mental health systems and are of utmost utility in evaluating the practices of existing systems. Mental Health Principle 23 establishes that each State must adopt the legislative, judicial, administrative, educational, and other measures that may be necessary to implement them.” *Id.*

¹⁷² However, the MI Principles contain several critical limitations in that they contain weak protections against the use of involuntary treatment and there is no overt recognition of one’s right to refuse treatment. Eric Rosenthal & Clarence J. Sundram, *International Human Rights and Mental Health Legislation*, BAZELON CENTER FOR MENTAL HEALTH LAW, 7–8 (Feb. 10, 2003), available at <http://www.mdri.org/report%20documents/NYLaw->

2008] *STANDARDS FOR MENTALLY ILL PRISONERS* 441

Principle 20 directly addresses detained mentally ill criminal offenders by explaining that “[a]ll such persons should receive the best available mental health care as provided in Principle 1. These Principles shall apply to them to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances.”¹⁷³

The European Prison Rules (EPR)¹⁷⁴ comprise an additional, influential, regionally-based,¹⁷⁵ group of guidelines, declared to be a “[r]evised European version of the Standard Minimum Rules for the Treatment of Prisoners,”¹⁷⁶ which pertain to standards of prison conditions and treatment in the U.K. The EPR can serve as yet another model for correctional systems in other countries. The Committee of Ministers, within the Council of Europe, adopted the EPR in 1987, the structure and content being broadly similar to that of the Standard Minimum Rules.¹⁷⁷ “The EPR provide standards for the treatment of prisoners which are lacking in the major European human rights instruments.”¹⁷⁸ In relation to mental health, section 26.1 calls on every institution to make one qualified general practitioner available, to organize medical services in a manner similar to the community or nation, and to “include a psychiatric service for the diagnosis and, in proper cases, the treatment of states of mental abnormality.”¹⁷⁹ The European Committee for Cooperation in Prison Affairs was formed to monitor and report every five years on the implementation of EPR by member states

article.doc. Thus, the MI principles should not be used as a model for crafting domestic legislation but are helpful in considering core minimum standards. *Id.*

¹⁷³ MI Principles, *supra* note 170, Principle 20(2). R

¹⁷⁴ Eur. Consult. Ass., *European Prison Rules*, Rec. No. R(87)3 (1987) [hereinafter *European Prison Rules*], available at <http://www.uncjin.org/Laws/prisrul.htm>.

¹⁷⁵ Some countries have chosen to incorporate the U.N. standards into their own resolutions and statutes, such as the EPR, to account for local customs and values. *See id.*

¹⁷⁶ *Id.*

¹⁷⁷ Groves, *supra* note 115, at 29. Europe has adopted the Standard Minimum Rules outright while keeping them current with their own local guidelines, in contrast to the United States. Sara A. Rodriguez, *The Impotence of Being Earnest: Status of the United Nations Standard Minimum Rules for the Treatment of Prisoners in Europe and the United States*, NEW ENG. J. ON CRIM. & CIV. CONFINEMENT, Winter 2007, at 61, 64. R

¹⁷⁸ Groves, *supra* note 115, at 29. R

¹⁷⁹ *European Prison Rules*, *supra* note 174, § 26.1. Other provisions of the European Prison Rules call for a medical officer to examine every prisoner for mental illness which should be treated. *Id.* §§ 29-30. The EPR also requires the medical officer to notify the prison director if the inmate’s mental health has been or will be negatively affected by continued detainment. *Id.* R

of the European Community (EC).¹⁸⁰ Unfortunately, compliance reports from member states were exclusively distributed to prison administrators¹⁸¹ and thus no public debate ensued regarding governmental attitudes toward the EPR; which in turn exerts no pressure on member states to comply with EPR guidelines.¹⁸²

IV. U.S., U.K., AND AUSTRALIAN INCORPORATION OF
INTERNATIONAL STANDARDS REGARDING THE TREATMENT
OF MENTALLY ILL INMATES: EXAMPLES, LESSONS, AND
WORK TO BE DONE

A. *U.S. on International Standards*

In the United States, “[prison officials] accept the minimum standards for prison conditions and the treatment of prisoners set by the Supreme Court as both a ceiling and a floor.”¹⁸³ International human rights law, on the other hand, “sets affirmative goals for prisoner mental health that challenge prison officials to provide the best mental health services they can to mentally ill prisoners,”¹⁸⁴ requiring humanity, dignity and respect when treating mentally ill inmates.¹⁸⁵ In the United States “there exists deeply imbedded resistance to the idea that texts of a super-legislative nature, such as the Constitution, ought to be construed in light of international law in general, and [international human rights] law in particular.”¹⁸⁶

The United States, in contrast to Europe, has yet to formally adopt the Standard Minimum Rules.¹⁸⁷ Instead, the United States relies on standards formulated by professional organizations¹⁸⁸ and court decisions in which judges have taken heed of the Standard Minimum Rules only in a peripheral manner, in the context of prisoner’s rights litigation.¹⁸⁹ In a rare showing, the Supreme Court in

¹⁸⁰ Groves, *supra* note 115, at 29.

¹⁸¹ *Id.*

¹⁸² *Id.*

¹⁸³ Fellner, *supra* note 58, at 410.

¹⁸⁴ *Id.*

¹⁸⁵ ICCPR, *supra* note 137, art. 10(1).

¹⁸⁶ Shany, *supra* note 141, 343.

¹⁸⁷ See Rodriguez, *supra* note 177, at 64–65 (describing the U.S.’s “indirect” incorporation of the Standard Minimum Rules).

¹⁸⁸ *Id.* One such organization is the National Commission on Correctional Health Care, which monitors the mental health care provided in prisons that voluntarily submit their institutions to audits. See 1998 COHEN *supra*, note 7, at 5.2.

¹⁸⁹ Rodriguez, *supra* note 177, at 64–65.

R

R

R

R

R

R

R

2008] *STANDARDS FOR MENTALLY ILL PRISONERS* 443

Estelle v. Gamble referenced part of the Standard Minimum Rules¹⁹⁰ as support for the assertion that “[t]he infliction of such unnecessary suffering [by not providing a prisoner with medical care] is inconsistent with contemporary standards of decency as manifested in modern legislation.”¹⁹¹ Yet, such references are few and far between. State courts have never explicitly discussed the Standard Minimum Rules with regard to prisons; in recent years, federal courts have rarely cited such standards.¹⁹²

Generally, the United States “is a party to, or at least not opposed to, several international treaties” such as the ICCPR and the Convention Against Torture, however, the United States has attached reservations to these treaties and “failed to pass domestic enabling legislation” for these instruments.¹⁹³ For instance, the United States ratified the ICCPR, but issued an understanding stating that article 10(3) “does not diminish the goals of punishment, deterrence and incapacitation as additional legitimate purposes for a penitentiary system.”¹⁹⁴ In another example, the United States remains a mere signatory but not a party to the International Covenant on Economic, Social and Cultural Rights (ICESCR), which provides that everyone should have the right to enjoy the highest attainable standard of physical and mental health.¹⁹⁵ As a signatory, the United States is nonetheless obliged to refrain from acts that would defeat the object and purpose of the treaty.¹⁹⁶

More recently, in another uncharacteristic display, the Supreme Court discussed the Eighth Amendment with reference to international practices and standards—albeit in the context of capi-

¹⁹⁰ Relevant Standard Minimum Rules provisions include: Rule 22 which requires prisons to maintain at least one competent medical officer on staff with knowledge of psychiatry; Rule 23 which concerns pre- and post-natal care for women prisoners; Rule 24 which requires physical and mental evaluations of prisoners upon admission and; Rule 25 which mandates that sick prisoners, mentally or physically, be attended to on a daily basis. Standard Minimum Rules, *supra* note 152, paras. 22-25.

¹⁹¹ *Estelle*, 429 U.S. at 104, n. 8.

¹⁹² To date, no published state law cases reference the words “Standard Minimum Rules” and “prisoner” among federal cases, just seventeen reference the Standard Minimum Rules either by the court in dicta or by the plaintiff in stating the basis for the claims.

¹⁹³ Martin A. Geer, *Human Rights and Wrongs in Our Own Backyard: Incorporating International Human Rights Protections Under Domestic Civil Rights Law—A Case Study of Women in United States Prisons*, 13 HARV. HUM. RTS. J. 71, 90 (2000).

¹⁹⁴ ILL-EQUIPPED, *supra* note 1, at 204 n.730.

¹⁹⁵ *See id.* at 206 n.744.

¹⁹⁶ *See id.*

R

R

tal punishment. In *Roper v. Simmons*, the Court held that the execution of individuals, who committed capital crimes while under the age of eighteen, is prohibited by the Eighth and Fourteenth amendments.¹⁹⁷ The Court, in devoted an unprecedented amount of the opinion to the point that practically every other nation in the world had ceased subjecting juveniles to the death penalty, save for the United States, stating, “[i]t is proper that we acknowledge the overwhelming weight of international opinion against the juvenile death penalty”¹⁹⁸ Such a bow to the practices and standards of other countries, with regard to criminal justice, indicates the Court may be willing to take heed of international practices when assessing acceptable treatment standards in the realm of correctional mental health.

B. *The United Kingdom on International Standards*

The United Kingdom has taken serious steps to synthesize international human rights standards with the country’s laws and practices in an extremely practical and thorough guide, “A Human Rights Approach to Prison Management—Handbook for Prison Staff.”¹⁹⁹ The guide is aimed at officers, guards, doctors, administrators and other day-to-day service providers in prisons. Jack Straw, the former British Minister responsible for prisons, embodies the governmental commitment to integrating international human rights standards with current practices by stating in the Handbook: “I strongly believe that the way societies treat those who have been deprived of their liberty is a litmus test of commitment to human rights. A wide range of international treaties and standards exist to guide prison services across the world. Britain supports the universal implementation of these agreements.”²⁰⁰ The Handbook further instructs that, “[a]ny medical treatment or nursing care provided by the prison administration should be at least comparable to what is available in the outside community.”²⁰¹

¹⁹⁷ *Roper v. Simmons*, 543 U.S. 551 (2005).

¹⁹⁸ *Id.* at 578.

¹⁹⁹ ANDREW COYLE, A HUMAN RIGHTS APPROACH TO PRISON MANAGEMENT—HANDBOOK FOR PRISON STAFF 3 (King’s College London Int’l Ctr. For Prison Studies 2002) (“This comprehensive handbook aims to translate universally agreed standards on prison reform into practical guidance for prison staff.”).

²⁰⁰ *Id.*

²⁰¹ *Id.* at 51.

2008] *STANDARDS FOR MENTALLY ILL PRISONERS* 445

This statement echoes several international instruments mandating parity between prison and community health care services.²⁰²

The Handbook plainly instructs that “[w]here prisoners are diagnosed as mentally ill they should not be held in prison but should be transferred to a suitably equipped psychiatric facility.”²⁰³ This transfer policy marks one of the greatest contrasts between the U.K. and U.S. systems. In the United States, “[e]xcept when transferred to acute care or hospital settings, prisoners who are mentally ill are typically confined in the same facilities as other prisoners.”²⁰⁴ Furthermore, the European Committee for the Prevention of Torture, of which the United Kingdom is a member, recognizes that inmates whose illnesses dictate the need for hospitalization should be transferred from prisons to mental health hospitals,²⁰⁵ providing a second basis for the U.K. transfer policy in addition to its domestic stance. In the United Kingdom and Australia, transferring mentally ill prisoners to more appropriate environments appears to be the normative approach whereas obstacles in the United States such as bureaucracy, the higher costs of maintaining secure psychiatric facilities, poor training of prison officials, and a general misunderstanding of psychiatric symptoms has yielded devastating results where prisoners languish in prison settings completely ill-suited for either correctional or psychological rehabilitation.²⁰⁶

²⁰² See European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 3rd General Report, § 31, CPT/Inf (93) 12 [EN] (June 4, 1993) (“[P]risoners are entitled to the same level of medical care as persons living in the community at large.” (applying to the U.K.)); see also *Health Care Hearing*, *supra* note 25. “Prisoners and detainees have the same rights to availability, access and quality of mental health care as the general population.” [Australian] National Statement of Principles for Forensic Mental Health 6 (2002), available at http://www.health.wa.gov.au/mhareview/resources/documents/FINAL_VERSION_OF_NATIONAL_PRINCIPLES_FOR_FMH-Aug_2002.pdf.

²⁰³ COYLE, *supra* note 199, at 55.

²⁰⁴ ILL-EQUIPPED, *supra* note 1, at 53.

²⁰⁵ See EUROPEAN COMMITTEE FOR THE PREVENTION OF TORTURE AND INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT, 3RD GENERAL REPORT ON THE CPT’S ACTIVITIES COVERING THE PERIOD 1 JANUARY TO 31 DECEMBER 1992, § 43 (June 4, 1993), available at www.cpt.coe.int/EN/annual/rep-03.htm (“[A] mentally ill prisoner should be kept in a hospital facility which is adequately equipped and possesses appropriately trained staff whether a civil mental hospital or a specially equipped psychiatric facility within the prison system.”).

²⁰⁶ For example, note the case of Timothy Souders:

After his arrest, a state psychologist said Souders (an inmate diagnosed as bipolar) was trying to manipulate the staff when he stabbed himself seven times in the stomach in a suicide attempt. Months later, in solitary, there was no psychi-

R

R
R

U.K. courts have explicitly considered their own laws in relation to international standards when assessing the rights of mentally ill inmates. In *R. v. London North and East Region Mental Health Review Tribunal*,²⁰⁷ the Court, in evaluating the appeals process available to mentally ill inmates challenging their detention, issued a declaration of incompatibility between Britain's Human Rights Act of 1988, the U.K.'s statutory integration of the European Convention for the Protection of Human Rights and Fundamental Freedoms, and the MHA.²⁰⁸ Section 73 of the MHA placed an unduly heavy burden on the appellant to prove he no longer suffered from mental illness; such a burden was held to be irreconcilable with the liberty right²⁰⁹ of the European Convention's Article 5.²¹⁰

In yet another showing of U.K. dedication to harmonizing its laws with international human rights aims, the House of Lords in *Drew*²¹¹ held that "an automatic life sentence [of detaining an individual in a hospital for treatment] imposed under Powers of Criminal Courts (Sentencing) Act 2000, s.109, was *not incompatible* with Article 3 of the European Convention on Human Rights if it did not deny a mentally disordered defendant the medical treatment required."²¹² Section 47 of the MHA empowered the Home Secretary to transfer the defendant to the hospital from prison for medical treatment so long as such actions were in compliance with the Convention.²¹³ Regarding mentally ill prisoners' rights, then, the MHA was judicially interpreted in light of the standards set forth by the European Convention on Human Rights.

atric intervention, even when Souders was raving. A social worker wanted him transferred to a hospital, but the paperwork never got done. The guards resorted again to chains, which the federal judge overseeing the prison criticized as "punitive restraints."

60 *Minutes*, *supra* note 20.

²⁰⁷ *R. v. London North and East Region Mental Health Review Tribunal*, 3 W.L.R. 512 (2001).

²⁰⁸ Megan Davis & George Williams, *A Statutory Bill of Rights for Australia? Lessons from the United Kingdom*, 22 U. QUEENSL. L.J. 1, 11 (Jan. 1, 2002).

²⁰⁹ The "[r]ight to liberty and security" concerns the standards for lawful arrests and detentions within the European Convention on Human Rights.

²¹⁰ Davis & Williams, *supra* note 208, at 11.

²¹¹ *R. v. Drew (Anthony James)* [2004] Crim. App. 65, 84 (2004).

²¹² D.A. Thomas, Case Comment, *Sentencing: Life Imprisonment—Hospital and Limitation Directions*, 6 CRIM. L. REV., 455, 457 (2006) (emphasis added).

²¹³ *Id.*

R

R

2008] *STANDARDS FOR MENTALLY ILL PRISONERS* 447

Although British legislators, judges, and prison officials have taken active steps to incorporate international human rights standards into domestic law concerning the treatment of the mentally ill, the United Kingdom, like the United States and Australia, can still do more. For example, the United Kingdom has not ratified the optional protocol to the ICCPR, “which allows individuals a right to petition the United Nations Human Rights Committee,” indicating that the British government’s commitment to human rights could arguably be stronger.²¹⁴ As for the EPR, it is not a treaty and does not pose binding obligations on its European Council member states like the United Kingdom,²¹⁵ not to mention its lack of enforcement mechanisms. Thus, European courts have generally avoided according the EPR any great deference.²¹⁶ The EPR does, however, articulate a concrete set of principles, providing guidance for those striving to improve prison conditions.²¹⁷

The Prison Reform Trust of England has published a comprehensive comparative analysis of the Prison Rules (1964) of England and the EPR, in effort to “highlight the inadequacy of the English rules by reference to the more detailed and progressive EPR,” which has, thus far, failed to incite British officials to conduct substantial review of current prison laws.²¹⁸ Exemplifying an emerging positive trend, the U.K. Joint Committee on Human Rights has integrated the guidance of the Committee for the Prevention of Torture (CPT) on at least one occasion, by noting that despite the CPT recommendation “that a doctor qualified in psychiatry be attached to the health service of each prison, most prisoners [in the U.K.] with mental health problems are attended to by doctors lacking such qualifications.”²¹⁹ This practice of explicitly highlighting the discrepancies between national practice and international standards is a critical first step toward correcting and improving psychiatric treatment in U.K. prisons.

As for the MHA’s compatibility with international human rights standards, the U.K. formed a Joint Committee on Human

²¹⁴ John Wadham, *The Human Rights Act: One Year On*, 6 EUR. HUM. RTS. L. REV. 620, 622 (2001).

²¹⁵ Groves, *supra* note 115, at 30.

²¹⁶ *Id.* at 31.

²¹⁷ *Id.*

²¹⁸ *Id.*

²¹⁹ Joint Committee on Human Rights, Sixth Report, Mental Health Act 1983 (Remedial) Order 2001 (2001-02 H.L. 57, H.C. 472), available at <http://www.publications.parliament.uk/pa/jt200203/jtselect/jtrights/67/67ap19.htm>.

Rights to review information submitted about statutes and evaluate legislation from a human rights standpoint.²²⁰ As of January 2002, the Joint Committee solicited comments on the human rights aspects of all Bills under consideration by inviting the views of concerned non-governmental organizations and academics.²²¹ The Human Rights Act of 1998,²²² the basis for the Joint Committee's appraisal of legislation, came into force in 2000 as a means for importing the European Convention on Human Rights²²³ into U.K. domestic law.²²⁴

When [the Joint Committee] examined the only draft remedial order so far laid before Parliament, to amend the Mental Health Act 1983 in the light of a declaration of incompatibility (between the Human Rights Act and Sections of the Mental Health Act) made by the Court of Appeal,²²⁵ the Committee wrote to a significant number of relevant organisations and expert individuals asking for their views, which were taken into account when the Committee wrote to the Minister in the Department of Health to express certain concerns about the draft order. . . .²²⁶

²²⁰ David Feldman, *Parliamentary Scrutiny of Legislation and Human Rights*, PUBLIC LAW 323, 333 (2002) (“[T]he Joint Committee on Human Rights has regularly received representations and submissions about Bills from individuals who are affected by Bills . . .”).

²²¹ *Id.*

²²² Human Rights Act, 1998, c. 42 (Eng.) available at <http://www.opsi.gov.uk/ACTS/acts1998/19980042.htm>.

²²³ European Convention on Human Rights, Nov. 4, 1950, 213 U.N.T.S. 222, available at <http://www.hri.org/docs/ECHR50.html>. Yet, the European Conventions' limitations have been raised since the “European Court of Human Rights [which enforces the European Convention on Human Rights] has allowed force-feeding and physical restraint, by prolonged strapping to a bed, as ‘medically justified’ and *declined to find that very poor conditions in prison hospitals or secure units were inhuman or degrading.*” Jonathan Bindman et al., *The Human Rights Act and mental health legislation*, 182 BRIT. J. PSYCHIATRY 91, 91 (2003) (emphasis added).

²²⁴ See Bindman et al., *supra* note 223, at 91.

²²⁵ In one example of a U.K. court's attempt to synthesize international treatment rights with domestic law, in response to the requirement that a patient carry the burden to establish that he should no longer be detained, the court responded that such a requirement, imposed by the Mental Health Act 1983, infringed his right to liberty under article 5(1)(4) of the European Convention for the Protection of Human Rights and Fundamental Freedoms. See *R. (on the Application of H) v. Mental Health Review Tribunal for North and East London Region*, [2001] 3 W.L.R. 512 (2001). The Court addressed how compliance could be obtained with article 5(1)(4) which would “require the tribunal to discharge a patient where it could not be shown that he suffered from a mental disorder warranting detention.” *Id.*

²²⁶ David Feldman, *supra* note 220, at 233.

2008] *STANDARDS FOR MENTALLY ILL PRISONERS* 449

Such communication among an official governmental committee, human rights experts, and the coordinated Department of Health, regarding the degree to which mental health legislation comports with human rights standards, reflects a highly proactive approach to conforming U.K. practices with overarching commitments to human rights for mentally ill prisoners. However, the courts may trump the committee's opinion on a bill's compatibility with human rights standards.²²⁷ Overall, "although the jurisprudence of the European Court of Human Rights has had some impact on the Mental Health Act 1983 and its interpretation, it has not set a high standard for modern mental health services," according to certain experts in the psychiatry field.²²⁸

C. *Australia on International Standards*

Australia has generally taken note of international human rights obligations and has paid particular attention to mentally ill prisoners' rights. For example, in 2004 the Australian Capital Territory passed the Human Rights Act, which protects the same rights articulated in the ICCPR.²²⁹ Thus, pursuant to the Human Rights Act, the Australian Human Rights Committee is enabled to report on the status of rights in Australia, which provides one avenue to conform the country's practices with ICCPR provisions.²³⁰ However, the broad international instruments relevant to prisons and prisoners have received considerably less attention in Australia when compared to the great amount of judicial scrutiny directed at prison officials' disciplinary actions.²³¹

²²⁷ "[W]hen the Joint Committee on Human Rights expresses reservations about the government's reasons for thinking that a provision in a Bill is, or will be implemented in a manner which is, compatible with Convention rights, it does not suggest categorically that the provision is incompatible. The separation of powers establishes that only a court can make a final decision on that matter." *Id.* at 332.

²²⁸ Bindman et al., *supra* note 223, at 91.

²²⁹ See Brian Walters, *Going the Wrong Way on Rights*, THE AGE ONLINE, July 20, 2006, <http://www.theage.com.au/news/opinion/going-the-wrong-way-onrights/2006/07/19/1153166452454.html> (describing the different steps of Australia's territories to pass legislation actualizing the ICCPR).

²³⁰ See *id.* "The Human Rights Committee has found 23 violations by Australia in recent times." *Id.*

²³¹ See generally Groves, *supra* note 115 (providing an examination of the international instruments dictating the treatment of prisoners, the legal effect of such instruments, and the degree to which international law can affect the management and treatment of Australian prisoners).

R

R

The High Court of Australia has broadly declared that “[w]hen the common law or statutory provisions are unclear . . . it is permissible for Australian courts to inform themselves about any suggested infractions of fundamental rights.”²³² Australia has ratified the First Optional Protocol to the ICCPR, effectively subjecting the country’s laws to the scrutiny of the U.N. Human Rights Committee.²³³ In another case, appellant’s counsel argued for the importation of several international standards, such as the Standard Minimum Rules and the ICCPR, to determine that a prisoner’s “mental illness made imprisonment more burdensome for him, and constituted punishment over and above that which was contemplated by the sentencing judge,” arguing that “forensic mental health facilities in Victoria fall short of international legal standards.”²³⁴ During oral argument, however, appellant’s counsel abandoned any reliance on these international treatment obligations by “correctly [according to the court] conced[ing] that none of the material which related to the general state of mental health facilities, national guidelines or international standards enlarged the appellant’s common law rights.”²³⁵ Thus, Australian courts have not been entirely sympathetic to prisoners’ invocations of international legal standards in making their claims for improved mental health care treatment.

Decisions that have questioned the congruence between general Australian prison practices and international standards provide insight as to how courts would handle similar issues involving mentally ill prisoners. For instance, in *Collins v. South Australia*, a plaintiff inmate challenged the prison’s practice of placing him with another inmate, in violation of the Standard Minimum Rules provision that “each prisoner shall occupy by night a cell by himself, except where special reasons exist.”²³⁶ The Court held that the

²³² *Vasiljkovic v. Commonwealth*, [2006] 228 A.L.R. 447, at para. 159 (concerning the extradition of a Croatian citizen charged of war crimes in his home country).

²³³ *Id.*

²³⁴ *R. v. Michael David Jones*, VSCA 266, 2006 WL BC200609879, para.10. “It was submitted that ‘breaches of international standards which may result in a prisoner suffering more than usual hardship in prison or being punished while in jail beyond that entailed by the deprivation of liberty should be taken into account in the exercise of the sentencing discretion.’” *Id.*

²³⁵ *Id.* para.11. “When considering the burden of imprisonment on an offender who requires psychiatric care, allowance may be made for the limited nature and quality of treatment available within our correctional institutions.” *Id.*

²³⁶ *Collins v. South Australia*, 74 SASR 200, 1999 WL 33629845 (handed down by the Supreme Court of the Territory of South Australia).

2008] *STANDARDS FOR MENTALLY ILL PRISONERS* 451

plaintiff's evidence presented a breach of the Rules, yet declared that "[t]he Minimum Rules are not a convention, treaty or covenant. They do not impose obligations on signatories. They merely declare principles. Consequently there are no obligations in International Law arising from them."²³⁷ The decision further stated, "[i]t is well established that the provisions of an international treaty to which Australia is a party do not form part of Australian law unless those provisions have been validly incorporated into our municipal law by statute"²³⁸ based on the "proposition that in our constitutional system the making and ratification of treaties fall within the province of the Executive."²³⁹ Accordingly, *Collins* announced that "a treaty which has not been incorporated into our municipal law cannot operate as a direct source of individual rights and obligations under that law."²⁴⁰ Thus, *Collins* stands as a significant obstacle to mentally ill prisoners who rely on international standards such as the Standard Minimum Rules to prompt Australian courts to improve prison health care.

The *Collins* Court nevertheless acknowledged that the Standard Minimum Rules were used in creating a local policy guide, the Standard Guidelines for Corrections in Australia 1996,²⁴¹ by incorporating principles from the Council of Europe's Standard Minimum Rules, while accounting for certain approaches to corrections unique to Australia.²⁴² The Court specifically noted that the Standard Guidelines for Corrections were prefaced by the statement:

These guidelines are not intended to be law or to be treated as absolute; they are for guidance. Whilst ultimately the desirable level of implementation is a political decision based on legislative provisions, government policies and the availability of resources, the guidelines do provide a base for protecting human rights in Corrections in Australia.²⁴³

The Court used this statement to render the Guidelines and Standard Minimum Rules lacking in force of law and therefore in-

²³⁷ *Id.* at 207–08.

²³⁸ *Id.* at 208.

²³⁹ *Id.*

²⁴⁰ *Id.* ("The Minimum Rules have not been enacted nor are they a schedule to any current State or Commonwealth law.")

²⁴¹ See *infra* note 250, for information on the Standard Guidelines and the relevant provisions regarding prisoner mental health treatment.

²⁴² *Collins*, 74 SASR at 208.

²⁴³ *Id.*

sufficient as a pillar for the plaintiff's arguments.²⁴⁴ Yet, the Court acknowledged such extra-judicial standards and deferred to political entities to enact such rights. In another example, the Commonwealth communicated to the Royal Commission into Aboriginal Deaths in Custody that the Standard Minimum Rules are not binding in international law but that they still establish a set of minimum guidelines.²⁴⁵

On the other hand, the Australian government has effectuated its commitment to correctional mental health through legislative channels. Australia appointed a Senate Select Committee on Mental Health (Select Committee), which recently examined the quality of mental health care for inmates.²⁴⁶ The Select Committee affirmed the findings of a much-relied-upon 1993 report, the "National Inquiry into the Human Rights of People with Mental Illness" ("Burdekin Report"), which stated that the rights of mentally ill people in the criminal justice system are indeed covered by: the ICCPR; the Convention Against Torture; the BPPAP; and the MI Principles.²⁴⁷ The Select Committee further recognized the work of individual state and territories where international principles for safeguarding the rights of mentally ill inmates were incorporated into local legislation.²⁴⁸ This answered the concerns of the *Collins* Court regarding whether international standards must be legitimately animated by lawmakers.

²⁴⁴ *Id.*

²⁴⁵ Groves, *supra* note 115, at 27.

²⁴⁶ The Senate Select Committee on Mental Health recently published a report on mental health, devoting an entire chapter to "Mental health and the criminal justice system." PARLIAMENT OF AUSTRALIA, SENATE SELECT COMMITTEE ON MENTAL HEALTH, FIRST REPORT: A NATIONAL APPROACH TO MENTAL HEALTH—FROM CRISIS TO COMMUNITY, Mar. 30, 2006, available at http://www.aph.gov.au/Senate/committee/mentalhealth_ctte/report/c13.htm.

²⁴⁷ *Id.*

²⁴⁸ *Id.*

The evidence demonstrates that state and territory governments are making progress in their endeavours to incorporate or reflect the above principle [e.g., the National Statement of Principles for Forensic Mental Health] in legislation. . . . The South Australian Department of Health, for example, stated that among its achievements was a review of the Mental Health Act and of section 269 of the Criminal Law Consolidation Act, and New South Wales is currently conducting a comprehensive review of the Mental Health Act 1990 [NSW]. . . . *It is not clear, however, that the reforms made in all jurisdictions to date have been sufficient to adequately reflect the UN Principles.*

Id. (emphasis added).

2008] *STANDARDS FOR MENTALLY ILL PRISONERS* 453

Despite Australia's dedication to complying with international standards in treating mentally ill prisoners, greater progress can still be made. For example, New South Wales (NSW) is the only Australian jurisdiction, and one of only a few in the western world, to hospitalize forensic patients within the precincts of a correctional facility, under the authority of corrections personnel, in violation of the Standard Minimum Rules which requires that "[p]ersons who are found to be insane shall not be detained in prisons."²⁴⁹ However, the fact that only one Australian jurisdiction currently houses mentally ill prisoners in correctional facilities, rather than in a secure hospital unit, suggests that the remaining Australian jurisdictions are indeed complying with the Standard Minimum Rules and other corresponding international standards which assert that mentally ill prisoners should receive care in more appropriately-resourced settings, outside of prisons and jails.

As discussed and referenced by the courts, the Australian government developed Standard Guidelines for Corrections in Australia (Australian Guidelines),²⁵⁰ a set of model rules which were fashioned after the Standard Minimum Rules and the EPR, yet the Australian Guidelines include several additional provisions dictating standards of care above and beyond the international requirements.²⁵¹ Unfortunately, "[t]he *Australian Guidelines* have been approved and adopted by Australian prison administrators but have not been incorporated into legislation and clearly do not have

²⁴⁹ Duncan Chappell, *Protecting the Human Rights of the Mentally Ill: Contemporary Challenges for the Australian Criminal Justice System*, 1 *PSYCHOLOGY, PSYCHIATRY AND LAW* 1, 17 (2004).

²⁵⁰ Australia, The Corrective Services Ministers' Conference, Standard Guidelines for Corrections in Australia (3d ed. 2004), available at http://aic.gov.au/research/corrections/standards/aust-stand_2004.pdf. Relevant provisions include:

1.3) All prisoners should be screened upon admission to enable the prison management to make an initial health and psychological assessment in order to identify and provide appropriate intervention for any pressing medical (including drug, alcohol or mental health) and welfare concerns. (p. 13);

2.32) Health professionals should advise the officer in charge of the prison whenever it is considered that a prisoner's physical or mental health has been, or will be, injuriously affected by continued imprisonment or by any condition of imprisonment, including where a prisoner is being held in separate confinement. (p. 21);

2.37) Prisoners who are suffering from mental illness or an intellectual disability should be provided with appropriate management and support services. (p. 21).

²⁵¹ Groves, *supra* note 115, at 31.

the force of law.”²⁵² Thus, the Australian Guidelines, however innovative and exemplary they may be in practically modeling the values of international human rights standards still fall short. For example, the Australian Guidelines fail to squarely address the consequences of breaching its provisions and lack specific remedies prisoners can seek for violations.²⁵³

The Human Rights and Equal Opportunity Commission (HREOC) of Australia plays an instrumental role in protecting and enforcing human rights for many individuals, including prisoners with mental illness.²⁵⁴ The HREOC, however, is limited in that it “may not make binding decisions as to any issue between the parties to a complaint,”²⁵⁵ sharply curtailing its power. When human rights violations are raised, HREOC’s jurisdictional reach and investigatory powers extend only to the acts or practices of Commonwealth agencies,²⁵⁶ further inhibiting mentally ill prisoners from effectively bringing claims against prisons for mistreatment under international human rights standards. Generally, Australia has taken seriously the international human rights standards with reference to mentally ill prisoners, yet the courts have often called on legislators to codify such guarantees, as they are currently difficult to enforce in practice.

²⁵² *Id.*; *accord*, Collins v. South Australia, 70 S.A. St. R. 200, 208 (1999).

²⁵³ Groves, *supra* note 115, at 31–32. In the U.K. the same challenge arises where it is difficult to determine a clear route for a prisoner to bring an action alleging that prison treatment of inmates, under relevant statutes, violates international human rights standards.

If a litigant challenges a decision to continue to detain him compulsorily under the Mental Health Act 1983 on the ground that the decision violates a Convention right . . . the argument can be addressed to the Mental Health Appeal Tribunal, but if that tribunal finds a violation it will have no power to award compensation for it unless the Minister for Health makes rules under clause 7(11) allowing it. . . . [*t*he outcome could be very complicated.

David Feldman, *Remedies for Violations of Convention Rights Under the Human Rights Act*, EUR. HUM. RTS. L. REV. 707 (1998) (emphasis added).

²⁵⁴ Groves, *supra* note 115, at 33–34.

²⁵⁵ Groves, *supra* note 115, at 35. See e.g., Cabal v. United Mexican States, FCA 1892 (2000) (unreported) (“Gray J declined to accord any weight to the preliminary findings of HREOC, which were formulated during an inquiry into the conditions under which Cabal was held, in determining whether harsh prison conditions and prolonged detention constituted ‘special circumstances’ for the grant of bail.”).

²⁵⁶ Groves, *supra* note 115, at 35 (“The vast majority of prisoners are held pursuant to sentences for offences committed under State and Territory law, and therefore remain beyond the jurisdiction of HREOC.”).

R

R

R

R

V. CONCLUSION

The U.N. has played a central role in formulating guidelines and expectations regarding the character and quality of treatment that mentally ill prisoners should receive, based on universal values of dignity and respect. The United States, United Kingdom, and Australia have all played a role, as signatories or parties, in the international human rights instruments discussed. The degree to which each country has concretely integrated those obligations into their own domestic laws and policies, through legislative and litigative channels, varies dramatically, with the United States often standing in last place in terms of judicial, legislative, and practical adherence to U.N.-sponsored human rights declarations concerning prisoner mental health.

The large number of inmates, several million, in the United States presents a seemingly insurmountable logistical obstacle to providing quality mental health treatment for mentally ill prisoners, who number in the hundreds of thousands. The U.S. prison system is simply overloaded, physically and financially, and reform has taken place predominantly in the guise of slow-moving, class-action litigation before justices who are generally unconvinced of the authoritativeness of international human rights standards. Only recently have U.S. legislators, through MIOTCRA, begun examining alternative routes for handling mentally ill individuals. MIOTCRA represents an important and unprecedented legislative effort to circumvent the narrow channel of rights afforded through the Eighth Amendment. Comprehensive, coordinated treatment for mentally ill individuals obviates the fate of entanglement with an ill-equipped criminal justice system.

The prison systems in the United Kingdom and Australia, although smaller in scale, have nonetheless taken more proactive steps to directly implement policies and practices in accord with human rights standards. Although judicial support for the authoritativeness of international standards has been somewhat weak, U.K. and Australian policymakers are prompted and encouraged to step in before litigation becomes necessary. Statutes and legislative pronouncements are paying greater heed to international human rights standards, even though causes of action for rights violations are difficult to bring successfully.

The U.K. guide "A Human Rights Approach to Prison Management," endorsed by U.K. government officials and embraced by

456 *CARDOZO J. OF INT'L & COMP. LAW* [Vol. 16:409

ground-level practitioners, embodies the values espoused by international human rights instruments and represents what is possible. This guide also hints at another key tactic used in improving conditions for mentally ill prisoners—constantly examining the practices and policies of *other* countries to see what works effectively to address the needs of the incarcerated mentally ill and aid individuals, such as Prisoner 1,²⁵⁷ who are suffering inhumane existences.²⁵⁸

²⁵⁷ See *supra* note 1.

²⁵⁸ The U.K. Guide notes that “[t]he Corrections Health Service of New South Wales in Australia, an organization separate from the prison system but working closely with it to provide health services to all prisoners in New South Wales prisons, produced a Code of Conduct and Ethics for its staff in 1999,” demonstrating the kind of world-wide best practices inquiry necessary for raising the overall level of care. COYLE, *supra* note 199, at 22, 27.