

Humane Treatment for Special Management Prisoners

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The Maine Association of Psychiatric Physicians is strongly opposed to the use of administrative segregation (formerly called solitary confinement) based on its potential for creating and exacerbating severe mental illness (SMI), worsening cognitive impairment, crippling social skills, and its lack of rehabilitative value.

Not surprisingly, a bipartisan national task force (The Commission on Safety and Abuse in America's Prisons) concluded after a year-long investigation in 2006, that no benefits of solitary confinement could be found, that the harm involved is clear, and recommended that the practice should be discontinued. In England, an article by Atul Gawande notes that the use of solitary confinement has become "almost negligible," replaced by demonstrably effective programs and activities to teach and practice social skills. These allow even troublesome prisoners more, not less control of their lives, and avoid the humiliation and degradation which only breed anger, despair, and the likelihood of further violence.

If the goal of the Corrections system is to ensure public safety, then segregation is a counterproductive failure. There is substantial data in the medical and criminal justice research literature to document the negative impact of this technique, even if we chose to ignore the mental health consequences. Prisoners who have experienced segregation and who are released back to the community relapse back into criminal behavior sooner and more aggressively than their general prison population counterparts.

Roughly half of the prisoners in administrative segregation were convicted of non-violent crimes, and if we include assault as an act probably not requiring administrative segregation, 2/3 of the prisoners in administrative segregation may not have needed such a high level of incarceration to start with (From "Sentences of Prisoners in the Special Management Unit on February 26, 2010, DOC). *See addendum below to see my calculations.*

Those who experience administrative or high risk segregation are known to experience unrelenting rage and an urge for revenge. How can this possibly improve public safety? We saw a striking example of this during public testimony to the Judiciary Committee during this past Legislative Session. One of the men who testified had been in administrative segregation. He was bent on confronting Commissioner Magnusson, became verbally loud and angry with the committee, and almost had to be escorted out. It is hard to imagine that man trying to function with the normal frustrations of a job.

Many prisoners in "solitary" are not only likely to have sexual and physical trauma histories, traumatic brain injuries and psychiatric disorders, but they are more likely to be illiterate and need a different approach to learning skills necessary to safely return to society. According to Maine Department of Corrections data, more than half of the prisoners in the Special Management Unit have a Severe Mental Illness (and this goes to 63% when addiction diagnoses are included).

Many states have managed to exclude prisoners with severe mental illness (SMI) from admission to Supermax prisons and from segregation units (Ohio, California, Illinois and Wisconsin), or have converted Supermax prisons to other uses (Virginia, Maryland, Ohio) and/or have provided psychiatric treatment alternatives to inmates with severe mental illness to avoid placement in Administrative Segregation confinement. (Colorado, Florida, New Jersey, New Mexico, Texas and the Federal Bureau of Prisons). Suits about this issue are pending in Connecticut and New York. Even Mississippi, which used to be the poster child for abusive prison environments, has introduced a Step Down, or Intermediate Unit for prisoners with

SMI, which teaches them skills that help keep them out of Segregation and makes successful community reintegration more likely. If Mississippi can do it, why not Maine?

Mississippi has also taken the creative and admirable step of introducing mental health and behavioral skills training for the prison officers. The officers who complete this training are given extra recognition and respect. Mississippi has also managed to get the MH health providers working as a team with the Corrections side of the equation, rather than in an adversarial relationship, something MAPP applauds and hopes to emulate. MAPP provided a copy of Dr. Kupers' paper to the committee during previous testimony; it contains more detail about the Intermediate Unit that Mississippi developed so successfully.

Interventions requiring top priority

1. Prisoners with serious mental illness should not be placed in administrative segregation. If a person's mental illness is so symptomatic that s/he is dangerous to the environment, that person needs treatment, not punishment.
2. Persons who are convicted of non-violent or low-level violence should not be housed in Supermax prisons.

Short term/low cost interventions that should happen quickly:

1. Use classification systems that already exist (e.g. in Ohio and Washington state) to identify and classify prisoners with SMI.
2. Just because a prisoner needs to be physically separated from others due to dangerousness does not mean that the prisoner needs to be shut off from all interpersonal and environmental contact. There is overwhelming data that this type of seclusion is not only harmful to the person, but is counterproductive. Violence toward staff and other prisoners actually GOES DOWN, costs of maintaining a prisoner actually GO DOWN when there is less use of the expensive Administrative Segregation. Costs to society GO DOWN with less use of Segregation because rates of recidivism are higher in prisoners who have experienced administrative segregation in a Supermax. (Kupers et al, Lovell et al).
3. Modifying individual and group activities, doors and windows, light-dark cycles, family contact, human interaction involving meals—none of these cost money (or much money) and make the environment more humane.
4. Prisoners placed in "solitary"/administrative segregation need to have a clear, consistently applied mechanism for "earning" their way out.

Intermediate Time Course: DOC and MH to work collaboratively on MH training for prison staff. Develop policies that make use of existing successful techniques and circumstances.

Acquire Expert Guidance: Instead of trying to re-invent the wheel, hire the consultation services of someone like Dr.Kupers who has managed to create a working, humane system in a very unlikely place (Mississippi).

Macro-level changes: Reducing overcrowding in prisons. This will take intervention at the legislative and gubernatorial level. In DOC's interactions with the other branches of government, we urge you to push for improving community mental health services, substance treatment and diversion and court-based community programs. Prevention and community treatment obviously cost less than housing a prisoner in Supermax.

Respectfully submitted on Behalf of MAPP,

Janis B. Petzel, M.D.

Immediate Past President

Maine Association of Psychiatric Physicians

Addendum:

How DOC Administrative Segregation Census Data from February 26,2010 was analyzed by MAPP:

Process: I defined "violent" as any sentence that could have potential direct consequences/danger to another person, even if one has to stretch to see the intentional violence or physical contact: Assault of any type; Arson; Manslaughter; Kidnapping; Murder; Sexual Crimes of any sort, e.g. contact, assault, gross sexual assault and visual assault of a child; Terrorizing; and Threatening. Anything else was considered a non-violent crime. Drug-related sentences were not counted as violent. I included that info because I thought the 2 issues might be related. They seemed to be inversely related, actually. The non-violent prisoners were more likely to have drug charges.

Of 91 prisoners on Feb 26, 2010, roughly half (45) were sentenced with non-violent charges, such as theft. Of these 45, 10 had concurrent drug charges. Prisoners #55 and #64's only sentences were for operating a motor vehicle after suspension.

Of the 46 charged with violent crimes as listed above, 3 had concurrent drug sentences. A few of the prisoners had more than 1 violent charge/sentence, so the numbers below add up to more than 46.

Assault	20	(2 with concurrent drug sentences)
Arson	2	
Kidnapping	2	(1 with concurrent murder)
Manslaughter	2	
Murder	9	
Sexual Crimes	8	(1 with concurrent murder, 1 with assault)
Terrorizing	2	
Threatening	5	(1 with drug sentence; 1 with assault)

Literature Cited:

Maine Department of corrections. Sentences of Prisoners in the Special Management Unit on February 26, 2010, documents provided to the Legislature during hearings for LD 1611, 2010.

Kupers et al. Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental health Programs. Criminal Justice and behavior 2009; 36; 1037-1050.

Lovell et al. Recidivism of Supermax Prisoners in Washington State. Crime and Delinquency, Sage publications (prepublication copy provided by Dr. Kupers, Feb 2010).

Metzner and Dvoskin. An overview of Correctional Psychiatry. Psychiatry Clinics of North America, Forensic Psychiatry. Vol 29(3), September 2006, pp.761-772.

States that Provide Mental Health Alternatives to Solitary Confinement. Maine ACLU 2010.

Contact Janis Petzel, M.D, MAPP LGA Chair at (207) 242-4007, petzeljanis@hotmail.com or MAPP Public Affairs Representative Jim Maier, M.D. at (207) 662-2004, Maierj@mmc.org

Dr. Petzel is a board certified psychiatrist in private practice in Hallowell, ME. She is the Immediate Past President of the Maine Association of Psychiatric Physicians.