Solitary Confinement: The Case for Change in Massachusetts

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PRISONERS' LEGAL SERVICES OF MASSACHUSETTS

Executive Summary

The Evidence Supports Reducing Reliance on Solitary Confinement

The harmful effects of solitary confinement (or segregation, as it is called in the Department of Correction) are well documented and broadly recognized. The experiences of a growing number of states that have reduced their use of solitary confinement – echoed in recent Department of Justice reforms – show numerous benefits.

Solitary confinement does not reduce prison violence..4

- The experience of states that have reduced their use of solitary confinement shows that doing so does not increase the level of violence in prison, and can even reduce it.
- Prisoners held in solitary confinement suffer psychological effects that make it harder for them to control their behavior. Correctional staff also report greater stress and risk of harm.
- On the other hand, rehabilitative programming and mental health treatment can help make prisons safer. This has been proven true in the Department's own Secure Treatment Units, which were shown to reduce use of force incidents, assaults, self-harm, and to save money on outside hospital trips.

The over-use of segregation is expensive..5

- States that have reduced segregation have reported substantial savings. In the federal system it can cost two to three times more to keep a prisoner in segregation than general population. Per-prisoner costs for Massachusetts prisoners in segregation are likely to be $100,000-$170,000 or higher.
- In order to reap the maximum benefit from reducing segregation, some of these savings should be invested in treatment, rehabilitation, education and employment programs that will help prisoners avoid segregation in prison and succeed on release, creating a virtuous cycle of reduced prison violence, reduced recidivism, and further savings.

The over-use of segregation is bad for public safety 5

- Prisoners in segregation are deprived of all the tools that they need to succeed and avoid recidivism on release – education, programming, employment, and meaningful contact with family and friends
- The psychological effects of solitary confinement are such that individuals released to the community may be unable to adjust to life outside of prison and at risk for recidivism. This is particularly true of prisoners who are released to the community directly from segregation.

Massachusetts Can and Should Take Immediate Steps to Reduce its Over-reliance on Segregation.

End long, punitive sanctions to the Departmental Disciplinary Unit (DDU) 6

- Massachusetts is an outlier in imposing disciplinary segregation sanctions of up to 10 years per offense, with no rehabilitation and no pathway out. Nearly all other states have far shorter disciplinary segregation terms, after which prisoners who are considered to pose a risk may be moved to administrative segregation.
- In addition to over-using disciplinary segregation, Massachusetts disproportionately imposes this harsh punishment on African American men, who make up about 25 percent of male DOC prisoners but nearly half of the DDU population.
- Segregation should not be used as punishment for more than a short period, after which, if there is a real security need, prisoners should be held in administrative segregation, with the safeguards and improved conditions described below.

Regulations should ensure that administrative segregation is used only for prisoners who pose a substantial threat, and only as long as they pose a substantial threat.....................6

- Administrative segregation should be used only when it is demonstrated that this is necessary for security, with due process protections, frequent reviews, and a way for prisoners to earn their way out of segregation. Prisoners in administrative segregation should have conditions and privileges equivalent to the general population to the extent possible.
- Massachusetts has regulations which provide this type of protection, but the DOC has refused to follow them. These regulations were drafted before the Department had long-term disciplinary segregation, and they remain a more effective way to handle prisoners who pose an ongoing threat of some sort.

Those with mental illness and other vulnerabilities should be diverted from segregation..7

- Study after study demonstrates that prolonged segregation can cause serious and permanent psychological damage. During the pendency of litigation filed in 2007, the Department created two Secure Treatment Units (STUs) with 29 beds for prisoners that have serious mental illness and would otherwise be in segregation. These units have been proven successful in reducing self-harm, and assaultive and destructive behavior, but the number of beds is inadequate to meet the prisoners' needs. PLS has written to the Commissioner with the accounts of a number of PLS clients who are housed in segregation despite extreme psychological distress.
- Segregation should be carefully limited for other vulnerable populations as well, including young adult prisoners, LGBTQ and gender nonconforming prisoners, pregnant and post-partum prisoners, deaf and blind prisoners, those with developmental disabilities, and prisoners with medical needs, in addition to those with mental illness.

Segregation should provide social contact and rehabilitative programs even for prisoners found to pose a substantial threat, and should give prisoners a pathway back to the general population 8

- Even for those prisoners who are found to pose a current threat sufficient to justify removal from the general prison population, secure confinement should not mean isolation and deterioration. The DOC can and should provide treatment, group programs and opportunities for social interaction even in the most secure settings, which will enable prisoners to more successfully transition to the general population and the community.
- A number of states have implemented programs designed to help prisoners function infraction-free in the general population and to reward them for their positive efforts while in segregation. Such programs, which can greatly reduce segregation time, provide treatment that has demonstrated effectiveness in reducing targeted behaviors and provide prisoners incentives to demonstrate positive behavior.

Let people out of segregation before release to the community...8

- DOC prisoners are sent straight to the street from months or years of segregation, even though studies show that this greatly increases the risk of recidivism.
- Massachusetts can do better, by ensuring that only the truly dangerous are in segregation during the six months before their release date and, for those prisoners (who should be few), providing social contact and targeted programing in segregation before they leave.

Introduction

Prisoners' Legal Services (PLS) welcomes this opportunity to share an overview of the research on isolated confinement[1] and recommendations for curbing the use of segregation in the Commonwealth. A groundswell of reform has led state and local jurisdictions across the country to reduce their reliance on segregation and in the process improve prison management and save taxpayer dollars.[2] The U.S. Department of Justice (DOJ) recently announced reforms in segregation practices in the Bureau of Prisons and made similar recommendations to the states.[3] Below PLS first summarizes some of the demonstrated benefits from reducing solitary confinement and then suggests steps which Massachusetts can take to join the growing trend toward more public safety oriented segregation policies and practices.

The Evidentiary Support for Reducing Reliance On Segregation

The harmful effects of isolation have been recognized by the National Commission on Correctional Health Care, the American Public Health Association, and the American Psychiatric Association.[4] The U.N. Special Rapporteur on Torture has found that severe negative effects "can occur after only a few days in solitary confinement," and has stated that "any imposition of solitary confinement beyond 15 days constitutes torture, or cruel, inhuman or degrading treatment or punishment." [5] The experience of jurisdictions that have limited the practice elsewhere shows the benefits that come from reducing unnecessary segregation.

Solitary confinement does not reduce prison violence.

The experience of states that have reduced segregation shows that doing so does not increase the level of violence in prison, and in some cases has reduced it.

- The General Accounting Office in 2013 reported that it had interviewed officials in five states that have reduced reliance on segregation -- Maine, Colorado, Kansas, Mississippi and Ohio -- and learned that in all five states there was no increase in violence when prisoners were moved to less restrictive housing.
- After Mississippi reduced the population in its "supermax" segregation unit by 85 percent, a study showed a 70 percent reduction in prison violence.
- Maine has cut its solitary confinement population in half and found no rise in violence and even a decline by some measures.
- Colorado closed a 316-bed solitary confinement facility and reduced the population in solitary by 36.9 percent. As a result the state saved an estimated $4.5 million in 2012-13 and $13.6 million in 2013-14 -- and prisoner-on-staff assaults there have been at their lowest since 2006.

The experience of these states is not surprising. Prisoners who are held in segregation for a substantial period of time are deprived of normal environmental stimulation and suffer symptoms such as panic, anxiety, withdrawal, hallucinations, hopelessness, paranoia and depression; the environment can cause prisoners to develop aggression and rage.[6] Correctional staff tasked with

managing solitary confinement units report greater levels of stress and are at greater risk of physical and psychological injury because of their exposure to the segregation environment.[7] The blue-ribbon Commission an Safety and Abuse in America's Prisons, formed by the Vera Institute, observed in its 2006 report, "There is troubling evidence that the distress of living and working in this environment actually causes violence between staff and prisoners…[T]he misuses of segregation works against the process of rehabilitating people, thereby threatening public safety."[8]

The weight of this experience disproves the assertion that segregation is a necessary tool to deter prison violence. On the other hand, rehabilitative programming and mental health treatment can help make prisons safer. Data provided by DOC's former mental health contractor, MHM Services, Inc., found that prisoners with mental illness who were removed from long term segregation and placed in mental health treatment units had sharp decreases in the number of use of force incidents, assaults on staff and other prisoners, suicide precautions, disciplinary reports, and trips to outside hospitals to treat self-injury. These decreases were dramatic both during their time in the treatment units and during the six months after their release from the units, as compared to the six months before their admission.[9] Indeed, DOC saved more than $600,000 because of the reduction in outside hospital trips alone.

The over-use of segregation is expensive.

As noted above, states that have reduced segregation have reported substantial savings. PLS does not know the precise cost of each segregation bed in Massachusetts, but we know that in the federal system it can cost two to three times more to keep a prisoner in segregation than general population. Prisoners in segregation in Massachusetts are handcuffed and escorted by at least two officers when they get their five hours a week of recreation in an outdoor cage, receive a visit (through glass), or go to the doctor. Massachusetts now spends $56,000 per year to house a male DOC prisoner in maximum security general population, and $40,000-$48,000 per year for mediums. So per-prisoner costs in segregation are likely to be between $100,000 and $170,000 per prisoner per year, or higher.

In order to reap the maximum benefit from reducing segregation, though, some of these savings should be invested in drug and clinical treatment, rehabilitation, education and employment programs that will help prisoners avoid segregation in prison and succeed on release, creating a virtuous cycle of reduced prison violence, reduced recidivism, and further savings.

The over-use of segregation is bad for public safety.

Prisoners in segregation are denied access to the types of programming shown to lead to reductions in recidivism and to increases in post-release employment opportunities.[10] At the same time, while family visitation is shown to decrease prisoners' risk of reoffending, all contact with family and friends is also highly restricted.[11] Indeed, segregation conditions essentially prevent prisoners from sustaining or creating social bonds.[12] In addition, the psychological effects of segregation, such as fear and withdrawal, can be long lasting, preventing prisoners released to the community from adjusting to life outside of prison.[13] The "paranoia and social anxiety" resulting from segregation means that released prisoners may have more difficulty "getting their bearings during the first few months" upon release, which is the period when they are at the greatest risk of reoffending.[14] Accordingly, prisoners held in segregation for an extended period time and certainly those released directly from segregation to the street are at high risk for failure, which is undeniably bad for public safety.

Steps that Massachusetts can and should take to reduce its over-reliance on segregation

Segregation is too costly, harmful and cruel to use when it is not necessary. This is why the Department of Justice and states from Colorado to Maine have taken steps to reduce it, and why even the American Society of Correctional Administrators has urged states to reduce unnecessary segregation. [15] There is much that Massachusetts can do to change a situation where segregation is, in the words of Colorado corrections commissioner Rick Raemisch, "over-used, misused and abused."

End long, punitive sanctions to the Departmental Disciplinary Unit (DDU).

Massachusetts is an outlier in imposing disciplinary segregation sanctions of up to 10 years per offense, with no rehabilitation and no pathway out. Indeed, prisoners can and do spend even longer periods in the DDU because they accumulate additional DDU sanctions while held there; the stress and other effects of isolation can make repeat violations within the DDU more likely. Nearly all other states have far shorter disciplinary segregation terms, after which prisoners who are considered to pose a risk may be moved to administrative segregation. The Justice Department's recommendations to the Bureau of Prisons would greatly reduce disciplinary segregation, limiting it to 60 days for the most serious offenses (or 90 days if it is a repeat offense), with far shorter sentences for lesser offenses. In addition to over-using disciplinary segregation, Massachusetts disproportionately imposes this harsh punishment on African American men, who make up just about 25 percent of male DOC prisoners but nearly half of the DDU population. African American and Latino prisoners together constitute two thirds of those in the DDU.[16]

The DOC has signaled some steps in the right direction. Proposed changes to the disciplinary regulations would enable the Superintendent to recommend prisoners for early release from the DDU, and proposed changes to the classification regulations appear to anticipate some sort of rehabilitative programing within the DDU. But these changes will only be meaningful if the Department spells out criteria that entitle a prisoner to early release, and provides DDU prisoners with structured out-of-cell programs and activities that will give them the tools to earn their release.

Ultimately, segregation should be used as punishment for only a short period of time, after which prisoners should be held in administrative segregation only if they pose an continuing security threat, with programming, treatment and the ability to earn release with good behavior.

Regulations should ensure that administrative segregation is used only for prisoners who pose a substantial threat, and only as long as they pose a substantial threat.

Reducing over-reliance on segregation also requires that administrative segregation be used only when necessary for security. Along these lines, the DOJ recommends that administrative segregation not be used "unless correctional officials conclude, based on evidence, that no other form of housing will ensure the inmate's safety and the safety of staff, other inmates, and the public. This determination should be guided by clearly articulated procedural protections, including the use of a multidisciplinary review team." In addition, "Officials should regularly review those in preventative segregation with the goal of transitioning inmates back to less restrictive housing as soon as it is safe to do so." The Justice Department also recommends that those in administrative

segregation "should be given the opportunity to participate in incentive or step-down programs that allow them to progress to less restrictive housing."

Massachusetts has regulations which provide this type of protection, but the DOC does not follow them. The Departmental Segregation Unit (DSU) regulations, 103 CMR 421, provide that prisoners may be held in administrative segregation only after due process ensures there is "substantial evidence" that they pose a "substantial threat" to safety or security. These regulations also require that prisoners in administrative segregation be given a conditional release date and be told how they can earn their release. Finally, they require that prisoners held in segregation for administrative – and not punitive – reasons be given programs and privileges equivalent to the general population to the extent possible. However, these regulations are not followed in any of DOC's segregation units, which are currently called Special Management Units (SMUs).

The Supreme Judicial Court recently ruled in *Cantell v. Commissioner*, No. SJC 12015, that DOC prisoners in administrative segregation in SMUs must be given the benefit of the DSU regulations if conditions in the SMUs are equivalent to a DSU (i.e., 23 hour a day cell confinement). These regulations were drafted before the Department had long-term disciplinary segregation, and they remain a more effective way to handle prisoners who pose an ongoing threat of some sort. In tandem with the elimination of long disciplinary sentences as suggested above, PLS urges the adoption of administrative segregation principles in line with the DSU regulations: segregation only as long as needed, a pathway out, and access to programs that address the prisoner's rehabilitative needs.

Those with mental illness and other vulnerabilities should be diverted from segregation.

Study after study demonstrates that prolonged segregation can cause serious and permanent psychological damage.[17] Segregated confinement's harsh conditions, sensory deprivation and lack of human contact have been shown to exacerbate serious mental illness and can lead to suicide and other self-harm. In 2007, after eleven DOC prisoners -- at least seven of whom suffered a documented serious mental illness -- committed suicide in segregation over a 28-month period, PLS and its colleagues brought a legal challenge to the Department's practice of holding prisoners with seriously mental illness in segregation.[18] During the pendency of this lawsuit, two secure treatment units (STUs) were created as an alternative to solitary confinement for seriously mentally ill prisoners. The settlement in this case required that prisoners designated as having serious mental illness would not be housed in segregation for more than a short period of time. Legislation passed in 2015[19] codified the settlement and the STUs. A study of prisoners housed in the STUs found decreased incidences of self-harm, and assaultive, destructive behavior,[20] suggesting that the units should be improved upon and expanded. Yet the 29 STU beds that were established are inadequate to meet the Department's needs.

The attached, confidential, "Attachment A" describes eight PLS clients who are housed in segregation despite clear psychological distress. In some cases, they have been designated as having serious mental illness but remain in segregation for nearly two years due lack of STU bed space. In other cases, the very restricted definition of "serious mental illness" employed by the DOC has excluded many who should not be exposed to segregated confinement. Most fundamentally, the psychological harm of segregation is not limited to those designated as SMI, and many prisoners with a range of symptoms should be given treatment rather than subjected to conditions which risk

harm and psychological deterioration. Even prisoners with less severe mental illness would benefit significantly from a unit that provides programing to reduce problem behaviors.

Segregation should be carefully limited for other vulnerable populations as well. The 2016 DOJ report recommends that all prison systems adopt specific protections for juveniles and young adult prisoners, LGBTQ and gender nonconforming prisoners, pregnant and post-partum prisoners, deaf and blind prisoners, those with developmental disabilities, and prisoners with medical needs, in addition to those with mental illness.[21] Legislation recently passed in New Jersey would exclude these groups from segregation.[22] Other states that have taken action to exclude vulnerable populations from segregation include New York (excluding pregnant prisoners, and developmentally disabled and intellectually challenged prisoners by settlement agreement)[23] and Colorado (excluding the seriously mentally ill pursuant to legislation).[24]

Segregation should provide social contact and rehabilitative programs even for prisoners who pose a substantial threat, and should give prisoners a pathway back to the general population.

Even for those prisoners who are found to pose a current threat sufficient to justify removal from the general prison population, secure confinement should not mean isolation and deterioration. The DOC can and should provide treatment, group programs and opportunities for social interaction even in the most secure settings, which will enable prisoners to more successfully transition to the general population and the community. Along these lines, the DOJ recommends, "Correctional systems should seek ways to increase the minimum amount of time that inmates in restrictive housing spend outside their cells and to offer enhanced in-cell opportunities. Out-of-cell time should include opportunities for recreation, education, clinically appropriate treatment therapies, skill-building, and social interaction with staff and other inmates."

Indeed, a number of states have followed the lead of Ohio and Mississippi to implement structured programs designed to help prisoners to function infraction-free in the general population and to reward them for their positive efforts while in segregation. These programs, often called step-down units, can greatly reduce the amount of time spent in segregation. They typically have features similar to what Massachusetts now offers only in its STUs, such as specific treatment (including cognitive behavioral therapy) that has demonstrated effectiveness in reducing targeted behaviors and behavior reinforcement systems that give prisoners multiple opportunities and incentives to demonstrate positive behavior.[25]

Let people out of segregation before release to the community.

The DOJ recommends that prisoners not be released directly from segregation to the street unless there is a compelling reason, and that segregation be avoided during the last 180 days of a prisoner's sentence, if possible. If a prisoner must be held in segregation during this time officials should provide targeted re-entry programming. As things stand, DOC prisoners are sent straight to the street from months or years of segregation. Massachusetts can do better by ensuring that only the truly dangerous are in segregation during the six months before their release date and, for those prisoners (who should be few), providing social contact and targeted programing in segregation before they leave. Studies show that prisoners released directly to the community from a segregation unit reoffend more quickly and at higher rates than do prisoners who spent at least three months in general population prior to their release.[26]

Conclusion

Massachusetts can and should join a historic movement away from a practice that history will regard as barbaric. Solitary confinement does not serve prison safety or public safety, and it wastes taxpayer funds as it destroys lives. PLS welcomes an ongoing discussion of how the Commonwealth can safely transform its segregation practices.

Notes

[1] "Isolated confinement" refers to cell confinement of approximately 23 hour per day. The term "solitary confinement" is also widely used to describe this practice, and the Department of Correction uses the term "segregation." All three terms are used interchangeably in this memorandum.

[2] *See* Vera Institute of Justice, "Solitary Confinement: Common Misconceptions and Emerging Safe Alternatives, May 2015, *available at* https://www.vera.org/publications/solitary-confinement-common-misconceptions-and-emerging-safe-alternatives.

[3] U.S. Dep't of Justice, U.S. Department of Justice Report and Recommendations Concerning the Use of Restrictive Housing (2016), *available at* http://www.justice.gov/restrictivehousing.

[4] *See* National Commission on Correctional Health Care, Position Statement, Solitary Confinement, *available at* http://www.ncchc.org/position-statements; American Public Health Association, Policy Statement, "Solitary Confinement as a Public Health Issue," *available at* https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/14/13/30/solitary-confinement-as-a-public-health-issue; American Psychiatric Association, Position Statement on Segregation of Prisoners with Mental Illness (December 2012).

[5] See Special Rapporteur on Torture, *Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, *delivered to the General Assembly*, U.N. Doc. A/66/268, at 17, 21 (Aug. 5, 2011).

[6] *See* Richard Korn, *The Effects of Confinement in the High Security Unit at Lexington,* 15 SOCIAL JUSTICE 8, 8-19 (1988); Richard Korn, *Follow-up Report on the Effects of Confinement in the High Security Unit at Lexington*, 15 SOCIAL JUSTICE 20, 20-29 (1988); Holly A. Miller & Glenn R. Young, *Prison Segregation: Administrative Detention Remedy or Mental Health Problem?*, 7 CRIMINAL BEHAVIOR AND MENTAL HEALTH 85, 85-94 (1997); Peter Suedfeld, et al., *Reactions and Attributes of Prisoners in Solitary Confinement,* 9 CRIMINAL JUSTICE & BEHAVIOR 303-340 (1982); *See also* Henrik Andersen, et al., *A Longitudinal Study of Prisoners on Remand: Repeated Measures of Psychopathology in the Initial Phase of Solitary Versus Nonsolitary Confinement*, 26 Int'l J. L. & Psychiatry 165, 165-177 (2003); S. L. Brodsky & F. R. Scogin, *Inmates in Protective Custody: First Data on Emotional Effects,* 1 FORENSIC REPORTS 267, (1988) ; Stuart Grassian, *Psychopathological Effects of Solitary Confinement*, 140 AM. J. OF PSYCHIATRY 1450 (1983); Stuart Grassian & N. Friedman, *Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement*, 8 INT'L J. L. & PSYCHIATRY 49-65 (1986); Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax" Confinement*, 49 CRIME & DELINQUENCY 124 (2003); Hans Toch, MOSAIC OF DESPAIR: HUMAN BREAKDOWN IN PRISON, (American Psychological Association, 1992) ; Richard Walters, et al., *Effect of Solitary Confinement on Prisoners*, 119 Am. J. Psychiatry 771, 771-773 (1963); Bruno M. Cormier & Paul J. Williams, *Excessive Deprivation of Liberty*, 11 CANADIAN PSYCHIATRIC ASSOC. J. 470, 470-484 (1966); Peter Suedfeld & Chunilal Roy, *Using Social Isolation to Change the Behavior of Disruptive Inmates*, 19 Int'l J. of Offender Therapy & Comparative Criminology 90, 90-99 (1975); Thomas B. Benjamin & Kenneth Lux, *Constitutional and Psychological Implications of the Use of Solitary Confinement: Experience at the Maine Prison*, 9 Clearinghouse Review 83-90 (1975).

[7] Cloud, David, JD MPH, Drucker, Ernest, PhD, Browne, Angela, PhD, Parsons, Jim, PhD, "Public Health and Solitary Confinement in the United States," American Journal of Public Health, Vol. 105, No. 1 (Jan. 2015). The correctional officers' union in Texas recently proposed abolishing solitary confinement on death row, explaining that prisoners who are stripped of all privileges become harder to manage and more dangerous to correctional officers. The Marshall Project, *Shifting Away from Solitary*, available at https://www.themarshallproject.org/2014/12/23/shifting-away-from-solitary.

[8] John J. Gibbons & Nicholas de B. Katzenbach, *Confronting Confinement: a Report of the Commission on Safety and Abuse in America's Prisons*," at 14-15 (2006), *available at* https://www.vera.org/publications/confronting-confinement.
[9] *Secure Treatment Unit Outcomes: An Analysis of All STU Admissions 2008 to the Present*, MHM Services, Inc., to the Department of Correction Health Services Division (1/18/13).
[10] *See* Haney, *supra* note 6, at 127.
[11] *See* Mears, Daniel P., Bales, William D., "Supermax Incarceration and Recidivism," Criminology (Oct. 2009) pp.1138.
[12] *See id.*
[13] Haney, *supra* note 6, at 140.
[14] Lovell, David, et. al, "Recidivism of Supermax Prisoners in Washington State," 53 Crime and Delinquency 634, vol. 53 at 635 (2007).
[15] The Liman Program, Yale Law School, & Association of State Correctional Administrators, "Time-In-Cell: The ASCA-Liman 2014 National Survey of Administrative Segregation in Prison," (August 2015), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2655627
[16] These figures are based on statistics contained in an Institutional Fact Card for DDU priosners dated February 20, 2015 which showed that 62 of 133 DDU prisoners were African American and 31 were Hispanic.
[17] A scholarship review in the American Journal of Public Health found, "Nearly every scientific inquiry into the effects of solitary confinement over the past 150 years has concluded that subjecting an individual to more than 10 days of involuntary segregation results in a distinct set of emotional, cognitive, social, and physical pathologies." Cloud, David, JD MPH, Drucker, Ernest, PhD, Browne, Angela, PhD, Parsons, Jim PhD, "Public Health and Solitary Confinement in the United States," American Journal of Public Health, Vol. 105, No. 1 (Jan. 2015). The National Commission on Correctional Healthcare also recently issued a position statement concluding that "Prolonged (greater than 15 consecutive days) solitary confinement is . . . harmful to an individual's health." http://www.ncchc.org/solitary-confinement
[18] *See Disability Law Center Inc. v. Massachusetts Department of Correction, et. al.*, 960 F.Supp.2d 271 (D. Mass. 2012).
[19] G.L. c. 127 §39A
[20] *Secure Treatment Unit Outcomes: An Analysis of All STU Admissions 2008 to the Present*, MHM services, Inc. to the Department of Correctional Health Services Division (January 18, 2013).
[21] Available at https://www.justice.gov/dag/file/815556/download.
[22] N.J. S.B. 51 (2016-2017) *available at* https://legiscan.com/NJ/text/S51/2016. This legislation would restrict segregation for any prisoner who: suffers a disability based on a mental illness; has a history of psychiatric hospitalization; has recently exhibited conduct indicating the need for further observation to determine the presence of mental illness; has a developmental disability; has a serious medical condition which cannot effectively be treated in isolated confinement; is pregnant or postpartum; has a significant auditory or visual impairment; or is perceived to be lesbian, gay, or transgender.
[23] *Peoples v. Fischer*, 1:11-cv-02694-SAS (S.D.N.Y. 2015).
[24] Colorado SB 14-064;
[25] See Perrien, Mary and Maureen L. O'Keefe, "Disciplinary Infractions and Restricted Housing," p.10, in Oxford Textbook of Correctional Psychiatry, Trestman, Applebaum and Metzner, eds. (May 2015).
[26] Lovell, David, et. al, "Recidivism of Supermax Prisoners in Washington State," 53 Crime and Delinquency 634, vol. 53 at 635 (2007); Cloud, David, JD MPH, Drucker, Ernest, PhD, Browne, Angela, PhD, Parsons, Jim PhD, "Public Health and Solitary Confinement in the United States," American Journal of Public Health, Vol. 105, No. 1 (Jan. 2015).

Attachment A

PLS provides the client information below to the recipients of this report with the understanding that the Commonwealth shares the obligation to maintain the confidentiality of protected health information and criminal offender record information. Upon request, PLS will provide a redacted version for public distribution.

1. Prisoners designated as having serious mental illness remain in segregation

The Eighth Amendment to the U.S. Constitution has been held to prohibit more than brief solitary confinement of prisoners designated as having serious mental illness (SMI).[1] Massachusetts law, G.L. c. 127 §39A, requires that such prisoners not be held in segregation longer than 30 days except in "exigent circumstances that would create an unacceptable risk to the safety of any person or where no secure treatment unit bed is available," and requires that they be placed in a secure treatment unit (STU). It also requires that any such segregated prisoner awaiting transfer to a STU shall be offered additional mental health services.

Below are two cases that illustrate violations of these provisions.

- Mr. [redacted] recently served 18 months in the DDU despite being designated as SMI by DOC mental health clinicians. If he has not already, he will very soon be sent back to general population without ever having received any genuinely enhanced mental health care, and after having been subjected to a prolonged period of solitary confinement in the DDU, which is widely known to exacerbate mental illness.

- [redacted] was designated as SMI by DOC mental health providers. Despite his diagnosis, he has been in solitary confinement for over a year and is now serving a sentence in the DDU. Mr. [redacted] has a long history of suicide attempts and hospitalizations. His mental health providers told him over a year ago that he would be transferred to the BMU. He was also told he would receive extra services while in the DDU, but these services consist only of an extra fifteen minutes of meeting time with his mental health clinician per week, which is a grossly insufficient response to his acute mental health symptoms.

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[1] *See Madrid v. Gomez*, 889 F. Supp. 1146, 1265-66 (N.C. C al. 1995) (subjecting prisoners with mental illness to prolonged isolation "cannot be squared with evolving standards of humanity or decency"); *Ruiz v. Johnson*, 37 F. Supp. 2d 855, 915 (S.D. Tex. 1999), *rev'd on onter grounds*, 243 F.3d 941 (5th Cir. 2001), *adhered to on remand*, 154 F. Supp. 2d 975 (S.D. Tex. 2001) (segregation of prisoners with serious mental illness violates Eighth Amendment);. *Coleman v. Brown*, 912 F.Supp. 1282, 1320-21 (E.D. Cal. 1995) (segregation of class of prisoners with mental illness violates Eighth Amendment); U.S. Department of Justice, *Investigation of State Correctional Institution at Cresson and Notice of Expanded Investigation*, Findings Letter, May 31, 2013 pp. 17-18, *available at* https://www.justice.gov/crt/special-litigation-section-cases-and-matters0 (under Pennsylvania) (prolonged solitary confinement of prisoners with mental illness can violate the Eighth Amendment).

2. Prisoners are held in segregation even when there are strong indications that they should be designated as having serious mental illness or where extended segregation placement is causing clear psychological harm.

After conducting extensive record reviews PLS has found a pattern of a failure on the part of mental health staff to designate prisoners with SMI who a) have a documented history of diagnoses that meet the SMI criteria and/or b) are exhibiting signs of significant functional impairment. While reasonable clinicians may differ with respect to whether a prisoner is properly designated as SMI, even where an SMI designation may not be warranted it is clear in many cases that the prisoner is decompensating and suffering psychological harm in segregation. A number of prisoners, in addition to having documented histories of severe mental illness, exhibit behaviors such as eating feces, smearing feces, refusing to shower, suicidal ideation, frequent instigation of planned uses of force, and frequent incidents of self-harm, but nonetheless remain in segregation.

- Mr. [redacted] recently received a 30-month DDU sentence and will likely complete his criminal sentence and re-enter society directly from the DDU. There are indicators that Mr. [redacted] should be designated as SMI, but regardless of whether he is properly considered SMI or not, he is clearly decompensating in segregation and his placement there is exacerbating his mental health and behavioral issues. As a result of his mental health issues he is in frequent conflict with correctional staff and regularly receives disciplinary reports. He has had at least 11 uses of force against him since 2015. He has a long history of mental illness, including suicide attempts and hospitalizations, and he has engaged in self-injurious behaviors by cutting himself. He had significant drug abuse at an early age and reports that he was repeatedly drugged as a child. Mr. [redacted] also suffers from a traumatic brain injury that is not treated or recognized by DOC. Mr. [redacted] has an open mental health case. In the community, Mr. [redacted] was diagnosed with and treated for Schizoaffective Disorder. Within the DOC, mental health staff have used several different diagnoses, ranging from Intermittent Explosive Disorder to Antisocial Personality Disorder. He has also been treated with psychotropic medication in the DOC, including Remeron, Vistaril and Lamactil. He reports having been treated successfully in the past with Seroquel, but DOC will not provide him with that medication to measure its effectiveness. DOC, in fact, recognized that Mr. [redacted] had a heightened need of mental health services, and housed him in the Residential Treatment Unit (RTU) for 7 months in 2015 before discharging him on the basis that he had difficulties with the staff there. It is unclear how mental health staff reached the clinical determination that Mr. [redacted] would have fewer difficulties in a less therapeutic setting, but despite the fact that this hypothesis was proven wrong almost immediately, no attempt was made to bring Mr. [redacted] back into a specialized mental health unit. The downgrade in mental health classification that accompanied Mr. [redacted]'s discharge from the RTU – a downgrade which was unsupported by any evidence of improvement in his mental health, but which was necessary to effect the discharge from the RTU – made him eligible for DDU placement.

- Mr. [redacted] is currently serving two concurrent DDU sentences. He will not complete these sentences until October 15, 2017. Mr. [redacted] has a long history of mental illness, both in prison and in the community, and there are indications that he should be designated SMI. His most consistent diagnosis prior to being in DOC custody was Bipolar disorder. DOC mental health clinicians changed this diagnosis to unspecified anxiety disorder, antisocial

personality disorder, and steroid addiction. He was also previously diagnosed by DOC clinicians with disruptive impulse control and conduct disorder. He has asked mental health to re-evaluate his diagnoses and consult his prior records, but they have placed the onus on him, from his cell in the DDU, to obtain his outside records. Despite being treated with Effexor, Tegretol, Remeron, and, until July 2016, Haldol, he is not considered to be SMI by DOC, and thus will remain in DDU with no enhanced mental health services whatsoever. Even if Mr. [REDACTED] should not be designated as SMI, it is clear that long term segregation is having a severe detrimental impact on his mental health and behavior. His continued placement in the DDU is not helping to control his behavior or enhance institutional security. In fact, Mr. [REDACTED] frequently ends up out of control as a result of his confinement in solitary conditions, his mental illness, and resulting decompensation. When Mr. [REDACTED] was originally sent to DDU it was to serve a six-month sentence, but, like many of PLS' mentally ill clients, he was given an additional 18-month DDU sentence in the midst of serving his first DDU sentence. Mr. [REDACTED] has been involved in at least 10 planned uses of force, which included the use of chemical agents that agitate both his mental illness and his asthma, and he has accumulated numerous disciplinary reports since arriving in the DDU. Mr. [REDACTED] is frustrated at his devastating inability to control his behavior while in segregation, explaining that he simply "doesn't know why he can't calm down." Mr. [REDACTED] is subject to an ineffective behavioral management plan that is punitive in nature and includes no incentives for good behavior, only continual punishments for poor behavior. These punishments include taking away his mirror and other property, leaving him with nothing in his cell but books and legal material. Recently Mr. [REDACTED] received yet another DDU-referred disciplinary report subsequent to an incident with correctional staff and spent a lengthy period on extra restraint status, subjected to full restraints and escorted by a full tactical move team every time he left his cell. Allowing Mr. [REDACTED] to flounder under these conditions of extreme isolation in the DDU will likely result in a continued downward spiral of mental health and behavioral management issues that psychologically damages Mr. [REDACTED] and does not serve the Department's interest in maintaining a safe and secure prison environment.

- Mr. [REDACTED] has a well-documented history of mental illness. DOC mental health providers have diagnosed him with both Axis I and Axis II disorders. His records further suggest that he suffers cognitive deficits related to previous head trauma and an associated seizure disorder. Mr. [REDACTED]'s family also reports a long history of Attention Deficit Hyperactivity Disorder. For a time, DOC recognized that Mr. [REDACTED] was in need of enhanced mental health treatment. He was a resident of the RTU until mental health abruptly downgraded his mental health designation and cleared him for general population. In 2014, almost immediately after this change in mental health designation and level of services, Mr. [REDACTED] was sentenced to 15 months in the DDU. Because DOC's mental health providers did not consider Mr. [REDACTED] to be seriously mentally ill, he was not diverted to a mental health unit or provided enhanced services. Mr. [REDACTED]'s abrupt change in mental health designation calls into question the veracity of the decision not to designate him as SMI and divert him from DDU. Regardless, his long standing mental health history, well known to the Department, should have been impetus enough to consider him for diversion to a treatment unit. Instead, his time spent in DDU continues to exacerbate his mental health condition and behavioral health. Since the end of his DDU sanction, Mr. [REDACTED] has spent long periods on mental health watches at SBCC, including a four-month mental health

watch stint earlier this year, and he was issued another DDU referred disciplinary report. Mr. ██████ is due to be released to the community in the next two-to-three years.

- Mr. ██████ suffers from a longstanding and crippling mental illness. Medical records from Bridgewater State Hospital (BSH) in 2012 and 2010 document his psychotic symptoms, paranoia, and delusional thinking. When SBCC staff first sent him to BSH in 2006, his diagnosis included depression with psychotic features, and he was described as delusional. This history certainly indicates that Mr. ██████ should be considered for a SMI designation. However, even if he is not designated as SMI, his longstanding and well documented mental illness indicates that long term placement in segregation will cause him significant psychological harm. In spite of this, Mr. ██████ recently spent months in segregation, where he deteriorated badly and received multiple disciplinary reports. At least one such disciplinary report reportedly led to a six-month DDU sanction for throwing a carton of sour milk at a correctional officer. Mr. ██████ received this DDU sanction despite having been previously approved to move to a Behavior Management Unit (BMU). Mr. ██████, however remains in segregation at SBCC where he has been since 12/1/15.

- Mr. ██████ had an open mental health case until June of 2015 when his case was closed, according to DOC records, at Mr. ██████'s request. Mr. ██████ reports that he has been diagnosed in the past with either Bipolar Disorder or Depression and PTSD. He has been treated with anti-psychotic medications and has attempted suicide at least once during a previous incarceration. Shortly after his mental health case became closed, on July 2, 2015, he was involved in an incident with correctional staff and sent to segregation. He remained in segregation pending a DDU hearing and was ultimately sentenced to one year in the DDU, which he has now served. While in segregation and DDU Mr. ██████'s mental health deteriorated significantly, and he attempted to access mental health services and have his mental health case reopened. He submitted numerous sick slips, sometimes as many as three times a week, asking to see a psychiatrist and stating that he wanted to be evaluated for medication. He reported anxiety, compulsive counting, talking to himself, increased depression, suicidality and significant and debilitating sleep disturbance. He also experienced decreased functionality, reporting an inability to leave his cell in order to shower as the result of fear of and ongoing conflict with correctional staff. Despite the fact that DOC recognized Mr. ██████ had mental illness before he removed himself from the mental health case load, when he reached back out, desperate for help after being removed to segregation, he was stonewalled and told he was not mentally ill. Whether or not Mr. ██████ is properly considered to fall under the technical rubric of the SMI designation, his well-known mental health history warrants that he at least be considered for diversion before being left to decompensate in segregation and DDU.

- Mr. ██████ has spent the majority of his DOC incarceration in segregation despite clear indicators that he should be designated as SMI. Regardless, it is clear he should be removed from segregation because it is causing him irreversible psychological harm. He has a long history of schizoaffective disorder. Despite Mr. ██████'s extensive diagnostic and mental health treatment history, he is not prescribed proper medication or mental health treatment at SBCC. As a result, Mr. ██████'s mental state and physical health have significantly deteriorated. Mr. ██████ has a lengthy mental health history indicating consistent diagnoses of Schizophrenia and Schizoaffective disorder. Beginning in 2003, Dr. Uzogara from Boston Medical Center diagnosed Mr. ██████ with paranoid schizophrenia and prescribed Mr.

200mg of Seroquel and 100mg of Zoloft continuously. In 2008, Dr. Valdez from Boston Health Care for the Homeless diagnosed Mr. with schizoaffective disorder and posttraumatic stress disorder, and prescribed him 200mg Seroquel and 100mg Zoloft. These prescriptions continued until 2010 when Mr. was at the Nashua Street Jail. While at Nashua Street Jail, Mr. was diagnosed with schizoaffective disorder and antisocial personality disorder. Mr. was prescribed a regimen of Wellbutrin, Haldol, and Trazadone until 2013. Also, when Mr. was at the Suffolk County House of Corrections in 2014 he was again diagnosed with schizoaffective disorder. His prescriptions consisted of different doses of Wellbutrin, Seroquel, Ziprasidone, Lithium, Perphenazine, and Risperdal. Despite this history, the DOC has refused to diagnose Mr. with a disorder that would qualify for the SMI designation. More perplexing is the fact that despite clear documentation of severe decompensation such as ingesting feces, smearing himself with feces, refusing to come out of his cell and paranoid delusions, Mr. has not been found to meet the SMI definition for functional impairment or seriously been considered for placement in a more appropriate treatment unit. Instead, he has spent almost his entire DOC sentence cycling between segregation and mental health watch.