No. 19-514

In the Supreme Court of the United States

NIKKO A. JENKINS, PETITIONER

v.

STATE OF NEBRASKA, RESPONDENT

ON PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF NEBRASKA

BRIEF OF NATIONAL DISABILITY RIGHTS NETWORK, DISABILITY RIGHTS NEBRASKA, AND SEVEN MENTAL HEALTH EXPERTS AS AMICI CURIAE

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

Miscellaneous—continued:

Page

Miscellaneous—continued:

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INTEREST OF AMICI CURIAE[1]

Amici are mental health professionals and organizations with direct experience working with incarcerated people both in solitary confinement and after their return to the community.

[1] Pursuant to Supreme Court Rule 37.6, counsel for amici states that no counsel for a party authored this brief in whole or in part, and that no person other than amici, their members, or their counsel made a monetary contribution to the preparation or submission of this brief. In an abundance of caution, counsel for amici notes that this brief is based on a brief filed by amici in the Nebraska Supreme Court. At that time, the American Civil Liberties Union, which now represents petitioner, was counsel to amici. Consent to the filing of this brief has been obtained pursuant to Rule 37.2.

Amicus National Disability Rights Network is the nonprofit membership organization for the federally mandated Protection and Advocacy (P&A) and Client Assistance Program (CAP) agencies for individuals with disabilities. Congress established the P&A and CAP agencies to protect the rights of people with disabilities and their families through legal support, advocacy, referral, and education. Collectively, the P&A and CAP agencies are the largest provider of legally based advocacy services to people with disabilities in the United States.

Amicus Disability Rights Nebraska is the P&A system for people with disabilities in Nebraska. It is independent of any public or private agency that provides treatment or services to people with disabilities, and its board of directors is composed of individuals with disabilities, family members, and other people who are interested in the rights of people with disabilities.

Amicus Kenneth Appelbaum, M.D., is Emeritus Professor of Psychiatry at the University of Massachusetts Medical School (UMMS). He has worked continuously with patients involved in the criminal justice system, including nine years as statewide Mental Health Program Director for the Massachusetts Department of Correction and ten years as Director of Correctional Mental Health Policy and Research for the UMMS Center for Health Policy and Research.

Amicus Kathryn A. Burns, M.D., has provided psychiatric care to inmates in jails and prisons. She has written correctional mental health policies and procedures and has been published in journals and peer-reviewed textbooks on topics pertaining to correctional mental health care. She was the Chief Psychiatrist for

the Ohio Department of Rehabilitation and Correction from 1995 to 1999 and again from 2013 until her retirement from state service in 2018.

Amicus Mary Buser, L.C.S.W., is a former Assistant Chief of Mental Health at the Solitary Confinement Unit on Rikers Island. She published an award-winning book, *Lockdown on Rikers: Shocking Stories of Abuse and Injustice at New York's Notorious Jail* and wrote an op-ed, "Solitary's Mockery of Human Rights," which was published in *The Washington Post*.

Amicus Stuart Grassian, M.D., is a Board-certified psychiatrist who was on the teaching staff of the Harvard Medical School for almost thirty years. He has extensive experience in evaluating the psychiatric effects of stringent conditions of confinement and has served as an expert in both individual and class-action lawsuits addressing this issue.

Amicus Craig Haney, Ph.D., J.D., is Distinguished Professor of Psychology and UC Presidential Chair at the University of California, Santa Cruz. He has conducted extensive research and published numerous articles on the psychological effects of solitary confinement and has provided expert testimony on the topic, including before the United States Senate.

Amicus Terry Kupers, M.D., M.S.P., is Professor Emeritus at The Wright Institute and Distinguished Life Fellow of The American Psychiatric Association. He has provided expert testimony in several lawsuits about prison conditions and published books and articles on related subjects, including *Solitary: The Inside Story of Supermax Isolation*, University of California Press, 2017.

Amicus Andrea "Andi" Weisman, Ph.D., has over 30 years of clinical experience and nearly 20 years of on-the-ground experience designing and implementing juvenile justice and adult correctional health and mental health programs. Her experience includes serving as Chief of Health Services for the Department of Youth Rehabilitation Services in Washington, DC.

Based on their experience, amici know first-hand the devastating impact of isolation on individuals, especially those with mental illness. Amici also know that individuals with mental illness are more likely to face solitary confinement in the first place. Amici submit this brief to elaborate on the long-standing and widespread consensus that prolonged solitary confinement can profoundly damage the mental health of inmates in ways that bear on their culpability for later acts.

SUMMARY OF ARGUMENT

By failing to give meaningful consideration to the impact of Jenkins' time in solitary confinement as sentencing mitigation, the Nebraska courts violated this Court's repeated directive that the Eighth Amendment requires consideration of "*any* aspect of defendant's character . . . that the defendant proffers as a basis for a sentence of less than death." *Lockett v. Ohio*, 438 U.S. 586, 604 (1978) (emphasis added).

I. Society has long recognized the devastating effects of solitary confinement on mental health. Over one hundred years ago, this Court recognized the "painful character" of solitary confinement. *In re Medley*, 134 U.S. 160, 171 (1890). In the years since, countless empirical studies from diverse scientific disciplines, including studies by amici, have confirmed this conclusion. As the research demonstrates, solitary confinement can cause

prisoners to enter unthinking fugue states, to hear persistent auditory hallucinations, to suffer from violent and uncontrollable obsessive thoughts, and to commit violent acts of self-mutilation. These symptoms do not always vanish after a prisoner is released; to the contrary, they often persist. The effects of solitary confinement are especially severe on prisoners who already have mental illness.

II. In light of this research, Jenkins' story was grimly predictable. Diagnosed with his first mental illness at age eight, Jenkins' incarceration began at age seventeen. During his time in prison, he spent 58 cumulative months in solitary confinement, where his mental health declined dramatically. Jenkins begged for mental health treatment and received virtually none. So certain was he of his condition that close to his release date he asked to be committed civilly rather than released to the community. If released, he predicted, his hallucinations would drive him to kill. Again, prison authorities ignored him and released him into the community directly from the cell where he had been confined, alone, for two uninterrupted years. Within three weeks of his release, Jenkins' prediction came true: he killed four people.

III. The same mental illness that made putting Jenkins in solitary confinement particularly dangerous also made it more likely for him to be confined in isolation in the first place. Corrections experts and mental health professionals agree that prison discipline systems too often punish prisoners for "misbehavior" that is really the expression of mental illness. That reaction to mental illness perpetuates a vicious cycle: inmates with mental illness are more likely to be placed in isolation, and the isolation is likely to exacerbate their mental illness,

which makes them all the more likely to be placed back in isolation once they are released.

The sentencing panel erred in refusing categorically to consider the mitigating impact of Jenkins' prolonged solitary confinement, and the Nebraska Supreme Court erred in affirming the panel's judgment. In concluding that Jenkins' conduct warranted placement in solitary confinement, the court failed to consider another possibility—that his conduct was itself a reflection of his mental illness, and that placing him in solitary confinement would only worsen his situation.

ARGUMENT

I. Solitary Confinement Has a Catastrophic Effect on Inmates' Mental Health

A. The catastrophic effects of solitary confinement on the human mind are well known. Countless empirical studies, "amassed over a period of many decades," have documented the "significant risk of serious harm" presented by isolating prisoners in solitary confinement. Craig Haney, *Restricting the Use of Solitary Confinement*, 1 Ann. Rev. Criminology 285, 286 (2018); *see also* National Commission on Correctional Health Care, *Position Statement on Solitary Confinement (Isolation)* (Apr. 10, 2016) [hereinafter "NCCHC Position Statement"] ("Many national and international organizations have recognized prolonged solitary confinement as cruel, inhumane, and degrading treatment, and harmful to an individual's health.").[2] Once isolated, otherwise mentally healthy prisoners are virtually certain to suffer at least some of the profound consequences of isolation: self-mutilation, psychosis, stupor, depression, anxiety, and

[2] https://www.ncchc.org/solitary-confinement.

many others. *Williams v. Sec'y Pa. Dep't of Corr.*, 848 F.3d 549, 566-67 (3d Cir. 2017). These symptoms can happen to "any prisoner" in solitary confinement, and they may last long after the prisoner is released from isolation. Office of the Inspector Gen., U.S. Dep't of Justice, *Review of the Federal Bureau of Prisons' Use of Restrictive Housing for Inmates With Mental Illness* 1 (2017).[3]

The damaging effects of solitary confinement on mental health have long been recognized. "One hundred and twenty-five years ago" this Court recognized the "'further terror'" represented by solitary confinement. *Davis v. Ayala*, 135 S. Ct. 2187, 2209 (2015) (Kennedy, J. concurring) (quoting *In re Medley*, 134 U.S. 160, 170 (1890)). In the nineteenth century case of *In re Medley*, the Court noted that historical experiments with solitary confinement proved the practice "too severe": "A considerable number of the prisoners fell . . . into a semi-fatuous condition, . . . and others became violently insane; others still, committed suicide; while those who stood the ordeal were not generally reformed . . . ." 134 U.S. at 168. Indeed, torturers throughout history have been well aware of the psychological effects of solitary confinement; witness the dreaded oubliettes of the Bastille,[4] the Byzantine Empress Theodosia's imprisonment

[3] https://oig. justice.gov/reports/2017/e1705.pdf.

[4] Tighe Hopkins, *The Dungeons of Old Paris* 204 (Tauchnitz ed. 1902) (1897).

of her enemy Photius,[5] or Aleksandr Solzhenitsyn's description of the Soviet Union's Sukhanovka Prison.[6]

B. The effects of prolonged solitary confinement are debilitating and long lasting. Recent psychological research has detailed the precise manner in which solitary confinement degrades the mind of the prisoner. Amicus Dr. Stuart Grassian, after observing "well over two hundred prisoners," has identified a set of "[s]pecific [p]sychiatric [s]ymptoms" associated with solitary confinement. Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 Wash. U.J.L. & Pol'y 325, 333 (2006). For example, almost a third of the prisoners described auditory hallucinations—hearing nonexistent voices whispering "frightening things." *Id.* at 335. Almost half experienced "[i]ntrusive [o]bsessional [t]houghts"—inescapable violent fantasies that were, to the prisoner, "entirely unwelcome, frightening, and uncontrollable." *Id.* at 336. Almost half suffered from paranoia, which often "deteriorated into overt psychosis"—the paranoid fantasies replacing reality in the prisoners' mind. *Id.* Slightly less than half experienced "[p]roblems with [i]mpulse [c]ontrol," finding themselves flying into fits of rage over "absolutely nothing," in the words of one prisoner, or impulsively engaging in self-mutilation. *Id.* Dr. Grassian also observed prisoners slipping into "mental torpor," being unable to read or concentrate or remember basic details. *Id.* at 331. Others suffered from a "loss of perceptual constancy (objects become larger and smaller, seeming to 'melt' or

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[5] Procopius, *The Secret History* 17-18 (Richard Atwater, trans., Cosimo Classics 2007).

[6] Aleksandr Solzhenitsyn, *Gulag Archipelago*, 181-84 (Harper and Row 1973).

change form, sounds becoming louder and softer, etc.)," which is a rare symptom ordinarily only seen in "especially severe, insidious, early onset schizophrenia." *Id.* at 337 & n.16.

The damage is often long lasting. Although some symptoms "are likely to subside upon termination of solitary confinement," even healthy prisoners "will likely suffer permanent harm as a result of such confinement." *Id.* at 332; *see also* NCCHC Position Statement, *supra* ("Some of these effects may persist after release from solitary confinement."). "[T]o exist and function in the socially pathological environment of solitary confinement, where their day-to-day life is devoid of meaningful interaction and closeness with others, prisoners have little choice but to adapt in socially pathological ways." Haney, *supra*, at 296-97. This damage builds over time as prisoners "gradually change their patterns of thinking, acting, and feeling to cope with the profoundly asocial world in which they are forced to live, as they attempt to adapt to the absence of social support and the routine feedback that comes from normal, meaningful social contact." *Id.* at 297. These conditions "can create or exacerbate serious psychological change in some inmates that is so negative and severe that it make[s] it difficult for them to return to the general population." *Id.* at 299 (alteration in original) (internal quotation marks omitted).

Self-directed physical brutality often accompanies the enduring mental brutality of solitary confinement. Prisoners in solitary confinement are almost seven times as likely to engage in self-mutilation as those in the general population. Fatos Kaba et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 Am. J. of Pub. Health 442, 445 (Mar. 2014).

The examples are gruesomely illustrative: one prisoner in solitary confinement slashed his wrists, Grassian, *supra*, at 334; a prisoner in a Broward County jail amputated his own penis and flushed it down the toilet, Brian Entin & Daniel Cohen, *Isolated and Mentally Ill*, 7 News Miami (Mar. 12, 2019);[7] a man in a federal "Supermax" prison bit off his own fingers, Associated Press, *Lawyer: Supermax Inmates moved amid lawsuit*, Denver Post (Dec. 9, 2013); and the list of horrors continues, *see, e.g.*, Lorraine Bailey, *Mentally Ill Ex-Prisoner Says Solitary Was Torture*, Court House News Service (Oct. 29, 2018) (describing an inmate in solitary confinement who castrated himself).

The mental and physical trauma resulting from solitary confinement is why the United Nations issued the "Nelson Mandela Rules," which prohibit "prolonged" use of the practice, defined as any period longer than fifteen days. G.A. Res. 70/175, annex, *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)*, Rules 43(b), 44 (Dec. 17, 2015). It is why other democracies generally use solitary confinement much more sparingly, and for shorter periods, than does the United States. Haney, *supra*, at 291. And, closer to home, it is part of the reason why in recent years states as diverse as New Jersey and North Dakota have moved to curtail dramatically the solitary confinement of prisoners. Assembly Bill No. 314, 2019 Leg. 218th Sess. (N.J. 2019); Cheryl Corley, *North Dakota Officials Think Outside the Box to Revamp Solitary Confinement*, NPR (July 31, 2018). Indeed, the

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[7] https://wsvn.com/news/investigations/isolated-and-mentally-ill-inmate-cuts-off-his-own-penis-flushes-it-down-toilet-inside-broward-jail/.

psychological effects of solitary confinement, as represented by this very case, prompted Nebraska to become the most recent state to follow suit. *See* 72 Neb. Admin. Code § 003.02 (diverting prisoners with serious mental illness "to the least restrictive environment" consistent with safety, security, and therapeutic needs).

C. Prisoners who are already mentally ill before being placed in isolation fare the worst. Dr. Grassian notes that those prisoners who present "evidence of subtle neurological or attention deficit disorder, or with some other vulnerability" are among the most "severely affected" by solitary confinement. Grassian, *supra*, at 332. And he is far from the only authority to highlight the especially brutal consequences of solitary confinement on inmates with mentally illness. *See, e.g.*, NCCHC Position Statement, *supra* ("It is well established that persons with mental illness are particularly vulnerable to the harms of solitary confinement."). A subcommittee of the United States Senate assessed the practice of housing inmates with mental illness in solitary confinement in federal and state prisons. Many doctors and professional organizations that provided testimony before that subcommittee emphasized the damage that solitary confinement causes to prisoners with preexisting mental illnesses. Witnesses testified that the extreme conditions that prisoners face "in solitary confinement can be harmful for anyone, but they particularly expose individuals with mental illness to substantial risks of future serious harm." *See, e.g.*, *Reassessing Solitary Confinement: The Human Rights, Fiscal, & Public Safety Consequences, Hearing Before the Subcomm. on Constitution, Civil Rights & Human Rights of the S. Comm. on the Judiciary*, 112th Cong. 23

(2012) (statement of Sen. Andrews) [hereinafter "*Reassessing Solitary Confinement Hearing*"].

In its statement to the committee, the American Psychiatric Association (APA), the main professional organization of psychiatrists in the United States, observed that "prolonged solitary confinement may be detrimental to persons with serious mental illness." Statement of the APA, *Reassessing Solitary Confinement Hearing*, *supra*, at 204. The APA explained that "[f]or persons with serious mental illness, these effects may exacerbate underlying psychiatric conditions, such as schizophrenia, bipolar disorder, and major depressive disorder." *Id.* at 205. It further noted that "[s]egregated prisoners with serious mental illness often require costly psychiatric hospitalization or crisis intervention services, and generally face bleak prospects of any medical improvement." *Id.*

The Department of Justice, responding to guidance from mental health and public health authorities, changed its own guidance in an effort to divert prisoners with mental illness away from solitary confinement. In 2017, "[t]he Department recommended that the [Bureau of Prisons] BOP expand its ability to divert inmates with serious mental illness to mental health treatment programs, by increasing the capacity of existing secure mental health units, and provided the BOP with an estimated cost of this expansion." Office of the Inspector Gen., *supra*, at 13.

Finally, consistent with the clear consensus of public health authorities and practitioners, a growing number of federal and state courts have held that placing individuals with serious mental illness in solitary confinement is cruel and unusual punishment. *See, e.g.*,

Ind. Prot. & Advocacy Servs. Comm'n v. Comm'r, Ind. Dep't of Corr., No. 1:08-CV-01317, 2012 WL 6738517 (S.D. Ind. Dec. 31, 2012) (holding that the Indiana Department of Correction's practice of placing prisoners with serious mental illness in segregation constituted cruel and unusual treatment in violation of the Eighth Amendment); *Jones 'El v. Berge*, 164 F. Supp. 2d 1096, 1101-02 (W.D. Wis. 2001) (granting a preliminary injunction using same rationale); *see also Ruiz v. Johnson*, 37 F. Supp. 2d 855, 915 (S.D. Tex. 1999), *rev'd on other grounds*, 243 F.3d 941 (5th Cir. 2001), *adhered to on remand*, 154 F. Supp. 2d 975 (S.D. Tex. 2001); *Coleman v. Wilson*, 912 F. Supp. 1282, 1320-21 (E.D. Cal. 1995); *Casey v. Lewis*, 834 F. Supp. 1477, 1549-50 (D. Ariz. 1993) *Arnold ex rel. H.B. v. Lewis*, 803 F. Supp. 246, 257 (D. Ariz. 1992); *T.R. v. S.C. Dep't of Corr.*, No. 2005-CP-40-2925 (S.C. Ct. Comm. Pl. Jan. 8, 2014).

II. Jenkins' Mental Decline in Solitary Confinement Was Profound

A. Jenkins was particularly vulnerable to the rigors of solitary confinement because he was mentally ill before setting foot in a prison. In the words of Dr. Eugene Oliveto, a psychiatrist with Douglas County Corrections, Jenkins was born with the "three bads": bad genes, bad environment, bad family. His father was psychopathic and abusive, and the rest of his family was "beyond dysfunctional." Report to the Nebraska State Legislature, Department of Correctional Services Special Investigative Committee 5 (Dec. 15, 2014) [hereinafter "Committee Report"]. Jenkins was placed in foster care at age seven and cycled through multiple group homes during his childhood. At age 14, he spent six months in the Youth Rehabilitation and Treatment Center. *Id.* at 6. His first mental health evaluation was an eleven-day

stay at the Richard Young Hospital at the age of eight, where he displayed the symptoms of bipolar disorder. *Id.* He began hearing non-existent voices at age nine. *Id.* at 13. This "long and serious history of mental illness" rendered Jenkins particularly unable to cope with the psychological trauma imposed by the 58 months he would spend in solitary confinement. Ombudsman's Report, State of Nebraska, Office of the Public Counsel/Ombudsman 13 (Dec. 9, 2013) [hereinafter "Ombudsman Report"].

Jenkins was incarcerated in 2003, when he was just 17 years old. For the first three years of his imprisonment, Jenkins was put in solitary confinement only sporadically and for relatively short periods. But in February 2007, Jenkins began an almost continuous three-year stint in isolation. Committee Report, *supra*, at 8. During this time, Jenkins "was locked up alone in a cell for 23 hours a day, and was, by definition, separated from most normal human contact." Ombudsman Report, *supra*, at 2. The only time Jenkins could leave his cell was for one hour a day, which he spent on his own in a small, fenced-in cage. Committee Report, *supra*, at 26.

Jenkins received a seventeen-month reprieve from solitary confinement in February 2010, when he was transferred to Douglas County Jail in connection with the adjudication of new criminal charges against him. Ombudsman Report, *supra*, at 10. There, he received "appropriate mental and behavioral health care" and was able to serve his time without being returned to isolation. Committee Report, *supra*, at 23. His time in general population came to an end in July 2011, however, when he was transferred back to Tecumseh State Correctional Institute and summarily returned to solitary confinement. *Id.* at 8. This final period of solitary con-

finement lasted for two more uninterrupted years. *Id.* In July 2013, he was released into the community directly from his solitary cell, with nothing more than a generic list of social services. Ombudsman Report, *supra*, at 40-41.

B. Jenkins' 58 total months in solitary confinement—the majority of his adult life—predictably "exacerbated" his mental illness. Committee Report, *supra*, at 23. After more than two years in solitary, he was claiming to have an "evil half" whom he wanted to choke. Ombudsman Report, *supra*, at 5. During his second extended term in solitary, he repeatedly mutilated his face. *Id.* The record also speaks of Jenkins engaging in "psychotic" mutilation of his own penis. Pet. App. 39a; *cf.* Grassian, *supra*, at 328 (describing "self-directed violence" exhibited by prisoners in solitary confinement). Jenkins also reported "hearing voices all the time." Ombudsman Report, *supra*, at 10; *cf.* Grassian, *supra*, at 335 (describing auditory hallucinations experienced by prisoners in solitary confinement). He saw "visions." Ombudsman Report, *supra*, at 18; *cf.* Grassian, *supra*, at 336 (describing visual hallucinations experienced by prisoners in solitary confinement). He experienced night terrors. Committee Report, *supra*, at 11; *cf.* Grassian, *supra*, at 335 (describing "severe panic attacks" experienced by prisoners in solitary confinement). He suffered from unwelcome, violent "obsessive thoughts." *See, e.g.*, Committee Report, *supra*, at 11; *cf.* Grassian, *supra*, at 336 (describing unwelcome, obsessive violent thoughts experienced by prisoners in solitary confinement).

Making matters worse, Jenkins often refused to take his medication, in the grip of paranoid fears that he was the target of a murder plot by prison guards. Commit-

tee Report, *supra*, at 13; *cf.* Grassian, *supra*, at 336 (describing paranoia felt by prisoners in solitary confinement). And he reported "step[ping] in and out of reality." Ombudsman Report, *supra*, at 16; *cf.* Grassian, *supra*, at 335 (describing "[p]erceptual [d]istortions" experienced by prisoners in solitary confinement). Indeed, Jenkins' bizarre and disturbing behavior during the second period of extended solitary confinement goes beyond anything reported in Dr. Grassian's article, including drinking his own urine and drinking and snorting his own semen. Committee Report, *supra*, at 21.

Importantly, it was after more than two near-continuous years in solitary confinement that Jenkins first began to hear the voice of "Apophis." Committee Report, *supra*, at 10. Apophis (sometimes spelled Opophis in the record) is the Greek name for Apep, the Egyptian God of Chaos. The voice of Apophis would become a recurrent theme in Jenkins' hallucinations, a "fixation." Ombudsman Report, *supra*, at 14 (quoting a prison-system mental health professional). Jenkins heard Apophis ordering him to commit all manner of violent, brutal acts such as "massacr[ing] children," inflicting "horrific acts" on "Catholics, whites, and children," or "kill[ing] Christians and Catholics." *Id.* at 48.

At first, Jenkins expressed a desire to rid himself of Apophis' influence. *Id.* at 14. He claimed to know the things Apophis was telling him to do were "wrong." *Id.* at 11. He was worried that, when released, he would act on Apophis' orders and was frustrated that the system was not taking his prediction seriously. *Id.* at 12. He "struggle[d]" with his violent thoughts; he told a mental health worker that "he doesn't want to do these things, but feels the destructive acts at his hand are inevitable."

Id. at 15. He said he was "afraid" that he would "rip someone's heart out." Committee Report, *supra*, at 17. But towards the end of his cumulative five-year period in isolation, Jenkins' resistance to Apophis evidently weakened. He claimed to be "a psychotic powerful warrior at the mercy of Apophis" and that he was "preparing for what is to come." Ombudsman Report, *supra*, at 21.

C. Throughout this period of mental decline, Jenkins was painfully aware of what was happening to him. He recognized that his grip on reality was slipping and, over the 58 cumulative months of isolation, made near-constant and "desperate" pleas for mental health care. Committee Report, *supra*, at 10. These requests went unheeded; while in solitary confinement Jenkins received "virtually no mental health treatment." *Id.* at 5. What little care he received came in the form of "cell door" visits from mental health professionals, "hardly a setting that is conducive to anything that would be characterized as 'therapeutic.'" Ombudsman Report, *supra*, at 35. The contrast with the seventeen-month period Jenkins spent in Douglas County Jail is particularly instructive. While there, Jenkins received "appropriate mental and behavioral health care." Committee Report, *supra*, at 23. He received weekly, in-person, mental health sessions. *Id.* at 10. Perhaps thanks to that care, Jenkins was able to "function with a relative degree of success in the general population of inmates." Ombudsman Report, *supra*, at 15.

But once Jenkins was returned to solitary confinement, his mental health began to decline yet again. This time the decline was so severe that Jenkins himself, just months before his release date, took the "rather extraordinary" step of asking to be sent to the prison system's psychiatric unit rather than released from pris-

on altogether. Ombudsman Report, *supra*, at 21. During his meetings with the prison's social worker, who was meant to help him prepare for his transition to civilian life, Jenkins renewed his request to be committed civilly rather than released. He explained that he "does not want to discharge to the community because he will kill people and cannibalize them and drink their blood." *Id.* at 22.

Again, authorities ignored this request, because of a bureaucratic "turf war" at the Department of Correctional Services that resulted in key information being deliberately withheld from decision makers. Committee Report, *supra*, at 22. Jenkins was released, directly from solitary confinement, into the public. Within three weeks, he had killed four people. He testified that these murders were committed at the behest of Apophis, the hallucination that first appeared to him while in solitary confinement years previously. Pet App. 19a.

III. Jenkins Was More Likely To Be Confined in Isolation Because of His Mental Illness

The lower courts blamed Jenkins for his confinement in isolation, and for that reason refused to consider his treatment by the state as mitigation. As an initial matter, whether a capital defendant's conduct provoked his placement in solitary confinement is beside the point; confinement in isolation indisputably produces lasting psychological effects that are relevant to mitigation, regardless of the reasons for that confinement. But the cruel irony of Jenkins' situation is that his mental illness made it more likely that he would be put in solitary confinement in the first place. Prisoners such as Jenkins with preexisting mental illness "face greater challenges in adapting to prison life and are consequently at higher risk for disciplinary action and segregation." Statement

of the APA, *Reassessing Solitary Confinement Hearing*, *supra*, at 203-04; *see also* NCCHC Position Statement, *supra* ("In many cases, individuals with mental health problems who have difficulty conforming to facility rules, but are not violent or dangerous, end up being housed in [solitary confinement].").

A study of 18,000 prisoners conducted by the University of Massachusetts Lowell found that prisoners like Jenkins "have a higher likelihood of being sentenced to [solitary confinement] compared with inmates without a mental illness." Kyleigh Clark, *The Effect of Mental Illness on Segregation Following Institutional Misconduct*, 45 Crim. Just. & Behav. 1363, 1363, 1368 (Sept. 2018). The study controlled for all other factors, suggesting that "mental illness alone" is the reason for this disparity. *Id.* at 1364. The effect is a vicious cycle, "in which mentally ill offenders are put in solitary confinement due to their mental illness, which is made worse by isolation, leading to further or worsening symptomatic behavior." *Id.* at 1378; *see also* NCCHC Position Statement, *supra.*

In recognition of this fact—that "an inmate's mental health symptoms [can] lead to placement or extension of placement" in solitary confinement—the Federal Bureau of Prisons requires psychologists to participate in prison disciplinary hearings to "advise . . . on the inmate's competency and responsibility" in light of his or her mental illness. U.S. Dep't of Justice, *Report and Recommendations Concerning the Use of Restrictive Housing* 51-52 (Jan. 2016).

The sentencing panel was evidently unaware that prison authorities often punish symptoms of mental illness with solitary confinement. It simply assumed that

Jenkins' five cumulative years of solitary confinement was "a result of his own actions" and not an apathetic institutional response to his underlying mental health issues, and therefore could be discarded entirely as mitigation. Pet. App. 95a. The Nebraska Supreme Court repeated this error when it held that considering the mitigating effect of Jenkins' solitary confinement would "reward" voluntary bad behavior on his part. Pet. App. 69a. These holdings are doubly erroneous. If solitary confinement undermines mental health, it must be considered as mitigation. And, in light of the relationship between mental illness and placement in solitary confinement, and in light of the absence of any protections in the system to ensure Jenkins was not being punished simply for suffering from symptoms of mental illness, this assumption was unwarranted and unfair.

CONCLUSION

For the foregoing reasons, amici curiae support the petition for certiorari and respectfully request that the petition be granted.

Respectfully submitted,

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