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Prison Conditions and Inmate Competency to Waive Constitutional Rights

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I. INTRODUCTION

There are hundreds of thousands of mentally ill men and women in United States jails and prisons, and the proportion of incarcerated individuals with serious mental illnesses is growing. The Bureau of Justice estimates that more than half of all inmates suffer from some sort of psychological condition, and the number of mentally ill people in prison is three times larger than the entire population of those in mental health hospitals. Of those who were not mentally ill when they entered prison, “15-20% will require some form of psychiatric intervention during their incarceration.” Almost all of these persons will need psychiatric treatment as a result of their experiences in solitary confinement. In Oregon, New York, California, and Washington, approximately one-quarter of all inmates in solitary confinement suffer from mental illness; in Iowa and Indiana, that proportion stands at one-half. Despite these astounding
statistics, few courts have ever questioned the competency of these individuals when they seek to waive constitutional rights after being placed in solitary confinement.

This essay argues that courts must revisit the question of competency whenever an inmate who has been subjected to solitary confinement seeks to waive constitutional rights. Although subjecting a person to solitary confinement may not violate the Eighth Amendment’s prohibition on cruel and unusual punishment, it may nevertheless impair an inmate’s exercise of constitutional rights by undermining his mental health and thus his capacity to appreciate the waiver of his core rights. To the extent that it does, allowing inmates to proceed without re-evaluating their competency at new junctures threatens the integrity of the judicial system and undermines the reliability of the adversarial process.

II. A BRIEF HISTORY OF SOLITARY CONFINEMENT AND SUPERMAX PRISONS

No formal definition of solitary confinement exists, however, it is typically described as the confinement of an inmate to a cell for all, or nearly all, of the day, with minimal or no environmental stimulation or opportunity for social interaction. Chase Riveland, a former Secretary of Corrections in Washington State and Colorado, has described the modern adaptation of solitary confinement as follows:

a highly restrictive, high-custody housing unit within a secure facility, or an entire facility, that isolates inmates from the general prison population and from the general prison population and from each other due to grievous crimes, repetitive assaultive or violent institutional basis, the threat of escape or actual escape from high-custody facility(s), or inciting or threatening to incite disturbances in a correctional institution.

Riveland terms this form of modern-day solitary confinement as “supermax.” Indeed, inmates in such facilities are often secluded in their cells anywhere from twenty-two to twenty-three and a half hours per day. The remaining hours are reserved for either showering or recreation without permitting the inmate to interact with others. The intense isolation imposed upon inmates by solitary confinement also prohibits them from conversing with other inmates

7 Id. at 5.
8 Id.
or prison officials: the confined inmates are categorically forbidden from verbally interacting with inmates during any movement through the prison; prison officials give them instructions through loud speakers; and prison officials almost always open and close cell doors electronically. The closest inmates come to human interaction occurs during mealtime, when, as one court has described, guards open a trap door "into the dead space of a vestibule through which [the] guard may transfer items to the inmate without interacting with him."12

When inmates in solitary confinement are permitted to engage in recreation, it often takes place within a completely enclosed space within the prison.13 In order to leave his cell, either for recreation or anything else, the inmate must undergo a "visual strip search" in front of the control tower officer. This requirement has radically reduced the number of inmates who leave their cells at all.14

Solitary confinement was revived in the United States during the twentieth century after decades of skepticism about its effectiveness.15 Although the practice was initially employed as a general penological model,16 its adverse psychological impact on inmates led prisons within the United States and other countries to abandon the practice.17 While solitary confinement was rejected as a general tool for maintaining prison order on the basis of its negative impact on inmates, solitary confinement was nonetheless deemed necessary and appropri-

17 See, e.g., Grassian, Psychopathological Effects, supra note 6, at 1450-51 (describing German studies that outlined the pervasive and widespread psychological problems among prison populations subjected to solitary confinement, including rampant delusions and incidents of amnesia). Many attribute the initial demise of solitary confinement as a general penological model to several high-profile incidents involving inmates who were subjected to long-term solitary confinement, including the death of five inmates at Auburn Prison in New York during the nineteenth century following a year of solitary confinement. See, e.g., Karen Blair, A 196 Year Push to Make Prisons Work, SCHOLASTIC UPDATE, Feb. 9, 1987, at 18.
ate in “extreme” cases. Such cases occurred when prison officials found it necessary to confine inmates who were deemed to be at high risk of escaping, harming themselves, or disrupting prison order.\(^\text{18}\)

This modern disciplinary form of solitary confinement took the shape of so-called “Segregated Housing Units” (SHU) or “Supermax Prisons,” both of which are now numerous and predominantly state-run. In fact, there is only one federal supermax facility in the United States—ADX Florence in Florence, Colorado. Many states have also created standalone facilities within lower security prisons that meet “supermax standards.”\(^\text{19}\) To date, approximately 30 states maintain some type of facility that can be described as “supermax.”\(^\text{20}\)

While all inmates are isolated and deprived to a certain extent, the usage of solitary confinement as a disciplinary measure is distinguishable from general imprisonment on three grounds. First, whereas most prison environments provide inmates with abundant opportunities for social interaction, the solitary confinement experience is specifically designed to severely limit human contact.\(^\text{21}\) The physical conditions of solitary confinement amplify the sense of isolation generally felt by prisoners, because unlike regular prison cells, solitary confinement cells tend to lack windows and barred doors.\(^\text{22}\) Second, solitary confinement is used as a punitive measure above and beyond general incarceration; inmates are specifically selected to undergo the deprivation innate to solitary confinement, a practice that imposes a distinct psychological hardship on inmates placed in solitary confinement.\(^\text{23}\) Third, assignment to solitary confinement is unrelated to an inmate’s original offense. Rather, it is a punitive measure “reserved for prisoners who commit serious disciplinary violations once in prison or who are deemed to endanger the safety of others or the security of the prison system.”\(^\text{24}\)


\(^{19}\) Theis, supra note 18, at 157 n.86 (noting that not all prisons derive from the same model, and accordingly some go by “various names including special housing unit, maxi-maxi, [and] maximum control facility”).

\(^{20}\) RIVELAND, supra note 18, at 1.


\(^{22}\) See Miller, supra note 14, at 158.

\(^{23}\) See Kurki & Morris, supra note 21, at 389.

\(^{24}\) Tachiki, supra note 13, at 1118.
There is limited information regarding how long inmates typically spend in solitary confinement.\(^{25}\) Sentences generally range from several days to several years, but in one extreme case, two prisoners at the Louisiana State Penitentiary at Angola have been in non-air conditioned isolation cells for 23 hours per day since 1972.\(^ {26}\)

III. PSYCHOLOGICAL STRESS AND INMATE ISOLATION

It is almost uncontested that conditions in supermax prisons generate deleterious effects among inmates. Only two post-World War II studies of the effects of solitary confinement on inmates’ mental health report only a minor psychological impact.\(^ {27}\) One of these was a longitudinal control group study of sixty inmates of whom slightly less than half remained in administrative segregation for sixty days. As those authors acknowledge, their findings that administrative segregation had little or no impact on inmates was “somewhat irrelevant to current segregation practices in the United States where offenders can be segregated for years for disciplinary infractions,” because inmates in their study were tested on average 3.6 days into their isolation, even if they remained in solitary confinement for a longer period of time.\(^ {28}\) The other study reported that solitary confinement can inflict inmates with numerous adverse health effects, including insomnia, dizziness, distortion of a sense of time, anger, apathy, and impaired memory, but rejected these effects as qualifying as significant impairments.\(^ {29}\)

Many researchers acknowledge that it can be difficult to pinpoint the precise symptoms suffered by isolated inmates placed in solitary confinement because inmates tend to hide their conditions.\(^ {30}\) Male inmates have been especially prone to this tendency. These inmates cite concerns that an inability to cope with solitary confinement is perceived as a weakness by those around


\(^ {27}\) IVAN ZINGER AND CHERAMI WICHMANN, *THE PSYCHOLOGICAL EFFECTS OF 60 DAYS IN ADMINISTRATIVE SEGREGATION* (1999); Peter Suedfeld et al., *Introduction and Historical Background, in Sensory Deprivation: Fifteen Years of Research* (1982).

\(^ {28}\) *Id.* at 64.

\(^ {29}\) Suedfeld, *supra* note 27.

them.\textsuperscript{31} Those who do reveal symptoms, even those as extreme as self-mutilation, are often interpreted by prison officials, including doctors and guards, as trying to manipulate the system in order to get special treatment.\textsuperscript{32}

Other researchers confirm that it is often extraordinarily difficult and traumatic for isolated individuals to talk about their experiences of solitary confinement both during and after.\textsuperscript{33} Some interpret the lack of complaints as a sign of a healthy adaptation strategy, while others recognize it as symptomatic of a form of social withdrawal that is typically accompanied by severe psychological problems.\textsuperscript{34} Regardless, inmates in solitary confinement tend to be underserved in terms of medical and psychological care. All agree that “supermax degrades the workers” who must observe inmates on a daily basis, to the extent that prison officials become “numb” towards inmates’ complaints or aberrant behavior.\textsuperscript{35}

This tendency is truly troubling when considered in light of the fact that solitary confinement produces a higher rate of psychiatric and psychological health problems than “normal” imprisonment. The Supreme Court first acknowledged the devastating effects of prolonged solitary confinement on prisoners not otherwise predisposed to mental illness during the nineteenth century:

A considerable number of prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community.\textsuperscript{36}

Fifty years later, the Court would refer to “solitary confinement” as one form of “physical and mental torture” used by governments to, among other things, coerce confessions.\textsuperscript{37} The psychiatric literature confirms the profound and negative impact of prolonged isolation. As early as 1912, adverse effects of conditions of imprisonment were documented to include “extremely vivid hallucinations.”

\textsuperscript{31} See Fellner & Mariner, supra note 9, at 63 n.120; Jergen Pauli Jensen, Report on Solitary Confinement in Danish Prisons (1988).
\textsuperscript{32} Ted Conover, Holding the Key; My Year as a Guard at Sing Sing 139 (2001); Stuart Grassian, Overview: Summary of Substantive Findings 20 (1999), http://www.hrw.org/reports/2003/usa1003/Grassian_Report_Eng_Site_Visit_One.pdf (describing this trend at Attica); Terry A. Kupers, Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It 5 (1999).
\textsuperscript{33} Jackson, supra note 30, at 30.
\textsuperscript{34} Toch, supra note 30, at 1 et seq.
\textsuperscript{35} Id. at 383.
\textsuperscript{36} In re Medley, 134 U.S. 160, 168 (1890) (describing the effects of solitary confinement).
cinations in multiple sensory modalities, including the visual, auditory, tactile, and olfactory”; “dissociative features including sudden recovery ‘as from a dream,’ with subsequent amnesia for the events of the psychosis”; “agitation and ‘motor excitement’ with aimless violence”; and “delusions as sudden, and in some reports, as precipitating at night.” In more than half of the substantial body of literature on prison conditions from the late nineteenth and early twentieth centuries, solitary confinement was cited as “responsible for precipitating psychosis, and rapid recovery was often noted when the prisoner’s solitary confinement was terminated.”

More recently, a study of inmates at the Massachusetts Correctional Institution at Walpole yielded similar observations. Prisoners in solitary confinement there were “hyperresponsive to external stimuli”; prone to “perceptual distortions, hallucinations and derealization experiences”; experienced profound affective disturbances including “massive free-floating anxiety” accompanied by “recurrent acute episodes of panic and dread of impending death; suffered from “primitive, ego-dystonic fantasies” involving revenge, torture, and mutilation of prison guards; and experienced a profound lack of impulse control.

A number of studies have documented the severe mental effects experienced by inmates placed in solitary confinement. For example, in the early 1990s, psychologist Craig Haney assessed the mental health of 100 inmates in California’s Pelican Bay SHU. The inmates were randomly selected and were assessed in two different face-to-face interviews. Considerable, severe, and highly prevalent effects of solitary confinement were found among those interviewed: ninety-one percent suffered from anxiety and nervousness; seventy percent “felt themselves on the verge of an emotional breakdown”; seventy-seven percent were in a state of chronic depression; sixty-six percent suffered from a patchwork of symptoms.

International studies confirm these trends. In a study of male patients in a psychiatric clinic in Zurich, approximately sixty-seven of whom were committed directly from solitary confinement, most were experiencing hospitalization resulting from mental illness for the first time. These prisoners were, unlike their non-solitary confinement prisoner counterparts, repeatedly hospitalized for psychiatric reasons, even though they had spent less overall time in solitary confinement (an average of eighty-six days) than their counterparts (an average of 173 days). In a follow-up to this study, thirty inmates in solitary confinement

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38 Paul Nitsche & Karl Willmanns, The History of the Prison Psychoses in Germany (1912).
39 Grassian, Psychopathological Effects, supra note 6, at 1451.
40 Id. at 1451-54.
42 Id. at 132-34.
were compared to a control group of twenty-eight inmates housed in regular cells. Isolated inmates had spent an average of ninety-one days in solitary confinement, whereas the control group had spent 326 days in prison. All participants had normal intelligence, but the group of isolated inmates "showed considerably more psychopathological symptoms than the control group... [and these] effects were mainly caused by solitary confinement."44

A Danish study involving 367 pretrial detainees reported a higher rate of psychiatric problems among isolated inmates than among a control group of non-isolated inmates. A higher incidence of psychiatric morbidity—mainly adjustment disorders—was found among those in solitary confinement (twenty-eight percent) than among those not in isolation (fifteen percent). The rate of psychiatric morbidity was highest (forty-three percent) among prisoners who had been in long-term solitary confinement exceeding two months.45 The second part of this study revealed even more disturbing findings. In assessing hospitalization rates among remand prisoners, researchers determined that if "a person remained in [solitary confinement] for 4 weeks the probability of being admitted to the prison hospital for a psychiatric reason was about twenty times as high as for a person remanded in [non-solitary confinement] for the same period of time."46

These symptoms are more or less in line with psychological observations of individuals who have lived under isolated and restricted conditions beyond the context of solitary confinement in prisons. In particular, reductions in the nature and variety of activity and stimulations available in one's surrounding environment and social deprivation have been demonstrated to lead to "acute disturbances of the normal personality."47 A more recent review has summarized several decades of research on people who were confined physically (through restrictions in their movements and activities) and socially (through physical isolation from the larger population). This review concluded that "[r]eports of an inability to concentrate or maintain focus are common" and that "isolation produces significant and often dramatic increases in suggestibility and hypnotizability" and attentional shifts of the type associated with hallucinations.48 Researchers also reported increased levels of psychological problems,

including sleep disturbances, impaired cognition, anxiety, hostility, minor forms of psychopathology, heightened frictions and social conflict among members of the confined group, and potential long-term animosities that could result in deterioration of interpersonal and family relationships.49

Studies confirm that psychological screening and training are requisite to prepare individuals, such as those working for the military, for assignments in isolated and confined environments. These precautions help to minimize the negative effects of the environment on those who will live there. Some studies have gone so far as to suggest that some individuals better adapt to physical or social confinement based upon their basic sense of purpose,50 a conclusion which—if true—has profound implications for those whose segregation necessarily carries a pejorative or negative meaning.

For mental patients specifically, professionals are divided over whether segregation should be permitted at all even beyond the prison system. Although segregation has proven therapeutic for some patients, there is an acute awareness of the “potential dangers” of seclusion that have resulted in mental health standards governing the manner and conditions under which such practices should be employed.51 Overall, “although it appears to be reasonably well-established that seclusion and restraint ‘work,’ i.e., they provide an effective means for preventing injury and reducing agitation, it is at least equally well-established that these procedures can have serious deleterious physical and (more often) psychological effects on patients.”52

There is no consensus on the question of duration with respect to post-isolation effects, however, and studies suggesting that post-isolation effects are chronic and severe are equally numerous.53 Although symptoms of mental deterioration can appear in otherwise healthy individuals after only a few days in isolation, some studies indicate that individuals recover quickly when solitary confinement is terminated.54 The majority of studies note, however, that many post-isolation inmates have trouble engaging in social behavior and fear emo-

49 Id. at 258 (noting that such environments are clearly “stressful” and that a “recurrent concern is that the stresses of isolation and confinement lead to poor mental health and negative moods”)

50 E.K. Eric Funderson, Mental Health Problems in Antarctica, 17 ARCH. ENVTL. HEALTH 558, 564 (1988).


54 See, e.g., Grassian, Psychopathological Effects, supra note 6, at 1453; Terry Kupers, Prison Madness (1999).
tional contact," and for some persons, supermax creates "psychological pressures that . . . uniquely disable prisoners for freeworld reintegration."56

IV. THE COURTS AND SOLITARY CONFINEMENT

Federal courts have given credence to the psychological literature, increasingly recognizing that solitary confinement in particular can seriously injure prisoners. For example, in Davenport v. DeRobertis,57 the Seventh Circuit noted that "the record shows, what anyway seems pretty obvious, that isolating a human being from other human beings year after year or even month after month can cause substantial psychological damage, even if the isolation is not total."58 In both Miller ex rel. Jones v. Stewart59 and Comer v. Stewart,60 the Ninth Circuit noted the profound deleterious effects supermax prison conditions can exert on inmates' mental health.61 In LaReau v. MacDougall,62 the Second Circuit refused to condone sensory deprivation in solitary confinement because of its adverse effects on inmates' psychological well-being.63 Numerous district courts have evinced the same or similar concerns about the effects of solitary confinement on inmates.64


57 844 F.2d 1310 (7th Cir. 1988).

58 Id. at 1313.

59 231 F.3d 1248 (9th Cir. 2000), vacated, 531 U.S. 986 (2000).

60 215 F.3d 910 (9th Cir. 2000).

61 Miller, 231 F.3d at 1252 ("it is well accepted that conditions such as those present in the [supermax facility] . . . can cause psychological decompensation to the point that individuals may become incompetent."); Comer, 215 F.3d at 916 ("we and other courts have recognized that prison conditions remarkably similar [to this supermax facility] can adversely affect a person's mental health.").

62 473 F.2d 974 (2d Cir. 1972).

63 Id. at 978 ("We cannot approve of threatening an inmate's sanity and severing his contacts with reality by placing him a dark cell almost continuously day and night.").

64 See, e.g., Kane v. Winn, 319 F. Supp. 2d 162, 205 (D. Mass. 2004) (citing a study for the proposition that solitary confinement commonly leads to pervasive psychological problems among inmates); Lee v. Coughlin, 26 F. Supp. 2d 615, 637 (S.D.N.Y. 1998) ("[t]he effect of prolonged isolation on inmates has been repeatedly confirmed in medical and scientific studies"); McClary v. Kelly, 4 F. Supp. 2d 195, 208 (W.D.N.Y. 1998) ("[t]he notion that prolonged isolation from social and environmental stimulation increases the risk of developing mental illness does not strike this Court as rocket science"); Madrid v. Gomez, 889 F. Supp. 1146, 1235 (N.D. Cal. 1995) ("many, if not most, inmates in [solitary confinement] experience some degree of psychological trauma in reaction to their extreme social isolation and the severely restricted environmental stimulation"); Bono v. Saxbe, 450 F. Supp. 934, 946 (E.D. Ill. 1978) ("[p]laintiffs’ uncontested evidence showed the debilitating mental effect on those inmates confined to the control unit"), aff'd in part and remanded in part on other grounds, 620 F.2d 609 (7th Cir. 1980).
Despite their ready acknowledgement of the potential negative effects of prison conditions, courts have been loathe to hold that solitary confinement violates the Eighth Amendment prohibition on cruel and unusual punishment. In fact, only one court has gone so far. In Ruiz v. Johnson, the Southern District of Texas held that conditions in some of Texas’ administrative segregation units were presumptively unconstitutional:

Before the court are levels of psychological deprivation that violate the United States Constitution’s prohibition against cruel and unusual punishment. It has been shown that defendants are deliberately indifferent to a systemic pattern of extreme social isolation and reduced environmental stimulation. These deprivations are the cause of cruel and unusual pain and suffering by inmates in administrative segregation, particularly in Levels II and III.

More commonly courts have held that while conditions in solitary confinement may “press the outer bounds of what most humans can psychologically tolerate,” the fact remains that it is unclear whether “there is a sufficiently high risk to all inmates of incurring serious mental illness from exposure to conditions [in solitary confinement] to find that the conditions constitute a per se deprivation of a basic necessity of life.”

Even if some courts have found that solitary confinement does not reach the level of cruel and unusual punishment, this does not negate its adverse impact on inmates’ psychological well-being. Yet this adverse impact has been largely overlooked by judicial decision-makers, with only one appellate court ever having asked whether prison conditions might adversely affect an inmate’s mental health to such an extent that it might impair his ability to exercise (or waive) constitutional rights. That court—the Ninth Circuit—has twice remanded cases to the district courts for evidentiary hearings on inmates’ competency, with special instructions to ascertain whether prison conditions rendered inmates incompetent to waive appeals of denial of habeas relief.

Other courts have avoided assessing an inmate’s competency after the trial phase because competency is viewed as static; that is, if an inmate is competent to stand trial in the first instance, courts generally assume his competency

66 Id. at 914-15.
67 See Madrid, 889 F. Supp. at 1267.
68 See Miller ex rel. Jones v. Stewart, 231 F.3d 1248, 1248 (9th Cir. 2000), vacated, 531 U.S. 986 (2000) (next friend motion and motion to stay execution of a prisoner who declined to seek federal habeas relief and refused to be represented by such attorney in doing so); see also Comer v. Stewart, 215 F.3d 910 (9th Cir. 2000), remanded to 230 F. Supp. 2d 1016 (D. Ariz. 2002) (motion to dismiss appeal of denial of federal habeas relief).
throughout that and later proceedings. However, this conception is flawed. The psychological literature makes clear that an inmate’s level of competency varies depending upon the conditions of incarceration. Thus, determining that an inmate is competent at trial will not establish that he is competent at subsequent judicial proceedings, and will especially not establish whether he is competent to proceed pro se. Rather, post-conviction environmental factors within a prison can exacerbate pre-existing propensities toward mental illness among at-risk prison populations and can undermine the mental health of even those individuals without any pre-existing propensities toward developing mental health conditions. As a result, the competency of inmates subjected to solitary confinement must be reevaluated at the point at which they seek to exercise their Sixth Amendment rights of self-representation if the integrity of the tribunal is to be preserved.

V. THE CASE FOR RE-EVALUATING INMATES

Though currently not standard practice, re-evaluation of an inmate’s competency is consistent with the Supreme Court’s elaboration of the right of self-representation extended to criminal defendants by the Sixth and Fourteenth Amendments. In Faretta v. California, the Court made it clear that the exercise of the right of self-representation is not an absolute right, but may be overridden to prevent “serious obstructionist misconduct.” The Court also described self-representation as subject to the protection of “the dignity of the courtroom” and compliance with “procedural and substantive law.” Then, in McKaskle v. Wiggins, the Court rejected a defendant’s objection to the role that standby counsel had played, and in so doing observed that “the defendant’s right to proceed pro se exists in the larger context of the criminal trial designed to determine whether or not a defendant is guilty of the offense with which he is charged.” Finally, in Martinez v. Court of Appeal of California, the Supreme Court declined to extend the right to self-representation to appeals of criminal convictions, noting that “[e]ven at the trial level . . . the government’s interest in ensuring the integrity and efficiency of the trial at times outweighs the defendant’s interest in acting as his own lawyer.”

Additionally, the Supreme Court has long recognized the overwhelming public interest in preventing mental incapacities from undermining the reliability of the adversarial process. This interest has also served to justify limits on

69 422 U.S. 806, 834 n.46 (1975).
70 Id. at 834.
the admissibility of evidence, in order to prevent "confusion of the issues." In the context of the right to counsel of choice, a defendant's decision "may be limited by the need for a fair trial." This independent public interest is reflected in *Faretta*, where common legal experience indicates that self-representation diminishes adversarial testing of the prosecution's case and frequently harms the defendant himself.

To the extent that mental illness impedes a defendant's ability to represent himself or to competently waive otherwise guaranteed rights, it necessarily poses a genuine threat to the vital public interest in reliable adjudication of contested criminal charges because the law governing competency to stand trial rests on this basis. In *Dusky v. United States*, the Court indicated that a defendant must have "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding" and "a rational as well as factual understanding of the proceedings against him" in order to be fit to stand trial. The Court later summarized this standard: "It has long been accepted that a person whose mental conditions is such that he lacks the capacity to understand the nature and object of the proceedings against him, to consult with counsel, and to assist in preparing his defense may not be subjected to a trial."

Then, in *Riggins v. Nevada*, Justice Kennedy agreed that "the State has a legitimate interest in attempting to restore the competency of otherwise incompetent defendants," sufficient to override an autonomy interest in refusing medication. Justice Kennedy added that due process would not even permit a State generally to recognize a defendant's competent waiver of the right to be competent at trial. Beyond the trial court, any decision to waive federally guaranteed rights requires that the court be convinced that the waiver decision was made intelligently and intentionally. This has been extended to post-conviction remedies where waiver of rights will result in the execution of the defendant. Waivers of constitutional rights, like petitioning for a writ of habeas corpus, in particular, are disfavored, and courts must indulge in every reasonable presumption against them.

This body of law reflects the overriding importance of the public interest in reliable adversarial testing of contested charges. Even the constitutional

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79 *Id.* at 140.
80 Johnson v. Zerbst, 304 U.S. 458, 467-68 (1938) (Sixth Amendment rights of defendant violated where he was denied counsel in federal court).
81 *Id.* at 464.
requirement is commonly stated in terms that flatly bar a defendant from standing trial who does not meet the standards for competence to stand trial. Congress adopted this standard by requiring that a trial court "order" a competency hearing, even *sua sponte*, "if there is reasonable cause to believe that the defendant may presently be suffering from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense." The committee report developed during the passage of this statutory provision explains that "it is mandatory that the court order a hearing" on competency if there is reasonable cause to believe that the defendant is lacking mental competence. Given the potentially devastating effects of solitary confinement on inmates, such reasonable cause should be deemed to exist in all cases where inmates have been isolated.

VI. A MODEL FOR COURTS: WHEN TO ORDER COMPETENCY DETERMINATIONS

The Ninth Circuit has provided other courts with a straightforward model for assessing an inmate's competency should he seek to waive constitutional rights. In *Comer v. Stewart* the court recognized that conditions on death row whereby inmates were effectively held in solitary confinement could have caused otherwise competent inmates to become incompetent and thus render them unable to waive their constitutional rights. In so doing, the Ninth Circuit relied upon the competency standard as set forth in *Rees v. Peyton*, which defined competency as "whether [the defendant] has capacity to appreciate his position and make a rational choice with respect to continuing or abandoning further litigation or on the other hand whether he is suffering from a mental disease, disorder, or defect which may substantially affect his capacity in the premises."
The district court's interpretation of the Ninth Circuit's instructions in 
Comer to assess the impact of prison conditions on inmates' competency technically differs from the actual instructions handed to the district court by the Ninth Circuit, which asked the district court to assess only whether prison conditions could have caused Mr. Comer to become impaired such that he should be deemed unable to waive his constitutional rights. The district court in Comer actually understood the Ninth Circuit to be directing it to undertake two separate (but related) inquiries: (1) whether Mr. Comer was competent to waive further appeals; and (2) whether that decision was rendered involuntary by the conditions of his incarceration.\(^9\) In other words, although the Ninth Circuit never explicitly directed the district court to consider voluntariness, the district court nevertheless segregated prison conditions \textit{qua} voluntariness from the mental competency determination itself.\(^{10}\)

Had the district court applied the Ninth Circuit's test literally, it might have relied upon the mental health profession to undertake a less-traditional analysis of the inmate's competency, by comparing a post-solitary competency determination with a previous determination of the inmate's mental health. Although it departs from the instruction of the Ninth Circuit, the district court's model has the virtue of obviating a judicial inquiry into the appropriateness or effectiveness of current psychological models used to evaluate competency by bifurcating the prison conditions inquiry from the psychological test itself.\(^{91}\) In so doing, the district court relied upon two cases in which other federal courts have held that conditions of confinement can render a waiver of rights involuntary: \textit{Groseclose ex rel. Harries v. Dutton}\(^{92}\) and \textit{Smith ex rel. Smith v. Armon Trout}.\(^{93}\)

In both of these cases, the conditions of confinement were substantially similar. In \textit{Groseclose}, the defendant was housed in a six-by-eight foot cell, containing a toilet with wash basin and a bunk bed occupying approximately

\(^9\) In \textit{Comer},

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[\text{the district court found that inmates spent 24 hours a day in windowless cells that were five to six feet wide and eight to ten feet long. Cells were cold, moist, and reeked of human excrement "caused by the bodily functions of inmates, eating, sleeping and eliminating under crowded conditions in the same immediate area." The court also noted the "unrelenting nerve-racking din that fills the segregation units," which caused "a profound impact on lockdown inmates, some of whom consider it to be the single worst aspect of their confinement." Vermin, including cockroaches, mice, and rats "that thrive[d] upon the accumulated filth" infested the unit.}
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\(^{10}\) \textit{See id.} at 918 (noting that the Ninth Circuit directed this Court to assess "whether Mr. Comer's particular conditions of confinement have rendered his decision to withdrawal his appeal involuntary").


one-third of the cell. The cell was illuminated by one sixty-watt light bulb. He had no window and the ventilation was so limited that cigarette smoke stained his cell walls, toilet odors made it difficult for him to sleep, and the prison’s use of oil-based paints caused him to suffer respiratory problems. The defendant was confined in his cell for twenty-three hours per day, and the temperature in the cell frequently reached “life threatening limits.”

By contrast, in Armontrout, the defendant’s cell was eight-by-nine feet. The cell had no ventilation and sewage backups frequently caused flooding. There were infestations of rats, roaches, and other pests. Inmates were allowed, at most, a forty-five minute exercise period six times per week, and were granted access to three showers. As in Groseclose, each cell was lit by a single low-wattage bulb suspended thirteen feet from the ground.

As with the district courts in Groseclose and Armontrout, the district court did not consider whether Mr. Comer’s conditions of confinement rendered him per se mentally incompetent. Rather, it was able to impute prison conditions into the competency determination by analyzing whether the conditions of confinement were so inhumane that they negated any will he might otherwise have had to continue living, and whether this could have served as the motivating factor in his decision to waive further post-conviction review. This model provides a judicially manageable standard for assessing whether prison conditions might render an inmate’s waiver of constitutional rights improper because it does not require a re-evaluation of psychological models used to test mental competence. It requires only a consideration of whether an inmate’s decision to waive key rights was made under duress sufficient to render the waiver invalid in cases where inmates were subjected to solitary confinement. Given the astounding and similar facts in cases adjudicated under this model, these three cases provide a sound basis for patterning future determinations of the voluntariness of waivers.

VII. CONCLUSION

Solitary confinement, particularly at supermax facilities, poses an acute threat to the mental health of inmates. The impact of isolation, even beyond the penal context, has been shown to adversely affect even the healthiest of individuals. When translated into the prison context, however, its impact is even more pronounced. The precise degree to which it undermines inmates’ competency is not yet fully understood; however, it is clear that solitary confinement has deleterious effects that may persist even beyond the period of confinement. More troubling, some inmates may superficially appear rational even though

94 Groseclose, 594 F. Supp. at 959.
95 Armontrout, 632 F. Supp. at 512 n.24.
96 Cf. Comer, 230 F. Supp. 2d at 1034 (assessing Mr. Comer’s mental competency, prison conditions notwithstanding); but see id. at 1028 et seq. (assessing the impact of prison conditions on the voluntariness of Mr. Comer’s decision).
they lack the requisite competency to fully appreciate their actions. They may thus fail to reach the threshold of competency needed to waive constitutional rights. For these inmates, a new conception of the role of competency determinations would help to ensure that only those inmates who are actually competent to waive constitutional rights are permitted by the courts to do so. The Ninth Circuit set an important precedent in Comer v. Stewart by recognizing that prison conditions do play a deleterious role in some inmates’ mental health by directing the district court to impute prison conditions into competency determinations. Given the severe impact that solitary confinement may have on the mental condition of inmates, other courts should follow suit and reconsider the competency of inmates when they seek to waive fundamental rights during the adjudicatory process, even if they had been deemed competent at the start of the trial proceedings.