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Dear Commissioners,

I regret I can't appear in person, because I value your work quite a lot. I hope it helps for me to submit a written statement.

The jail and prison population in the U.S.A. has quadrupled since 1980, and correctional facilities have become massively overcrowded. Crowding increases the rates of violence, mental breakdowns, and suicides "inside." Meanwhile, rehabilitation programs have been dismantled, and correctional systems have expanded the proportion of prisoners sent to punitive solitary confinement.

The number of prisoners with significant psychiatric disorders has also been growing rapidly. According to the U.S. Department of Justice, over 250,000 prisoners suffer from mental illnesses. The reasons for the expanding prevalence of mental illness in correctional settings include the shortcomings of public mental health systems, the tendency for post-Hinckley criminal courts to give less weight to psychiatric testimony, harsher policies toward drug offenders including those with dual diagnoses, and the growing tendency for local governments to incarcerate homeless people for a variety of minor crimes.

Prisoners suffering from serious mental illnesses are prone to victimization by other prisoners and are disproportionately victims of rape. A large proportion of these prisoners do most of their time confined to their cells. Many, as victims or aggressors, find their way into

punitive segregation. Many others voluntarily remain in their cells all day in order to avoid victimization on the yard. Cell confinement is likely to lead to further emotional deterioration.

When I began serving in the late 1970s as a psychiatric expert in class action lawsuits about the psychological effects of jail and prison conditions, I was mainly concerned about overcrowding. Research showed that crowding causes a whole list of destructive effects, including increased violence, more suicides, more serious psychiatric breakdowns, a higher prevalence of hypertension, and more stress-related physical illness. By 1990, there was still unconscionable crowding, but the new cause of human breakdown was excessive solitary confinement. A growing proportion of prisoners were being sent to what used to be called “the hole,” but instead of spending ten days or a month in a dark dungeon, they found themselves in a high tech, super-clean supermax cell where the lights would be kept on around the clock. The prisoners have great difficulty sleeping because the steel and cinderblock design magnifies sound and the banging of doors and hollering of officers wakes them throughout the night. Deprived of sleep, lacking in human contact and entirely idle, many inhabitants of supermaximum security units suffer emotional breakdown.

Many thousands of prisoners are actually spending years in punitive solitary confinement only to be set free with a few dollars and a bus ticket when their release date arrives. In other words, they “max out of the SHU.” They return to their community, having had no human contact for years, no preparation to help them “go straight,” and full of rage about the brutal conditions and lack of respect they have been forced to endure. Is it any surprise this group of ex-prisoners is very prone to substance abuse and crime? Meanwhile, the rate of parole violation is rising rapidly. More parolees are being caught with dirty urines and returned to prison. (What sense does this make, given that few will receive treatment for their addictions inside, whereas community drug treatment programs could help many of them become clean and sober?)

There is a tendency to focus precious mental health resources on those who suffer from a "major mental illness," including Schizophrenia, Bipolar Disorder and severe Depression. While prisoners suffering from these conditions deserve comprehensive mental health services, other disorders can cause as much suffering and disability, including anxiety, phobia, obsessive-compulsive disorder, and post-traumatic stress disorder (PTSD). PTSD is especially important, since we know that prisoners, on average, have suffered from a lifetime of severe traumas, including the domestic violence they witnessed or fell victim to as children, the violence and deaths they saw on the streets, and the violence they experienced as adults prior to incarceration. Then, as convicts, they experience new traumas.

Rape in women's prisons illustrates the pattern. Whereas the perpetrator of rape in men's prisons is usually another male prisoner, in women's prisons the perpetrator is almost always a male staff member. Both Human Rights Watch and Amnesty International have issued reports condemning this unconscionable but widespread abuse of human rights. Rape is massively underreported because the women are terrified of retaliation by the staff member, whom they believe is very unlikely to face punishment. A large proportion of women prisoners suffered sexual and physical abuse as children and domestic violence as adults. When, because of inadequacies in correctional mental health programs, the traumatized women receive insufficient treatment, the PTSD and depression they develop makes it very difficult for them to succeed after being released.

Sixty to eighty percent of prisoners have a substance abuse problem. "Dual diagnosis," or co-occurring mental illness and substance abuse, is widespread among prisoners. We know that a prisoner with a substance abuse history who does not undergo any serious treatment for the problem in prison is likely to relapse into substance abuse after being released. Yet the percentage of prisoners provided with substance abuse treatment (nationally) while imprisoned

dropped from 17 percent to 10 percent during the 1990s. Obviously, a large number of prisoners who would benefit from drug and alcohol treatment do not receive it.

The same conditions that worsen psychiatric disorders make treatment problematic. Psychotropic medications are not very effective when the patient is confined to a cell, the clinician has little if any opportunity to develop a therapeutic relationship or even educate the patient about the illness and the need for medications, and there are no group therapies nor psychiatric rehabilitation programs. Yet this is precisely the situation in many jails and prisons. In supermaximum security units the psychiatrist might even be forced to interview prisoners at their cell doors with absolutely no confidentiality.

Of course, there are dedicated clinicians trying their best to relieve suffering and provide quality services. And they often find a niche within a prison system where they are able to do good work. For example, there are many model programs where prisoners can be thoroughly examined and engage in treatment while being provided a modicum of safety. But usually these programs are small and fail to reach the majority of prisoners in need of treatment.

No set of changes limited to jail and prison mental health programs will result in major improvements. Of course, it would help a little to double or triple the number of correctional psychiatrists, but that would not alter the fact that many psychiatric patients are victimized and many others wind up in punitive detention. Change must occur at the society-wide level as well as within the corrections system as a whole.

At the societal level, the jail and prison population could be greatly reduced by instituting diversion programs for non-violent offenses, especially drug-related crimes and crimes committed by people suffering from serious mental illnesses. Approximately 75 percent of people entering prison today have not been convicted of a violent crime. And 90 to 95 percent will be released. Criminal defendants suffering from serious mental illnesses, and those who

commit minor crimes involving alcohol and drugs, have a much better prognosis if they are diverted into the appropriate mental health or drug treatment program.

While diversion offers hope for reducing the prison population and providing treatment for many offenders, it also has the potential to increase the repressiveness of the criminal justice system. There are certainly cases involving dangerous felons where release from custody requires involuntary outpatient commitment. But new laws that expand involuntary outpatient treatment programs could also be applied to many other individuals who have not done anything wrong except fail to comply with their treatment and recycle into the hospitals. We need to guarantee constitutional safeguards as we proceed cautiously in regard to involuntary outpatient treatment and commitment.

At the level of entire prison systems, general rehabilitation and education programs need to be re-established. Idleness is not good for anyone's mental health. In the community, mental health providers make use of local educational opportunities and job-training programs to help patients regain independence and health. Likewise, in correctional facilities where there are attractive rehabilitation and educational programs, prisoners with mental illnesses can make use of them to recover and stay out of trouble. In addition, there needs to be less reliance on punitive segregation and supermaximum security. Inevitably prisoners with serious mental illnesses collect in these solitary confinement units. There are other, more effective ways to reduce violence in prisons, for example by involving the majority of prisoners in meaningful activities which they are loath to jeopardize by getting into trouble.

Finally, correctional mental health services and psychiatric rehabilitation programs need to be upgraded. There needs to be better staff collaboration, so prisoners with behavior problems as well as mental disorders can be managed without being relegated to long-term solitary confinement. There need to be more stepdown units, roughly equivalent to residential

treatment facilities in the community, where prisoners with serious mental disorders can be partially sheltered as they undergo treatment. Mental health staff need to make contact with prisoners' families and need to do conscientious post-release treatment planning. We know very well how to establish and run all the components of a comprehensive mental health treatment program, and there is no reason not to do so in our jails and prisons.

Sincerely,

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