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Testimony of

The Legal Aid Society, Prisoners' Rights Project

June 19, 2012

Before the Senate Judiciary Subcommittee on the Constitution,

Civil Rights, and Human Rights:

Reassessing Solitary Confinement:

The Human Rights, Fiscal, and Public Safety Consequence

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To the Senate Committee:

The Legal Aid Society thanks Chairman Durbin, Senator Graham, and Members of the Subcommittee for the opportunity to submit this written testimony on the issue of solitary confinement in New York prisons.

My name is Sarah Kerr. I am a staff attorney at the Prisoners' Rights Project ("PRP") of the Legal Aid Society. PRP has been a leading advocate for constitutional and humane conditions of confinement for prisoners incarcerated in the New York City and New York State correctional systems since it was established by the Legal Aid Society in 1971. The Prisoners' Rights Project has participated in several federal lawsuits that address the inappropriate use of solitary confinement of prisoners with mental illness. Along with others we were counsel in the state-wide lawsuit, *Disability Advocates, Inc. v. New York State Office of Mental Health*, 02 CIV 4002 (S.D.N.Y.) *("DAI v. OMH")*, which sought to improve mental health services in the prisons including in the solitary confinement settings in New York prisons.[1]

I offer this testimony based on ongoing contact with and advocacy on behalf of prisoners of the State of New York, knowledge of the New York State Department of Corrections and Community Supervision (DOCCS) and the New York State Office of Mental Health (OMH) through litigation and other advocacy, as counsel for the plaintiff, Disability Advocates, Inc., in the litigation *DAI v. OMH* and as counsel in prior litigation concerning the solitary confinement of prisoners with serious mental illness at several New York State prisons.

Introduction:

My comments will focus on the significant progress made in providing for mental health treatment in the New York State prisons including limiting the placement of prisoners with serious mental illness in solitary confinement settings, taking mental illness into account during disciplinary hearings, creating and expanding residential mental health treatment settings in the prisons and the importance of the Special Housing Unit (SHU) Exclusion Law passed by the New York State Legislature. In addition to barring prisoners with serious mental illness from harmful solitary confinement, recommendations for providing for prisoners with mental illness include the need for external oversight, training, and a full range of programs and services.

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[1] *Disability Advocates, Inc. v. New York State Office of Mental Health*, No. 1:02-cv-04002 (S.D.N.Y. 2007) was brought by Disability Advocates, Inc., the Prisoners' Rights Project of the Legal Aid Society, Prisoners' Legal Services of New York, and the law firm of Davis Polk & Wardwell. A similar case was recently settled in Massachusetts. *Disability Law Center, Inc. v. Mass. Dept. of Correction, et al*., Civ. No. 07-10463 (U.S.D.C. Mass.). Nina Loewenstein, from Disability Advocates, Inc. ("DAI") and Karen Murtagh from Prisoners' Legal Services of New York ("PLS"), co-counsel in the state-wide litigation, also expect to submit written testimony to Congress.

Progress did not occur overnight. At the end of a two-decade course of litigation, the primary lesson is that the humane treatment of prisoners with mental illness – which includes keeping them out of solitary confinement settings – must be addressed as part of the overall mental health program of the prison system.

Efforts to Improve Mental Health Treatment for Prisoners in New York:

Eng v. Goord, Civ 80-385S (W.D.N.Y.) and *Anderson v. Goord*, 87 CV 141 (N.D.N.Y.):

A little more than twenty years ago I went to Attica Correctional Facility to speak to prisoners who were housed in solitary confinement at that prison. I was just beginning to monitor a settlement agreement in *Eng v. Goord* that was supposed to result in the removal of prisoners with serious mental illness from solitary confinement at that one prison. I spoke with many prisoners over several days. A shocking number of the prisoners I spoke with had been in solitary confinement for years, many with long sentences yet to be served. Some never expected to be let out of solitary confinement and many were in fact correct that their sentence to solitary confinement exceeded their criminal sentence. They were scheduled to be released from solitary confinement to the street (a practice that continues to occur). Some of the prisoners were extremely psychiatrically deteriorated at the time of my interviews. Attica staff informed me that some of the prisoners on my list "never come out of their cells and will likely refuse to see you." I was informed by a DOCCS Supervisor that one of the individuals that I was hoping to see "believed that he was Jesus Christ and was from another planet." The staff member who informed me of this told me that this prisoner would refuse the interview — she had *never* seen him come out of his cell over a period of many years in solitary confinement.

Many prisoners did come to speak to me in the attorney visit area. I had written to them indicating when I would come and many entered the interview area eager to share their experiences. I spoke with prisoners who had scars up and down their arms from acts of self-harm committed while in solitary confinement. Some said cutting relieved the stress of isolation, others appeared depressed and offered no explanation for their self-harming acts. Some spoke of the lack of visits from their family: because they had been in prison too long, were too far from home, or because they asked them not to come because they didn't want them to see them "like this" – referring to the non-contact visit room where some prisoners in solitary confinement were permitted family visits in small booths behind metal grates covered in Lexan.

The prisoner who believed he was Jesus Christ from outer space did come to speak to me. Staff told me they were shocked that he had agreed to the interview. He was disheveled but calm, gentle seeming and completely delusional. He spoke of outer space, and of being the Savior and made no logical sense during our exchange. Although he was known by everyone (security and clinical staff at Attica) to be delusional, he was not removed from solitary confinement despite his obvious treatment needs and despite the language of the settlement agreement that I was there to enforce. According to Attica clinical staff he was "functioning adequately" in solitary confinement.

The last prisoner I spoke with on the last day told me of his lack of hope, his depression, the desperation that he felt daily. When he began to weep quietly sitting across from me, I opened the window to let more of the spring breeze in. I told him that I could stay until the end of the shift when my visit time was to end. We sat there for another half hour, he weeping quietly and I trying not to join him and feeling inadequate. It was at this time that the Prisoners'

Rights Project began to understand the scope of the problem of solitary confinement of prisoners with mental illness in New York and to consider how the situation could be improved.

At Attica, despite a settlement requiring removal from solitary confinement for prisoners with serious mental illness who were "known to be at substantial risk of serious mental or emotional deterioration," prisoners were deemed by OMH clinical staff "functioning adequately" unless they deteriorated to the point of requiring crisis intervention. The settlement provision was interpreted to be coterminous with the prisoner requiring hospitalization due to being a danger to self or others. There was in effect a revolving door between SHU and psychiatric hospitalization: prisoners who psychiatrically deteriorated due to isolation in solitary confinement were hospitalized, stabilized, and sent back to solitary confinement, where they predictably deteriorated and were hospitalized again.

Further litigation in *Eng v. Goord* resulted in an amended settlement agreement and the creation of the first solitary confinement mental health treatment program in New York. At Attica, prisoners with serious mental illness in solitary confinement received two hours of out-of-cell treatment five days a week. However, the reforms developed in *Eng* were inadequate to address the scope of the problem. Prisoners with mental illness were moved from Attica to solitary confinement in other prisons where there was no treatment program and no settlement; the program worked for some prisoners but did not provide sufficiently individualized treatment to accommodate others with varied mental health treatment needs. Prisoners who succeeded in the program and were released from solitary confinement often returned to solitary soon thereafter. Moreover, the treatment program simply did not address the root problem of prisoners with mental illness violating prison rules due to the symptoms of their illness.

One other case predated our filing of a state-wide claim. *Anderson v. Goord* was litigation about treatment and due process rights of prisoners in solitary confinement at two New York prisons It resulted in improved state-wide regulations concerning disciplinary hearings that required that mental illness be considered when determining culpability as well as mitigating and determining an appropriate penalty, and regulations requiring that security and mental health staff meet to consider time cuts and discuss problems or consider other ameliorative interventions for prisoners with serious mental illness in solitary confinement.[2] The changes in the disciplinary hearing regulations began to address the root problem concerning discipline for symptomatic behavior yet there remained limited treatment opportunities and limited residential mental health treatment units.

Disability Advocates, Inc. v. New York State Office of Mental Health ("DAI v. OMH") & the SHU Exclusion Law:

DAI v. OMH was brought with the goal of improving the entire prison mental health treatment system state-wide in New York.[3] We had learned in the prior litigation that keeping prisoners with mental illness out of solitary confinement required comprehensive reform of the mental health treatment system as well as aspects of the disciplinary system. We knew we had to improve mental health treatment at the front door to the prison, as well as at the door to the

[2] 7 N.Y.C.R.R. §§ 251.2, 254.6, 254.7 and 310.

[3] *Disability Advocates, Inc. v. New York State Office of Mental Health*, No. 1:02-cv-04002 (S.D.N.Y. 2007). The case was brought by Disability Advocates, Inc., the Prisoners Rights Project of the Legal Aid Society, Prisoners Legal Services of New York, and the law firm of Davis Polk & Wardwell.

solitary confinement housing areas. The *DAI v. OMH* complaint reflected our understanding that one of the results of inadequate mental health treatment was that prisoners with mental illness became trapped in the disciplinary process and ended up in solitary confinement settings, where they deteriorated psychiatrically. The grossly disproportionate numbers of suicides that occurred in solitary confinement demonstrated the tragic consequences of the failure to intervene and remove prisoners with serious mental illness from solitary confinement. The settlement reflected our understanding that to keep prisoners with mental illness out of solitary confinement, it is necessary to create other places to keep them. Many prisoners with mental illness simply cannot be housed in the general prison population consistent with their own safety and the safety and good order of the prison.

DAI v. OMH went to trial in 2006 and after the initial phase of testimony was presented, the parties – encouraged by the judge who had heard the testimony of prisoners and psychiatric experts and who had toured three prisons with the parties – entered negotiations. These resulted in a private settlement agreement (PSA) which included among its provisions a *minimum* of two hours per day of out-of-cell treatment or programming for prisoners with serious mental illness in solitary confinement, universal and improved mental health screening of all prisoners upon admission to the state prison system, creation and expansion of residential mental health programs including creation of a regional mental health unit (RMHU) where prisoners with serious mental illness who would otherwise have been held in solitary confinement would receive at least *four* hours per day of out-of-cell treatment or programming. The PSA required and improved suicide prevention assessments upon admission to solitary confinement, improved treatment and conditions for prisoners in psychiatric crisis in observation cells, and directed further modifications to the disciplinary process e.g. restricting charges for acts of self-harm and barring certain restrictive punishments. The result of the litigation is that there is now an array of residential and non-residential mental health treatment programs available to New York State prisoners in need. There are medium security prisons with sufficient mental health treatment staff so that prisoners with serious mental illness may be housed there. (Previously, only the maximum security prisons had full-time psychiatric coverage, which meant that prisoners with serious mental illness were housed in maximum security prisons regardless of whether there was an actual security need for them to be in those harsher conditions.) A stated goal of the agreement was to treat rather than isolate and punish prisoners with serious mental health needs.

Simultaneous to the *DAI v. OMH* litigation efforts, a broad coalition of prisoner and mental health advocates, ex-offenders, and family members created a coalition to end the use of solitary confinement for offenders with mental illness. The coalition, Mental Health Alternatives to Solitary Confinement ("MHASC"), participated actively in community organizing and lobbying efforts to educate the public and politicians about the problems experienced by offenders with mental illness incarcerated in solitary confinement settings.[4] Members of MHASC assisted legislators in drafting state legislation to end solitary confinement for offenders with mental illness in New York State prisons altogether.

[4] On several occasions New York State legislators held public hearings about mental health care in the state prisons. *DAI v. OMH* counsel, psychiatric experts, ex-prisoners and MHASC family members testified about their knowledge of problems with the overuse of solitary confinement by NY DOCCS and its deleterious effect on offenders with mental illness.

That legislation passed in modified form in 2008.[5] The SHU Exclusion Law does not completely bar the use of solitary confinement for prisoners with serious mental illness. It expanded on some of the provisions of the *DAI v. OMH* PSA and adopted other PSA provisions without modification. It defines "serious mental illness," and provides for prisoners with serious mental illness to be diverted or removed from segregated confinement to RMHUs where they will receive a minimum of *four* hours of out-of-cell mental health treatment or programming. The law provides that confidential meetings with qualified mental health staff are offered more frequently than every 90 days in solitary confinement at OMH level one and two facilities (*i.e.* those holding prisoners with more serious mental health treatment needs) and are offered on a routine basis by qualified clinical staff. The SHU Exclusion Law provides that a state agency, the Commission on Quality of Care and Advocacy for Persons with Disabilities, has oversight responsibilities to ensure that the SHU Exclusion Law is followed. CQCAPD must publicly report findings to the New York State Legislature on compliance with the SHU Exclusion Law each year. The passage of the SHU Exclusion Law expanded upon and made permanent the improvements to the New York prison system.

For many prisoners with serious mental illness the changes have been extremely beneficial. Overall, the increase in available treatment opportunities has, for many prisoners with serious mental illness, greatly improved their periods of stability and we have witnessed improved clinical response to relapse by OMH clinical staff in the prisons. Some prisoners with serious mental illness have succeeded in moving out of solitary confinement into less restrictive housing areas. However, not all are able to maintain sufficient psychiatric stability to remain free of new disciplinary charges.

For some prisoners with serious mental illness the changes in the disciplinary process have led to lower penalties at disciplinary hearings and in some cases substantial time cuts by treatment teams or Joint Case Management Committees ("JCMC") in the RMHUs. However, it is not our experience that time cuts and consideration of mental illness at disciplinary hearings have been effective for every prisoner with serious mental illness or that the process is consistent. Many prisoners with serious mental illness are now serving long sentences to solitary confinement in the RMHUs where they receive four hours per day of out-of-cell treatment and programming. The RMHU is substantially less isolating than solitary confinement but some prisoners remain unable to succeed and move on to general population or to the less restrictive residential mental health treatment units.

We continue to witness ongoing problems with treatment and discipline of prisoners with mental illness including under diagnosis, failure to identify and designate inmate-patients with serious mental illness and overly punitive disciplinary sanctions imposed against some prisoners with mental illness. Most of these reflect failure to follow the requirements of the *DAI v. OMH* settlement, the SHU Exclusion Law, and the agencies' own policies. Several recent suicides in New York prisons illustrate the tragic outcomes that can accompany failure to fully remedy these problems and to identify and remove from solitary confinement prisoners with serious mental illness. Suicide investigation reports conducted by the New York State Commission on Correction or by CQCAPD reflect inconsistent assessments, failures to accurately diagnose and identify inmate-patients with serious mental illness and unchecked punitive response to symptomatic behaviors. The redacted CQCAPD and SCOC Reports on the 2009 and 2010

[5] Most of the provisions of the statute appear as amendments to N.Y. Correction Law §§ 137 and 401.

suicides of A.W.; G.P. and A.H. described below raise serious concerns about the failure of OMH to provide a continuum of care to the prisoners in their care, and failure to comply with OMH policy and procedure, the *DAI v. OMH* settlement and cognate provisions of the SHU Exclusion Law.

Suicides of A.W., G.P. and A.H.

The redacted SCOC Report on the suicide of A.W. on March 12, 2010, demonstrated failures of the prison risk assessment, suicide screening and mental health reception screen and evaluation of A.W.. A.W. was re-admitted to prison on February 9, 2010 as a parole violator. In accordance with the policies in effect pursuant to the *DAI v. OMH* settlement, he should have received an initial suicide screen upon admission, a complete mental health reception screen within 14 days of admission, and given his history (the report indicates that A.W. was designated as having a serious mental illness while incarcerated from August, 2007 to October, 2009), an in-depth mental health evaluation following the screening. Instead, he was inexplicably designated as not in need of OMH services. SCOC noted a clear failure to follow the reception screening and evaluation policy by examining and responding to the extensive documentation of his mental health treatment history.

The redacted SCOC Report on the suicide of G.P. on September 22, 2009, identifies problems with providing adequate treatment and a continuum of care; the report characterizes his treatment history as "inattentive case management with multiple changes in treatment regime at a distance without clinical encounters."

The reports about the suicide of A.H. in solitary confinement at Great Meadow on June 20, 2010 are far too reminiscent of the failures in treatment and unchecked punitive responses to symptomatic behaviors that led us to file *DAI v. OMH*. A redacted CQCAPD investigation notes changes in diagnosis, mental health level, medications, failure to provide trauma treatment and numerous failures to properly document his mental status. The failure to communicate about his condition led to a failure to conduct a mental health assessment when he was transferred between SHUs prior to his suicide. The redacted SCOC Report includes disturbing changes in treatment from entries that stated a "need for psych meds on permanent basis" to discontinuance of psychiatric medications without explanation. A discharge plan from the state forensic hospital recommending that A.H. be placed into a Transitional Intermediate Care Program was not followed by OMH prison staff. The SCOC concluded "[i]n the case of A.H., as his mood and behavior became increasingly unstable, punitive responses to those behaviors led to further decompensation, while treatment interventions decreased." The repeated punitive responses to A.H. as he psychiatrically deteriorated in solitary confinement exemplify the importance of vigilance and monitoring, and the need for diversion from harmful solitary confinement.

The inexplicable change from a designation of serious mental illness to an OMH level 6 "not in need of services" and the "multiple changes in treatment regime", changes in OMH level, medications and diagnoses described in these reports unfortunately mirror problems identified throughout the *DAI v. OMH* litigation and intended to be cured by the Private Settlement Agreement ("PSA"). The parties negotiated the PSA requirement that reception screening would be conducted by OMH clinical staff after plaintiff's psychiatric experts systematically identified

inappropriate diagnoses and changes in diagnoses of inmate-patients throughout the DOCCS population.[6]

Another example is a prisoner with serious mental illness now housed in an RMHU who was transferred there from solitary confinement at Southport where he accumulated multiple additional disciplinary infractions and solitary confinement sentences prior to being identified as having a serious mental illness. Even with the added protections in place (periodic confidential mental health assessments with a clinician), this prisoner had deteriorated in solitary confinement at Southport to the point of requiring crisis treatment by mental health staff before any effective action was taken. This prisoner has now been assessed as having a serious mental illness and has been diverted from Southport to an RMHU pursuant to the SHU Exclusion Law.

Persistent failures by DOCCS and OMH staff to adequately diagnose and detect mental illness, and to adequately accommodate serious mental illness during the disciplinary process, despite concerted efforts at reform over the past decades, demonstrate that the difficult task of improving mental health treatment and disciplinary systems is not finished and requires continued oversight. Prison systems resist reform even under the best of circumstances.

Recommendations:

- Prisoners with Serious Mental Illness Must Not be Housed in Solitary Confinement. Prisoners who suffer from serious mental illness should not be housed in solitary confinement in prisons or jails. This restriction should not be limited to so-called "Supermax" facilities, and we should reconsider the over-reliance on solitary confinement for *all* prisoners whether diagnosed with a serious mental illness or not. When Judge Lynch[7] approved the *DAI v. OMH* PSA he stated:

  > [G]reater attention should probably be paid to the problem of extremely lengthy SHU confinement even to those who are not mentally ill. As we learned during the trial, New York does not have a formal Supermax prison, but when numerous lengthy disciplinary sanctions of SHU confinement are made to run consecutively, prisoners in effect are kept in conditions at least as rigorous and perhaps even more so than in any official Supermax facility perhaps without as carefully thought about consequences as would exist in more official decision to relegate a prisoner to a formal Supermax institution. Tr. p. 9, 4/27/07.

- Definition of Serious Mental Illness. The obligation to provide mental health treatment to prisoners in need is not limited to a rigid diagnostic criteria. Any prisoner, regardless of diagnosis or lack of diagnosis, who develops a serious mental health need while incarcerated must be provided with needed treatment. Criteria for exclusion from harmful solitary confinement should take this into consideration and be inclusive of functional impairments including e.g. acts of self-harm and suicidality.

[6] *DAI v. OMH*, Supplemental Report of Terry Kupers, M.D., M.S.P., November 29, 2005, pp. 27-28, Trial Exhibit 3; *DAI v. OMH*, Report of Terry Kupers, M.D., M.S.P., June 1, 2005, pp. 23-29, 38-41, 105-130, Trial Exhibit 2.

[7] Judge Gerard E. Lynch, then of the United States District Court for the Southern District of New York, now serving on the United States Court of Appeals for the Second Circuit.

- Periodic Confidential Mental Health Assessments (of all prisoners housed in solitary confinement) by Qualified Clinical Staff. Humans, whether diagnosed with a serious mental illness or not, fair poorly in solitary confinement. "Walking rounds" of solitary confinement housing are wholly inadequate to enable clinical staff to identify and intervene when prisoners deteriorate due to the conditions of isolation in solitary confinement. It is simply not enough to walk through a solitary confinement housing area glancing into cells or briefly speaking with the prisoners. The need for vigilance to detect signs of mental illness for prisoners in solitary confinement requires periodic mental health assessments by qualified clinical staff in a confidential setting, if tragic consequences are to be prevented.

- Qualified Staff and Periodic Training. Effective treatment with positive outcomes requires qualified, experienced, trained clinical staff. The requirement of qualified and licensed clinical staff is extremely important in the closed setting of a prison where there is no choice of treatment, where access to advocates and family is limited, and where the population is often extremely impaired.

- Outside Monitor. Institutions – especially closed institutions like prisons which are not subject to public scrutiny – cannot be relied on to police themselves, especially where there is a long history of bad choices and bad policy that the institution must put behind it. There must be external review of the performance of prisons in managing and treating these difficult patients.

- Stop the Revolving Door: Prison systems must critically examine and end the continued punitive response to symptomatic behaviors of prisoners with mental illness in their care. Prisoners who deteriorate in solitary confinement must be diverted into alternative settings which provide out-of-cell treatment and programming to end the pattern of repeated punitive responses, psychiatric deterioration in solitary confinement and the need for crisis intervention.

- Quality Assurance. Implement a quality assurance system that measures effectiveness of treatment and provides evidence-based outcome measures to improve clinical practices. For example, information that should be tracked includes but is not limited to: frequency of changes from a diagnosis that qualifies as a serious mental illness to one that does not, frequency of changes to diagnosis in general, frequency of medication changes and medication discontinuance, and need for crisis intervention. By tracking information on changes in treatment regimes and outcomes, a system will be able to identify personnel and facilities which require performance improvement resources and will be able to improve the continuity of care for their inmate-patients and prevent tragic outcomes.

- Open Communications. Encourage open communications between agencies involved in providing mental health treatment and security to the vulnerable population of prisoners with serious mental illness – information that will assist in understanding the symptoms and nature of mental illness can reduce confrontations between staff and prisoners. Advocates for prisoners and family members of prisoners should also have the ability to communicate with security and treatment personnel concerning prisoners in their care.

- Reduction of Solitary Confinement. Sentences to disciplinary solitary confinement and solitary confinement in administrative segregation should not be long-term placements. Systems that house prisoners for months, years and decades rather than days and weeks should reconsider their practices and find alternatives to harmful solitary confinement.

- Other Alternatives. New York has implemented reforms for prisoners with serious mental illness with some notable success. These programs which include time cuts, incentives and programming with increased out-of-cell activities can be models for prisoners without serious mental illness as well. Introduction of shorter time periods in solitary confinement can also include reductions in the isolating aspects of this form of confinement. For example, periodic phone calls to family, access to television or other media, educational programs and substance abuse treatment programs can be made available.

Conclusion:

Prisoners with mental illness may have little or no ability to advocate for themselves within the prison. Inadequate mental health care in prison and the hostile and punitive reaction of prison staff, officials and other prisoners to the behaviors caused by their illnesses make coping with prison extremely difficult for prisoners with mental illness. When prisoners with mental illness are not adequately treated, they become increasingly incapable of conforming to institutional rules of conduct and, as a result, often are charged with disciplinary infractions.[8] As a result, solitary confinement cells in prisons are disproportionately, and inappropriately, filled with the prisoners who suffer from a mental illness.[9] Under the stringent restrictions of solitary confinement, prisoners with mental illness frequently receive additional disciplinary charges, prolonging their confinement in prison[10] and in the environment of solitary confinement that aggravates their illnesses and further isolates them from the limited mental health treatment available in prison. Many of the most seriously disabled prisoners end up in the "revolving door" between a solitary confinement setting and a state forensic psychiatric facility or crisis observation unit.[11] An expert in the effects of solitary confinement on prisoners with mental illness, Dr. Stuart Grassian, aptly termed this particular revolving door the "misery-go-round."[12]

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[8] Many disciplinary infractions against prisoners with mental illness reflect conduct which is symptomatic of their mental illness. For example, prisoners with mental illness are often punished for committing unhygienic acts, for flooding their cells, damaging property, being untidy, and for committing acts of self harm. More serious conduct can also be the product of mental illness, such as charges of violent conduct, harassment, arson and assault.

[9] In *Eng v. Goord*, Civ 80-385S (W.D.N.Y.), the N.Y. DOCS *Mental Health Services Plan for Special Housing Unit Patients at Attica Correctional Facility*, reported that between 30-40% of prisoners housed in the Attica SHU were on the active OMH caseload. Contrast this to the of 10-15% of the total prison population generally estimated to have mental illness. See, USDOJ Special Report, July 1999, *Mental Health and Treatment of Inmates and Probationers.*

[10] Prison disciplinary sanctions lead to lengthier prison terms. Discipline may result in the loss of good time and/or parole authorities may look at a lengthy disciplinary history as a reason to deny release.

[11] For example, one prisoner with schizophrenia was admitted to the state forensic hospital on more than 20 occasions since his incarceration in the late 1970s; he was housed continuously in some form of 23 hour solitary confinement for at least the period from early 1991 through May 2000.

[12] *Perri v. Coughlin*, 1999 WL 395374 (N.D.N.Y. 1999).

The harmful effects of isolation in solitary confinement on prisoners with mental illness and on other prisoners is well known and well documented. Steps can and must be taken to ameliorate the effects of solitary confinement for prisoners with mental illness and we must also take steps to reduce the current over-reliance on solitary confinement in America's prisons.

Improvements in prison mental health treatment are important not only for prison management but also for re-entry. The opportunities and services available in jail or prison, and the conditions under which prisoners are held, directly affect the skills, problems and needs prisoners will have at the time of their release. If mental health programs are unavailable, ineffective or oppressive in prison and jail, the released offender will be less likely to seek and participate in necessary treatment after release. Prisoners with mental illness who are not treated and who psychiatrically deteriorate in prison are less likely to be able to cope with prison, and are more likely to be punished for symptomatic behaviors that may violate prison rules. Discipline in prison may result in denial of parole, lengthening the period of expensive incarceration, placement into solitary confinement housing which may in turn cause additional psychiatric deterioration including acts of self harm (including a disproportionate number of prison suicides), additional rule breaking and more discipline. The end result of such neglect is that offenders are released to the community who are psychiatrically unhealthy, have been restricted from developing skills (including daily living and coping skills), and who may have developed a strong distrust for mental health treatment staff and the correctional and criminal justice systems for failing to intervene and assist them during their incarceration.

New York has been taking steps to improve its treatment of prisoners with serious mental illness who are disciplined with solitary confinement in its prisons. The progress towards reform in New York has taken many years, has been significant, but has also been slow and inconsistent. The improvements to policies and expansion of mental health treatment options in New York are thoughtful and can be looked to as a model for other systems with the understanding that implementation of changes in policy requires more than re-writing the policies. To implement change, there must be leadership, supervisory staff and line staff willing to work to make a change. If they are, they will see the difference I see between those first hopeless and despairing prisoners I interviewed at Attica and the condition and expectations of prisoners I interview today.

I thank the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights for attention to the important issue of solitary confinement in our prisons. I appreciate the opportunity to provide this written testimony.

Dated: June 15, 2012

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