**THE USE OF ISOLATION AND MENTAL ILLNESS IN BOP**

* Consistent reports from Federal Defenders, our own investigation at Terre Haute, and the work of Prof. Laura Rovner and the clinic at University of Denver related to conditions at the ADX **- confinement of SMI in isolation, lack of appropriate mh care for those in solitary**
* **BOP lags far behind the states with regard to its treatment of mentally ill prisoners, especially those in segregation.**
	+ The current BOP “Psychology Services Manual” was published in 1993. The most recent amendment was made in 1995.
	+ The current BOP Program Statement entitled “**Institution Management of Mentally Ill Inmates**” was drafted in 1995.
	+ Several parts of the current BOP Program Statement governing conditions in segregation **Special Housing Units were written in 1987**.
* **State Systems are generally better than BOP on these issues** -- Compare to state conditions where public organizing, legislation and litigation have lead to policies and practices w/in state DOCs that severely limit use of isolation and ensure that the Severely mentally ill are not placed in solitary confinement and procedural and medical protections are in place to ensure that prisoners confined in isolation are monitored so that they do not become mentally ill.
	+ Fedl courts recognize that isolated confinement inflicts serious psychological harm on many prisoners **– Miller, Madrid, Lee v. Coughlin**
	+ Only 1 court approached holding that isolated confinement is a *per se* 8th amendment violation **– Ruiz v. Johnson**
	+ **Every Fedl Court to consider the question has held that supermax confinement of the SMI is unconstitutional.** Ruiz, Coleman, Madrid, Casey v. Lewis

**ABA Criminal Justice Standards on the Treatment of Prisoners – approved by House of Delegates, Feb. 2010 – reflect national consensus on issues of isolation and protections for the mentally ill.**

* Def of long-term segregated housing;
* Screening procedures to ensure safety of prisoners by precluding SMI from isolation;
* setting up structured, meaningful review of mental health in isolation;
* limiting placement in isolation to no more than a year.
* The generally accepted definition of “segregation,” as embodied by **ABA Standard 23-1.0(o)** is considerably broader:

The term **“segregated housing”** means housing of a prisoner in conditions characterized by substantial isolation from other prisoners, whether pursuant to disciplinary, administrative, or classification action. “Segregated housing” includes restriction of a prisoner to the prisoner’s assigned living quarters.

* “**Long-term segregated housing”** is defined as “segregated housing that is expected to extend or does extend for a period of time exceeding **30 days**.” Proposed ABA Standard 23-1.0(p).
* **ABA Standard 23-2.8(a) states:**

No prisoner should be placed in segregated housing for more than 1 day without a mental health screening, conducted in person by a qualified mental health professional, and a comprehensive mental health assessment if clinically indicated. If the assessment indicates the presence of a serious mental illness, or a history of serious mental illness and decompensation in segregated settings, the prisoner should be placed in an environment where appropriate treatment can occur. Any prisoner in segregated housing who develops serious mental illness should be placed in an environment where appropriate treatment can occur.

* **ABA Standard 23-3.8(b) states:**

Conditions of extreme isolation should not be allowed regardless of the reasons for the prisoner’s separation from the general population. Conditions of extreme isolation generally include a combination of sensory deprivation, lack of contact with other persons, enforced idleness, minimal out-of-cell time, and lack of outdoor recreation.

* **ABA Standard 23-6.11(d) states, in part:**

**Prisoners diagnosed with serious mental illness should not be housed in settings that may exacerbate their mental illness** or suicide risk, particularly in settings involving sensory deprivation or isolation.

**WE’D LIKE TO SEE BOP POLICY AND PRACTICE UPDATED TO REFLECT THE LEGAL AND CORRECTIONAL CONSENSUS RELATED TO HOUSING THE MENTALLY ILL IN SOLITARY-CONFINEMENT LIKE CONDITIONS.**

**This requires a policy and practice update.**

**STAFFING MAKES THIS IMPOSSIBLE = It also requires rethinking mental health staffing in the system. It is clear that the current mental staffing patterns at BOP are not adequate to ensure that the SMI aren’t placed in solitary and that mental illness does not develop for those housed there.**

**September 15, 2009 testimony of Director Lappin** before Senate Subcommittee on Human Rights and the Law

* As of this week, there are more than 208,000 inmates in the BOP system. Assuming Director Lappin is correct that approximately 19% of the population suffers from a mental illness, then there are approximately **39,000 mentally ill prisoners in BOP** custody.
* Director Lappin testified that BOP employs only **30 FTE psychiatrists** (although this staffing level may be supplemented with an unspecified number of contractor hours). This results in **one psychiatrist per 1,317 mentally ill prisoners.**
* Director Lappin testified that BOP’s **30 FTE psychiatrists are located primarily at BOP’s medical referral centers.** Given that there are **only six or so medical referral** centers, this means that the overwhelming majority of BOP’s approximately 115 facilities lack an on-site psychiatrist.
* Director Lappin testified that approximately 16,000 prisoners are prescribed psychotropic medications. This means that there is **1 psychiatrist per 533 prisoners on psychotropics**. **1:150 is reasonable**
* Director Lappin testified that, in **FY 2008, BOP psychologists conducted 37,263 individual counseling sessions.** This results in **approximately 0.96 counseling sessions per mentally ill prisoner, per year.**
* Many mental health assessments are conducted through solid cell doors, in earshot of security staff. These assessments may consist of little more than asking the prisoner if he is OK. Proper assessments require that the prisoner be removed from his cell and evaluated in a private setting.