Comments by Dr. Terry Kupers to the June 19, 2012 Hearing Before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights: Reassessing Solitary Confinement - The Human Rights, Fiscal, and Public Safety Consequences

Greetings Hon. Senators:

I regret that because of professional commitments I will not be able to testify in person at this important subcommittee meeting. Thank you for taking on this timely topic. I hope you will consider my written comments. I am a Board-certified psychiatrist, Institute Professor at The Wright Institute, Distinguished Life Fellow of the American Psychiatric Association and recipient of the 2005 Exemplary Psychiatrist Award from the National Alliance on Mental Illness (NAMI). My publications include the book, Prison Madness: The Mental Health Crisis Behind Bars and What We Must do About It (Jossey-Bass/ Wiley, 1999), as well as a professional article about the successful downsizing of a supermaximum facility in Mississippi.[1] I have served as a psychiatric expert in numerous lawsuits involving the psychiatric effects of jail and prison conditions, the quality of mental health treatment in correctional settings and the effects of sexual abuse on prisoners. I am federal court-approved Monitor for Presley v. Epps,[2] concerning the exclusion of prisoners with serious mental illness from the Supermaximum Unit 32 at Mississippi State Penitentiary, and the establishment of a "stepdown" mental health treatment program (see attached article).

In my opinion, an historic wrong turn occurred in American penology in the 1980's. Unprecedented prison crowding (the prison population had multiplied 4 to 6 times in a decade) and forced idleness (rehabilitation programs had been downsized because of concerns about "coddling prisoners") led to rapidly rising rates of violence and psychiatric breakdown in the prisons. Instead of arriving at the obvious correct conclusion (supported by scientific research at the time) that the crowding and idleness caused serious damage and

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[1] "Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs," T.A. Kupers, T. Dronet, M. Winter, et al., Criminal Justice and Behavior, October, 2009.

[2] Presley v. Epps, No. 4:05CV148-JAD (N.D. Mississippi, 2005 & 2007).

needed to be reversed (for example, by removing low level drug offenders from prison and treating them in the community), and educational and training programs needed to be re-instituted and strengthened, corrections authorities instead opted to place the blame for the uncontrollable violence on a new breed of prisoners, "super-predators," and proceeded to place a growing proportion of those they vilified as "the worst of the worst" in round-the-clock solitary confinement.

A major problem with supermax confinement, and a major reason to reverse the trend of recent decades toward long-term isolation, is the effect of long-term isolation and stark idleness on prisoners' mental stability and on recidivism rates, and this is a grave concern even with prisoners who do not suffer from serious mental illness. My views on these matters are based on a careful review of the existing literature on solitary confinement[3] and my own direct observations and analyses of the effects of long-term solitary confinement in work that I have been engaged in for more than three decades. I have toured and inspected numerous "supermax" penal institutions, interviewed and evaluated very many prisoners confined under these severe conditions, and discussed isolation practices and procedures with correctional staff and officials from around the country. I have been asked to render expert opinions in legal cases that focused on whether being housed in supermax facilities constitutes "cruel and unusual punishment," and I have been consulted about the implementation of resultant consent decrees.

You will be hearing testimony from my colleague, Prof. Craig Haney, whose studies of the detrimental effects of long-term isolation are groundbreaking.[4] He found extraordinarily high rates of symptoms of psychological trauma. More than four out of

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[3] For example, see Scharff-Smith, P. (2006). The effects of solitary confinement on prison inmates: A brief history and review of the literature. In M. Tonry (Ed.), Crime and justice (Vol. 34, pp. 441-528). Chicago: University of Chicago Press; and Cloyes, K., Lovell, D., Allen, D., & Rhodes, L., Assessment of Psychosocial Impairment in a Supermaximum Security Unit Sample, 33 Criminal Justice and Behavior 760-781 (2006).

[4] Haney, C., Banks, C., and Zimbardo, P., Interpersonal dynamics in a simulated prison. International Journal of Criminology and Penology, 1, 69-97 (1973); and Haney, C., Reforming Punishment: Psychological Limits to the Pains of Imprisonment. Washington, DC: American Psychological Association Books (2006). Haney, C., and Lynch, M., Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement, 23 New York University Review of Law and Social Change 477-570 (1997); Haney, C., Mental Health Issues in Long-Term Solitary and "Supermax" Confinement, 49 Crime & Delinquency 124 (2003).

five of those evaluated suffered from feelings of anxiety and nervousness, headaches, troubled sleep, and lethargy or chronic tiredness, and over half complained of nightmares, heart palpitations, and fear of impending nervous breakdowns. Equally high numbers reported specific psychopathological effects of social isolation, including obsessive ruminations, confused thought processes, an oversensitivity to stimuli, irrational anger, and social withdrawal. Well over half reported violent fantasies, emotional flatness, mood swings, chronic depression, and feelings of overall deterioration, while nearly half suffered from hallucinations and perceptual distortions, and a quarter experienced suicidal ideation.

Dr. Stuart Grassian has also provided pioneering work on the harmful psychological effects of solitary confinement. In his initial article on the topic, Dr. Grassian reported on 15 prisoners kept in isolation for varying amounts of time at a Massachusetts prison.[5] Dr. Grassian described a particular psychiatric syndrome resulting from the deprivation of social, perceptual, and occupational stimulation in solitary confinement. This syndrome has basically the features of a delirium, and among the more vulnerable population, can result in an acute agitated psychosis, and random violence – often directed towards the self, and at times resulting in suicide. He has also demonstrated in numerous cases that the prisoners who end up in solitary confinement are generally not, as claimed, "the worst of the worse"; they are, instead, the sickest, most emotionally labile, impulse-ridden and psychiatrically vulnerable among the prison population.

Two-thirds of the prisoners Dr. Grassian initially studied had become hypersensitive to external stimuli (noises, smells, etc.) and about the same number experienced "massive free floating anxiety." About half of the prisoners suffered from perceptual disturbances that for some included hallucinations and perceptual illusions, and another half complained of cognitive difficulties such as confusional states, difficulty concentrating, and memory lapses. About a third also described thought disturbances

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[5] Stuart Grassian, Psychopathological Effects of Solitary Confinement, 140 American Journal of Psychiatry 1450-1454 (1983). See also, Stuart Grassian and Friedman, N., Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement, 8 International Journal of Law and Psychiatry 49-65 (1986).

such as paranoia, aggressive fantasies, and impulse control problems. Three out of the fifteen had cut themselves in suicide attempts while in isolation. In almost all instances the prisoners had not previously experienced any of these psychiatric reactions.

I have toured and inspected numerous "supermax" penal institutions, interviewed and evaluated numerous prisoners confined under these severe conditions, and discussed isolation practices and procedures with correctional staff and officials from around the country, Europe and Africa. In other words, I have been studying the plight of mentally ill prisoners for decades.[6] I have written extensively about the harm that long-term isolated confinement causes in prisoners, especially those suffering from serious psychiatric conditions. As one stunning index of the magnitude of this harm, national data indicate that fully half of the suicides that occur in a prison system occur among the 3% to 8% of the prisoners who are consigned to segregation or isolation.

An alarmingly large proportion of prisoners who have been consigned to supermaximum security isolation in recent decades suffer from serious mental illness. It is stunningly clear that for them, time served in isolation and idleness exacerbates their mental illness and too often results in suicide. This is the main reason that federal courts have ruled that prisoners with serious mental illness must not be subjected to long-term isolation.[7] For other prisoners, those who do not suffer from an obvious mental disorder, time in isolation brings about the disturbing symptoms Drs. Haney and Grassian have enumerated, and has the effect, on average, of worsening recidivism rates.

Recently I have been asked by attorneys to investigate the effects of very long term solitary confinement (over a decade) upon prisoners who do not exhibit an obvious serious mental illness. These are individuals who do not participate in mental health treatment, who have refused to inform on other prisoners as a condition of release from supermaximum confinement, and many of them have long ago become eligible for parole but parole boards have told them that because they remain in isolated confinement they cannot be paroled. The referral question I am asked is whether their continuing isolated confinement causes

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[6] For example, see: T. Kupers, Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It. San Francisco: Jossey-Bass/Wiley (1999).

[7] Madrid v. Gomez, 889 F Supp. 1146 (N.D. Calif., 1995); Jones 'El v. Berge, 164 F. Supp. 2d 1096 (W.D. Wis. 2001); Presley v. Epps, No. 4:05CV148-JAD (N.D. Mississippi, 2005 & 2007).

additional psychiatric harm. My preliminary answer (my investigation is ongoing) is that very long-term isolation and idleness has produced in these prisoners, on average, disabling symptoms beyond those reported by Haney, Grassian and others (whose studies mostly involved prisoners who had been in solitary confinement for a matter of months or a few years). Those disturbing symptoms continued and worsened over ensuing decades, but additionally, these prisoners have become severely cut off from their own feelings and have turned inward so they hardly engage in any social activity at all, even considering their very limited options within the isolation unit. The damage is cumulative and severe.

Then, too often, a certain number of prisoners are released straight out of solitary confinement to the community at the end of their prison sentence (this is called "maxing out of the SHU"). This creates huge problems for them in adjusting to community life, and needless to say the recidivism and parole violation rates for the group who "max out of the SHU," as well as for those who spent considerable time in isolation, is extremely dire. Whether or not prisoners are permitted to "max out of the SHU," the period of isolation and idleness has very negative effects on their chances of succeeding at "going straight" after being released.

By now there is a growing national trend away from the use of long-term solitary confinement in corrections.[8] Of course, there are compelling economic justifications that partially explain this trend. Supermax prisons, where prisoners are confined in their cell nearly 24 hours per day and take part in few if any growthful activities, are very expensive to operate. In addition, however, there are the important mental health concerns and public safety justifications mentioned above. Because this kind of confinement is not only painful but also potentially damaging — and, for some prisoners, irreversibly so — it is a cruel and singularly inappropriate form of punishment. Beyond doing more to debilitate than rehabilitate the prisoners who are subjected to it, solitary confinement undermines the ability of many of them to succeed in the

[8] Erica Goode, Prisons Rethink Isolation, Saving Money, Lives and Sanity, New York Times, March 10, 2012 [available at: http://www.nytimes.com/2012/03/11/us/rethinking-solitary-confinement.html?pagewanted=all]

community after their eventual release from prison.[9] This evidence—that it appears to increase rather than reduce recidivism—raises public safety concerns.

Moreover, supermax prisons do not reliably reduce violence or disciplinary infractions within the larger prison systems in which they function; in some instances they appear to make it worse.[10] Nor do they alleviate the problem of prison gangs. The California Department of Corrections has aggressively pursued the use of long-term solitary confinement for more than 20 years and the state prison system is now plagued with perhaps the worst gang problem in the nation.

Recently, I served as an expert witness, and then as a court-approved monitor, in litigation in Mississippi that required the Department of Corrections (Mississippi DOC) to ameliorate substandard conditions at the super-maximum Unit 32 of Mississippi State Penitentiary at Parchman, remove prisoners with serious mental illness (SMI) from administrative segregation, provide them with adequate treatment, and re-examine the entire classification system. Pursuant to two federal consent decrees, the Mississippi DOC greatly reduced the population in administrative segregation and established a step-down mental health treatment unit for the prisoners excluded from administrative segregation. After 800 of the approximately 1,000 prisoners in the super-maximum security unit were transferred out of isolated confinement, there was a large reduction in the rates of misconduct and violence, not only among the prisoners transferred out of supermax, but in the entire Mississippi Department of Corrections.[11]

Thus, long-term solitary confinement places prisoners at grave risk of psychological harm without reliably producing any tangible benefits in return. There is no hard evidence that supermaximum security facilities actually ever reliably reduced system-wide prison violence or enhanced public safety. Fears that a significant reduction in the supermax population or the

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[9] For example, see: Lovell, D., Johnson, L., & Cain, K., Recidivism of Supermax Prisoners in Washington State, 53 Crime & Delinquency 633-656 (2007); Mears, D., & Bales, W., Supermax Incarceration and Recidivism, 47 Criminology 1131 (2009).

[10] Briggs, C., Sundt, J., & Castellano, T., The Effect of Supermaximum Security Prisons on Aggregate Levels of Institutional Violence, 41 Criminology 1341-1376 (2003).

[11] See T. Kupers, T. Dronet et al, Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs, 36 Criminal Justice and Behavior 1037-1050, October, 2009, attached.

outright closure of a facility will result in heightened security threats and prison violence have not been born out by experience. In fact, as the example cited above makes clear, recent experience in Mississippi found exactly the opposite—that a drastic reduction in the supermax population was followed by a reduction in prison misconduct and violence.

As prison populations slowly decline, and the nation's correctional system re-dedicates itself to program-oriented approaches to positive prisoner change, the resources expended on long-term solitary confinement should be redirected to more cost-effective solutions. In Mississippi and elsewhere, supermax prisons are beginning to be seen as an expensive anachronism. I urge the Subcommittee to promote legislation that will reduce reliance on supermaximum security facilities, reduce the abuses that have accompanied the trend toward long-term prisoner isolation, and require effective rehabilitation for prisoners. I would be happy to help the Subcommittee in its work.

Thank you for considering these comments.

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