Testimony on LB 598
Before the Judiciary Committee
Nebraska Legislature
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Good afternoon Senator Seiler and members of the Judiciary Committee. For the record my name is Brad B-R-A-D Meurrens M-E-U-R-R-E-N-S and I am the Public Policy Specialist with Disability Rights Nebraska, the designated Protection and Advocacy organization for Nebraskans with Disabilities. I am here today in support of LB 598.

We conducted a literature review on selected issues surrounding mental illness and corrections. I have attached our report to my testimony. We limited the scope of our research to four issues which, from our perspective, are of particular importance: 1) The use and effects of solitary confinement; 2) In-house mental health treatment; 3) Reentry and discharge planning; and 4) Community-based mental and physical health services. I will focus my comments today on the effects of solitary confinement or isolation/segregation.

Despite early enthusiasm, concerns were raised over the psychological and health effects of solitary confinement as early as the 1820's. Seeing the effects of total isolation on inmates in a New York penitentiary was enough for the governor of the state to end it in 1821[1]. Reports in the 1840's from physicians in the New Jersey and Rhode Island state penitentiaries noted a decrease in psychotic behavior when inmates were removed from solitary confinement and were able to interact with each other[2]. In

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[1] Smith, P. S. (2006). "The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature." *Crime and Justice*, *34*(1), 441–528.
[2] Ibid.

1890, the U.S. Supreme Court surveyed the history of extreme isolation use among American prisons and identified devastating psychological effects:

> "A considerable number of the 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 service to the community"[3].

Stuart Grassian identified a variety of physiological and psychological symptoms exhibited by prisoners in Secure Housing Units (read: isolation/segregation) which he called "SHU Syndrome"[4]. The symptoms included social withdrawal, anxiety, panic attacks, irrational anger and rage, loss of impulse control, paranoia, hypersensitivity to external stimuli, chronic depression, difficulties with concentration and memory, perceptual distortions and hallucinations.

Dr. Grassian concludes:

> "The restriction of environmental stimulation and social isolation associated with confinement in solitary are strikingly toxic to mental functioning, producing a stuporous condition associated with perceptual and cognitive impairment and affective disturbances. In more severe cases, inmates so confined have developed florid delirium—a confusional psychosis with intense agitation, fearfulness, and disorganization. But even those inmate[s] who are more psychologically resilient inevitably suffer severe psychological pain as a result of such confinement, especially when the confinement is prolonged, and especially when the individual experiences this confinement as being the product of an arbitrary exercise of power and intimidation. Moreover, the harm caused by such confinement may result in prolonged or permanent psychiatric

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[3] 134 U.S. 160 (1890).

[4] Stuart Grassian, 2006, "Psychiatric Effects of Solitary Confinement", Washington University Journal of Law and Policy

> disability, including impairments which may seriously reduce the inmate's capacity to reintegrate into the broader community upon release from prison."[5]

In his review of solitary confinement and 'Supermax' prisons, Dr. Craig Haney wrote that there is "an extensive empirical literature that clearly establishes their potential to inflict psychological pain and emotional damage."[6] Serious symptoms can occur in healthy individuals after only a few days in isolation.

Individuals with mental illness have more difficulty adjusting to prison conditions and are more likely to commit infractions.[7] Symptoms of mental illness may result in placement in segregation[8]. Consequently, studies have found some prisons with half of all inmates in segregation to be individuals with a diagnosable mental illness. Once in segregation, the conditions generally worsen an inmate's psychiatric symptoms, which can then be used to justify keeping them in segregation[9].

O'Keefe and colleagues noted, "Inmates released directly from segregation to the streets had dramatically higher rates and severity of detected recidivism than inmates in Administrative Segregation who first released to General Population."[10]

A common argument used in justifying the use of administrative segregation is that the prisoners are too dangerous to be released into the general population. While this may be true in some cases, lowering the number of prisoners in segregation has actually been associated in some cases with a decrease in violence. Starting at page 8, our study looked at the experiences of Mississippi, Washington, Virginia, and Colorado regarding the integration of inmates in segregation into the general population. Our

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[5] Ibid., p. 354

[6] Haney, C., 2003. "Mental Health Issues in Long-Term Solitary and "Supermax" Confinement", *Crime & Delinquency*, *49*(1), 124–156, http://cad.sagepub.com/content/49/1/124.abstract

[7] Smith, P. S. (2006). "The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature." Crime and Justice, 34(1), 441–528.

[8] Ibid.

[9] Ibid. and Metzner, J. L., & Fellner, J. (2010). "Solitary Confinement and Mental Illness in US Prisons: A Challenge for Medical Ethics". *Journal of the American Academy of Psychiatry and the Law Online*, *38*(1), 104–108.

[10] O'Keefe, M. L., Klebe, K. J., Metzner, J., Dvoskin, J., Fellner, J., & Stucker, A. (2013)."A Longitudinal Study of Administrative Segregation". *Journal of the American Academy of Psychiatry and the Law Online*, *41*(1), 49–60.

report indicates that these states did not experience an increase in violence when reintegrating isolated inmates into the general population, largely due to increased mental health treatment provided to inmates in isolation/segregation and/or successful transition or “step down” programs. In December 2013, the Colorado Department of Corrections declared that individuals with “major mental illnesses” would no longer be sent to solitary confinement.

Nebraska must examine and reduce its use of solitary confinement and segregation. We applaud LB 598 as an effort to understand Nebraska’s use of solitary confinement / isolation / segregation policy and to work towards reduction. We support the planning, oversight, and reporting requirements outlined in Section 2 of the bill and its emphasis on planning to reduce the use of isolation/segregation. We applaud the creation of clear prohibition in Section 3 and the promulgation of rules and regulations that will provide clear criteria and procedures for the use of each confinement level. Other states’ experiences lead us to believe that the transition planning outlined in Section 3(2) is advantageous. We support the data reporting requirements in Section 5. We are pleased to see the creation of the long-term segregation workgroup as it will provide sustained attention to this issue.

However, we have a few recommendations to improve the language of the bill as introduced:

1. Page 2, line 25: “…recommendations, ~~and~~ frequency, and time spent in isolation or segregation”.

2. Page 3, line 30: “…individualized transition plans , developed with the active participation of the committed offender”

3. Page 4, line 6: “…security of a correctional institution would be placed at imment and substantial risk. We would also recommend that there be a neutral party, such as the court, to make the determination when the publication of directives, manuals, guidance, etc. should be denied public view.

4. Page 4, line 30: add the Governor as a recipient of the quarterly report from the director

5. Page 5, line 6: add another sub point to capture the *number* of inmates in segregation or isolation who have been diagnosed with a mental illness or mental disability and type.

6. Page 5, line 25: add representation by a former inmate who experienced solitary confinement, isolation, or segregation.

7. Page 5, line 27-28: “procedures related to the proper treatment and care of offenders in ~~long-term~~ segregation and isolation.”

Disability Rights Nebraska believes the time has come to review and reduce Nebraska’s use of isolation and segregation in its correctional system. We recommend that LB 598 be advanced.