Disability Rights Nebraska

Protection and Advocacy for People with Disabilities

Testimony on LB 1208
Before the Judiciary Committee
Nebraska Legislature
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Good afternoon Senator Lathrop and members of the 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 Director at Disability Rights Nebraska. We are the designated Protection and Advocacy organization for persons with disabilities in Nebraska, and I am here today in support of LB 1208.

The prevalence rates of prisoners with disabilities is significant. The criminal justice system is housing such a significant number of people with mental illness, either diagnosed or not, that many authors have deemed U.S. prisons as "the new asylums"[1]. Research indicates that people with mental illness continue to be overrepresented within the criminal justice system (see table 1), inmates typically have significant and multiple health problems, and the incidence of co-occurring disorders (simultaneous substance abuse and mental illness) is common. As the Council of State Governments Justice Center writes in 2013[2]:

> "In a study of more than 800 individuals released from U.S. prisons, nearly all—eight in 10 men and nine in 10 women—had chronic health conditions requiring treatment or management…People in the study often had more than one type of health problem-conditions that they had when they entered the facility and that required ongoing attention upon release. Roughly four in 10 men and six in 10 women reported a combination of physical health, mental health, and substance use conditions... Co-occurring mental health and substance use disorders are common. In prisons, approximately 30 percent of individuals with substance use disorders also have a major mental health disorder. Conversely, in jails, an estimated 72 percent of individuals with serious mental illnesses have a substance use disorder. In prisons, co-occurring disorder estimates range from 3 to 11 percent of the total incarcerated population."

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[1] See Frontline, "The New Asylums" (video), http://www.pbs.org/wgbh/pages/frontline/shows/asylums/

[2] Council of State Governments Justice Center (2013), "Health, Mental Health, and Substance Use Disorders FAQs", available at: http://csgjusticecenter.org/substance-abuse/faqs/

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Table 1 Estimated Proportion of Adults with Mental Health, Substance Use, and Co-occurring Disorders in U.S. Population and under Correctional Control and Supervision[3]

	General Public	State Prisons	Jails	Probation and Parole
Serious Mental Disorders	5.4%	16%	17%	7-9%
Substance Use Disorders (Alcohol and Drugs) — Abuse and/or Dependence	16%	53%	68%	35-40%
A Co-occurring Substance Use Disorder When Serious Mental Disorder Is Diagnosed	25%	59%	72%	49%
A Co-occurring Serious Mental Disorder When Substance Use Disorder Is Diagnosed	14.4%	59.7%	33.3%	21%

Our research on solitary confinement indicates that segregation (whether long-term or short-term), can have significant negative effects on an inmate's psychiatric condition. Generally speaking, they worsen (which can then be used to justify keeping them in segregation longer). A unique symptomology of inmates in solitary confinement includes irrational anger and rage, loss of impulse control, paranoia, and perceptual distortions/illusions/hallucinations. Serious symptoms can occur even in individuals without mental illness after being isolated for only a few days.

Social isolation is a known risk factor for suicide among people with serious mental illness[4]. A 2014 study of the medical records of over 240,000 jail inmates found a significant association between solitary confinement, diagnosis of serious mental illness, and self-harm or suicide[5]. More specifically, although only 7% of inmates were in solitary confinement, they accounted for 53% of acts of self-harm.

Equally important is the residual effect after release as the damage can be long-lasting. O'Keefe and colleagues noted, "inmates released directly from segregation to the streets had dramatically higher rates and severity of detected recidivism than AS [Administrative Segregation] inmates who first released to GP [General Population]." I would point you to Section 2 of our report (see handout) for a discussion of "step down" programs for inmates released from segregation and the impacts of community release directly from segregation.

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[3] See Fred Osher, M.D., David A. D'Amora, M.S., Martha Plotkin, J.D., Nicole Jarrett, Ph.D & Alexa Eggleston, J.D., Council of State Governments Justice Center, Criminal Justice/Mental Health Consensus Project, *Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery* (2012), https://www.bja.gov/Publications/CSG_Behavioral_Framework.pdf

[4] Fenton, W. S. (2000) "Depression, suicide, and suicide prevention in schizophrenia" *Suicide and Life-Threatening Behavior*, *30*(1), pp. 34–49.

[5] Kaba, F., Lewis, A., Glowa-Kollisch, S., Hadler, J., Lee, D., Alper, H., Parsons, A. (2014). "Solitary confinement and risk of self-harm among jail inmates" *American Journal of Public Health*, *104*(3), pp. 442– 447.

We support the limitations and conditions that LB 1208 places on the use and duration of segregation. Given the significant impact restrictive housing may have on an inmate's mental status, both for inmates in the vulnerable population category and those who are not, we strongly support the provision of the bill allowing inmates in long-term restrictive housing to have continuous access to mental health treatment and programming.

We recommend LB 1208 be advanced.