

AFFIDAVIT OF TERRY A. KUPERS, M.D., M.S.P.
REGARDING LIKELY EFFECTS OF PROLONGED ISOLATED CONFINEMENT
IN THE CASE OF MR. SYED HASHMI

1. I am Institute Professor in the Graduate School of Psychology of the Wright Institute in Berkeley and maintain a clinical practice of psychiatry in Oakland, California. I have been asked by counsel to provide an opinion about the psychiatric effects of long-term isolated confinement in a high security prison. The referral questions include:

How does prolonged (1.5 to 2.5 years) solitary confinement affect a person?

How does it affect the person's ability to assist his counsel or make knowing decisions in his case?

What ameliorative steps can corrections make to ensure security without damaging the imprisoned person?

2. In terms of my qualifications, I am a Diplomate of the American Board of Psychiatry & Neurology (Psychiatry, 1974, for life). I am a Distinguished Life Fellow of the American Psychiatric Association. I currently serve as Consultant to the Psychiatry Department of the Contra Costa County Jail; and to Paths to Recovery, a collaboration between the California Department of Corrections and Rehabilitation, local rape crisis counseling centers and Stop Prisoner Rape. In 2005 I received the Exemplary Psychiatrist Award from the National Alliance on Mental Illness (NAMI) at the annual meeting of the American Psychiatric Association.

3. I received a B.A. in Psychology from Stanford University in 1964, with Distinction; an M.D. from UCLA School of Medicine in 1968 where I was elected to Alpha Omega Alpha Honor Society; I have been licensed to practice medicine in the State of California since 1968; I completed Internship at Kings County Hospital/ Downstate Medical Center in Brooklyn in 1969; I completed residency training in Psychiatry at UCLA Neuropsychiatric Institute (NPI), with a year elective at Tavistock Institute in London, in 1972; I did a fellowship in Social and Community Psychiatry (including Forensic Psychiatry) at UCLA NPI from 1972 to 1974; and I received a Masters Degree in Social Psychiatry (M.S.P.) from UCLA at the conclusion of that fellowship. Between 1974 and 1977, I was Assistant Professor in the Department of Psychiatry and Co-Director of the Psychiatry Residency Training Program of the Charles Drew Postgraduate Medical School in Los Angeles, and I was a staff psychiatrist and Co-Director of the Outpatient Clinic at Martin Luther King, Jr. Hospital. From 1977 to 1981, I was staff psychiatrist and Co-Director of the Partial Hospital Program at the Richmond (California) Community Mental Health Center (Contra Costa County Mental Health Services). I have conducted a private practice of psychiatry since 1974, and have been on the faculty of the Wright Institute since 1981.

4. I have written four books: Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It (Jossey-Bass/Wiley, 1999); Ending Therapy: The Meaning of Termination (New York University Press, 1988); Revisioning Men's Lives: Gender, Intimacy

and Power (Guilford Press, 1993); and Public Therapy: The Practice of Psychotherapy in the Public Mental Health Clinic (Free Press, 1981). I am a co-editor of and contributor to Prison Masculinities (Temple University Press, 2001). I have written over two dozen articles, including "Malingering in Correctional Settings," (Correctional Mental Health Report, 5, 6, 81-, March/April, 2004), "Toxic Masculinity as a Barrier to Mental Health Treatment in Prison" (Journal of Clinical Psychology, Vol. 61, 6, 2005), "The Mental Health Crisis Behind Bars," (Harvard Mental Health Letter, July, 2000), and "Trauma and Its Sequelae in Male Prisoners" (American Journal of Orthopsychiatry, 66,2,1996, pp. 189-196). Among book chapters I have written are "Psychotherapy with Men in Prison" (in A New Handbook of Counseling & Psychotherapy Approaches for Men, eds. Gary Brooks and Glenn Good, Jossey-Bass/Wiley, 2001), "Posttraumatic Stress Disorder (PTSD) in Prisoners," (in Managing Special Populations in Jails and Prisons, ed. Stan Stojkovic, Civic Research Institute, Kingston, NJ, 2005), and "Schizophrenia, its Treatment and Prison Adjustment" (in Managing Special Populations in Jails and Prisons, ed. Stan Stojkovic, Civic Research Institute, Kingston, NJ, 2005). I am Contributing Editor of Correctional Mental Health Report, and I am on the Editorial Advisory Board of three other professional journals.

5. I have testified in over twenty criminal and civil proceedings, including state and federal courts, regarding jail and prison conditions, their effects on prisoners, and the quality of mental health services. I have served as a consultant regarding prison conditions and the quality of correctional mental health care to the U.S. Dept. of Justice, Civil Rights Division, and to Human Rights Watch and Amnesty International. I am currently serving as monitor for psychiatry in the Presley v. Epps consent decree involving mental health care at Unit 32, a supermaximum security facility at Mississippi State Penitentiary at Parchman (US Dist Ct ND Mississippi, Greenville Div, No. 4:05-CV-00148). I have conducted trainings for correctional and mental health staff in departments of corrections. My *curriculum vitae* is attached.

6. I have been asked by attorney Sean Maher to provide professional opinions concerning the isolated confinement of Syed Hashmi at the Metropolitan Correctional Center in New York pending trial. It is my understanding that Mr. Hashmi has been confined alone in a cell with extremely limited contact with other human beings, especially inmates, he has been permitted only very restrictive contact and communications with family and friends as well as restricted visits and communications with attorneys, and he has been permitted very constricted amenities and activities. In other words, he has been almost entirely isolated and idle in a cell at least since October, 2007, when Special Administrative Measures (SAM) were initiated. In preparation for this affidavit I have spoken with Mr. Maher on the phone and reviewed the Memorandum from Mathew Friedrich, Acting Attorney General, to Harley Lappin, Director, Federal Bureau of Prisons, stamped October 22, 2008, and I have reviewed the Indictment of Mr. Hashmi in U.S. Dist. Court, Southern District of New York.

7. The features of high security isolated confinement or "longterm segregated housing." The prisoner is restricted to a cell, typically with a few hours per week of out-of-cell recreation. In many of these facilities the prisoner is either permitted "recreation" in a small "yard" hardly larger than a cell, or is consigned to a rectangular space the prisoners refer to as "dog runs." There is rarely any equipment for exercise, and in many such settings most of the prisoners opt to refuse to "go to the yard." Prisoners eat meals in their cells. There are few if any rehabilitation or education programs. Visiting is severely restricted, "non-contact" visits usually

occur in a cubicle where the prisoner sits on one side of a lexsan (indestructible plexiglass) partition and the visitor(s) on the other side, and they converse on phones or through small holes in the partition. Amenities are very limited, the prisoner usually being denied any possessions other than pencil and paper and a few books and personal photos. Most of the supermaximum security facilities I have inspected have no window to the outside that can be opened, and the cell doors, often constructed of solid metal or fine mesh that restricts visibility, are operated by remote control by an officer in a control booth. Thus the prisoner is almost entirely isolated and idle. When prisoners are taken from their cells and transported to the clinic or a visit, they are shackled and accompanied by officers. But they are usually not permitted to communicate with other prisoners, and their contact with the officers aside from transportation is limited to officers passing food trays through a slot in their cell door and then picking up the empty tray. This does not amount to "sensory deprivation," since there is often a constant din of noise from the slamming of doors and officers yelling orders - but the almost total lack of meaningful human communication amounts to a deprivation equivalent to classic experiments on total sensory isolation. Then there are cell extractions. This is an especially gruesome procedure, a "take down," where the team that does the taking down wears full-body padding and helmets replete with visors. It can be initiated for provocations as minor as a prisoner refusing an officer's order to return his food tray after the meal is over. The scene goes something like this: The prisoner says "You're going to have to come in here and get it!." The officers go off and assemble an emergency team - several large officers in total body protective gear who, with a plastic shield, are responsible for doing "take-downs" of rowdy or recalcitrant prisoners, many of whom suffer from serious mental illness. The emergency team appears at the prisoner's cell door. The officers spray the prisoner through the food port with mace, and then barge in all at once, slamming the prisoner against the back wall with their shields and grabbing his extremities. The prisoner is bruised and hurt in the process and sometimes sustains major injuries, bone bones or a smashed face. That is a cell extraction. According to the Memorandum from Mathew Friedrich to Harley Lappin, October 22, 2008, spelling out the provisions of SAM in Mr. Syed's case, his conditions of confinement are even more restrictive and isolated than is usually the case even in supermaximum security facilities I have toured.

8. The psychological effects of long-term isolated confinement. Social scientists have been studying the effects of isolated confinement for many years. Social psychologist Hans Toch summarizes the hundreds of interviews he did with prisoners, many in long-term isolated confinement in New York State DOCS correctional facilities.¹ He coined the term "isolation panic" for the symptoms he regularly discovered in the men, including panic, rage, a sense of total loss of control, an experience of emotional breakdown; many exhibited very regressed behavior and many resorted to self-mutilation². Toch distinguished between incarceration, which is difficult but tolerable, and isolated confinement, which is not tolerable for many. Social psychologist Craig Haney has conducted research with a large number of prisoners in isolated confinement. He randomly selected prisoners in segregated housing and found very high prevalence rates for a large list of emotional symptoms. Over 80% of the prisoners

1 Toch, Hans, Men in Crisis: Human Breakdown in Prisons, Chicago: Aldine, 1975, pp. 20.

2 Ibid., pp. 38-43.

reported massive anxiety. Likewise, over 80% of the prisoners complained of headaches, troubled sleep, and lethargy. Over half complained of nightmares, heart palpitations, violent fantasies, depression or despair, and fear of impending nervous breakdown. Complaints of obsessive ruminations, confused thought processes, oversensitivity to stimuli (a strong startle reaction), irrational anger and social withdrawal were widespread.³ Psychiatrist Stuart Grassian examined a large number of prisoners during their stay in segregated, near-solitary confinement units and concluded that these units, like the sensory deprivation environments that were studied by psychologists in the 1960s, often induce psychosis, especially in prisoners who have histories of mental illness or a predisposition to psychiatric breakdown. Even prisoners who do not become frankly psychotic frequently report a number of serious psychiatric symptoms, including but not limited to: A. Massive free-floating anxiety; B. Hyper-responsiveness to external stimuli, including a startle response; C. Perceptual distortions and hallucinations in multiple spheres (auditory, visual, olfactory); D. Derealization experiences; E. Difficulty with concentration and memory; F. Acute confusional states, at times associated with dissociative features, mutism, and subsequent partial amnesia for those events; G. The emergence of primitive, ego-dystonic (discomforting) aggressive fantasies; H. Ideas of reference (Paranoia) and persecutory ideation, at times reaching delusional proportions; I. Motor excitement, often association with sudden violent destructive or self-mutilatory outbursts; and J. Rapid reduction of symptoms upon termination of isolation.⁴ I will not review all of the research literature here, but there has been a substantial amount of research into the harmful effects of isolated confinement, especially if the prisoner thus confined suffers from a serious mental illness or is vulnerable to mental illness. In their amicus brief in Wilkinson v. Austin, leading mental health experts summarize the clinical and research literature about the effects of prolonged isolated confinement and conclude: “No study of the effects of solitary or supermax-like confinement that lasted longer than 60 days failed to find evidence of negative psychological effects” (Appended to this Report, at p. 4).

9. The psychological effects of isolated confinement were imposed for an indeterminate period. One of the most shocking statistics I have come upon is that approximately half of the successful suicides that occur in an entire state's prison system (not attempts - actual deaths) involve the 6% to 8% of prisoners who are in segregated/isolated confinement. In other words, only 6% to 8 % of prisoners are in segregation at any given time; the suicide rate in prison is approximately twice as high as in the free community but half of all prison suicides involve the relatively small proportion of prisoners in segregation. This is a stunning finding, and a clear reflection of the despair that is bred in long-term segregation units such as supermaximum security facilities. It is clear to mental health clinicians that human beings cannot live without hope. It is bad enough to be placed in an extraordinarily harsh environment such as isolated confinement, but then to have to live with the certainty that one will never be released from these extremely harsh conditions causes a very deep level of despair, and that is why such a disproportionate number of prison suicides occur in long-term segregation units. We can extrapolate from this statistic about the despair that drives some to take their own lives, and we

³ Haney, Craig, “Mental Health Issues in Long-Term Solitary and ‘Supermax’ Confinement,” *Crime & Delinquency*, 49,124,127,2003.

⁴ Grassian, Stuart, “Psychopathological effects of Solitary Confinement,” *American Journal of Psychiatry*, 140, 11, 1450-1454, 1983

discover that a high degree of despair pervades the entire population in long-term segregation. This reality is confirmed by the many interviews I have conducted with this population of prisoners. And this is why a much more huge number of suicide attempts occur there, as well as other forms of self-harm such as self-mutilation for non-suicidal purposes. The chronic despair and lack of hope breaks prisoners down and causes immense pain and suffering.

10. How prisoners with serious mental illness fare in high security isolated confinement. Of course, if emotional symptoms emerge in relatively healthy prisoners who are relegated to long-term isolated confinement, prisoners who are already known to suffer from or be vulnerable to serious mental illness will suffer severe psychiatric morbidity, disability, suffering and mortality. Sheilagh Hudgins and Gilles Cote performed a research evaluation of penitentiary inmates in a Supermaximim Security Housing Unit and discovered that 29% suffered from severe mental disorders, notably Schizophrenia.⁵ It has been my experience, from tours and well over a thousand clinical interviews with prisoners in isolated confinement units in ten states, that the conditions that cause emotional distress in relatively healthy prisoners cause psychotic breakdowns, severe affective disorders and suicide crises in prisoners who have histories of serious mental illness, as well as in a certain number of prisoners who never suffered a breakdown in the past but are prone to break down when the stress and trauma become exceptionally severe.⁶ Also from my experience, I have determined that the longer the period of isolated confinement, the more likely that these negative effects will occur (although in some cases of serious mental illness, a particularly vulnerable prisoner will be unable to tolerate isolated confinement even for a day). The data provided by Drs. Grassian and Haney, of psychiatric symptoms that regularly appear in relatively healthy individuals in isolated confinement, offers a clue to why prisoners prone to mental illness suffer breakdowns and despair. When an average individual who is placed in an environment develops massive free-floating anxiety, hyper-responsiveness, paranoid ideas, confusion, perceptual distortions, motor excitement and so forth, and becomes frightened he will not be able to control his aggressive fantasies, just imagine how difficult it would be for someone who is prone to paranoid psychosis or suicidal despair to remain balanced. Dr. Grassian's last reported psychiatric symptom, the rapid reduction of symptoms upon termination of isolation, may or may not occur – in my clinical experience, once an individual crosses a line into psychosis or depressive despair, it is very possible that removal from the harsh conditions of isolated confinement will not be sufficient to bring him or her back to a normal mental state.

11. Effects which regularly arise from there being no family visits or very restricted visits. The most striking feature of the literature about the benefits of visits for prisoners, their families and

⁵ Hodgins, S. & G. Cote. "The Mental Health of Penitentiary Inmates in Isolation," Canadian Journal of Criminology, 177-182, April, 1991.

⁶ Kupers, T. Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It. San Francisco: Jossey-Bass/Wiley, 1999. See also Kupers, T. "Schizophrenia, its Treatment and Prison Adjustment," in Managing Special Populations in Jails and Prisons, ed. Stan Stojkovic, Kingston, NJ: Civic Research Institute, 2005.

communities, is that there is little if any contrary argument and conflicting data to the general principle that the better the quality of visitation throughout a prisoner's incarceration, the better the effects on the prisoner, his or her post-release adjustment, the family of the prisoner and the community. Quality visitation throughout a prisoner's term has impressive positive effects on the recidivism rate. There is such a strong and universal consensus on this point that many states assume the positive correlation in their official policies. For example, Florida's 1999 Statute 944.8031, "Inmate's family visitation...", begins: "The Legislature finds that maintaining an inmate's family and community relationships through enhancing visitor services and programs and increasing the frequency and quality of the visits is an underutilized correctional resource that can improve an inmate's behavior in the correctional facility and, upon an inmate's release from a correctional facility, will help to reduce recidivism." The classic study was done by Holt and Miller⁷. Among other things, they showed that California prisoners who have regular, continuing visits with (at least three) family members show a significantly lower recidivism rate when compared with those who do not have such visits throughout their prison term. Prisoners with no visitors were six times more likely to re-enter prison during the first year of parole as those with three or more visitors. I have written from a clinical perspective, with case reports, about the importance of quality family visitation in terms of the prisoner's mental health, his or her ability to participate successfully in prison programs and stay out of disciplinary trouble while incarcerated, and his or her potential for success at becoming a productive citizen after being released; and the negative consequences of impaired or less-than-quality visitation during incarceration⁸.

12. My opinion regarding a prisoner's ability to comply with good disciplinary procedure and gain release from isolated confinement. In supermaximum confinement units, many prisoners experience induced desperation, for example fearing that they will never be released because the severe isolation exacerbates their anger about what they consider unfair and excessive punishment, and they are very aware of the fact that their anger will lead them to get into arguments with officers which will result in additional disciplinary write-ups or "tickets," and therefore additional time in isolation. Many prisoners in such settings have confided that they are certain they will never get out of segregation alive. In fact, their expressed concern has significant basis in objective circumstances. I have discovered very many prisoners in supermaximum security units who have the following pattern in terms of their disciplinary history: They received a few disciplinary write-ups or "tickets" prior to the one that sent them to long-term segregation, but then, once in segregation, the frequency of their "tickets" and the severity of the offenses rises precipitously. They begin to be disciplined more often, and the additional disciplinary write-ups do result in additional time in supermax segregation. Many tell me it is a vicious cycle. The longer time they spend in supermax segregation, the angrier and more out of control they become, which results in more tickets, and since the tickets carry with them a longer stint in segregation, the vicious cycle seems without end.

⁷ Holt, Norman & Donald Miller. (1972). Explorations in Inmate-Family Relationships. Sacramento: Research Division, Department of Corrections, State of California.

13. My opinion on the ability of a prisoner in isolated confinement to work with counsel to prepare legal challenges. Among the regularly occurring psychiatric symptoms in prisoners who are forced to endure prolonged periods in isolated confinement are cognitive impairment, memory problems, an inability to concentrate, mounting rage, increasing paranoia and massive free floating anxiety. Many prisoners in long-term isolated confinement report to me that they have given up trying to read altogether, because they find that their problems concentrating and remembering mean that they cannot remember what they read three pages earlier, and this makes their reading meaningless. Obviously, this set of symptoms greatly impairs a prisoner in terms of understanding legal proceedings, collaborating with attorneys and preparing legal challenges. In fact, this is confirmed by my experience as an expert psychiatric witness in criminal trials. Prolonged isolated confinement quite often and predictably results in a significant degree of incompetence to stand trial, whether or not the prisoner's mental state deteriorates to the point where he or she exhibits chronic serious mental illness.

14. Regarding ameliorative steps that can be made to ensure security without damaging the imprisoned person, there are many. If security requires separation from other prisoners and restriction of unsupervised contact with people outside of the correctional facility, this does not mean that the incarcerated individual must be starkly isolated, nor that he be entirely idle. He can be removed from his cell for significant periods each day, and permitted to take part in productive activities such as recreation, spending time in the library, attending religious events and so forth. He can have social contact with individuals deemed "safe" from a security standpoint, for example officers who staff the day room or recreation area where he is permitted out of cell activities. He can be provided adequate commissary. He can be permitted to pray, even if only while separated from others. In other words, since it is the isolation and idleness that wreak psychiatric damage as well as great pain and suffering, he can be permitted daily interactions with staff members and activities that are considered safe, while still being separated from other prisoners whenever contact with them creates a security problem. Traditionally, prisoners who are separated for their own protection should be permitted the same activities and amenities as are prisoners in the general population security level where they would otherwise be assigned - protection requires separation, not isolation and idleness. Similarly, in this case, security concerns are used to rationalize extremely harsh conditions of confinement, where security concerns could be satisfied without institution extremes of isolation and idleness.

Respectfully submitted,

Terry A. Kupers/sig

Terry A. Kupers, M.D., M.S.P.

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