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S. HRG. 112–879

REASSESSING SOLITARY CONFINEMENT: THE HUMAN RIGHTS, FISCAL, AND PUBLIC SAFETY CONSEQUENCES

HEARING

BEFORE THE

SUBCOMMITTEE ON CONSTITUTION,
CIVIL RIGHTS AND HUMAN RIGHTS

OF THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

JUNE 19, 2012

Serial No. J–112–80

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REASSESSING SOLITARY CONFINEMENT: THE HUMAN RIGHTS, FISCAL, AND PUBLIC SAFETY CONSEQUENCES

TUESDAY, JUNE 19, 2012

U.S. SENATE,
SUBCOMMITTEE ON THE CONSTITUTION, CIVIL RIGHTS, AND HUMAN RIGHTS,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:06 a.m., in Room SD–226, Dirksen Senate Office Building, Hon. Richard J. Durbin, Chairman of the Subcommittee, presiding.

Present: Senators Durbin, Franken, and Graham.

OPENING STATEMENT OF HON. RICHARD J. DURBIN, A U.S. SENATOR FROM THE STATE OF ILLINOIS

Chairman DURBIN. Good morning. This hearing of the Subcommittee on the Constitution, Civil Rights, and Human Rights will come to order. Today's hearing is entitled "Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences." In a moment, I will be joined by Senator Graham, who is running a bit late this morning. He is the Subcommittee Ranking Member, and he will make an opening statement when he arrives.

First, I want to note there is significant interest in today's hearing. For those who have not been able to get a seat in this hearing room, we have an overflow room with a live video feed. It is next door in the Hart Building, Room 216, if you are communicating with others who are waiting outside; Hart, Room 216.

America has led the fight for human rights throughout the world. This Subcommittee has tried to play some part in that, holding the first congressional hearings on issues like rape as a weapon of war, and passing legislation like the *Genocide Accountability Act*.

But we also have an obligation to look in the mirror, to look at our own human rights record. Today in the United States, more than 2.3 million people are imprisoned. This is, by far, the highest per capita rate of prisoners in the world. African Americans are incarcerated at nearly six times the rate of white Americans, Hispanics nearly twice as frequently. These numbers translate into human rights questions, challenges, and issues that we cannot ignore.

I held a hearing on mental illness in U.S. prisons in 2009. I have authored the *Fair Sentencing Act*, which finally reduced dramati-

cally the disparity between crack and powder cocaine, though I will tell you I believe it should be a strict one-to-one ratio. We clearly have made improvements, but there is more to be done.

We are here today to consider another critical issue: What do America's prisons say about our Nation and its values? What does the number of people we have in prison say? What does it say when we consider how we treat the people who are in prison? This is the first-ever congressional hearing on solitary confinement. The practice it is called many different things: supermax, segregation, isolation, among other names.

At this point I am going to show a brief video clip, which is compelling.

[Videotape played.]

Chairman DURBIN. Seventeen-year-old James Stewart was held in solitary confinement in an adult prison for two months. His sister Nicole Miera is here. She joins us. Nicole, thank you for sharing your brother's story.

Unfortunately, Jimmy Stewart's story is all too common. Fifty percent of all prison suicides occur in solitary confinement. Jimmy was locked up in a cell like the one to my left. This was prepared as part of a trial. It is a replica of a solitary confinement cell, and it was sent to us to be here at the hearing. I stepped inside briefly before the hearing started, but there is no way that a brief visit there could give you any feeling for what it must be like to spend extended periods of time—hours, days, weeks, months, years—in that confined space for 23 hours a day.

In 1995, a federal district court described similar cells at California's Pelican Bay State Prison as follows:

"The cells are windowless; the walls are white concrete. . . . The overall effect is one of stark sterility and unremitting monotony. Inmates can spend years without ever seeing any aspect of the outside world except for a small patch of sky. One inmate fairly described [it] as being 'like a space capsule where one is shot into space and left in isolation.'"

Imagine, 23 hours a day in one of those cells, with little, if any, human contact.

The United States holds far more prisoners in segregation or solitary confinement than any other democratic nation on Earth. The Bureau of Justice Statistics found that in 2005, U.S. prisons held 81,622 people in some type of restricted housing. In my home state of Illinois, 56 percent of the prison population has spent time in segregation.

If I had one request to my colleagues on this Judiciary Committee, it is to visit a prison. Do it frequently. See what it is like. I have done it, most recently in Pekin at the federal facility. But I have been to Tamms, which is our maximum confinement facility in the State of Illinois. It is an eye opener to understand what it means when you start talking about the sentencing aspects of America's criminal justice system.

We did not always use solitary confinement at such a high rate. But in the 1980s, things started changing. We began creating expensive supermax prisons designed to hold people in isolation on a massive scale. These supermaxes, just like the crack cocaine sen-

tencing laws, were part of a tough-on-crime policy that many of us thought made sense at the time.

But we now know that solitary confinement is not just used for the worst of the worst. Instead, we are seeing an alarming increase in isolation for those who do not really need to be there, and for many vulnerable groups like immigrants, children, LGBT inmates, supposedly there for their own protection.

That is why I have advocated for a change in the Justice Department's new national prison rape standards, to help ensure that sexual assault victims are only placed in solitary when absolutely necessary. We have heard from Nicole Miera about the tragic consequences of locking up children in isolation. That is why the American Academy of Child and Adolescent Psychiatry has called for a ban on solitary confinement for all children under the age of 18. That ban might have saved your brother's life. In January, I visited an immigration detention center in deep southern Illinois and saw segregation units typical of those found at many county jails. I might remind you that people being held there are not there for criminal detention.

Even for adults convicted of serious crimes, experts say far too many are in solitary confinement. Some are already seriously mentally ill before they are confined. They require extensive monitoring and treatment, the exact opposite of isolation. Others who may not have had any psychological problems before isolation can be driven into a psychosis or suicidal state. And there is also the more basic question of how prisons treat people in solitary. Their conditions of confinement, I think we all agree, need to meet basic standards of decency.

As far back as 1890, the 19th century, the Supreme Court recognized the risks of solitary, describing the isolated inmates at one prison with the following words:

"A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide." That was written in 1890.

And our colleague and former POW Senator John McCain of Arizona, who has lived through it, said, "It's an awful thing, solitary. It crushes your spirit and weakens your resistance more effectively than any other form of mistreatment."

This is also a public safety issue. As the bipartisan Commission on Safety and Abuse in America's Prisons found, "Increasing the use of high-security segregation is counterproductive, often causing violence inside facilities and contributing to recidivism after release." We have a responsibility, I will acknowledge, to protect prison guards, men and women who put their lives on the line to protect all of us. We also must have a clear-eyed view of the impact of isolation on the vast majority of prisoners who will one day be released.

Solitary confinement also is extremely costly. Tamms, which I mentioned earlier, in Illinois, our only supermax prison, has by far the highest per prisoner cost of any Illinois prison—$61,522 a year this last Fiscal Year for supermax prisoners, compared to $22,000 for other prisoners.

A number of states are starting to reassess solitary confinement. We will hear about some things today that are eye opening. These states have implemented reforms and reduced the use of solitary, lowering prison violence and recidivism rates, and saving millions of dollars.

As a result of the work we have done preparing for this first-of-its-kind hearing, I am working on legislation to encourage reforms in the use of solitary confinement. We can no longer slam the cell door and turn our backs on the impact our policies have on those incarcerated and the safety of our nation.

[The prepared statement of Senator Richard Durbin appears as a submission for the record].

As I mentioned, Senator Graham is running a little late. At this point he would be—here he is. Just in time. Well, that was perfect. I will give you just a moment to gather—if you would like to make an opening statement, Senator Graham. I have just completed my own and you walked in. Do you want to do it now?

Senator GRAHAM. Very briefly.

Chairman DURBIN. Sure, please.

STATEMENT OF HON. LINDSEY GRAHAM, A U.S. SENATOR FROM THE STATE OF SOUTH CAROLINA

Senator GRAHAM. Mr. Chairman, I am sorry I am late. I have got to run to a hearing in the Armed Services Committee about an officer's nomination, but I just want to say, one, I look forward to hearing the testimony. Senator Durbin has been very outspoken and concerned about the way we run our prisons and how people are treated, and I think that is a compliment to him. And we will see where the information takes us, and I have tried to be balanced in my view toward detention. I think that, you know, the American values are on display when you have the power to confine someone. It says a lot about who we are as a nation. The individual conduct has to be balanced against who we want to be as a nation, and I understand the need to protect prisons from people who are acting out and doing things that are disruptive to the prison environment. At the same time, we want to make sure our detention policies live within the values of who we are, and that is, try to turn people around, not just protect them, keep them off the streets, but try to be constructive in changing people's behavior and lives.

So thank you for the hearing.

Chairman DURBIN. Well, thank you, Senator Graham, and I want to say that Senator Graham and I agreed on the witness list. This is truly a bipartisan effort. And I hope more and more of that is evident here. We sure need it.

I also want to note that we invited the Civil Rights Division of the Justice Department to participate, but they declined. We will be following up with them to make them aware of the results of today's hearing and ensure that they are enforcing the federal civil rights laws that protect prisoners held in our prisons across America.

Now, our first witness is Charles Samuels, Director of the Federal Bureau of Prisons. Director Samuels will have five minutes for an opening statement, and his complete written statement will be included in the record. If you would please step forward, Director

Samuels, it is the custom of the Committee to administer an oath. Please raise your right hand. Do you affirm the testimony you are about to give before the Committee will be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. SAMUELS. I do.

Chairman DURBIN. Let the record indicate that the witness answered in the affirmative.

Director, we are going to give you five minutes for an opening statement, put your whole written statement in the record, and perhaps ask a few questions. So would you proceed?

STATEMENT OF THE HONORABLE CHARLES E. SAMUELS, JR., DIRECTOR, FEDERAL BUREAU OF PRISONS, WASHINGTON, DC.

Mr. SAMUELS. Good morning, Chairman Durbin and Ranking Member Graham. I want to thank you for inviting me to testify today on the important issue of the role of segregated housing in corrections.

Inmate safety and well-being is of the utmost importance to the Bureau, as is the safety of our staff and the community at large. As such, we do all that we can to ensure that we provide outstanding care, treatment, and programming to federal inmates, giving them the best opportunity for successful reentry to their communities. In order to provide these important services, it is critical that we run our institutions in a safe and orderly manner. Prisons must be secure, orderly, and safe in order for our staff to be able to supervise work, provide training, conduct classes, and run treatment sessions. When institutions are not safe, inmates have diminished access to programming opportunities. Further, unsafe institutions place staff and other inmates at risk and pose a danger to the community at large.

The Bureau houses inmates in the least restrictive conditions necessary to ensure the safety and security of staff, inmates, and the public. The vast majority of our inmates are housed in general population units and are able to move freely about the compound during the day and evening. Inmates at our lower security levels, minimum and low, have greater freedom than those at the higher security institutions, medium and high.

Inmates who are disruptive and aggressive toward others endanger the safety and security of our institutions. Accordingly, removing and segregating them from the general population allows us to continue to operate the institutions with open inmate movement.

Fortunately, very few inmates require separation from the general population at any point in time. We only undertake these conditions of confinement when absolutely necessary. This allows us to maximize the use of staff time and space.

As you know, the Bureau population continues to increase, and limited budgets have prevented us from increasing our capacity and our staffing to keep pace with this growth. We face dramatically increasing inmate-to-staff ratios and extreme levels of crowding, about 40 percent over capacity systemwide and 51 percent over capacity in our high-security institutions where our most violent offenders are housed.

When inmates are placed in restricted housing, there are a variety of significant safeguards in place to ensure inmates' due proc-

ess rights are protected. Additionally, inmates' mental health is always a factor in decisions regarding segregated housing. Bureau psychologists are integrally involved in the restricted housing placement process, and all staff who work in these units receive training and input from psychology services above and beyond our general staff training.

Let me take a moment to address the concept of solitary confinement or isolation. All inmates in our restricted housing units have contact with staff, out-of-cell time for recreation, and an opportunity to program. Accordingly, we do not consider any inmates to be held in isolation, though we are aware that some might use this term to refer to all restricted housing placements regardless of the extent of contacts with other individuals.

The Bureau primarily uses three types of restricted housing to maintain safety and security: Special Housing Units, Special Management Units, and the administrative maximum security institution, Florence, Colorado, the ADX. I have discussed the specifics of each of these units in detail in my written statement.

With the exception of the ADX, which houses our most violent and dangerous offenders—for example, offenders who have murdered staff members or who have been involved in multiple inmate homicides—virtually all inmates within our restricted housing units are housed with other inmates, and all inmates within restricted housing have access to staff throughout the day. They are also provided time outside of their cells for indoor and outdoor recreation, almost always with other inmates, and they continue to have access to reentry programming.

At the ADX, inmates are housed in single cells and have very limited contact with other inmates. However, they have individualized contact with staff throughout the day. Extensive safeguards are in place to ensure we continue to provide security and a high level of care for medical and mental help for all inmates regardless of where they are housed.

Chairman Durbin, this concludes my formal statement. I appreciate you raising the important issue of segregated housing within prisons. The use of any form of restricted housing, however limited, remains a critical management tool that helps us maintain safety, security, and effective reentry programming for all federal inmates.

Again, I thank you and Mr. Graham for your support for our agency. The mission of the Bureau of Prisons is challenging. By maintaining high levels of security and ensuring inmates are actively participating in evidence-based reentry programs, we serve and protect society.

I would be pleased to answer any questions you or Mr. Graham may have.

[The prepared statement of Mr. Samuels appears as a submission for the record.]

Chairman DURBIN. Director Samuels, thank you. I did not formally introduce you, but I want to thank you as Director of the Federal Bureau of Prisons since December 21, 2011, the eighth Director since the Bureau's establishment. You oversee all the Bureau of Prisons' institutions and facilities, and I thank you for being here.

Because Senator Graham has a closed session of the Armed Services Committee and has to leave, I have asked him if he would be kind enough to open with questions before I ask any.

Senator GRAHAM. Well, thank you, Mr. Chairman.

One of the roles that Congress provides in our democracy is oversight, and this is an issue that I am glad that we are talking about because I want people in your business to know that Congress cares. I want the communities of interest who follow humane treatment of detainees to know that we care. And I also want to let family members who may have a loved one in a prison that we are going to care about them, too.

I know we have a special prison for very disruptive people, for people who have, as you indicated, a pattern of violence against guards or fellow inmates. That I understand. But in a normal prison population, what percentage of disruptive behavior that leads to segregation or solitary confinement, whatever term you want to use, is due to mental illness versus just people acting up?

Mr. SAMUELS. In the Bureau, for our population, three percent of inmates suffer from a serious mental illness, so the majority of the inmates are not within that category. And I would also say that within our population 92 percent of the inmates are actively and freely moving about within the general population.

Senator GRAHAM. What is the longest someone can be confined in isolation?

Mr. SAMUELS. It varies. We have individuals for different moments of time, which our overall goal and objective is always to minimize the length of time that the individual is actually placed in restricted housing.

Senator GRAHAM. Does it work as a deterrent to the population as a whole, the fact that you may be segregated? To the prison population as a whole, does this act as a deterrent to people acting up, the possibility of solitary confinement?

Mr. SAMUELS. We believe with solitary confinement for the inmates who pose the most violence and disruption within the facility that we utilize it as a deterrent to correct the behavior.

Senator GRAHAM. Do you think it works as a deterrent?

Mr. SAMUELS. Yes.

Senator GRAHAM. What makes you say that?

Mr. SAMUELS. Within our assessment from what we have viewed with inmates who have been placed in restrictive housing, we have seen where the number of assaults throughout our system at various levels has improved. And when I say "improved," I would say any assaults against other inmates as well as our staff. And we utilize this tool to ensure the safety and security of our facilities. And we always work with the inmates by using verbal communication and different forms of interaction to encourage inmates to be productive and not be engaged in violence and disorder within the facility because it makes it better for us to manage them as well as giving them an opportunity——

Senator GRAHAM. What kind of oversight do you have in terms of the decision to segregate a person, to put them in a solitary confinement environment? What kind of checks and balances do you have there to make sure it is just not because a particular guard

does not like a particular prisoner and to make sure that there is sort of a due process way in and a due process way out?

Mr. SAMUELS. All of the requirements for restrictive housing require due process, and I will start with our special housing unit process, which every facility within the Bureau, with the exception of our minimum security camps, has a special housing unit. If an inmate is charged for violating the rules and they are placed in segregation, they are given notice of the charges, and they have an opportunity to appeal the charges. And there is an investigative process that takes place, and if the inmate requires a staff representative and/or witnesses and any information that could be presented if they believe that it helps them explain their belief that they do not believe the charges are warranted, that process is in place.

We also have procedures in place for the inmates to file an appeal, which they can do at the local level and with our regional offices all the way up to our headquarters in Washington, DC.

Senator GRAHAM. Do you have any information to share with the Committee about the mental health effects on solitary, segregated confinement?

Mr. SAMUELS. I do not have any written study internal to the Bureau regarding the effects, but what I can tell you is that all of our staff who work in the mental health care field are trained, and they are given specialized training to deal with individuals who suffer from serious and/or mental health illnesses. And we go as far as to ensure that our staff throughout the agency also receive——

Senator GRAHAM. But there is no study or no academic guidance about how this technique affects people that you are aware of?

Mr. SAMUELS. We have not conducted an internal study within the Bureau.

Senator GRAHAM. Is that something you think would be good to do?

Mr. SAMUELS. We would welcome any research or literature regarding concerns relative to that area.

Senator GRAHAM. OK. And my last question would be: At the State level, how familiar are you with State procedures? And are you confident that they have similar checks and balances?

Mr. SAMUELS. I would say in most of the correctional institutions throughout the country at the State level that many of the practices are somewhat similar.

Senator GRAHAM. Thank you, Mr. Chairman.

Chairman DURBIN. Thanks a lot, Senator Graham. I appreciate your coming.

As most of you understand, we have competing hearings, overlapping hearings, and the fact that Senator Graham was here is appreciated very much. I am sure his staff will continue to follow this, and he will follow the testimony. And I thank Senator Franken for joining me here.

Mr. Samuels, let me ask you a couple of questions. First, it is my understanding that those who are seriously mentally ill are not supposed to be assigned to supermax facilities like Florence, Colorado. Is that true?

Mr. SAMUELS. You are correct. Our policy prohibits any inmate who suffers from a serious psychiatric illness to be placed in that confinement.

Chairman DURBIN. So obviously there must be an evaluation before someone is assigned to a supermax facility, and I would like to ask you what that evaluation consists of.

Mr. SAMUELS. When individuals are being reviewed for placement at the ADX for that type of confinement, we have our psychology services staff, they conduct an evaluation, which is part of the referral process.

Chairman DURBIN. How long would that evaluation process last?

Mr. SAMUELS. Initially, it is part of the process, but once they are actually placed in the facility, if we determine——

Chairman DURBIN. Before. I am talking about before they are referred to a supermax facility to determine whether or not they are suffering from a serious mental illness. How long would that evaluation last?

Mr. SAMUELS. The in-person evaluation with our staff, that can take anywhere from a week to two weeks with an assessment of the individual.

Chairman DURBIN. How much time one-on-one between a psychologist and the inmate?

Mr. SAMUELS. It varies.

Chairman DURBIN. Can you give me an idea? Is it a matter of minutes, hours?

Mr. SAMUELS. I can give you later for the record, I mean, an average, but I would say—because this is being conducted, sir, throughout the country at various locations, and to give a specific amount of time——

Chairman DURBIN. OK, that is fair. But I would appreciate if you would get back to me.

[The information appears as a submission for the record.]

Chairman DURBIN. So there is a population of about 450, roughly, at the supermax facility in Florence, Colorado. Is that correct?

Mr. SAMUELS. About 490.

Chairman DURBIN. 490.

Mr. SAMUELS. Yes.

Chairman DURBIN. And is there an ongoing evaluation of the mental health of the inmates at Florence?

Mr. SAMUELS. Yes, sir.

Chairman DURBIN. And how many professionals are on staff at Florence to achieve that?

Mr. SAMUELS. The staffing at the facility, we have a ratio which—outside of the medical and the psychology staff, the average is more or less around 20 staff there for that. But we——

Chairman DURBIN. Excuse me. Twenty for physical and mental health evaluation?

Mr. SAMUELS. Yes, but—we have a psychiatrist who is on staff, and we also have 35 psychiatrists throughout the Bureau, and we use telepsychiatry.

Chairman DURBIN. I am going to zero right in to supermax here and ask you to separate those who would handle routine physical issues and those who are charged with dealing with the psycho-

logical, mental health of the prisoners, the 490. How many at Florence?

Mr. SAMUELS. I will have to submit that for the record, sir.

Chairman DURBIN. I understand there are two. Do you know? That is OK. I am not going to put you on the spot. Do get back——

Mr. SAMUELS. The numbers that you provided me are for the staff that are there, and what I wanted to articulate is that Bureau-wide we utilize the resources for the staff who are spread out, and that was one of the references I made with telepsychiatry. But the onsite staff would fall within the number that you referenced.

Chairman DURBIN. Two?

Mr. SAMUELS. Yes, sir.

Chairman DURBIN. So we are dealing with a supermax facility, the highest incidence of segregation and isolation. We want to make certain—or at least our policy is that those with serious mental illness will not be sent there in the first place. And there are 490 persons there, and there are two onsite—I am going to use that until—we will have the record corrected if I am wrong—to evaluate these prisoners once there.

Now, do you believe that isolation, 23-hour isolation, has a negative impact on the mental health of an individual?

Mr. SAMUELS. I believe for those individuals who warrant placement in restrictive housing due to their behavior associated with mental health for the safety and security of the individual, the facility, and staff in general, there is a method and a process for ensuring that the inmate receives periodic evaluations and mental health treatment from our mental health providers to determine that we are monitoring these individuals in a manner that we can safely house them within those conditions.

Chairman DURBIN. I will concede the fact that there is a monitoring responsibility, and perhaps it is written into the guidelines for the Federal Bureau of Prisons. But I am asking you as a person who has been in corrections, do you believe you could live in a box like that 23 hours a day, a person who goes in normally, and it would not have any negative impact on you?

Mr. SAMUELS. I would say that for individuals who are in that status, that for any inmate within the Bureau of Prisons, our objective is always to have the individual to frequently be in the general population. And we do everything that we can with our resources to ensure that we are working toward—working to get the individual out into the general population.

Chairman DURBIN. I am trying to zero in on a specific question. Do you believe that confinement, solitary confinement, 23 hours a day, five hours a week in which you are allowed to leave that box or something that size, do you believe based on your life experience in this business that that is going to have a negative impact on an individual?

Mr. SAMUELS. Sir, I would say I do not believe it is the preferred option and that there would be some concerns with prolonged confinement.

Chairman DURBIN. OK. I think that is fair.

I went to Tamms, a state facility in Illinois, where we have isolation, and they took me into what was—almost an incredible experience. It was a class that was being taught to five men who were

in 23-hour isolation, if you can imagine, and they were each confined to a plastic holding chamber, fiberglass holding chamber. Think in your mind of "Silence of the Lambs" for a moment here. And they were each in these isolated boxes, fiberglass boxes, and a teacher was standing in front of them. I have no idea what she was teaching. But they gave me an opportunity to walk up and speak to each one of them, look them in the eye and talk for just a few moments.

I am not an expert. I am not a psychologist. I do not know. Some of them, I would ask them how long their sentence was and such, and two or three—two volunteered that they felt that this was the best thing for them, this isolation. They felt that, they expressed that.

One man said to me that he had been sentenced to 25 years, but he received an additional sentence of 50 years since he had been in prison. And I said, "What happened?" He said, "They took me out of isolation, put me in a cell with another person, and I told them if they did, I would kill him. And I did. I told them to leave me alone, I just want to be alone." He murdered another inmate and was sentenced to another 50 years.

So what I am trying to say here is I do not want to just put you on the spot about whether that is the right thing to do or a good thing to do. I want to put it in the context of maintaining an institution and the order in the institution and the protection of innocent people who are part of that institution. Trying to strike some balance here. I would say that man who wants to be alone and isolated has proven that is the best place for him. All right? I cannot go any further in my evaluation.

But the point I am trying to get to is this: I worry—I do not think he will ever come out of prison. I worry about those who end up in isolation for extended periods of time, who are subjected to mental stress that none of us can even imagine, and then ultimately go home out in the general population.

Is it your feeling that once having gone through that experience it is more likely that a person will have problems when they finally emerge from the corrections system?

Mr. SAMUELS. From my experience, I would say that we definitely want to ensure that any inmate within the Bureau at any time during their incarceration that we are doing everything that we can to improve their lives and that they are on a path for productive efforts toward reentry. And if an individual is placed in that status for restrictive housing—and I know earlier a comment was made that many of these individuals, which, in fact, 95 percent of the inmates within the Bureau of Prisons will be released back to society at some point in time, that we are doing everything that we can to provide them the necessary training and skills. And so it is productive not only for the inmate but for the Bureau of Prisons to have these individuals working toward being removed from that status with the appropriate medical care and the psychological investment to ensure that we are proceeding in that manner.

Chairman DURBIN. So let me zero in here. I know that is your goal, and I am glad because that is the right goal. Is your goal served or is it a disservice to your goal the isolation experience that an inmate might go through?

Mr. SAMUELS. For individuals who have worked their way into restrictive housing for the safety and the good order of the prison population, as I mentioned earlier, many of these individuals at the ADX are there for egregious acts, and when you look at the Bureau's population of 218,000, 490 is less than one-third of one percent for our entire population. So these individuals are the most disruptive and the most challenging within the Bureau of Prisons.

However, having said that, we continue to do everything that we can to work toward getting them out of that status, and many of these individuals are there and they will continue to act out.

Chairman DURBIN. Senator Franken.

Senator FRANKEN. Thank you, Director Samuels. I understand everything you have been saying—I really do—in response to the Chairman's questions. I guess what he was driving at was—well, let me ask you this first. What percentage of those who have been in solitary confinement end up being released ultimately? You said 95 percent of all federal prisoners end up being released. What percent of the people who have been in solitary confinement end up being released?

Mr. SAMUELS. The percentage is going to vary because with solitary confinement, which we do view as temporary housing, that many of these individuals are going to be released and placed back in the general population, so I would not be able to give you a specific percentage for an overall term for inmates who have been placed in restrictive housing because it varies.

Senator FRANKEN. OK, because it seemed to me like the question that the Chairman was asking was does this—you know, what effect does this have on the mental health of people who are placed in solitary, and if they are released, do they present more of a danger to society for having been in solitary. But I do not think I will get a good—I mean, you know, a definitive answer to that.

Mr. SAMUELS. If I may, I would respond that it was brought to my attention that the most recent and most rigorous study that has been done was completed by the Colorado Department of Corrections as recently as 2009, and in their study they identified that no negative effect on individuals in restricted housing has occurred.

Senator FRANKEN. No negative effect?

Mr. SAMUELS. Yes.

Senator FRANKEN. OK. Mr. Nolan made some policy recommendations in his written testimony. I would like to hear your views on three of those.

First, Mr. Nolan suggests that solitary confinement should be limited to cases of a clear danger of violence that cannot be controlled in other settings. That is first.

Second—and I will repeat these if you want. Second, he says that each inmate should be screened for mental illnesses before being placed in solitary confinement and that they should be evaluated periodically by a psychiatrist who is independent from the corrections department.

And, third, he says that inmates should have an opportunity to challenge decisions to send them into solitary confinement and that they should have a chance to notify their families that they are being placed in solitary confinement.

Are these policies that the Bureau already has in place? And if not, would it consider implementing them?

Mr. SAMUELS. I will start with the first comment as far as limiting the placement for individuals who pose a clear danger to the correctional environment, and I believe that is what we are doing. As I stated, if you look at our population of 218,000 inmates, we have, you know, seven percent at any given time who are placed in restricted housing, and it is temporary in many cases.

Senator FRANKEN. What percent? I am sorry.

Mr. SAMUELS. Seven percent, and that would be——

Senator FRANKEN. What was that very small percentage that you talked about just a few minutes ago where you said 435 or something?

Mr. SAMUELS. That is at the ADX, which is our most restrictive housing for the Bureau of Prisons. We have less than one-third of one percent of individuals housed, so 490 inmates throughout the country who have been placed in that status for an entire population out of 218,000.

Senator FRANKEN. But seven percent at any one time are in solitary.

Mr. SAMUELS. It is seven percent at any given time throughout the Bureau of Prisons. We have individuals who could be placed in SHU, which is our special housing unit, and our special management unit.

Senator FRANKEN. Which is solitary confinement.

Mr. SAMUELS. Yes.

Senator FRANKEN. OK. That is what I wanted to be clear. Is that limited to cases of clear danger of violence that cannot be controlled in other settings?

Mr. SAMUELS. Yes.

Senator FRANKEN. Okay. So that is in place already?

Mr. SAMUELS. Yes.

Senator FRANKEN. OK. Second, he says that each inmate should be screened for mental illnesses before being placed in solitary confinement, and they should be evaluated periodically by a psychiatrist who is independent from the corrections department. Is that in place?

Mr. SAMUELS. Yes, within our system we have well over 1,300 mental health staff that work for the Bureau of Prisons. And when inmates are placed in restricted conditions for confinement, an assessment is conducted by the staff in conjunction with the correctional services staff and other key departments within the Bureau of Prisons. And so there is an evaluation period to ensure that these inmates are being monitored carefully.

If any inmate goes beyond a 30-day period, they are also provided an in-person assessment by a psychologist within the Bureau. At every facility within the Bureau of Prisons, we have a doctoral level chief psychologist who oversees these types of issues within the institution, because we believe that the mental health management and the well-being of these individuals should be something that is routine and ongoing.

Senator FRANKEN. OK. Maybe I did not say it clearly. He said "should be evaluated periodically by a psychiatrist who is independent from the corrections department." It seems that what you

are saying is—and I am sure that you are doing it as well as you can and for the reasons that you are doing it, but that is not the case right now. They are not evaluated by someone who is independent of the agency, right?

Mr. SAMUELS. I would say that the majority of the inmates in restricted housing are not being evaluated by an external mental health professional. However, when needed, we utilize those resources to assist our staff.

Senator FRANKEN. OK. All I am saying is that his recommendation is that they be screened periodically by someone independent from corrections, so that is not in place.

Third, he says that inmates should have the opportunity to challenge decisions that send them into solitary confinement and that they should have a chance to notify their families that they are being placed in solitary confinement. Is that the policy now?

Mr. SAMUELS. Yes, when inmates are placed in restrictive confinement, they are given due process and an opportunity to challenge their placement in restrictive confinement, and that is in place.

Senator FRANKEN. And are they allowed to tell their families?

Mr. SAMUELS. The individuals are given an opportunity to make a phone call to their family members, and they are also provided access to utilize mail as well as participate in visiting.

Senator FRANKEN. Thank you.

Thank you, Mr. Chairman.

Chairman DURBIN. Thank you, Senator.

Some States are—we are going to hear from Commissioner Epps of Mississippi. Some States, like Mississippi, Ohio, and Maine, are undergoing significant reforms in their prison systems and reducing or eliminating the use of supermax facilities, segregated housing, and special housing units. Mississippi has been able to reduce its segregated population, and prison safety has improved. It has also reported a significant reduction in cost as a result.

Are you familiar with these state initiatives? And what is the Federal Bureau of Prisons doing to either study or follow these models?

Mr. SAMUELS. I am very familiar with the initiatives that you stated, and I would reiterate again within the Bureau of Prisons, I believe that with our classification system and how we review these inmates on an individual case for the behavior that has led them to be placed, that our numbers are relatively small because we are looking at a small number of inmates out of our entire population that are actually placed in restrictive housing, and it is for a temporary placement. And it is not something that we look at for long term.

So we believe that with the numbers, if you look at the information that is at some point provided, you will see that our numbers are not very high when you compare us to a State system.

Chairman DURBIN. I do not want to draw the wrong conclusion from that, but I think your answer was the States can do what they wish, but our numbers are so small, we are not going to get into this business of reform.

Mr. SAMUELS. No. What I am saying is that if you look at the before and after of their numbers and compare the classification

tools that are used on the determination of whether or not an individual should be placed in restricted housing based on the safety, security, and order of the prison environment, if you have individuals who have the propensity to harm others, and in many cases who have killed other individuals, that these are individuals who have proven that they are going to require a restrictive form of confinement until it is proven otherwise with their behavior over a period of time that we are comfortable to ensure the safety of the facility putting them back in general population. So I am saying, sir, that the majority of the inmates that we have within these conditions of confinement, that through our review process and our monitoring of the status of these individuals, we believe that we are doing what we can and our best to maintain the safe order of the facility.

Chairman DURBIN. So let us look at the numbers. We asked the Bureau of Prisons how much time people spend in isolation. Here is what they said: The mean amount of time an inmate spends at supermax ADX facilities, 531 days in isolation, roughly a year and a half that we are talking about here. The mean amount of time in Special Management Units, which I assume would be in other prisons where people are put in segregation or isolation, 223 days, which would be over seven months, seven and a half months. The mean amount of time in Special Housing Units, 40 days.

So has the Bureau of Prisons studied whether these time periods could be reduced? And do you think there is a possibility of reducing these time periods without compromising the safety of the institution?

Mr. SAMUELS. I think the possibility of evaluating further what we can do to ensure that inmates are not staying any longer than necessary, which is something that we definitely as an agency will always strive to do because it is, again, not good for the individual to be in prolonged——

Chairman DURBIN. I am asking—let me be more specific. Is there a study underway—I mean, are people actually looking at this and thinking we may want to change policy? That is what I am driving at in terms of how many people are in segregation, isolation, and how long they stay. Are you studying this?

Mr. SAMUELS. This is something that we are looking at internally within the Bureau regarding the timeframe of inmates' placement and what we can do internally with the resources we have to manage these types of inmates.

Chairman DURBIN. Since 2006, there have been 116 suicides in the Federal Bureau of Prisons; 53 of the 116 were in segregated housing, ADX, SMUs, and SHUs. That does not include attempted suicides. So do you consider this to be an indication that the stress level for an inmate is higher if they are put in segregation?

Mr. SAMUELS. We would say that individuals placed in restricted housing—I would say the stress level is obviously higher, and as a result, we have done everything we can internally to increase our staffing and the resources that are required to manage that type of population. It is costly, and that is why I believe, and to your point, anything that we can do internally within the Bureau to ensure that we are not increasing costs and/or placing individuals unnecessarily, we want to do that because it is to the individual's ben-

efit to be in general population as well as for our management abilities to effectively have, you know, control in an appropriate manner for the facility to have those individuals out freely moving about the general population as opposed to catering to——

Chairman DURBIN. Let me get down to some of the more graphic, and I will not go into detail here in the hearing, but it is there on the record. I have read stories about federal inmates and inmates at State facilities in isolation who have clearly reached a point where they are self-destructive. They are maiming themselves, mutilating themselves, doing horrible things to themselves. They are in an environment within that cell that is awful by any human standard.

What happens next in the Federal Bureau of Prisons when someone has reached that extreme?

Mr. SAMUELS. If an individual is exhibiting that type of behavior due to suffering from, you know, serious psychiatric illness, those individuals are not, within our policy, individuals that we would keep at the ADX or in restrictive housing. These individuals are referred to our psychiatric medical centers for care, and we believe that is important, and we would never under any situation believe that those individuals should be continued to be housed in that type of setting.

Chairman DURBIN. Well, because this is a matter of pending litigation, I am not going to go with any more specificity into it.

I still go back to the possibility that of the 490 inmates, you have two professionals who are monitoring the psychological health of those inmates, and the impact of solitary or the impact of any prison policy on them. And it strikes me that it raises a serious question. How many people work at the ADX facility that might have prisoner contact?

Mr. SAMUELS. We have on average anywhere from 360 staff for our staffing complement for the ADX, but back to the number of psychologists, at the site for ADX in total, we have nine psychologists that work at the complex.

Chairman DURBIN. Nine?

Mr. SAMUELS. Nine.

Chairman DURBIN. OK. Is there a person who has the responsibility of hearing inmate complaints about treatment at the ADX facility?

Mr. SAMUELS. Yes.

Chairman DURBIN. What is that title or designation?

Mr. SAMUELS. If an individual is raising complaints against the facility, it is more of an internal review process where they can raise complaints to the correctional services supervisor, the associate warden or warden, and with our procedures it can go to the regional director for that region, and all the way to our headquarters in Washington.

Chairman DURBIN. Is that person designated a special investigative agent?

Mr. SAMUELS. Yes, if there are allegations brought against staff or issues within the facilities, that would be the position.

Chairman DURBIN. Do you know who that person is at the ADX facility?

Mr. SAMUELS. I know the position, not the individual.

Chairman DURBIN. Well, once again, this is a matter that has been raised as part of pending litigation. I will not get into it, but there have been questions raised as to the possible conflict of interest of this individual who is reported to be married to one of the corrections officers at the supermax facility and is supposedly the watchdog or whistleblower on behalf of prisoners who would protest treatment by the corrections officers. Do you think that on its face this is a conflict?

Mr. SAMUELS. I would say due to the pending litigation and in the interest of the Bureau, I cannot respond to that question, sir.

Chairman DURBIN. Understood. Mr. Samuels, the Commissioner of the Maine Department of Corrections, Joseph Ponte, has implemented a number of reforms in his state by working side-by-side with mental health workers, corrections officers, and advocacy groups. These reforms led to more than a 50-percent reduction of Maine's administrative segregation population. In written testimony for this hearing, Commissioner Ponte wrote that the first step in evaluating a corrections system is to be aware of what the current body of research tells us about changing prisoner behavior.

Do you share the Commissioner's belief about the importance of understanding current research?

Mr. SAMUELS. Yes.

Chairman DURBIN. I hope that that will lead to an honest evaluation of how we can continue to make for a safe prison system, one that is fair and humane, one that anticipates, as you said, that the vast majority of those inmates will one day be back on the street, and the condition that they will be in when they return to society.

There will be written questions, I think, along the way here, but I appreciate your testimony today. Thank you very much for joining us.

Mr. SAMUELS. Thank you.

Chairman DURBIN. I would like to call the second panel. I want to ask consent that Senator Leahy's statement be placed in the record, and since there is no one else here at the moment, that consent is given unanimously.

[The prepared statement of Chairman Leahy appears as a submission for the record.]

Chairman DURBIN. Before you all get comfortable, I will ask you to please stand and raise your right hand. Do you solemnly swear the testimony you give will be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. EPPS. I do.

Mr. ANDREWS. I do.

Mr. GRAVES. I do.

Mr. HANEY. I do.

Chairman DURBIN. Thank you. Let the record reflect that all four witnesses answered in the affirmative.

One of the witnesses who had planned on being on this panel, Pat Nolan, President of the Justice Fellowship, could not attend due to illness. He was very upset that he could not because he wanted to be here. We wish him a speedy recovery.

Christopher Epps was first appointed Commissioner of the Mississippi Department of Corrections in 2002 by then-Governor Ron-

nie Musgrove, who was a Democrat. Since then he has been reappointed by two different Republican Governors—former Governor Haley Barbour and current Governor Phil Bryant. Commissioner Epps is the longest-serving Commissioner in the history of the agency. As the President-Elect of the American Correctional Association, Commissioner Epps will begin serving that term in 2013. He has also previously served as the President of the Southern States Correctional Association, sits on a number of boards and committees, and received a long list of awards and honors. He received his master's degree in guidance and counseling from Liberty University in Lynchburg, Virginia; his bachelor of science in elementary education from Mississippi Valley State University.

Commissioner Epps, thank you for joining us today, and please proceed with your testimony.

STATEMENT OF CHRISTOPHER EPPS, COMMISSIONER, MISSISSIPPI DEPARTMENT OF CORRECTIONS, JACKSON, MISSISSIPPI

Mr. EPPS. Thank you, Mr. Chairman. I appreciate the invite. Let me just say good morning to everyone.

I began my career as a corrections officer—and I have held 10 positions up to commissioner—back in 1982 when I started. And back then, solitary confinement was sparingly utilized for the most incorrigible and dangerous offenders. There was very limited space. We only have 56 cells at a place called Mississippi State Penitentiary known as Parchman.

A tragic murder of a corrections officer occurred in 1989, and that prompted construction of a unit called Unit 32 at the Mississippi State Penitentiary at Parchman. Unit 32 was a 1,000-bed maximum security unit where all the inmates were in lockdown in single-cell housing for 23 or 24 hours a day, seven days a week. The unit was opened in 1990, and it was all single-cell.

Mr. Chairman, for this hearing, I would like to use the American Correctional Association term for administrative segregation, solitary confinement, and that is a formal separation from general population administered by a classification committee or other authorized group when the continued presence of the inmate in general population would pose a threat, a serious threat, to life, property, self, staff, or other inmates, or to the secure, orderly running of the institution.

I was convinced, after operating Unit 32 back at Parchman, that an inmate should remain in administrative segregation until he demonstrated over a period of time that his behavior had changed and he was no longer a threat to staff, other offenders, and public safety. And in this case, it could be for many years, and for some it was not until they were released from prison or they died in Unit 32. The prison was easy to enter, but it was almost impossible to be released without exemplary behavior.

Along came "Truth in Sentencing" in 1995 where inmates had to do 85 percent of their sentence regardless of their behavior, and increased incarceration of mentally ill individuals compounded the situation of hopelessness at the prison. Young offenders with long sentences and involved in gangs became a large percentage of the population. Again, Unit 32 was not air conditioned, 1,000 beds, sin-

gle cell. One inmate told me, as I was touring the facility one day, he said, "Commissioner, you have taken all hope. We have nothing to lose."

Unit 32 conditions of confinement was increasingly litigated with a 2003 consent decree regarding death row offenders in *Russell* v. *Mississippi Department of Corrections*, and a second consent in 2007 for administrative segregation offenders in *Presley* v. *MDOC*. In May 2007, violence began to erupt at Unit 32 and continued throughout the summer. We had three homicides and many serious disruptive incidents, and we had a suicide. I finally realized that it was time for a change.

So we began to reform Unit 32 by thinking outside the box, and we got together with the National Institute of Corrections as well as the ACLU, and we collaborated with Dr. James Austin, and we came up with a valuable classification system. And what came out of that was we had many inmates that were overclassified.

In addition to that, we hand-picked staff, and we gave staff a 20-percent increase in pay for working in the max unit. We also implemented multidisciplinary teams to make decisions regarding the mentally ill. We were also able to develop a program for those who were in the administrative segregation programs such as group counseling, alcohol and drugs, life skills, and anger management. They were all started for offenders.

We were able to use all of these tools and put them in our tool bag, and the Mississippi Department of Corrections administrative segregation reforms resulted in a 75.6 percent reduction in the administrative segregation population from over 1,300 in 2007 to 316 by June 2012. Because Mississippi's total adult inmate population is 21,982 right now, that means that 1.4 percent are currently in administrative segregation. And out of that number, 188 are participating in the program.

To me, it is real simple as it relates to administrative segregation. One, you have to have in place a genuine documented classification system; two, you have to have programs in place; three, you have to have provisions in place to make sure that only the right people can go to administrative segregation. It has to be myself, my Deputy Commissioner of Institutions, or the Director of Classification to put you in there, to approve. And in addition to that, over time we were able to save $5.6 million by all this reclassification.

Corrections is no different than anything else in our nation. These cells have to be used as high-cost real estate. In Mississippi, to house an inmate on administration segregation costs $102.27 a day, whereas, a medium security inmate, it costs $43.72 a day.

I think we, as corrections leaders, must realize that to be successful, we have to always be willing to change and listen to all the stakeholders involved in the criminal justice system. We cannot take a one-sided approach. And I have been most successful when I made decisions that were in the best interest of all.

Corrections is like climbing a mountain. We never get to the top. We have to continue to climb and do the very best we can.

Mr. Chairman, I thank you for the opportunity to appear before you today, sir.

[The prepared statement of Mr. Epps appears as a submission for the record.]

Chairman DURBIN. Thanks for that testimony. I will have a few questions for you.

Craig Haney is a professor of psychology at the University of California, Santa Cruz, and he is director of their legal studies program. Since the late 1970s, Professor Haney has been one of the leading experts on the psychological effects of prison isolation and solitary confinement. He has conducted systematic, in-depth assessments of hundreds of solitary or supermax prisoners in different states. He has also testified as an expert witness about the psychological impact of solitary confinement in several landmark federal cases. He was recently appointed to the National Academy of Science's committee studying prison conditions and prison policy. He has served as a consultant to the U.S. Department of Justice, the California State Legislature, and many others. He received his Ph.D. in psychology and a J.D. from Stanford University.

Professor Haney, the floor is yours.

STATEMENT OF CRAIG HANEY, PH.D., PROFESSOR OF PSYCHOLOGY, UNIVERSITY OF CALIFORNIA, SANTA CRUZ, CALIFORNIA

Mr. HANEY. Senator Durbin, thank you for the opportunity to participate in this historic hearing.

I am someone who has probably spent almost as much time inside our nation's prisons and jails over the last 30 years as I have inside the classroom at my beautiful home university. This has included inspecting dozens of solitary confinement units across the country and interviewing, as you said, many hundreds of men and women who are confined in their cells on average 23 hours a day, many for years, even decades.

I brought some photographs to illustrate what solitary confinement looks like and how it is practiced now in the United States that your staff has kindly agreed to show.

Many isolation prisons are stark and foreboding structures. The cell blocks are typically small and are sometimes overseen by armed correctional officers. The cells themselves are often scarcely larger than the size of a king-size bed. Prisoners thus eat, sleep, and defecate each day in areas just a few feet apart from one another.

It is hard to describe in words what such a small space begins to look like, feel like, and smell like when someone is required to live virtually their entire life in it.

Because contact visiting is prohibited in solitary confinement, prisoners never touch another human being with affection. Their only regular so-called interactions occur when corrections officers place food trays on the slots of their doors, the same slots where prisoners are first handcuffed anytime their cell doors are opened. Indeed, the only time they are physically touched is when being placed in mechanical restraints—leg irons, belly chains, and the like. They are escorted by no fewer than two and sometimes as many as five correctional officers any time they are taken out of their unit.

Their one hour a day outside of their cells is termed "yard time," but it occurs in a place that barely resembles a yard. It consists, instead, of an exercise pen or cage or a concrete enclosed area that prevents any view of the outside world.

There is a disturbingly high concentration of mentally ill prisoners in solitary confinement, as you have heard. If they are fortunate enough to be in a unit that provides them with treatment, they are usually unfortunate enough to receive it in a treatment cage, or in several of them, in a unique form of group therapy.

As you mentioned earlier, Senator, your colleague Senator McCain has characterized solitary confinement as an awful thing, correctly noting that "it crushes your spirit and weakens your resistance more effectively than any other form of mistreatment."

I agree, and know that for some prisoners less resilient than he, solitary confinement precipitates a descent into madness. Some isolated prisoners smear themselves with feces, sit catatonic in puddles of their own urine, or shriek wildly and bang their fists or heads against the walls that contain them.

In some cases, the reactions are even more tragic and bizarre, including grotesque forms of self-harm and mutilation. Prisoners have amputated parts of their own bodies or inserted tubes and other objects into their penises in acts that unfortunately can be met with an institutional matter-of-factness that is equally disturbing.

Less extreme and much more common reactions include panic attacks, hypervigilance, and paranoia; cognitive dysfunction, hopelessness, and depression; and anger and rage.

Although solitary confinement certainly does not drive everyone who experiences it crazy, we do know that time spent in these places is often more than merely painful, moving beyond suffering to placing prisoners at grave risk of psychological harm.

In addition, isolated prisoners frequently develop forms of social pathology, ways of being that are functional to surviving the asocial world of solitary confinement, but profoundly dysfunctional when these prisoners are returned to a mainline prison or released, as most of them are, into the free world where they now must interact effectively with others or risk permanent marginalization. Indeed, this enforced asociality and the virtually total lack of training or meaningful programming that isolated prisoners typically receive can significantly impede their post-prison adjustment, raising important concerns about the effect of solitary confinement on recidivism and public safety.

As prison populations continue to gradually decline in the United States and the Nation's correctional system rededicates itself to program-oriented approaches designed to produce positive prisoner change, our use of solitary confinement should be radically rethought and restricted, and the resources now expended on it redirected to more humane, cost-effective, and productive strategies of prison management.

It is my sincere hope that this Committee will help lead the way.

[The prepared statement of Mr. Haney appears as a submission for the record.]

Chairman DURBIN. Professor Haney, thank you. I read your testimony carefully, and I know that you have spent a lifetime focusing on this, and I thank you for coming here today.

Stuart Andrews is a partner at the law firm of Nelson Mullins Riley & Scarborough in Columbia, South Carolina. He is the head of his firm's South Carolina health care group and former chairperson of the firm's pro bono program. He serves on a number of statewide task forces on health care policy in South Carolina, and among his previous posts, he was Executive Director of the South Carolina Legal Services Association, Chairman of the South Carolina Legal Services, and Chairman of the South Carolina State Board of Education. He received his bachelor's degree from Erskine College, and his J.D. from the University of South Carolina School of Law.

Senator Graham asked that he be part of this panel, and I am more than happy that you have joined us today. Mr. Andrews, please proceed.

STATEMENT OF STUART M. ANDREWS, JR., PARTNER, NELSON MULLINS RILEY & SCARBOROUGH LLP, COLUMBIA, SOUTH CAROLINA

Mr. ANDREWS. Thank you, Mr. Chairman. Thank you particularly for your interest in this subject of enormous significance to men and women incarcerated in our prisons and jails throughout our Nation.

I am grateful for the opportunity to provide the Committee with information concerning the use of solitary confinement in South Carolina prisons, particularly the use to which inmates diagnosed with mental illness have been subjected.

The Nelson Mullins law firm represents a class of inmates with serious mental illness in South Carolina prisons, many of whom have spent significant time in solitary confinement. I am appearing today on behalf of that class and its guardian ad litem, Joy C. Jay, as well as on behalf of Protection and Advocacy for People with Disabilities, a South Carolina nonprofit organization charged by federal and state law to protect and advocate for the rights of people with disabilities.

After years of investigations, reports, and negotiations, the inmate class and P&A filed suit in South Carolina state court in June 2005 against the South Carolina Department of Corrections, alleging violations of the South Carolina Constitution's prohibition against cruel and unusual punishment and seeking injunctive relief to require the provision of adequate mental health services to our class. After more than six years of litigation, a bench trial was held in February and March of this past year, although no ruling has been entered to date.

A major issue in the trial was the extensive reliance by the Department of Corrections on solitary confinement as a means of managing inmate conduct, particularly inmates with mental illness. During their imprisonment, nearly half of the nearly 3,000 men and women with mental illnesses on the department's caseload have been held in solitary confinement for periods cumulatively averaging almost two years.

The effects of the conditions in solitary confinement can be harmful for anyone, but they particularly expose individuals with mental illness to substantial risks of future serious harm—the applicable Eighth Amendment standard applied in systemic conditions cases like ours. To illustrate some of what we have learned about the operation of solitary confinement in our State's prisons, I would like to call to your attention to two individuals who have been members of our class.

The first is Theodore Robinson, who is a 50-year-old man with paranoid schizophrenia serving a life sentence. Mr. Robinson's speech is highly disorganized, and he has a history of bizarre behavior, such as drinking his own urine. Like many people with schizophrenia, he suffers hallucinations and delusions. For example, he believes that at night while he sleeps doctors secretly enter his cell and perform surgery on him.

From 1993 through 2005, a period of 12 consecutive years, Mr. Robinson was kept in solitary confinement. Fifteen days after our lawsuit was filed, however, the department removed Mr. Robinson from solitary and placed him in its psychiatric residential program.

Other inmates with serious mental illness have not been so lucky. In South Carolina, mentally ill inmates are twice as likely as other inmates it to be in solitary confinement; two and a half times as likely to receive a sentence in solitary that exceeds their projected release date from prison; and over three times as likely to be assigned to an indefinite period of time in solitary.

Mentally ill inmates placed in solitary are not limited to those with mild mental disorders. Like Theodore Robinson, many are diagnosed with schizophrenia or other serious mental illnesses, such as bipolar disorder, schizoaffective disorder, or major depression. A Department of Corrections psychiatrist at Lee Correctional Institution, for example, estimated that 40 to 50 percent of her caseload who were in solitary confinement were "actively psychotic."

Perhaps the single most deplorable solitary confinement unit in the South Carolina prison system is the cell block at Lee Correctional Institution known as Lee Supermax. On February 18, 2008, an inmate named Jerome Laudman was found in a Lee Supermax cell, lying naked without a blanket or mattress, face down on a concrete floor in his own vomit and feces. He died later that day in a nearby hospital. The cause of death was reported as a heart attack, but hospital records noted hypothermia, with a body temperature upon arrival at the hospital of only 80.6 degrees.

Mr. Laudman suffered from schizophrenia, mental retardation, and a speech impediment. According to his mental health counselor, he had never acted in an aggressive or threatening manner.

On February 7, 2008, 11 days before his death, Laudman was moved to Lee Supermax, purportedly for hygiene reasons because he refused to take a shower, although no one later admitted to ordering the move.

On February 11th, one week before Mr. Laudman's death, a correctional officer saw him stooped over like he was sick or weak. The officer noticed styrofoam trays piled up inside his door that had not been collected. He considered notifying a unit captain or administrator, but was discouraged by his supervisor. On the afternoon of Mr. Laudman's death, two nurses were called to Mr.

Laudman's cell. They observed him lying face down in his own waste and vomit, but still alive. The styrofoam trays were still there, with rotted food. The conditions were so foul that the nurses and the correctional officers whom they summoned refused to enter the cell to remove Mr. Laudman, who was still alive at that point. So instead they called two inmate hospice workers, who took 30 minutes to get there, at which point they removed the body. Later that day in a hospital, Mr. Laudman died.

In South Carolina, a disproportionate number of mentally ill inmates are placed in solitary confinement. Many are actively psychotic. Conditions are atrocious, mental health services inadequate, and stays are inhumanely long. Theodore Robinson was fortunate. After 12 consecutive years in solitary, he was transferred to a psychiatric residential program, but coincidentally, two weeks after he filed a lawsuit against the department.

Jerome Laudman was not so fortunate. After 11 days in Lee Supermax, he died of neglect in a cold, filthy cell.

For other inmates with mental illness in solitary confinement in South Carolina, the story is ongoing. Will they receive adequate mental health treatment to stabilize their mental illness? How well will the solitary prepare them to handle the transition back into the community? These questions, and their implications for the constitutional rights of all mentally ill inmates in South Carolina, remain unanswered today, and we thank you and this Committee for undertaking them to try to improve and correct the conditions to which inmates in solitary are subjected.

Thank you.

[The prepared statement of Mr. Andrews appears as a submission for the record.]

Chairman DURBIN. Thank you for your testimony. I think your dedication as an attorney in private practice really is an indication of why they call it a profession and not just a job.

Mr. ANDREWS. Thank you, sir.

Chairman DURBIN. Thank you.

Anthony Graves is the next witness. He served 18 years incarcerated and on death row in Texas. A federal appeals court overturned his conviction in 2006. He was completely exonerated in 2010. The Burleson County District Attorney deemed Mr. Graves "an innocent man." Texas Governor Rick Perry described Mr. Graves' case as "a great miscarriage of justice."

Since his release, Mr. Graves has had the courage to speak out about our criminal justice system. He founded AnthonyBelieves.com, which is dedicated to criminal justice reform.

It took courage for you to come here today, and we appreciate your testimony. The floor is yours.

STATEMENT OF ANTHONY C. GRAVES, FOUNDER, ANTHONY BELIEVES, HOUSTON, TEXAS

Mr. GRAVES. Thank you, Mr. Chairman. My name is Anthony Graves, and I am death row exonoree number 138. I was wrongfully convicted and sentenced to death in Texas back in 1992. Like all death row inmates, I was kept in solitary confinement under some of the worst conditions imaginable, with the filth, the food, the total disrespect of human dignity. I lived under the rules of a

system that is literally driving men out of their minds. I survived the torture, but those 18 years were no way to live.

I lived in a small 8-by-12-foot cage. I had a steel bunk bed with a very thin plastic mattress and pillow that you could only trade out once a year. I have back problems as a result. I had a steel toilet and sink that were connected together, and it was positioned in the sight of male and female officers. Degrading.

I had a small shelf that I was able to use as a desk to write on and eat on. There was a very small window up at the top of the back wall. In order to see the sky, you would have to roll your plastic mattress up to stand on. I had concrete walls that were always peeling with old paint.

I lived behind a steel door that had two small slits in it, the space replaced with iron mesh wire, which was dirty and filthy. Those slits were cut out to communicate with the officers that were right outside your door. There was a slot that is called a pan hole, and that is how you would receive your food. I had to sit on my steel bunk like a trained dog while the officers would place the trays in my slot. This is no different from the way we train our pets.

The food lacks the proper nutrition because it is either dehydrated when served to you or perhaps you will find things like rat feces or a small piece of broken glass. When I was escorted to the infirmary one day, I was walking past where they fixed the food, and I watched a guy fix this food, and he was sweating in it. That was the food they were going to bring me.

There is no real medical care. I had no television, no telephone, and, most importantly, I had no physical contact with another human being for 10 of the 18 years I was incarcerated. Today I have a hard time being around a group of people for long periods of time without feeling too crowded. No one can begin to imagine the psychological effects isolation has on another human being.

I was subjected to sleep deprivation. I would hear the clanging of metal doors throughout the night or an inmate kicking and screaming because he has lost his mind. Guys become paranoid, schizophrenic, and cannot sleep because they are hearing voices. I was there when guys would attempt suicide by cutting themselves, trying to tie a sheet around their neck or overdosing on their medication. Then there were the guys that actually committed suicide.

I will have to live with these vivid memories for the rest of my life. I would watch guys come to prison totally sane, and in three years they do not live in the real world anymore. I know a guy who would sit in the middle of the floor, rip his sheet up, wrap it around himself, and light it on fire. Another guy would go out in the recreation yard, get naked, lie down and urinate all over himself. He would take his feces and smear it on himself as though he was in combat. They ruled he was competent to be executed.

I knew guys who dropped their appeals, not because they gave up hope on their legal claims but because the conditions were just intolerable. They would rather die than continue to exist under such inhumane conditions.

Solitary confinement breaks a man's will to live and he deteriorates right in front of your eyes. He is never the same person again. Then his mother comes to see him. She cannot touch him.

She has not touched him in years. She watches as her son sits right there and deteriorates in front of her eyes. This thing has a ripple effect. It does not just affect the inmate; it affects his family, his siblings, his children, and, most importantly, it affects his mother.

I have been free for almost two years, and I still cry at night because no one out here can relate to what I have gone through. I battle with these feelings of loneliness. I have tried therapy but it did not work. The therapist was crying more than me. She could not imagine how inhumanely our system was treating people.

I have not had a good night's sleep since I have been out. I only sleep about two and a half to three hours a night, and then I am up. My body has not made the adjustment. I have mood swings that just cause emotional breakdowns. I do not know where they come from. They just come out of nowhere. Solitary confinement makes our criminal justice system criminal.

It is inhumane, and by its design it is driving men insane. I am living amongst millions of people out here, but I still feel alone. And I cry at night because of these feelings. I want them to stop, but they will not.

I watched men literally self-mutilate themselves. They had to be put on razor restrictions because if they are given a razor, they would cut their own throat, their own neck, whatever they could cut on their bodies. They would just stand there in front of you and cut themselves.

This one man in particular that I watched do this, they took him over to what they called the psychiatric ward. A few days later, he hung himself—all because of the conditions.

There is a man sitting on Texas death row right now who was housed in solitary confinement who pulled his eye out and swallowed it—all because of the conditions. Solitary confinement dehumanizes us all.

Thank you, Chairman.

[The prepared statement of Mr. Graves appears as a submission for the record.]

Chairman DURBIN. No. Thank you.

A few years ago, there was a man sitting in that chair who told the story of his sister who was sentenced to nearly 22 years in prison for a case of crack cocaine. He was from Alton, Illinois. He was raising his sister's kids. And a few of us sitting here listening to his story said, "We have got to do something about this," and we did. Not as much as we should have, but we did. He did not know when he made his trip out here and sat at that table that talking into that microphone would change anything. But it did.

And you have got to feel the same way. There is real value in your life and that you are here today telling this story on behalf of a lot of people who cannot speak for themselves. If you were not here, if your voice was not heard, they would have no one. So your courage in telling this story, as tough as it must have been, ought to tell you about the value you have still in life and what you can still bring, so thank you. Thank you for that.

Mr. GRAVES. Thank you, sir.

Chairman DURBIN. I am going to ask a few questions now of the panel.

First, Professor Haney, you heard the testimony from the Bureau of Prisons about its supermax, with 490 inmates. I tried to get on the record—and in fairness to the Bureau, I want them to give me the best information they can about screening before someone goes to the supermax, and once in the supermax, how prisoners are monitored, how many professionals are there to do the job, and once someone is in that isolated circumstance, if they start exhibiting things that should be carefully monitored, who would do it.

You have been through this. You have been through federal prisons, state prisons, and others. What can you tell us about the conditions at our federal supermax prison and how the issue of mental illness is handled there?

Mr. HANEY. Well, Senator, I have been through the ADX facility many times. I have toured and inspected it on five or six different occasions, and I am familiar with many of the prisoners who are there. And my understanding and analysis of that facility bears almost no relationship to what you heard.

Unfortunately, the Federal Bureau of Prisons, in my opinion, does the same inadequate job as the state systems that we have been talking about do. Those inadequacies extend to the evaluations of the people who go into the system in the first place. We put far too many people inside solitary confinement, people who should be categorically excluded. Juveniles and the mentally ill, for example, still show up inside these systems of isolation, and should not. And in the federal system, there are mentally ill prisoners, in my opinion, who are in ADX, people with long mental health histories documented by the Bureau of Prisons itself.

We keep them in far too long. There are prisoners who are in solitary confinement for decades in this country. In the system that I know best, California, in the notorious Pelican Bay Security Housing Unit, there are about 500 men who have been in solitary confinement for 10 years or longer, nearly 100 who have been in solitary confinement for 20 years, essentially since the facility opened in 1989.

There are prisoners at the ADX who have been in solitary confinement, not only at ADX but including their time elsewhere, for decades. We keep them far too long, and the Bureau of Prisons keeps them far too long as well.

We fail in terms of the kinds of programs that we provide for people while they are there. What are the conditions of confinement? They are far too severe to serve any rational penological purpose. And then we do precious little in terms of providing transitional services for them when they are released. There are state systems around the country that have literally no transitional services, so they currently release people directly out of solitary confinement. Sometimes prisoners who have been there for many years, even decades, come directly out of that environment onto the streets of free society.

Chairman DURBIN. It is a mistake, I know, but I am going to do it anyway, to take anecdotal evidence and try to turn it into some profound revelation. But my trip to Tamms, my brief encounter with people facing this, and two very violent criminals who said they felt better now in this circumstance than they had ever felt in their lives. So have you run into that phenomenon?

Mr. HANEY. Yes, and I think, first of all, I want to commend you for being one of the few Senators who knows directly about which we speak, because you visit these places, and I think it is hard to understand and grasp the reality of these institutions unless you go there. And so I would endorse your earlier recommendation to your fellow Senators to visit these institutions and talk to the people who are there. But let me say a couple things about the anecdote that you shared.

One is that it is, I think, important to separate solitary confinement from being single-celled or single-housed. There are many prisoners who prefer to be alone in their cells, but not alone in their cells under solitary confinement-type conditions. So many people who say they would prefer being in isolation are talking about isolation versus being double-celled or more, or worse, in very crowded prison conditions, which some people simply cannot psychologically tolerate.

In the old days, before prison overcrowding became the norm in the United States, most prisoners were single-celled. Now, as I am sure you know, most prisoners are double-celled or housed in crowded dormitories. There are some prisoners who simply cannot handle confinement in a cell not much bigger than the one that you have constructed in the courtroom that they have to share with another person. They simply cannot manage that psychologically. And nowadays, unfortunately, they are given the Hobson's choice of either trying to tolerate that kind of enforced confinement with another person or committing a disciplinary infraction because that is the only way that they can attain single-cell housing—by being placed in solitary confinement. So that is one issue.

The other issue is that one of the very serious psychological consequences of placing people in solitary confinement for long periods of time is that it renders many people incapable of living anywhere else. In other words, they have to transform themselves, their habits of being, their ways of acting and thinking and relating to themselves as well as the world, premised on the assumption that they will not be around other human beings. And they actually get to the point where they find that it is frightening to be around other people. Many of the people who I work with who come out of solitary confinement and go either into mainline prisons or come out into free society talk about being anxious, overcome, overwhelmed with anxiety when they are around other human beings because they become accustomed to being isolated or being alone.

Chairman DURBIN. Let me ask you about the double-celling, because that is what I found in Pekin—Pekin, Illinois, Federal correctional facility. And I asked them to take me to the segregated unit, and they did, and we walked through it briefly and looked at the exercise area, which looked exactly like the cages that you showed in your photographs here. And I spoke to the guards afterwards, correctional officers, because I wanted to hear from their perspective, too. It is their lives that are on the line here, so we have got to be sensitive to that.

Mr. HANEY. Absolutely.

Chairman DURBIN. And they said, one of them said in candor, "I do not think this makes the situation any better. Some of them are

stuck in a cell with somebody who is worse off than they are. It is a threat to them."

Mr. HANEY. Yes.

Chairman DURBIN. You know, sharing that cell. He said, "So we kind of look at the prison overcrowding and putting two people in that kind of space is making the situation much worse."

He was not arguing the mental illness part of it. He was arguing institutional order as part of it. What has been your experience?

Mr. HANEY. Well, you know, unfortunately, I think that prisoners who are living under the kinds of conditions you just described have the worst of both worlds. They are simultaneously segregated from the normal prison population and the activities and programming that they might engage in, and crammed together in a small cell around the clock, with another person: simultaneously isolated and overcrowded. They really cannot relate in any meaningful way to the people with whom they are celled, and so they basically develop a kind of within-cell isolation of their own, and it adds to the tension, and the tensions then can get acted out on each other. It creates hazards for the people who are forced to live that way. It creates hazards for the correctional officers who have to deal with prisoners who are living under those kinds of pressures.

Chairman DURBIN. I am going to ask just a couple more questions while Senator Franken prepares his notes. I thank him for returning here. I know, as I said, my colleagues are loaded with assignments here. Thank you, Senator Franken, for coming back here.

Commissioner Epps, what a story. I was trying to remember where I had heard of Parchman prison, and it was in a song somewhere, so it has got kind of a legendary reputation of being a pretty tough place.

Mr. EPPS. Yes, sir.

Chairman DURBIN. That the State of Mississippi, which many folks up north may not look to for leadership but clearly is a leader when it comes to this issue. Tell me, how did you pull this off politically? In a State that is get tough, law and order, what you are saying is do not be so darn mean to these inmates, it ain't helping things and it is costing a lot of money. We can punish them as they should be punished. We can keep order in these prisons. We can save some money in the process and be a little more humane. How did you pull that off politically? Were you forced to it by a court order or something?

Mr. EPPS. Well, actually, we were being sued, Mr. Chairman, but we sat down with the ACLU, we sat down with our classification experts——

Chairman DURBIN. Now, I am trying to get that together in my mind.

[Laughter.]

Mr. EPPS. We did. And what happened was, you know, we did what we felt was right, and today I still feel like we made the right decision.

Mississippi is a very conservative State. They are tough on crime. We are tough on crime in Mississippi. And we was looking at the situation in that we learned very quickly that what we was doing was not working. And we just had violence.

Chairman DURBIN. In what was it not working? What did you say to the average person in the street, here is why we have got to change it?

Mr. EPPS. Well, from May 2007 to August 2007, three homicides, highly unusual; one suicide. And in that period of time, that is highly unusual in any prison environment.

In addition to that, the assaults of violence was high, you know, on staff. Inmates was throwing urine and feces on staff. They was hurting themselves. And so we had to look at the entire situation as it relates to what we were doing, and we looked at it and we found that based on giving inmates privileges, based on allowing inmates what we call a progressive step-down unit—you go from one level to another one with privileges—also for the mentally ill, group counseling and training all of our staff to include the corrections officers, and giving them an incentive and getting buy-in. And what came after that was it started working, and even the inmates told me, they said, "Commissioner, we told you we could do it."

And so I feel real good about it, and we did that back in 2008, and here we are four years later and it is still working.

Chairman DURBIN. You are President-Elect of the American Correctional Association, and when you take over next year, what are you going to take away from your experience in Mississippi in terms of talking to other folks who are running state correctional associations?

Mr. EPPS. Well, no one here, I do not believe, wants an inmate living next to them that just got out of maximum security. So what we got to decide is who we are mad with and who we are afraid of. I would take to them that since we changed Unit 32 and we closed it because we do not need it anymore, violence reduced by 50 percent. I would take to them, second, that you got to have accountability in place. When I started, you did one piece of paper called a detention notice, and you just put on there the inmate is interfering with the orderly running of the institution, and they went to solitary confinement. That is too easy. You have got to have a check and balance. Today it has to come up to my desk.

In addition to that, we got to make sure that we realize that 95 percent of all the individuals who are incarcerated in Mississippi is coming back to our neighborhood whether we like it or not.

And so to me as a Commissioner for the Mississippi Department of Corrections, or any agency head in any state, that is our responsibility, and that is on our report cards to make sure we do that.

Chairman DURBIN. Good. Senator Franken.

Senator FRANKEN. Thank you, Mr. Chairman.

I want to thank all the witnesses. I have read your testimony. I am sorry I had to miss your oral testimonies. As I said, I did read your written testimony last night, and especially, Mr. Graves, thank you. What you described is just heartbreaking. I really admire your courage to come here and tell your story. I know that cannot be easy, and I wish you peace and that you can eventually come to grips with this. I do not know how you can—eighteen and a half years. But thank you, and thank you for your strength. I think it takes real strength and courage to tell your story.

As Chairman Durbin mentioned in his opening remarks, America incarcerates more people per capita than any of the world's democ-

racies. We have five percent of the world's population and yet 25 percent of the world's inmates. And I think we need to take a really hard look at our criminal justice system. I thank you, Commissioner Epps, for your work. And we need to make serious reforms, and that is why I support the *Criminal Justice Commission Act* which Senator Webb has been working on for years now. The bill would convene a commission of experts to make policy recommendations that would help make criminal justice fairer and less costly.

Do each of you agree with this top-to-bottom review of the criminal justice system, that it would be useful? And what issues should that commission consider in making its recommendations? This is wide open to anyone. Mr. Haney, I see you are turning on your microphone.

Mr. HANEY. I enthusiastically support these recommendations. I think this is an evaluation that is long overdue. We have been in this country mired in a series of policies that have led to mass incarceration. The topic of today's hearing, I think, is an outgrowth of that mass incarceration movement.

I think the kinds of reforms that many of us have testified about today, both in our oral and written testimony, with respect to solitary confinement can and should be done in conjunction with reform of the entire system. They are interconnected, obviously, and I think part of the way in which the system as a whole has deteriorated is what has led to the kind of extremes and outrages that have occurred inside solitary confinement units.

We can reform solitary confinement, and we should, but it is part of a larger system that needs to be evaluated and understood as flawed in many of the same ways. We put far too many people in prison. We pay far too little attention to what happens to them while they are there. We keep them there for far too long, and then we disregard what happens to them when they try to make the difficult transition to come out into the free world.

These kinds of problems are exacerbated with respect to solitary confinement, but they are not unique to solitary confinement, and so looking at the system as a whole I think is an extraordinarily important goal.

Mr. ANDREWS. Senator, if I may, while it is certainly critical to examine the entire system, it would be a mistake, in my view, if the analysis were limited to the criminal justice system. I think as everyone in this room is aware, particularly with regard to inmates with mental illness, the increase in the number of individuals with mental illness who have been incarcerated can be directly correlated to decisions by the State and Federal Governments to deinstitutionalize Psychiatric hospitals and to reduce support for programs for the mentally ill throughout the country. And that occurred. It is directly related to the increase in the incarceration rates, and to the degree that this Committee's work is done in isolation from community-based mental health services, it will be missing a large part of the remedy, in our view.

Senator FRANKEN. I am in total agreement with that, and we have had testimony about, you know, the criminal justice system being a substitute for a real mental health policy in our society.

One of the federal solutions to this problem is the *Mentally Ill Offender Treatment and Crime Reduction Act*, or MIOTCRA, which provides courts, police, and prisons the resources they need to address the special needs of people with mental health problems. But that bill is scheduled to expire next year unless Congress acts.

Do you all agree that this law should be extended? And what recommendations do you have for Congress as we revisit that law? In other words, what recommendations do you have to address the overincarceration of people with mental health problems?

Mr. ANDREWS. Well, I would like to address the issue concerning the failure of any independent review or right to access to counsel by inmates with mental illness. From the public defenders' point of view throughout the State systems, there is a substantial shortage of those positions. While all States, including South Carolina, are attempting to address that, the recent economic problems and the budgetary limitations have imposed greater stresses on those systems, which makes it difficult for public defenders to properly raise the issues related to mental illness that directly relate to the crimes with which their clients are charged.

There is a secondary issue that has been raised by your previous questions related to the three particular recommendations that you asked of Commissioner Samuels, and that has to do with the due process that is available for inmates, particularly with mental illness, to be able to challenge determinations concerning solitary confinement. Without the availability of an independent ombudsman, or an independent counsel for those individuals, it is a system just reviewing itself. And it is the fox guarding the hen house in a way, that in hundreds of cases we examined, rarely, if ever, results in any true due process or fairness for the inmates themselves.

Senator FRANKEN. You talk about having an independent psychiatrist.

Mr. ANDREWS. Independent psychiatrist, counselor, and evaluation, that is right. And, frankly, access to counsel who can represent the interests of these individuals who are rarely in a position of ever effectively representing themselves.

Senator FRANKEN. Sure.

Mr. EPPS. Senator, what I find as I travel throughout our great country is that we incarcerate so many people until the problem is that once we get them incarcerated, we do not have moneys to do what needs to be done. I would like to start more on the front end in that—you take Mississippi. I am housing 15 percent of mentally ill today, and a lot of them are being housed, the mentally ill, in the county jails. You know, more support is needed on the front end for the mentally ill person before they get into the incarceration system. And, therefore, we will not be having these conversations or as much conversation as about the treatment and the due process.

Senator FRANKEN. It is, again, always being penny wise and pound foolish in terms of not investing this money on the upstream side so that we do not have all these costs downstream.

Thank you, Mr. Chairman.

Chairman DURBIN. Thank you, Senator Franken.

Mr. Graves, we talked about isolation and segregation and so forth. From your testimony, it sounds as if you were sharing a cell, at least some part of the time. Is that a fact?

Mr. GRAVES. No, sir. At one point we were sort of like in a group setting. They moved us from one death row to another death row. We went from max to supermax. So we had a program that, you know, if you were—it was an incentive program that if you were a model prisoner, you could actually be a part of this work program. And as a result, you would get like more time out of your cell, and you could play basketball and all that in a group setting. And then there was an attempted escape, and politicians got involved, see, because the escapes, they were always there, but the politicians got involved in this escape. And because the politicians got involved, they decided, well, we need to move them to a supermax to show that we are really tough on crime. And not only did they move us to a supermax, but they took away everything that would be considered a privilege. You could no longer piddle where guys were piddling and making little toys for homeless children. That was taken away from us. You no longer had group rec where guys could go out and just interact with one another, whether they were talking about the law or talking about their family. You know, something that helped them maintain their sanity, that was taken from us.

Everything that they could take from us that was called a privilege they did, and they put us in supermax, and they said, "You are going to stay here 22 to 24 hours a day until you are executed." And so, therefore, they moved us to that supermax, and we stayed there 22 to 23 hours a day, 24 hours a day from Friday to Monday.

Chairman DURBIN. By yourself?

Mr. GRAVES. By yourself. Some guys go into solitary, they come back and they will place them in a cell with some other guy. This was before we went to the supermax. And I remember this one guy who was in solitary, when they brought him back, he had become so paranoid, they put him in a cell with someone, he woke up screaming. He had taken some cans, put them in his pillow sack, and was beating his cellmate because he started thinking that the guy was stealing his addresses off of his letters. You become schizophrenic, you become paranoid. And he just woke this guy up beating him and screaming and hollering. And he was just taken out of solitary and put in a cell with another person, and he ended up almost taking that person's life.

So this is the effect of solitary confinement. That guy was fine before he went there. This whole emotion of—I was listening to what the gentleman was talking about solitary confinement and the limited time that they spent. I spent 10 years. And I know guys who have spent 20 and 30 years, and they are not in touch with the real world anymore.

So for someone to sit up here and say that it does not have an effect, an impact on a person's life, I say to that same person: "Go live there for 30 days, and then I will listen to you, because right now you are just basing everything on theory or you are a scholar. But you go live there 30 days, and then when you come back, I will listen to everything you have to say, because I know what you are going to say. That is hell. That is hell. And it is driving me insane."

And we can sit here, and we can talk back and forth about it intelligently, but the bottom line is we as American citizens are driving other American citizens out of their minds, and we act like that is OK.

Chairman DURBIN. Can I ask you a personal question?

Mr. GRAVES. Yes, sir.

Chairman DURBIN. You have told us so much about what you have been through. Was there anything that kept you going spiritually through this?

Mr. GRAVES. Yes. I kept my eyes on God because I said to myself I know who I am. I am not going to let a label define me. I am innocent. I am a son, I'm a father, and I'm a brother. And they cannot take from me what I am not going to give to them. They could not take my dignity, and I refused to give it to them. That is what kept me sane, my defiance—and my naivete, because I was naive in thinking that they just could not execute a man who did not do something.

Chairman DURBIN. Good for you. Thank you. Again, thank you to all of you. Mr. Andrews, thank you so much. And as I said before, the fact that an attorney in private practice would have such public sensitivity and consciousness is so critically important.

Professor Haney, we could not have done this without you. You have done such amazing research in this area.

And, Commissioner Epps, you have set a standard now.

Mr. EPPS. Thank you. Thank you, Mr. Chairman.

Chairman DURBIN. You set a standard. Mississippi is leading us in terms of where we need to be thinking about going.

Mr. EPPS. Yes, sir.

Chairman DURBIN. What a hearing. I have been through a lot of them. I cannot remember another one quite like this one, about an issue that we all kind of knew in the back of our minds was there, but we do not like to look at. It makes us feel bad. You think about the victims of crime, facing them, and they are saying, "Wait a minute, it may be tough in that cell, but my daughter is not alive today." You have heard that one, haven't you? We all have, over and over again.

And you think about the correctional officers who want to come home at night to their families, too. That is one of the elements. But, basically, when you step back and look at what happened in Mississippi, you really come to the conclusion that we can have a just society and we can be humane in the process. We can punish wrongdoers, and they should be punished under our system of justice. But we do not have to cross that line, and we all kind of know where that line is. Where we have stepped over it, we are no longer just ourselves in the way we are acting. That means taking a look at some things we do not like to look at or talk about. And, Mr. Graves, you made a point. Politicians get elected and reelected by being tougher and tougher sometimes, and maybe it is time for us to step back and say let us be smart, let us be thoughtful. When it is all over, let us write a record that we can be proud to tell our children about in terms of who we are and what we have done.

Well, we have a better chance to do that than most here in the U.S. Senate. This is just a sample of the testimony that has been submitted of all of the groups that wanted to be here and wanted

to testify. It is an indication, I think, of the fact that the time is due for us to have this conversation about where we are going.

I want to thank everybody who did attend the hearing today, including those in the overflow room, about 80 people in this room and 180 in the overflow room. And it is important for Members of Congress that there is this level of public interest in the issue.

There is a lot of work that goes on behind the scenes before we can come together for two hours and talk about something that affects so many people, so many innocent people and those who are not innocent but need to be treated fairly.

I want to thank Hayne Yoon, a detailee from the Federal Public Defender's office; Subcommittee Counsel Mara Silver; Nick Deml, Subcommittee Staff Assistant; legal interns Lindsay Dubin and Joseph Spielberger; and, of course, my chief attorney, Joe Zogby, who time and again has led us into some very interesting hearings, and I hope productive. From the Committee staff: Chief Clerk Roslyne Turner; Hearing Clerk Halley Ross; and the following individuals from the Architect of the Capitol who put that cell together so we could see it: Assistant Superintendent Marvin Simpson, James Adkins, Alvin Parlett, and Paul Bosch.

Supreme Court Justice Anthony Kennedy once wrote: "When the door is locked against the prisoner, we do not think about what is behind it."

We have a greater responsibility. As a profession, as a people, we should know what happens after the prisoner is taken away. I hope today's hearing is an important first step toward ensuring that all prisoners are treated with justice and dignity when the door is locked against them.

My staff just reminded me to make a motion to put these statements in the record, if there is no objection. And there is none.

[The information appears as a submission for the record.]

Chairman DURBIN. If there are no further comments from Senator Franken, I want to thank the witnesses, all of you, for attending and being part of this hearing, and this hearing will stand adjourned.

[Whereupon, at 12:01 p.m., the Subcommittee was adjourned.]

[Questions and answers and submissions for the record follow.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Witness List

Hearing before the
Senate Committee on the Judiciary
Subcommittee on the Constitution, Civil Rights and Human Rights

On

"Reassessing Solitary Confinement: The Human Rights, Fiscal and Public Safety Consequences"

Tuesday, June 19, 2012
Dirksen Senate Office Building, Room 226
10:00 a.m.

Panel I

The Honorable Charles Samuels, Jr.
Director
Federal Bureau of Prisons
Washington, DC

Panel II

Commissioner Christopher Epps
Mississippi Department of Corrections
Jackson, MS

Stuart M. Andrews, Jr.
Partner
Nelson Mullins Riley & Scarborough LLP
Columbia, SC

Anthony Graves
Founder
Anthony Believes
Houston, TX

Dr. Craig Haney
Professor of Psychology
University of California, Santa Cruz
Santa Cruz, CA

Pat Nolan
President
Justice Fellowship/Prison Fellowship Ministries
Leesburg, VA

PREPARED STATEMENTS OF COMMITTEE AND SUBCOMMITTEE CHAIRMEN

Statement of Senator Patrick Leahy (D-Vt.)
Chairman, Senate Judiciary Committee,
Hearing on "Reassessing Solitary Confinement: The Human Rights, Fiscal and Public Safety Consequences"
June 19, 2012

Today the Senate Judiciary Committee is holding a hearing on the use of solitary confinement in our prisons. I want to thank Senator Durbin for his effort to shine a light on this critical issue that has serious human rights, fiscal, and public safety consequences.

Many Americans know that solitary confinement is regularly used as a disciplinary tool in prisons across the country at both the state and federal levels, but we rarely stop to think about whether the use of solitary confinement is actually effective. In the face of mounting evidence that the use of solitary confinement may in fact be counterproductive, this hearing is an excellent opportunity for the Committee to get a better understanding of this practice.

In order to be an effective deterrent, a prison sentence is not meant to be a pleasant experience, and as a former prosecutor I believe that individuals convicted of serious crimes deserve to face serious consequences. Once criminals enter the prison system though, we cannot forget our obligations to continue to treat them fairly and humanely. Nor can we forget that the vast majority of prisoners will someday be released back into our communities.

Although solitary confinement was develop as a method for handling highly dangerous prisoners, it is increasingly being used with inmates who do not pose a threat to staff or other inmates. Far too often, prisoners today are placed in solitary confinement for minor violations that are disruptive but not violent. At the same time, conditions within segregation units have become increasingly harsh. In many cases, human contact is virtually eliminated. Officers deliver meal trays through a door slot, and visits by mental health staff are conducted through the cell door. Interaction with other prisoners is often not allowed, and visits with family members may be prohibited for a year or more.

There are significant fiscal, safety and humanitarian consequences for this trend toward increasingly harsh conditions of solitary confinement and its more frequent use to punish non-violent behavior. Evidence provided by the Vera Institute and others now suggests that placing inmates in solitary confinement with minimal human contact for days, months and years is exceptionally expensive and, in many cases, counterproductive. Not only do these studies show that segregation does little or nothing to lower overall rates of violence, there is evidence that it actually increases recidivism rates after release, posing a danger to the public.

I believe strongly in securing tough and appropriate prison sentences for people who break our laws. But it is also important that we do everything we can to ensure that when these people get out of prison, they reenter our communities as productive members of society. That is why I have long been a champion of the Second Chance Act and why I am working hard to see that important law reauthorized. We must do more than simply warehouse inmates, and solitary confinement is the extreme end of this approach. By giving inmates the tools to better themselves through job skills training, treatment and counseling, and support for transitional housing

programs designed to ease the reentry process, we can improve their lives and the safety of communities across the country.

Unfortunately the use of solitary confinement can hinder those efforts for rehabilitation and does so at extraordinary financial and humanitarian cost. Prison costs are crippling state, and federal budgets, and overcrowding has become a serious safety risk in many facilities. The mental health problems caused or exacerbated by solitary confinement create very serious human rights concerns for inmates. There is evidence that solitary confinement is used more frequently to house inmates with mental illness. These are often the individuals who most need human contact and support, and the use of solitary confinement as a behavioral management tool in these cases raises significant humanitarian concerns, as well as the risk of increased recidivism.

I want to thank Senator Durbin for holding this important hearing. This is an issue that has far reaching implications and deserves to be better understood. We must find an alternative to more prisons and harsher sentences. There are far better ways to keep future generations safe and save taxpayers money at the same time. I look forward to hearing from all of the witnesses.

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Opening Statement of Senator Dick Durbin
"Reassessing Solitary Confinement: The Human Rights, Fiscal and Public Safety Consequences"
Hearing before the Senate Committee on the Judiciary
Subcommittee on the Constitution, Civil Rights and Human Rights
Tuesday, June 19, 2012

As Prepared for Delivery

America has led the fight for human rights around the world. This Subcommittee has tried to play a part in this effort, holding the first Congressional hearings on issues like rape as a weapon of war, and passing legislation like the Genocide Accountability Act.

But we also have an obligation to look in the mirror and consider our own human-rights record. Today in the United States, more than 2.3 million people are imprisoned. This is – by far – the highest per capita rate of prisoners in the world. And African Americans are incarcerated at nearly six times the rate of whites, while Hispanics are incarcerated almost twice as much. These numbers translate into human rights issues that we cannot ignore.

That's why I held a hearing on mental illness in prison in 2009. That's why I authored the Fair Sentencing Act, which reduces the sentencing disparity between crack and powder cocaine.

And that's why we're here today. This is the first-ever Congressional hearing on "solitary confinement," also known as supermax housing, segregation, and isolation, among other names.

At the outset, I'd like to show a short video clip.

Seventeen year-old James Stewart was held in solitary confinement in an adult prison for two months. His sister Nicole Miera joins us today. Nicole, please stand. Thank you for sharing your brother's story.

Unfortunately, Jimmy's story is all too common. Approximately fifty percent of all prison suicides occur in solitary confinement. Jimmy was locked up in a cell like the one to my left. This replica is built to the scale of a standard solitary confinement cell.

In 1995, a federal district court described similar cells at California's Pelican Bay State Prison:

> "The cells are windowless; the walls are white concrete. ...The overall effect [] is one of stark sterility and unremitting monotony. Inmates can spend years without ever seeing any aspect of the outside world except for a small patch of sky. One inmate fairly described [it] as being 'like a space capsule where one is shot into space and left in isolation.'"

Imagine spending 23 hours a day in a cell like that – for days, months, years – with no window to the outside world and very little, if any, human contact.

The United States holds far more prisoners in solitary than any other democratic nation. The Bureau of Justice Statistics found that in 2005, U.S. prisons held 81,622 people in some kind of restricted housing. In my home state of Illinois, 56% of the prison population has spent time in segregation.

We didn't always use solitary confinement at such a high rate. But in the 1980's, states began creating expensive "supermax" prisons designed to hold people in isolation on a mass scale. These supermaxes, just like the crack cocaine sentencing laws, were part of the tough-on-crime policies that seemed to make sense at the time.

But we now know that solitary confinement isn't just used for the worst of the worst. Instead, we are seeing an alarming increase in isolation for those who don't need to be there – and for vulnerable groups like immigrants, children, LGBT inmates, supposedly for their own protection.

That's why I advocated for a change in the Justice Department's prison rape standards, to help ensure that sexual assault victims are only placed in solitary when absolutely necessary. And you heard from Nicole Miera about the tragic consequences of locking up children in isolation. That's why the American Academy of Child and Adolescent Psychiatry has called for a ban on solitary confinement for children under 18. In January, I visited an immigration detention center in Illinois, and saw segregation units like those found at any county jail – for people who have not been convicted of any crime.

Even for adults convicted of serious crimes, experts say far too many are in solitary confinement. Some are already seriously mentally ill and require intensive monitoring and treatment, the exact opposite of isolation. Others who may not

have any psychological problems before isolation can become psychotic or suicidal. And there is also the more basic question of how prisons treat people in solitary. Their conditions of confinement need to meet basic standards of decency.

As far back as 1890, the Supreme Court recognized the risks of solitary, describing the isolated inmates at one prison this way:

> "A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide."

And our colleague and former POW John McCain said, "It's an awful thing, solitary. It crushes your spirit and weakens your resistance more effectively than any other form of mistreatment."

This is also a public-safety issue. As the bipartisan Commission on Safety and Abuse in America's Prisons found, "Increasing the use of high-security segregation is counterproductive, often causing violence inside facilities and contributing to recidivism after release." We have a responsibility to protect the prison guards who put their lives on the line to protect all of us. But we also must have a clear-eyed view of the impact of isolation on the vast majority of prisoners who will be released one day to rejoin our communities.

Solitary confinement is also extremely costly. For example, Tamms, Illinois's only supermax prison, has by far the highest per prisoner cost of any Illinois prison – $61,522 in Fiscal Year 2010 – as compared to an average of $22,043 for other prisons.

A number of states are starting to reassess solitary confinement. They have implemented reforms and reduced the use of solitary, lowering prison violence and recidivism rates, and saving millions of dollars.

As a result of the work we have done preparing for this first-of-its-kind hearing, I am working on legislation to encourage reforms in the use of solitary confinement. We can no longer slam the cell door and turn our backs on the impact our policies have on the incarcerated and the safety of our nation.

PREPARED STATEMENT OF CHARLES E. SAMUELS, JR.

Department of Justice

STATEMENT OF

CHARLES E. SAMUELS, JR.
DIRECTOR OF THE FEDERAL BUREAU OF PRISONS

BEFORE THE

COMMITTEE ON THE JUDICIARY
SUBCOMMITTEE ON THE CONSTITUTION, CIVIL RIGHTS AND HUMAN RIGHTS
UNITED STATES SENATE

REGARDING

REASSESSING SOLITARY CONFINEMENT: THE HUMAN RIGHTS, FISCAL, AND PUBLIC SAFETY CONSEQUENCES

PRESENTED

JUNE 19, 2012

STATEMENT OF CHARLES E. SAMUELS, JR.
DIRECTOR OF THE FEDERAL BUREAU OF PRISONS
BEFORE THE UNITED STATES SENATE

COMMITTEE ON THE JUDICIARY
SUBCOMMITTEE ON THE CONSTITUTION, CIVIL RIGHTS AND HUMAN RIGHTS

REASSESSING SOLITARY CONFINEMENT: THE HUMAN RIGHTS, FISCAL, AND PUBLIC SAFETY CONSEQUENCES

JUNE 19, 2012

Introduction

Good morning, Chairman Durbin, Ranking Member Graham, and Members of the Subcommittee. Thank you for the opportunity to appear before you today to discuss the housing of inmates and the circumstances under which segregation-type housing is used within the Bureau of Prisons (Bureau) to ensure safety and security. Although this is my first appearance before this Subcommittee as Director, I have been with the Bureau for nearly 24 years, having started as a correctional officer and then holding many positions including Warden and Assistant Director. Chairman Durbin, I appreciate you and other members of the Judiciary Committee for your support of the Bureau over the years, and I look forward to continuing our work together.

First, I want to thank you for raising the important issue of the role of inmate segregated housing in corrections. Inmate safety and well-being is of the utmost importance to the Bureau, in addition to ensuring the safety of our staff and the community at large. As such, we want to do all that we can to ensure that while they are in our custody we provide outstanding care, treatment, and programming that will provide them the best opportunity for successful reentry to their communities. In order to provide these important services, it is critical that we run our institutions in a safe and orderly manner. Said another way, prisons must be secure, orderly, and safe in order for our staff to be able to supervise work details, provide training, conduct classes, and run treatment sessions. When institutions are not safe, inmates who are motivated to program and improve their lives have diminished access to programming opportunities. Further, unsafe institutions place staff and other inmates at risk, and potentially pose a danger to the community at large, for example in situations of inmate escapes or disturbances.

In order to effectively carry out our mission - to protect society by confining offenders in the controlled environments of prisons and community-based facilities that are safe, humane, cost-efficient, and appropriately secure, and that provide work and other self-improvement opportunities to assist offenders in becoming law-abiding citizens - at times we must remove some of the most dangerous and disruptive offenders from the institution's general population. Usually such removal continues for only brief periods of time until the disruptive inmate can demonstrate his or her ability to refrain from misconduct within the institution. And only a very small subset of the population are housed away from the general population at any point in time. The vast majority of our inmates remain in general population throughout their term of incarceration and work safely and effectively to achieve their reentry program goals.

The Bureau is the nation's largest corrections system with responsibility for incarcerating nearly 218,000 inmates. Currently, we confine more than 177,000 inmates in 117 facilities with a total rated capacity of 127,236. The remaining almost 41,000 inmates are managed in contract care consisting primarily of privately operated prisons.

Within our population there are a small number of inmates (estimated at 3.6%) who suffer from serious mental illness or significant developmental disabilities. Rigorous policies and practices ensure that the needs of these inmates are identified and appropriately managed. We are mindful of the limitations and challenges these inmates face, and we ensure that they are appropriately assessed and treated throughout the course of their incarceration. We also ensure that they are held accountable for behaviors that are directly under their control and not attributed to a mental illness; this ensures the safety and security of all inmates.

Our psychologists work closely with staff and inmates to ensure that these mental health needs are carefully considered with respect to housing and disciplinary decisions. For safety reasons, this population is sometimes housed in by segregated housing. In some instances, restricted housing may still be required for these inmates, to ensure safety and security. Our psychologists monitor and treat these inmates in view of their needs, and staff who interact with these inmates while in restricted housing are aware of and responsive to their special needs.

We are also aware that some inmates with mental illness who are asymptomatic in the general population may develop symptoms upon placement in segregated housing. In order to ensure that the mental health of these inmates does not deteriorate in segregated housing, these inmates are identified based on their history of mental health problems. SHU and supervisory correctional staff are educated about their disabilities by means of a tracking roster, and are required to contact a psychologist if the inmate is placed in a segregation unit, so that preventative interventions can occur.

Finally, we are aware of the claims that some individuals have made regarding the potential negative impact of long-term extreme isolation on individuals. Thus, we seek to ensure that these inmates are not completely isolated as that term may be typically understood. Nearly all of these inmates continue to have interactions with other inmates, albeit through more restrictive settings or means. They all have daily interactions with staff, who are vigilant in monitoring for signs of distress. They also have other opportunities for interaction with others (through telephone calls and visits), as well as access to a wide range of programming opportunities that can be managed in their restrictive housing settings. Bureau psychologists receive specialized training on responding to the needs of mentally ill offenders in segregation units. Additionally, all staff are trained on an annual basis in suicide prevention and in identifying and addressing mental health disorders that can contribute to deterioration of mental health. Correctional Counselors, Lieutenants, and Health Services staff receive additional training on mental health problems and the appropriate steps to take when problems are identified.

As you know, our agency has no control over the number of inmates who come into federal custody and little control over how long they stay. The inmate-to-staff ratio in our

institutions has increased from 3.6-to-1 in 1997 to 4.9-to-1 today. Rigorous research has demonstrated that both increased crowding and an increase in the inmate-to-staff ratio result in an increased number of serious assaults.

System-wide, the Bureau is operating at 40 percent over its rated inmate capacity. Crowding is of special concern at our higher security facilities—with 51 percent overcrowding at our high security institutions - United States Penitentiaries (USPs) and 48 percent at our medium security Federal Correctional Institutions (FCIs). While the Bureau continues to provide appropriate necessities like toilets, showers, and meals, staffing issues may impact the availability of productive work and program opportunities. Inmate overcrowding may become a catalyst for violence which poses real risks to the lives of staff and inmates. Crowding also strains facilities' infrastructure, including water, sewage, and power systems.

The combined inmate population confined in medium and high security facilities represents over 45 percent of the inmate population housed in Bureau facilities. At the medium security level approximately 76 percent of inmates have a history of violence, 42 percent have been sanctioned for violating prison rules, and half have sentences in excess of 8 years. At the high security level, half of the inmates have sentences in excess of 12 years, 70 percent have been sanctioned for violating prison rules, and more than 90 percent have a history of violence. One out of every six inmates at high security institutions is gang affiliated. There is a much higher incidence of serious assaults by inmates on staff and inmates at medium and high security institutions than at the lower security level facilities. Last year, more than three-quarters of serious assaults against staff occurred at medium and high security institutions.

Despite this myriad of challenges, we have been fortunate to experience relatively few instances of significant violence within our facilities. I attribute this success to the hard work of our staff who collectively work 24 hours a day to ensure the safe and orderly operation of our 117 federal prisons. Respect is a key component to this and, along with our other core values of integrity and correctional excellence, is critical to our agency's continued effectiveness. Inmates and staff alike are expected to treat everyone – other inmates and staff, visitors, and the public – with dignity and respect.

Inmate Management

The Bureau houses inmates in the least restrictive conditions necessary to ensure the safety and security of all inmates, staff, and the public. As such, the vast majority of inmates are housed in General Population (GP) units within an institution and are able to move freely about the compound during the day and evening. We recognize GP is generally the best housing option for our inmate population both in terms of programming and staffing costs. As such, only a very small proportion of offenders are held in more restricted housing, and most for only brief periods of time.

With few exceptions, all sentenced inmates in the Bureau of Prisons who are medically able to do so are required to work – most work in jobs such as food service, landscaping, infrastructure maintenance (heating, cooling, electrical, plumbing, carpentry), or as orderlies within the housing units. Inmates may also seek work in Federal Prison Industries (FPI), one of

the Bureau's most important correctional programs that has proven to reduce recidivism.

We also offer a variety of inmate reentry programs such as a substance abuse treatment, education, occupational/vocational training, faith-based programming, and cognitive-behavioral therapy programs. These important programs not only teach inmates skills that will help them transition effectively to their local community upon release, but also help keep inmates productively occupied and decrease misconduct. Indeed, rigorous research has demonstrated many of these programs (FPI, Residential Drug Abuse Programming, and Education/Occupational/Vocational Training) reduce recidivism. Open movement on the compound at virtually all security levels, to include our high security institutions, allows inmates to safely and efficiently access these important reentry tools without requiring significant staff resources. Open movement also allows inmates to efficiently access medical, dental, and mental health care appointments, another critical component of our program.

While the majority of the inmates within our population comply with rules, some engage in willful misconduct and may require more restrictive housing to maintain the safety of the inmate him/herself, the inmate population, staff, and the public. The Bureau primarily uses three types of more restrictive housing to maintain safety and security: Special Housing Units (SHU), Special Management Units (SMU), and the Administrative Maximum Security Institution, Florence, Colorado (ADX). These restricted or segregation-type housing in the Bureau provide inmates with ample opportunities for staff interaction, reentry programming, and time outside the cell for recreation. Moreover, aside from the ADX, the segregated housing units typically have two inmates assigned to each cell. Housing within the ADX is single celled – each inmate has his own cell. Even there, however, inmates are not housed in extreme "isolation" or "solitary confinement," but continue to interact with staff and other inmates on a more restricted basis. Placement in the ADX is restricted to inmates who clearly pose an extreme safety risk and need stringent restrictions to maintain safety for other inmates, staff, institutional operations and the public.

Special Housing Units (SHU)

Every federal prison, with the exception of minimum security prison camps, has a SHU to securely separate inmates from the general population. SHUs house two broad categories of inmates: (1) inmates who are in disciplinary segregation status, and (2) inmates who are in administrative detention status. An inmate can submit a formal grievance challenging his or her placement in the SHU through the Administrative Remedy Program, outlined in 28 Code of Federal Regulations, part 542.

Disciplinary segregation (DS) is a sanction for an inmate's commission of a prohibited act in a correctional facility. Prohibited acts include assault, possession of contraband, fighting, and refusing direct orders from staff.

Administrative detention (AD) is not punitive, rather inmates are generally placed in AD status for three reasons: 1) for investigation of potential misconduct, 2) for protection of themselves or other inmates until appropriate steps can be taken to transfer them to another facility, or 3) until further information is available about their background that allows us to

determine a safe and appropriate facility to house them.

Within seven days of placement in AD or DS, the inmate's status is reviewed at a hearing the inmate can attend. Inmates who are being protected from the general population can request another hearing at any time if they feel their placement in the SHU as a protection case is unnecessary. After these initial reviews, every inmate in both AD and DS receives recurring seven day reviews to ensure basic necessities are met, including sufficient recreation, meals, and showers. Every thirty days the inmate's status is reviewed at a hearing the inmate can attend.

SHU units are supervised by correctional officers who are present in the SHU 24 hours per day and who monitor inmates every thirty minutes. Additionally, correctional staff is available to meet with SHU inmates when requested by the inmate.

Inmates are not only visited by correctional officers, but also by unit team staff and programming staff. A unit team staff visits with the inmates on their caseload once per day. Programming staff visit with inmates for recreation, education, and chaplaincy needs. Every morning and evening all SHU inmates receive a visit from a health services staff member to ensure any medical needs are promptly addressed. Emergency medical care is always available and inmates can take prescribed medications in a SHU. Additionally, mental health and psychology staff makes weekly rounds in SHU and examine each inmate in a personal interview every 30 days of continuous placement in a SHU, or more often as needed or requested for the inmate. All inmates in a SHU receive the opportunity to exercise outside their cells at least five hours per week. This usually occurs in five one-hour periods throughout the week, and a SHU inmate generally shares the recreation area with at least one other inmate.

Special Management Units (SMU)

In fiscal year 2008 the Bureau began converting some existing bed space to Special Management Units (SMUs). These units are part of a 4 stage program lasting 18-24 months, which is designed to assist inmates in modifying behavior that has proven to be confrontational, resistant to authority and disregardful of institution rules. Many of these inmates have participated or had leadership roles in gang-related activity and therefore, present unique security and management concerns. We currently operate five male SMUs in USP Lewisburg, Pennsylvania (1,155 inmates); USP Allenwood, Pennsylvania (225 inmates); USP Florence, Colorado (193 inmates with 500 additional beds brought online by August, 2012); FCI Talladega, Alabama (76 inmates), FCC Oakdale, Louisiana (62 inmates with 260 additional beds by August, 2012). USP Atlanta, Georgia will activate a 60 male bed SMU in August, 2012, to bring our total to six SMUs. As of May 25, 2012, 871 inmates have completed the SMU program.

Inmates are referred for consideration for placement in SMU after a review by the institution warden and the Regional Director. A trained Hearing Administrator notifies the inmate prior to the SMU placement hearing and provides the inmate with specific evidence (unless such information would jeopardize the safety and security or endanger staff or others). The inmate has the opportunity to be present during the hearing, make an oral statement, and present documentary evidence to the Hearing Administrator. The inmate may also have a staff

representative to compile evidence and witness statements for the hearing. Following the hearing, the Regional Director makes the final determination regarding whether or not the evidence supports the appropriateness of SMU placement. The inmate is informed of the decision and his right to appeal the designation through the Bureau's Administrative Remedy Program.

Conditions of confinement for SMU inmates is more restrictive than for general population inmates. An inmate's individual conditions are limited as necessary to ensure the safety of others, to protect the security or orderly operation of the institution, or protection of the public, but all inmates continue to have access to Bureau reentry programming, including drug treatment, medical and mental health care, education, religious services, legal, recreation, commissary, correspondence, social visiting, and telephone privileges. While privileges are initially limited (e.g., less personal property, less commissary), inmates may gradually earn more privileges and are allowed to interact with one another based on their involvement in educational and counseling programs as well as their adherence to institution rules and regulations. Because of the extra supervision SMU inmates require, additional psychologists, counselors, and correctional officers are assigned to the units. The additional staff not only increase security, but also improves the chances of successfully modifying the inmates' behavior.

Following completion of the four phase SMU program, inmates may be considered for redesignation to a less restrictive facility. To qualify for consideration, the inmate must have, for a period of 12-18 months, abstained from gang-related activity, serious or disruptive misconduct, and group misconduct that adversely affect the orderly operations of the prison. The inmate must also demonstrate a sustained ability to coexist with other inmates and staff. Upon meeting those qualifications, the Unit Team, with the concurrence of the warden, submits a request for redesignation to another facility. If the inmate is not deemed appropriate for redesignation after 24 months of SMU placement, the Regional Director must approve continued SMU housing for that inmate.

U.S. Penitentiary – Administrative Maximum (ADX) in Florence, Colorado

The ADX is a 490-bed male facility constructed in 1994 that currently houses one-fifth of one percent (0.2%) of the Bureau's overall inmate population. The ADX houses those inmates within the Bureau that require the most security and supervision – inmates who cannot be safely managed in a less restrictive environment. As such, these inmates are single-celled and have less contact with other inmates than inmates housed elsewhere within our system. However, they actually have greater individualized contact with staff, as the inmate to staff ratio at ADX is dramatically lower than it is at any other federal prison in the country. By housing such offenders in one facility built with this specific mission, the Bureau can more effectively maintain the safety of both staff and inmates, while eliminating the need to increase the security of other high security level penitentiaries.

All inmates who are designated to the ADX receive a due process hearing prior to their placement at the facility. In order to be considered for placement in a less restrictive environment, inmates must maintain clear conduct, participate in a variety of programming opportunities, and demonstrate an overall positive institutional adjustment. All inmates housed

in the ADX have access to reentry programming, including drug treatment, education, religious services, legal, recreation, case management, mental/physical health care, correspondence, visiting, and commissary.

This institution has three types of housing units: *General Population, Special Security, and Control Unit.*

General Population (ADX GP)

An inmate may be referred to the ADX GP because their placement in other correctional facilities creates a risk to the institutional security, or staff, inmate, or public safety, or because their status before or after incarceration precludes their safe housing at another institution.

Inmates are referred for consideration for placement in ADX GP after a review by the institution warden and the Regional Director. Central Office (Bureau headquarters) staff then conducts a preliminary review of the case, and if it appears the inmate may be appropriate for ADX GP, a trained Hearing Administrator conducts a hearing where the inmate may be present, make an oral statement, and present documentary evidence. The inmate may also have a staff representative compile evidence and witness statements for the hearing. The hearing report and recommendations are provided to the inmate, and forwarded to the National Disciplinary Hearing Administrator. The Assistant Director of the Correctional Program Division within Central Office makes the final placement determination. The inmate is informed of the decision and his right to appeal the designation through the Bureau's Administrative Remedy Program.

There are four ADX GP housing units, each with the capacity to house 64 inmates. ADX GP inmates receive up to 10 hours of out-of-cell exercise weekly, and are able to converse with other inmates in adjoining recreation areas. They also receive two monitored 15-minute telephone calls monthly. If an inmate maintains clear conduct, positive adjustment, and successful programming (generally for a minimum of 12 months), he is eligible for placement into the institution's step-down component of the general population program.

Inmates assigned to the Step-Down component (capacity of 32) are afforded up to 15 hours out-of-cell exercise weekly, and three 15-minute telephone calls monthly. Inmates who adhere to these provisions for six months may progress to the Transitional phase of the step-down component.

The Transitional phase of the Step-Down unit has a capacity to house up to 32 inmates. The transitional phase allows inmates increased out-of-cell time and four telephone calls per month. Inmates who adhere to the programming requirements for six months may be moved to the Pre-Transfer phase.

The Pre-Transfer phase is the final phase of the step-down component. Ordinarily, this is the final program requirement prior to transfer out of the ADX to the GP of another high security facility. Inmates in this phase are allowed to utilize common recreation areas and barbering facilities, and are provide 300 minutes per month for telephone calls. Inmates in this phase are usually required to remain in this unit for 12 months before being considered for transfer to

another institution. During this 12-month phase, staff can sufficiently monitor each inmate's adjustment in the least restrictive environment within the institution prior to transferring him to another facility.

Control Unit Program

Within the ADX, the Control Unit houses inmates who are the most disruptive individuals within the Federal prison system. Inmates are designated to the unit as a disciplinary sanction that is the result of serious misconduct during service of their sentence (e.g., murdering an inmate with high risk for a repeat offense, murder of a staff member, extraordinarily extreme flight risk). Designation to the Control Unit requires approval by the Regional Director and Assistant Director of the Correctional Programs Division.

Control Unit inmates are afforded individual recreational opportunities up to seven hours a week and receive one 15-minute telephone call monthly. When moved outside of their cells, these inmates are restrained and escorted by three staff. The period of time an inmate is assigned to the Control Unit is determined based on the severity of the misconduct that caused his placement in the unit.

The Control Unit referral proeedures are similar to the ADX GP referral procedures described above, but must include a psychologist's review of the inmate's mental status. Inmates currently suffering from active significant mental disorders or major physical disabilities are not referred to the Control Unit. As with other ADX referrals, the inmate may be present and provide evidence at the hearing, is informed of the final decision, and may appeal the decision through the Administrative Remedy Program.

Once transferred to the Control Unit, inmates are evaluated by a psychologist every thirty days. The Control Unit team also meets with the inmate and makes an assessment of his progress every thirty days. At least once every 60-90 days, the Regional Director and Assistant Director review the status of the Control Unit inmate to determine the readiness for release from the unit. The inmate is normally interviewed in person.

Only the Regional and Assistant Director may authorize an inmate's release from the Control Unit. In making this decision, they consider involvement in work, recreation, and program assignments, interactions with others (inmates and staff), adherence to policy, personal grooming and cleanliness, and quarters' sanitation.

Special Security

The Special Security Unit houses up to 64 offenders (with an additional 32 cells available) who have Special Administrative Measures (SAMs) imposed by the Attorney General. SAMs are special conditions of confinement or limitation of privileges that are reasonably necessary to prevent disclosure of national security information or prevent acts of violence and/or terrorism, outlined in 28 Code of Federal Regulations, part 501.2 and 501.3. SAMs restrict access to mail, media, telephone, and/or visitors, depending upon the specific risk factors. The referral process is similar to the other ADX referral procedures. Similar to ADX GP, this is

a three phase program with increased out of cell time or increased telephone calls monthly based upon positive adjustment and programming, again depending upon the specific SAMs conditions.

Mental Health and Restricted Housing

The conditions of confinement for any inmate within a correctional setting may impact his/her mental health, either positively or negatively. When an inmate is initially designated to the Bureau and upon movement to different institutions, Bureau psychologists review the inmate's history for evidence of mental illness and screen for any current signs of psychological distress; their findings are then taken into consideration when making decision about inmate housing and programming. Specifically, we consider the presence of, severity, and type of mental illness; prior incarceration experiences; the degree of family support; compliance with medication if applicable; compliance with other recommended treatment options; and inmate security level.

All inmates can request psychological services at any time. Moreover, all are psychologically assessed after 30 consecutive days in SHU, SMU, and ADX Control Unit and Special Security Unit. These assessments address their adjustment to their surroundings and threat posed to self, staff, and other inmates. Copies of these assessments are forwarded to the Captain and the Unit Team to ensure that staff is aware of any issues or concerns confronting inmates in restricted housing.

Suicide is always a concern in segregated housing. As such, the Bureau has long maintained a rigorous suicide prevention program throughout our prisons that involves intensive staff training, inmate education, and psychological intervention. As a result of this program, the Bureau has relatively low rates of suicide, with a rate of 6 per 100,000 during fiscal year 2011. Note our rate of 6 per 100,000 is down from 35 per 100,000 in 1970. By comparison, recent Center for Disease Control statistics reveal that suicide rates in the community of males 25 to 64 years of age increased from 21 per 100,000 in 2000 to 25 per 100,000 in 2009. The Bureau also has several suicide prevention safeguards in place for inmates in SHU. Beyond the annual suicide prevention training that all Bureau staff complete, staff working in the SHU also undergo additional supplemental suicide prevention training to ensure they are well trained on risk factors, warning signs, and appropriate responses to inmates who may experience distress while in SHU. Inmates in these units are routinely monitored by all staff for any behavioral changes that might indicate risk.

Conclusion

Chairman Durbin, this concludes my formal statement. I thank you for raising the important issue of isolation and segregated housing within the Bureau of Prisons, and reiterate that this restricted form of housing applies to only a small number of inmates within the Bureau. The use of restricted housing, however limited, remains a critical management tool that helps us maintain safety, security, and effective reentry programming for the vast majority of federal inmates housed in general population.

Again, I thank you Chairman Durbin, Mr. Graham, and the Subcommittee for your

support for our agency. The mission of the Bureau of Prisons is challenging. While there are many facets to our operations, the foundation for it all is safe, secure, orderly institutions, and each and every staff member in the Bureau is critical to this mission. Through the continuous diligent efforts of our staff, who collectively work 24 hours each day, 365 days per year - weekends and holidays - we protect the public. By maintaining high levels of security and ensuring inmates are actively participating in evidenced-based reentry programs, we serve and protect society. I would be pleased to answer any questions you or other Members of the Subcommittee may have.

PREPARED STATEMENT OF CHRISTOPHER EPPS

Reassessing Solitary Confinement
The Human Rights, Fiscal, and Public Safety Consequences
Commissioner Christopher Epps
Written Testimony
Public Hearing June 19, 2012
Dirksen Senate Office Building Room 226

I am Christopher B. Epps, Commissioner of Corrections for the State of Mississippi and President Elect of the American Correctional Association.

I have been the Commissioner for almost ten years. I was appointed by a Democratic governor, Ronnie Musgrove and reappointed by two Republican governors, Haley Barbour and Phil Bryant.

I began my career as a correctional officer at the Mississippi State Penitentiary in 1982. Back then, solitary confinement was sparingly utilized for the most incorrigible and dangerous offenders. There was limited cell space available for this specialized population. The tragic murder of a correctional officer in 1989 prompted the construction of Unit 32 at the Mississippi State Penitentiary in Parchman. Unit 32 was a 1,000 bed maximum security unit where all the inmates were in lockdown in single cells for 23 or 24 hours a day, 7 days a week. The unit was opened in 1990 and operated as a single-person celled, administrative segregation unit. Administrative segregation is used for inmates considered a threat to staff, other inmates, or property. These inmates are placed in a single cell for 23 hours a day during weekdays and 24 hours a day on weekends and holidays. During this time, I was the Deputy Superintendent for Operations at the Mississippi State Penitentiary, and I believed administrative segregation was necessary to isolate offenders to provide a safe and secure environment for staff and offenders. I was convinced that an offender should remain in administrative segregation until he demonstrated over a period of time that his behavior had changed and he was no longer a threat to staff, other offenders, and public safety. In many cases this could be for years, and for some, not until their release from prison or death.

Unit 32 began to be recognized as the end of the road by staff and offenders in the Mississippi Department of Corrections. The prison was easy to enter but it was almost impossible to obtain release without exemplary behavior. Staff took the approach that finding reasons to keep offenders in administrative segregation versus finding reasons to release an offender was best to maintain a safe and secure environment. "Truth in Sentencing" laws requiring offenders to serve 85% of their sentence regardless of their behavior and increased incarceration of mentally ill individuals compounded the situation of hopelessness at the prison. Young offenders involved in gangs with long sentences became a large percentage of the population. Offenders began to see Unit 32 as a place where you were housed in a cell without air-conditioning, 23 hours a day, with minimal interaction with others. The environment created a situation where the norm was to be disruptive as there were no incentives to change behavior. As one offender told me, "you took

all our hope and we have nothing to lose." Unit 32 conditions of confinement were increasingly litigated with a 2003 Consent Decree regarding Death Row offenders in *Russell v. Mississippi Department of Corrections (MDOC),* and a second Consent Decree in May 2007 for other administrative segregation offenders in *Presley v. MDOC.* Beginning in May 2007, violence began to erupt at Unit 32 and continued through the summer with 3 homicides, many serious disruptive incidents, and a suicide. I began to realize a need for change. A different approach was needed due to the deteriorating and dangerous environment and increased litigation. The good intention of utilizing large administrative segregation units in the Mississippi Department of Corrections was no longer effective. We needed a different approach.

We began to reform Unit 32 by thinking outside the box and recognizing the need to utilize all available resources. The smartest decision I made was utilizing recognized corrections experts provided by the National Institute of Corrections and the American Civil Liberties Union. My staff and I began to collaborate with the plaintiffs' attorneys to cease a previous attitude of conflict and discord and jointly determine strategies that would achieve a common goal of improved conditions while providing safety and security. Dr. James Austin, the *Presley v. MDOC* plaintiffs' expert, was an invaluable resource in developing a classification model with objective criteria for placement in administrative segregation and a documented individualized plan for each offender on how to work his way out of administrative segregation. The individualized plan utilized objective criteria, involved the offender, and required face-to-face reviews to discuss progress. Every offender knew exactly what he had to do to obtain his release from administrative segregation and/or increase his privileges. We developed specific administrative housing units for the mentally ill with specially trained correctional officers.

We also implemented multi-disciplinary teams to make decisions regarding mentally ill offenders. We developed administrative segregation programs enabling offenders to have graduated incentives with promotions through phases until the majority could be ultimately released from administrative segregation. We made sure that before anyone was released from prison, they went through the step-down unit before they got to general population. Group counseling, alcohol and drugs, life skills, and anger management programs were started for offenders. Group counseling was conducted outside the cells by using an innovative method of attaching leg restraints to a floor restraint. This provided the necessary security to allow face-to-face interaction between offenders. For those offenders who could not be released from administrative segregation because of a lengthy history of violence, gang leadership, escape, or other serious reasons, programs were developed that simulated a general population environment in a high-security setting. We reviewed all offenders at Unit 32 utilizing the revised classification model for administrative segregation. We also eliminated the practice of utilizing subjective decisions to place and keep offenders in administrative segregation.

The Mississippi Department of Corrections administrative segregation reforms resulted in a 75.6% reduction in the administrative segregation population from over 1,300 in 2007 to 316 by June 2012. Because Mississippi's total adult inmate population is 21,982 right now, that means

that 1.4% are currently in administrative segregation. The administrative segregation population reduction has not resulted in an increase in serious incidents. The administrative segregation reduction along with the implementation of faith-based and other programs has actually led to 50% fewer violent incidents at the penitentiary.

The Mississippi Department of Corrections was able to close Unit 32 in January 2010 due to the reduced administrative segregation population, resulting in an annual savings of approximately $5.6 million. The reforms also resulted in a dismissal of the *Presley v. MDOC* lawsuit in August 2011. We now have a recidivism rate of 27% over a 3-year period, which is one of the lowest in the country, and it is due to our programs such as Adult Basic Education, vocational school, alcohol and drug programs, fatherhood education, and pre-release programs, as well as our reentry programs.

These reforms were successful because all persons involved had buy-in. Staff at all levels and the offender population were educated and understood what the reforms were and why they were being implemented. Leadership from the Central Office was deployed on-site to actively participate in implementing reforms, which prevented an attitude from field staff that decisions were being made from "higher ups" without any knowledge of what was really going on at Unit 32. I made frequent visits to Unit 32 to demonstrate my commitment to and involvement in implementing the reforms, listening to the concerns of staff and the offender population. Collaboration between all was essential to the success of the reforms. This included management, line staff, offenders and *Presley v. MDOC* plaintiff attorneys and their experts.

I often say, "You have to decide who you are afraid of and who you are mad at" when making decisions on the use of administrative segregation in prison. Almost 95% of all offenders will return to society. There are a very small number of offenders who have to be in administrative segregation because of their continued threat to staff and offenders. These are the offenders we are "afraid of" because of their demonstrated violence or threats to the public. Corrections professionals and the criminal justice system must be careful not to use administrative segregation in prison to manage those who we are mad at because this is an expensive option that takes away resources from important government areas such as education, human services, healthcare, etc., which are the services most needed to make a better society.

Corrections is no different than anything else in our nation; it continues to change and improve. Corrections leaders must realize that to be successful you must always be willing to change and listen to all stakeholders involved in the criminal justice system. You cannot take a one-sided approach. I have been most successful when I have made decisions that were in the best interest of all. We must continue to climb the corrections mountain.

Thank you for the opportunity to appear before the Subcommittee.

PREPARED STATEMENT OF STUART M. ANDREWS, JR.

TESTIMONY

of

Stuart M. Andrews, Jr.

on behalf of:

Joy C. Jay, Guardian *ad Litem* for T.R., P.R., K.W., and A.M. on behalf of themselves and others similarly situated; and Protection and Advocacy for People with Disabilities, Inc.

on

Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences

before the
Subcommittee on the Constitution, Civil Rights and Human Rights
Committee on the Judiciary
United States Senate

JUNE 19, 2012

Chairman Durbin, Ranking Member Graham, and Honorable Committee Members,

Thank you for your interest in these issues of enormous significance to men and women incarcerated in prisons and jails throughout our nation. I am grateful for the opportunity to provide the Subcommittee with information concerning the use of solitary confinement in South Carolina prisons, particularly the use to which inmates diagnosed with mental illness are exposed.

Nelson Mullins law firm represents a class of inmates with serious mental illness in South Carolina prisons, many of whom have spent significant time in solitary confinement. I am appearing today on behalf of that class and its guardian *ad litem*, Joy C. Jay, as well as on behalf of Protection and Advocacy for People with Disabilities, Inc. (P&A), a South Carolina nonprofit organization charged by federal and state law to protect and advocate for the rights of people with disabilities.

After years of investigations, reports, and negotiations, the inmate class and P&A filed suit in South Carolina state court in June 2005 against the South Carolina Department of Corrections, alleging violations of the South Carolina Constitution's prohibition against cruel and unusual punishment and seeking injunctive relief to require the provision of adequate mental health services. After more than six years of litigation, a bench trial was held in February and March of 2012. No ruling has been entered to date.

A major issue in the trial was the extensive reliance by the Department of Corrections on solitary confinement as a means of managing inmate conduct, particularly inmates with mental illness. During their imprisonment, half of the nearly 3,000 men and women with mental

illnesses on the Department's caseload have been held in solitary confinement for periods averaging almost two years.

The effects of conditions in solitary confinement in South Carolina's prisons can be harmful for anyone, but they particularly expose individuals with mental illness to substantial risks of serious future harm – the applicable Eighth Amendment standard. To illustrate some of what we have learned about the operation of solitary confinement in South Carolina prisons, I would like to call to your attention three individuals who are, or in one case was, a member of the class of inmates we represent.

A. Theodore Robinson

Theodore Robinson is a 50-year old man with paranoid schizophrenia serving a life sentence in the South Carolina Department of Corrections. Mr. Robinson's speech is highly disorganized and he has a history of bizarre behavior, such as drinking his urine. Like many people with schizophrenia, he suffers from hallucinations and delusions. For example, he believes that at night while he sleeps doctors secretly enter his cell and perform surgery on him.

From 1993–2005, a period of twelve consecutive years, Mr. Robinson was kept in solitary confinement. Fifteen days after our lawsuit was filed, the Department removed Mr. Robinson from solitary and placed him in its psychiatric residential program. Ex. 1.

B. Overrepresentation of Mentally Ill Inmates in Solitary Confinement

Other inmates with serious mental illness have not been so lucky. In South Carolina mentally ill inmates are twice as likely to be in solitary confinement as inmates without mental illness (15.81% v. 7.85%); two and a half times as likely to receive a sentence in solitary that exceeds their release date from prison (4.65% v. 1.86%); and over three times as likely to be assigned to an indefinite period of time in solitary (8.66% v. 2.78%). Ex. 2.

Mentally ill inmates placed in solitary confinement in South Carolina prisons are not limited to those with mild mental disorders. Like Theodore Robinson, many are diagnosed with schizophrenia or other serious mental illnesses, such as bipolar disorder, schizoaffective disorder, or major depression. A Department of Corrections psychiatrist at Lee Correctional Institution, for example, estimated that 40-50 percent of her patients in solitary confinement were "actively psychotic." Ex. 4.

C. Conditions and Access to Mental Health Services in Solitary Confinement Units

Testimony at our recent trial confirmed that inmates in solitary are confined to their cell 23-24 hours a day. They are not allowed to hold a prison job or to attend educational classes, religious groups, or any structured therapeutic activities. Phone calls and visitation often are suspended for years at a time. Sessions with psychiatrists and mental health counselors are rarely held in confidential settings, but instead in the presence or hearing of correctional officers and other inmates.

Sessions with psychiatrists and counselors are not only lacking in confidentiality, they are infrequent and irregular. Edward Barton is another South Carolina inmate who, like Theodore Robinson, is diagnosed with paranoid schizophrenia. Mr. Barton has spent the past eight years in solitary. He is scheduled to remain there until 2016, when he will be released from prison, straight from solitary confinement into society. Mr. Barton has visual, auditory, and tactile hallucinations. He sees dead people and floating fire; voices tell him his relatives are dead and order him to set his cell on fire; he feels flames burning his arms and the soles of his feet. By policy, Mr. Barton is supposed to see a mental health counselor every 30 days, but his medical records show that during a sixteen-month period from July 2008 to November 2010 there were:

- four occasions where over 60 days passed without a counseling session; and

- one period of 9 months without a counseling session.

Ex. 5. Mr. Barton's contact with psychiatrists while in solitary is also limited. During one eleven-month period in 2010-2011 he went four months without seeing a psychiatrist, then went another six months before seeing a psychiatrist again. Ex. 6.

D. Lengths of Stay in Solitary

Edward Barton and Theodore Robinson are not the only South Carolina inmates with mental illness who have spent years in solitary confinement. Evidence presented at trial showed that it is not uncommon for inmates with serious mental illness to be confined in solitary for five years, ten years, or longer.

In South Carolina there are two forms of punitive solitary confinement: (1) disciplinary detention (DD), in which an inmate is sentenced to a specific length of time in solitary for violation of Department rules; and (2) security detention (SD), in which an inmate is assigned to solitary for an indefinite length of time after a determination that the inmate poses a security risk. As of September 1, 2011, the length of the average cumulative DD sentences for inmates without mental illness was 383 days; for inmates with mental illness it was 657 days, almost 2 years. Ex. 7.

The Department has a policy called "Guilty But Not Accountable" or "GBNA," which in theory should reduce time served in solitary confinement for mentally ill inmates, but which in practice is meaningless. Under the policy, when a mentally ill inmate is charged with a disciplinary infraction his mental health counselor makes a recommendation to a hearing officer on whether the inmate should be held accountable for his actions. The Department's mental health counselors, however, are not qualified to make such determinations, as only thirteen percent are licensed. Ex. 8. Counselor attitudes towards inmate accountability are reflected in

the testimony of the Regional Mental Health Coordinator for one of South Carolina's four administrative regions, who testified under oath as follows:

> Q: What effect does mental illness have on an inmate's ability to. . . to comply with rules of prison?
>
> A: None.
>
> Q: None?
>
> A: None.

Ex. 9.

Given such attitudes, it is not surprising that the GBNA policy has had no effect on the solitary confinement sentences of mentally ill inmates. A review of Departmental records of 1,252 mentally ill inmates sentenced to solitary confinement from 2009-11 revealed that only 25 (2%) had been found "Guilty But Not Accountable." Moreover, for those 25 inmates the finding that they were not accountable for their actions had had absolutely no effect on the length of their sentences in solitary. Ex. 10.

E. Crisis Intervention

A particularly disturbing form of solitary confinement in South Carolina is the practice known as crisis intervention. Although crisis intervention is considered a clinical status for inmates who are suicidal or threatening self harm, the Department places crisis inmates naked in stripped-out solitary confinement cells located in disciplinary lockup units. Stripped-out cells consist of nothing but steel and concrete. Inmates testified that on crisis they seldom receive a blanket, are never provided a mattress, and are forced to sleep on concrete or steel bunks without any bedding material. Inmates describe crisis intervention cells as cold and filthy, with floors and walls smeared with the blood and feces of previous inhabitants.

Lengths of stay in crisis cells typically range from a few days to two weeks, but records show some inmates are kept in these conditions for months. Except for greater restrictions, inmates in crisis are treated as other inmates in solitary. Inmates testified that when on crisis they remain in their cells 24 hours a day, seldom are permitted to shower, are not allowed to participate in structured therapeutic activities, and rarely see a psychiatrist. Contact with mental health counselors is through the cell door, brief, impersonal, and not confidential.

From 2008-2010 at least one South Carolina prison, Lieber Correctional Institution, routinely placed crisis inmates naked in shower stalls, rec cages, interview booths, and holding cells for hours and even days at a time, as documented in Department logs. Ex. 11. Typically, these spaces did not have toilets and were not suicide resistant. Established to provide a therapeutic setting, crisis intervention in South Carolina prisons instead is a punitive process, in most cases wholly devoid of any therapeutic benefit.

F. Death by Neglect: Jerome Laudman and Lee Supermax

Perhaps the single most deplorable solitary confinement unit in the South Carolina prison system is the cellblock at Lee Correctional Institution known as Lee Supermax. Department officials insist this is not a true maximum security unit and prefer to characterize it as the "cells with private showers." Lee Supermax cells do, in fact, have private showers controlled by security staff, but the shower drains are usually stopped up, according to inmate testimony. As a result, when the showers are turned on they flood the cells, leaving standing water up to six inches high. Inmates describe the cells as cold, vermin-infested, and filthy.

On February 18, 2008 an inmate named Jerome Laudman was found in a Lee Supermax cell, lying naked without a blanket or mattress, face down on a concrete floor in vomit and feces. He died later that day in a nearby hospital. The cause of death was a heart attack, but hospital

records also noted hypothermia, with a body temperature upon arrival at the hospital of only 80.6 degrees. Ex. 12 at 900-01, 909.

On June 8, 2008 an internal investigator for the Department of Corrections issued a report on Mr. Laudman's death. Ex. 12. That investigative report is the source for the following information.

Jerome Laudman suffered from schizophrenia, mental retardation, and a speech impediment. Ex. 12 at 908. According to his mental health counselor, Laudman had never acted in an aggressive or threatening manner. *Id.* at 909. On February 7, 2008 – eleven days before his death – Laudman was moved to Lee Supermax, purportedly for hygiene reasons, because he refused to shower, although no one admitted to ordering the move. *Id.* at 901-03. A correctional officer told the investigator that the lieutenant in charge physically threw Laudman, who was naked and handcuffed, into the Supermax cell, even though Laudman was not resisting. When the lieutenant realized he had placed Laudman in the wrong cell, he took him out and "shoved" him into another cell, where Laudman, still handcuffed, fell on the concrete bunk. *Id.* at 901. According to his mental health counselor, Laudman was not on crisis intervention, even though he was placed in Supermax without clothing, blanket, or mattress. *Id.* at 902. The mental health counselor stated he was never made aware of Laudman's transfer to Supermax. *Id.*

On February 11, one week before Laudman's death, a correctional officer saw him "stooped over like he was real weak or sick." The officer noticed styrofoam food trays piled up inside his cell door that no one had collected. He considered notifying a unit captain or administrator about Laudman's condition but his supervisor advised him against it. *Id.* at 904. Two other Supermax inmates grew concerned because Laudman was "ignored by officers" and

three or four days had passed without any noises from Laudman's cell. The inmates warned officers that Laudman was not eating or taking his medicine. *Id.* at 903-04.

On the morning of February 18, Officer Shepard saw Laudman lying on the floor of his cell in "feces and stuff." Shepard notified his supervisor, but was told "not to stress about it." Shepard noted that Laudman stayed in the same position all morning. *Id.* at 905.

That afternoon two nurses, Andrews and Thompson, were called to Laudman's cell where they observed him lying facedown covered in feces and vomit, but still alive. The styrofoam trays were still there, containing rotting, molding food. One of the nurses described the stench from the cell as the worst thing she had ever smelled. *Id.* at 905-07.

The conditions were so foul that both nurses and officers who had joined them refused to enter the cell to remove Laudman. Instead, they called for two inmate hospice workers, and waited a half hour before they arrived. After the inmate hospice workers removed Laudman from his cell he was transported to a nearby hospital, where he died later that day. *Id.* at 905-07.

The Department of Corrections never ordered a quality assurance review in the aftermath of Laudman's death. Seven months after Laudman's death, Plaintiffs' experts inspected Lee Supermax and described it as "filthy." Ex. 13. At the 2012 trial the Lee warden testified that he had never personally visited or inspected the cell where Laudman died.

G. Conclusion

In South Carolina a disproportionate number of mentally ill inmates are placed in solitary confinement. Many are actively psychotic. Conditions are atrocious, mental health services inadequate, and stays inhumanely long. Theodore Robinson was fortunate – after twelve consecutive years in solitary he was transferred to a psychiatric residential program (coincidentally, just two weeks after he sued the Department of Corrections). Jerome Laudman

was not so fortunate – after eleven days in Lee Supermax he died of neglect in a cold, filthy cell. For Edward Barton, the story is ongoing. Will he be released from prison into society as scheduled in 2016, after twelve consecutive years of solitary? Will he receive adequate treatment meanwhile to stabilize his profound schizophrenia? How well will solitary prepare him to handle the transition back into society? These questions, and their implications for the constitutional, civil, and human rights of all mentally ill inmates in South Carolina prisons, remain unanswered.

PREPARED STATEMENT OF ANTHONY GRAVES

ANTHONY BELIEVES

IN TRUTH
IN JUSTICE
IN STANDING UP FOR WHAT IS RIGHT
IN YOU

Testimony by Anthony C. Graves

Presented to the Senate Judiciary Committee
Subcommittee on The Constitution, Civil Rights & Human Rights
"Reassessing Solitary Confinement: The Human Rights, Fiscal and Public Safety Consequences"
Hearing Date: June 19, 2012

My name is Anthony Graves and I am death row exonoree number 138. I was wrongfully convicted and sentenced to death in Texas back in 1992, where my nightmare began. Like all death row inmates, I was kept in solitary confinement. I lived under some of the worst conditions imaginable with the filth, the food, the total disrespect of human dignity. I lived under the rules of a system that is literally driving men out of their minds. I was one week away from my 27th birthday when I was arrested, and this emotional torture took place for the next 18.5 years. I survived the torture by believing in my innocence and hoping that they would make it right. My life was saved, but those 18.5 years were no way to live.

I lived in a small 8 by 12 foot cage. I had a steel bunk bed, with a very thin plastic mattress and pillow that you could only trade out once a year. By the time a year comes around, you've been virtually sleeping on the steel itself. I have back problems as a result. I had a steel toilet and sink that were connected together, and it was positioned in the sight of male and female officers. They would walk the runs and I would be in plain view while using the toilet.

I had a small shelf that I was able to use as a desk to write on. This was the same shelf that I ate at. There was a very small window up at the top of the back wall. In order to see the sky or the back of the building you would have to roll your plastic mattress up to stand on. I had concrete walls that were always peeling with old dull paint. It's the image of an old abandoned one room project apartment.

I lived behind a steel door that had two small slits in it, the space replaced with iron mesh wire, which was dirty and filthy. Those slits were cut out to communicate with the officers that were right outside your door. There was a slot that's called a pan hole and that's how you would receive your food. I had to sit on my steel bunk like a trained dog while the officer delivered my food tray. He would take a steel crow bar and stick it into the metal lock on the pan hole, it would fall open, which then allowed the officer to place your tray in the slot. Afterward, he then steps back, which was the signal for me to get off the bunk and retrieve my food. This is no different from the way we train our pets.

The food lacks the proper nutrition, because it is either dehydrated when served to you or perhaps you'll find things like rat feces or a small pieee of broken glass. When escorted to the infirmary I would walk by the kitchen and see an inmate cooking the food and sweating into it. The inmates who do have a little support from the outside usually try to only eat the food they can purchase from the prison commissary.

There is no real medical care. After I was exonerated and able to go to a doctor, I was told that the food I had been eating caused me to have over 13 percent plaque in my veins, which can cause strokes, heart attacks, and aneurysms. I had no television, no telephone, and most importantly, I had no physical contact with another human being for at least 10 of the 18 years I was incarcerated. Today I have a hard time being around a group of people for long periods of time without feeling too crowded. No one can begin to imagine the psychological effects isolation has on another human being.

I was subjected to sleep deprivation. I would hear the clanging of metal doors throughout the night, an officer walking the runs and shining his flash light in your eyes, or an inmate kicking and screaming because he's losing his mind. Guys become paranoid, schizophrenic, and can't sleep because they are hearing voices. I was there when guys would attempt suicide by cutting themselves, trying to tie a sheet around their neck or overdosing on their medication. Then there were the guys that actually committed suicide.

I will have to live with these vivid memories for the rest of my life. I would watch guys come to prison totally sane and in three years they don't live in the real world anymore. I know a guy who would sit in the middle of the floor, rip his sheet up, wrap it around himself and light it on fire. Another guy would go out in the recreation yard, get naked, lie down and urinate all

over himself. He would take his feces and smear it all over his face as though he was in military combat. This same man was executed; on the gurney and he was babbling incoherently to the officers, "I demand that you release me soldier, this is your captain speaking." These were the words coming out of a man's mouth, who was driven insane by the prison conditions, as the poison was being pumped into his arms. He was ruled competent to be executed.

I knew guys who dropped their appeals; not because they gave up hope on their legal claims but because of the intolerable conditions. I was able to visit another inmate before he was executed. I went there to lift his spirits and he ended up telling me that he was ready to go, and that I am the one who is going to have to keep dealing with this madness. He would rather die than continue existing under such inhumane conditions.

Solitary confinement does one thing, it breaks a man's will to live and he ends up deteriorating. He's never the same person again. Then his mother comes to see her son sitting behind plexiglass, whom she hasn't been able to touch in years, and she has to watch as her child deteriorates right in front of her eyes. This madness has a ripple effect. It doesn't just affect the inmate; it also affects his family, his children, his siblings and most importantly his mother.

I have been free for almost two years and I still cry at night, because no one out here can relate to what I have gone through. I battle with feelings of loneliness. I've tried therapy but it didn't work. The therapist was crying more than me. She couldn't believe that our system was putting men through this sort of inhumane treatment.

I haven't had a good night sleep since my release. My mind and body are having a hard time making the adjustment. I have mood swings that cause emotional break downs. Solitary confinement makes our criminal justice system the criminal.

It is inhumane and by its design it is driving men insane. I am living amongst millions of people in the world today, but most of the time I feel alone. I cry at night because of this feeling. I just want to stop feeling this way, but I haven't been able to.

End of Testimony

PREPARED STATEMENT OF DR. CRAIG HANEY

Testimony of Professor Craig Haney
Senate Judiciary Subcommittee on the Constitution, Civil Rights, and
Human Rights Hearing on Solitary Confinement
June 19, 2012

Chairman Durbin, Ranking Member Graham, and distinguished members of the Subcommittee: My name is Craig Haney. I am a Professor of Psychology at the University of California, Santa Cruz, and someone who has been studying the psychological effects of solitary confinement for well over 30 years. My academic interest in prisons more generally began even earlier in my professional life. In 1971 I was one of the principal researchers in a widely publicized study that came to be known as the "Stanford Prison Experiment." My colleagues and I placed a carefully screened group of psychologically healthy college students in a prison-like environment, randomly assigning half to be guards, half prisoners. We observed with increasing concern and dismay as the behavior of the otherwise psychologically healthy volunteers in our simulated prison rapidly deteriorated into mistreatment and emotional breakdowns.[1] When I began to study real prisons, examining and evaluating conditions of confinement in prison systems throughout the United States and in a number of foreign countries, I continued to be guided by the early lesson of the Stanford Prison Experiment: prisons are psychologically powerful places, ones that are capable of shaping and transforming the thoughts and actions of the persons who enter them, often in unintended and adverse ways.

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[1] For example, see: C. Haney, Curtis Banks & Philip Zimbardo, Interpersonal Dynamics in a Simulated Prison, 1 International Journal of Criminology and Penology 69 (1973); and C. Haney & Philip Zimbardo, The Past and Future of U.S. Prison Policy: Twenty-five Years After the Stanford Prison Experiment, 53 American Psychologist 709-727 (1998).

Since that time, I have toured and inspected numerous solitary confinement units across the country, in state prison systems from Massachusetts to California, and the federal "supermax" in Florence, Colorado (ADX). I have conducted systematic psychological assessments of approximately 1000 isolated prisoners, most of whom have been confined in solitary confinement units for periods of years, and even decades, during which time they have been kept separate from other prisoners, and denied the opportunity to have any normal human social contact or to engage in any meaningful social interaction.[2]

The Historical Context

As I mentioned above, the increased use of isolated or solitary confinement in American prisons began in the late 1970s and early 1980s. In a certain sense, it represented a return to a long-discredited practice that the nation had abandoned a century ago. As you may know, there was a time in our history when all prisons were operated as solitary confinement units, or nearly so. However, as the U.S. Supreme Court noted in an 1890 case, In re Medley, by the end of the 19th century, solitary confinement had already come to be known as an "infamous punishment," largely because, as the Court acknowledged: "A

[2] Much of my professional access to conditions of solitary confinement and to the large number of prisoners and staff whom I have interviewed has occurred in the context of constitutional litigation in which I have been asked or appointed to help determine whether and how isolated prisoners were being subjected to potentially cruel and unusual punishment. For example, see, Madrid v. Gomez, 889 F.Supp. 1146 (N.D. Cal. 1995); Ruiz v. Johnson, 37 F.Supp. 2d 855 (S.D. Tex. 1999). I was the principal author of the Brief of Professors and Practitioners of Psychology and Psychiatry As Amicus Curiae in Austin v. Wilkinson, 545 U.S. 209 (2005). This work has provided me with a rare opportunity not only to conduct in-depth inspections of many solitary confinement units and to interview numerous prisoners and staff members who live and work there, but also to review an extensive number of prison documents, records, and files that pertain to the operation of the units themselves.

considerable number of the prisoners [in solitary] fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide, while those who stood the ordeal better were not generally reformed and in most cases did not recover sufficient mental activity to be of any subsequent service to the community."[3]

Indeed, the Court's Medley opinion echoed observations that had been made even earlier by Alexis d'Tocqueville, who concluded that solitary confinement in American prisons "devours [its] victims incessantly and unmercifully" and noted that the "unfortunate creatures who submitted to [it] wasted away,"[4] and by Charles Dickens, who, although himself no stranger to harsh and degrading conditions, termed solitary confinement a "dreadful" punishment that inflicted terrible psychic pain that "none but the sufferers themselves can fathom, and which no man has a right to inflict upon his fellow creatures."[5]

I wish I could say that the nation's return to this long discredited practice was occasioned by significant advances in the way that solitary confinement is now implemented, or that new psychological insights had emerged to lessen previously widespread concerns about its damaging effects. I cannot. Instead, I believe the renewed use of long-term solitary confinement is the result of the confluence of three unfortunate trends—the era of "mass imprisonment" that began in the mid-1970s and produced widespread prison overcrowding, the shift in responsibility for housing the mentally ill to the nation's prison systems, and

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[3] In re Medley, 134 U.S. 160, 168 (1890).

[4] Quoted in Torsten Eriksson, The Reformers, An Historical Survey of Pioneer Experiments in the Treatment of Criminals. New York: Elsevier (1976), at 49.

[5] Charles Dickens, American Notes for General Circulation. London: Chapman and Hall (1842), at 119-20.

the abandonment of the rehabilitative ideal and its corresponding mandate to provide prison programming and treatment. The renewed widespread use of solitary confinement emerged as an administrative stop-gap—an ill-advised but expedient measure to keep the resulting and potentially very problematic prison dynamics in check. I believe it has become increasingly clear that this approach to prison management has created far more problems than it solved.

The Conditions of Solitary Confinement

I should acknowledge that the term "solitary confinement" is a term of art in corrections. Solitary or isolated confinement goes by a variety of names in U.S. prisons—Security Housing, Administrative Segregation, Close Management, High Security, Closed Cell Restriction, and so on. But the units all have in common the fact that the prisoners who are housed inside them are confined on average 23 hours a day in typically windowless or nearly windowless cells that commonly range in dimension from 60 to 80 square feet. The ones on the smaller side of this range are roughly the size of a king-sized bed, one that contains a bunk, a toilet and sink, and all of the prisoner's worldly possessions. Thus, prisoners in solitary confinement sleep, eat, and defecate in their cells, in spaces that are no more than a few feet apart from one another.

Beyond the physical limitations and procedural prohibitions that are central to solitary confinement units, these places must be "lived in," typically on a long-term basis. Reflect for a moment on what a small space that is not much larger than a king-sized bed looks, smells, and feels like when someone has lived in it for 23 hours a day, day after day, for years on end. Property is strewn around, stored in whatever makeshift way possible, clothes and bedding soiled from recent use sit in one or another corner or on the floor, the residue of recent meals

(that are eaten within a few feet of an open toilet) here and there, on the floor, bunk, or elsewhere in the cell. Ventilation is often substandard in these units, so that odors linger, and the air is sometimes heavy and dank. In some isolation units, prisoners are given only small amounts of cleaning materials—a Dixie cup or so of cleanser—once a week, making the cells especially difficult to keep clean.

Inside their cells, units, and "yards," isolated prisoners are surrounded by nothing but concrete, steel, cinderblock, and metal fencing—often gray or faded pastel, drab and sometimes peeling paint, dingy, worn floors. There is no time when they escape from these barren "industrial" environments. Many prisoners sit back on their bunks, look around at what has become the sum total of their entire lives, hemmed in by the tiny space that surrounds them and, not surprisingly, become deeply despondent.

Virtually all of the solitary confinement units with which I am familiar prohibit contact visits of any kind, even legal visits. This means that prisoners go for years—in some cases, for decades—never touching another human being with affection. Indeed, the only regular "interactions" that prisoners housed in these units routinely have occur when correctional officers push food trays through the slots on their doors two or three times a day in order to feed them. The only form of actual physical "touching" they experience takes place when they are being placed in mechanical restraints—leg irons, belly chains, and the like—in a procedure that begins even before their cell doors are opened, and which is done every time they are taken out of their cells by correctional staff, on the relatively infrequent occasions when this occurs.

When prisoners in solitary confinement or "lock-up" units leave their cells for what is, typically, an average of one hour a day, it is usually to go to a so-called "yard." I say "so-called" because the "yard" in most of these units bears no relationship to the image this word ordinarily conjures. Instead, the yard often

consists of a metal cage, sitting atop a slab of concrete or asphalt or, in the case of California's Pelican Bay, a concrete-enclosed pen, one surrounded by high solid walls that prevent any view of the outside world. Federal Judge Thelton Henderson, who presided over a landmark case examining conditions of confinement at the Pelican Bay Security Housing Unit or "SHU," noted that the image of prisoners trying to exercise in these concrete pens—their only regular opportunity to be out of their windowless cells each day—was "hauntingly similar to that of caged felines pacing in a zoo."[6] It is an apt description that unfortunately applies to many prisoners in many such "yards" around the country. In fact, the haunting similarities to zoos are not limited merely to the nature of the yards; one is hard-pressed to name any other place in our society where sentient beings are housed and treated the ways that they are in solitary confinement.

The emptiness and idleness that pervade most solitary confinement units are profound and enveloping. The prison typically provides the prisoners in these units with literally nothing meaningful to do. That emptiness, when combined with the total lack of meaningful social contact, has led some prisoners into a profound level of what might be called "ontological insecurity"—they are not sure that they exist and, if they do, exactly who they are. A number of prisoners have told me over the years that they actually have precipitated confrontations with prison staff members (that sometimes result in brutal "cell extractions") in order to reaffirm their existence.

The Makeup of Solitary Confinement Units

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[6] Madrid, supra note 2, at 1229.

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You are no doubt wondering who is confined in these units. That is, what does a prisoner have to do in order to be housed in such a place? In fact, some of the prisoners have done very serious things, including assaulting other prisoners or even staff members; some have even committed in-prison homicides. However, in most isolation units these prisoners are the exception rather than the rule. A number of prisoners are in solitary confinement for having committed an unacceptably high number of minor offenses. An even larger number are housed there because they are alleged to be prison gang members or associates, an offense that, in and of itself, can result in indefinite solitary confinement, even though the prisoners in question may not have engaged in any overt rule violations other than their alleged connection to the gang, and may remain entirely free of disciplinary write-ups during the many years of their indefinite isolation. Allegations of gang membership are inherently subjective and can be unreliable. Prisoners who are erroneously classified in this way are hard-pressed to establish facts and may be confined in isolation on this incorrect basis indefinitely.[7]

In addition, there are two very problematic but little publicized facts about the group of prisoners who are housed inside our nation's solitary confinement units. The first is that a shockingly high percentage of them are mentally ill, and often profoundly so. In some cases, the mental illness was pre-existing and may even be the primary cause of the disciplinary infraction that brought them to the solitary confinement unit in the first place. In other instances, however, the signs and symptoms of mental illness appear to have emerged only after the prisoner's term in solitary confinement began. Studies indicate that approximately a third of

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[7] For example, see: Erica Goode, Fighting a Drawn-Out Battle Against Solitary Confinement, New York Times, March 30, 2012. [available at: http://www.nytimes.com/2012/03/31/us/battles-to-change-prison-policy-of-solitary-confinement.html?pagewanted=all]

the prisoners in solitary confinement units suffer from mental illness, [8] but in some units the figure is higher—half or more. Approximately 50% of all prison suicides occur in solitary confinement units.[9]

The other very troublesome but rarely acknowledged fact about solitary confinement is that in many jurisdictions it appears to be reserved disproportionately for prisoners of color. That is, the racial and ethnic overrepresentation that occurs in our nation's prisons generally is, in my personal experience, even more drastic inside solitary confinement units. Although these data are not systematically collected and made available for analysis overall, a study that I conducted in a Security Housing Unit in California confirmed that approximately 90% of the prisoners housed there were of color (i.e., Latino or African American).

The Psychological Effects of Solitary Confinement

What are the consequences of confinement in such harsh and deprived places? Your colleague, Senator John McCain, characterized solitary confinement as "an awful thing," noting that: "It crushes your spirit and weakens your

[8] Specifically, two separate studies have found that 29% of the prisoners in solitary confinement suffer from a "serious mental disorder." Hodgins, S., and Cote, G., The Mental Health of Penitentiary Inmates in Isolation, 33 Canadian Journal of Criminology 177-182 (1991); Lovell, D., Cloyes, K., Allen, D., & Rhodes, L., Who Lives in Super-Maximum Custody? A Washington State Study, 64 Federal Probation 33-38 (2000). If the definition of mental illness is broadened to include "psychosocial impairments," then one study has found approximately 45% of solitary confinement prisoners are so afflicted.

[9] Mears, D.P. & Watson, J., Towards a Fair and Balanced Assessment of Supermax Prisons, 23 Justice Quarterly, 232 (2006); Way, B., Miraglia, R., Sawyer, D., Beer, R., & Eddy, J. (2005). Factors Related to Suicide in New York State Prisons, 28 International Journal of Law and Psychiatry, 207 (2005); Patterson, R.F. & Hughes, K., Review of Completed Suicides in the California Department of Corrections and Rehabilitation, 1999 to 2004, 59 Psychiatric Services 676-682 (2008). See, also: Cloyes, K., Lovell, D., Allen, D., & Rhodes, L. Assessment of Psychosocial Impairment in a Supermaximum Security Unit Sample, 33 Criminal Justice and Behavior 760-781 (2006).

resistance more effectively than any other form of mistreatment. Having no one else to rely on, to share confidences with, to seek counsel from, you begin to doubt your judgment and your courage."[10] My observations of the effects of solitary confinement as it is practiced inside our nation's prisons are consistent with Senator McCain's. The level of suffering and despair in many of these units is palpable and profound.

As the federal judge who heard testimony about California's Pelican Bay Security Housing Unit concluded, the severe deprivation and oppressive control conditions in these places "may press the outer bounds of what most humans can psychologically tolerate."[11] For a number of prisoners, those bounds are greatly exceeded, and the consequences of their long-term solitary confinement are truly extreme. Serious forms of mental illness can result from these experiences. Moreover, many prisoners become so desperate and despondent that they engage in self-mutilation and, as I noted early, a disturbingly high number resort to suicide. Indeed, it is not uncommon in these units to encounter prisoners who have smeared themselves with feces, sit catatonic in puddles of their own urine on the floors of their cells, or shriek wildly and bang their fists or their heads against the walls that contain them. In some cases the reactions are even more tragic and bizarre, including grotesque forms of self-harm and mutilation—prisoners who have amputated parts of their own bodies or inserted tubes and other objects into their penises—and are often met with an institutional matter-of-factness that is equally disturbing.

I recall a prisoner in New Mexico who was floridly psychotic and used a makeshift needle and thread from his pillowcase to sew his mouth completely

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[10] Quoted in Richard Kozar, John McCain: Overcoming Adversity. Chelsea House (2001), at p. 53.

[11] Madrid, supra note 2, at p. 1267.

shut. Prison authorities dutifully unstitched him, treated the wounds to his mouth, and then not only immediately returned him to the same isolation unit that had caused him such anguish but gave him a disciplinary infraction for destroying state property (i.e., the pillowcase), thus ensuring that his stay in the unit would be prolonged. A prisoner at the federal supermax prison—ADX—who had no pre-existing mental disorder before being placed in isolation, has suffered from severe mental illness for years now. While in solitary confinement he has amputated one of his pinkie fingers and chewed off the other, removed one of his testicles and scrotum, sliced off his ear lobes, and severed his Achilles tendon with a sharp piece of metal. He remains in a standard solitary confinement unit rather than a psychiatric facility. Another prisoner, housed long-term in a solitary confinement unit in Massachusetts, has several times disassembled the television set in his cell and eaten the contents. Each time, his stomach is pumped and, after a brief stay in a psychiatric unit, he is returned to the same punitive isolation where this desperate and bizarre behavior occurred.

Beyond these extreme cases, solitary confinement places all of the prisoners exposed to it at grave risk of harm. In fact, the scientific literature on the effects of solitary confinement has been accumulated over many decades, by researchers from a number of different countries who have varying academic backgrounds. Despite the methodological limitations that come from studying human behavior in such a complex environment, most of the research has reached remarkably similar conclusions about the adverse psychological consequences of solitary confinement. Thus, we know that prisoners in solitary confinement suffer from a number of psychological and psychiatric maladies, including: significantly increased negative attitudes and affect, irritability, anger, aggression and even rage; many experience chronic insomnia, free floating anxiety, fear of impending emotional breakdowns, a loss of control, and panic

attacks; many report experiencing severe and even paralyzing discomfort around other people, engage in self-imposed forms of social withdrawal, and suffer from extreme paranoia; many report hypersensitivity to external stimuli (such as noise, light, smells), as well as various kinds of cognitive dysfunction, such as an inability to concentrate or remember, and ruminations in which they fixate on trivial things intensely and over long periods of time; a sense of hopelessness and deep depression are widespread; and many prisoners report signs and symptoms of psychosis, including visual and auditory hallucinations.[12] Many of these symptoms occur in and are reported by a large number of isolated prisoners. For example, in a systematic study I did of a representative sample of solitary confinement prisoners in California, prevalence rates for most of the above mentioned symptoms exceeded three-quarters of those interviewed.[13]

In addition to the above clinical symptoms and syndromes, prisoners who are placed in long-term isolation often develop what I have characterized as "social pathologies," brought about because of the pathological deprivations of social contact to which they are exposed. The unprecedented totality of control in these units occurs to such an exaggerated degree that many prisoners gradually lose the ability to initiate or to control their own behavior, or to organize their personal lives. Prisoners may become uncomfortable with even small amounts of freedom because they have lost confidence in their own ability to behave in the absence of constantly enforced restrictions, a tight external structure, and the ubiquitous physical restraints. Even the prospect of returning to the comparative

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[12] For citations to the studies in which these specific adverse effects have been reported, see: C. Haney, Mental Health Issues in Long-Term Solitary and "Supermax" Confinement, 49 Crime & Delinquency 124-156 (2003), and C. Haney, The Social Psychology of Isolation: Why Solitary Confinement is Psychologically Harmful, Prison Service Journal UK (Solitary Confinement Special Issue), Issue 181, 12-20 (2009).

[13] See supra, note 12, Haney, 2003.

"freedoms" of a mainline maximum security prison (let alone the free world) fills them with anxiety.

For many prisoners, the absence of regular, normal interpersonal contact and any semblance of a meaningful social context in these isolation units creates a pervasive feeling of unreality. Because so much of our individual identity is socially constructed and maintained, the virtually complete loss of genuine forms of social contact and the absence of any routine and recurring opportunities to ground thoughts and feelings in a recognizable human context lead to an undermining of the sense of self and a disconnection of experience from meaning. Some prisoners experience a paradoxical reaction, moving from initially being starved for social contact to eventually being disoriented and even frightened by it. As they become increasingly unfamiliar and uncomfortable with social interaction, they are further alienated from others and made anxious in their presence. In extreme cases, another pattern emerges: this environment is so painful, so bizarre and impossible to make sense of, that they create their own reality—they live in a world of fantasy instead. Finally, the deprivations, restrictions, the totality of control, and the prolonged absence of any real opportunity for happiness or joy fills many prisoners with intolerable levels of frustration that, for some, turns to anger, and then even to uncontrollable and sudden outbursts of rage.

A Culture of Harm

Most of the analyses of the harmfulness of solitary confinement are directed at the extreme levels of material deprivation, the lack of activity and other forms of sensory stimulation, and, especially, the absence of normal or meaningful social contact that prisoners experience and suffer from in these settings. This

emphasis is not misplaced. There is no widely accepted psychological theory, correctional rationale, or conception of human nature of which I am aware to suggest that exposure to these powerful and painful stressors is neutral or benign and does not carry a significant risk of harm.

To be sure, the extreme deprivation, the isolating architecture, the technology of control, and the rituals of degradation and subjugation that exist in solitary confinement units are inimical to the mental health of prisoners. However, it would be naïve to assume that the nature of these environments does not also affect the staff who work inside.[14] In many such places, thinly veiled hostility, tension, and simmering conflict are often palpable. The interpersonal toxicity that is created in these environments can engender mistreatment and even brutality. What might be termed an "ecology of cruelty" is created in many such places where, at almost every turn, guards are implicitly encouraged to respond and react to prisoners in essentially negative ways—through punishment, opposition, force, and repression.

For many correctional officers, at least initially, this approach to institutional control is employed neutrally and even-handedly—without animus and in response to actual or perceived threats. However, when punishment and suppression continue—largely because of the absence of any available and sanctioned alternative approaches—they become functionally autonomous and often disproportionate in nature. Especially when the use of these techniques persists in spite of the visible pain and suffering they bring about, it represents a form of cruelty (notwithstanding the possible lack of cruel intentions on the part of many of those who employ the harsh techniques themselves).

Unfortunately, the culture of harm that is created in many of these units

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[14] C. Haney, A Culture of Harm: Taming the Dynamics of Cruelty in Supermax Prisons, 35 Criminal Justice and Behavior 956-984 (2008);

also affects service providers, including those who are supposed to address the mental health needs of prisoners. Despite the large concentration of mentally ill prisoners in solitary confinement, the quality of mental health care in these units is sometimes much worse than elsewhere in the prison system. Some of this is due to limited resources; some prisons simply do not have the personnel to provide the kind of care that solitary confinement prisoners need. Some of it stems from built-in practical limitations. That is, solitary confinement units are located in separate, distant areas of the prison, access to the units themselves is difficult, and the procedures whereby prisoners are transported from their cells are cumbersome. But some of the poor quality care in certain units derives from the culture of harm to which I referred and the ease with which it is possible to simply "get used to" practices and procedures that would be seen as unacceptably compromised and inadequate in any other setting. For example, in many solitary confinement units it is not uncommon for mental health services to be delivered in "treatment cages" (or what prisoners sometimes refer to as "shark cages" because of their resemblance to those underwater contraptions)—telephone-booth sized metal cages in which prisoners are confined during their "therapeutic hour."

Public Safety Concerns

A critically important but widely overlooked aspect of solitary confinement in the United States is the potential threat it represents to public safety. Solitary confinement not only subjects prisoners to the kind of psychologically damaging experiences I have described above but also does so without providing them with any opportunities to obtain meaningful programming or rehabilitative services.

As a result, many prisoners are significantly handicapped when they attempt to make their eventual transition from prison back into the free world.

Indeed, there is some recent, systematic evidence that time spent in solitary confinement contributes to elevated rates of recidivism.[15] The explanation for this troubling fact is not difficult to discern. Without oversimplifying, one of the things we have learned about how prisoners make successful transitions back into their communities of origin is that positive re-entry depends on their ability to connect to a supportive, caring group of other people, and the ability and opportunity to become gainfully employed. Solitary confinement significantly impedes both things. Prisoners' social skills atrophy severely under their starkly deprived and isolated conditions of confinement. The absence of any meaningful activity (let alone rehabilitative programming) in solitary confinement means that their often already limited educational and employment skills will have further deteriorated by the time they are released. Many prisoners come out of these units damaged and functionally disabled, and some are understandably enraged by the ways in which they have been mistreated. Crime—sometimes violent crime—is one predictable result. Moreover, very few solitary confinement units operate "step down" or transitional programs that assist prisoners in negotiating the steep barrier from isolation to the intensely social world outside of prison.

In some instances, the failures that solitary confinement prisoners experience when they try to make this nearly impossible transition on their own are tragic, not just for themselves but for others who may become the innocent victims of their desperate plight. For example, some years ago I encountered one

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[15] For example, see: Lovell, D., Johnson, L., & Cain, K., Recidivism of Supermax Prisoners in Washington State, 53 Crime & Delinquency 633-656 (2007); Mears, D., & Bales, W., Supermax Incarceration and Recidivism, 47 Criminology 1131 (2009).

California prisoner who had been convicted of non-violent drug offenses, and entered the prison system with no pre-existing symptoms of mental illness. Yet, when I saw him he was lying catatonic, unresponsive, and incoherent on the floor of his isolation cell in a California SHU unit. He was eventually diagnosed as schizophrenic, but was retained in the same unit where his mental illness had originated. The next time I encountered him was several years later, after he had been released from prison. He was on trial for capital murder, an offense that had been committed just months after being taken directly from his isolation cell, placed on a bus and eventually onto the streets of a California city, with no pre-release counseling or transitional housing of any kind. I wish that I could say that this tragic and extreme outcome was the only one of its kind that I have personally encountered, but it certainly is not.

Proposed Remedies

Solitary confinement continues to be used on a widespread basis in the United States despite empirical evidence suggesting that its existence has done little or nothing to reduce system-wide prison disorder or disciplinary infractions.[16] In fact, at least one prison system that drastically reduced the number of prisoners whom it housed in solitary confinement by transferring them to mainline prisons experienced an overall reduction in misconduct and violence system-wide.[17] As prison populations continue to gradually decline, and the nation's correctional system rededicates itself to program-oriented

[16] Briggs, C., Sundt, J., & Castellano, T., The effect of Supermaximum Security Prisons on Aggregate Levels of Institutional Violence, 41 Criminology 1341-1376 (2003).

[17] See T. Kupers, T. Dronet et al, Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs, 36 Criminal Justice and Behavior 1037-1050 (2009.

approaches designed to produce positive prisoner change, the resources expended on long-term solitary confinement should be redirected to a more cost-effective and productive strategy of prison management.

Several years ago, after it had conducted a number of public hearings in locations around the country, the bipartisan Commission on Safety and Abuse in America's Prisons, chaired by former Attorney General Nicholas Katzenbach, called supermax prisons "expensive and soul destroying"[18] and recommended that prison systems "end conditions of isolation."[19] Short of that, in my opinion, there are some things that can and should be implemented on a nationwide basis. Solitary confinement continues to be structured and operated in ways that are designed to deprive, diminish, and punish. With that in mind, steps need to be taken to entirely exclude the most vulnerable prisoners from exposure to these conditions,[20] significantly limit the time that all other prisoners are housed there,[21] provide all prisoners with meaningful steps or pathways that they can pursue to accelerate their release from solitary,[22] significantly change the nature

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[18] Gibbons, J., & Katzenbach, N. (2006). Confronting Confinement: A Report of the Commission on Safety and Abuse in America's Prisons. New York: Vera Institute of Justice, at p. 59.

[19] Id. at 57.

[20] Persons under the age of 18 and those who suffer from serious mental illness are singularly unsuited for long-term solitary confinement and they should be absolutely excluded from being housed there. In fact, persons with serious mental illnesses are categorically excluded from solitary confinement in a number of states (e.g., California, Wisconsin, Ohio), but not all. Moreover, the ABA Standards on the Treatment of Prisoners (at section 23-2.8(a)) require this. See: http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners.html#23-2.7

[21] In terms of time limits, the new ABA Standards define "long term" segregation as 30 days or more, and impose a presumptive limit of one year on placement in disciplinary housing (section 23-4.3(b)). In my opinion, that limit is arguably too long. However, if US prisons complied even with the ABA Standards, it would result in a significant improvement.

[22] For example, see the general discussion in: C. Haney, The Psychological Impact of Incarceration: Implications for Post-Prison Adjustment, at pp. 33-66. *See, also*, Joan Petersilia, When Prisoners Come Home: Parole and Prisoner Reentry. New York: Oxford University Press (2003).

of the isolation units themselves to mitigate the damage that they inflict, [23] and provide prisoners who are being released into mainline prison populations or into free world communities with effective transitional services to ensure their post-solitary success and reduce the risk of harm to others once they are released.

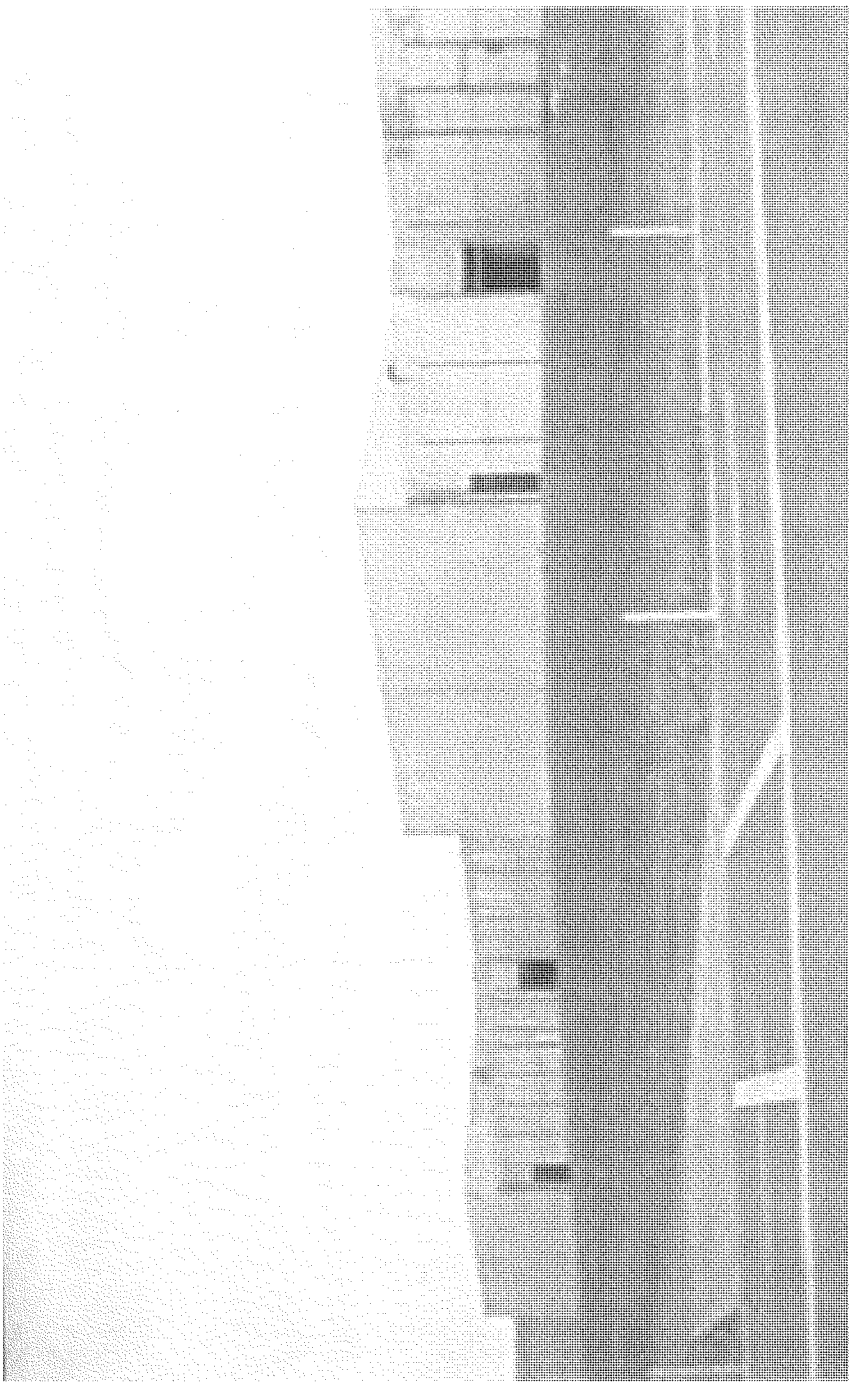
The grave psychological risks posed by solitary confinement make the overall mental health recommendations urgently important. Prisoners must be systematically screened for mental illness as they come into solitary confinement units, and continuously monitored for signs of developing mental illness. Those whose problems may fall below the standard required for exclusion and who therefore remain in solitary confinement must be given access to enhanced (rather than substandard) mental health resources. Finally, all isolated prisoners must be provided with transitional or "step down" services and programs designed to meaningfully address the psychological changes that they are likely to have undergone in the course of their solitary confinement.

Thank you for the opportunity to participate in this historic hearing and to help the Subcommittee address this very significant issue. I am hopeful that it

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[23] Elsewhere I have proposed list of "limiting standards" that I believe should be enforced in all solitary confinement units. See C. Haney and Mona Lynch, Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement, New York Review of Law & Social Change, 23, 477-570 (1997), at pp. 558-566. These standards that are "rooted in the psychological literature and intended as the basis for a more effective, realistic, and psychologically meaningful oversight" of solitary confinement. Id. at p. 560. Many of our proposed standards were designed to prevent or limit the potential damage of the harsh solitary confinement regime on prisoners, including due process protections for all prisoners in advance of their placement in isolation (irrespective of the purpose for that placement); screening prisoners out of solitary confinement if their specific medical or mental health conditions (not just serious mental illness) made them especially vulnerable to the harmful consequences that we identified; prohibiting the placement of prisoners in isolation that whose disciplinary infractions resulted from pre-existing psychiatric disorders; placing severe time limits on the duration of confinement for all prisoners (prohibiting total isolation and extreme segregation of the sort that occurs in "dark cells," while permitting somewhat longer periods of isolation for less draconian segregated housing); monthly mental health evaluations to determine continued fitness for segregated housing; and access to therapy, work, educational, and recreational programs and visitation—comparable to what is offered in mainline units—for prisoners confined in solitary confinement for longer than 3 months.

will mark the beginning of urgently needed and long-term Congressional oversight and reform.







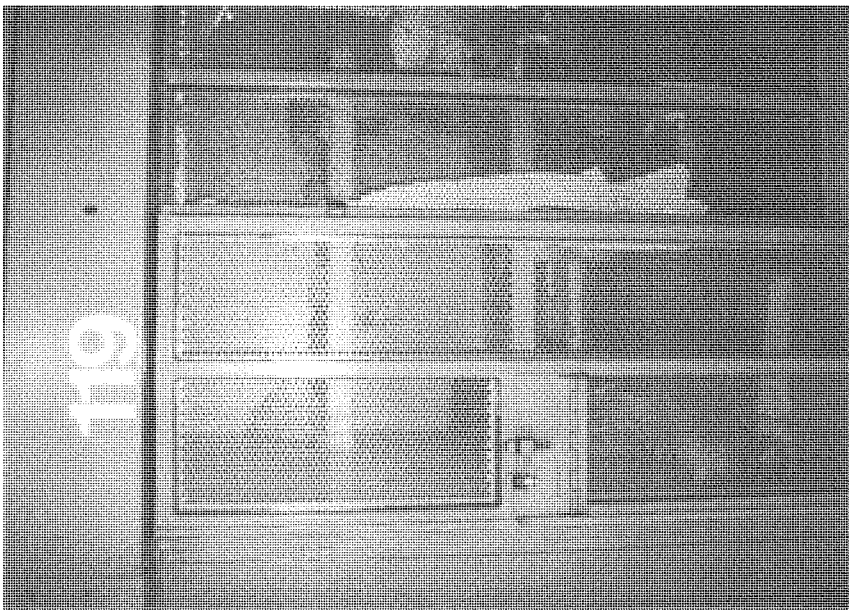
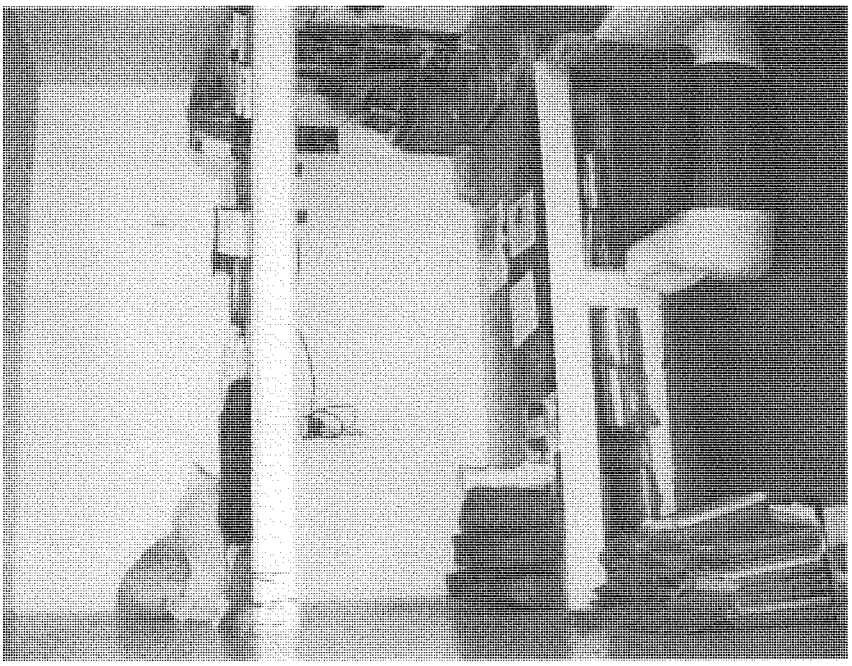
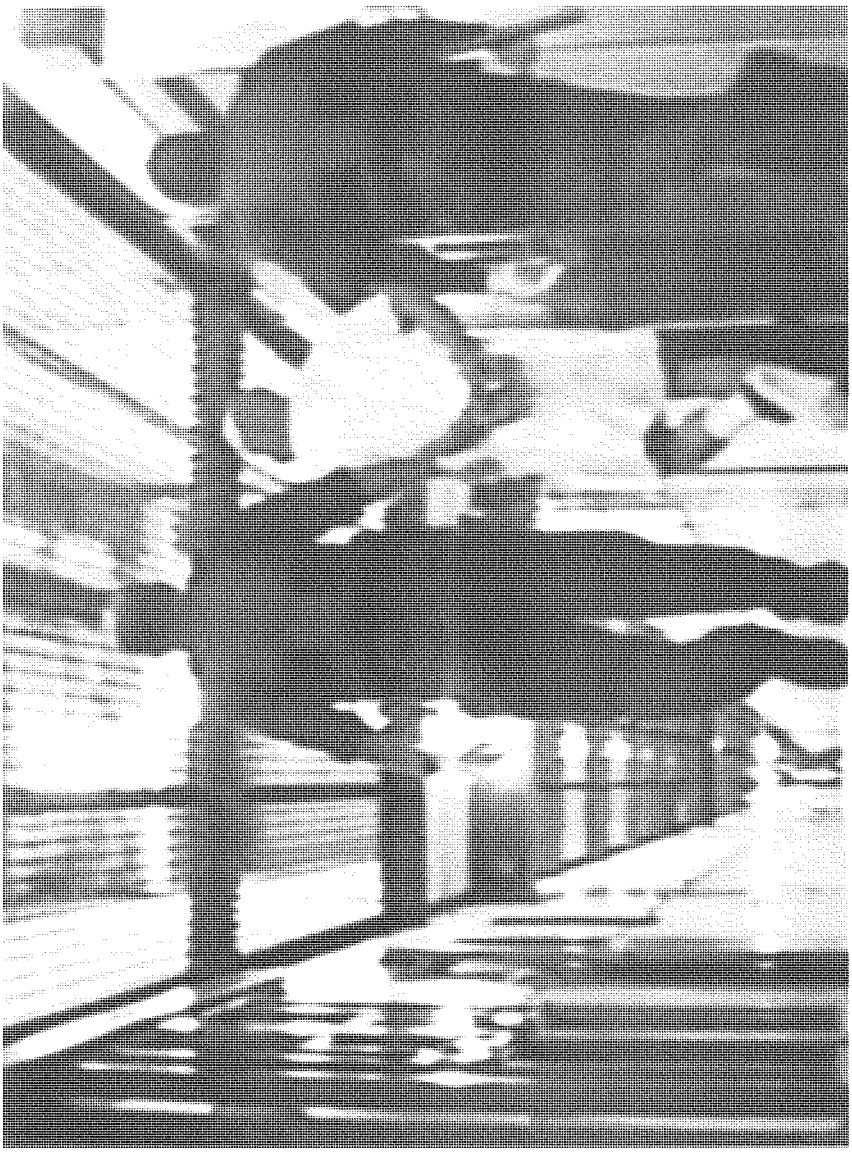


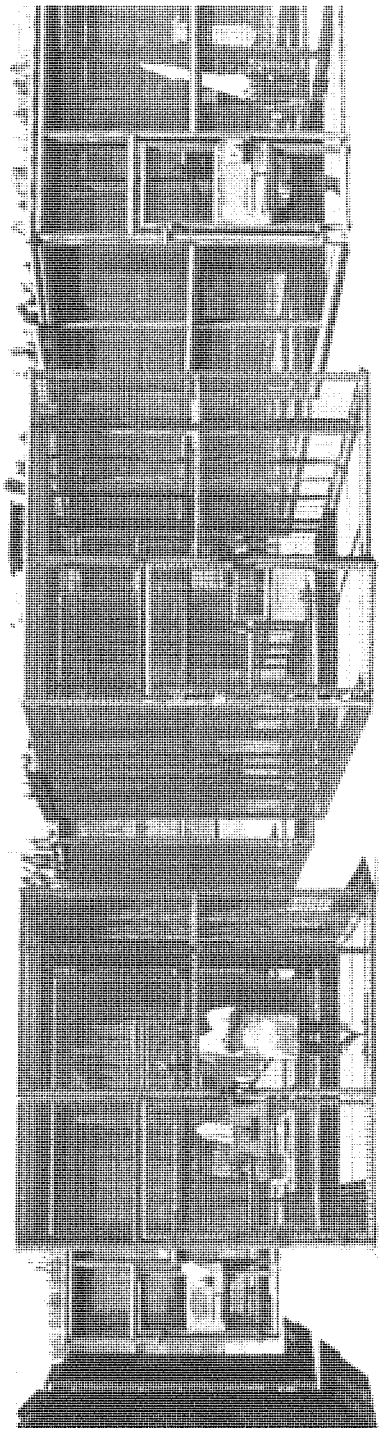
Fig. 6

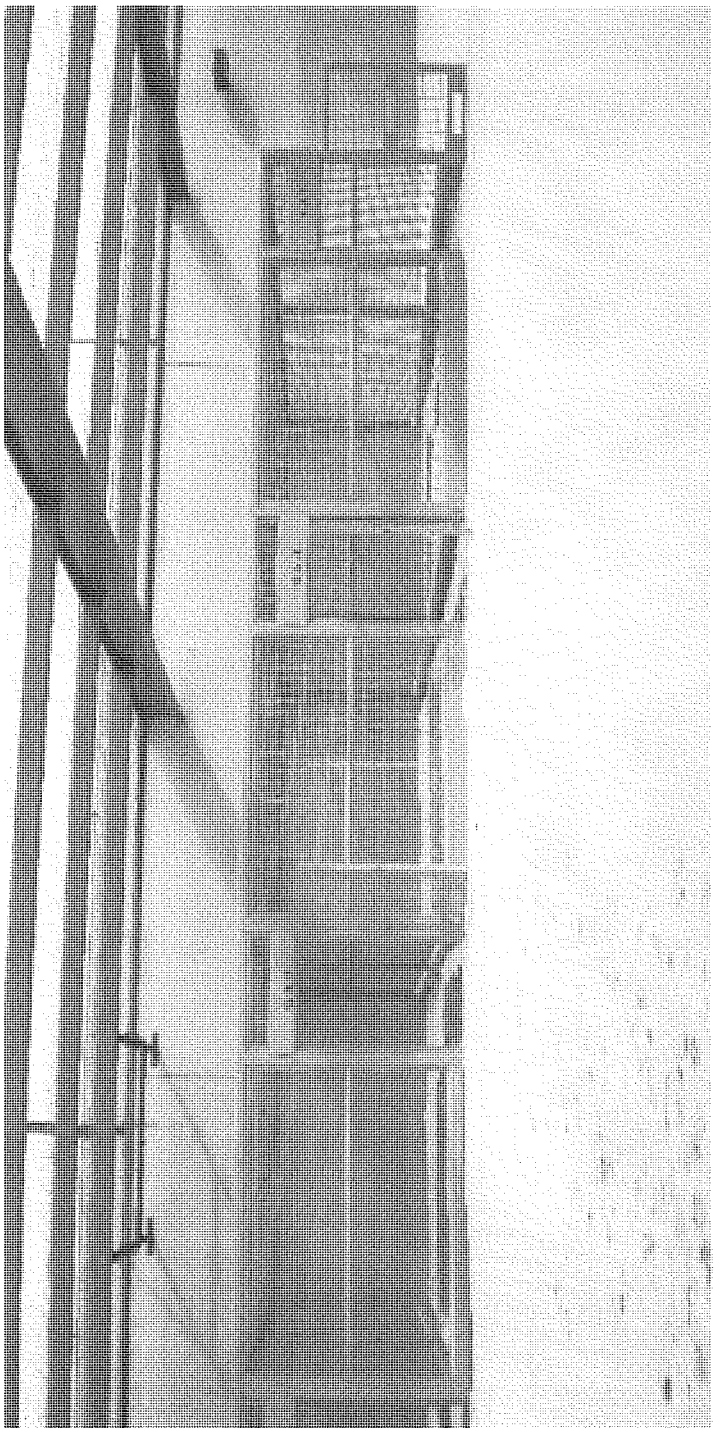


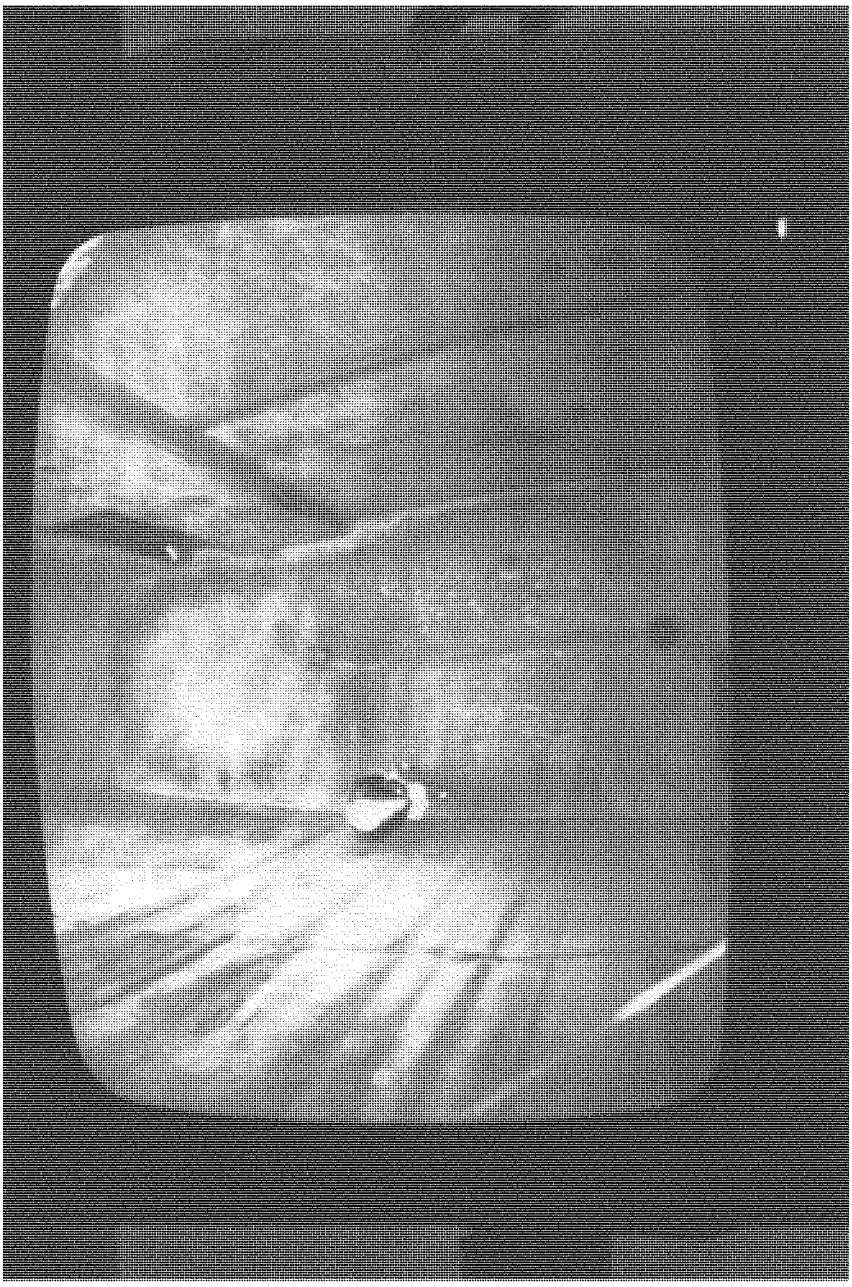


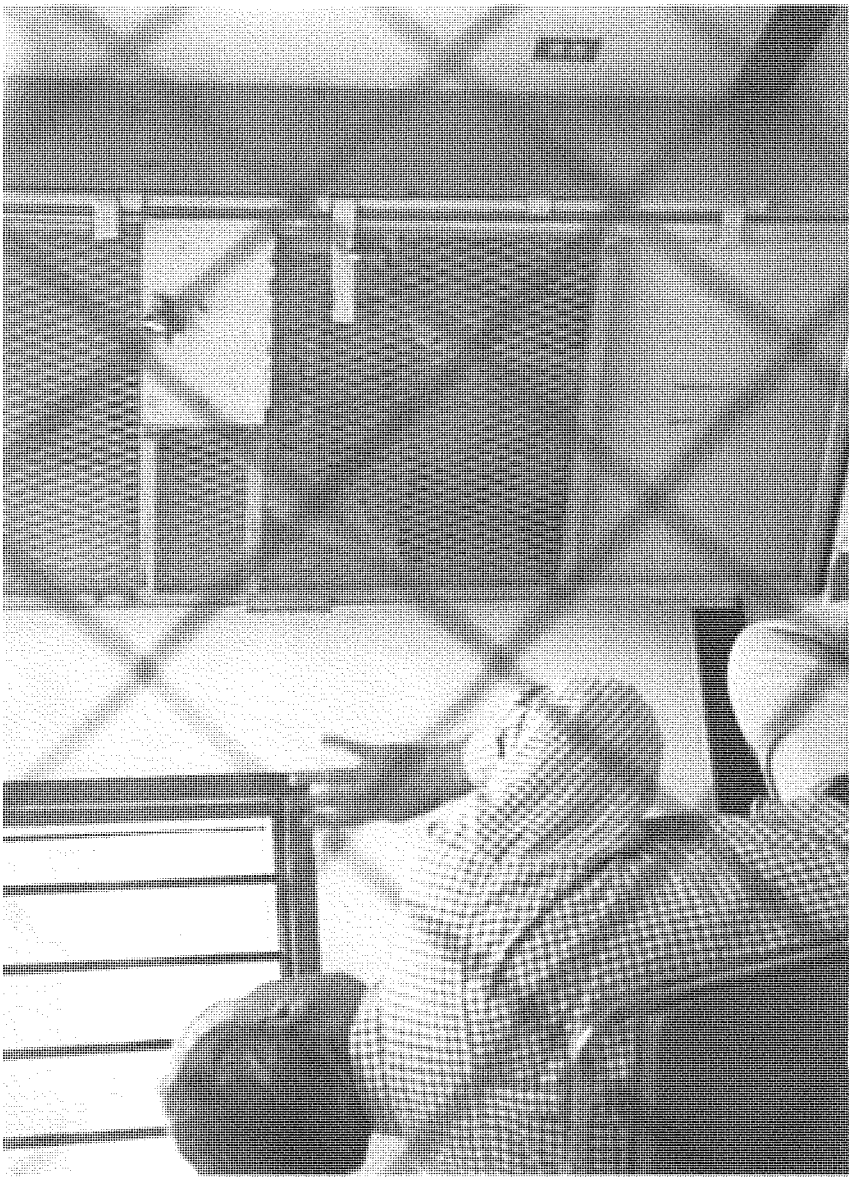


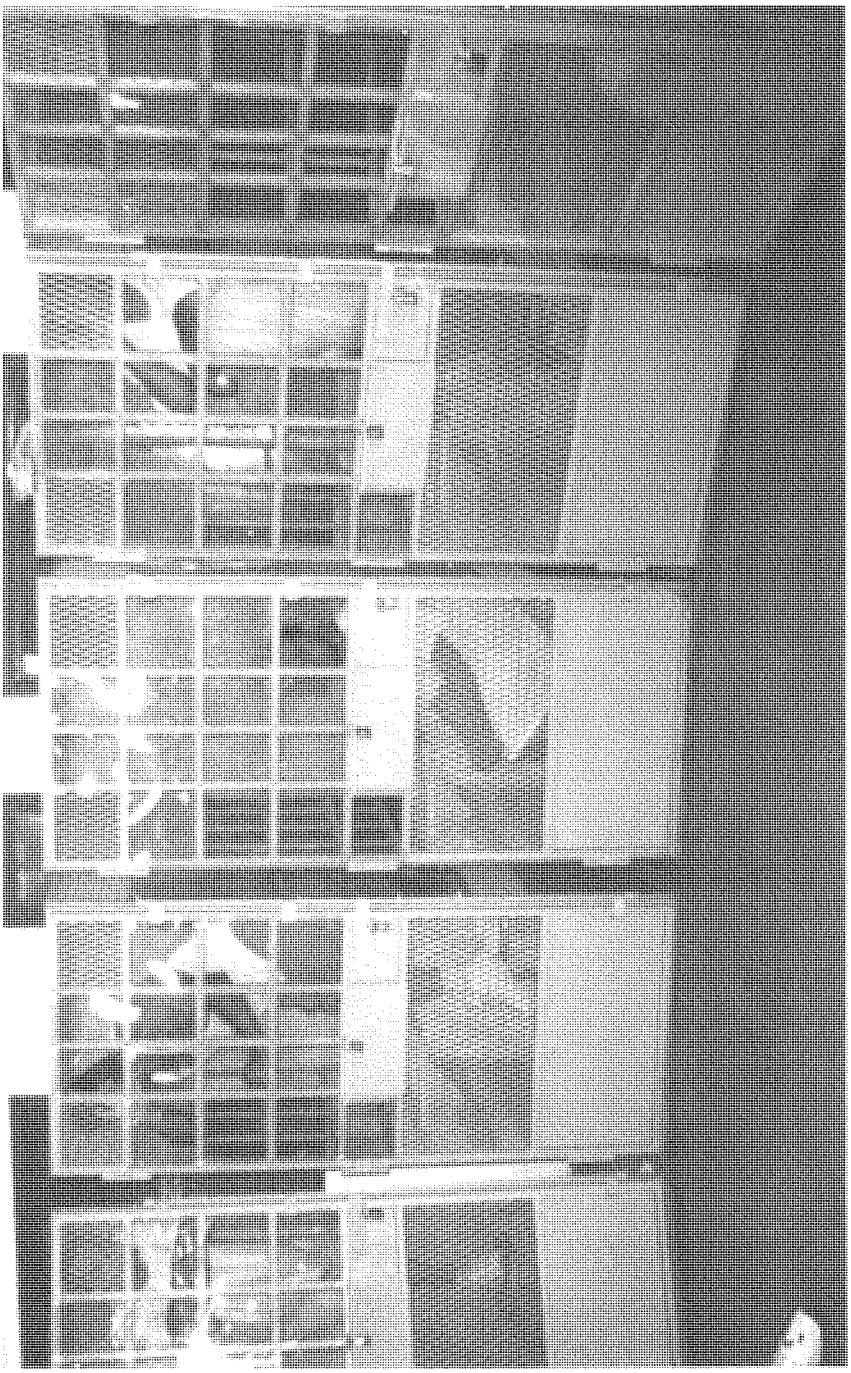


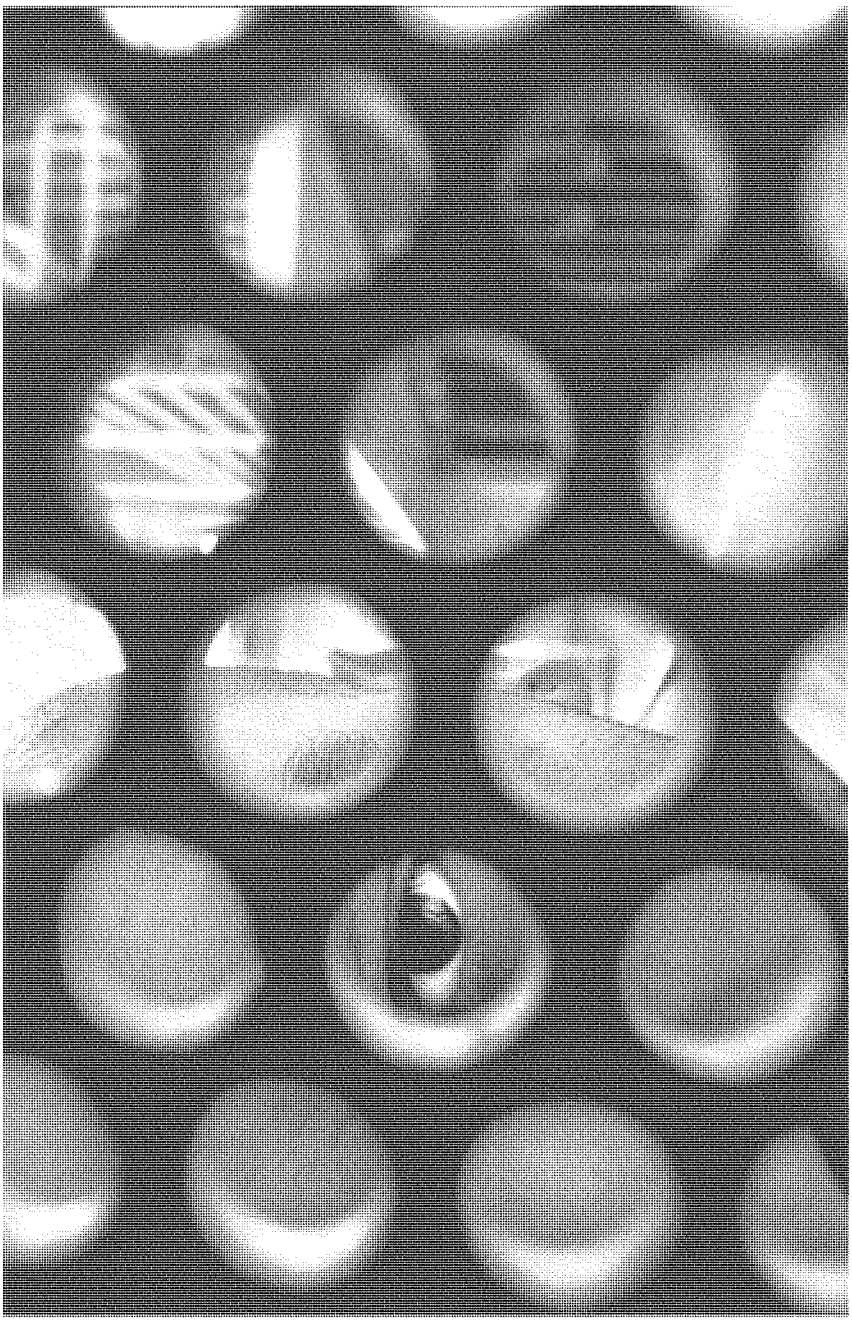












PREPARED STATEMENT OF PAT NOLAN

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Pat Nolan, President

Testimony of Pat Nolan
President of Justice Fellowship
Before the Senate Judiciary Subcommittee on the
Constitution, Civil Rights, and Human Rights
Reassessing Solitary Confinement:
The Human Rights, Fiscal, and Public Safety Consequences
June 19, 2012

Mr. Chairman and members, I am grateful for this opportunity to discuss the impact of solitary confinement on inmates, corrections officers and on public safety.

My name is Pat Nolan. I am a President of Justice Fellowship, the division of Prison Fellowship Ministries that works to reform the criminal justice system. This is an important topic to our ministry because it was after witnessing the horrid and brutal conditions of Walla Walla Prison that our founder Chuck Colson added reform of the justice system to the work of Prison Fellowship.

Chuck had gone to Walla Walla to preach the Gospel and lead a Bible study. The prison had been locked down for over 9 months in retaliation for the murder of a correctional officer. During those long months, the prisoners were confined to their cells, forced to brush their teeth and drink water from their toilet bowls.

During those 9 months they were allowed out of their cells only once every 14 to 20 days to "shower". However, it was not like any shower any of us have experienced. Officers shouted instructions to strip, and the cell doors were opened. The lieutenant shouted instructions that they were to run to the shower room, through the running showers and back to their cells without stopping. They were forced to run between phalanxes of officers who rained blows on the running inmates with their batons. One inmate slipped on the wet floor and was viciously beaten by multiple officers until he could struggle back to his feet on his own.

Chuck was the first outsider to enter the prison after the lockdown ended. At his Bible study one of the inmates challenged Chuck to "tell the world what you have seen here". And Chuck said he would. A large number of the press was waiting outside the prison gates as Chuck exited. He told them about the conditions inside the prison and said, "You can't treat inmates like animals and then expect them to live decent lives after they are released." And he committed to work to reform the system, and from that searing experience he founded Justice Fellowship, the part of the ministry that I lead.

I bring a unique background to this work. I served for 15 years as a member of the California State Assembly, four of those as the Assembly

Republican Leader. I was a leader on crime issues, particularly on behalf of victims' rights. I was one of the original sponsors of the Victims' Bill of Rights (Proposition 15) and was awarded the "Victims Advocate Award" by Parents of Murdered Children. I was prosecuted for a campaign contribution I accepted, which turned out to be part of an FBI sting. I pleaded guilty to one count of racketeering, and served 29 months in federal custody.

While I was still in prison Chuck recruited me to put my experience as a lawyer, a legislative leader and a prisoner to use in service to prisoners, whom Jesus referred to as "the least of these, my brothers and sisters".

And so I come before you today to ask that you consider the toll taken on inmates held in solitary confinement, as well as the impact on the officers and the general public of holding so many prisoners in "the hole" for such long periods of time.

During my 15 years in the legislature and the 15 years since being released from prison I have visited many ad seg units, including Pelican Bay, Folsom, San Quentin, Corcoran and San Luis Obispo in California, Angola in Louisiana, and Huntsville in Texas. I also served as a member of both the National Prison Rape Elimination Commission and the Commission on Safety and Abuse in America's Prisons. Based on all I have learned through these activities I implore you to help the corrections community and the public to rethink how many inmates we send to solitary confinement and for how long.

A particular focus of my legislative activity was aimed at assisting the mentally ill who had been placed in California's jails and prisons. In an ironic twist, I was the floor manager for the bill which authorized the construction of Pelican Bay, California's "Supermax", the first state facility in the US designed exclusively for isolating prisoners. I say my support of the bill was "ironic" because the facility was sold to the legislature as being needed to house the "worst of the worst" inmates, not for those prisoners suffering with mental illness.

The justification for the extremely high costs involved in constructing and operating the Supermax was that moving the most violent prisoners to a single facility would make the other prisons safer. Sadly, the reality has been very different.

Solitary Confinement is Not Limited to Extremely Violent Inmates. The number of extremely violent prisoners was far less than the prisons officials had estimated. These officials didn't want the legislature to find out that there were a large number of empty beds in such an expensive facility.

So, they did what any good bureaucrat would do: they filled the beds with prisoners who weren't the "worst of the worst". They widened the net to include additional categories of prisoners. They added inmates who were incorrigible (i.e. difficult to manage). Most of these are mentally ill. By definition, someone who is psychotic has difficulty understanding and following orders. These prisoners are not bad, they are sick. However, many corrections officers find them difficult to manage, and write them up for violations of policies. After several "shots" they sent them to isolation. This makes the officers' jobs easier, but it also exacerbates the underlying

mental illness of the inmates, driving them deeper and deeper into mental illness.

Frequently inmates who are discipline problems are sent to segregation units, and once there they are kept for exceedingly long periods. For instance, the Vera Institute reports that a young prisoner was caught with 17 packs of Newport cigarettes, which is contraband in a non-smoking facility. He was given a penalty of 15 days in solitary confinement for each pack of cigarettes, which resulted in him being in isolation for 8 months!

The net has also been widened with gang members, some with no record of violence in prison, and often with very little evidence of gang affiliation. The isolation of alleged gang members disproportionately affects Latino and African-American inmates. However, white power gangs are shipped to isolation as well.

And last, they have added litigious inmates. Prisoners are known for asserting novel claims, and some do it frequently. These lawsuits are irritating. By sending these vexatious litigants to isolation, prison officials can discourage them from continuing with their annoying claims. Often in the transfer to isolation the inmate's legal files get lost. This may seem like just deserts for those who abuse our legal system with absurd claims. But the problem with this whole process is that some of those inmates who irritate corrections officers were successful in the courts because they had legitimate claims. Sadly, these inmates are just as irritating to some officials as those who file bogus claims, and these legitimate claimants end up in solitary, too.

The decision to send someone to solitary is most often made with no chance for the inmates to plead their case or appeal the decision. When the decision is made to transfer an inmate to isolation they are not afforded an opportunity to let their family know where they are. This causes great anxiety. They are suddenly unable to contact their loved one, which causes deep concern that they have been stricken by a serious illness or have been badly injured. The inmate arrives at the "hole" without any of their belongings, and no money on their account to make a call or buy a stamp to let their family know where they are.

Victims of Sexual Assault Are Often Placed in Solitary. The scandal of rape in prison has begun to be addressed because of the leadership of Congress in passing the Prison Rape Elimination Act. One of the common practices that should be corrected is placing victims in "protective custody". The attacker is often left in the general population while the victim is in solitary. This is unjust. In solitary the victim loses many privileges including calls home and visits, and they are prevented from participating in education classes and religious services.

The PLRA Often Prevents Legitimate Claims from Reaching Court. The Prison Litigation Reform Act was intended to eliminate nuisance suits by prisoners. While it has certainly reduced the burden of absurd claims, it has come at a high cost. Many victims of prison rape end up without recourse as a result of the PLRA. As I mentioned before I served on the National Prison Rape Elimination Commission, and we heard distressing testimony from victims that were prevented from going to court because of artificially short deadlines imposed by prison systems. The NPREC strongly recommended that Congress amend the PLRA to take these situations into

account. I also urge you to examine the strictures of PLRA and the attendant limitations of redress for the consequences of solitary confinement. The PLRA has made it more difficult for inmates with legitimate claims to pursue them. I hope Congress will find the right balance between stopping the abuse of our courts while keeping them available for rightful claims.

Pelican Bay: A Sanitary Dungeon. I took a group of journalists into Pelican Bay. Among them was David Aikman who was formerly Senior Foreign Correspondent for Time Magazine. He was the author of three of its Person of the Year cover stories. David was appalled at what he saw, and referred to the prison as a "sanitary dungeon". The men are held in their cells for at least 22 1/2 hours a day, with only a blank wall to stare at out their cell doors. David explained, "Exercise is 90 minutes of pacing like a grief-stricken dog around the bottom of a concrete well 20 feet by 10 feet by 20 feet high with a wire grating over the top." An inmate told us that in the recreation area he had once seen a bird fly overhead - the only time he ever saw any living thing outside his unit.

Spending Years in Isolation without Being Touched by A Human Being is Unhealthy. During what often ends up as years in solitary inmates are not touched by another human being, save when they are being moved by corrections officers, at which times they are loaded down with literally pounds of manacles and shackles with guards on either side of them. As they shuffle through the cell block, the inmates avoid eye contact because they are unsure how to react to a "free person".

Other witnesses with training in psychology can explain in proper medical terms the impact that this isolation has on people, even the strongest personalities. But I can tell you my observation is that these men are deteriorating quickly. They look like whipped dogs.

Straight from Solitary to the Street. When their sentence is finished, these men who are deemed so dangerous a moment before are frog walked to the gate and released - turned loose with no preparation. That is a practice that is horribly dangerous to the public, and also frightening to the inmates.

Having had no control over any aspect of their lives, even such a small matter as when they can exercise, they are then set loose with hundreds of key decisions confronting them, such as where to sleep, where to get a meal, how to get medical care, and where to find a job, etc. etc. The list is long, with many difficult choices, and no preparation for making good choices. Hans Toch, a noted criminologist, warns that "Supermax prisons may turn out to be crucibles and breeding grounds of violent recidivism. . . . [Prisoners] may become 'the worst of the worst' because they have been dealt with as such".

No Positive Activities to Occupy the Hours. Inmates in solitary confront the twin curses of loneliness and boredom. They are seldom given access to enriching activities such as education classes or religious programs. Without positive stimulation the mind rapidly deteriorates.

For juveniles in custody, this is particularly problematic. They could benefit greatly from education classes and job preparation. Yet, juveniles in adult facilities are often kept in isolation for their own protection. However, that

protection comes at a terrible price, because the youngsters have nothing positive to help them develop critical brain functions.

The Decision to Place an Inmate in Solitary is Seldom Reviewed. While some prisoners are so dangerous that they must be separated from other prisoners, solitary confinement is not limited to those circumstances and is overused. Many prisons do not have a policy of regularly reviewing each case to determine if such isolation is necessary. This results in many prisoners remaining in solitary for long periods of time, causing deterioration of their mental condition.

The Commission on Safety and Abuse in America's Prisons devoted an entire chapter of its report to Segregation. The chapter is a thorough analysis of the overuse of segregation, and the Commission made many good recommendations for reforms. I strongly suggest that anyone studying this issue begin by reading that chapter.

Recommendations of Justice Fellowship.

1. Limit solitary confinement to cases of clear danger of violence that cannot be controlled in other settings.
2. Review each case individually each month to determine whether solitary is still appropriate. The policy should be to transfer inmates out of segregation as soon as possible. (The American Correctional Association requires such reviews in their standards for accreditation).
3. Provide opportunities for inmates in segregation to engage in productive activities, such as education, treatment, and religious programs.

4. Allow inmates in segregation to have regular and meaningful human contact.
5. Carefully review each case for mental illness before confining an inmate in isolation. Evaluate mentally ill inmates at periodic intervals, with the reviews performed by psychiatrists who are not employed by the corrections department.
6. Allow inmates to challenge the decision to send them to segregation units.
7. NEVER release inmates directly from solitary confinement to the streets. Allow gradual decompression, with increasing opportunities for the inmate to make choices.

Conclusion. It is troubling that so many inmates are held in the harsh circumstances of solitary confinement for such long periods of time without recourse and without a systematic review of their cases. The harm that such prolonged periods of isolation cause are well documented, and these policies put the public at great risk after the inmates held in isolation are released.

The Church is called to speak for those who have no voice. And we are compelled to call out for reform in the overuse of solitary confinement.

We are a better nation than to allow this to be done in our institutions. A civilized nation should not allow its people to be treated like this. Sir Winston Churchill once said that, "the mood and temper of the public in regard to the treatment of crime and criminals is one of the most unfailing tests of the civilisation of any country". By that measure we fail. However,

we have the opportunity to change the policies that cause such harm, and restore our nation to the ranks of civilized countries.

We have heard encouraging testimony from such leaders as Commissioner Epps who has shown that prisons can be peaceful and orderly without resorting to isolation of prisoners. Mr. Epps is not alone. Other state correctional administrators have courageously reformed their policies on isolation, and their prisons are safer as a result.

So, also, Congress can address the overuse of solitary confinement. Prison Rape is an example where Congress has shown leadership in addressing appalling corrections practices in the past. While many officials denied the scandal of rape in America's prisons, Congress spoke with one voice by passing the Prison Rape Elimination Act, which has already begun to change the culture in prisons from tolerating prison rape to effective prevention policies, including prosecution of those who commit it. PREA started with public hearings to call attention to the prevalence and harm of prison rape.

So also, this hearing begins the effort to reform our policies on solitary confinement. Mr. Chairman, we applaud you for calling attention to the harm that is done by overuse of solitary confinement, and we stand committed to help you press for reforms.

Reassessing Solitary Confinement:
The Human Rights, Fiscal, and Public Safety Consequences

Hearing before the Senate Judiciary Subcommittee on the
Constitution, Civil Rights, and Human Rights

June 19, 2012

Statement submitted by
The American Bar Association

For the Hearing Record

Members of the Subcommittee on the Constitution, Civil Rights, and Human Rights:

I am Thomas M. Susman, Director of the American Bar Association (ABA) Governmental Affairs Office. I am submitting this statement on behalf of the ABA for inclusion in the hearing record of the Subcommittee's hearing on June 19, 2012, "Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences."

The ABA commends the Subcommittee for its examination of the important issue. We share a growing concern with many others over what has become the prolonged solitary confinement instituted in federal and state prisons and jails. The costs—to the public fisc, to prisoners, and to the communities to which the vast majority of prisoners once isolated will return—are immense. For that reason, segregation—while occasionally necessary for safety reasons—should be imposed in the most limited manner possible. The ABA urges the Subcommittee to undertake a further investigation as to how the use of long-term solitary confinement may be restricted so as to promote the safe, efficient, and humane operation of prisons.

The Subcommittee's attention to this issue is timely. Over the past fifteen years, the use of solitary confinement has attracted growing concern due to its documented human and fiscal costs. Anthony Graves and others provided written and oral testimony about personal tolls from living in solitary confinement for extended periods. Their individual experiences—as noted in Dr. Craig Haney's testimony—find support in a variety of studies that suggest that isolation decreases brain activity and can provoke serious psychiatric harms—including severe depression, hallucination, withdrawal, panic attacks, and paranoia—some of which may be long-lasting. Some data suggest that prisoners who have spent long periods in isolation are more likely to reoffend, and many report that these prisoners have a more difficult time creating lasting social bonds that are necessary to reintegration.

These concerns have prompted a flurry of litigation over the past two decades. The Supreme Court in *Wilkinson v. Austin*, 545 U.S. 209 (2005), recognized that prisoners have a liberty

interest in avoiding placement in so-called "supermax" facilities, the severe restrictions of which represent a steep departure from typical prison conditions. While the Eighth Amendment boundaries of solitary confinement are not yet precisely drawn, a number of lower courts have held that, due to the deleterious effects of long-term isolation, administrators may not place prisoners with serious mental illness in supermax prisons. Just this past month, two more class actions have been filed challenging the placement of mentally ill prisoners in California and federal supermax prisons.

The ABA has long been committed to promoting a criminal justice system, including humane and safe prisons, that reflects American values. Since the 1960s, the ABA's multivolume Criminal Justice Standards[1] has guided the development of law and practice in the American criminal justice system. In 2004, the ABA began the work of updating its standards—last drafted in 1981—governing the treatment of prisoners. Drafters consulted with a range of institutional actors to devise a set of standards that were grounded in legal and constitutional principles, recognized the rights prisoners, and provided sufficient operational leeway for administrators' professional judgment. In February 2010, a set of ABA Standards for Criminal Justice on the Treatment of Prisoners was approved by the ABA House of Delegates.

The ABA Standards contain specific guidance as to the use of prolonged isolation and apply to all prisoners in adult correctional facilities, including jails. The standards regarding solitary confinement center around a core ideal: "Segregated housing should be for the briefest term and under the least restrictive conditions practicable and consistent with the rationale for placement and with the progress achieved by the prisoner."[2] The ABA Standards regulate various forms of segregation, including administrative and disciplinary segregation, long- and short-term. The Standards recognize that "[c]orrectional authorities should be permitted to physically separate prisoners in segregated housing from other prisoners" but stipulate that such separation "should not deprive them of those items or services necessary for the maintenance of psychological and physical wellbeing." (23-3.8) The Standards forbid in all instances "extreme isolation," which is defined to "include a combination of sensory deprivation, lack of contact with other persons, enforced idleness, minimal out-of-cell time, and lack of outdoor recreation." (23-3.8). In short, while it may be necessary physically to separate prisoners who pose a threat to others, that separation does not necessitate the social and sensory isolation that has become routine.

A broad array of reasons may justify placement in short-term segregation (23-2.6), whereas administrators should use "long-term segregated housing sparingly" and only where serious

[1] The full text of the ABA Standards is published at http://www.americanbar.org/content/dam/aba/publishing/criminal_justice_section_newsletter/crimjust_policy_midyear2010_102i.authcheckdam.pdf. Relevant standards have been reproduced in the Appendix to this Statement.

[2] AM. BAR ASS'N, ABA STANDARDS FOR CRIMINAL JUSTICE: TREATMENT OF PRISONERS intro. (3d ed. 2011), available at http://www.americanbar.org/content/dam/aba/publishing/criminal_justice_section_newsletter/crimjust_policy_midyear2010_102i.authcheckdam.pdf; *see also* Margo Schlanger, Margaret Love & Carl Reynolds, CRIMINAL JUSTICE MAGAZINE (Summer 2010).

safety concerns are at stake. (23-2.7).[3] Placement in long-term segregation requires notice and hearing (including the ability to present evidence and available witnesses) and a showing by a preponderance of the evidence that the requirements have been met. (23-2.9) Continuing segregation requires an individualized plan so that the prisoner understands what is expected, as well as meetings between administrators and the prisoner at least every 90 days. For prisoners who are placed in long-term segregation, the Standards call for the effective monitoring and treatment of their mental health needs. (23-2.8) Finally, prisoners with serious mental illness may not be placed in segregation; the Standards instead call for the development of high-security mental health housing appropriate for prisoners whose mental illness interferes with their appropriate functioning in general population.

The ABA Standards reflect a growing trend among states—especially commissioners of corrections—that are seeking alternatives to long-term isolation. As the Subcommittee heard from Mississippi Corrections Commissioner Christopher Epps, many states are finding that it is possible to reduce reliance on solitary confinement without sacrificing the safety of prison staff, other prisoners, or the public. Following a public report at the behest of the state legislature, Maine Commissioner Joseph Ponte enacted a series of reforms to reduce reliance on solitary confinement. New York enacted a law making it more difficult to put seriously mentally ill prisoners in solitary confinement. The Colorado Department of Corrections is undertaking a legislatively mandated audit of its use of segregation and alternatives thereto; the Department announced in March 2012 that it would close a 312-bed Supermax facility by early 2013. Texas and New Mexico are undertaking similar studies, and the Illinois Governor has announced that Tamms—a supermax prison—will close in the end of August 2012.

We greatly appreciate the Subcommittee's attention to this important matter.

[3] The term "long-term segregated housing" means segregated housing that is expected to extend or does extend for a period of time exceeding 30 days. AM. BAR ASS'N, ABA STANDARDS FOR CRIMINAL JUSTICE: TREATMENT OF PRISONERS, Standard 23-1.0 (o): Definitions, (3d ed. 2011).

APPENDIX

ABA Standards for Criminal Justice (Third Edition), Treatment of Prisoners (2010)

Standard 23-2.6 Rationales for segregated housing

(a) Correctional authorities should not place prisoners in segregated housing except for reasons relating to: discipline, security, ongoing investigation of misconduct or crime, protection from harm, medical care, or mental health care. Segregated housing should be for the briefest term and under the least restrictive conditions practicable and consistent with the rationale for placement and with the progress achieved by the prisoner. Segregation for health care needs should be in a location separate from disciplinary and long-term segregated housing. Policies relating to segregation for whatever reason should take account of the special developmental needs of prisoners under the age of eighteen.

(b) If necessary for an investigation or the reasonable needs of law enforcement or prosecuting authorities, correctional authorities should be permitted to confine a prisoner under investigation for possible criminal violations in segregated housing for a period no more than [30 days].

Standard 23-2.7 Rationales for long-term segregated housing

(a) Correctional authorities should use long-term segregated housing sparingly and should not place or retain prisoners in such housing except for reasons relating to:

(i) discipline after a finding that the prisoner has committed a very severe disciplinary infraction, in which safety or security was seriously threatened;
(ii) a credible continuing and serious threat to the security of others or to the prisoner's own safety; or
(iii) prevention of airborne contagion.

(b) Correctional authorities should not place a prisoner in long-term segregated housing based on the security risk the prisoner poses to others unless less restrictive alternatives are unsuitable in light of a continuing and serious threat to the security of the facility, staff, other prisoners, or the public as a result of the prisoner's:

(i) history of serious violent behavior in correctional facilities;
(ii) acts such as escapes or attempted escapes from secure correctional settings;
(iii) acts or threats of violence likely to destabilize the institutional environment to such a degree that the order and security of the facility is threatened;
(iv) membership in a security threat group accompanied by a finding based on specific and reliable information that the prisoner either has engaged in dangerous or threatening behavior directed by the group or directs the dangerous or threatening behavior of others; or
(v) incitement or threats to incite group disturbances in a correctional facility.

Standard 23-2.8 Segregated housing and mental health

(a) No prisoner diagnosed with serious mental illness should be placed in long-term segregated housing.

(b) 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 prompt 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.

(c) The mental health of prisoners in long-term segregated housing should be monitored as follows:

(i) Daily, correctional staff should maintain a log documenting prisoners' behavior.

(ii) Several times each week, a qualified mental health professional should observe each segregated housing unit, speaking to unit staff, reviewing the prisoner log, and observing and talking with prisoners who are receiving mental health treatment.

(iii) Weekly, a qualified mental health professional should observe and seek to talk with each prisoner.

(iv) Monthly, and more frequently if clinically indicated, a qualified mental health professional should see and treat each prisoner who is receiving mental health treatment. Absent an individualized finding that security would be compromised, such treatment should take place out of cell, in a setting in which security staff cannot overhear the conversation.

(v) At least every [90 days], a qualified mental health professional should perform a comprehensive mental health assessment of each prisoner in segregated housing unless a qualified mental health professional deems such assessment unnecessary in light of observations made pursuant to subdivisions (ii)-(iv).

Standard 23-2.9 Procedures for placement and retention in long-term segregated housing

(a) A prisoner should be placed or retained in long-term segregated housing only after an individualized determination, by a preponderance of the evidence, that the substantive prerequisites set out in Standards 23-2.7 and 23-5.5 for such placement are met. In addition, if long-term segregation is being considered either because the prisoner poses a credible continuing and serious threat to the security of others or to the prisoner's own safety, the prisoner should be afforded, at a minimum, the following procedural protections:

(i) timely, written, and effective notice that such a placement is being considered, the facts upon which consideration is based, and the prisoner's rights under this Standard;

(ii) decision-making by a specialized classification committee that includes a qualified mental health care professional;

(iii) a hearing at which the prisoner may be heard in person and, absent an individualized determination of good cause, has a reasonable opportunity to present available witnesses and information;

(iv) absent an individualized determination of good cause, opportunity for the prisoner to confront and cross-examine any witnesses or, if good cause to limit such confrontation is found, to propound questions to be relayed to the witnesses;

(v) an interpreter, if necessary for the prisoner to understand or participate in the proceedings;

(vi) if the classification committee determines that a prisoner is unable to prepare and present evidence and arguments effectively on his or her own behalf, counsel or some other appropriate advocate for the prisoner;

(vii) an independent determination by the classification committee of the reliability and credibility of confidential informants if material allowing such determination is available to the correctional agency;

(viii) a written statement setting forth the evidence relied on and the reasons for placement; and

(ix) prompt review of the classification committee's decision by correctional administrators.

(b) Within [30 days] of a prisoner's placement in long-term segregated housing based on a finding that the prisoner presents a continuing and serious threat to the security of others, correctional authorities should develop an individualized plan for the prisoner. The plan should include an assessment of the prisoner's needs, a strategy for correctional authorities to assist the prisoner in meeting those needs, and a statement of the expectations for the prisoner to progress toward fewer restrictions and lower levels of custody based on the prisoner's behavior. Correctional authorities should provide the plan or a summary of it to the prisoner, and explain it, so that the prisoner can understand such expectations.

(c) At intervals not to exceed [30 days], correctional authorities should conduct and document an evaluation of each prisoner's progress under the individualized plan required by subdivision (b) of this Standard. The evaluation should also consider the state of the prisoner's mental health; address the extent to which the individual's behavior, measured against the plan, justifies the need to maintain, increase, or decrease the level of controls and restrictions in place at the time

of the evaluation; and recommend a full classification review as described in subdivision (d) of this Standard when appropriate.

(d) At intervals not to exceed [90 days], a full classification review involving a meeting of the prisoner and the specialized classification committee should occur to determine whether the prisoner's progress toward compliance with the individual plan required by subdivision (b) of this Standard or other circumstances warrant a reduction of restrictions, increased programming, or a return to a lower level of custody. If a prisoner has met the terms of the individual plan, there should be a presumption in favor of releasing the prisoner from segregated housing. A decision to retain a prisoner in segregated housing following consideration by the classification review committee should be reviewed by a correctional administrator, and approved, rejected, or modified as appropriate.

(e) Consistent with such confidentiality as is required to prevent a significant risk of harm to other persons, a prisoner being evaluated for placement in long-term segregated housing for any reason should be permitted reasonable access to materials considered at both the initial and the periodic reviews, and should be allowed to meet with and submit written statements to persons reviewing the prisoner's classification.

(f) Correctional officials should implement a system to facilitate the return to lower levels of custody of prisoners housed in long-term segregated housing. Except in compelling circumstances, a prisoner serving a sentence who would otherwise be released directly to the community from long-term segregated housing should be placed in a less restrictive setting for the final months of confinement.

Standard 23-3.8 Segregated housing

(a) Correctional authorities should be permitted to physically separate prisoners in segregated housing from other prisoners but should not deprive them of those items or services necessary for the maintenance of psychological and physical wellbeing.

(b) Conditions of extreme isolation should not be allowed regardless of the reasons for a 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.

(c) All prisoners placed in segregated housing should be provided with meaningful forms of mental, physical, and social stimulation. Depending upon individual assessments of risks, needs, and the reasons for placement in the segregated setting, those forms of stimulation should include:

(i) in-cell programming, which should be developed for prisoners who are not permitted to leave their cells;
(ii) additional out-of-cell time, taking into account the size of the prisoner's cell and the length of time the prisoner has been housed in this setting;

(iii) opportunities to exercise in the presence of other prisoners, although, if necessary, separated by security barriers;
(iv) daily face-to-face interaction with both uniformed and civilian staff; and
(v) access to radio or television for programming or mental stimulation, although such access should not substitute for human contact described in subdivisions (i) to (iv).

(d) Prisoners placed in segregated housing for reasons other than discipline should be allowed as much out-of-cell time and programming participation as practicable, consistent with security.

(e) No cell used to house prisoners in segregated housing should be smaller than 80 square feet, and cells should be designed to permit prisoners assigned to them to converse with and be observed by staff. Physical features that facilitate suicide attempts should be eliminated in all segregation cells. Except if required for security or safety reasons for a particular prisoner, segregation cells should be equipped in compliance with Standard 23-3.3(b).

(f) Correctional staff should monitor and assess any health or safety concerns related to the refusal of a prisoner in segregated housing to eat or drink, or to participate in programming, recreation, or out-of-cell activity.



Written Statement of the American Civil Liberties Union Before the United States Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights

Hearing on

Reassessing Solitary Confinement:
The Human Rights, Fiscal, and Public Safety Consequences
Tuesday, June 19, 2012
at 10:00 am

The American Civil Liberties Union (ACLU) welcomes this opportunity to submit testimony to the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights for its hearing on *"Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences,"* and urges the Subcommittee to take action to curb the dangerous overuse of solitary confinement in American prisons, jails, juvenile detention centers, and other places of detention.

The American Civil Liberties Union is a nationwide, nonprofit, non-partisan organization with more than a half million members, countless additional activists and supporters, and 53 affiliates nationwide dedicated to the principles of liberty and equality embodied in our Constitution and our civil rights laws. Consistent with that mission, the ACLU established the National Prison Project in 1972 to protect and promote the civil and constitutional rights of prisoners. Since its founding, the Project has challenged unconstitutional conditions of confinement and over-incarceration at the local, state and federal level through public education, advocacy and successful litigation. The ACLU's national ***Stop Solitary*** campaign, which works to end the pervasive use of long-term solitary confinement and to divert children and persons suffering from mental disabilities and mental illness out of solitary altogether. Due to unprecedented state budget problems that are forcing a second look at the explosive growth in corrections costs, the current focus of ***Stop Solitary*** is to ensure that the public and our leaders know that the monetary cost of solitary confinement, coupled with the human cost of increased psychological suffering and sometimes irreparable harm, far outweighs any purported benefits, and that there are more effective and humane and less costly alternatives.

I. The Dangerous Overuse of Solitary Confinement in the United States

Over the last two decades corrections systems have increasingly relied on solitary confinement – even building entire institutions called "supermax" prisons, where prisoners are held in conditions of extreme isolation, sometimes for years or even decades. Although supermax prisons were rare in the United States before the 1990s, today forty-four states and the federal government have supermax units or facilities, housing at least 25,000 people nationwide.[1] But this figure does not reflect the total number of prisoners held in solitary confinement in the United States on any given day. Using data from a census of state and federal prisoners conducted by the federal Bureau of Justice Statistics, researchers estimate that over 80,000 prisoners are held in "restricted housing," including administrative segregation, disciplinary segregation and protective custody – all forms of housing involving substantial social isolation.[2]

This massive increase in the use of solitary confinement has led many to question whether it is an effective and humane use of scarce public resources. Many in the legal and medical fields criticize solitary confinement and supermax prisons as both unconstitutional and inhumane, pointing to the well-known harms associated with placing human beings in isolation and the rejection of its use in American prisons decades earlier. Indeed, over a century ago, the Supreme Court noted that:

> [Prisoners subject to solitary confinement] fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community.

In re Medley, 134 U.S. 160, 168 (1890).

Other critics point to the enormous costs associated with solitary confinement. For example, supermax institutions typically cost two or three times more to build and operate than even traditional maximum-security prisons.[3] Despite the significant costs, almost no research has been done on the outcomes produced by the increased use of solitary confinement or supermax prisons. In the research that has been conducted there is little empirical evidence to suggest that solitary confinement makes prisons safer. Indeed, emerging research suggests that supermax prisons actually have a negative effect on public safety.[4] Despite these concerns, states and the federal government have continued to invest scarce taxpayer dollars in constructing supermax prisons and enforcing solitary confinement conditions. Yet there are stark new fiscal realities facing our communities today and for the foreseeable future. Both state and federal governments confront reduced revenue and mounting debt that are leading to severe cuts in essential public services like health and education. Given these harsh new realities, it is time to ask whether we should continue to rely on solitary confinement and supermax prisons despite their high fiscal and human costs.

A. What is solitary confinement?

Solitary confinement is the practice of placing a person alone in a cell for 22-24 hours a day with little human contact or interaction; reduced or no natural light; restriction or denial of reading material, television, radios or other property; severe constraints on visitation; and the inability to participate in group activities, including eating with others. While some of the specific conditions of solitary confinement may differ between institutions, generally the prisoner spends 23 hours a day alone in a small cell with a solid steel door, a bunk, a toilet and a sink.[5] Human contact is generally restricted to brief interactions with corrections officers and, for some prisoners, occasional encounters with healthcare providers or attorneys.[6] Family visits are limited and almost all human contact occurs while the prisoner is in restraints and behind some sort of barrier.[7] Frequently prisoners subjected to solitary confinement are only allowed one visit per month.[8] ***The amount of time a person spends in solitary confinement varies, but it can last for months, years or even decades.***

Solitary confinement goes by many names whether it occurs in a supermax prison or in a separate unit within a regular prison. These separate units are often called disciplinary segregation, administrative segregation, control units, security housing units (SHU), special management units (SMU), or simply "the hole." Recognizing the definitional morass, the American Bar Association has created the following general definition of solitary confinement, which it calls "segregated housing":

> 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.[9]
>
> The term "long-term segregated housing" means segregated housing that is expected to extend or does extend for a period of time exceeding 30 days.[10]

The stated purpose of solitary confinement is to confine prisoners who have violated prison rules or prisoners who are considered too dangerous to house with others. It is also sometimes used to confine prisoners who are perceived as vulnerable, such as youths, the elderly, the medically frail, or

individuals identified as lesbian, gay, bisexual, transgender or intersex (LGBTI), or otherwise gender non-conforming.

B. ***The detrimental effects of solitary confinement***

Solitary confinement is well recognized as painful and difficult to endure. "It's an awful thing, solitary," U.S. Senator John McCain wrote of his time in isolation as a prisoner of war in Vietnam. "It crushes your spirit and weakens your resistance more effectively than any other form of mistreatment."[11] Senator McCain's experience is consistent with the consensus among researchers that solitary confinement is psychologically harmful.[12] For example, in their amicus brief in the Supreme Court case *Wilkinson v. Austin*, a group of nationally recognized mental health experts summarized the clinical and research literature and concluded: "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".[13] After their review of the clinical and research materials, the experts noted that "[t]he overall consistency of these findings – the same or similar conclusions reached by different researchers examining different facilities, in different parts of the world, in different decades, using different research methods – is striking." [14]A California prison psychiatrist summed it up more succinctly: "It's a standard psychiatric concept, if you put people in isolation, they will go insane. . . . Most people in isolation will fall apart."[15]

People subject to solitary confinement exhibit a variety of negative physiological and psychological reactions, including: hypersensitivity to external stimuli;[16] perceptual distortions and hallucinations;[17] increased anxiety and nervousness;[18] revenge fantasies, rage, and irrational anger;[19] fears of persecution;[20] lack of impulse control;[21] severe and chronic depression;[22] appetite loss and weight loss;[23] heart palpitations;[24] withdrawal;[25] blunting of affect and apathy;[26] talking to oneself;[27] headaches;[28] problems sleeping;[29] confusing thought processes;[30] nightmares;[31] dizziness;[32] self-mutilation;[33] and lower levels of brain function, including a decline in EEG activity after only seven days in solitary confinement.[34] In addition to increased psychiatric symptoms generally, suicide rates and incidents of self-harm are much higher for prisoners in solitary confinement. In California, for example, although less than 10% of the state's prison population was held in isolation units in 2004, those units accounted for 73% of all suicides.[35] One study examined the impact of solitary confinement on the amount of time that passes between incidents in which prisoners harm themselves.[36]

C. Mentally ill people are dramatically overrepresented in solitary confinement

There is a popular misconception that all prisoners in solitary confinement are violent, dangerous, and disruptive, or the "worst of the worst."[37] But any prison system only has a handful of prisoners that actually meet this description. If the use of solitary confinement were restricted solely to the dangerous and predatory, most supermax prisons and isolation units would stand virtually empty. The reality is that solitary confinement is overused and misused. One reason is that elected officials pushed to build solitary confinement facilities based on a desire to appear "tough on crime," rather than actual need as expressed by corrections professionals.[38] As a result, many states built large supermax facilities they didn't need, and now fill the cells with relatively low-risk prisoners.[39]

Who are the thousands of people who end up in solitary confinement? The vast majority are not incorrigibly violent criminals; instead, many are severely mentally ill or cognitively disabled prisoners, who find it difficult to function in prison settings or to understand and follow prison rules.[40]

For example, in Indiana's supermax, prison officials admitted that "well over half" of the prisoners are mentally ill.[41] On average, researchers estimate that at least 30% of the prisoners held in solitary confinement are mentally ill.[42]

Solitary confinement is psychologically difficult for even relatively healthy individuals, but it is devastating for those with mental illness. When people with severe mental illness are subjected to solitary confinement they deteriorate dramatically. Many engage in bizarre and extreme acts of self-injury and suicide. It is not unusual for prisoners in solitary confinement to compulsively cut their flesh, repeatedly smash their heads against walls, swallow razors and other harmful objects, or attempt to hang themselves. In Indiana's supermax, a mentally ill prisoner killed himself by self-immolation; another man choked himself to death with a washcloth.[43] Such incidents are all too common in similar facilities across the country. These shattering impacts of solitary confinement are so well-documented that federal courts have repeatedly held that placing the severely mentally ill in such conditions is cruel and unusual punishment under the Eighth Amendment to the Constitution.[44]

D. Children are also subjected to the damaging effects of solitary confinement

Youth in both the juvenile justice system and the adult correctional system are routinely subjected to solitary confinement. In adult prisons and jails, youth are often placed in "protective custody" by corrections officials for safety reasons. Unfortunately, "protective custody" is almost always synonymous with solitary confinement. Despite the prevalence of youth in adult facilities in the United States, most adult correctional systems offer few if any alternatives to solitary confinement as a means of protecting youth.[45] As a result, they may spend weeks, months or years in solitary confinement. In juvenile facilities, solitary confinement is frequently used as a sanction for disciplinary infractions. These sanctions can last for hours, days, weeks or longer, and often open the door to abusive isolation practices.[46] While the use of solitary confinement in youth facilities is generally of much shorter duration than in adult facilities, the greater impact of isolation on the psyche of children and its negative effect on youth development—and ultimately, rehabilitation—raise serious legal and moral questions about current practices.

Children have special developmental needs and are even more vulnerable to the harms of prolonged isolation than adults.[47] Young people's brains are still developing, placing youth at higher risk of psychological harm when healthy development is impeded.[48] Children experience time differently than adults, and have a special need for social stimulation.[49] And youth frequently enter the criminal justice system with histories of substance abuse, mental illness and childhood trauma, which often go untreated in isolation, exacerbating the harmful effects of solitary confinement.[50] A serious and tragic consequence of the solitary confinement of youth is the increased risk of suicide and self-harm, including cutting and other acts of self-mutilation. In juvenile facilities more than 50% of all youth suicides occur in isolation.[51] For youth in adult jails the suicide rates are even higher. Suicides of youth in isolation occur nineteen times more often than in the general population; youth suicide rates are thirty-six times higher in adult jails than in juvenile detention facilities.[52] At the same time, youth in isolation are routinely denied minimum education, mental health, treatment, and nutrition,[53] which directly affects their ability to successfully re-enter society and become productive adults.[54]

For these reasons, efforts are underway to end this practice. Legislators in some states, like California, have introduced legislation to limit solitary confinement of youth,[55] while other states have raised the age at which children may be charged as adults.[56] This month the Department of

Justice issued national standards under the Prison Rape Elimination Act (PREA) stating that "[a]s a matter of policy, the Department supports strong limitations on the confinement of adults with juveniles."[57] As part of these standards the Department has recognized the dangers of placing children in solitary and mandated that facilities make "best efforts" to avoid isolating them.[58] Internationally, the United Nations Special Rapporteur on Torture has called for a global ban on the solitary confinement of children under 18.[59]

E. Vulnerable LGBTI prisoners and immigration detainees are too often placed in solitary confinement

For prisoners and detainees who are lesbian, gay, bisexual, transgender, have intersex conditions (LGBTI), or are gender nonconforming, solitary confinement is too often the correctional management tool used to separate them from the general population. This problem has now been recognized in the Department of Justice's recently finalized PREA regulations.[60] Among other provisions, the new regulations include measures to prevent the use of segregation and solitary confinement in correctional facilities. While correctional officials often justify the use of solitary confinement as necessary protection for vulnerable LGBTI prisoners, the stigmatizing effect of this practice can cause significant harm. For example, untreated gender identity disorder (GID) and denial of medically necessary care for those who are transgender often results in depression and suicidal ideation, among other symptoms, which are made significantly worse by forced segregation and isolation. The new PREA regulations recognize that solitary confinement for LGBTI prisoners can be psychologically damaging and physically dangerous.[61] At this time, however, such isolation remains broadly practiced by corrections facilities and places of detention nationwide.

Increasingly, concerns have also been raised about the placement of vulnerable prisoners in segregation in immigration detention facilities around the country. In May 2012, the American Civil Liberties Union Foundation of Georgia (ACLU of Georgia) released a report on the four immigration detention facilities in Georgia titled *Prisoners of Profit: Immigrants and Detention in Georgia.*[62] The report covers the largest immigration detention facility in the United States, the Stewart Detention Center, as well as the North Georgia Detention Center (NGDC), Irwin County Detention Center, and Atlanta City Detention Center (ACDC). The report's findings raise serious concerns regarding violations of detainees' rights, including the placement of individuals with mental disabilities in segregation units and the failure to provide adequate mental health care.[63]

F. Solitary confinement is inconsistent with international human rights principles

The U.N. Committee Against Torture, the official body established pursuant to the Convention Against Torture – a treaty ratified by the United States – has recommended that the practice of long-term solitary confinement be abolished altogether and has particularly criticized solitary confinement practices in the United States.[64] Moreover, in a groundbreaking global study on solitary confinement, presented last year to the United Nations General Assembly, the U.N. Special Rapporteur on Torture called on all countries to ban the practice, except in very exceptional circumstances, as a last resort, and for as short a time as possible. The Special Rapporteur concluded that solitary confinement is a harsh measure that may cause serious psychological and physiological adverse effects. He found that solitary confinement can amount to cruel, inhuman or degrading treatment or punishment and even torture. He recommended both the prohibition of solitary confinement as punishment and the implementation of alternative disciplinary sanctions. He also called for increased safeguards from abusive and prolonged

solitary confinement, the universal prohibition of solitary confinement exceeding 15 days, and the discontinuance of solitary confinement for juveniles and mentally disabled persons.[65]

II. Solitary Confinement is Costly and Jeopardizes Public Safety

Despite its pervasive use in U.S. prisons, jails, youth facilities and detention centers, there is little evidence on the utility or cost-effectiveness of solitary confinement as a corrections tool.[66] In particular, there is little evidence that solitary confinement, supermax institutions or administrative segregation units significantly reduce prison violence or deter future crimes.[67]A 2006 study found that opening a supermax prison or special housing unit (SHU) had no effect on prisoner-on-prisoner violence in Arizona, Illinois and Minnesota.[68] The same study found that creating such isolation units had only limited impact on prisoner-on-staff violence in Illinois, none in Minnesota, and actually increased violence in Arizona.[69] A similar study in California found that supermax or administrative segregation prisons had increased rather than decreased violence levels.[70]

Some proponents of solitary confinement assert that isolating "the worst of the worst" creates a safer general population environment where prisoners will have greater freedom and access to educational and vocational programs.[71] Others defend solitary confinement as a general deterrent of disruptive behavior throughout the prison system.[72] However, there is only anecdotal support for these beliefs.[73] Indeed, some researchers have concluded that more severe restrictions imposed on prisoners in solitary confinement increase levels of violence and other behavioral and management problems.[74]

Although there is little empirical evidence that solitary confinement is an effective prison management tool, there is ample evidence that it is the most costly form of incarceration. Supermax prisons and segregation units are considerably more costly to build and operate, sometimes costing two or three times as much as conventional facilities.[75] Staffing costs are much higher – prisoners are usually required to be escorted by two or more officers any time they leave their cells, and work that in other prisons would be performed by prisoners (such as cooking and cleaning) must be done by paid staff. Solitary confinement therefore represents an enormous investment of public resources. For example, a 2007 estimate from Arizona put the annual cost of holding a prisoner in solitary confinement at approximately $50,000 compared to only about $20,000 for the average prisoner.[76] In Maryland, the average cost of housing a prisoner in the state's segregation units is three times greater than in a general population facility; in Ohio it is twice as high; and in Texas the costs are 45% greater.[77] In Connecticut the cost of solitary is nearly twice as much as the average daily expenditure per prisoner;[78] and in Illinois it is three times the statewide average.[79]

Not only is there little evidence that the enormous outlay of resources for these units makes prisons safer, there is growing concern that such facilities are actually detrimental to public safety. A blue ribbon commission chaired by the Hon. John J. Gibbons and Nicholas de B. Katzenbach raised concerns regarding the overuse of solitary confinement, particularly the practice of releasing prisoners directly from segregation settings to the community.[80] One study of prisoners held in solitary confinement noted that such conditions may "severely impair . . . the prisoner's capacity to reintegrate into the broader community upon release from imprisonment."[81] The pervasive use of solitary confinement means that thousands of prisoners are now returning to the community after spending months or years in isolation. This means that society must face the huge problem of re-socializing individuals who are poorly prepared to return safely to the community.

In most systems, many prisoners in solitary confinement are released directly to the community. In California, for example, nearly 40% of segregated prisoners are released directly to the community without first transitioning to lower security units.[82] Colorado also releases about 40% of its supermax population directly to the community.[83] Mental health experts have noted the problems with direct release from isolation and called for prerelease programs to help prisoners held in solitary confinement transition to the community more safely.[84]

Although there is not yet comprehensive national research comparing recidivism rates for prisoners released directly from solitary with those released from general population, preliminary research in California suggests that the rates of return to prison are at least 20% higher for solitary confinement prisoners.[85] Similarly in Colorado, two-thirds of prisoners in solitary confinement who were released directly to the community returned to prison within three years, but prisoners who transitioned from solitary confinement into the general prison population before community re-entry experienced a six percent reduction in their comparative recidivism rate for the same period.[86]

A 2001 study found that 92% of Connecticut prisoners who had been held at the state's supermax prison were rearrested within three years of release, while only 66% of prisoners who had not been held in administrative segregation were rearrested in the same time period.[87] These findings are consistent with a recent study in Washington State that tracked 8,000 former prisoners upon release. The study found that not only were those who came from segregation housing more likely to commit new offenses upon release, they were also more likely to commit violent crimes. Significantly, it was prisoners released directly from segregation who had much higher recidivism rates compared to individuals who spent time in a conventional prison setting before return to the community (64% compared with 41%).[88] This finding suggests a direct link between recidivism and the extreme and debilitating conditions in segregation.[89]

III. There are Better Alternatives to Solitary Confinement

A growing number of states have taken steps, either independently or because of litigation, to regulate the use of solitary confinement for both disciplinary and non-disciplinary reasons. These steps have been taken for several reasons, including the human and fiscal costs of solitary confinement, concern for public safety, and the lack of empirical evidence to support the practice. As a recent *New York Times* article explains, these measures represent an "about face" from the routine use of solitary confinement.[90] Below we briefly discuss some of the states beginning to address the overuse of solitary confinement in the last few years.

In March 2011, the **Maine** Department of Corrections recommended tighter controls on the use of special management units (SMUs). Due to subsequent reforms, the SMU population was cut by over fifty percent; expanded access to programming and social stimulation for prisoners was implemented; and personal approval of the Commissioner of Corrections is now required to place a prisoner in the SMU for longer than 72 hours.[91]

Over the last few years **Mississippi** has also revolutionized its use of solitary confinement. In the process, the state reduced the segregation population of one institution from 1000 to 150 and eventually closed the entire unit.[92] Prison officials estimate that diverting prisoners from solitary confinement under Mississippi's new model saves about $8 million annually.[93] At the same time, changes in the management of the solitary confinement population reduced violence levels by 70%.[94]

State legislatures have also addressed the problems created by the overuse of solitary confinement and its damaging effects on the mentally ill. For example, **New York** passed a law that excludes the seriously mentally ill from solitary confinement; requires periodic assessment and monitoring of the mental status of all prisoners subject to solitary confinement for disciplinary reasons; creates a non-disciplinary unit for prisoners with psychiatric disabilities where a therapeutic milieu is maintained and prisoners are subject to the least restrictive environment consistent with their needs and mental status; and requires that all staff be trained to deal with prisoners with mental health issues.[95]

Several states, including Colorado, Michigan, Illinois, New Mexico, Virginia and Texas, have recently initiated other reforms.

- In 2011, the **Colorado** Legislature required a review of administrative segregation and reclassification efforts for prisoners with mental illness or developmental disabilities.[96] At the same time, the Colorado Department of Corrections (CDOC) identified administrative segregation reform as a management priority and made a formal request to the National Institute of Corrections, U.S. Department of Justice, for an external review and analysis of its administrative segregation operations. As a result of the reforms implemented through this process in the last few months, CDOC has reduced its administrative segregation population by 36.9%.[97] After taking these steps to reduce the use of administrative segregation, the CDOC recently announced the closure of a 316-bed supermax facility, which is projected to save the state $4.5 million in Fiscal Year 2012-13 and $13.6 million in Fiscal Year 2013-14.[98]
- Correctional leaders in **Michigan** have recently reformed administrative segregation practices through incentive programs that have reduced the length of stays in isolation, the number of prisoners subject to administrative segregation, and the number of incidents of violence and other misconduct. Reduction in segregation has produced better prisoner outcomes at less cost; segregation in Michigan costs nearly double what the state typically pays to incarcerate each prisoner.[99]
- In **New Mexico** the state legislature mandated a study on solitary confinement's impact on prisoners, its effectiveness as a prison management tool, and its costs.[100] The Lieutenant Governor of **Texas** similarly commissioned a study on the use of administrative segregation in the Texas Department of Criminal Justice, including the reasons for its use, its impact on public safety and prisoner mental health, possible alternative prison management strategies, and the need for greater reentry programming for the population.[101] The **Virginia** Senate passed a joint resolution mandating a legislative study on alternative practices to limit the use of solitary confinement, cost savings associated with limiting its use, and the impact of solitary confinement on prisoners with mental illness, as well as alternatives to segregation for such prisoners.[102] Recently, the Governor of **Illinois** announced a proposal to close the state's notorious supermax prison, Tamms Correctional Center. The closure of Tamms will reportedly save $21.6 million in the upcoming fiscal year and $26.6 million annually thereafter.[103]

Finally, in recognition of the inherent problems of solitary confinement, the **American Bar Association** recently approved standards to reform its use. The ABA's *Standards for Criminal Justice, Treatment of Prisoners* address all aspects of solitary confinement (the Standards use the term "segregated housing").[104] The solutions presented in the Standards represent a consensus view of

representatives of all segments of the criminal justice system who collaborated exhaustively in formulating the final ABA Standards.[105]The following illustrate some of those solutions:

a. Provide adequate and meaningful process prior to placing or retaining a prisoner in segregation to be sure that segregation is warranted. (ABA Treatment of Prisoners Standard 23-2.9 [hereinafter cited by number only])
b. Limit the duration of disciplinary segregation — in general, stays should be brief and should rarely exceed one year. Longer-term segregation should be imposed only if the prisoner poses a continuing and serious threat. Segregation for protective reasons should take place in the least restrictive setting possible. (23-2.6, 23-5.5)
c. Decrease extreme isolation by allowing for in-cell programming, supervised out-of-cell exercise time, face-to-face interaction with staff, access to television or radio, phone calls, correspondence, and reading material. (23-3.7, 23-3.8)
d. Decrease sensory deprivation by limiting the use of auditory isolation, deprivation of light and reasonable darkness, punitive diets, etc. (23-3.7, 23-3.8)
e. Allow prisoners to gradually gain more privileges and be subject to fewer restrictions, even if they continue to require physical separation. (23-2.9)
f. Refrain from placing prisoners with serious mental illness in segregation. Instead, maintain appropriate, secure mental-health housing for such prisoners. (23-2.8, 23-6.11)
g. Carefully monitor prisoners in segregation for mental health deterioration and deal with deterioration appropriately if it occurs. (23-6.11)

IV. Recommendations

The ACLU urges the Subcommittee to take steps to end the overuse of solitary confinement in the United States. A necessary first step toward reforming this practice and promoting a safer, more humane, and more cost-effective criminal justice system is to promote transparency in segregation practices at the local, state, and federal level. There is currently no requirement that correctional systems explain to the public who is placed in isolation; why they are placed in isolation; the conditions they are subject to while in isolation; how long they remain there; and what they can do to work their way out. Simply subjecting solitary confinement practices to public scrutiny would empower citizens, taxpayers, lawmakers, and correctional officials to make informed choices about the use of segregation, and would promote greater accountability for practices that too often have been shrouded in secrecy and therefore subject to abuse.

The ACLU also urges the Subcommittee to take steps to ensure that children under the age of 18 and persons with mental illness are not subject to solitary confinement in local, state or federal places of detention. These steps would bring segregation practices closer to compliance with both U.S. Constitutional law and international human rights standards, as well as established psychiatric and child development research.

Finally, the ACLU urges the Subcommittee to promote adoption of the ABA's *Standards for Criminal Justice, Treatment of Prisoners* related to the use of "segregated housing" as guidelines for all policies and practices related to the use of solitary confinement in places of detention under the jurisdiction of the federal government.

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Reassessing Solitary Confinement:
The Human Rights, Fiscal, and Public Safety Consequences
Hearing Before the Senate Judiciary Subcommittee on the
Constitution, Civil Rights, and Human Rights

June 19, 2012

Statement submitted by
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Dear Committee Members:

The American Civil Liberties Union of Connecticut applauds the Committee's attention to this important matter. The ACLU of CT receives dozens of letters each year from prisoners at Northern Correctional Institution, Connecticut's supermax prison. These letters describe the acute distress, as well as the hopes, of the men, some of whom have been confined in isolation for more than a decade.

We wish to provide a brief statement by Malcolm Rahmeen, who was incarcerated at Northern from December 2010 until his release in March 2012. Mr. Rahmeen, who has a long and documented history of depression, suicide attempts, and substance abuse, attempted suicide three times during his stay at Northern. We are glad to report that the Department of Correction has begun to make reforms to its classification system, leading to some reduction in the number of people held at Northern. Nonetheless, many prisoners remain in conditions similar to those described below, and Mr. Rahmeen's words stand as a testament to the grave harms that prolonged social and sensory deprivation entail, as well as to the human spirit needed to overcome them.

> Since my confinement at Northern Correctional Institution began, I have seen and heard enough of the negative and destructive to last me, or any man, a lifetime. I was first transferred to Northern on 12/03/10. Northern is Connecticut's supermax Prison, where inmates are generally in solitary confinement, in what is called the Administrative Segregation Program, or ASP. The Administrative Segregation Program (ASP) at Northern is a minimum of 305 days in duration, or 7,200 hours. Out of 7,200 hours, ASP prisoners spend 6,807 hours in a 7 x 12 foot cell. Less than 20 of these 7,200 hours are dedicated to any sort of rehabilitation-related programming.

ASP prisoners are afforded only a small view of the outside world for this period—through a 3 foot by 5 inch slit in their cells. That's it. We were not allowed to have or watch any TV. To exit the cell for exercise, phone calls, or visits, the ASP population at Northern must endure cavity searches. While in "Phase One" of the ASP, a prisoner is required to bathe with iron "Smith and Wesson" shackles clamped on his ankles. During my time at Northern, I estimate that approximately 40% of the prisoners on my unit were in single cell isolation for *twenty-three* hours a day.

To this day, I do not understand why I was forced to endure those many months at Northern. I was classified as a level 5, which is the highest and considered the most dangerous score in the CDOC. I never assaulted a CDOC employee. I never assaulted a prisoner in the CDOC. I never set fire, tried to escape or was ever charged with possessing contraband while in the CDOC. I never destroyed state property while in the CDOC, save for two incidents while I was on suicide watch placement.

On December 11, 2010, just 8 days after I had arrived at Northern, I was placed on suicide watch. I was placed in Cell 101 on Cell Block 1, in a "strip cell", which is no different from a regular cell, save for the top iron bunk bed and the table-stool unit being removed. On suicide watch, we were often left in handcuffs, shackles, tether-chain and pad-lock, for hours and sometimes days on end. The cell was freezing, and it was impossible to properly use the toilet or feed ourselves. After being placed on suicide watch in Cell 101, I was placed on this "in-cell restraint" status, for 24 hours unprotected.

Shortly after this, I witnessed an incident that traumatized me, and truly impressed upon me the conditions at Northern. In February of 2011, I watched a prisoner as he started bashing his head against his cell door window. That man was suffering and had been completely denied the mental health care he needed; he was depressed and hurt, he needed someone to understand. So it seemed to me then, when he started banging his head, that it was more like a cry for help—BOOM, BOOM, BOOM! However, he started to gather rhythm; he gritted his teeth—BOOM, BOOM, BOOM, BOOM! And I realized that he was self-sedating. The physical pain was quickly becoming preferable to the psychological and emotional pain. I watched him in his agonizing bliss as his tears mixed with blood from his wound.

A prison guard had been by earlier and had seen the prisoner hurting himself, but there was no injury then so the guard kept going. Now he stopped; I could tell by the guard's profile that for just a brief second he softened and humanity was coming through, but just as quickly as it came it went, and he walked away as if those streams of blood were water. While he walked past my cell I asked him to help the prisoner—he said, "It's just a little blood."

In March 2011, I again attempted suicide by hanging. That time, my cries for help were met with a "cell extraction." Guards rushed into my cell, beat me, and sprayed mace in my face. Following this, I was taken to yet another "strip cell," placed again on suicide watch, in the same mace covered restraints. I remained hogtied in chains like this for 72 hours. A third suicide attempt in May 2011 met with a similar response. On all three occasions, my days-long confinement in the "strip cell" only exacerbated my mental condition.

At one point, I angrily protested to a corrections officer that "no human being should be treated this way". He responded, "That's even considering you are a human being."

I saw other prisoners accept this notion that they were, or had been made, less than human, and attempt to end their own lives.

This should come as no surprise. Can less than 20 hours of group programs compensate for 6,807 hours of social isolation and reduced environmental stimulation, as well as the repressive cavity and other search and restraint policies? Is this current curriculum prudent, and in its current state, is it worth the communities' tax dollars and resources? Does the said amount of isolation and sensory deprivation pose a risk to the mental health of its subjects, and thereby, the community at large once these individuals are released directly from that tiny cell into your neighborhood? You cannot isolation chaos and expect rehabilitation.

When prisoners are smearing their blood and feces on walls, eating food out of their toilets; when they are swallowing pens, overdosing, asphyxiating, cutting, and hanging themselves, one should begin, *at the very least,* to do a thorough evaluation to find out what and put in place the reforms needed.

As a man of many mistakes, but even greater dreams and hopes, I am compelled to declare—out of the isolation that enveloped me—that it is time for institutions like Northern to be reformed. I believe in the American ideals of equality and individual dignity, and I know we can—and must—do better.

Thank you for the opportunity to be heard.

Respectfully submitted,

David McGuire
Staff Attorney



Written Statement of the
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Senate Judiciary Subcommittee on the
Constitution, Civil Rights, and Human Rights

June 19, 2012

Reassessing Solitary Confinement:
The Human Rights, Fiscal, and Public Safety Consequences

Chairman Durbin, Ranking Member Graham, and Distinguished Members of the Subcommittee:

The American Civil Liberties Union of Maine ("ACLU of Maine") appreciates the opportunity to provide testimony to you on this critical issue. We are one of the ACLU's 53 state affiliates, and reform of the use of solitary confinement is one of our top priorities. We advocate in the legislature, in the courts, and in the court of public opinion for the civil and human rights of the people of Maine.

Maine Represents An Example of What Is Possible

As a result of over five years of advocacy by the ACLU of Maine and our colleagues, and leadership from our current Department of Corrections Commissioner, Maine has reduced the population of its solitary confinement "Special Management Unit" by over 70%. Prisoners who do end up in solitary confinement spend less time there, are treated like human beings while there, and are shown a clear path to reentry back into the general prison population. All of this has been accomplished without compromising the safety of prison staff or other prisoners, and with significant cost and resource savings to the prison. Maine represents a model for what is possible in solitary confinement reform—a rebuttal to everyone who tells you that this reform cannot or should not be done. We heard these objections as well, and we write today to tell you that they are not credible.

An Intolerable Situation

In Maine, prior to 2010, solitary confinement meant isolation alone in a 86 square foot cell, with limited natural lighting, for 23 hours per day during the week, and 24 hours per day on the weekends. The only break in this monotony of isolation was one hour of outdoor exercise (only on weekdays) alone in a small yard, though for much of the year in Maine outdoor exercise is not an attractive proposition. Other than fleeting interactions with correction staff, prisoners had no human contact during their stays in the Special Management Unit. They did not even have access to radios or television, which could have provided some proxy for human contact. The cell doors in Maine's Special Management Unit are too thick to allow conversations among prisoners. Medical and mental health screenings were sporadic and brief—often conducted through the cell door—and record keeping was inconsistent.

The impact of this lack of human contact was clear. Prisoners frequently exhibited symptoms of serious mental illness, even in cases when no such symptoms had previously manifested.

The purported justifications for subjecting prisoners to isolation varied widely, and the nexus between such treatment and any legitimate penological goals was often impossible to discern. For example, prisoners at the Maine State Prison could be sent to the Special Management Unit for "disciplinary segregation"—as punishment for an assortment of rule violations from the serious (fighting) to the trivial (moving too slowly in the lunch line). And, despite the seriousness of solitary confinement, prisoners in disciplinary hearings were rarely provided assistance understanding the process or a meaningful opportunity to present a defense.

Other prisoners were sent to the Special Management Unit for "administrative segregation". In the event of a fight, for example, the prison might send both the aggressor and the victim to the Special Management Unit while the matter was investigated. The timeline for investigation was vague, and the depth and quality were suspect. A prisoner might spend days, weeks, or months in the Special Management Unit as a result of being attacked by another prisoner. Even after a prisoner had completed a term of disciplinary isolation or been adjudged the victim rather than the aggressor in a fight, a prisoner might remain in solitary confinement for additional days, weeks, or months because of a shortage of beds in the general population units.

In some cases, prisoners were released straight out of the Special Management Unit onto the streets of Maine communities. Because of the destabilizing effects of isolation, releasing someone back into life on the "outside" abruptly and with no support leads to difficulty for both the former prisoner and the community. The cost of this practice was spread among family members, community members, and taxpayers who pay for court and corrections costs in the event of recidivism.

In short, there were problems with Maine's Special Management Unit at all stages: the way that prisoners were sent there, the way they were treated while there, and when and how they were released.

The Effects of Long-Term Isolation

These were serious problems—constitutional problems—because of the effects that long-term isolation has on a person's mind. The Eighth Amendment to the United States Constitution prohibits the infliction of "cruel and unusual punishments," and isolating people until they start hearing voices, losing touch with reality, sinking into depression, and losing the ability to cope is most certainly cruel. You will receive testimony submitted by those who have suffered solitary confinement, and we trust that you will give it considerable weight though you will, no doubt, find some of the stories difficult to believe. It is difficult to accept that we subject our fellow human beings to such brutal treatment: difficult, but necessary. Solitary confinement inflicts punishment that can cause even previously healthy people to become desperate to die.

Psychiatrists and psychologists who study prisoners and prison systems have documented these effects. A number of these studies were summarized in an article by Dr. Atul Gawande, entitled *Hellhole*, which appeared in in *The New Yorker* magazine in March 2009.[1] The piece fueled the desire in Maine to initiate change to reduce the use of solitary confinement for healthy prisoners, ban its use for prisoners with serious mental illness, and impose increased regulation, oversight and due process. Dr. Gawande documented some of the more horrific examples of solitary confinement and its effects from across the country, and he also noted that America embraces this form of punishment far in excess of any other country. He specifically noted that there were more prisoners in solitary confinement in Maine (population 1.2 million) than in England (population 50 million). Mainers did not appreciate this notoriety and set out to do something about it.

In 2010, Mainers mobilized around legislation to reduce and reform the use of solitary confinement, and experts from around the country joined in the effort. One well-know expert, Dr. Stuart Grassian, testified before the Maine Legislature that "restrictions on environmental and social stimulation has a profoundly deleterious effect on mental functioning."[2] Dr. Grassian also noted the following:

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[1] Atul Gawande, *Hellhole*, THE NEW YORKER, March 30, 2009.

[2] *An Act to Ensure Humane Treatment for Special Management Prisoners Testimony: Hearing on LD 1611 before the Joint Committee on Criminal Justice and Public Safety*, 124th Maine Legislature (February 17, 2010) (statement of Stuart Grassian, M.D.).

> [D]eprived of a sufficient level of environmental and social stimulation, individuals will soon become incapable of maintaining an adequate state of alertness and attention to the environment. Indeed, even a few days of solitary confinement will predictably shift the electroencephalogram (EEG) pattern towards an abnormal pattern characteristic of stupor and delirium.[3]

Dr. Grassian concluded:

> Institutions like the SMU [Maine's Special Management Unit] 'look' good; they make it seem like we are 'getting tough on crime'. But in reality, we are getting tough on ourselves. 95% of all incarcerated individuals are eventually released, some directly out of SMU settings. We have succeeded in making those individuals as sick, as internally chaotic, as we possibly can.[4]

Another highly-regarded expert, Dr. Terry Kupers, also testified before the Maine legislature that segregation systems like Maine's are inhumane: "Human beings require some degree of social interaction and productive activity to establish and sustain a sense of identity and to maintain a grasp on reality."[5]

In their testimony, both Dr. Grassian and Dr. Kupers emphasized that isolation does not need to be complete in order to be dangerously debilitating; it is the absence of "meaningful" social interaction that destroys a person's ability to cope. The occasional site of a guard or sound of a distant human voice does not qualify, and the increased use of modern technology (surveillance cameras, timed lights, and remote locks) in Maine and elsewhere have only added to prisoners' isolation.

At the legislative hearing, representatives from the Maine Psychological Association and the Maine Association of Psychiatric Physicians echoed Dr. Grassian's and Dr. Kupers's conclusion that long-term isolation is incompatible with basic human needs. The Maine Psychological Association observed that most prisoners held in long-term isolation for longer than 3 months

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[3] *Id.*
[4] *Id.*
[5] *An Act to Ensure Humane Treatment for Special Management Prisoners Testimony: Hearing on LD 1611 before the Joint Committee on Criminal Justice and Public Safety*, 124th Maine Legislature (February 17, 2010) (statement of Terry Kupers, M.D., M.S.P.).

"experience lasting emotional damage if not full-blown psychosis and functional disability."[6] In all, twenty-nine witnesses testified in support of legislation to limit the use of solitary confinement in Maine—doctors, ministers, lawyers, professors, former prisoners, family members, and many others. Twenty-nine witnesses may not sound like that many from the perspective of the United States Senate, but for a small state like Maine it indicates high level of support.

A Human Rights Problem of a Constitutional Dimension

The ACLU of Maine helped organize the support for the reform bill because we believed that the policies and practices at the Maine State Prison Special Management Unit violated the Constitution. Punitive isolation can violate the Eighth Amendment's prohibition of cruel and unusual punishment,[7] as can psychological harm from lack of meaningful social contact.[8]

There is increasing judicial consensus that placement of seriously mentally ill prisoners in segregated confinement violates the Constitution because it predictably leads to severe pain and suffering.[9] In fact, every federal court that has considered the issue has found that holding individuals with serious mental illness in isolated confinement with limited social interaction amounts to cruel and unusual punishment.[10] The basis of these rulings is the understanding that,

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[6] *An Act to Ensure Humane Treatment for Special Management Prisoners Testimony: Hearing on LD 1611 before the Joint Committee on Criminal Justice and Public Safety*, 124th Maine Legislature (February 17, 2010) (statement of Sheila Comerford, Executive Director, Maine Psychological Association).

[7] *Hutto v. Finney*, 437 U.S. 678, 685 (1978) (finding that evidence sustained finding that conditions in isolation cells violated prohibition against cruel and unusual punishment, and district court had authority to place maximum limit of 30 days on confinement in isolation cells).

[8] *Ruiz v. Johnson*, 37 F. Supp. 2d 855 (S.D. Tex. 1999).

[9] *See id.* at 915 (S.D. Tex. 1999) ("[c]onditions in TDCJ-ID's administrative segregation units clearly violate constitutional standards when imposed on the subgroup of the plaintiff's class made up of mentally-ill prisoners"); *Coleman v. Wilson*, 912 F.Supp. 1282, 1320-21 (E.D. Cal. 1995); *Langley v. Coughlin*, 715 F. Supp. 522, 540 (S.D.N.Y. 1988) (holding that evidence that prison officials fail to screen out from SMU "those individuals who, by virtue of their mental condition, are likely to be severely and adversely affected by placement there" states an Eighth Amendment claim).

[10] For example, in *Jones 'El v. Berge*, 164 F. Supp. 2d 1096 (W.D. Wis. 2001), a court ordered a Wisconsin prison to remove all individuals with serious mental illness from the Supermax and, further, to monitor the mental health status of inmates sent to the Supermax to prevent future violations; in *Austin v. Wilkinson*, 189 F. Supp. 2d 719 (N.D. Ohio 2002), a court enjoined the State of Ohio from returning any individual with serious mental illness to the Ohio State Penitentiary; in *Ayers v. Perry*, which was settled, New Mexico agreed to keep inmates with serious mental illness out of the Special Controls Facility at the

for prisoners who already suffer from serious mental illness, segregation inflicts serious psychological pain and exacerbates mental illness with catastrophic effects (such as self-mutilation, disassociation, suicide, playing with urine and feces, and extreme combativeness towards guards and staff).[11] Solitary confinement makes healthy people sick, and sick people worse.

Extreme social isolation and reduced environmental stimulation is cruel and unusual punishment.[12] While the court in *Madrid v. Gomez*, a challenge to the conditions at Pelican Bay State Prison in California, did not find *per se* constitutional violations for *all* prisoners in solitary confinement, it did find Eighth Amendment violations for certain categories of mentally ill prisoners.[13] For these inmates, placement in the Secure Housing Unit was unconstitutional and "the mental equivalent of putting an asthmatic in a place with little air to breathe."[14] *Jones 'El v. Berge*, settled through a comprehensive consent decree, required that seriously mentally ill prisoners be identified and removed from Wisconsin's Supermax Correctional Institution. The settlements in *Jones 'El, Austin v. Wilkinson* and other cases provide for the *permanent* exclusion of seriously mentally ill prisoners from long-term isolation.

The Fourteenth Amendment's guarantee of due process is also at stake when prisoners are sent to solitary units or supermax prison. Long-term isolation is so qualitatively different from the normal prison setting that it can only be constitutionally imposed through clear policies that are accessible and comprehensible to the prisoner. Additionally, prisoners need to be given a meaningful opportunity to dispute the accusation of wrongdoing against them, and if they are not able to do so because they lack the intellectual capacity, they need to have assistance. In *Wilkinson v. Austin*, for example, the U.S. Supreme Court ruled that prisoners have a due process-protected liberty interest in avoiding placement at Ohio's Supermax prison, due to the

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Penitentiary of New Mexico in Santa Fe and the Southern New Mexico Correctional Facility in Las Cruces.

[11] *See* Jules Lobel, Prolonged Solitary Confinement and the Constitution, 11 U. Pa. J. Const. Law 115 (2009).

[12] *See* David Fathi, *The Common Law of Supermax Litigation*, 24 Pace L. Rev. 675, 681 (2004).

[13] *Madrid v. Gomez,* 889 F. Supp. 1146 (N.D. Cal. 1995).

[14] *Id.* at 1265.

extreme isolation and limited environmental stimulation they face at that facility.[15] Accordingly, the Court said, prisoners are entitled to meaningful due process protections prior to their transfer to that facility.[16] Even before the Supreme Court's ruling in *Wilkinson*, courts had ruled that placement in solitary confinement, by virtue of lack of contact, loss of privileges and dearth of work or educational opportunities imposes an "atypical and significant hardship" which gives rise to a liberty interest and to due process rights.[17]

The guarantee of due process also requires that any prisoner placed in long-term isolation is required to have meaningful, regular, periodic reviews to determine whether the confinement continues to be necessary. In weighing the government's interest in long-term isolation, courts have said that while the government has an interest in avoiding the imposition of additional, costly, or complex procedures, especially in the context of a correctional facility, prisoners are still required to be afforded meaningful process.

"Meaningful review" means that hearings must not be perfunctory; inmates must actually have the potential to impact the outcome. And, the process must include an opportunity to be heard, consideration of the inmate's behavior, and an evaluation and determination of whether the reason(s) for confinement remain valid. Further, in *Wilkinson* the Supreme Court held that due process includes a prisoner's right to a statement of reasons for placement or retention in segregation, as well as a statement explaining what they must do to earn their way out.[18]

Maine's Path to Reform

Maine's solitary reform legislation did not become law, for reasons that are likely familiar to you. Opponents said that solitary confinement did not really exist in Maine; they said that even if solitary confinement did exist, it did not have the effects that critics claimed; they said that even if solitary confinement did have substantial negative effects on prisoners' mental health, the

[15] *Wilkinson v. Austin*, 545 U.S. 209 (2005).
[16] *Id.* at 224.
[17] *See, e.g., Colon v. Howard*, 215 F.3d 227, 231-32 (2nd Cir. 2000) (finding 305 days in segregated housing unit to be an atypical and significant hardship); *Hatch v. District of Columbia*, 184 F.3d 846, 858 (D.C. Cir. 1999) (ruling that on remand, court should determine whether twenty-nine weeks of segregation is atypical); *Williams v. Fountain,* 77 F. 3d 372 n.3 (11th Cir. 1996) (finding one year in solitary confinement atypical and significant).
[18] *Wilkinson*, 545 U.S. at 225-26.

prisoners deserved that treatment because of the awful things they had done; and if that treatment was not deserved, then the prison still had no choice but to use long-term isolation because there was no other meaningful way to deter rule-breaking in the prison environment. Opponents of reform also claimed that change would be too costly, and that it would lead to an increase in violence.

Instead of legislating reform of the use of solitary confinement, the Maine legislature did what legislative bodies often do when faced with politically-fraught issues: it authorized a study. A group of government officials from the Maine Department of Health and Human Services and the Maine Department of Corrections was charged with reviewing the use of solitary confinement in Maine's corrections system, with special emphasis on due process rights and the needs of prisoners with mental illness. The conclusions of that study were nothing short of extraordinary, especially in light of the fact that it was conducted entirely by government insiders. They echoed much of what the advocacy community—ACLU, the Maine Prisoner Advocacy Coalition, the NAACP, the Maine Council of Churches, and others—had been saying for a number of years:

- Prisoners were subjected to solitary confinement for "extraordinary" periods of time while officials investigated whether the prisoner was the victim or the perpetrator of a particular offense;[19]
- Prisoners were sometimes kept in solitary confinement simply because the prison could not find a bed for them in a general population unit;[20]
- The prison underutilized alternative sanctions and incentives for controlling behavior, which led to overuse of solitary confinement;[21]
- Prisoners were not provided with assistance in responding to accusations of rule-breaking, which was especially difficult for prisoners with mental illness or cognitive impairment;[22]
- Even a brief visit to the women's solitary unit by investigators resulted in feelings of claustrophobia;[23]
- A number of individuals with apparent symptoms of serious mental illness were housed in the Special Management Unit, despite policies prohibiting such housing;[24]

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[19] FINAL REPORT OF REVIEW OF DUE PROCESS PROCEDURES IN SPECIAL MANAGEMENT UNITS AT THE MAINE STATE PRISON AND THE MAINE CORRECTIONAL CENTER 4 (March 2011).
[20] *Id.* at 6.
[21] *Id.* at 7.
[22] *Id.*
[23] *Id.* at 8-9.
[24] *Id.* at 9.

- The prison had too few mental health staff, and mental health screenings and evaluations were inadequately documented;[25]

The report noted that reforms might have costs, but that those costs needed to be viewed in light of the countervailing costs of recidivism, harm to communities, public safety, and "the simple humanity of what we do."[26]

This report forced even the most dismissive defenders of the status quo to acknowledge that Maine's use of solitary confinement needed to be reformed. At the ACLU of Maine, we prepared to take the Department of Corrections to court if it would not implement substantial reforms consistent with the recommendations of the study commission and the demands of the Constitution, but that litigation was ultimately not necessary. Instead, a new Corrections Commissioner was appointed, and he immediately convened a working group of advocates, health care workers, and corrections professionals to implement the study's recommendations and reform Maine's Special Management Unit.

Within one year, Commissioner Joseph Ponte substantially reduced the use of solitary confinement, the amount of time prisoners would spend in solitary confinement, and the likelihood that prisoners would remain in solitary any longer than necessary:

- Solitary confinement in Maine is now reserved for the most serious offenses, and most prisoners are punished in their own units (by losing privileges or being confined to their own cell within the general population);
- A prisoner cannot be sent to the Special Management Unit for more than three days without the approval of the Commissioner himself;
- When a prisoner is sent to the Special Management Unit, his bed remains open until he returns;
- Prisoners in the Special Management Unit have the opportunity to have their punishment time cut in half through good behavior;
- Prisoners in the Special Management Unit have an opportunity to interact with other prisoners and with mental health staff in a group setting, and they have an opportunity to attend group religious services. Attendance in group treatment sessions earns the prisoner additional recreation time, which can be used indoors or outdoors;
- Prisoners are more closely monitored for changes in mental health status;
- Prisoners in the Special Management Unit have access to televisions, radios and reading material, which alleviate some of the oppressive qualities of isolation.

[25] *Id.* at 10.
[26] *Id.* at 13.

These changes have lead to a 70% reduction in the use of solitary confinement at the Maine State Prison, and that reduction has not been accompanied by an increase in violence towards guards or other prisoners. Maine's prison is now a safer and more humane place because of these reforms. There was resistance to their implementation, but through determination and leadership by both the advocacy community and Commissioner Ponte, Maine is now a model for what is possible across the country.

We hope that, someday, we will be able to look back on this hearing as an important turning point, away from the use of long-term isolation in our prisons, and towards what Maine has shown is possible.

Respectfully Submitted,

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Hearing before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights on Solitary Confinement in U.S. Prisons

Testimony of the New York Civil Liberties Union
on the Use and Effects of Extreme Isolation in New York Prisons

July 19, 2012

The New York Civil Liberties Union thanks Chairman Durbin, Senator Graham, and Members of the Subcommittee for the opportunity to submit this written testimony on the issue of "solitary confinement" in New York prisons.

The New York Civil Liberties Union ("NYCLU") was founded in 1951 as the New York affiliate of the American Civil Liberties Union, and is a nonprofit, nonpartisan organization with nearly 50,000 members across the state. Our mission is to defend and promote the fundamental principles and values embodied in the Constitution, New York laws, and international human rights laws, on behalf of all New Yorkers, including those incarcerated in our jails and prisons.

Over the past year, the NYCLU has conducted an investigation into the use of solitary confinement – or what we describe as "extreme isolation" – in New York state prisons. During this investigation, the NYCLU has heard many stories about extreme isolation from prisoners, their families, correctional employees (including mental health professionals and clergy) and advocates. Many of these individuals and organizations will be submitting testimony on New York's use of extreme isolation, including the recent success in passing legislation to protect prisoners suffering from serious mental illness from conditions of extreme isolation, and the long road to fully implementing the promise of that legislation.

We write to provide the Subcommittee with testimony on three discrete features of New York's use of extreme isolation: (1) the types of extreme isolation used in New York prisons; (2) the conditions of extreme isolation from the perspective of prisoners and corrections employees who live and work in these environments; and (3) the frequency with which New York uses extreme isolation to summarily punish non-violent misconduct by prisoners.

As discussed below, the evidence shows that New York uses extreme isolation far too often and for far too long, often for minor violations of prison rules. New York's dependence on extreme isolation abandons rehabilitative efforts in favor of severe punishment that causes significant, often long-lasting, pain and suffering. It makes the jobs of corrections employees who work with prisoners held in these punitive and isolating conditions more difficult. This use of extreme isolation is unlikely to effectively deter the minor misconduct at issue, and leaves prisoners unprepared to rejoin our communities upon release.

The Types of Extreme Isolation Used in New York Prisons

Many different terms describe "solitary confinement" in the federal and state correctional systems, including "supermax," "special housing units" or "SHU," "prolonged isolation," and "the Box." All of these terms describe circumstances in which corrections officials choose to isolate prisoners from all meaningful social contact and environmental stimuli. The NYCLU believes the term "extreme isolation" is most apt in describing the use of isolation in New York. "Extreme isolation" captures the range of ways in which the New York Department of Corrections and Community Supervision ("DOCCS") subjects prisoners to isolation. Moreover, it incorporates two independent, but related, concepts: (1) the degree of isolation a prisoner experiences and (2) the length of time a prisoner experiences such isolation – either or both of which may independently, or in combination, be considered extreme.

DOCCS uses three general types of isolated confinement, all of which may be properly described as extreme isolation. The first is "keeplock," the practice of isolating prisoners to their cells within the general prison population. The second and third are "single-cell SHU" and "double-cell SHU." "SHU" stands for Special Housing Unit, a group of cells separated from the general prison population, where prisoners are isolated and stripped of virtually all privileges. Prisoners in single-cell SHUs are confined to a cell alone; prisoners in double-cell SHUs are confined to a cell with another individual.

DOCCS subjects prisoners to these three forms of extreme isolation – keeplock, single-cell SHU, and double-cell SHU – for a variety of reasons. But by far the most prevalent is to punish those who violate prison rules, a practice known in New York, and in many other corrections systems, as "disciplinary segregation." Of the nearly 4,500 prisoners who may be isolated in a single-cell or double-cell SHU at any given time in New York prisons, and of the many thousands more subject to keeplock, only a tiny percentage are subject to extreme isolation because their mere presence in the general prison population is deemed to pose a substantial threat to safety and security ("administrative segregation") or for their own protection ("protective custody").

Living and Working in Extreme Isolation in New York Prisons

Keeplock: Prisoners in keeplock are confined to their cells in the general prison population for 23 hours a day. They recreate either alone or with others for an hour a day. They maintain the property in their cell and certain other privileges, such as access to the commissary. They cease all education or vocational training, addiction or behavioral therapy, and all other programming or rehabilitative activity.

Single-Cell SHU: Prisoners in single-cell SHU are confined to their cells – some sealed by solid steel doors – for 23-24 hours a day, totally isolated from meaningful human contact. They receive their meals through a narrow slot in their cell door.

They recreate alone in a small cage, no larger than their cell, enclosed by high concrete walls or wire mesh, for an hour a day. In some circumstances, they are forced to "recreate" in these

small, barren spaces while in handcuffs. Many prisoners and corrections officers have described this cage as a "human kennel."

Their personal possessions are limited to legal materials and a few personal books and magazines. They receive no programming or rehabilitative activity, nor transitional services, even if they are within a few months of returning to society.

Many prisoners have described the mental and emotional toll that these conditions have taken on them. One prisoner, who has withstood years of extreme isolation, described the range of emotions he has experienced over that period:

> *These cells are designed to isolate and discourage any natural conversation. The air vents hum loudly all 24/7 hrs a day enough to cause deafness. When you're out af the cell it seems different because the noise level changes. With so little to do your mind rots with thoughts that are uncommon or unnatural and you wonder where the hell did that come from. It goes further than daily doldrums because a lack of any constructiveness only contributes to destructiveness and the Prison System is designed to make a person like myself and others unfortunate to self-destruct become numb lose the sense of reality to the degree that any cammotion at all is better than vegetating by letting hours pass without nathing an your mind or will to do anything. I can become bitter thinking about the experiences had in these Special Housing Units and the bad far outweighs the goad to the point of even trying to write family, there's nothing to share because the starkness leaves you wanting to rant and rave until they come to kick the remaining sense out of you . . . .*

Another prisoner, whom DOCCS punished by placement in a single-cell SHU, described the experience:

> *Its crazy they really treat us like where some animal. I guess they forget people make mistakes which land them in jail and the fact that we was living a normal life too before our conviction. . . . I don't even tell my family the things I go through cause I don't want them to worry about me. I still be having a lot of mood swings lately, I don't be meaning any harm I just be mad at my situation and I take it out on other inmates verbally and police sometimes. It gets reall lonely in here, especially if you don't have family to communicate with or send you books. Im greatful to have that, but after you be in this cell for so long it hard to keep your mind outside of these four wall, all you have is memorys.*

Most of these men fear their return to the general prison population, or for those who will be directly released from extreme isolation, to society. One prisoner described finding himself "snapping at others" in "daily outbursts" and observed that he "wasn't like this before." He concluded, "I'm hoping I change back when I go back to being around people." As explained by

a correctional officer, "Some guys are in SHU for nothing, [they] turn into this violent thing in the Box."

One prisoner who has since returned to the general prison population after being sent to the SHU for punishment noticed that the effects of extreme isolation have lingered with him:

> *I don't really know how to explain my transition to [general prison population]. When I arrived here I was terror stricken for the first two weeks, at least. That kind of behavior is nothing like me at all. Its when I got here that I realized how badly the box had effected my charrecter. I've always been somewhat anti-social, but my confidence in myself and my ability to communicate is more challenged now then it has been since I was a teenager. My depression is pretty bad off too. All I know tho is I was fine in [the general prison population] and then I went to [the SHU] and it seems like part of me is still there.*

Another prisoner described his frustration at not being able to access any programming while in SHU that would prepare him to rejoin the community upon release from prison:

> *But the nightmare starts with the realization 'Im going home from the Box' lacking any transitional services of all sorts. Me personally, I read to keep my mind strong and intellect growing! And I have a strong desire to <u>never</u> return to jail. But I <u>need</u> help from the 'professionals' that work for the state because its so obvious my ways aren't quite the right ones. Do you know what I mean?*

<u>Double-Cell SHU</u>: Prisoners in double-cell SHU are subject to all the same conditions as those in single-cell SHU, but also share their cell with another individual. For many prisoners, their relationship with their cell-mate is marked by intense frustration, antagonism, and violence or the constant threat of violence. This dynamic is an unavoidable consequence of isolating two men together in a small and cramped space where they must shower, urinate and defecate in full view of each other, and discuss any medical or mental health problems at their cell door within close earshot of each other.

One prisoner, whose disciplinary issues have all been for non-violent and minor misconduct, observed that sharing a double-cell SHU resulted in physical altercations with his cell-mate. Sometimes, he would "want to fight just because of the close space." He explained that "the littlest things cause people to bug out," and that even if his cell-mate "didn't do nothing," he would just get "so pissed off" that he would start a fight.

Another prisoner, who shared a double-cell SHU for a short period with a friend of his, made similar observations. He and his cell-mate ended up fighting in their cell:

> *To be clear, we did not fight for any other reason than that we found we simply could not get along while being locked together if locked 24 hours in a cell. I was having my problems & he was burdend by the fact that his wife had just died & with both our moods being dark & depressing all the time we didn't mix well & after a few days I ended up attacking him. Someone I consider a close personal friend, because of my own inability to function normaly in the box. He has since then forgiven me . . . .*

Working in SHU: Correctional officers ("CO") who have worked in the Special Housing Units say, "The job changes you." One retired CO stated, "Overall the SHUs are more stressful to work." Some COs who have worked in the SHU complain in particular of nightmares and emotional distress. "You have to be on edge all the time," one retired CO shared.

Interactions between COs and prisoners in the SHU further strain this tension, with negative effects on COs. According to a chaplain who formerly worked in a SHU, "the atmosphere [of] the SHU is difficult not just for the inmates in it, but also for corrections officers." In facilities where prisoners are "locked up all day long, the position of the CO changes from what people are used to . . . [it is] . . . not a wonderful way to conduct human relationships."

DOCCS' Dependence on Extreme Isolation as a Disciplinary Response

DOCCS utilizes extreme isolation far too often and for far too long for minor, non-violent misconduct. DOCCS's dependence on extreme isolation as a one-size-fits-all disciplinary response interrupts or ends prisoners' rehabilitation, makes correctional officers' jobs more difficult and dangerous, and is less effective than other disciplinary alternatives.

Like all highly regulated prison environments, DOCCS has a long list of rules governing every aspect of prisoners' behavior. DOCCS vests its correctional officers with virtually unbridled discretion to punish any rule violation with extreme isolation, and substantial discretion regarding the length of the extreme isolation imposed. As a result of this policy, DOCCS sentences many prisoners to brutal stints in extreme isolation for non-violent misbehavior.

For example, minor misconduct such as leaving a classroom, leaving work duty without permission, or smoking a cigarette in an unauthorized area, can result in the punishment of a month of extreme isolation. Drug or alcohol-related offenses, such as testing positive on an urinalysis, typically lead to 3 months of extreme isolation for the first offense, 6 months for the second offense, and a year for the third offense.

Indeed, many prisoners we have communicated with are serving time in extreme isolation for such minor violations of prison rules. For example, one prisoner received four months of extreme isolation for a series of minor misbehaviors, including leaving class without permission, smoking a cigarette in the bathroom, sleeping through work duty, and visiting another prisoner's dormitory. This prisoner was only 21 years old at the time he was transferred to the SHU to serve his 120 day sentence. Another prisoner has repeatedly bounced in and out of the

SHU for drug use. Most recently, DOCCS elected to punish him with extreme isolation for a year because of a single positive test for marijuana on an urinalysis.

While DOCCS is quick to impose extreme isolation in response to minor misbehavior by prisoners in the general prison population, additional punishment for minor misbehavior once a prisoner is already in the SHU is even more swift and severe. Thus, prisoners in extreme isolation face the very real possibility of earning additional lengthy disciplinary sentences that keep them in the SHU beyond their initial sentence. For example, one prisoner in the SHU received an additional six months of extreme isolation as punishment for refusing to hand his food tray back to a CO after a meal. Another prisoner in the SHU received an additional six months of extreme isolation as punishment for "tampering with property" when he returned a used but broken razor to a CO who was collecting such items.

Lengthy sentences to extreme isolation are unlikely to effectively deter misbehavior. Prisoners who engage in non-violent behavior in violation of technical rules are often manifesting symptoms of pre-existing mental illness or behavioral problems. There is no evidence to suggest that subjecting these prisoners to extreme isolation will improve their ability to obey minor prison rules, especially as compared to well-established alternatives like counseling and treatment. Similarly, for those prisoners who purposefully and knowingly disregard prison rules by engaging in non-violent misconduct, like drug use, lengthy sentences to extreme isolation totally suspend the rehabilitative programming that could effectively alter their behavior, such as substance abuse treatment. Instead, punishing these prisoners with extreme isolation simply engenders anger, hostility, and depression (and rarely deters drug use, which continues unabated in SHU), which correctional officers working in the SHUs are then forced to confront on a daily basis.

In some cases, DOCCS use of extreme isolation does not just interrupt rehabilitative programming or therapy – it abandons it entirely. In these cases, a prisoner's disciplinary sentence to extreme isolation eclipses the remainder of his or her entire prison sentence. DOCCS requires these prisoners to serve the remainder of their prison sentence in extreme isolation, and releases them directly from such conditions back to their communities with no transitional programming. One prisoner, who is serving a four-year prison sentence for a drug-related offense, is currently in extreme isolation and will be held in SHU until he is released. He has observed, quite obviously, that he is "not prepared" to return to society.

***

Prisoners, corrections professionals, advocates, and the public all want safe and effective prisons. All of these stakeholders share the belief that prisons should be safe places for those who live and work in them. All also want to ensure that when people who have been sent to prison are released – as the vast majority of prisoners ultimately are – incarceration has effectively prepared them to rejoin and strengthen our communities.

Whether the extraordinarily severe punishment of extreme isolation should be imposed on prisoners should be evaluated against this overall goal of ensuring safe and effective prisons. In New York, the evidence demonstrates that DOCCS's dependence on extreme isolation as a one-size-fits-all disciplinary solution is a significant impediment to this common objective. Extreme isolation leaves prisoners unprepared to re-enter society. It imposes severe anguish and psychological pain on prisoners who have committed little more than minor misconduct or non-violent drug use. And it takes a severe toll on correctional officers who must wrestle with the psychological and physical costs of managing prisoners living in these punitive and isolating conditions.

We thank the Committee for holding this hearing and for taking the opportunity to consider the grave implications of extreme isolation on prisoners, corrections officers, and the public. We urge the Committee to take action to facilitate substantial reforms to the use of extreme isolation around the country, and in New York.

Sincerely,

Taylor Pendergrass
Senior Staff Attorney

Scarlet Kim
Legal Fellow

Testimony of
The Reverend J. Edwin Bacon, Rector
All Saints Church, Pasadena, California
Senate Judiciary Committee
Subcommittee on the Constitution, Civil Rights and Human Rights
Hearing on Reassessing Solitary Confinement
June 19, 2012

Mr. Chairman, Members of the Subcommittee, thank you for this opportunity to submit testimony on behalf of All Saints Church, Pasadena. All Saints is a 3500 member parish deeply committed to peacemaking and social justice. Our Vestry, the governing body of the parish, demonstrated its unequivocal opposition to torture in all forms by passing a Vestry Resolution in March, 2010, making clear its opposition to torture by all countries, including our own. During this month of June, which is Torture Awareness Month, we are displaying a banner on the lawn of the church that says: All Saints Stands Against Torture. I believe that prolonged solitary confinement meets the criteria for torture and must be abolished in our prisons, jails and detention centers. Your hearing on solitary confinement brings national attention to this issue in an unprecedented way.

Last summer and fall, hunger strikes in the SHUs (Security Housing Units) at several California prisons brought national attention to the circumstances and conditions of prolonged solitary confinement. A widely held misconception is that inmates are placed in SHU for a relatively short period of time, usually as a consequence for a violent act or other serious rules violation. In reality, the average length of time in SHU in our state is 6.7 years; many inmates have been in SHU for decades. Inmates are confined to a small, windowless 8 X 10 cell for a minimum of 23 hours a day. One hour of exercise is usually permitted in a small, confined exercise pen. There is virtually no human contact or meaningful activity. A host of psychological studies have shown that these conditions literally drive people insane. While the numbers of men in SHU in California depend on the precise definition of a security housing unit, between 3,000 and 11,000 persons in California are subjected to prolonged isolation. It is particularly tragic that in this state, juveniles are subjected to solitary confinement.

Juan Mendez, Special Rapporteur for Torture for the United Nations, has testified that "indefinite and prolonged solitary confinement in excess of 15 days should be subject to an absolute prohibition". (UN News Centre, Oct. 18, 2011). Members of our parish have begun to correspond with men in SHU in California prisons, all who have been in SHU for several years; some have been in SHU for twenty years or more. This length of time so greatly exceeds what Juan Mendez states is the humane limit for

solitary confinement that it is clear that human rights abuses of enormous magnitude are occurring in prisons in our own nation.

There are many well-grounded moral and psychological reasons to insist on humane standards and conditions for isolation. It is as a priest that I am primarily opposed to prolonged solitary confinement.

At the beginning of our holy history is the story of God creating a partner, saying that people should not live alone. We are meant to live in community. To deny that human contact – over the course of many years – is an absolute violation of what God recognized as absolutely essential.

Our faith tradition holds most deeply that each person is created in the image of God, that the divine and the sacred is within each person. The violation of the human needs of those in prolonged solitary confinement is a violation of the sacred.

What we call in our faith tradition the New Testament is very clear about our responsibility toward those in prison. Jesus says that when we visit those in prison, we are visiting Him. The apostle Paul, in the letter to the Hebrews (Chapter 13:3) says to the early Christian church: "Remember those in prison as though you yourself were in prison; those who are being tortured as though you yourselves were being tortured".

Justice and compassion call out for us to care for those in solitary confinement. Those most directly impacted are the inmates in solitary confinement. The circumstances of their detention causes anguish for their families and loved ones. And yet, all of us are impacted, because the way in which we as a society treat others pervades our culture and diminishes us all

I ask each of you to support legislation that sets humane standards for the practice of solitary confinement in our prison and detention system. I believe that security and humanity can co-exist. I believe that it is our moral obligation, but most profoundly, our obligation as people of faith and conscience.

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As a parishioner at All Saints Church, Pasadena, I add my signature of support to the testimony of The Reverend Rev. J. Edwin Bacon, Rector, submitted to the Senate Judiciary Subcommittee on the Constitution, Civil Rights and Human Rights.

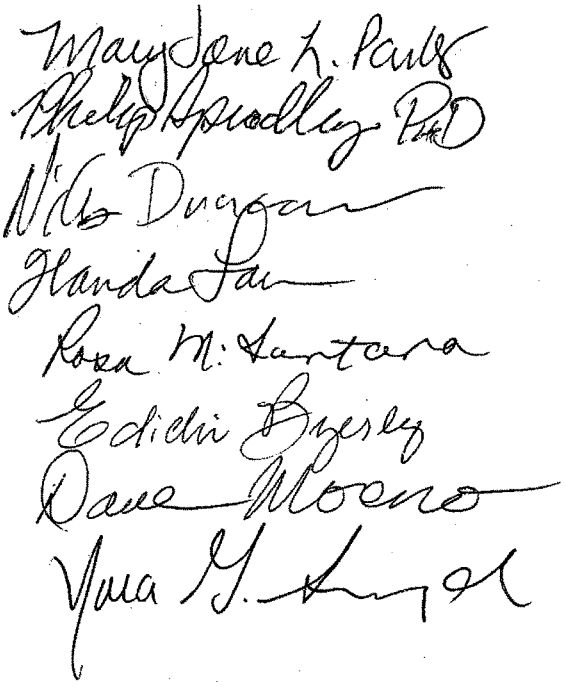
Susan Pindak

Phyllis R Manley

Valerie Coachman-Moore

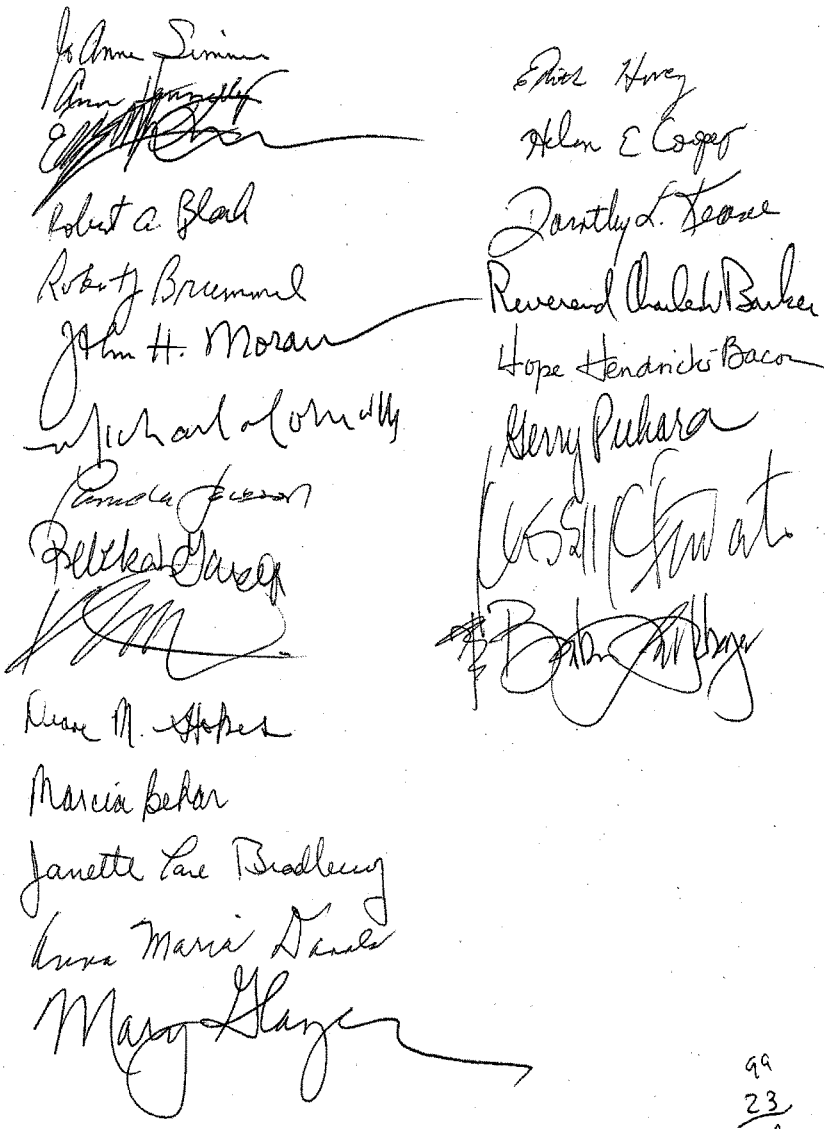
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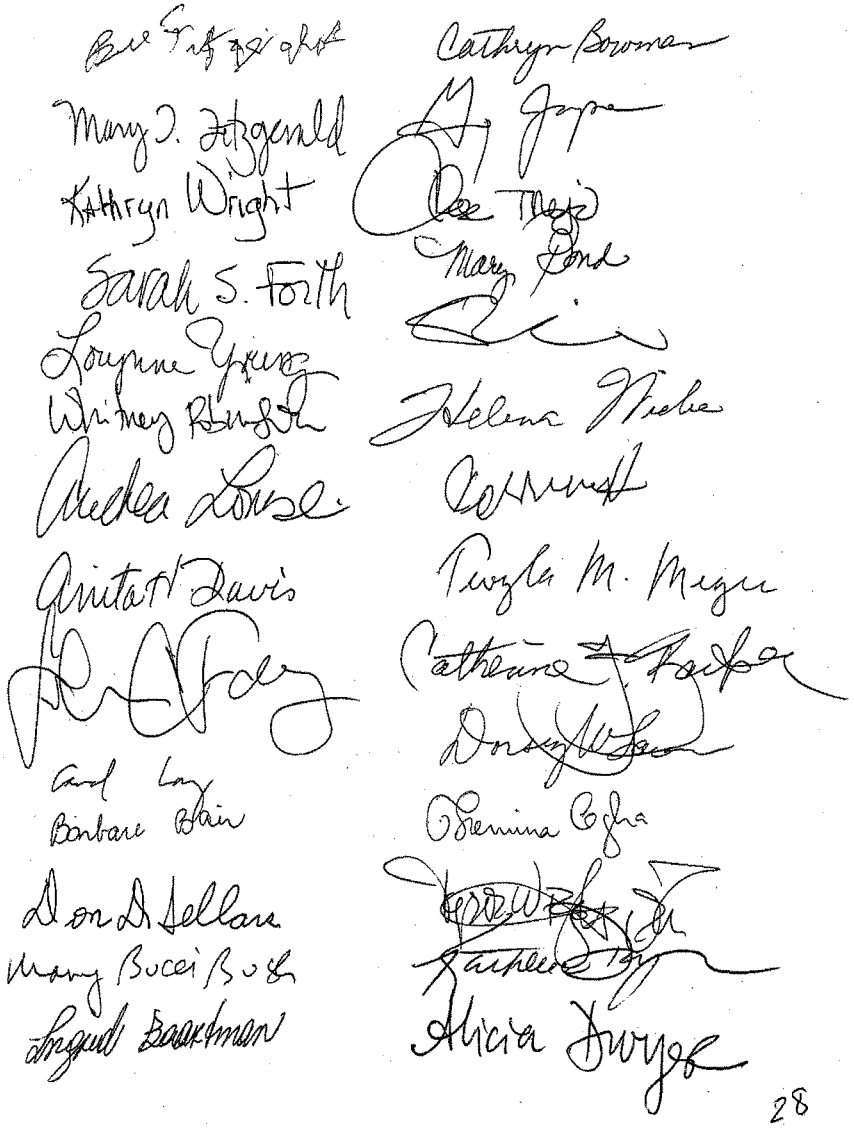
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Judith Van Vleet (Judith Van Vleet)
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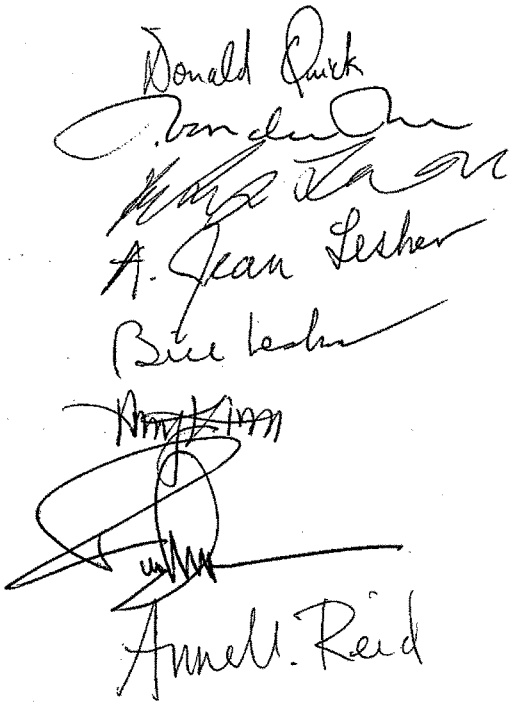
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Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences

Hearing Before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights

The Honorable Dick Durbin, Chair

Tuesday, June 19, 2012

Written Statement Submitted by:
Professor Angela A. Allen-Bell
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I begin with an expression of immense gratitude to Senator Dick Durbin and the Senate Subcommittee on the Constitution, Civil Rights, and Human Rights for having the compassion, courage and fortitude to explore an issue that promises no personal advancement for anyone. Efforts relative to the issue of solitary confinement and its abuses are patently selfless and profoundly pious. Work on behalf of vulnerable and disesteemed inmates yields few monetary rewards and invites a barrage of cynicism. Thank you for exemplifying leadership and for undertaking this long overdue expedition and for spearheading this much needed inquest.

I recently authored an article where I examined some of the constitutional issues surrounding solitary confinement practices in the United States. The article is published in the spring 2012 issue of the Hastings Constitutional Law Quarterly. The article is titled: "Perception Profiling & Prolonged Solitary Confinement Viewed Through The Lens of The Angola 3 Case: When Prison Officials Become Judges,

Judges Become Visually Challenged and Justice Becomes Legally Blind." While the article uses the case of the Angola 3, two Louisiana men who have been held in solitary confinement for **40 years**, as a case study, the article should in no way be viewed as a work that is limited in nature to the case of the Angola 3.[1] Instead, the article uses cases and authorities from across the nation in an attempt to study the issue of prolonged solitary confinement. What was revealed in the end was the fact that the Angola 3's case was in no way an isolated incident or a paranormal event. The fate of the Angola 3 is representative of a documented, dangerous trend in penal institutions whereby many inmates are subject to solitary confinement despite having committed absolutely no infraction behind prison walls and, once there, are trapped for indefinite or permanent periods because there is no meaningful review process in place and because there is a lack of judicial oversight.

My article discusses three constitutional concerns relative to current prolonged isolation practices, the first of which is due process. The article discusses how a meaningful process can and should be afforded to inmates when their stay in prolonged isolation is evaluated at periodic intervals. Thereafter, the article addresses how the current prolonged isolation practices undermine the Doctrine of Separation of Powers. This is followed by an explanation of how and why judicial abstention has lead to abuses. A prominent contention of my article is that judges are the only people authorized to impose sentences and that prison officials are only authorized to impose

[1] Robert Wilkerson King, Herman Wallace, and Albert Woodfox are known as the "Angola 3." Robert Wilkerson King was freed in 2001 after approximately 29 years in extended lockdown. Herman Wallace and Albert Woodfox remain in custody and in extended lockdown, which is akin to solitary confinement. They were both placed in extended lockdown in 1972.

necessary discipline. When prison officials impose extreme and prolonged disciplinary measures that are not justifiable for disciplinary or administrative purposes, prison officials, in effect, re-sentence a defendant (sometimes even to death). Because the administrative process often does not lend itself to meaningful substantive judicial oversight, courts are frequently unable to serve their function, which is to effect justice in such an instance where the lines of separation between branches have been impermissibly crossed. My article demonstrates how, if unchecked, this results in a situation where prison officials have more sentencing power than courts. And, worse, where prison officials use that power to silence voices they do not want heard or to remove influences they do not want dispersed amongst the prison population. Lastly, the article offers a suggested national legislative model for the periodic review process. This model attempts to rectify procedural and substantive shortcomings in the current review process.

I will briefly outline my research findings. It is my hope that you will read the work in its entirety and use it as a part of your committee's efforts and considerations.

<u>14th Amendment (Due Process Clause) and the Periodic Review Process</u>

The article offers the following insight relative to these topics:

> As a result of there being no exact standards governing periodic review hearings, review hearings are in many instances nothing more than ritualistic exercises in formality. Often, the proceedings are hollow in that they do not genuinely probe into the suitability of an inmate's custody change, and they do not rule based on a measurable evidentiary standard. Many review hearings serve as veils for a predetermined decision to maintain an inmate in isolation on an indefinite or permanent basis. Further complicating the situation is the fact that judicial challenges to such proceedings may fall upon deaf ears because courts, concerned only with procedure and satisfied with the knowledge that a "process" was afforded, feel their work is done....[T]his does not comport with due process. Because

inmates have no constitutional right to release from prolonged isolation, it is imperative they be afforded a just process when they are evaluated at periodic intervals....

39 Hastings Const. L.Q. 763, 797-8 (Spring 2012) (citations omitted).

Separation of Powers

On this issue, the article states:

As an extension of the executive, corrections administrators may not, according to the Doctrine of Separation of Powers, encroach upon the powers of the legislative or judicial branches of government. By design, a warden plays a very different role in the life of an inmate than does a sentencing judge, whose primary function it is to impose sentences. A sentencing judge has authority to remand a defendant to the custody of the corrections department. In most instances, a sentencing judge has no authority over how or where a defendant spends his time in custody. Once a defendant is taken into custody, his relationship with prison officials and administrators begin. What is important is the delineation of power between the two officials. Judges are not equipped with prison administrative authority and wardens are not equipped with sentencing authority.

It is the obligation of penitentiary officials to insure that inmates are not subjected to any punishment beyond that which is necessary for the orderly administration of (the prison). When prison officials impose pretextual and/or extreme and prolonged disciplinary or administrative measures that are not absolutely necessary for prison security purposes or genuinely connected to legitimate penological concerns, the prison official leaves the realm of discipline and enters the realm of sentencing/resentencing. In doing so, prison officials not only abuse their authority, but they assume authority they lack.

39 Hastings Const. L.Q. 763, 803-4 (Spring 2012) (citations omitted).

Judicial Abstinence and the Potential for Abuses

My article expresses:

Currently, there exists "a policy of minimum intrusion into the affairs of state prison administration" and a belief that state "prison officials . . . be vested with broad discretion . . ." With respect to inmate periodic review hearings, this often results in courts limiting their involvement to ensuring

that inmates are afforded the process to which they are entitled. Often, courts will not evaluate or engage in a meaningful review of the process' substance.

*****

[O]ne might argue that, in the prison setting, courts have created a layer of immunity for prison officials, by refusing to scrutinize penal decision-making during the periodic review process. What is needed is a firm legal line....The legal line should memorialize the crossing point into too far. The challenge lies in stopping courts from enabling transgressions by prison officials with their silence, while at the same time ensuring that the courts are not put in the position of having to micromanage prison officials.

39 Hastings Const. L.Q. 763, 806-8 (Spring 2012) (citations omitted).

Reform Proposal: Legislative Model for the Periodic Review Process

My article advocates the following:

Conceding that prison officials must have liberal charge of an institution, this authority needs to be somewhat less absolute than it currently is. A lack of accountability or oversight corrupts as much as it serves to ratify innocent errors in judgment. The major reform advanced herein is that institutions should no longer have complete authority over decisions regarding inmates' exoduses from solitary confinement. As an alternative, a tiered approach should be implemented, whereby prison officials make the initial decision to place a prisoner in isolation and retain authority over the first periodic review, but where, thereafter, other eyes begin to watch, other ears begin to listen, and other minds begin to ponder the fate of the isolated inmate. This reform is consistent with the aspirations of the Supreme Court, which expressed that, in both civil and criminal proceedings, due process requires an "adjudicator who is not in [the] situation." In furtherance of this view, the Court has explained that "[e]ven an appeal and a trial de novo will not cure a failure to provide a neutral and detached adjudicator." Another significant proposed reform is that the process be regulated by actual legislation and not by the administrative rule-making process. The proposed model follows:

1. Preliminary Considerations

This model is intended to have both prospective and retroactive application.

This model assumes all players will be trained and informed, as a minimum, on the unique intricacies of penal institutions, solitary confinement, and due process.

2. Placement into Solitary Confinement

Prison officials should maintain exclusive control over the process employed to place an inmate into solitary confinement.

Prison officials should maintain exclusive control over the periodic review process until completion of the first review.

When being placed in solitary confinement, prisoners should know the reason for the placement and the duration of their sentence to solitary confinement, and should be provided with a case plan enumerating exactly what must be done to earn their exodus.

Placement in solitary confinement as a result of perceptions that are not incident to actual actions or specific, actual, and legitimate security or penological concerns should be prohibited. Continued placement in solitary confinement based on dated security concerns should not be allowed.

Prolonged solitary confinement should be abolished. However, the practice of reassigning an inmate to solitary confinement for a defined time, following an adverse review, should be allowed.

Once in solitary confinement, inmates must have a means of defending their interests at review proceedings. They must have access to some programs and services so reformation can be established during the review process.

3. Periodic Reviews

Reviews should be conducted at regular intervals. Four months is the recommendation.

Burden of Proof: At every stage of the review process, the prison should bear the burden of showing: (1) that the case plan could be accomplished; and (2) how the inmate failed to satisfy the case plan.

After completion of the first review, prison officials should no longer retain exclusive control over the review process.

The initial review should be conducted by prison officials. If the decision is unfavorable, a seven-member special review board should be empanelled for all future reviews.

The seven-member special review board should be comprised of:

One ethicist or member of the clergy (to serve as Chair).

One mental health professional or a social worker.

One prisoner advocate or an exonerated person.

One current academician.

One former military leader or one former prison administrator.

One former member of law enforcement.

One lawyer (familiar with civil due process protections).

The ethicist or clergy member should chair the board, as well as empanel the board from a pro bono list made available by professional organizations or by way of an official call for board volunteers.

Members should not receive remuneration or anything of value in exchange for their service and should not be appointed by the prison. While having local members would be ideal, there would be no opposition to members from across jurisdictional lines. In fact, such would serve to promote national uniformity.

Decisions should be made by the will of four members.

4. Periodic Review Determinations (by Prison Officials or by Special Review Board)

The aim should be a determination of whether the inmate satisfied the case plan or if the inmate made a genuine attempt at satisfying the case plan.

The inmate's release from confinement should be viewed on par with the prison administration's administrative and management concerns.

The warden must articulate the penological interest at issue and present verifiable reasons for the placement request. The warden's views should be considered. The warden's statement should be treated as equal to the other evidence.

Psychological evaluations should be an integral part of every review proceeding. They should be treated as equal to the other evidence.

The inmate's disciplinary record should be an integral part of every review proceeding. It should be treated as equal to the other evidence. The absence of recent infractions should be persuasive, but not outcome determinative.

Release denials should require a short statement of reasons for continued confinement, as well as articulation of future release criteria in the form of a supplemental case plan.

Decisions should be made upon a showing of a preponderance of actual evidence to justify keeping a person in isolation. Said evidence should establish that the prisoner "poses a credible continuing and serious threat to the security of others or to the prisoner's own safety."

Expert opinions may be considered during the review process. If used, they should be treated as equal to the other evidence.

5. Court's Role in the Review Process

The review should extend to the procedure afforded, as well as to the merits of the adverse finding. When reviewing the merits, the aim should be a determination of whether the inmate satisfied the case plan or if the inmate made a genuine attempt at satisfying the case plan.

When reviewing the merits, courts should ensure:

The burden of proof was met.

> The inmate's release from confinement was viewed on par with the prison administration's administrative and management concerns.
>
> Due process was afforded. This means that:
> a. Substantively, the inmate had the opportunity to show that no credible continuing and serious threat to the security of others or to the prisoner's own safety exists.
> b. A sincere effort was made at determining if the inmate satisfied or genuinely attempted to satisfy the case plan.
> c. The current punishment is connected to a current security concern and not a dated one.
> d. The current punishment is connected to a legitimate security threat and not a perceived one.
> e. The decision was made upon a showing of a preponderance of actual evidence establishing that the prisoner poses a credible continuing and serious threat to the security of others or to the prisoner's own safety.
> After six periodic reviews (under the same case/issue), judicial review may be sought by any aggrieved party (prison official or the inmate).
>
> 39 Hastings Const. L.Q. 763, 809-16 (Spring 2012) (citations omitted).

The late Professor Derrick Bell spoke these insightful words:

> Telling the truth can be hard and even painful work, but lying, keeping the truth secret, is far more painful. When we think lying isn't hard and painful, it's rarely because its become easy and pleasant; more likely it's because we have put up a wall between ourselves and our awareness of our captivity. This is why I am surprised that so few people in difficulty fail to tell the truth when confronted with conduct that is dishonest or less than honorable—even when admitting that conduct could lead to civil liability or criminal prosecution....Generally, though, the truth will come out; when it does, chances are that you will be worse off for having dissembled, evaded, or out-and-out lied.[2]

On the question of how solitary confinement is being used in America's penal institutions, truth is our serum and our magic portion. We must drink of it and we must generously pass the cup. For too long, the truth has been silenced, withheld and

[2] Derrick Bell, *Ethical Ambition Living a Life Worth Meaning and Worth*, 119 (Bloomsbury 2002).

suppressed were solitary confinement is concerned. We must now be liberated by this truth. And after our work of exposing the truth is done, we must not recline or delight in a sense of accomplishment. Meaningful change must follow, lest we become victims of inertia.

I offer the conclusion to my article as my closing remarks:

> Some estimate there to be between 50,000 and 80,000 inmates in solitary confinement in this country on any given day. Given the broad appeal of prolonged isolation, there must exist a uniform and constitutionally sound periodic review process. There is simply no way to refute the urgency of the present. This process should not rob prison officials of needed authority, but also must not mute the voices of inmates subject to the prolonged nature of the confinement for reasons that do not amount to legitimate penological interests or security concerns. Perception profiling and arbitrary use of prolonged isolation and/or abuse of prolonged isolation as a management style is inconsistent with best practices, as well as with constitutional mandates. Incidentally, Louisiana does not allow a veil of secrecy to surround the fate of abused animals after they have been rescued. By the strength of law, the rescuer "shall keep a special book for the purpose of registering any animal entrusted to their care . . . and the book shall be open to inspection at all times." Under this legislation, research facilities must be inspected, and they must produce annual reports showing compliance with standards.
>
> When prison officials stop acting as administrators and effectively begin handing down sentences, they, for all practical purposes, become judges. The Separation of Powers Doctrine prohibits prison officials from acting with this authority. When judges abstain from meaningful involvement in the periodic review process, they look, but fail to see the very thing they are uniquely positioned to see. They do not see the need for justice and interpretation of law--due process law. The judge, by his omission, renders justice legally blind as far as the inmate is concerned. The legally blind can innocently be a detriment to those around them.
>
> Incarceration by its very nature invites condescension toward and perhaps even disdain for inmates. But it offers no reason or excuse to diminish the rights or the humanity of the incarcerated. Affording justice to inmates does not and should not depend on the good faith or forbearance of prison officials. It is mandated by our form of government. Mindless insistence on maintaining order in prisons without concern for the rights of inmates is antipodal to democracy.
>
> 9

> Due process looks to the "justice of the procedure itself." A simulated process akin to a hearing, where formalities can be documented, but where no meaningful probing occurs, is unjust and unconstitutional. It amounts to nothing more than procedural automation in a legal assembly line where unfavorable reviews are mass-produced.....
>
> 39 Hastings Const. L.Q. 763, 818-20 (Spring 2012) (citations omitted).

To review my article in its entirety, the publication details are listed below:

Title: Perception Profiling & Prolonged Solitary Confinement Viewed Through The Lens of The Angola 3 Case: When Prison Officials Become Judges, Judges Become Visually Challenged and Justice Becomes Legally Blind.

Citation: 39 Hastings Const. L.Q. 763 (Spring 2012).

Link to the article:

https://download.acrocomcontent.com/adc/open/A3(HastingsArticle).pdf?objectID=4NXHVMdsMEmdWt92mqPNFw&assetID=*lOOQjEwoUIfduXNbU7YXA&workflow=GetAsset&sid=&cvn=17&dimension=0&ticket=DE5A102EDE3AA3EBBE9DAFFB0F305A432A924A9470AFF72F3D4D1BE8D0B015CFED5AF52645D48DDA31A01F68D190A514BEA898CE3F3007FED925BC979837859FE6B03259A644A9F95C77E6D13AF3FC220DDE72355D7A854EE22A536D0B2F028E2F6665D64A4095255CDC0C4F731CD2213CA349DB8215ADCC8F7DC119AB9495580397761D52235C8518055CF2DA1EB761DF90847872F400C96509BE21B8D71C60C90A5E07C40946F068CEB51DC4789D9051A4E4EE627218358DE12C516B795B38D1523755F6EA1F65041D3E3371DD55CA63E3104B

Link to the article along with information about the Angola 3 case:

http://angola3news.blogspot.com/2012/06/hastings-constitutional-law-quarterly.html

Filename: A3(CongressionalStatement)
Directory: C:\Users\Bell\Documents
Template: C:\Users\Bell\AppData\Roaming\Microsoft\Templates\Normal.dot
Title: Article
Subject:
Author: Bell
Keywords:
Comments:
Creation Date: 6/15/2012 12:26 AM
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Last Saved By: Bell
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Written Statement Submitted to the
Senate Judiciary Subcommittee on the Constitution, Civil Rights and Human Rights

Regarding the June 19, 2012 hearing:
Reassessing Solitary Confinement: The Human Rights, Fiscal and Public Safety Consequences

American Academy of Child and Adolescent Psychiatry
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Mr. Chairman and Members of the Committee:

The American Academy of Child and Adolescent Psychiatry (AACAP) would like to thank the committee for holding your hearing on Reassessing Solitary Confinement: The Human Rights, Fiscal and Public Safety Consequences. Solitary confinement amongst juveniles is an issue of critical importance. There are severe psychiatric consequences that can occur when an individual is put into prolonged solitary confinement. Due to juvenile's developmental vulnerabilities the potential psychiatric consequences of prolonged solitary confinement are especially severe. This is tragically reflected in the statics, the majority of suicides in juvenile correctional facilities occur when a juvenile is isolated or in solitary confinement.

The AACAP is a medical membership association established by child and adolescent psychiatrists in 1953. Now over 8,500 members strong, AACAP is the leading national medical association dedicated to treating and improving the quality of life for the estimated 7-12 million American youth under 18 years of age who are affected by emotional, behavioral, developmental and mental disorders. The AACAP adopted the following policy statement regarding the use of solitary confinement for juvenile offenders in April of this year due to concerns about the risks associated with the use of solitary confinement in juvenile facilities:

Policy Statement of the American Academy of Child and Adolescent Psychiatry on Solitary Confinement of Juvenile Offenders

Approved by Council, April 2012

Solitary confinement is defined as the placement of an incarcerated individual in a locked room or cell with minimal or no contact with people other than staff of the correctional facility. It is used as a form of discipline or punishment.

The potential psychiatric consequences of prolonged solitary confinement are well recognized and include depression, anxiety and psychosis.[1] Due to their developmental vulnerability, juvenile offenders are at particular risk of such adverse reactions.[2] Furthermore, the majority of suicides in juvenile correctional facilities occur when the individual is isolated or in solitary confinement.

Solitary confinement should be distinguished from brief interventions such as "time out," which may be used as a component of a behavioral treatment program in facilities serving children and/or adolescents, or seclusion, which is a short term emergency procedure, the use of which is governed by federal, state and local laws and subject to regulations developed by the Joint Commission, CARF and supported by the National Commission of Correctional Healthcare (NCHHC), the American Correctional Association (ACA) and other accrediting entities.

The Joint Commission states that seclusion should only be used for the least amount of time possible for the immediate physical protection of an individual, in situations where less restrictive interventions have proven ineffective. The Joint Commission specifically prohibits the use of seclusion "as a means of coercion, discipline, convenience or staff retaliation." A lack of resources should never be a rationale for solitary confinement.

The United Nations Rules for the Protection of Juveniles Deprived of their Liberty establish minimum standards for the protection of juveniles in correctional facilities. The UN resolution was approved by the General Assembly in December, 1990, and supported by the US. They specifically prohibit the solitary confinement of juvenile offenders. Section 67 of the Rules states:

"All disciplinary measures constituting cruel, inhuman or degrading treatment shall be strictly prohibited, including corporal punishment, placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned." In this situation, cruel and unusual punishment would be considered an 8th Amendment violation of our constitution.[3]

Measurements to avoid confinement, including appropriate behavioral plans and other interventions should be implemented.[4]

The American Academy of Child and Adolescent Psychiatry concurs with the UN position and opposes the use of solitary confinement in correctional facilities for juveniles. In addition, any youth that is confined for more than 24 hours must be evaluated by a mental health professional, such as a child and adolescent psychiatrist when one is available.

References

1. *Grassian, Stuart. "Psychiatric Effects of Solitary Confinement." Journal of Law and Policy. (2006): 325-383.*
2. *Mitchell, Jeff, M.D. & Varley, Christopher, M.D. "Isolation and Restraint in Juvenile Correctional Facilities." J.Am. Acad. Child Adolesc. Psychiatry, 29:2, March 1990.*
3. *Vasiliades, Elizabeth. "Solitary Confinement and International Human Rights: Why the U.S. Prison System Fails Global Standards." American University International Law Review 21, no. 1 (2005): 71-99.*
4. *Sedlak, Andrea, McPherson, Carla, Conditions of Confinement, OJJDP, May 2010.*

We thank you for your consideration of the above recommendations and for your leadership on this crucial issue. If you should have any questions please contact Michael Linskey at the American Academy of Child and Adolescent Psychiatry at (202) 587-9667.

Sincerely,

Martin J. Drell, M.D.
President

Senate Judiciary Committee
Subcommittee on the Constitution, Civil Rights and Human Rights

Reassessing Solitary Confinement: The Human Rights, Fiscal and Public Safety Consequences

Tuesday, June 19, 2012, 10 a.m.
Dirksen Senate Office Building Room 226

Submitted by James A. Gondles Jr., Executive Director
AMERICAN CORRECTIONAL ASSOCIATION
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As executive director of the American Correctional Association, I respectfully submit the following public correctional policies and accreditation standards for review and consideration by the committee. For your information, we gladly provide you with our Public Correctional Policy on Use of Appropriate Sanctions and Controls, as well as the Public Correctional Policy on Conditions of Confinement. The policies have been reviewed and ratified by ACA's Executive Committee, Board of Governors and Delegate Assembly. They represent the association's position on the subject and are designed to guide and help determine present and future decisions of criminal justice practitioners.

The standards were developed by the Standards Committee and ACA staff in concert with the Commission on Accreditation for Corrections (CAC). The committee allows for extensive debate regarding correctional policies and procedures and includes input from all our members and others, including any concerned citizens or advocates. Their goal is to make certain that the standards are practical in their application and that they truly improve the quality of life for both staff and offenders.

ACA and CAC recognize that solitary confinement is, at times, a necessary administrative tool. In the profession today, we generally do not use the term "solitary confinement" with much frequency. In standards, we refer to it as "special management." The generic term is "segregation" and encompasses administrative segregation, protective custody and disciplinary detention. The principle on which special management decisions are made is simple: Inmates who threaten the secure and orderly management of the institution may be removed from the general population and placed in special housing units (SHUs). Likewise, ACA and CAC advance the principle that the institutions must protect the safety and constitutional rights of inmates and seek a balance between expression of individual rights and preservation of institutional order. With regard to classification, we promote the principle that inmates are classified to the most appropriate level of custody and programming, both on admission and upon review of their status.

Comments are included along with the adopted and published standards. They are used to help practitioners and provide guidance in application or compliance with the standard(s). They are not part of the standard itself and are not considered during the audit and accreditation process.

Founded in 1870, ACA is the oldest and largest professional correctional organization in the world. ACA represents all disciplines within the corrections profession, and its more than 19,000 members include practitioners working in juvenile and adult prisons and jails; halfway houses; treatment facilities; probation, parole and community corrections agencies; as well as academics in the field and other concerned citizens. ACA promotes excellence in corrections by offering professional development and certification, online training, standards and accreditation, and research and publications.

CAC is a nonprofit body that is comprised of corrections professionals from across the country, some who are appointed and some who are elected. Its composition ensures that the commission is completely independent and impartial. The main responsibility of this board is to conduct the accreditation hearing to verify that those agencies applying for accreditation comply with the applicable standards.

Public Correctional Policy on Use of Appropriate Sanctions and Controls

1984-7

Introduction:

In developing, selecting and administering sanctions and punishments, decision-makers must balance concern for individual dignity, public safety and maintenance of social order. Correctional programs and facilities are a costly and limited resource; the most restrictive are generally the most expensive. Therefore, it is good public policy to use these resources wisely and economically.

Policy Statement:

The sanctions and controls imposed by courts and administered by corrections should be the least restrictive, consistent with public and individual safety and the maintenance of social order. Selection of the least restrictive sanctions and punishments in specific cases inherently require balancing several important objectives – individual dignity, fiscal responsibility, effective correctional operations, the interest of the victim and severity of the crime. To meet these objectives, correctional agencies should:

A. Advocate to all branches of government and to the public at large, the development and appropriate use of a wide range of sanctions, punishments, programs and facilities;

B. Recommend the use of the least restrictive appropriate dispositions in judicial decisions;

C. Classify persons under correctional jurisdiction to the least restrictive appropriate programs/facilities; and

D. Employ only the level of regulation and control necessary for the safe and efficient operation of programs, services and facilities.

This Public Correctional Policy was unanimously ratified by the American Correctional Association Delegate Assembly at the Winter Conference in Denver, Jan. 12, 1984. It was reviewed Aug. 15, 1990, at the Congress of Correction in San Diego, with no change. It was reviewed Jan. 18, 1995, at the Winter Conference in Dallas, with no change. It was reviewed and reaffirmed Jan. 12, 2000 at the Winter Conference in Phoenix, with minor amendments. It was reviewed and amended Aug. 13, 2008, at the Congress of Correction in New Orleans.

Public Correctional Policy on Conditions of Confinement

1987-1

Introduction:

Juvenile and adult correctional systems must provide services and programs in an environment that promotes and protects public safety and the safety, rights and dignity of staff, volunteers, victims and those persons served by these systems.

Policy Statement:

Sustaining safe, secure and constitutionally acceptable conditions of confinement requires adequate resources and effective management of staff, operational procedures, programs, the physical plant and the offender population. To support safe, secure and constitutionally acceptable conditions, agencies should:

A. Establish and maintain a safe and humane population limit for each facility and housing unit therein based upon recognized professional standards;

B. Provide an environment that will support the health and safety of staff, volunteers and confined persons. Such an environment results from appropriate design, construction and maintenance of the physical plant as well as the effective and efficient operation of the facility and the provision of adequate and appropriate services for offenders;

C. Maintain a professional and accountable work environment for staff that includes job-specific training and supervision, sufficient staffing and effective deployment of staff to carry out the mission of the facility; and

D. Maintain a fair and structured environment that provides a range of gender- and culturally-responsive programs and services appropriate to the needs and requirements of offenders in a climate that encourages responsible behavior and positive change.

This Public Correctional Policy was unanimously ratified by the American Correctional Association Delegate Assembly at the Congress of Correction in New Orleans, Aug. 6, 1987. It was reviewed and amended at the Congress of Correction in San Diego, Aug. 15, 1990. It was reviewed Jan. 18, 1995, at the Winter Conference in Dallas, with no change. It was reviewed and reaffirmed Jan. 12, 2000, at the Winter Conference in Phoenix, with minor amendments. It was reviewed and amended at the Congress of Correction in Baltimore, Aug. 10, 2005. It was reviewed and reaffirmed without change at the 140th Congress of Correction in Chicago, Aug. 4, 2010.

American Correctional Association

Standards for Adult Correctional Institutions (ACI); 4th Edition

PHYSICAL PLANT – INMATE HOUSING

Special Management Housing

- 4-4141: All cells/rooms in segregation provide a minimum of 80 square feet, of which 35 square feet is unencumbered space.

  Comment: Segregated inmates are confined in cells/rooms for more extended periods during the day. Therefore, the cell/room must provide additional space for in-cell activity.

INSTITUTIONAL OPERATIONS — SPECIAL MANAGEMENT

General Policy and Practice

- 4-4249: When segregation units exist, written policy and procedure govern their operation for the supervision of inmates under administrative segregation, protective custody, and disciplinary detention.

  Comment:

  Administrative Segregation: The classification committee, or in an emergency, the warden/superintendent, may place in administrative segregation an inmate whose continued presence in the general population poses a serious threat to life, property, self, staff, other inmates, or to the security or orderly running of the institution. Inmates in administrative segregation because of behavioral problems should be provided with programs conducive to their well-being. Inmates pending investigation for a trial on a criminal act or pending transfer can also be placed in administrative segregation; this segregation may be for relatively extensive periods of time.

  Protective Custody: Inmates requesting or requiring protection from the general population may be placed in protective custody. Inmates in protective custody should be allowed to participate in as many as possible of the programs afforded the general population, providing such participation does not threaten institutional security. Each protective custody case should be reviewed frequently with the goal of terminating the separate housing assignment as soon as possible.

Disciplinary Detention: The disciplinary committee may place inmates with serious rule violations in disciplinary detention only after an impartial hearing has determined (1) that other available alternative dispositions are inadequate to regulate the inmate's behavior within acceptable limits and (2) that the inmate's presence in the general inmate population poses a serious threat to the orderly operation of security of the institution. Total isolation as punishment for a rule violation is not an acceptable practice; when exceptions occur they should be justified by clear and substantiated evidence and should be fully documented.

Admission and Review of Status

- 4-4251: Written policy, procedure and practice provide that an inmate is admitted to the segregation unit for protective custody only when there is documentation that protective custody is warranted and no reasonable alternatives are available.

  Comment:

  Protective custody should be used only for short periods of time, except when an inmate needs long-term protection and the facts are well-documented. Admission to protective custody should be fully documented with a consent form signed by the inmate.

- 4-4252: Written policy, procedure and practice provide that an inmate is placed in disciplinary detention for a rule violation only after a hearing by the disciplinary committee or hearing examiner.

- 4-4253: Written policy, procedure and practice provide for a review of the status of inmates in administrative segregation and protective custody by the classification committee or other authorized staff group every seven days for the first two months and at least every 30 days thereafter.

  Comment:

  A hearing should be held to review the status of any inmate who spends more than seven continuous days in administrative segregation and protective custody to determine whether the reasons for the placement still exist.

- 4-4254: Written policy, procedure and practice specify the review process used to release an inmate from administrative segregation and protective custody.

  Comment:

  An inmate should be released by action of the appropriate authority.

- 4-4255 (Revised August 2008): There is a sanctioning schedule for institutional rule violations. Continuous confinement for more than 30 days requires the review and approval of the warden/superintendent or designee. Inmates held in disciplinary detention for periods exceeding 60 days are provided the same program services and privileges as inmates in administrative segregation and protective custody.

  Comment:

  The time an inmate spends in disciplinary detention should be proportional to the offense committed, taking into consideration the inmate's prior conduct, specific program needs, and other relevant factors.

Telephone Privileges

- 4-4271 (Revised August 2005): Written policy, procedure and practice provide that inmates in administrative segregation and protective custody are allowed telephone privileges.

  Comment:

  This standard also applies to inmates held in disciplinary detention for more than 60 days.

- 4-4272: Written policy, procedure and practice provide that, unless authorized by the warden/superintendent or designee, inmates in disciplinary detention are allowed limited telephone privileges except for calls related specifically to access to the attorney of the record.

Administrative Segregation/Protective Custody

- 4-4273: Written policy, procedure and practice provide that inmates in administrative segregation and protective custody have access to programs and services that include, but are not limited to, the following: educational services, commissary services, library services, social services, counseling services, religious guidance and recreational programs.

  Comment:

  Although services and programs cannot be identical to those provided to the general population, there should be no major differences for reasons other than danger to life, health or safety. Inmates in administrative segregation and protective custody should have the opportunity to receive treatment from professionals such as social workers, psychologists, counselors and psychiatrists. The standard also applies to inmates held in disciplinary detention for more than 60 days.

Access to Counsel

- 4-4275: Written policy, procedure and practice ensure and facilitate inmate access to counsel and assist inmates in making confidential contact with attorneys and their authorized representatives; such contact includes, but is not limited to, telephone communications, uncensored correspondence and visits.

  Comment:

  Institutional authorities should assist inmates in making confidential contact with attorneys and their authorized representatives; these representatives may include law students, special investigators, lay counsel, or other persons who have a legitimate connection with the legal issue being pursued. Provision should be made for visits during normal institutional hours, uncensored correspondence, telephone communications and after-hour visits requested because of special circumstances.

Protection from Harm

- 4-4281 (MANDATORY): Written policy, procedure and practice protect inmates from personal abuse, corporal punishment, personal injury, disease, property damage and harassment.

  Comment:

  In situations where physical force or disciplinary detention is required, only the least drastic means necessary to secure order or control should be used. Administrative segregation should be used to protect inmates for themselves or other inmates.

** *4-4281-1*

Added August 2002. Written policy, procedure and practice ensure that information is provided to offenders about sexual abuse/assault including:

- *Prevention/intervention;*
- *Self-protection;*
- *Reporting sexual abuse/assault; and*
- *Treatment and counseling.*

The information is communicated orally and in writing, in a language clearly understood by the offender, upon arrival at the facility.

Special Needs Inmates

- 4-4305: Written policy, procedure and practice provide for identification of special needs inmates.

Comment:

Special needs inmates include, but are not limited to: drug addicts and drug abusers, alcoholics and alcohol abusers, inmates who are emotionally disturbed or suspected of being mentally ill, the mentally retarded and those who pose a high risk or require protective custody. Procedures should identify the number, type and frequency of commitment for special need inmates, and special programs should be instituted for their appropriate management when the numbers or frequency of commitment warrant. Every possible effort should be made to place the mentally ill and mentally retarded in a noncorrectional setting.

American Friends Service Committee

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STATEMENT OF

AMERICAN FRIENDS SERVICE COMMITTEE

HEARING: "Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences"

SENATE COMMITTEE on the Judiciary

SUBCOMMITTEE on the Constitution, Civil Rights, and Human Rights

UNITED STATES SENATE

JUNE 19, 2012

Chairman Durbin, Ranking Member Graham and members of the Subcommittee: I am honored to submit this testimony for the record on behalf of the American Friends Service Committee (AFSC) regarding today's hearing on solitary confinement, which has been a focus of our work for more than 25 years. We thank you for holding this critical and timely hearing.

Solitary confinement is characterized by long periods of isolation, with little or no human contact, often including lights on, or off, for 24 hours per day, deliberately loud sounds, extreme hot or cold, menacing dogs and other egregious violations of human rights.

We find the use of solitary confinement to be:

Pervasive – far overused and racially disparate
Illegal – a form of torture recognized and prohibited under international law
Harmful – to the mental health of those with and without pre-existing mental conditions

Solitary confinement is Pervasive. Solitary confinement is widely used in almost every state and within the federal system, in both dedicated long term supermax prisons and other forms of control units, and as shorter-term punishment units. The numbers are difficult to determine, due to lack of consolidated recording and reporting and other problems such as inconsistent definitions, changing policies and court decisions. Many experts are finding solitary confinement widely overused.

In addition the practice suffers from the same racial disparities evidenced in other aspects of the criminal justice system, with people of color significantly over-represented.

Solitary confinement is Illegal. The use of long term solitary confinement is in violation of international covenants:

- International Covenant on Civil and Political Rights, Articles 7, 10, 16
- U.N. Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Articles 1, 4
- U.N. Declaration of Human Rights, Article 5
- American Convention on Human Rights (ratified by 24 OAS (Organization of American States) nations, but not the U.S.)

Although officials often claim that there is no clear definition of torture, torture is defined by the UN Convention Against Torture as, "any state-sanctioned action by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for obtaining information, punishment, intimidation, or for any reason based on discrimination."

- By this definition, security housing units fail on several counts: they cause severe pain both physical and mental; they do primarily for the purpose of punishment, intimidation, or with the hope of extracting information; and they are the most racially segregated part of the prison system.

Solitary confinement also violates the U.S. Constitution's 8th Amendment ban on cruel and unusual punishment. Its use in the United States has been rejected by the European Union, which will not extradite people to the U.S. if they will be placed isolation. The U.S. has come under frequent condemnation from the United Nations Committee on Torture and the UN Special Rapporteur on Torture for the cruelty of this practice.

Solitary confinement is harmful. AFSC has documented the harms of solitary confinement in reports.

- Supermax units are damaging to prisoners' mental health
- There is no evidence that supermax units reduce prison violence
- Long-term isolation is linked to increased recidivism.

In 1944, the Quakers formed the Prison Service Committee to provide support to and monitor the incarceration conditions people who had been imprisoned for of conscientious objection to war. Since that time, the American Friends Service Committee has sought to

provide individual and collective advocacy over conditions of incarceration, policy advocacy against mass incarceration, the death penalty, "life without parole," and immigration detention. In the course of our work we have documented scores of prison abuses including the use of stun guns and restraint devices, rape, prison chain gangs, and inadequate medical care. Letters we have received from prisoners across the U.S. document significant, systemic problems in the area of solitary confinement.

Please allow us to share a few examples of testimony that we have gathered directly from people who have experienced solitary confinement. Some of these conditions have been witnessed directly by our staff in the course of their work inside prisons.

> *If you do something wrong, they lock you down. They make you go to bed early and feed you when they want to feed you. They lock you in this little cell (she describes something about 3 x 5). I cried every night there. It's painful. I felt like I couldn't get air. I cried every night there.*
> A.H. age 17, New Jersey

> *I went in when I was 14 to the Essex County Juvenile Detention Center. They have what they call an "MCU" there, and it's like the "hole" in a regular prison.* ***[MCU - "management control unit" - a form of solitary confinement which may be an administrative, rather than punitive sanction]*** *Kids that fight go in there. If you refuse, they come and get you. You don't see anybody in there. The lights go off early and there are no visits there. They bring the food to you. They even turnoff the toilets at 9 p.m. so if you have to go, you can't flush. It's freezing at night. There is no heat at all in lockdown.*
> D.D. age 15, New Jersey

> *I was placed in solitary confinement for trying to escape from prison. The actual sanction for the attempted escape was only 30 days, but once that sanction ended the prison administrators continued to hold me in solitary for the next 120 months. I was not allowed to participate in any sort of group therapy, religious services, vocational training, educational courses, or rehabilitative programs. I was allowed to shower three times a week; each shower was seven minutes. I was allowed to go outside into a small cage for one hour, five times a week. For any of this movement outside of my cell, my hands were cuffed behind my back before the officers would open my cell door, then I was searched.*

> *It is difficult to describe what such a long time in solitary confinement feels like, as it is difficult to gauge how it has affected me. For ten years though I was powerless... There was no way to block out the sounds of a neighbor who was kicking with all of his might on his steel cell door because an officer refused to let him shower. There was constant stress because of my inability to earn a release, which in turn extended my incarceration for six years. My weight dropped from 170 lbs to 145 lbs, and I developed high blood pressure that required a number of medications.*

> *In response to my pleas for release, the warden would merely tell me to keep on "doing good time..." I would appeal to him about my many years of exemplary behavior...He never*

commended me, however, and never released me from solitary. I ended up serving ten years in solitary confinement.

Peter Martel, Program Associate, AFSC Criminal Justice Program-Michigan; law degree candidate

Families are also affected:

My son was able to escape the frightening conditions of 4-A, one of two SHU ***[Special Housing]*** *units, (guards setting up rooster fights and shooting from the tower) by reading—although he did experience one of the set up fights—not by choice. We all sent books, as many as we could each month, and newspapers and magazines which he passed along to others. But, in this, reading and family, he was more fortunate than most. Because Corcoran was off in the middle of nowhere and the guard's union was so powerful, murder and mayhem on the part of a few guards prevailed in 4-A of the Corcoran SHU. Despite photos of yard fights and the Preston case, no guard was punished. It was almost as frightening to be a parent at that time as to be a prisoner.*
Parent of a SHU prisoner, California, 2008

Our advocacy work has yielded results

Through the efforts of AFSC, its regional programs, and allies, we have achieved the following changes in the use of solitary confinement:

- *Maine* – 60% reduction in prison population held in isolation, and the ending of solitary confinement in the mental health unit
- *Michigan* – 30% reduction in people held in administrative segregation since 2008; closure of a maximum security prison;
- *New Jersey* - secured litigation leading to release of 80 people from a control unit and closing of security threat group ("gang") unit;
- *California* – AFSC regional director chosen mediator by hunger strikers at Pelican Bay facility over conditions; minor concessions won; larger issues currently in litigation;

The American Friends Service Committee is heartened by the Subcommittee's leadership in holding this hearing, and we are grateful for the opportunity to present stories drawn from our organizational experience with individuals and communities impacted by solitary confinement. We urge the Committee to move swiftly and take concrete actions to prohibit solitary confinement at the federal, state and local level:

- AFSC supports congressional efforts that seek an immediate end to the use of solitary confinement for extended periods, as recommended by the U.N. Special Rapporteur;

- AFSC calls for congressional action to establish independent prison oversight boards, with prisoner access without fear of reprisals;

- AFSC requests congressional action to require full collection and comparative reporting, by the Department of Justice, of data on all solitary confinement in U.S. federal, state and local prisons and jails.

Thank you again for this opportunity to express the views of the American Friends Service Committee. We welcome the opportunity for further dialogue and discussion about these important issues.

Appendix

These and other AFSC materials on solitary confinement may be found on our resource page:
http://afsc.org/resource/solitary-confinement

Reports

The Lessons of Marion: The Failure of Maximum Security Prison, A History and Analysis, 1985

The Use of Control Unit Prisons in the United States, 1997

Survivor's Manual, 1997; *tinyurl.com/qa-sis*

Torture in US Prisons – Evidence of Human Rights Violations, 2001

Our Children's House, 2002

The Prison Inside the Prison: Control Units, Supermax Prisons, and Devices of Torture, 2003; *tinyurl.com/qa-pip*

Buried Alive: Solitary Confinement in Arizona's Prisons and Jails, 2007; *tinyurl.com/qa-buried-az*

Tolerating Failure: The State of Health Care and Mental Health Care Delivery in the Michigan Department of Corrections, 2007; http://prisoneradvocacy.org/downloads/tolerating_failure_sans_title.pdf

Buried Alive: Long-Term Isolation in California's Youth and Adult Prisons, 2008; *tinyurl.com/qa-buried-ca*

Inalienable Rights, 2009.

Private Prisons: The Public's Problem, 2012; *tinyurl.com/qa-private*

Books

Beyond Prisons: A New Interfaith Paradigm for Our Failed Prison System, by Laura Magnani and Harmon Wray, 2006; *www.quakerbooks.org*

When the Prisoners ran Walpole: A True Story in the Movement for Prison Abolition, by Jamie Bissonette with Robert Dellelo, et al, 2008; *http://southendpress.org/2007/items/87705*

Marshall Law: The Life and Times of a Baltimore Black Panther, by Marshall "Eddie" Conway and Dominique Stevenson, 2011; *www.quakerbooks.org*

Film/DVD

Stop Torture in U.S. Prisons! by Claire Schoen with Tony Heriza *tinyurl.com/qa-torture*

Concrete, Steel & Paint, by Tony Heriza and Cindy Burstein; *www.concretefilm.org*

Testimony of
Roy Speckhardt, Executive Director
American Humanist Organization
Before the
Senate Judiciary Committee
Subcommittee on the Constitution, Civil Rights and Human Rights
Hearing on Reassessing Solitary Confinement
June 19, 2012

Mr. Chairman, Members of the Subcommittee, thank you for this opportunity to submit testimony on behalf of the American Humanist Association concerning the harmful use of solitary confinement in our nation's federal prisons, jails, and detention centers. We are encouraged that a growing number of states across the nation are reassessing this practice and implementing policies to limit its use. In light of the high cost of solitary confinement and its diminishing returns, we are grateful for the Subcommittee's timely review of the federal system's use of isolation today.

The American Humanist Association is an educational organization that strives to bring about a progressive society where being good without gods is an accepted way to live life. We are accomplishing this through our defense of civil liberties and secular governance, by our outreach to the growing number of people without traditional religious faith, and through a continued refinement and advancement of the humanist worldview. Humanism encompasses a variety of nontheistic views (atheism, agnosticism, rationalism, naturalism, secularism, and so forth) while adding the important element of a comprehensive worldview and set of ethical values---values that are grounded in the philosophy of the Enlightenment, informed by scientific knowledge, and driven by a desire to meet the needs of people in the here and now.

Across our nation prisoners, inmates, and detainees are being confined in a small cells for 22-24 hours per day for weeks, months, even years. Many studies have documented the detrimental psychological and physiological effects of long-term solitary confinement, including hallucinations, perceptual distortions, panic attacks, and suicidal ideation. Considering this severe harm, we strongly believe prolonged solitary confinement is a violation of the inherent dignity in every human being.

The use of solitary confinement has increased dramatically in the last few decades. The Commission on Safety and Abuse in American's Prisons noted in their report, *Confronting Confinement*, that from 1995 to 2000, the growth rate of segregation units significantly surpassed the prison growth rate overall: 40% compared to 28%. Rather than a last resort, solitary confinement has become a default management and discipline tool.

The drastic rise in solitary confinement has cost us financially, as the daily cost per inmate in a solitary confinement unit far exceeds the costs of housing an inmate in lower security facility since solitary confinement units require individual cells and significantly more staff. The success of several states such as Mississippi, Maine, and Colorado in maintaining prison security while reducing their use of isolation demonstrates that solitary is not the only, or best, option.

Further, we must not neglect the larger public safety impact. The negative effects of prolonged solitary confinement harm our communities, as demonstrated by the fact that prisoners who are freed directly from solitary confinement cells are significantly more likely to commit crimes again. Successful

reentry of these citizens to our local communities therefore requires preparation for release while they are still incarcerated. This is why the American Humanist Association recent sent a letter along with faith groups to the Senate Subcommittee on Commerce, Justice, Science, and Related Agencies asking Congress to expand programming options, such as job training and drug rehabilitation programs, for current inmates.

Mr. Chairman, Members of the Subcommittee, the American Humanist Association believes strongly that the United States should do everything it can to reverse our nation's harmful and expensive reliance on solitary confinement. We have a moral obligation to uphold the dignity and the mental health of those currently incarcerated. To that end, we would strongly support your leadership in sponsoring legislation that would limit the use and length of solitary confinement. We implore you to immediately take steps to end the use of prolonged solitary confinement. Your hearing today is a very important effort in doing that, and we thank you for the opportunity to contribute to it.

American Psychiatric Association
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Telephone: 703.907.7800

Statement of

JAMES H. SCULLY, Jr., M.D.
MEDICAL DIRECTOR AND CEO
ON BEHALF OF
THE AMERICAN PSYCHIATRIC ASSOCIATION

for the

United States Senate Committee on the Judiciary,
Subcommittee on the Constitution, Civil Rights,
and Human Rights

June 19, 2012

The American Psychiatric Association (APA), the medical specialty society representing over 36,000 psychiatric physicians nationwide, appreciates the opportunity afforded Chairman Durbin and Ranking Member Graham to submit the following statement regarding today's hearing: *Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences.*

The practice of segregating prisoners for disciplinary or safety reasons has grown in the United States, and the prevalence of the practice remains unique among developed nations. The exact number of segregated prisoners nationwide is not known; however, Solitary Watch has recently estimated the number to be approximately 82,000. While the specific conditions of segregation vary between prison systems, a few generalizations can be made. Segregated prisoners spend 23 or more hours each day locked in isolation. There is limited allowance for solitary recreation, and virtually no opportunity for educational advancement, vocational pursuits, or social interaction. Furthermore, segregated prisoners receive healthcare services apart from the general prison population – often within segregated prison units.

The APA acknowledges the research that suggests prolonged solitary confinement may be detrimental to persons with serious mental illness. The number of prisoners with serious mental illness has risen since 1980. Current estimates place the number of prisoners with psychiatric disorders between 8% and 19%, with an additional 15% to 20% of prisoners requiring some form of psychiatric intervention during incarceration.[1] Furthermore, prisoners with serious mental illness often face greater challenges in adapting to prison life, and are consequently at higher risk for disciplinary action and segregation.[2]

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[1] Jeffrey L. Metzner, MD, and Jamie Fellner, Esq., "Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics," *American Academy of Psychiatry and the Law Vol. 38*, 2010, 105.

[2] See Donald W. Morgan, MD, et al, "The Adaptation to Prison by Individuals with Schizophrenia," *American Academy of Psychiatry and the Law Vol. 21*, 1993, 427-33; David Lovell and Ron Jemelka, "When Inmates Misbehave: The Costs of Discipline," *The Prison Journal Vol. 76*, 1996, 165-79.

Segregation over prolonged periods of time may produce harmful psychological effects. These effects may include anxiety, anger, cognitive disturbance, perceptual distortion, obsessive thoughts, paranoia, and psychosis.[3] For persons with serious mental illness, these effects may exacerbate underlying psychiatric conditions, such as schizophrenia, bipolar disorder, and major depressive disorder.[4] Segregated prisoners with serious mental illness often require costly psychiatric hospitalization or crisis intervention services, and generally face bleak prospects of any medical improvement.

Given that solitary confinement may exacerbate psychiatric conditions in prisoners with serious mental illness, it is not surprising that suicide rates have long been disproportionately higher among segregated prisoners than the general prison population.[5] A nationwide study of 401 prison suicides in 1986 concluded that two out of every three completed suicides occurred in some form of control unit. Another study conducted found that 70% of completed suicides in 2005 in California prison systems occurred in solitary confinement.[6] These sobering studies clearly illustrate the inherent danger solitary confinement holds for prisoners with serious mental illness.

The APA believes that the mental health effects associated with prolonged solitary confinement should be closely considered by the Chairman, Ranking Member, and other members of the Subcommittee, and should influence any future policy made on the practice of solitary confinement in the United States.

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[3] Metzner and Fellner, 104.

[4] Ibid.

[5] Ibid., 105.

[6] See Lindsay M. Hayes and Joseph R. Rowan, "National Study of Jail Suicides: Seven Years Later," National Center on Institutions and Alternatives, 1988; and Don Thompson, "Convict Suicides in State Prison Hit Record High," *Associated Press*, January 3, 2006, in Sal Rodriquez, "Fact Sheet: Psychological Effects of Solitary Confinement," Solitary Watch, http://solitarywatch.files.wordpress.com/2011/06/fact-sheet-psychological-effects-final.pdf (accessed 12 June 2012).

Psychiatric physicians are uniquely trained to provide medical and mental health care to their patients. Regrettably, a majority of prison segregation units in the United States lack an environment in which psychiatric physicians can thoroughly evaluate, consult, and treat their patients with appropriate confidentiality. Furthermore, psychiatric physicians who practice in prison systems are often challenged by limited budgetary resources to provide adequate care to segregated prisoners, many of whom experience exacerbated psychiatric symptoms under solitary confinement.

The APA believes that any initiative to address the practice of solitary confinement in the United States must also address the physician's ethical responsibility to provide the highest level of medical and mental health care to incarcerated patients. This entails greater investments in the psychiatric physician workforce, enhanced efforts to educate all physicians about correctly diagnosing and treating mental illness, and repurposed space in prison segregation units that ensures that patients receive appropriate confidential evaluation, consultation, and treatment services. Together, these investments promise to increase the overall well-being of the entire prison population while reducing overall healthcare costs.

Once again, the APA appreciates the opportunity afforded by Chairman Durbin and Ranking Member Graham to provide this statement on behalf of its members. Should you have any questions or need further information, please do not hesitate to contact my staff, Jeffrey P. Regan, at (703) 907-7800 or jregan@psych.org.

AMNESTY INTERNATIONAL

Statement by Amnesty International USA

Prepared for the Hearing on Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences, before the U.S. Senate Committee on the Judiciary Subcommittee on the Constitution, Civil Rights and Human Rights

June 18, 2012

Chairman Durbin, Ranking Member Graham, and Members of the Subcommittee:

Amnesty International is a Nobel Peace Prize-winning grassroots activist organization with more than 3 million supporters, activists and volunteers in more than 150 countries campaigning for human rights worldwide. The organization investigates and exposes abuses, educates and mobilizes the public, and works to protect people wherever justice, freedom, truth and dignity are denied. Amnesty International USA is the largest country section of the organization, with nearly 250,000 members who work for human rights independently, through national online networks, or with high school, college or community groups.

Amnesty International USA (AIUSA) welcomes this opportunity to address the U.S. Senate Committee on the Judiciary Subcommittee on the Constitution, Civil Rights and Human Rights on the issue of solitary confinement in the United States.[1] Amnesty International has for years monitored maximum security conditions in the U.S., including in Arizona, California, Colorado, Illinois, New York, Virginia and Texas. Last November, Amnesty International toured the Security Housing Units in three prisons in California, where in July and October of last year, thousands of prisoners went on hunger strike to protest conditions in the state's

[1] In a recent report on this issue, reviewing the practice internationally, the UN Special Rapporteur on Torture defined solitary confinement as the "physical and social isolation of individuals who are confined to their cells for 22 to 24 hours a day". Amnesty International uses the term "solitary confinement" and "isolation" interchangeably to describe circumstances in which prisoners are confined to small, usually single (but sometimes double) cells for 22 hours or more a day, with no group activities and only limited contact. States use a variety of terms to describe their "super-maximum" isolation units, including "Special Management Units" and "Security Housing Units" – all such units are covered by the concerns outlined in this statement.

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Security Housing Units.[2] Last month, Amnesty released a report on maximum security prisons in Arizona, entitled *USA: Cruel isolation – Amnesty International's concerns about conditions in Arizona maximum security prisons.*[3] Attached as an appendix is a sampling of Amnesty International's concerns regarding maximum security isolation in prisons in Arizona, California and Illinois, as well as our concerns about pre-trial prisoners in U.S. federal custody.

The U.S. stands virtually alone in the world in incarcerating thousands of prisoners in long-term or indefinite solitary confinement.[4] More than 40 states are believed to operate "super-maximum security" units, collectively housing at least 25,000 prisoners.[5] This number does not include the many thousands of other prisoners serving shorter periods in punishment or administrative segregation cells. In a few states, such as California, prisoners have spent decades in indefinite isolation.

While prison authorities have always been able to segregate prisoners for their own protection or as a penalty for disciplinary offenses, super-maximum security facilities differ in that they are designed to isolate prisoners long-term as an administrative control measure. It is a management tool that is increasingly under question, by human rights experts and others, both for the inhumanity of the conditions of confinement as well as the effectiveness of such systems.

Amnesty International believes that holding any individual in long-term isolation absent a severe, continuing threat that cannot be contained by alternative means, is disproportionately harsh. International and regional human rights organizations and experts have called on states to limit the use of solitary confinement and impose it only in exceptional circumstances, for as short a time as possible.[6] The American Bar Association

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[2] "USA: Amnesty International calls for urgent reforms to California security housing units as prison hunger strike resumes", 4 October 2011: http://www.amnesty.org/en/library/asset/AMR51/085/2011/en/01f5bb3c-3076-46db-b472-61cdb614e724/amr510852011en.pdf

[3] http://www.amnesty.org/en/library/asset/AMR51/023/2012/en/6a0fe437-9362-47fd-af51-7b7c4cda05bf/amr510232012en.pdf

[4] http://www.amnesty.org/en/news/isolated-and-dehumanised-inmates-arizona-s-isolation-units-2012-04-03

[5] Daniel P. Mears, "Evaluating the Effectiveness of Supermax Prisons," Urban Institute Justice Policy Center, March 2006, p. ii, available at http://www.urban.org/UploadedPDF/411326_supermax_prisons.pdf

[6] This was reiterated by the Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment in his report to the UN General Assembly in October 2011 (supra at note 2), which referred to the consistent recommendations of international and regional human rights treaty bodies, organizations and

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(ABA) in its standards on the treatment of prisoners[7] has stated that segregation for more than one year should be imposed only if the prisoner poses a "continuing, serious threat" (23-2.7), and that all prisoners in segregated housing should be provided with "meaningful forms of mental, physical and social stimulation", including, where possible, more out-of-cell time and opportunities to exercise in the presence of other prisoners (23-3.8). The ABA standards also state that segregation in "protective custody" should take place "in the least restrictive setting possible (23-5.5).

AI has reviewed conditions in isolation facilities across the United States, and considers many of them to fall far short of minimum standards for humane treatment. Most prisoners are held in solitary cells 22-24 hours a day, in conditions of reduced sensory stimulation. Some cells have no windows to the outside and no or limited access to natural light, which is in direct contravention of the United Nations Standard Minimum Rules for the Treatment of Prisoners. Article 11 of the Standard Minimum Rules states: "In all places where prisoners are required to live or work, (a) windows shall be large enough to enable the prisoners to read or work by natural light, and shall be so constructed that they can allow the entrance of fresh air whether or not there is artificial ventilation."[8]

Amnesty International recognizes that it may be necessary at times to segregate prisoners who have committed serious rule violations or who are an ongoing threat to the safety of staff or other prisoners. However, international standards provide that all prisoners, whatever their custody status, are entitled to humane treatment. Article 10 of the International Covenant on Civil and Political Rights,[9] which the United States has ratified, provides that "all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person", a standard which the United Nations Human Rights Committee, the treaty monitoring body, has stressed is a "fundamental and universally applicable rule".[10]

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experts over the years. The Special Rapporteur defined solitary confinement as the "physical and social isolation of individuals who are confined to their cells for 22 to 24 hours a day".

[7] ABA Criminal Justice Standards on Treatment of Prisoners, approved by the ABA House of Delegates, February 2010.

[8] http://www2.ohchr.org/english/law/treatmentprisoners.htm

[9] http://www2.ohchr.org/english/law/ccpr.htm

[10] Human Rights Committee General Comment 21 on Article 10 (concerning humane treatment of persons deprived of liberty).
http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/3327552b9511fb98c12563ed004cbe59?Opendocument

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BACKGROUND

Prisoners in super-maximum units have few possessions and no access to work or rehabilitation programs. Contact with staff and other prisoners is minimized, and they are held behind barriers at all times, even during medical or psychological consultations, which can serve to dehumanize prisoners and hinder communication. Contact with the outside world is also far more limited than for other prisoners: inmates in super-maximum units can be held for decades never touching another person. Many states do not provide the minimum amount of outside exercise required under the Standard Minimum Rules[11], or if they meet this standard, Amnesty International is told it is often routinely denied through lack of staffing. When there is outdoor exercise, this is usually taken alone, often in an enclosed yard with little access to sunlight and no view to the outside, compounding isolation and sensory deprivation.

Although the Standard Minimum Rules do not have the binding force of a treaty, they are internationally agreed minimum standards for the living conditions and treatment of prisoners worldwide. The provisions relating to light and air are fundamental quality of life requirements that apply to all prisoners regardless of their custody status.

Standards set out by the American Correctional Association (ACA) also require that "all inmate rooms/cells provide access to natural light" and that "segregation housing units provide living standards that approximate those of the general population".[12]

MEDICAL AND MENTAL HEALTH CONCERNS

There is a significant body of evidence, both in the United States and elsewhere, that isolation in conditions of reduced environmental stimulation, even for relatively short periods of time, can cause serious psychological harm, including anxiety and depression, perceptual distortions and psychosis.[13] As U.S. courts have recognized, such conditions can have negative effects on individuals with no pre-existing illness and can be particularly harmful in the case of those who already suffer from mental illness. The severe negative

[11] "21. (1) Every prisoner who is not employed in outdoor work shall have at least one hour of suitable exercise in the open air daily if the weather permits." http://www2.ohchr.org/english/law/treatmentprisoners.htm

[12] Standards for Adult Correctional Facilities, 4th Edition (4-4147-148, 4-4140). The ACA standards appear to allow for a natural light source within 20 feet of a cell rather than directly into the cell itself. As Amnesty International has noted elsewhere, this standard may have been acceptable for old-style facilities with open barred cells but is not an adequate standard for modern, closed-cell units where little light enters the cells.

[13] Findings of studies published in numerous articles, e.g. Stuart Grassian, "Psychiatric Effects of Solitary Confinement", Journal of Law and Policy, and in court rulings and testimony.

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APPENDIX
SAMPLING OF AI'S CONCERNS REGARDING MAXIMUM CUSTODY ISOLATION THE U.S.

Amnesty International considers conditions in maximum custody isolation facilities – including confinement to enclosed or windowless cells, lack of access to natural light and fresh air, lack of exercise, lack of educational and rehabilitation programs, and social isolation – are contrary to international standards for humane treatment; the cumulative effects of such conditions, particularly when imposed for a prolonged or indefinite period, constitute cruel, inhuman or degrading treatment or punishment in violation of international law.

ARIZONA
In April of this year, Amnesty International issued a report on the conditions under which prisoners are confined in the Special Management Units (SMUs) of Arizona State Prison Complex (ASPC)-Eyman and other maximum custody facilities operated by the Arizona Department of Corrections (ADOC). More than 2,900 prisoners are held in Arizona's highest security maximum custody facilities, the majority in the SMUs at ASPC-Eyman. Most are confined alone in windowless cells for 22 to 24 hours a day in conditions of reduced sensory stimulation, with little access to natural light and no work, educational or rehabilitation programs. Prisoners exercise alone in small, enclosed yards and, apart from a minority who have a cellmate, have no association with other prisoners. Many prisoners spend years in such conditions; some serve out their sentences in solitary confinement before being released directly into the community. While the Arizona authorities classify maximum security inmates as those posing the highest institutional security risk, Amnesty International's findings suggest that some prisoners are confined to the units who do not fit this criteria. The organization is further concerned that many of those confined to the units suffer from mental illness or disability and are held in conditions likely to exacerbate their illness or disability.

CALIFORNIA
More than 3,000 state prisoners in California are confined to Security Housing Units (SHUs). They include Pelican Bay State Prison, where more than 1,000 prisoners are currently housed in windowless cells for 22.5 hours a day, in conditions which a court stated in January 1995 "may press the outer bounds of what most humans can psychologically tolerate". Thousands of prisoners in California went on hunger strike in July and October of last year to protest cruel conditions of isolation in the state's SHUs. At the time of the

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hunger strike, more than 500 prisoners in Pelican Bay had spent at least 10 years in these conditions, and 78 had spent 20 years or more in the SHU. Amnesty International joined others in condemning disciplinary action taken against hunger strikers and urging an end to inhumane conditions.

In March of this year, Amnesty International welcomed proposals by the California Department of Corrections and Rehabilitation to provide a route out of isolation for validated gang members through a step-down process, which would take place in four stages, each lasting a minimum of 12 months. However, Amnesty is concerned that the plan does not appear to include physical changes to the SHUs, nor does it allow any group interaction for at least the first two years.

ILLINOIS

In February of this year, Illinois Governor Pat Quinn announced a proposal to close Tamms Correctional Center as part of a series of measures to cut the state's budget which will be considered by the state legislature. According to Amnesty International's information, prisoners at Tamms Correctional Center are confined alone for 23 or 24 hours a day in sparsely equipped concrete cells, with no work or group educational or recreational programs. All meals are taken in the cells. Prisoners exercise alone for a maximum of 5-7 hours a week in a high-walled, bare, partially-covered yard with no view apart from a small section of sky.

Contact with the outside world is also severely restricted, with prisoners denied phone calls and allowed only non-contact visits, conducted through a thick glass screen and intercom system. Prisoners are chained to the floor during visits and some have their wrists shackled together, allowing little movement. Despite the stringent security measures, prisoners are reportedly subjected to strip searches, including body cavity searches, before and after each visit. Because of the conditions imposed, and the remote location of the facility, many prisoners reportedly receive visits only rarely.

The prison was designed to house inmates considered too disruptive or dangerous to remain in the state's general prison population, while providing a means by which prisoners could move back to less restrictive facilities if their behavior improved. However, Amnesty International is concerned by the reported secrecy and lack of transparency in current procedures for transferring prisoners to and from Tamms, and the absence of any external oversight of such decisions. According to prison monitoring bodies, many prisoners are unaware of why they have been denied requests to transfer out of Tamms. More than 80

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prisoners (around a third of the total) are believed to have been held in the facility for at least ten years, many since it opened in 1998, without any reasonable means of gaining release from their indefinite solitary confinement.

Amnesty International is concerned by reports that a significant number of prisoners currently housed in Tamms suffer from mental illness or psychological problems which are exacerbated by the harsh conditions of isolation. Prisoners have been described as engaging in disturbed behaviors such as self-mutilation, smearing feces on cell surfaces, throwing bodily liquids or howling. It is alleged that seriously mentally ill prisoners, or those with histories of mental illness, have been sent to Tamms despite regulations which allow for the exclusion of such individuals from the facility.

PRE-TRIAL PRISONERS IN U.S. FEDERAL CUSTODY

Amnesty International has called for a review of conditions in the Special Housing Unit (SHU) of the federal Metropolitan Detention Center (MCC) in New York, where prisoners have sometimes spent long periods confined to small cells with little access to natural light or fresh air. The unit, known as MCC 10th Floor South, comprises six cells where prisoners are confined alone for 23 or 24 hours a day. Amnesty International has been told that the windows in the cells are painted over so that there is no view to the outside and little natural light. Prisoners held in the unit have no contact with other inmates and eat all meals in their cells, which are reportedly furnished only with a concrete bed, toilet and sink. They have no outdoor exercise, contrary to the UN Standard Minimum Rules for the Treatment of Prisoners. The unit has been used to house, among others, pre-trial detainees charged with terrorism-related offences. Most have been placed under Special Administrative Measures (SAMs), rules which impose severe restrictions on communication with other inmates and the outside world.

Amnesty International believes that the combined effects of prolonged isolation and other deprivations in the unit amount to cruel, inhuman and degrading treatment.

Several lawyers who have represented prisoners in MCC 10th Floor South have told Amnesty International that the conditions had a negative impact on their clients' mental state, causing agitation, depression and an inability to focus. They also reported that the non-contact visitation made it difficult to communicate with their clients, particularly when dealing with large amounts of evidentiary materials. This raises concern that such conditions may impair a defendant's ability to assist in his or her defense and thus the right to a fair trial.

Reassessing Solitary Confinement:
The Human Rights, Fiscal, and Public Safety Consequences

Hearing Before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights

June 19, 2012

Statement submitted by

Hope Metcalf, Director of the Arthur Liman Public Interest Program, and Judith Resnik, Arthur Liman Professor of Law

Yale Law School

June 15, 2012

In keeping with Arthur Liman's commitment to a just and humane criminal justice system, much of the work of the Arthur Liman Public Interest Program at Yale Law School focuses on understanding the uses and implications of incarceration in the United States.[1] During the past few years, a special concern has been the use of prolonged solitary confinement—*i.e.*, placing individuals in physical and social isolation in their cells for 22 to 24 hours per day and often for indefinite periods of time. At the Fourteenth Annual Liman Colloquium—*Imprisoned*—held in 2010, more than 400 participants addressed the unprecedented numbers of individuals held in U.S. prisons.[2] In the fall of 2011, we taught a weekly seminar, *Abolition: Slavery, Supermax, and Social Movements*, which posed the question whether "Supermax" – prisons organized to keep individuals in confinement indefinitely in conditions of extreme sensory and social deprivation – should be the subject of an "abolition" movement, as was slavery.

In the spring of 2012, the Liman Program, working with the ABA Subcommittee on Solitary Confinement and Columbia Law School, co-sponsored a roundtable, *Incarceration and Isolation*. The day-long meeting brought together leaders in corrections, experts in law, criminology, sociology, and psychology, and lawyers and others in the field. In advance, we worked with a group of law students who reviewed public information so as to provide a picture of what solitary confinement looks like inside of America's prisons.[3] A summary of preliminary findings follows.

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[1] The Arthur Liman Public Interest Program and Fund at Yale Law School was created in 1997 to forward the commitments of Arthur Liman (YLS '57) to public service in the furtherance of justice. Arthur Liman was chief counsel to the New York State Special Commission on Attica Prison, which in 1972 issued a major report on prison conditions. Thereafter, Arthur Liman served as President of the Legal Aid Society of New York and of the Neighborhood Defender Services of Harlem; Chair of the Legal Action Center in New York City; Chair of the New York State Capital Defender's Office; and Special Counsel to the United States Senate Committee Investigating Secret Military Assistance to Iran and the Nicaraguan Opposition.

Judith Resnik is the Arthur Liman Professor of Law at Yale Law School and the Founding Director of the Liman Public Interest Program and Fund. Her article, *Detention, The War on Terror, and the Federal Courts*, 110 COLUM. L. REV. 579 (2010), focused in part on solitary confinement. Hope Metcalf is Director of the Liman Program. She also supervises the Detention and Human Rights Clinic, and is a co-chair of the ABA Subcommittee on Solitary Confinement. These comments reflect the authors' personal views. For additional details of the Liman Program, see http://www.law.yale.edu/intellectuallife/ArthurLimanPIFellowship&fund.htm.

[2] Liman Newsletter, *Imprisoned* (Fall 2010), http://www.law.yale.edu/documents/pdf/Liman/Liman_NL_2010_web.pdf.

[3] The Liman Survey of Prolonged Solitary Confinement was done by Yale Law students Brian Holbrook, Danielle Lang, Albert Monroe, Ester Murdukhayeva, Katherine Oberembt, Yaman Salahi, and by Columbia Law student Joanna Wright. In addition to supervision from us and Brett Dignam, Clinical Professor of Law at Columbia Law School, the Senior Liman Fellow in Residence, Sia Sanneh, oversaw the data collection and analysis. For each of the fifty states, the student-researchers examined statutes, administrative regulations, correctional rules and procedures, policies and classification instruments. In some instances, they turned to prisoner handbooks and to state public record and FOIA requests. Our statement is also informed by the collective efforts of Isra Bhatty, Katherine D'Ambrosio, Emily Gerrick, David Lebowitz, Matthew Lee, Kate Mollison, Jamelia Morgan, Sophia

We submit this statement based on our study of the law, policy, and practices of solitary confinement. We are concerned that prolonged solitary confinement is used too often, for too long, and with too little oversight. Given the immense fiscal, societal, and human costs, we hope that this Hearing will be the first of many to address the harms of prolonged solitary confinement so as to develop new laws to limit its uses.

I. A Survey of State and Federal Policies on the Isolation of Prisoners in the United States: The Limited Public Information about the Process, Duration, and Practices of Confinement

Our specific concern is the development in the 1970s in the United States of a new form of incarceration – an institution organized to keep people in isolation indefinitely. To provide a window into the nature of the isolation, we borrow a description from the 2005 decision, *Wilkinson v. Austin*, of the United States Supreme Court, which detailed one state's Supermax facility – the institution that opened in Ohio in 1998 to confine more than five hundred prisoners.[4] Conditions there were:

> more restrictive than any other form of incarceration in Ohio, including conditions on its death row . . . . [A]lmost every aspect of an inmate's life is controlled and monitored. Inmates must remain in their cells, which measure 7 by 14 feet, for 23 hours per day. A light remains on in the cell at all times, though it is sometimes dimmed, and an inmate who attempts to shield the light to sleep is subject to further discipline. During the one hour per day that an inmate may leave his cell, access is limited to one of two indoor recreation cells.
>
> Incarceration . . . is synonymous with extreme isolation. In contrast to any other Ohio prison . . . [the] cells have solid metal doors with metal strips along their sides and bottoms which prevent conversation or communication with other inmates. All meals are taken alone in the inmate's cell instead of in a common eating area. Opportunities for visitation are rare and in all events are conducted through glass walls. It is fair to say [Supermax] inmates are deprived of almost any environmental or sensory stimuli and of almost all human contact.
>
> Aside from the severity of the conditions, placement at [the Supermax] is for an indefinite period of time, limited only by an inmate's sentence. For an inmate serving a life sentence, there is no indication how long he may be incarcerated . . . once assigned there.[5]

Shin, Helen Vera, and Rachel Wiener, who were members of the Detention and Human Rights Clinic at Yale Law School.

[4] 545 U.S. 209 (2005).

[5] *Id.* at 214-15.

Given this description, we sought to learn more about the use of prolonged isolation around the United States. As noted, we relied on publicly available data, some of which is summarized below. We learned that very limited information is available to enable a concrete and specific understanding of the numbers of persons in prolonged solitary confinement, the characteristics of those persons, the processes that were provided before they were placed in isolation, and the rules that permit them to exit from that isolation.[6] For several states, student-researchers were unable to find any policies or regulations available to the public about the use of segregation. Of the policies that were available, many were written in vague and general terms. Another caveat is that, in many states, the Department of Corrections is exempt from ordinary Administrative Procedure Act requirements for policy-making, and therefore policies can change without either notice or comment.[7] In short, the Spring 2012 Liman Survey of Prolonged Solitary Confinement is a preliminary review that will be augmented when additional materials become available.

Yet another challenge in providing a national picture is that various terms are used to describe the placement of individuals in long-term solitary confinement.[8] One common formulation refers to "punitive segregation" or "disciplinary segregation,"[9] which is the

[6] In terms of national data collection, other researchers have reviewed statistics compiled by the Bureau of Justice Statistics (BJS) and have concluded that as of 2005, 81,622 individuals were in forms of "restrictive housing." Angela Browne & Suzanne Agha, *Prisons Within Prisons: The Use of Segregation in the United States*, 21 Federal Sentencing Reporter 1, 1 (October 2011) (citing James J. Stephan, *Census of State and Federal Adult Correctional Facilities*, 2005 (Bureau of Justice Statistics, U.S. Department of Justice, October 2008)).

[7] *See, e.g.*, N.D. CENT. CODE § 28-32-01(11)(f) (1991) ("A rule concerning only inmates of a correctional or detention facility" is exempted from the North Dakota Administrative Agencies Practice Act). For a list of states that exempt prison rulemaking from their APAs, see Giovanna Shay, *Ad Law Incarcerated*, 14 BERKELEY J. CRIM. L. 329 app. at 376 (2009).

[8] Jurisdictions also are not consistent in how they designate individuals for the highest classification levels. For example, some states use the terms "maximum security" or "maximum custody," but others use the designation "close custody." *Compare* Ky. DOC Policy 18.5, at 2 (May 14, 2008), http://corrections.ky.gov/communityinfo/Policies%20and%20Procedures/Documents/CH18/18-5%20Custody%20and%20Security%20Guidelines.pdf, *with* Miss. DOC Inmate Handbook Ch. 1, at 1-2 (Jul. 11, 2011), http://www.mdoc.state.ms.us/Inmate_Handbook/CHAPTER%201.pdf, *and* Idaho DOC Control Number 303.02.01.001, at 7 (Aug. 19, 2010), http://www.idoc.idaho.gov/sites/default/files/webfm/documents/about_us/policies_and_forms/policypublic/3030201001.pdf. Some states have small units at one or more specific facilities designated as long-term housing for inmates with a prolonged pattern of disciplinary sanctions, referred to as "Intensive Management Units" or "Special Management Units." *See* Wash. DOC Policy 320.255 (July 9, 2009) ("Intensive Management Units"), http://www.doc.wa.gov/policies/showFile.aspx?name=320255; Pa. DOC Policy DC-ADM 802 (June 7, 2011) ("Special Management Units"), http://www.portal.state.pa.us/portal/server.pt/document/919463/802_administrative_custody_procedures_pdf.

[9] *E.g.*, Ala. DOC Policy 804.02, at 1 (July 9, 1995) ("punitive segregation"), http://www.correct.state.ak.us/pnp/pdf/804.02.pdf; Ark. DOC Policy 10-20, at 1 (July 23, 2010) ("punitive segregation"); Conn. DOC Directive 9.5, at 4 (Jan. 1, 2008) ("punitive segregation"), http://www.ct.gov/doc/LIB/doc/PDF/AD/ad0905.pdf; Neb. DOC Regulation 210.01, at 2 (June 29, 2010) ("disciplinary segregation"), http://www.corrections.nebraska.gov/pdf/ar/classification/AR%20210.01.pdf; Wyo.

placement in solitary confinement as punishment for *past conduct*. This form of segregation is typically for a set duration and consecutive terms may be served. Placement in solitary confinement for the possibility of *future wrongdoing* is frequently referred to as "administrative segregation,"[10] which often is not limited its duration and which is an umbrella for a range of rationales for the placement of an individual in isolation.[11]

Despite these limits, our preliminary review of public information offers a few lessons. First, the profound isolation that Ohio imposed, as the Supreme Court described in *Wilkinson* is not, we regret to report, unusual. Indeed, the common feature of the custody settings that our research identified is that prisoners spend a minimum of twenty-three hours per day in a cell.[12] Other common conditions include very limited access to phone and visitation privileges. Likewise, access to outside recreation areas is generally limited to three to five hours per week.

Second, all states provided written notice of the reasons for placement in advance of or contemporaneous with confinement, but corrections officials generally have a great deal of discretion in the initial and continuing placement of prisoners in administrative segregation. In determining whether someone should be assigned to administrative segregation, many correctional systems use a list of factors[13] that specify particular justifications but also typically include broad, catch-all provisions.[14] Further, in the public data reviewed thus far, no system placed a definite time limit on the use of administrative segregation.

DOC Policy 3.101, at 17 (Oct. 15, 2009) ("disciplinary segregation"), http://doc.state.wy.us/Media.aspx?mediaId=340.

[10] *E.g.*, Haw. Corrections Administration Policy 11.01, at 1 (Dec. 12, 2009); Minn. DOC Directive 301.085 (June 3, 2008), http://www.doc.state.mn.us/DocPolicy2/html/DPW_Display_TOC.asp?Opt=301.085.htm; Nev. DOC Administrative Regulation 507 (May 20, 2010), http://www.doc.nv.gov/sites/doc/files/pdf/AR507.pdf; Ohio Department of Rehabilitation & Corrections Administrative Rule 1-10-15 (Jan. 1, 2003), http://www.drc.ohio.gov/web/administrative_rules/documents/1-10-15.pdf.

[11] A third common category is protective segregation, or protective custody, which is used when prison officials believe that a given prisoner is at risk from others in the general population.

[12] *E.g.*, 20 ILL. ADM. CODE 504.620 (2012); Pa. DOC Policy DC-ADM 801, at 6-1 (June 13, 2008), http://www.portal.state.pa.us/portal/server.pt/document/916568/801_inmate_discipline_pdf; Vt. DOC Policy 410.06, Attach. 1 (Dec. 18, 2006), http://www.doc.state.vt.us/about/policies/rpd/correctional-services-301-550/401-500-programs-security-and-supervision/410.06%20Restrictive%20Housing.pdf; Wash. DOC Policy 320.255, at 3 (Aug. 9, 2009), http://www.doc.wa.gov/policies/showFile.aspx?name=320255.

[13] In some states, prisoners may be put in long-term isolation based on classification determinations. *See, e.g.*, Cal. Dep't of Corrections and Rehabilitation, Expert Panel Study of the Inmate Classification Score System 2 (Dec. 2011), http://www.cdcr.ca.gov/Reports/docs/2010-2011-Classification-Study-Final-Report-01-10-12.pdf.

[14] For example, Nebraska considers the following factors in placing a prisoner in administrative segregation:

1. The threat potential to staff and/or inmates posed by the inmate.
2. The behaviors leading to the inmate's referral or placement on Administrative Segregation status.
3. The inmate's history of or lack of predatory behavior.
4. The inmate's history of or lack of assaultive behavior.

A third lesson is that, while a few states delineate ways in which prisoners can be moved out of prolonged confinement, most of the policies reviewed lacked specificity. Some jurisdictions have "step-down" or transitional programming available for prisoners prior to transfer to general population or release.[15] Data are not publicly available about either the rates of exit or the other effects of these programs.[16] While many states appear to allow individuals in long-term administrative segregation to have some access to programs such as life skill classes and other educational programs available to other inmates, such access is generally limited to offering inmates written materials to use in their isolation cells.[17]

Fourth, a diversity of rules govern placement. As noted, all states provide written notice in advance of or contemporaneous with placement in administrative segregation. Some states permit hearings, which may include the opportunity for written or oral testimony, prior to placement. Several states appear to provide written notice but no hearing.[18]

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5. The inmate's history of or lack of escape/attempted escapes.
6. The inmate's history of or lack of membership in a criminal threat group.
7. The injuries the inmate may have caused to others.
8. The inmate's use of weapon(s) in this or prior incidents.
9. The inmate's documented mental health issues.
10. The inmate's prior criminal history.
11. The inmate's prior disciplinary record (misconduct reports, etc.).
12. The inmate's history of or lack of illicit drug use within the [correctional system].
13. The programming that the inmate has or has not completed.
14. The prior classification decisions involving the inmate 's status.
15. The inmate's documented behavior (incident reports, etc.) and interactions with staff and other inmates.
16. The professional judgment and recommendations of Nebraska Department of Correctional Services staff regarding the classification of the inmate.
17. The real or perceived threat of harm to the inmate from other inmates.
18. The inmate's statements regarding admission of prior actions, a commitment to changing behavior, and accountability for prior acts.
19. Any other information regarding the inmate that the classification authority deems appropriate.

Nebraska Department of Correctional Services, Admin. Reg. 201.05 (July 28, 2010).

[15] *See, e.g.*, Bureau of Prisons, Institution Supplement, General Population and Step-Down Unit Operations (Oct. 13, 2006) (describing "step-down" program at Florence ADX); Connecticut Department of Corrections, "Northern Correctional Institution Administrative Segregation Program," (undated), www.ct.gov/doc/lib/doc/pdf/northernascc.pdf.

[16] Litigation has generated some information about these programs' operations. *See* Submission of Laura Rovner, at 9-10, filed in *Ahmad et al. v. United Kingdom*, Application Nos 24027/07, 11949/08 and 36742/08, Euro. Ct. Hum. Rts (Apr. 20, 2009) (citing testimony of Florence ADX warden and describing how federal step-down program at Florence ADX is designed, in theory, to be completed in 36 months, but in practice, five percent of prisoners completed the program in that period).

[17] Florida's program, for example, is a general transitional program mandated by statute for all inmates in the six months prior to their release from prison. FLA. ADMIN. CODE 33-601.504 (2012).

[18] These are Wisconsin and Michigan.

Processes regarding the review of continued placement are yet more variable and provide fewer procedural protections. For most states, it appears that review could occur on an informal level by staff members or a classification committee. The content of such reviews is unclear. Public information did not often explain whether inmates receive notice, can present new evidence, or obtain a staff advocate for the informal reviews.[19] Further, for states that use static factors for confinement—such as the severity of offense, or membership/affiliation with a security threat group—it is extremely difficult to show a change in circumstances, meaning that an individual is likely to be left in segregation for long periods.[20]

Fifth, a great deal of variation exists in the treatment of the mentally ill. Ten states provide some restriction on placing mentally ill inmates in solitary confinement.[21] In a few states, there appear to be absolute bars on such placements.[22] Several other states' regulations

[19] *See, e.g.*, 15 Cal. Code Reg. 3341.5 (8)(c)(2)(A)(1); Arizona Department of Corrections, Department Order Manual, Order 801.04..

[20] A recent report by California's Department of Corrections shows that reliance on static factors can extend periods of isolation. The March 2012 report analyzed California's classification system, which uses points-based instruments; an inmate receives more points for meeting enumerated criteria. Beyond a certain threshold, that inmate is classified as "close custody," and placed in isolation. The report concluded that the use of "Mandatory Minimum" scores, which applies additional points to inmates incarcerated for certain violent or sex crimes, crimes of public notoriety or crimes carrying life sentences, "appear[s] to 'trap' many well-behaving inmates into higher housing levels." CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION, EXPERT PANEL STUDY OF THE INMATE CLASSIFICATION SCORE SYSTEM 2 (Dec. 2011). The report further cautioned against overinclusive classification. It concluded that placing inmates whose scores are just above the threshold for close custody has "a criminogenic effect" on those individuals and does not predict institutional misbehavior. *Id.* The report also identified mental illness, which can manifest in behavior that in turn results in an increased classification score, as one of the critical factors behind overclassification. *Id.* at 140.

[21] Conn. Admin. Directive 9.5.10.I (Jan. 1, 2008) (providing that prisoners' mental health will be considered before disciplinary measures are imposed that could result in transfer to administrative segregation), http://www.ct.gov/doc/LIB/doc/PDF/AD/ad0905.pdf; Brian Mast v. J. David Donahue, No.2:05-cv-00037 LJM/WGH, Private Settlement Agreement Between Defendants and Plaintiffs 2 (Jan. 23, 2007) (Indiana will not place mentally ill offenders in isolation); Me. DOC Policy Number 15.1, Administrative Segregation Status, at 8 (Sept. 1, 2011); Mich. DOC Policy Directive 04.06.182, Mentally Disabled Prisoners in Segregation, at 1 (Dec. 29, 2010), http://www.michigan.gov/documents/corrections/0406182_342182_7.pdf; Mont. DOC Policy Directive 4.5.21, at 1 (Oct. 27, 2009), http://www.cor.mt.gov/content/Resources/Policy/Chapter4/4-5-21.pdf; N.H. ADMIN. CODE R. COR 404.07 (2012) (punitive segregation); N.M. DOC Level V/VI Table of Procedures, Forms, and Attachments, at 7 (Aug. 25, 2010), http://www.corrections.state.nm.us/policies/current/CD-143000.pdf; N.C. DOC, Division of Prisons Policy & Procedures C.1700 High Security Maximum Control, at 1 (Nov. 1, 2011), http://www.doc.state.nc.us/dop/policy_procedure_manual/C1700.pdf; Vt. DOC Rule 05-049, Classification, Treatment and the Use of Administrative and Disciplinary Segregation for Inmates with a Serious Mental Illness (Dec. 2005), http://doc.vermont.gov/about/policies/rpd/correctional-services-301-550/361-370-programs-treatment-programs/370%20Classification,%20Treatment%20and%20Use%20of%20Admin%20and%20Discip%20Seg%20for%20Inmates%20with%20a%20SMI.pdf.

[22] Some rules come from policies, and others from court orders or settlement decrees. *See, e.g., Mast v. Donahue*, No.2:05-cv-00037 LJM/WGH, Private Settlement Agreement Between Defendants and Plaintiffs, 2 (Jan. 23, 2007) (Indiana will not place mentally ill offenders in isolation); N.M. DOC Level V/VI Table of Procedures, Forms, and Attachments, at 7 (Aug. 25, 2010), http://www.corrections.state.nm.us/policies/current/CD-143000.pdf.

appear effectively to exclude severely mentally ill prisoners from solitary confinement.[23] The definition of what constitutes "serious mental illness" is a distinct question to which some states provide written answers.[24]

A final lesson is that demographic information as to the use of long-term isolation is largely unavailable. In 1999, Roy D. King published a chart identifying some 25,000 inmates in solitary confinement in American prisons.[25] *See* Appendix A. Updated specifics and sources are difficult to obtain, except in a few instances. In Pennsylvania, for example, correctional authorities provide a breakdown, in monthly population reports, of the number of inmates in segregation.[26] In Idaho, one can work backward by determining which facilities are classified as "Supermax" to learn the number of beds in those facilities.[27]

Going beyond population numbers, ascertaining demographic characteristics about the solitary population and the frequency of isolation is even more difficult. Basic data as to the functioning of systems for isolation—the reasons for admission, the duration of stays, the prevalence of mental illness and recidivism rates—are unavailable. Racial, gender, ethnic, and age breakdowns for inmates in solitary are also generally unpublished.[28]

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[23] North Carolina's regulations require that the Director of the Division of Mental Health (or designee) personally approve the placement of every inmate placed into solitary confinement with a diagnosis of serious mental illness. N.C. DOC, Division of Prisons Policy & Procedures C.1700 High Security Maximum Control, at 1 (Nov. 1, 2011), http://www.doc.state.nc.us/dop/policy_procedure_manual/C1700.pdf. Montana's regulations state that "unstable psychiatric illness" and other mental and medical illnesses contraindicate solitary confinement. Mont. DOC Policy Directive 4.5.21, at 1 (Oct. 27, 2009), http://www.cor.mt.gov/content/Resources/Policy/Chapter4/4-5-21.pdf. Maine's regulations state that no inmate will be placed into solitary confinement if the inmate's physical or mental condition contraindicates the placement. Me. DOC, Policy Number 15.1, Administrative Segregation Status, at 8 (Sept. 1, 2011). In practice, this excludes all severely mentally ill from solitary confinement. *See* Lance Tapley, *Reducing Solitary Confinement*, PORTLAND PHOENIX, Nov. 2, 2011.

[24] For example, Vermont defines "serious mental illness" as the "[s]ubstantial disorder of thought, mood, perception, orientation or memory, any of which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life. This includes, but is not necessarily limited to, diagnoses of schizophrenia, schizoaffective disorder, psychotic conditions not otherwise specified, bipolar disorder, and severe depressive disorders." Vermont DOC Rule 05-049, Classification, Treatment and the Use of Administrative and Disciplinary Segregation for Inmates with a Serious Mental Illness (Dec. 2005).

[25] Roy D. King, *The Rise and Rise of Supermax: An American Solution in Search of a Problem?*, 1 PUNISHMENT & SOC'Y 163, 175 tbl.1 (1999).

[26] Pa. DOC Monthly Population Report, as of Feb. 29, 2012, at 2, http://www.portal.state.pa.us/portal/server.pt/document/1227704/mtpop1202_pdf.

[27] Idaho DOC Standard Reports for September 2011, at 7 (396 inmates incarcerated at Idaho Maximum Security Institution), http://www.idoc.idaho.gov/content/document/standard_monthly_rept_sept_2011; Idaho DOC, "Idaho Maximum Security Institution", http://www.idoc.idaho.gov/content/locations/prisons/idaho_maximum_security_institution (describing custody levels for offenders at IMSI).

[28] Our students found two states, Colorado and Washington, that have participated in or authored studies examining rates of mental illness among subsets of their solitary confinement inmate populations. *See* Maureen

In sum, while we had hoped to be able to sketch a clear national picture of solitary confinement in the United States circa 2012, we cannot do so. Individual correctional departments may well have detailed data on how many inmates are held in solitary settings, the causes for their placement, and the length of confinements, but such information is not reported systematically to permit interjurisdictional comparisons and a national overview.

II. The Law of Solitary Confinement

The 2005 Supreme Court description in *Wilkinson* of the extreme sensory deprivation is chilling. One might think that such a description would lead to a prohibition—that individuals could not be subjected to isolation and sensory deprivation indefinitely. Indeed, in 1890, the Supreme Court, objecting to the solitary confinement of an individual convicted of murder, observed when solitary confinement had been used in the 1820s, "after even a short confinement," such detention put a prisoner "into a semi-fatuous condition," making him unable to "recover sufficient mental activity to be of any subsequent service to the community."[29] About a century later, in the 1970s, the Court approved district court findings that Arkansas's use of indefinite punitive isolation (in that instance, an "average of 4 . . . prisoners were crowded into windowless 8'x10' cells containing no furniture other than a source of water and a toilet that could only be flushed from outside the cell") violated the Eighth Amendment.[30]

A number of lower courts echoed those concerns in describing the effects of long-term solitary confinement.[31] The Southern District of Texas in 1999 quoted the following expert description:

O'Keefe, Administrative Segregation for Mentally Ill Inmates, 45 J. OFFENDER REHABILITATION 149-65 (2007) (indicating 37% of the inmates in administrative segregation in Colorado had developmental disabilities or mental health needs); David Lovell & Clark Johnson, *Felony and Violent Recidivism Among Supermax Prison Inmates in Washington State: A Pilot Study* 6 (2004) (indicating 21% "probable mental illness rate" among prisoners in Washington's Intensive Management Unit), http://www.son.washington.edu/faculty/fac-page-files/Lovell-SupermaxRecidivism-4-19-04.pdf.

[29] *In re Medley*, 134 U.S. 160, 168 (1890).

[30] *Hutto v. Finney*, 437 U.S. 678, 682 (1978).

[31] *See, e.g.*, *Madrid v. Gomez*, 889 F. Supp. 1146, 1230-31 (N.D. Cal. 1995) (observing that "[s]ocial science and clinical literature have consistently reported that when human beings are subjected to social isolation and reduced environmental stimulation, they may deteriorate mentally and in some cases develop psychiatric disturbances [including] perceptual distortions, hallucinations, hyperresponsivity to external stimuli, aggressive fantasies, overt paranoia, inability to concentrate, and problems with impulse control," and that "[t]here is also an ample and growing body of evidence that this phenomenon may occur among persons in solitary or segregated confinement—persons who are, by definition, subject to a significant degree of social isolation and reduced environmental stimulation."); *see also Miller* ex. rel. *Jones v. Stewart*, 231 F.3d 1248, 1252 (9th Cir. 2000) ("[I]t is well accepted that conditions such as those present in [solitary confinement] . . . can cause psychological decompensation to the point that individuals may become incompetent."); *Davenport v. DeRobertis*, 844 F.2d 1310, 1313 (7th Cir. 1988) (noting that "isolating a human being from other human beings year after year or even month after month can cause substantial psychological damage, even if the isolation is not total"); *McClary v. Kelly*, 4 F.

> In a number of instances, there were people who had smeared themselves with feces. . . . There were many people who were incoherent when I attempted to talk to them, babbling, sometimes shrieking, other people who appeared to be full of fury and anger and rage and were, in some instances, banging their hands on the side of the wall and yelling and screaming, other people who appeared to be simply disheveled, withdrawn and out of contact with the circumstances or surroundings. . . . These were people who appeared to be in profound states of distress and pain.[32]

Those observations find support in an array of studies.[33]

However, in 2005 in *Wilkinson*, the Court's description of the harms of Supermax sustained only its conclusions that such conditions were "dramatic departure from the basic conditions of [the inmate's] sentence" so as to constitute an "atypical and significant hardship,"[34] sufficient to require a modicum of process under the Fourteenth Amendment.

In contrast, the trial court in the *Wilkinson* litigation had mandated that certain kinds of minor infractions in prison could not result in such a severe sanction as confinement in

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Supp. 2d 195, 208 (W.D.NY. 1998) ("A conclusion . . . that prolonged isolation from social and environmental stimulation increases the risk of developing mental illness does not strike this court as rocket science.").

[32] *Ruiz v. Johnson*, 37 F. Supp. 2d 855, 909-10 (S.D. Tex. 1999), *rev'd on other grounds*, 243 F.3d 941 (5th Cir. 2001).

[33] Stuart Grassian & Terry Kupers, *The Colorado Study vs. the Reality of Supermax Confinement*, CORR. MENTAL HEALTH REP., at 1, 9 (May-June 2011) ("Just about everyone who has taken a serious look . . . has concluded there is serious harm from long-term isolated confinement."); Jeffrey L. Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, 38 J. AM. ACAD. PSYCHIATRY L., 104, 104 (2010) (solitary confinement "can be as clinically distressing as physical torture."); Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 WASH. U. J.L. & POL'Y 325, 331 (2006); A. Vrca, V. Bozikov, Z. Brzovic, R. Fuchs & M. Malinar, *Visual Evoked Potentials in Relation to Factors of Imprisonment in Detention Camps*, 109 INT. J. LEGAL MED. 114, 114-16 (1996) (study of prisoners of war from former Yugoslavia, finding that the two factors that had the most significant effect on brain waves were solitary confinement and physical trauma to the head resulting in loss of consciousness; less significant factors included torture by electrocution and extreme cold).

Solitary confinement has been shown to induce symptoms of serious mental illness. Thomas B. Benjamin & Kenneth Lux, *Solitary Confinement as Psychological Punishment*, 13 CAL. W. L. REV. 265, 268 (1977) (noting that isolation induces "depersonalization, hallucination and delusions"); Richard Korn, *The Effects of Confinement in the High Security Unit at Lexington*, 15 SOC. JUST. 8, 14-15 (1988) (same, as to claustrophobia, rage, severe depression, hallucination, withdrawal, blunting of affect, and apathy); Grassian & Kupers, *Colorado Study*, *supra* note 28, at 333, 335-36 (same, as to hyperresponsivity, panic attacks, or paranoia). In another study, "almost ninety percent of . . . prisoners had difficulties with 'irrational anger,' compared with just three per cent of the general population," attributable to "the extreme restriction, the totality of control, and the extended absence of any opportunity for happiness or joy." *Id.*

[34] *Wilkinson*, 545 U.S. at 222-23 (citing *Sandin v. Conner*, 515 U.S. 472, 483-85 (1995)).

Supermax.[35] Further, the lower courts had concluded that the procedural protections provided by Ohio were insufficient and that additional procedures were required.[36]

The Supreme Court, however, cut back on the lower courts' imposition of more procedural requirements and accepted Ohio's minimal process. All that was required was notice of "a brief summary of the factual basis for the classification," and "a rebuttal opportunity" at the two levels of internal review.[37] Detained prisoners could not present adverse witnesses.[38] The obligation for a short statement of reasons for confinement was, according to the Court, enough to buffer against "arbitrary decision-making."[39]

Further, while the question posed for the Supreme Court was not the constitutionality of Supermax under the Eighth Amendment but rather the processes used to place prisoners there, the Court appeared to endorse at least some forms of Supermax confinement. The opinion advised that the "harsh conditions [of Supermax] may well be necessary and appropriate in light of the danger that high-risk inmates pose both to prison officials and to other prisoners."[40] Thus, "[p]rolonged confinement in Supermax may be the State's only option for the control of some inmates."[41]

Since *Wilkinson*, courts have rejected a variety of claims seeking remedies for prisoners' prolonged isolation.[42] Only a few forms of solitary confinement have been found actionable, such as "28 to 35 year confinements" in lockdown in the Louisiana State Penitentiary in Angola.[43] In addition, courts have found that such confinement is impermissible for the mentally ill.[44]

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[35] *Austin v. Wilkinson*, 204 F. Supp. 2d 1024, 1028 (N.D. Ohio 2002).

[36] *Austin v. Wilkinson*, 372 F.3d 346, 360-61 (6th Cir. 2004); *Austin v. Wilkinson*, 189 F. Supp. 2d 719, 743-46 (N.D. Ohio 2002).

[37] *Wilkinson*, 545 U.S. at 226.

[38] *Id.* at 228.

[39] *Id.* at 226.

[40] *Id.* at 224.

[41] *Id.* at 229.

[42] *See, e.g., Estate of DiMarco v. Wyo. Dept. of Corrections*, 473 F.3d 1334, 1336 (10th Cir. 2007); *Al-Amin v. Donald*, 165 Fed.Appx. 733, 738 (11th Cir. 2006); *Skinner v. Cunningham*, 430 F.3d 483, 485 (1st Cir. 2005); *Hill v. Pugh*, 75 Fed. Appx. 715, 721 (10th Cir. 2003).

[43] *Wilkerson v. Stalder*, No. 00-304-C, 2007 WL 2693852, at *1 (M.D. La. Sept. 11, 2007); *see also Scarver v. Litscher*, 434 F.3d 972, 974 (7th Cir. 2006); *Bailey v. Fansler*, No. 04- 1175-PHX-MHM, 2009 WL 151204, at *1 (D. Ariz. Jan. 21, 2009); *Farmer v. Kavanagh*, 494 F. Supp. 2d 345, 347 (D. Md. 2007). Further, in *Westefer v. Snyder*, 422 F.3d 570 (7th Cir. 2005), the court noted that placement in Supermax resulted in the almost complete deprivation of "human contact," attorneys included. *Id.* at 589. Given that at least some prisoners confined to the facility were not given the reasons for their placement, the case survived a motion for summary judgment. *Id.* at 590.

[44] *See, e.g., Jones 'El v. Berge*, 164 F. Supp. 2d 1096, 1098 (W.D. Wis. 2001) ("Most inmates have a difficult time handling these conditions of extreme social isolation and sensory deprivation, but for seriously mentally ill inmates, the conditions can be devastating."); *Ruiz*, 37 F. Supp. 2d at 915 ("Conditions in [the prison's]

We hope that the Supreme Court will revisit the constitutionality of long-term isolation in light of its more recent law on conditions of confinement. In 2011, *Brown v. Plata* upheld a three-judge district court's conclusion that it had the authority to remedy the unconstitutional conditions in California's prisons.[45] The Court explained that all "[p]risoners retain the essence of human dignity inherent in all persons" and that "[r]espect for that dignity animates the Eighth Amendment prohibition against cruel and unusual punishment."[46]

The research cited underscores the harms that long-term isolation imposes on individual personhood and its assault on human dignity. Our hope is that *Plata* indicates that, when a full record of the effects of Supermax is before it, the Supreme Court will recognize that long-term solitary confinement is at odds with the prohibition on cruel and unusual punishment as well as the values of individual dignity and liberty protected by the U.S. Constitution.

III. A Growing Commitment to End Extreme Isolation

A. Reforms in the States

Many directors of state correction systems are at the forefront of reforms limiting prolonged solitary confinement. Recognizing the serious impact of long-term social and sensory deprivation on prisoners, families, communities, and state budgets, these states—Maine, Mississippi, New York, Colorado, Illinois, New Mexico, and Texas—have all changed their policies.

In 2010, the Maine Legislature required the Department of Corrections to review its use of solitary confinement and report its findings back to the Legislature. The report, issued in March 2011, called for improvements in mental health care and alternatives aimed at "behavioral intervention" in the general prison population.[47] Since then, Commissioner Joseph Ponte instituted a series of reforms in the Maine State Prison's Supermax unit.

- The unit's population was cut by more than half;
- "Cell extractions"—or the forcible removal of prisoners from cells—were discontinued;
- A prisoner could not be placed in the Supermax unit for longer than 72 hours without personal approval by the Commissioner;

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administrative segregation units clearly violate constitutional standards when imposed on the subgroup of the plaintiffs' class made up of mentally-ill prisoners.").

[45] 131 S. Ct. 1910 (2011).

[46] *Id.* at 1928.

[47] Final Report of Review of Due Process Procedures in Special Management Units at the Maine State Prison and the Maine Correctional Center (Mar. 2011), http://www.aclu.org/files/assets/maine_-_final_doc_report_on_smus.pdf.

- A committee composed of corrections officials and members of the public was appointed to continue review and reforms.[48]

According to Commissioner Ponte, these reforms did not require substantial new funds.[49]

Mississippi has also changed the manner in which it uses long-term isolation. Between 2007 and 2009, the Mississippi Department of Corrections (MDOC) reduced the population in its Supermax facility (known as "Unit 32") from approximately 1000 to less than 100.[50] The MDOC revised classification criteria so that prisoners eligible for confinement at Unit 32 were those who had committed serious violent acts while incarcerated or had attempted escape.[51] Individual management plans were mandated for each prisoner, so that they had concrete goals on how to earn their way out of Unit 32.[52] In addition, the MDOC created a "step-down" unit for prisoners with serious mental illness who had been previously isolated; these prisoners are housed in a small unit with supervised group and other activities to encourage their transition to general population.[53] In Unit 32, violence by prisoners and the use of force by staff declined.[54] In 2010, the MDOC closed Unit 32.[55]

In 2011 and 2012, other states instituted measures to stem the over-use of solitary confinement. New York enacted a law making it more difficult to put seriously mentally ill prisoners in solitary confinement.[56] Colorado enacted a law in August 2011 requiring the Department to provide a report regarding the use of administrative segregation[57] and directed

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[48] Lance Tapley, *Maine's Dramatic Reduction of Solitary Confinement*, CRIME REPORT (July 21, 2011), http://www.thecrimereport.org/archive/2011-07-maines-dramatic-reduction-of-solitary-confinement.

[49] Lance Tapley, *Reform Comes to the Supermax*, PORTLAND PHX. (May 25, 2011), http://portland.thephoenix.com/news/121171-reform-comes-to-the-supermax/.

[50] Terry A. Kupers et al., *Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs*, 36 CRIM. JUST & BEHAV. 1037, 1046 (2009).

[51] Kupers, *supra* note 45, at 1046.

[52] *Id.* at 1047

[53] *Id.* at 1043.

[54] *Id.* at 6-7.

[55] John Buntin, *Exodus: How America's Reddest State – And Its Most Notorious Prison – Became a Model of Corrections Reform*, 23 GOVERNING 20, 27 (2010).

[56] 2008 N.Y. Sess. Laws 1 (McKinney) (codified as amended primarily at N.Y. CORRECT. LAW § 1, 137, 401, & 401-a and at N.Y. MENTAL HYG. LAW § 45.07 (McKinney 2011) (excluding prisoners who are actively suicidal or who have Axis I diagnoses, except under "exceptional circumstances," and mandating at least two hours of mental health treatment for such prisoners).

[57] Colorado Laws 2011, Ch. 289, § 1, eff. July 1, 2011 (codified at C.R.S.A. § 17-1-113.9(1) (requiring report from CDOC "concerning the status of administrative segregation; reclassification efforts for offenders with mental illnesses or developmental disabilities, including duration of stay, reason for placement, and number and percentage discharged").

that funds be directed to support mental health treatment and alternatives to segregation.[58] Colorado's Department of Corrections thereafter undertook an audit of its use of solitary confinement and announced in March 2012 that it would close a 312-bed Supermax facility by early 2013.[59] In May 2012, concerned about the economic costs of its Supermax prison, the Illinois governor announced a proposal to close the facility.[60] The New Mexico Legislature directed a committee to study solitary confinement's impact on inmates, its effectiveness in "reducing problems," and its cost.[61] Likewise, the Texas Lieutenant Governor commissioned a study on the use of administrative segregation and its impact on mental health and recidivism, as well as options for alternative methods of confinement and reentry programming.[62]

B. American Bar Association Standards on the Treatment of Prisoners

In 2005, the American Bar Association began a project to develop contemporary standards for prison administration. Participants included a range of institutional actors.[63] In 2010, the ABA House of Delegates approved a revised set of Standards on the Treatment of Prisoners.[64]

The standards regarding solitary confinement center around a core ideal: "Segregated housing should be for the briefest term and under the least restrictive conditions practicable and

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[58] Colorado Laws 2011, Ch. 289, § 1, eff. July 1, 2011 (codified at C.R.S.A. § 17-1-113.9(2)) (directing funds made available from savings due to new earned time law be used "to support behavior-modification programs, incentive programs, mental health services or programs, or similar efforts designed as viable alternatives to administrative segregation additional funding for treatment and alternative placements for mentally ill prisoners in solitary confinement.").

[59] Kristen Wyatt, *Colorado Closing Canon City Prison*, Colorado Springs Gazette (Mar. 19, 2012) http://www.gazette.com/news/colorado-135471-denver-prison.html.

[60] Steve Mills, *Quinn's Prison Plan Causes Stir,* CHI. TRIBUNE (Feb. 23, 2012), http://www.chicagotribune.com/news/local/ct-met-illinois-state-budget-prisons-20120223,0,3394133.story.

[61] New Mexico House of Representatives, "A memorial requesting the appropriate legislative interim committee to convene a working group to gather information regarding the use of solitary confinement in New Mexico public and private correctional facilities, to determine the impact of solitary confinement on inmates and to assess the effectiveness of solitary confinement in reducing problems and costs." www.nmlegis.gov/sessions/11%20regular/final/HM062.pdf (2001).

[62] Press Release, Office of the Lieutenant Governor, Lt. Governor Dewhurst Issues Select Interim Charges Relating to Transportation, Homeland Security and Criminal Justice (Jan. 13, 2012), http://www.ltgov.state.tx.us/prview.php?id=337.

[63] "Based on constitutional and statutory law, a variety of relevant correctional policies and professional standards, the deep expertise of the many people who assisted with the drafting, and the extensive contributions and comments of dozens of additional experts and groups, they set out principles and functional parameters to guide the operation of American jails and prisons, in order to help the nation's criminal justice policy-makers, correctional administrators, legislators, judges, and advocates protect prisoner's rights while promoting the safety, humaneness, and effectiveness of our correctional facilities." AM. BAR ASS'N, ABA STANDARDS FOR CRIMINAL JUSTICE: TREATMENT OF PRISONERS intro. (3d ed. 2011) [hereinafter ABA STANDARDS].

[64] *ABA Adopts Host of Criminal Justice Measures*, ABA JOURNAL (Feb. 8, 2010), http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners.html.

consistent with the rationale for placement and with the progress achieved by the prisoner."[65] Appendix B sets forth ABA Standards on solitary confinement.

C. International Legal Norms

The reforms in several states and the ABA Standards reflect a growing consensus on the treatment of prisoners that is shared internationally. The United States is a signatory to a number of international human rights agreements that govern the treatment of prisoners and "mandate that prisoners be treated with humanity and respect for the inherent dignity of the human person."[66] Those principles have been interpreted to limit the use of solitary confinement.[67] In 2011, the United Nations' Special Rapporteur on Torture and Other Cruel, Inhuman, or Degrading Treatment exhorted all countries to "re-evaluate and minimize" and to abolish completely its use for juveniles and prisoners with mental illness.[68] Based on existing research, the Special Rapporteur concluded that fifteen days is the maximum period prisoners can spend in solitary confinement without suffering permanent mental harm.[69] The Special Rapporteur

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[65] ABA STANDARDS 23-2.6(a).

[66] International Covenant on Civil and Political Rights art. 7, Dec. 16, 1966, S. Treaty Doc. No. 95-20, 999 U.N.T.S. 171 (ratified in 1992) (prohibiting "cruel, inhuman, or degrading treatment or punishment" and requiring that "[a]ll persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person."); *see also* Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted Dec. 10, 1984, 108 Stat. 382, 463-64, 1465 U.N.T.S. 85 (ratified in 1992) (prohibiting torture, defined as "[a]n act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as . . . punishing him for an act he . . . committed or is suspected of having committed or intimidating or coercing him . . . when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity."); Universal Declaration of Human Rights, G.A. Res. 217 (III) A, U.N. Doc. A/RES/217(III) (Dec. 10, 1948) ("[n]o one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.").

[67] *See, e.g.*, UN General Assembly, Torture and other cruel, inhuman or degrading treatment or punishment: note by the Secretary-General, 28 July 2008, A/63/175 pp. 18-20, available at: http://www.unhcr.org/refworld/docid/48db99e82.html (interim report of U.N. Special Rapporteur Manfred Nowak criticizing use of solitary confinement); Comm. Against Torture, Report of the Committee Against Torture, 73, U.N. Doc. A/61/44 (Nov. 14–15, 2005; May 1–19, 2006) (questioning the United States about its supermax practice and its effects on prisoners' mental health); Comm. Against Torture, Report of the Committee Against Torture, 32, U.N. Doc. A/55/44 (Nov. 8-19, 1999; May 1–19, 2000) (expressing concern about the United States' "excessively harsh regime of the 'supermaximum' prisons"); *see also* Standard Minimum Rules for the Treatment of Prisoners, R. 57, E.S.C. Res. 663C, U.N. Doc. E/3048 (Aug. 30, 1955) amended by E.S.C. Res. 2076, U.N. Doc. E/5988 (May 13, 1977) ("Imprisonment and other measures which result in cutting off an offender from the outside world are afflictive by the very fact of taking from the person the right of self-determination by depriving him of his liberty. Therefore the prison system shall not, except as incidental to justifiable segregation or the maintenance of discipline, aggravate the suffering inherent in such a situation."); ISTANBUL STATEMENT ON THE USE AND EFFECTS OF SOLITARY CONFINEMENT, *reproduced in* 18 Torture 56 (2008) (statement by international group of experts in law, medicine, and criminology).

[68] U.N Special Rapporteur on Torture, Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 2, ¶ 31, ¶ 81, U.N Doc. A/66/268 (Aug. 5, 2011) (citations omitted).

[69] *Id.*

observed that "[c]onsidering the severe mental pain or suffering solitary confinement may cause when used as a punishment, during pretrial detention, indefinitely or for a prolonged period, for juveniles or persons with mental disabilities, it can amount to torture or cruel, inhuman or degrading treatment or punishment."[70]

Conclusion

We applaud this Committee for putting on the agenda the need to rethink the role of extreme isolation in American criminal justice system. Detention in democratic orders requires respect for the individual dignity and for the worth of all persons.

This understanding of American obligations is longstanding. As Arthur Liman explained in 1971:

> [N]o excuse can justify the failure of the American public to demand a better system of criminal justice, from arrest, trial and sentencing to ultimate release from confinement. . . .
>
> The larger obligation to continue the search for a better and a more humane system of criminal justice, from arrest to release after imprisonment, requires the alert attention of every thinking citizen. . . .
>
> Change should not be lightly undertaken, but the *status quo* can no longer be defended. The only way to salvage meaning out of the otherwise senseless killings at Attica is to learn from this experience that our Atticas are failures. The crucial issues remain unresolved; and they will continue unresolved until an aroused public demands something better.[71]

More than forty years later, the human suffering described in *Wilkinson*, documented by social scientists, and experienced by tens of thousands of incarcerated Americans, "demands something better."

Respectfully submitted,

Hope Metcalf Judith Resnik

*Prepared with the assistance of Brian Holbrook (YLS 2012), Brandon Trice (YLS 2012), and Eva Yinan Song (Yale College 2014).

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[70] *Id.*

[71] ATTICA: THE OFFICIAL REPORT OF THE NEW YORK STATE SPECIAL COMMISSION ON ATTICA xi (Bantam Books, 1972).

Appendix A

States with Supermax Facilities, 1997–1998

	Supermax Beds	Sentenced Prison Pop.	Incarceration Rate per 100,000	Percent of Total Beds
Northeast	*3,214*	*163,836*		*2.0*
Connecticut	586	13,005	397	4.5
Maine	100	1,542	123	6.5
Massachusetts	124	10,847	278	1.1
New Jersey	96	28,361	351	0.3
New York	2,000	70,026	386	2.9
Pennsylvania	200	34,963	291	0.6
Rhode Island	108	2,100	213	5.1
Midwest	*2,290*	*216,391*		*1.1*
Illinois	500	40,788	342	1.2
Indiana	85	17,730	301	0.5
Michigan	421	44,771	457	0.9
Minnesota	120	5,306	113	2.3
Nebraska	164	3,329	200	4.9
Ohio	500	48,002	429	1.0
Wisconsin	500	14,682	283	3.4
South	*7,584*	*480,061*		*1.6*
Florida	1,000	64,540	437	1.5
Georgia	10	35,722	472	0.3
Louisiana	1,048	29,265	672	3.6
Maryland	286	21,088	413	1.4
Mississippi	1,756	14,548	531	12.0
North Carolina	300	27,726	370	1.1
Oklahoma	392	20,542	617	1.9
South Carolina	200	20,264	536	1.0
Texas	1,229	140,729	717	0.9
Virginia	1,267	27,524	407	4.6
West Virginia	96	3,160	174	3.0
West	*6,542*	*242,315*		*2.7*
Arizona	1,728	22,353	484	7.7
California	2,942	154,368	475	1.9
Colorado	750	13,461	342	5.6
Idaho	96	3,946	323	2.4
Montana	64	2,242	25	2.9
Nevada	430	8,884	518	4.8
Oregon	196	7,589	232	2.6
Washington	300	13,198	233	2.3
Wyoming	36	1,566	326	2.3
All states	19,630	1,102,603	—	1.8

Sources: King 1999, updating figures from Riveland 1999b.

Table 1 from Daniel P. Mears, Evaluating the Effectiveness of Supermax Prisons 74 app. tbl.1 (2006), originally published as Table 1 in Roy D. King, The Rise and Rise of Supermax: An American Solution in Search of a Problem?, 1 Punishment & Soc'y 163, 175 tbl.1 (1999), reproduced with the permission of Professors Mears and King.

Reproduced in Judith Resnik, *Detention, The War on Terror, and the Federal Courts*, 110 COLUM. L. REV. 579, 643 (2010).

APPENDIX B

ABA Standards for Criminal Justice (Third Edition), Treatment of Prisoners (2010)[72]

Standard 23-2.6 Rationales for segregated housing

(a) Correctional authorities should not place prisoners in segregated housing except for reasons relating to: discipline, security, ongoing investigation of misconduct or crime, protection from harm, medical care, or mental health care. Segregated housing should be for the briefest term and under the least restrictive conditions practicable and consistent with the rationale for placement and with the progress achieved by the prisoner. Segregation for health care needs should be in a location separate from disciplinary and long-term segregated housing. Policies relating to segregation for whatever reason should take account of the special developmental needs of prisoners under the age of eighteen.

(b) If necessary for an investigation or the reasonable needs of law enforcement or prosecuting authorities, correctional authorities should be permitted to confine a prisoner under investigation for possible criminal violations in segregated housing for a period no more than [30 days].

Standard 23-2.7 Rationales for long-term segregated housing

(a) Correctional authorities should use long-term segregated housing sparingly and should not place or retain prisoners in such housing except for reasons relating to:

(i) discipline after a finding that the prisoner has committed a very severe disciplinary infraction, in which safety or security was seriously threatened;
(ii) a credible continuing and serious threat to the security of others or to the prisoner's own safety; or
(iii) prevention of airborne contagion.

(b) Correctional authorities should not place a prisoner in long-term segregated housing based on the security risk the prisoner poses to others unless less restrictive alternatives are unsuitable in light of a continuing and serious threat to the security of the facility, staff, other prisoners, or the public as a result of the prisoner's:

(i) history of serious violent behavior in correctional facilities;
(ii) acts such as escapes or attempted escapes from secure correctional settings;
(iii) acts or threats of violence likely to destabilize the institutional environment to such a degree that the order and security of the facility is threatened;
(iv) membership in a security threat group accompanied by a finding based on specific and reliable information that the prisoner either has engaged in dangerous or threatening

[72]The full text of the ABA Standards is published at http://www.americanbar.org/content/dam/aba/publishing/criminal_justice_section_newsletter/crimjust_policy_midyear2010_102i.authcheckdam.pdf

behavior directed by the group or directs the dangerous or threatening behavior of others; or
(v) incitement or threats to incite group disturbances in a correctional facility.

Standard 23-2.8 Segregated housing and mental health

(a) No prisoner diagnosed with serious mental illness should be placed in long-term segregated housing.

(b) 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 prompt 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.

(c) The mental health of prisoners in long-term segregated housing should be monitored as follows:

(i) Daily, correctional staff should maintain a log documenting prisoners' behavior.

(ii) Several times each week, a qualified mental health professional should observe each segregated housing unit, speaking to unit staff, reviewing the prisoner log, and observing and talking with prisoners who are receiving mental health treatment.

(iii) Weekly, a qualified mental health professional should observe and seek to talk with each prisoner.

(iv) Monthly, and more frequently if clinically indicated, a qualified mental health professional should see and treat each prisoner who is receiving mental health treatment. Absent an individualized finding that security would be compromised, such treatment should take place out of cell, in a setting in which security staff cannot overhear the conversation.

(v) At least every [90 days], a qualified mental health professional should perform a comprehensive mental health assessment of each prisoner in segregated housing unless a qualified mental health professional deems such assessment unnecessary in light of observations made pursuant to subdivisions (ii)-(iv).

Standard 23-2.9 Procedures for placement and retention in long-term segregated housing

(a) A prisoner should be placed or retained in long-term segregated housing only after an individualized determination, by a preponderance of the evidence, that the substantive prerequisites set out in Standards 23-2.7 and 23-5.5 for such placement are met. In addition, if long-term segregation is being considered either because the prisoner poses a credible continuing

and serious threat to the security of others or to the prisoner's own safety, the prisoner should be afforded, at a minimum, the following procedural protections:

(i) timely, written, and effective notice that such a placement is being considered, the facts upon which consideration is based, and the prisoner's rights under this Standard;

(ii) decision-making by a specialized classification committee that includes a qualified mental health care professional;

(iii) a hearing at which the prisoner may be heard in person and, absent an individualized determination of good cause, has a reasonable opportunity to present available witnesses and information;

(iv) absent an individualized determination of good cause, opportunity for the prisoner to confront and cross-examine any witnesses or, if good cause to limit such confrontation is found, to propound questions to be relayed to the witnesses;

(v) an interpreter, if necessary for the prisoner to understand or participate in the proceedings;

(vi) if the classification committee determines that a prisoner is unable to prepare and present evidence and arguments effectively on his or her own behalf, counsel or some other appropriate advocate for the prisoner;

(vii) an independent determination by the classification committee of the reliability and credibility of confidential informants if material allowing such determination is available to the correctional agency;

(viii) a written statement setting forth the evidence relied on and the reasons for placement; and

(ix) prompt review of the classification committee's decision by correctional administrators.

(b) Within [30 days] of a prisoner's placement in long-term segregated housing based on a finding that the prisoner presents a continuing and serious threat to the security of others, correctional authorities should develop an individualized plan for the prisoner. The plan should include an assessment of the prisoner's needs, a strategy for correctional authorities to assist the prisoner in meeting those needs, and a statement of the expectations for the prisoner to progress toward fewer restrictions and lower levels of custody based on the prisoner's behavior. Correctional authorities should provide the plan or a summary of it to the prisoner, and explain it, so that the prisoner can understand such expectations.

(c) At intervals not to exceed [30 days], correctional authorities should conduct and document an evaluation of each prisoner's progress under the individualized plan required by subdivision (b) of this Standard. The evaluation should also consider the state of the prisoner's mental health;

address the extent to which the individual's behavior, measured against the plan, justifies the need to maintain, increase, or decrease the level of controls and restrictions in place at the time of the evaluation; and recommend a full classification review as described in subdivision (d) of this Standard when appropriate.

(d) At intervals not to exceed [90 days], a full classification review involving a meeting of the prisoner and the specialized classification committee should occur to determine whether the prisoner's progress toward compliance with the individual plan required by subdivision (b) of this Standard or other circumstances warrant a reduction of restrictions, increased programming, or a return to a lower level of custody. If a prisoner has met the terms of the individual plan, there should be a presumption in favor of releasing the prisoner from segregated housing. A decision to retain a prisoner in segregated housing following consideration by the classification review committee should be reviewed by a correctional administrator, and approved, rejected, or modified as appropriate.

(e) Consistent with such confidentiality as is required to prevent a significant risk of harm to other persons, a prisoner being evaluated for placement in long-term segregated housing for any reason should be permitted reasonable access to materials considered at both the initial and the periodic reviews, and should be allowed to meet with and submit written statements to persons reviewing the prisoner's classification.

(f) Correctional officials should implement a system to facilitate the return to lower levels of custody of prisoners housed in long-term segregated housing. Except in compelling circumstances, a prisoner serving a sentence who would otherwise be released directly to the community from long-term segregated housing should be placed in a less restrictive setting for the final months of confinement.

Standard 23-3.8 Segregated housing

(a) Correctional authorities should be permitted to physically separate prisoners in segregated housing from other prisoners but should not deprive them of those items or services necessary for the maintenance of psychological and physical wellbeing.

(b) Conditions of extreme isolation should not be allowed regardless of the reasons for a 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.

(c) All prisoners placed in segregated housing should be provided with meaningful forms of mental, physical, and social stimulation. Depending upon individual assessments of risks, needs, and the reasons for placement in the segregated setting, those forms of stimulation should include:

> (i) in-cell programming, which should be developed for prisoners who are not permitted to leave their cells;

(ii) additional out-of-cell time, taking into account the size of the prisoner's cell and the length of time the prisoner has been housed in this setting;
(iii) opportunities to exercise in the presence of other prisoners, although, if necessary, separated by security barriers;
(iv) daily face-to-face interaction with both uniformed and civilian staff; and
(v) access to radio or television for programming or mental stimulation, although such access should not substitute for human contact described in subdivisions (i) to (iv).

(d) Prisoners placed in segregated housing for reasons other than discipline should be allowed as much out-of-cell time and programming participation as practicable, consistent with security.

(e) No cell used to house prisoners in segregated housing should be smaller than 80 square feet, and cells should be designed to permit prisoners assigned to them to converse with and be observed by staff. Physical features that facilitate suicide attempts should be eliminated in all segregation cells. Except if required for security or safety reasons for a particular prisoner, segregation cells should be equipped in compliance with Standard 23-3.3(b).

(f) Correctional staff should monitor and assess any health or safety concerns related to the refusal of a prisoner in segregated housing to eat or drink, or to participate in programming, recreation, or out-of-cell activity.

Reassessing Solitary Confinement:

The Human Rights, Fiscal, and Public Safety Consequences

Hearing Before the Senate Judiciary Subcommittee on the

Constitution, Civil Rights, and Human Rights

June 19, 2012

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Senator Durbin and Members of the Committee:

This testimony is submitted by Marty Beyer, Ph.D., a clinical psychologist and consultant in juvenile justice and child welfare matters, and Sandra Simkins and Laura Cohen, who are clinical law professors at the Rutgers University School of Law in Camden and Newark, New Jersey, respectively, where they specialize in juvenile and criminal justice. Among us, we have nearly 75 years of experience working with incarcerated youth and adults around the country. And, over the last three years, Professors Simkins and Cohen have had the extraordinary privilege of co-directing the New Jersey Juvenile Indigent Defense Action Network ("JIDAN"), a component of the John D. and Catherine T. MacArthur Foundation's "Models for Change" juvenile justice system reform initiative.

Through JIDAN, we and our law students have provided legal representation to nearly 100 adolescents confined in New Jersey's long-term secure juvenile facilities. We monitor our clients' conditions of confinement; work to ensure that they receive necessary mental health, drug treatment, and educational services; help them navigate facility grievance procedures; plan for their return to the community; advocate on their behalf in parole proceedings; assist with the re-entry process; and provide legal representation in parole revocation hearings. This work has afforded us an up-close view of the impact of isolation practices on youth, which we would like to share with you today.

I. YOUTH ARE UNIQUELY VULNERABLE TO THE THE HARMFUL EFFECTS OF ISOLATION.

Numerous studies have attributed the following negative effects to isolation of adult inmates:

- Impaired sense of identity, hypersensitivity to stimuli, confusion, memory loss, irritability, and anger.

- Aggression and rage: attacks on staff, destruction of property, and collective violence.
- Lethargy, helplessness, hopelessness, and depression.
- Self-mutilation, suicidal ideation, and emotional breakdowns.
- Psychosis, hallucinations, and paranoia.
- Overall deterioration of mental and physical health.
- Produces indices of psychological trauma & psychopathic behaviors.1

According to the American Academy of Child and Adolescent Psychiatry, these effects are not merely present, but magnified, when young people are held in solitary confinement:

> The potential psychiatric consequences of prolonged solitary confinement are well recognized and include depression, anxiety and psychosis. Due to their developmental vulnerability, juvenile offenders are at particular risk of such adverse reactions. Furthermore, the majority of suicides in juvenile correctional facilities occur when the individual is isolated or in solitary confinement.2

The unique vulnerability of youth to the harmful effects of segregation is attributable, in part, to the developmental factors that led the United States Supreme Court to declare unconstitutional the juvenile death penalty.3 Because youth lack the future orientation of adults, they may not be able to see the temporariness of isolation and, as a result, fall deeper into depression. The susceptibility of youth to peer influence also plays a role, since young people in isolation are deprived of whatever socialization is available to those in the general population. They usually eat their meals alone in the cells. Recreation and exercise activities are solitary. They may have no one to talk with other than by yelling through the cell door. Isolation prevents youth from meeting their social needs, which further contributes to depression.

During adolescence, furthermore, young people gradually define their moral values—and

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1 CRAIG HANEY, THE PSYCHOLOGICAL IMPACT OF INCARCERATION: IMPLICATIONS FOR POST-PRISON ADJUSTMENT 14 (2001), *available at* http://aspe.hhs.gov/hsp/prison2home02/ haney.pdf.

2 American Academy of Child and Adolescent Psychiatry, Policy Statement: Solitary Confinement of Juvenile Offenders (approved April 2012), available at http://www.aacap.org/cs/root/policy_statements/solitary_confinement_of_juvenile_offenders (internal citations omitted).

3 *Roper v. Simmons,* 543 U.S. 541 (2005)

tend to be moralistic—and are insistent upon what should be and intolerant of anything that seems unfair. Youth view isolation as unfair, but do not have the adult cognitive abilities to say, "This is not unfairness directed at me personally, isolation is the consequence for certain behaviors for all residents." Especially for youth of color, isolation may be perceived as degrading and racist; girls may also object to isolation as discriminatory. It is normal for youth to protest unfairness, and when their protest does not get attention, they are likely to become more agitated. As a result, they "act out," perpetuating the cycle of segregation.

Many youth in juvenile facilities have experienced abuse, neglect, significant loss, exposure to violence, and other trauma. Trauma slows development and can cause disturbances of emotional regulation, relationships, and communication. The depression, difficulties trusting others, fearfulness, aggression, substance abuse, and concentration problems common in delinquent youth are often caused by untreated trauma. For those who have been abused and/or neglected, being in isolation is likely to activate painful memories and may be experienced as re-victimization. Isolation can make traumatized youth feel once again that they cannot control hurtful things that happen to them. Such powerlessness is damaging and can undermine progress a young person has made in recovering from earlier trauma.

Isolation also increases the risk of suicide among incarcerated youth. In 1999, the Office of Juvenile Justice and Delinquency Prevention, U.S. Justice Department released a national study of suicides in public and private juvenile facilities. The study found that 50 percent of youth who committed suicide were in isolation at the time of their suicide and sixty-two percent had previously been in isolation.4 Even youth who had not previously expressed thoughts of

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4 Hayes, Lindsay M., "Juvenile Suicide in Confinement: A National Survey," National Center on Institutions and Alternatives, February 2004, at p. x, http://nicic.org/Library/020131).

harming themselves can become desperate, hopeless and suicidal in isolation. For youth who are already talking about or have previously attempted suicide, isolation is a dangerous practice that should be prohibited. While regularly checking on a suicidal teen in isolation may prevent death, the young person's mental health deteriorates.

Finally, incarcerated youth disproportionately suffer from unmet mental health needs. According to the Center for Juvenile Justice, between 50 to 75% of incarcerated youth have diagnosable mental health problems. Youth suicides in juvenile detention and correctional facilities are more than four times greater than youth suicides in the general public. Incarcerated African-American youth are less likely than their white peers to have previously received mental health services, leaving them more vulnerable while in custody.5 And yet, despite these well-documented needs, two-thirds of juvenile detention centers hold youth who are simply waiting for mental health treatment, and one-quarter of these detention centers provide no or poor quality mental health services.6 This confluence of an urgent need for mental health services and the lack of such services within juvenile facilities renders mentally ill youth disproportionately likely to incur time in punitive and/or "close watch" isolation, with devastating consequences.

II. NEW JERSEY JIDAN CLIENTS HAVE SUFFERED THE DETRIMENTAL CONSEQUENCES OF SEGREGATION.

Four clients of the New Jersey JIDAN project illustrate all too well the harmful effects of isolation. Perhaps the most egregious example is Timothy.7 When first referred to us, Timothy was 16 and had been incarcerated for approximately 7 months. He was escorted by guards to his first meeting with his lawyer in leg-irons, hands cuffed behind his back. He wore

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5 Center for Juvenile Justice, Handle With Care: Serving the Mental Health Needs of Young Offenders, (2000).

6 U.S. House of Representatives Committee on Government Reform—Minority Staff Special Investigation Division, *Incarceration of Youth Who Are Waiting for Community Mental Health Services in the United States*, (July 2004).

7 Clients' names have been changed to protect their identities.

no real clothes, no prison issued jumpsuit. Instead, his body was covered with a sleeveless, thigh-length robe, held together by a few Velcro strips. Self- mutilation scars, too numerous to count, covered his arms.

Documents later confirmed what Timothy told his lawyer that first day: he had spent twenty-four hours a day in an isolation-type cell for approximately 180 of the 225 days he had been in the facility. The 7' x 7' cell had a mattress (no sheets or blankets), a sink, a toilet, and a small sealed window near the ceiling. Nothing else was permitted in the cell. All meals were eaten in the cell. There was no school or books. There was no exercise. The only time he was permitted to leave the cell was to shower.

Prior to entering the juvenile justice system, Timothy had a long history of involvement in New Jersey's children's mental health and foster care systems. The self-mutilating and other behaviors that led prison officials to segregate him were exacerbated, rather than treated, during his six months in isolation. And yet, the isolation continued until vigorous legal advocacy extricated him from the facility.

Another New Jersey JIDAN client, Wally, tragically illustrates the increased suicide risk associated with isolation. A fifteen year-old boy with a history of mental health needs and aggressive behaviors, Wally spent approximately 178 of his 225 day commitment in isolation conditions identical to Timothy's. Like Timothy, he had no access to books or other reading materials, auditory stimulation, or substantial conversation. Within a few days of being placed in the "seg unit," Wally began to report auditory and visual hallucinations and demonstrate outrageous behaviors such as throwing bodily fluids. Within a week he began to self-mutilate by "cutting." Soon thereafter, he attempted suicide by hanging himself on five different occasions.

Since the creation of the nation's first "Children's Court" in 1899, rehabilitation has been

a central goal of the juvenile justice system. Juvenile facilities are charged with addressing the behavioral and other needs that lead or contribute to a youth's involvement in the system. Yet, with client after client, we have seen the system resort to isolation to control challenging behaviors in the short run, with no attempt made to understand or treat the underlying cause of a young person's actions. Take, for example Jonathan, who had already endured a lifetime of domestic violence when first incarcerated at age 16. Jonathan's educational and mental health records, which followed him into custody, documented in detail his multiple psychological diagnoses, including an anxiety disorder that leaves him unable to interact normally in a group setting. This condition has obvious implications for a youth in custody, yet the facility administration made no accommodations for him. Instead, Jonathan initially was placed in a dormitory with approximately 30 other boys, did not receive ongoing psychological counseling, and had only intermittent interactions with a social worker. Predictably, his behavior deteriorated, leading to frequent terms in "the box," or punitive isolation.

Numerous pleas for psychiatric treament went unheeded by facility officials. Jonathan thus came to believe that the "box" presented his only escape from what were, for him, the insufferable group dynamics that define prison life. He began to engage in prohibited behaviors for the express purpose of being placed in segregation and, when he was due to be released back to the general population, would commit offenses of escalating seriousness in order to remain there. These offenses gave rise to at least two new deliquency complaints and may well lead to his transfer to the adult prison system. In a seven-month period, he spent approximately three months in solitary confinement, yet was never seen by a psychiatrist. When released from custody, he will not have finished high school, will have had no vocational training, and will be substantially more scarred than he was when he entered the system.

Jonathan's response to isolation is consistent with the research of psychiatrist and noted isolation expert Stuart Grassian, who has observed:

> This harm is most commonly manifested by a continued intolerance of social interaction, a handicap which often prevents the inmate from successfully readjusting to the broader social environment of general population in prison and, perhaps more significantly, often severely impairs the inmate's capacity to reintegrate into the broader community upon release from imprisonment.8

In addition to over-reliance on isolation for punitive purposes, juvenile facilities tend to use it as a stop-gap measure when young people need individualized treatment for medical or other reasons, often inflicting grave harm in the process. In the most egregious example of this that we have seen, 17-year-old Lawrence was held in "medical isolation" for nearly five months after his eyeball was stabbed by another resident. As a result of the assault, Lawrence required multiple surgeries and lost 90% of his vision in the injured eye. Claiming concerns that he might re-injure the eye, facility officials confined him to a glass-walled box within the medical unit for 24 hours a day, allowing him to leave only to shower. He had no privacy; there were no curtains to cover the class and he was in full view of other residents and staff. He was not permitted to attend school or interact with other residents in any way; instead, several times a week a teacher would slip schoolwork under the door for him. Not suprisingly, Lawrence failed to do the work.

Lawrence had endured a lifetime's worth of tragedy before his incarceration. His mother died when he was an infant, he never knew his father, and he found his grandmother, who raised him after his mother's death, dead when he was just eight years old. When he was 15, he was shot in the chest; a bullet remains lodged in his lung. His full-scale IQ is in the borderline range, and he suffered from post-traumatic stress disorder and clinical depression prior to the attack. In short, he desperately needed supportive services, including counseling and special education. Instead, the isolation drove him into a profound depression; he refused to take medication

8 Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 WASH. U. J.L. & POL'Y 325, 333 (2006).

prescribed to prevent infection in his eye, refused to do his school work, refused to talk. It was only after extensive legal advocacy that facility officials agreed to release him from the isolation box. He spent the remainder of his time in the facility in the general medical unit without incident.

III. INTERNATIONAL STANDARDS AND DOMESTIC LAW RECOGNIZE THE DANGERS OF JUVENILE ISOLATION.

International and domestic juvenile justice standards, as well as a substantial body of case law, recognize the dangers, and often prohibit the use of, juvenile isolation. Rule 67 of the United Nations Rules for the Protection of Juveniles Deprived of Their Liberty, for example, prohibits the use "closed or solitary confinement" of juveniles.9 The Rule further defines such punishment as "cruel, inhuman, or degrading treatment."10 Other international bodies and human rights experts, including the Human Rights Committee, the Committee against Torture, and the U.N. Special Rapporteur on Torture, have concluded that long term isolation may amount to cruel, inhuman, or degrading treatment in violation of the International Covenant on Civil and Political Rights and the Convention against Torture and Other Cruel, Inhuman, and Degrading Treatment or Punishment.

Similarly, leading American juvenile justice organizations have sought to limit the use of solitary confinement. These include, among others, the Juvenile Detention Alternatives Initiative of the Annie E. Casey Foundation, the United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention, Standards for the Administration of Juvenile Justice, the American Bar Association (ABA) Juvenile Justice Standards Relating to Corrections Administration, the Council of Juvenile Correctional Administrators ("CJCA"), and the

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9 G.A. Res. 45/113, , 68th plen. mtg. United Nations Rules for the Protections of Juveniles Deprived of Their Liberty, at11 (Dec. 14, 1990).
10 Id.

American Correctional Association ("ACA").

Finally, a number of U.S. courts have determined that excessive use of isolation is detrimental to the rehabilitation of youth, sometimes in violation of the Eight Amendment. *See, e.g., Lollis v. New York Department of Social Services,* 322 F. Supp. 473, 482 (S.D.N.Y. 1970); *Morales v. Thurman,* 569 F.Supp. 332 (1983); *Nelson* v. *Heyne,* 355 F. Supp. 451, 456 (N.D. Ind. 1972); *Inmates of the Boys' Training School v. Affleck,* 346 F. Supp 1354, 1372 (D.R.I. 1972). In *Affleck,* the court stated:

> To confine a boy without exercise, always indoors, almost always in a small cell, with little in the way of education or reading materials, and virtually no visitors from the outside world is to rot away the health of his body, mind, and spirit. To then subject a boy to confinement in a dark and stripped confinement cell with inadequate warmth and no human contact can only lead to his destruction.
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> Id. at 1365-66.

IV. RECOMMENDATIONS FOR REFORM

In light of the foregoing, we respectfully urge this sub-Committee to consider the following recommendations for reform:

- Require juvenile facilities to implement policies and procedures that prohibit any isolation for youth at risk of suicide and in all other situations except for brief periods of time (i.e., "time outs" of four hours or less)
- Ensure that all incarcerated youth have legal representation throughout their confinement in order to protect them from excessive isolation and other unconstitutional conditions of confinement.
- Review of promising efforts to reduce the use of isolation in New York, Massachusetts, Maine, Ohio, and Connecticut

Thank you for your interest in this essential issue.

Respectfully submitted,

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Testimony of Samantha Buckingham

Clinical Professor, Loyola Law School

Co-Director, Juvenile Justice Clinic, Center for Juvenile Law and Policy

I am faculty at Loyola Law School in Los Angeles, California.[1] Through my work at Loyola's Center for Juvenile Law and Policy, I am the co-director of a juvenile justice clinic. Within the clinic, I teach substantive classes on trial skills and juvenile law and I supervise law students representing clients in delinquency proceedings in Los Angeles. In addition, I teach Criminal Procedure and a seminar course on issues in criminal justice. Before joining the faculty at Loyola, I was a trial attorney at the Public Defender Service for the District of Columbia ("PDS"). At PDS, I represented three categories of clients: 1) children charged in delinquency court, 2) children charged as adults with serious and violent felonies, including homicide, and 3) adults charged with serious and violent felonies, including homicide. Prior to becoming a lawyer, I taught high school and ran an after-school volunteer program at the Maya Angelou Public Charter School in Washington, D.C. As a teacher, I worked with many youth who had been adjudicated delinquent and had spent time in juvenile correction facilities.

My testimony will describe how the use of solitary confinement impacted two clients I have represented. These two stories illuminate some of the problems with the use of solitary confinement with vulnerable populations, particularly children, children charged as adults, the mentally ill, those who have previously endured abuse and neglect, and those who are at risk for suicide. My testimony will also propose a framework through which to view the efficacy of solitary confinement and suggest some questions that deserve greater research and attention in the committee's quest to understand the issues related to solitary confinement more fully.

INMATE STORIES

I offer what I know about the experiences of two clients who have been placed in solitary confinement. I share these two stories to provide the committee with a lens through which to view in human terms some of the challenges with the use of solitary confinement in U.S. prisons and jails. The first story belongs to Joan,[2] a mentally ill, previously abused, female juvenile client held in an adult facility and locked down 23 hours a day, seven days a week, on the basis that it was for her own protection. The

[1] My testimony is offered in a personal capacity and is not a representation of either Loyola Law School or the Center for Juvenile Law and Policy.

[2] Joan is not her real name. To protect attorney client confidences, I have changed her name. I have purposefully decided to refer to her by a name because I believe that to do so promotes her humanity.

second story belongs to Bob,[3] a mentally ill, previously abused, adult male client serving time on a drug distribution charge and held in solitary confinement as punishment.

JOAN'S STORY

Mentally Ill, Previously Abused, Female Juvenile Client held in an Adult Facility and Locked Down 23 hours a day, seven days a week, on the basis that it was for her own protection.

Joan's background:

Joan was abused and neglected in her childhood. Joan was born in extreme poverty to an alcoholic, crack-addicted mother. Joan was addicted to crack at birth and experienced withdrawal in the first breaths of her life. Joan was raised by this same parent, a mother who had struggled due to her own mental health issues, abuse she had suffered, and addictions. Joan was exposed to extreme violence and abuse in her early life. She saw and heard her mother being raped. She saw her mother burned. She saw her mother running naked through the streets in her neighborhood. Early childhood records indicated that Joan came to school without adequate clothing and was hungry. Joan was a child who should have been identified as in need of special education services. At ten years old, Joan was left alone to care for several younger siblings, including one sibling who was developmentally disabled. Joan was left alone and responsible for her siblings for over a week before a parent returned.

Joan had behavior problems in school and was adjudicated delinquent, all before she was thirteen years old. Though Joan had experimented with some substances, she adamantly refused to touch crack because of her experience growing up with a crack addicted mother. Psychologists and psychiatrists who evaluated Joan thought her delinquent acts were a cry for help. In particular, doctors believed that Joan's aggressive acting out directed at women was indicative of Joan's anger towards her mother.

Joan was diagnosed with bi-polar disorder and chronic post traumatic stress disorder ("PTSD").

At fifteen, Joan moved in with her much older boyfriend. In that household, were several adult men, all much older than Joan. At sixteen, Joan was charged with killing of one of those men. There were extenuating circumstances in that case, such as Joan's mental health status, previous inappropriate actions towards Joan by the adult man, and drug use by the adult man shortly before the incident which led to his death.

Joan was arrested and detained. Joan was charged as an adult and held in an adult facility.

The circumstances under which Joan was held:

The facility where Joan was detained had no other juveniles charged as adults. On the basis that it was for Joan's own protection, the correctional facility held Joan in a cell 23 hours a day, seven days a week. Initially, she did not have access to mental health treatment or appropriate education.

[3] Bob is not the real name of my client. To protect attorney client confidences, I have changed his name. I have purposefully decided to refer to him by a name because I believe that to do so promotes his humanity.

Through litigation, her conditions of confinement improved, but were never consistent with what would have been afforded her had she been held in a unit with other juveniles.

Joan reported that she felt as though solitary confinement was being used to punish her. She felt that time passed extremely slowly. Joan felt hopeless and scared.

Joan hoarded medication she received and attempted suicide. She also acted out against female corrections officers. The corrections officers who were charged with Joan's care were not specially training in dealing with juveniles, juveniles charged as adults, or the mentally ill.

Lessons from Joan's story:

- Mentally ill are held in solitary confinement, even when there is no basis to punish them;
- Juveniles are held in solitary confinement as a way to separate them from adults, even when there is no basis to punish them;
- There is no screening process to determine if solitary confinement may have deleterious effects on the individual;
- There is no accommodation for vulnerable individuals, including juveniles and mentally ill;
- The use of solitary confinement with juveniles can impact their access to education;
- The use of solitary confinement with juveniles can communicate to juveniles that they are being punished whether or not punishment is the stated reason for its use;
- Juveniles in solitary confinement may feel like time passes very slowly, more slowly than the passage of time is felt by adults;[4]
- The use of solitary confinement can impact the prisoner's access to mental health services; [5]
- As a matter of policy and in an effort to adhere to sight and sound restrictions that necessitate separation of juveniles and adults in adult facilities, [6] juveniles may be held in solitary confinement;
- The conditions in solitary confinement can exacerbate mental health symptoms;[7]

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[4] *See* JUVENILES IN ADULT PRISONS AND JAILS: A NATIONAL ASSESSMENT (October 2000), United States Department of Justice, Office of Justice Programs, Bureau of Justice Assistance, at 25 ("What may be acceptable as punishment for adults may be unacceptable for children. Children have a very different perception of time (five minutes may seem like an eternity), and their capacity to cope with sensory deprivation is limited.")

[5] *See* Jeffrey L. Metzner, M.D., and Jamie Fellner, "Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics," *The Journal of the American Academy of Psychiatry and the Law,* vol. 38, No. 1, 104-108 (2010) (internal citations omitted).

[6] The federal Juvenile Justice and Delinquency Prevention Act ("JJDPA"), 42 U.S.C. §5633 (2003) provides guidelines for incarcerating juveniles in adult jail, including a "sight and sound" restriction that prohibits juveniles from being able to see or hear adult inmates. See 42 U.S.C. § 5633 (a) (13) ["no juvenile will be detained or confined in any jail or lockup for adults ... only if such juveniles do not have contact with adult inmates and only if there is in effect in the State policy that requires individuals who work with both such juveniles and adult inmates in collocated facilities have been trained and certified to work with juveniles."]; *See* Interim Report of Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. UN General Assembly. New York: United Nations, UN Doc A / 66 /268: 13 (2011).

- The conditions in solitary confinement can lead to greater incidents of violence;[8]
- The link between solitary confinement and future acts of violence should be further explored;
- Suicide attempts can be a by-product of the conditions in solitary confinement, particularly with vulnerable populations such as juveniles and the mentally ill.[9]

BOB'S STORY

Mentally Ill, Previously Abused Adult Male Client Serving time on a drug distribution charge and held in solitary confinement as punishment.

Bob's Background:

As a child, as young as eight years old, Bob was physically and sexually abused by multiple members of his family. In order to avoid staying with abusers, Bob turned to jumping out of moving car, running away from home, living on the streets, selling drugs to earn money to support himself, and using drugs to escape his reality. Looking back, Bob reflected to me that he was not "living pretty," but he was "surviving."

Bob had several juvenile adjudications involving drugs. At eighteen, Bob was convicted of drug distribution and sentenced to federal prison. At the time of his incarceration, Bob had no record of violence.

Bob was diagnosed with depression, schizophrenia (which is characterized by paranoia as well as auditory and / or visual hallucinations), schizoaffective disorder (which is both mania and a mood disorder), and post-traumatic stress disorder ("PTSD").

While incarcerated for drug distribution, Bob's mental health worsened. Bob experienced his first hallucination at eighteen while serving his sentence. The voices Bob heard communicated messages that were degrading and debasing of Bob, often telling Bob that he should be dead.

While incarcerated, Bob was exposed to violence, was the victim of violence, and acted out violently in the prison environment. Bob witnessed many acts of violence, including seeing other inmates beaten to

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[7] *See* Interim Report of Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, at 26-27, citing Sharon Shalev, A Sourcebook on Solitary Confinement (London Manheim Centre for Criminology, 2008), at 15-17 (additional internal citation omitted).

[8] *See* Id.

[9] *See* Id; *See* Metzner, M.D., and Fellner, 2 (internal citations omitted); *See* JUVENILES IN ADULT PRISONS AND JAILS: A NATIONAL ASSESSMENT (October 2000), United States Department of Justice, Office of Justice Programs, Bureau of Justice Assistance, at 7-8 ("Research has shown that juveniles in adult facilities are at much greater risk of harm than youth housed in adult facilities. The suicide rate for juveniles held in jails is five times the rate in the general youth population and eight times the rate for adolescents in juvenile detention facilities.") (citation omitted). *See also* Joshua T. Rose, *Innocence Lost: The Detrimental Effect of Automatic Waiver Statutes On Juvenile Justice*, 41 BRANDEIS L. J. 977, 993 (2003) ("juveniles adjudicated in the adult system . . . are more likely to suffer the terrible consequences of being incarcerated in adult facilities").

death right in front of him. Bob was stabbed in the head and back by another inmate. Bob was raped (sodomized) in prison. Bob reported being extremely concerned for his own personal safety, one of the hallmarks of individuals who suffer from PTSD. Bob reported that it was out of concern for his own safety that Bob himself acted out violently in prison. Bob was punished with solitary confinement. Bob's first of several suicide attempts occurred in solitary confinement. Bob ingested cleaning fluid he had requested under the guise of cleaning his cell along with medication he had been hoarding. Bob passed out and hit his head on the toilet, sustaining an injury. He was hospitalized.

During the course of his incarceration, Bob spent several stints in solitary confinement. Bob attempted suicide several times. While in prison, though Bob received medication, Bob did not receive treatment for his PTSD, history of sexual abuse, history of physical abuse, mental illness, and the neglect he suffered as a child.

After spending greater than a decade incarcerated on drug distribution, Bob was released from prison and turned once again to street drugs to cope with a very scary reality. Bob recounted that he felt unprepared to live in the outside world. Within a few years, Bob was arrested for, and ultimately convicted of, a homicide.

Lessons from Bob's story:

- Mentally ill are held in solitary confinement as a form of punishment;[10]
- There is no screening process to determine if solitary confinement may have deleterious effects on the individual;
- There is no accommodation for vulnerable individuals, including mentally ill;
- The use of solitary confinement can impact the prisoner's access to mental health services;[11]
- The conditions in solitary confinement can exacerbate mental health symptoms;[12]
- The conditions in solitary confinement can lead to greater incidents of violence;[13]
- The link between solitary confinement and future acts of violence should be further explored;
- Suicide attempts can be a by-product of the conditions in solitary confinement, particularly with vulnerable populations such as the mentally ill.[14]

RECOMMENDATIONS

Framework:

In assessing the effectiveness of solitary confinement, the committee might consider the following:

I. What are the goals of the use of solitary confinement?

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[10] *See* Interim Report of Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 12-13 (2011)
[11] *See* Metzner, M.D., and Fellner, 2 (internal citations omitted).
[12] *See* Interim Report, 18 and 26-27 (internal citations omitted).
[13] *See* Id.
[14] *See* Id; *See* Metzner, M.D., and Fellner, 2 (internal citations omitted).

a. Are these goals broad? For instance, to reduce violence in society generally.
b. Are these goals specific? For instance, to reduce violence on one particular cell block?

II. How well are the goals achieved?
a. How well are the goals achieved as measured by the fiscal expense?
b. How well are those goals achieved as measured in human success, such as having prisoners behave in a manner in which society expects outside the walls of prison? Outcomes here may be viewed in the long-term, both by those subjected to solitary confinement and by all prisoners who are aware of its use and effects.
c. Are there other more effective measures?

When stopping to ask what the goal is in implementing solitary confinement, the committee may find, for instance, that the goal of protecting vulnerable individuals, such as juveniles, may not be as legitimate a goal as the removal of violent offenders from the general prison population.

As for solitary confinement's efficacy specifically as a punishment, the committee should consider whether any of the five over-arching justifications for punishment are furthered by its use. They are:

1) rehabilitation,

2) deterrence (both *general deterrence* to the wider prisoner community and *specific deterrence* to that particular prisoner who is being held in solitary confinement),

3) incapacitation,

4) retribution (which, at first blush, seems to have less force in the prison context than in society), and

5) restitution (which seems wholly inapplicable given the inability of prisoners in solitary confinement to repay any debts).

It seems the strongest argument for the use of solitary confinement can be made for incapacitation; the separation of those who are the most dangerous and volatile from the remainder of the prison population in the short-term may reduce the violence those removed and isolated prisoners may have committed against others in the prison. It may be impossible to predict the future violent acts that may have happened if the prisoner remained in general population. However, if solitary confinement only exacerbates, rather than resolves, the instances of violence that may have led to a prisoner's solitary confinement in the first place, then the overall goal to reduce violence may not be effectively achieved by the use of solitary confinement. I would urge the committee to balance long-term rehabilitation goals with short-term incapacitation goals. If a solution is effective in the short-term, but exacerbates the problem when taking a long view, then its efficacy overall, measured in both fiscal and human cost, is severely undermined.

Suggested Areas To Gather Research:

- What steps are taken to address a problem prior to the implementation of solitary confinement? Is there a graduated approach? How is solitary confinement determined as an intervention tool in each instance of its use?
- Who decides to implement solitary confinement? Is it a corrections officer? Does this person have any specialized training? Is that training sufficient?
- Is a prisoner's mental health a factor in determining whether solitary confinement will be appropriate and effective at achieving the desired end?
- If solitary confinement is used in prisons, should those corrections officers responsible for its implementation have specialized training in mental health, dealing with the mentally ill, and dealing with the types of problems presenting in those prisoners who are exposed to solitary confinement in that facility?
- How can a prisoner's experience in solitary confinement be monitored effectively, in particular for mentally ill?[15]
- What is the link between solitary confinement and future acts of violence?
- Is solitary confinement justifiable for use on prisoners who are serving sentences which will allow them to return to our community?

CONCLUSION

I urge the committee not to lose sight of the individuals who are directly impacted by the use of solitary confinement. As I hope the two stories I relayed demonstrate, the individuals who find themselves in solitary confinement have a past and a future. Their pasts may make them more vulnerable and susceptible to the damaging psychological impacts of solitary confinement. Their futures, and the lives of all those with whom they interact, may be negatively impacted by the use of solitary confinement to the extent that it exacerbates violence, propensity for self-harm, and general mental health conditions. I urge the committee to keep the long-term impact of the use of solitary confinement in their calculus.

The committee should examine further the use of solitary confinement with vulnerable populations, particularly children, children charged as adults, the mentally ill, those who have previously endured abuse and neglect, and those who are at risk for suicide. The committee should limit the use of solitary confinement with these populations.

The committee should also endeavor to learn more about the development of any screening processes to determine who may be subjected to solitary confinement, the individuals who decide which prisoners to subject to solitary confinement, how those decision-makers are trained for this task, and how prisoners subjected to solitary confinement are monitored, especially their mental health.

[15] Often video monitors are used and mental health professionals conduct rounds without actually interacting with the prisoners in solitary confinement. *See* Metzner, M.D., and Fellner, 2 (internal citations omitted).

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Senator Durbin
U.S. Congressional Committee on Solitary Confinement

June 15, 2012

Senator Durbin and Esteemed Committee Members,

I appeal to you on behalf of any and all men and women confined to Solitary Confinement even for a day! I find that I am unable to spend a long period of time thinking of those who have indeterminate SHU (segregated housing unit) terms. Perhaps, I have read too much from them related to the bleak conditions of their existence, and yet, it seems, I cannot read enough. I am both drawn to them and actually frightened when I consider what they are forced to endure. As I believe we have a tendency to do, I try to imagine myself in their shoes and the thought paralyzes me.

I have known two men who have been in SHU for 16 and 23years respectively for a period of 12 years. I have become acquainted with an additional 27 men from Pelican Bay, Corcoran and Tehachapi SHU's, who have corresponded with CFASC since the 2011 hunger strikes.

We asked that they share their experiences, fears, feelings, hopes and despair with us. Interestingly enough, only one person who wrote back spoke of intense despair to the point of wanting death to take him. Others were clear that the experience was brutal, that it was soul crushing, that the fight against insanity was ongoing throughout the days, months and endless years. But quite clearly, within their writings, I sensed a strain of hope and commitment to the ongoing fight for justice which they kicked into gear last year with their life-threatening hunger strikes. It should be noted that many, if not all, who participated in the second hunger strike were written up and stripped of their newly gained "privileges".

In California, for the first time in countless years, SHU "dwellers" are hearing the collective voice of their loved ones leading organizations, working within coalitions, participating in hearings, lawsuits, street actions, speaking in churches and at universities. These voices of scarred family members are certain to force a change over time and the men feel this to be true.

I have many writings which were sent to CFASC over the period of just under 11 months. Each man who reached out to us did so knowing that we would use their words to force a change into being. I am writing the men today asking that they write out their truth and mail it to CFASC giving permission for us to share it with all who are willing to consider what they have to say.

Thank you for the opportunity to communicate with you and beyond that, we are eternally grateful to you, Senator Durbin for holding these first ever US Congressional Hearings on Solitary Confinement.

geri silva, coordinator for California Families to Abolish Solitary Confinement - CFASC

COMMENTS TO THE JUNE 29, 2012, HEARING
BEFORE THE SENATE JUDICIARY SUBCOMMITTEE
ON THE CONSTIUTTION, CIVIL RIGHTS AND HUMAN RIGHTS

To: Senate Judiciary Committee
Subcommittee on the Constitution, Civil Rights and Human Rights

From: Geoffrey A. Gaskins, M.Div.
Project Director, California Interfaith Campaign on Solitary Confinement

Date: June 15, 2012

Re: Hearing on Reassessing Solitary Confinement, June 19, 2012

Honorable Senators of the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights:

I thank you for the opportunity to submit on behalf of the California Interfaith Campaign on Solitary Confinement (CICSC) the following comments concerning the use of prolonged solitary confinement in our nation's prisons and other places of detention. CICSC joins a growing number of organizations across the nation calling for comprehensive review of penal policies and practices regarding isolated confinement, and we are grateful for your attention to this matter.

The California Interfaith Campaign on Solitary Confinement is affiliated with the National Religious Campaign Against Torture and is being established to raise awareness among faith communities in California about prolonged solitary confinement policies and practices in our state's prison system. While exact numbers are hard to come by, we believe that, today, over 3,500 people were being held in solitary confinement in California special housing units (SHUs)—513 for more than ten years, 78 for more than twenty—and hundreds more are being held in Administrative Segregation, awaiting a SHU assignment. People of faith and other people of conscience all over California are calling for an end to this practice as a long-term solution for individual prisoners.

Prolonged solitary confinement has long been considered a form of torture that destroys the humanity of those who suffer it. Our laws and all faith traditions recognize the inherent and inviolable dignity of every human being. As Justice Thurgood Marshall so poignantly stated: "When the prison gates slam behind an inmate, he does not lose his human quality ...."[1] Prolonged solitary confinement destroys that human quality, often irreparably. Any practice that promotes that end does not reflect the values and moral principles that ground our nation and it is to this issue—the moral issue—that I here submit my comments for your consideration.

As you may know, the history of solitary confinement in U.S. penal institutions has a religious underpinning. Edith E. Flynn and Margaret Zahn, in their article, "Prisons and Jails: Development of Prisons and Jails in the United States" notes this history:

[1] *Procunio v. Martinez*, 416 U.S. 326, 428 (1974).

> Reflecting the legacy of their European ancestors, the American colonists made extensive use of corporal punishment, with death, mutilation, branding, and whipping decreed for serious offenses, and public ridicule, such as the stocks, the pillory, the public cage, or the ducking stool, imposed for lesser offenses. In general, the colonial penal system was harsh, exacting, and motivated principally by revenge....
>
> After the Revolutionary War... reform-minded colonists began to experiment with new criminal codes.... They also embarked on a course of penal reform that would not only affect America but eventually spread throughout the world."[2]

By 1787, a small group of concerned citizens in Pennsylvania organized the Philadelphia Society for Alleviating the Miseries of Public Prisons to advocate for reforms to make prisons more humane. Pennsylvania Quakers provided significant support for the Society's efforts at prison reform and came up with the idea of solitary confinement as a rehabilitation practice. It was thought that prisoners confined in solitary conditions, with time to reflect on their actions, would be rehabilitated through penitence. The term "penitentiary" comes from the Quaker idea that solitude would bring about penitence.

The Wall Street Jail in Philadelphia was the first to experiment with solitary confinement. First constructed in 1776, according to Flynn and Zahn, "this jail had all of the hellish characteristics of its predecessors." Men, women, and children were kept in the same facility, where conditions were brutal and inhumane. The Wall Street Jail was renovated in 1790, becoming the nation's first "penitentiary." Debtors were separated from hardened felons, and men, women, and children were segregated. Corporal punishment was banned and new legislation developed by the Philadelphia Society shifted the focus from physical, often arbitrary punishment of offenders to their reform and rehabilitation. Inmates were given a Bible and religious instruction to facilitate solitary contemplation, and assigned to hard labor to teach self-control. It was thought that the combination of contemplation and self-control would bring about rehabilitation and redemption, and prisoners would be returned to society as law-abiding citizens.

Then, as now, extreme sensory deprivation and the total lack of human contact led to the development of psychoses and other forms of mental and physical illnesses in prison populations. Then, as now, suicide was a frequent response of prisoners who were left in solitary confinement for prolonged periods. By the late 1880s, U.S. prisons authorities began looking at clinical evidence from Europe that confirmed the dire effects of solitary confinement experienced in Wall Street Jail and other U.S. penitentiaries, and the practice of solitary confinement was abandoned in U.S. prisons from the 1880s to 1970 when it was revived in even more extreme forms as supermax prisons and special housing units.

What began with a religious impulse toward reformation and rehabilitation has become an often cruel and capricious system of warehousing inmates, with little, if any, concern for the genuine reformation and rehabilitation. And we all suffer consequences. Prisoners suffer years and

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[2] Prisons and Jails - Development of Prisons and Jails in the United States - Private, Inmates, Penal, and Punishment http://law.jrank.org/pages/18929/Prisons-Jails.html#ixzz1VbpPydbB.

decades under conditions of extreme sensory deprivation and near-total social isolation. Our communities suffer when people who have been subjected to prolonged periods of social isolation are returned to our communities psychologically broken, unfit for social intercourse, and more likely to re-offend. Guards, prison staff, and other prison officials may also suffer a kind of moral injury from participating in practices and policy-making that essentially cage other human beings and encourage their inevitable physical and mental degradation. I suggest, further, that the soul of our nation is degraded, as is our ability to face the international community as the champions of human rights we claim to be.

We should also be cognizant of how the implementation of solitary confinement in U.S. prisons reinforces cultural biases and prejudices with which we have struggled throughout our history, particularly those around race and religion. In California, nearly ninety percent of solitary inmates are members of racial, ethnic, sexual, and religious minorities who are often assigned to solitary confinement as punishment for expressions of otherwise protected forms of religious and cultural traditions. Consider:

- Native American and Rastafarian inmates have been put into solitary confinement for not submitting to policies regarding hair length. "[I]n Virginia, over 30 inmates were moved to a maximum security facility for "non-compliance"... with standards that require hair to be above one's shirt collar and beards to be completely shaven."[3]

- For Muslims held in Communications Management Units (CMUs), our cultural bigotry is particularly evident. Clearly, widespread Islamophobia contributes to the disproportionate number of Muslim inmates being placed into CMUs. The Center for Constitutional Rights estimates that sixty percent to seventy-five percent of those in CMUs are Muslim, and unlike other federal inmates, CMU prisoners are forbidden any personal contact with their children, spouses, family members, or other loved ones.

- Homosexual, bisexual, and transgender inmates—sixty-seven percent of whom report having been sexually assaulted either by inmates or guards—have reported intentionally committing minor infractions in prison, knowing solitary confinement would be the outcome, yet preferring the horror of solitary to the horror of being repeatedly raped.

Prisoners are routinely assigned to solitary confinement—for a minimum sentence of six years in California—for minor infractions of prison rules, without having participated in any criminal activity during their incarceration. An inmate can be sentenced to solitary confinement for six years for talking to another prisoner assumed to be a member of prison gang; or for possessing artwork or literature assumed to contain gang symbols or unsanctioned philosophical ideology; or based on uncorroborated accusations made by other prisoners. Prisoners suffering from various forms of mental illness who, by virtue of their illnesses, are constitutionally unable to follow rules consistently, are likely to end up in solitary confinement, exacerbating their conditions and often leading to complete psychotic breakdowns.

We know from psychological research dating from the eighteenth century to the work of contemporary experts like Drs. Terry Kupers and Stuart Grassian that prolonged solitary

[3] http://prisonintro.blogspot.com/2011/03/respecting-inmate-culture.html.

confinement creates, exacerbates, or encourages profound mental and physical pain and suffering, often with permanent long-term consequences. Extreme isolation and sensory deprivation can induce psychoses, delirium, systemic physical degradation, premature aging, and chronic and acute depression, among other serious physical and psychological damage. To intentionally inflict this kind of physical and mental pain and suffering surely constitutes torture under UN statutes which define "torture" in exactly these terms. (I suggest, further, that prolonged solitary confinement also violates Eighth Amendment provisions in the U.S. Constitution against cruel, unusual, and excessive punishment.) It is for these reasons, among others, that the use of solitary confinement has been largely abandoned by most of the international community, which leaves the United States in league with some of the most notorious human rights violator nations in the world.

Proponents of the use of solitary confinement say that solitary confinement is necessary to maintain safety within prisons and the public safety without. We know from recent efforts reducing solitary confinement populations in prisons in Maine, Colorado, and Illinois, however, that reducing solitary confinement populations does not make prisons or the public more unsafe; rather, the contrary has turned out to be true. Moreover, the annual cost of maintaining an inmate in solitary confinement (approximately $71,000-$78,000 in California) is significantly higher than housing that person in the general population (approximately $58,000 in California), taxing already strained state budgets. These considerations, taken with all of the research and our centuries of experience, suggest that we seriously ask ourselves why our penal institutions continue to use prolonged solitary confinement. Prolonged solitary confinement serves no good purpose. It does not make us safer; it does not make prisons safer; it is needlessly expensive given the alternatives; and prolonged solitary confinement arguably constitutes torture under both domestic and international law.

Given what we know about prolonged solitary confinement, then, we must conclude that prolonged solitary confinement violates the "standards of decency that mark the progress of a maturing society." These are Chief Justice Earl Warren's words in *Trop v. Dulles* (356 U.S. 86 (1958)) and constitute the basis upon which he believed the Eighth Amendment of the U.S. Constitution "must draw its meaning." In our continued use of solitary confinement, we, as a nation, have failed that standard. Prolonged solitary confinement violates the standards of decency and morality that truly mark the progress of a maturing society. A maturing society cannot abide the systemic use of torture in its institutions, and we continue to do so to our enduring shame.

The twelfth century Jewish sage Maimonides has stated the following:

> Redeeming captives takes precedence over providing food and clothing for the poor. There is no greater mitzvah than redeeming captives, for the captive is in the category of the starving, the thirsting, and the naked, indeed in danger of losing their own life. One who remains indifferent to the captive's redemption transgresses." (*Mishneh Torah*, "Laws of Gifts to the Poor." 8:10)

From the Christian Scriptures we read:

> Remember those in prison, as though you were in prison with them; those who are being tortured, as though you yourselves were being tortured." (Hebrews 13:3)

What is expressed in these teachings is a recognition the inherent worth of each human being, without qualification. In the Abrahamic traditions, every human being is considered created in the image of God and, therefore, capable of redemption and worthy of an opportunity for personal transformation. For this reason, as people of faith, we are called to defend the human dignity within each person, even those in prison; perhaps especially those in prison. As Rev. Richard Killmer, Executive Director of the National Religious Campaign Against Torture, has written,

> "The National Religious Campaign Against Torture vehemently believes that even those convicted of crimes are human beings with inherent dignity and worth, and they deserve humane treatment."[4]

What concerns people of faith in this conversation is how prolonged solitary confinement destroys the humanity of both those who suffer it and those to promote and perpetuate it. Indeed, when human beings in our institutions are subjected to conditions that destroy who they are and who they can be, it is incumbent upon all people of conscience to challenge ourselves and our institutions to higher standards of moral conviction.

If, knowing what we know, we allow prolonged solitary confinement to continue, we must ask ourselves what this says about who we have become as a people. And that is the question I hope receives thoughtful consideration in your deliberations about this matter. The issue of prolonged solitary confinement is not only about those who are suffering, some for decades, under unconscionable conditions in prisons across the nation. It is also about who we are as a people to condone such practices. Ultimately, as a people, we are responsible for the moral and ethical standards that guide our public institutions and to which they must be held accountable. And we, as a people, stand convicted to the extent that we allow systemic torture in the form of prolonged solitary confinement in U.S. prisons to continue. As a people, knowing what we know, I suggest to you that nothing less than the soul of our nation is at stake.

Thank you for your time and your thoughtful attention to this matter.

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[4] http://obrag.org/?p=41341.

Statement from Ronald Ahnen, President, and Marilyn McMahon, Executive Director, of California Prison Focus, a human rights organization located in Oakland, California, that works to expose and to end human rights abuses in California prisons, especially the practice of long term solitary confinement.

Dear Honorable Senators:

We represent California Prison Focus, a non-profit human rights organization. For over two decades, California Prison Focus has been in the forefront of the fight to limit and ultimately to eliminate long term solitary confinement in our state. We welcome this opportunity to provide information to the committee regarding the horrific conditions of the solitary confinemnet units in California prisons, principally the Security Housing Units (SHUs)[1] and the Administrative Segregation Units (ASUs)[2].

We hear directly from prisoners through correspondence and in-person interviews with hundreds of prisoners in solitary confinement. For over a decade, California Prison Focus has regularly published reports on SHU conditions in our newspaper called *Prison Focus*. Each issue contains ample information about the kinds of abuses that occur to prisoners who are housed in solitary confinement, especially conditions at Pelican Bay, Corcoran, and other SHU prisons. Past issues are available free of charge on our website: www.prisons.org.

Last July 1st, prisoners in the SHU at Pelican Bay State Prison (Crescent City, California) launched a hunger strike to push for five core demands. The authors of this statement served on

[1] SHUs in California are similar to solitary confinement in other states but in some respects are worse. For example, telephone calls to family are forbidden, except when an immediate family member dies. We know of no other prison system in the United States that forbids any phone contact with families. Pelican Bay's SHU cells have no windows. Even legal visits are non-contact (speaking over a phone through plexiglass).

[2] ASUs exist in each California prison and are either used to house prisoners in solitary confinement on a short term basis, or as "temporary" housing for those awaiting availability of a SHU cell. In the latter case, prisoners can spend as much as two or three years in ASU.

the seven-person mediation team that helped to clarify and explain the prisoners' demands to high ranking state officials and facilitated an end to the hunger strike.

California Prison Focus has an intimate knowledge of conditions in solitary confinement in our state. In our statement, we would like to describe briefly how the process to place prisoners in solitary confinement is blatantly misused by prison officials, to enumerate a number of ways in which the prisons violate the basic human rights of prisoners in the SHUs, and to describe briefly some reasonable alternatives to solitary confinement.

Placement in solitary confinement

Probably the largest and most often heard untruth of prison officials and security personnel is that prisoners in solitary confinement are "the worst of the worst." CDCR claims that only the most dangerous persons who are unwilling to undergo programming with other prisoners on a general population yard, and who commit crimes, violent acts, or other serious rule violations are housed in solitary confinement.

This claim is patently false. Our investigations reveal that many SHU prisoners have had very few violent incidents or rules violations—or none at all for decades. Some prisoners who have been in SHU for years have committed no violent act ever, either before they were sent to prison or after.

In California, the majority of the 4,100 prisoners housed in long term solitary confinement are there due to alleged membership in or association with prison gangs. Some 3,000 California prisoners are labeled as "gang associates," that is, prisoners who, although not accepted as members of a prison gang, have been seen to "associate" with prison gang members or other associates. Such associations, however, are often innocuous. For example, one prisoner

in general population may start a conversation with another. He may not know that the other is alleged to be a gang member or associate. The fact of their conversation—no matter what the content—is used by CDCR as proof of gang association. Other examples of the flimsy, illegitimate, or meaningless items of evidence that have been used to "prove" gang affiliation include:

1) Statements of a prisoner informant that a specific prisoner is a gang affiliate; the accused cannot see or refute these nor know the identify of his accuser;
2) Possession of materials that contain the name or image of George Jackson, the radical Black prisoner killed by prison guards in the early 1970s (who was, by the way, not a gang member);
3) One's signature on a birthday card that an alleged gang member has also signed;
4) A tattoo of a cultural symbol such as the Huelga bird (the logo of the United Farm Workers), a dragon, or a shamrock;
5) One's name appearing on a list said to be a gang roster, which was really the membership list of the prison-sponsored Men's Advisory Council;
6) A poem in Spanish with the adjective "northern" in it (taken as indicia of membership in the Northern Structure prison gang);
7) An essay on the history of African-American liberation;
8) Signing a letter "Now and Forever Yours" as a sign of affiliation with the "Nuestra Familia" prison gang due to the similarity in initials;
9) Talking to another prisoner who is a gang member—of a different gang than the accused is alleged to belong to.

Why do prison officials falsely allege gang membership? Our investigative findings suggest that inmates who regularly register complaints about the behavior or misapplication of prison rules by guards and other staff are targeted for gang investigation for the sole purpose of removing that person from a specific yard or prison. In addition, jailhouse lawyers, prisoners who help other inmates file formal complaints or lawsuits, and prisoners with a clear socio-political perspective and the ability to articulate it are gang-validated in proportions that defy the odds that this could be coincidental. The only reasonable conclusion is that these prisoners are targeted by guards and gang investigators for standing up for their rights or those of others. More than one prisoner has heard a gang investigator brag that he could gang-validate any prisoner. Prisoners relate hearing boasts like, "Point to anyone, and I can validate him."

The use of false gang validation and subsequent invalid SHU assignment violates due process rights and is contrary to both national and international law. For these reasons, on May 31, 2012, California Prison Focus, with the Center for Constitutional Rights and others, filed a class action lawsuit (*Ruiz v. Brown*) against state officials, alleging the unconstitutionality of California's SHU policies and gang-validation processes.

To obtain release from the SHU, gang-validated prisoners must demonstrate that they are disassociating themselves from the gang they with which they are allegedly affiliated. They can do this only by "debriefing," that is, providing information about the gang's activities and naming names of gang members. Providing such information is of course impossible for those prisoners who were falsely validated; thus they have no hope of being released to General Population.[3] Prisoners are sometimes prodded by gang investigators to name particular individuals as gang affiliates. Alternatively, inmates may offer information about prisoners they suspect are gang

[3] Regulations do call for a review of gang status at least every six years through which a person may be considered "inactive" in the gang and released from the SHU. Very few prisoners are ever deemed inactive, however, and some of those, despite their inactive status, are still held in the SHU.

members—without any real evidence. The incentive to lie about these matters is great, for it is the only real path out of the SHU. Being pressured to give information about the possible criminal activities of others while under duress is torture. Long term solitary confinement, as currently practiced in California, is nothing short of torture. The practice must be abolished.

Conditions in Solitary Confinement

Prisoners in long term solitary confinement are only allowed out of their 80 square foot cell once a day for up an hour or an hour and a half. In actuality, prisoners report to us that their "yard" and out of cell time is often cancelled or reduced for any of a variety of reasons. The term "yard" should not be understood to mean an outside space or anything with greenery. At Pelican Bay State Prison, the "yard" is a simply a larger concrete cell at the end of the corridor, with high concrete walls and a half-open ceiling. The "yard" gives prisoners some access to natural sunlight, but they never see the out of doors. They see no trees or grass for the years or decades they are locked in SHU. Their cells have no windows.

SHU prisoners are not allowed contact visits and are only touched by another human being when a guard shackles or unshackles them.

Most of us cannot imagine the long term psychological effects of living nearly 24 hours a day in a very small concrete cell, or having to share that cell with another person. Psychiatrist Terry Kupers and other experts have testified in court to the psychosis that is caused by such confinement (see Dr. Kupers statement to the committee). The Honorable Judge Thelton Henderson of the 9th U.S. District Court noted in 1995 that solitary confinement "may well hover on the edge of what is humanly tolerable." In addition, Judge Henderson noted that placing a mentally ill person in solitary confinement is "the mental equivalent of putting an

asthmatic in a place with little air."[4]

Many prisoners have reported to us that they began to become violent or suicidal for the first time in their lives only *after* being placed in the SHU. Indeed, it is common for prisoners at Pelican Bay State Prison to develop symptoms of mental illness due to their placement in SHU after a number of months or years, and then to be removed to Corcoran State Prison's SHU where they receive treatment mostly in the form of medication. Sessions with a psychiatrist are typically once every one to three months and last for only a few minutes as their purpose is just to renew medication prescriptions.

Thus, SHU prisoners suffer severe and permanent psychological damage. Unfortunately, that is not where the torture or abuse of prisoners in SHU ends. Prison officials routinely provide substandard medical care to SHU prisoners as an added incentive to induce debriefing. Many prisoners report that they are told directly by medical personnel, "if you want better medical care, then debrief." One prisoner told us that he was in the last stages of his fatal disease and was encouraged by his doctor to get in touch with his long estranged family members soon. He made the request for a phone call on this emergency basis. The request was granted. But when the guards arrived to his door to escort him to the phone, they instead held up a paper sign with one word on it: "debrief." The message was clear: this dying man would only be allowed to say good-bye to his family if he agreed to debrief. This act was particularly cruel, but unfortunately not out of step with the kind of physical and psychological abuses to which inmates in SHU are constantly subjected.

SHU inmates are unable to participate in any programming except for correspondence courses that they themselves must pay for out of their own funds. In order to students to

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[4] *Madrid v. Gomez*, 889 F. Supp. 1146, 1265 (N.D. Cal. 1995).

graduate, CDCR must provide exam proctors, something it had refused to do in recent years and one of the five core demands of last year's hunger strike (see below). CDCR provides no funds for educational courses designed to rehabilitate these inmates, despite the agency's name. Visits are tremendously difficult for families, given Pelican Bay State Prison's location only a few miles from California's northern border--about a fourteen-hour drive each way from Los Angeles, where many of the families live. After such travel, the visit with their loved one lasts less than an hour and a half. Research demonstrates that family visits are one of the strongest predictors of successful rehabilitation and reduced recidivism.

When prisoners are released from SHU due to debriefing, they are placed on a "special needs" or "protective custody" yard because their lives are in danger from other members of the gang about which they offered information (regardless of whether they were truly affiliated). These prisoners continue to suffer mental agony and guilt, knowing that any day they or their loved ones out on the street can be a target of gang violence.

If a prisoner finishes his prison term while in the SHU, he will parole from SHU directly to the street. This procedure provides no opportunity whatsoever for the inmate to adjust to living among others and practicing normal social interactions. The results are a lower probability of success in completing parole and a higher probability of recidivism.[5]

July 1, 2011 Hunger Strike and Five Core Demands

Prisoners in the SHU at Pelican Bay State Prison organized a hunger strike in 2011 to protest the immoral, illegal, and inhumane conditions of solitary confinement. Their demands were: 1) an end to group punishments, 2) elimination of prison informants and an end to the debriefing requirement to get out of SHU, 3) CDCR compliance with the recommendations of

[5] See Joan Petersilia, *When Prisons Come Home*. Oxford University Press, 2003.

the 2006 bi-partisan Commission's report on the Safety and Abuse in America's Prisons, 4) adequate food, and 5) greater educational opportunities and miscellaneous items such as the right to phone calls, photos sent home, warmer clothing, wall calendars, etc.

In the name of the Prisoner Hunger Strike Solidarity coalition, California Prison Focus contacted the CDCR before the start of the hunger strike, in an attempt to head it off by winning the demands of the prisoners. The CDCR refused. Instead, they put the lives of thousands of prisoners at risk while simultaneously admitting that their conditions were, in fact, not in line with national best practices. The restrictions on SHU prisoners at Pelican Bay State Prison are among the most severe in the nation, with no phone calls to loved ones, no windows, and no access to the out of doors.

The hunger strike was successful in obtaining some movement on the part of CDCR toward improving somewhat the very restrictive living conditions of SHU prisoners. Unfortunately, the most important demands have gone unfulfilled to date. To wit, group punishments continue, debriefing and gang validation processes continue, and the recommendation of the 2006 bipartisan Commission—that solitary confinement be used only as a last resort, and then only for the shortest time possible—remains unfulfilled. California Prison Focus and other organizations were hopeful when CDCR announced that they would be modifying their gang validation and SHU placement policies, but unfortunately the proposed changes do not go far enough. Prisoners can still be placed in long term solitary confinement for years and decades on end without ever having committed a crime, a violent act, or a serious rules violation. A book, a name on a list, and having one's name mentioned while someone else is debriefing is enough.

Alternatives to Solitary Confinement and Opportunity Costs

Reasonable alternatives to the heavy use of solitary confinement exist and have been demonstrated to work. In California State Prison---Lancaster, inmates organized a peer to peer program called the "Honors Program" in which prisoners renounced all gang and racial groupings and instead taught many different kinds of basic skills to one another. The program was quite successful for over a decade, but was recently cancelled due to budget cuts.

Another alternative, proposed by the representatives of the hunger strikers, is the Max B program in which those prisoners who are deemed unacceptable for general population placement are allowed to have small group interactions and programming. Surely the prisoners and staff would benefit from having prisoners programming who desire to do so. Yet CDCR recently rejected their proposal out of hand.

Finally, we offer a word about cost. While the moral imperative to end long term solitary confinement for all prisoners is more than enough reason to abandon this barbaric practice, we add that it has tremendous opportunity costs. CDCR spends hundreds of millions of dollars to investigate and hold prisoners in solitary confinement. Every dollar we spend on over-incarcerating and torturing California prisoners is a dollar that we cannot spend on education or social programs that can alleviate economic and social ills and prevent the conditions that foment crime in the first place. In other words, spending so much money on solitary confinement leads to greater crime, higher recidivism, increased overcrowding of prisons, greater prison gang membership, and ultimately more solitary confinement. This vicious cycle must be stopped.

Eliminating long term solitary confinement is the only possible way out of this problem. Juan Mendez, the U.N. Special Rapporteur on Torture and a torture survivor himself, argues that no one should be kept in solitary confinement for more than 15 days. Long term solitary

confinement is immoral and violates U.S. commitments as a signatory of the U.N. Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. We applaud the committee's efforts to investigate this matter fully, and we urge you in the strongest manner possible to adopt legislation that will outlaw this horrendous practice once and for all in our nation.

Respectfully submitted,

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June 14, 2012

Honorable Richard J. Durbin
United States Senator
Washington, D.C. 20510

Dear Senator Durbin and Honorable Members of the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights:

The California Public Defenders Association (CPDA), a statewide organization of nearly 4,000 public defenders, private defense counsel, and investigators, initially would like to thank you for conducting the first-ever Congressional hearing on solitary confinement for federal, state, and local prisoners and detainees, and affording the opportunity for mail-in comments.

Over the last several decades, as the Committee knows, and will hear, the United States has witnessed an explosion in the use of solitary confinement. As an organization that deals with the defense of persons charged with, or convicted of, crimes, CPDA has witnessed this explosion. We have seen it in many different forms.

Initially, solitary confinement was reserved for incarcerated individual who broke the rules, or committed crimes, within penal institutions, including juvenile institutions. What we have seen is the increasing use of solitary confinement as a permanent, or, at least semi-permanent housing situation for individuals in custody.

A given is that the vast majority of people who are incarcerated, will at some point be released from incarceration and back into society at large. The question is, will these people be better citizens upon their release? Clearly, the use of systemic, long-term, use of solitary confinement does nothing to prepare these people for their eventual, inevitable, release.

Solitary confinement does nothing positive for these people. Many of the people who end up in solitary confinement have mental disorders that must be dealt with, and solitary confinement does nothing to treat these mental disorders. It only makes the person sicker. Another aspect of solitary confinement is that while not all people have mental disorders when they are first subjected to solitary confinement, based on the isolation and lack of social interaction, they will have mental disorders upon their eventual release.

Another issue with the use of solitary confinement is its use without any semblance of due process. It is usually done by administrative action or classification. In essence, the institution is prosecutor, jury, judge, and often the only witnesses.

In California, at the end of 2011, as referenced by the California Department of Corrections and Rehabilitation (CDCR), there were 5,649 inmates in Special Housing Units (SHU's). SHU's are used for inmates who are in single prisoner cells, isolated from contact with other inmates. While prison population has decreased, the population of persons in SHU's has increased. (9/30/11 thru 12/31/11)

Hon. Richard J. Durbin
United States Senator

The actual quote by Russian novelist Fyodor Dostoyevsky is "The degree of civilization in a society can be judged by entering its prisons", has been paraphrased as "Judge a society by the way it treats its prisoners. Or, said another way "Any society, any nation, is judged on the basis of how it treats its weakest members — the last, the least, the littlest." (Cardinal Roger Mahony, In a 1998 letter, Creating a Culture of Life) There can be no doubt that prisoners are among the weakest members of a society. The use of solitary confinement on inmates is inhumane, and should not be used in a civilized society to the extent that it is.

In the 2009 New Yorker publication, Atul Gawade stated, "human beings are social creatures" in a way that we "exist as a normal human being requires interaction with other people." In the same article, Gawade refers to John McCain's recount of his history as a POW in the Vietnam War who spent more than two years in solation in a fifteen-by-fifteen-foot cell, denied any human contact. McCain noted, "it crushes your spirit and weakens your resistance more effectively than any other form of mistreatment." A later US military study of about a hundred and fifty returning naval aviators from imprisonment in Vietnam "found social isolation to be as torturous and agonizing as any physical abuse they suffered." And in the ways that this punishment is torturous, solitary confinement is a moral violation of basic human rights. The UN Convention Against Torture defines torture as any state-sanctioned act ""by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person." Solitary confinement, through numerous studies over decades have shown that it is a form of punishment that is agonizing, torturous, and just as, if not more, tormenting as physical abuse that has a tremendous impact on the mental growth of human being. Therefore, solitary confinement should be made illegal in any case, as it is a moral violation of human rights.

In the 1960s, an EEG study found that prisoners who were solitarily confined for more than a week had different brain wave patterns than normal patterns. The study concluded that "without sustained social interaction, the human brain may become as impaired as one that has incurred a traumatic injury." (Gawade) Solidarity confinement is a direct traumatic injury that has a much more lasting impact on the mental health of those who are confined.

Looking at long-term effects, those who are in solitary confinement are more likely to develop mental illness and once released from prison, will require medications or medical attention that will eventually come out of the expense of tax dollars. Therefore, confining prisoners will prove to be expensive and later paying for medical fees such as medication, counseling, and medical technology including checkups and hospital stays, for the released prisoners will be even more, unnecessarily expensive. Instead, of taking a longer route that does not benefit anyone, it is most beneficial, moral, and cost effective to discourage solitary confinement and seek alternatives such as counseling programs. Even if it may seem more expensive initially, in the long term, the more expensive investment can potentially bring the most effective and positive results.

In 1842, the novelist Charles Dickens visited the Eastern Pennsylvania Penitentiary and said: "The system here is rigid, strict and hopeless solitary confinement. I believe it...to be cruel and wrong. I hold this slow and daily tampering with the mysteries of the brain, to be immeasurably worse than any torture of the body."

Again, on behalf of the California Public Defenders Association, thank you for shedding light on this problem.

Very Truly Yours,

Margo George

Margo George, Chair
Legislative Committee
California Public Defenders Association

PUBLIC TESTIMONY
CAMPAIGN FOR THE FAIR SENTENCING OF YOUTH
BEFORE THE U.S. SENATE
JUDICIARY COMMITTEE ON
THE CONSTITUTION, CIVIL RIGHTS, AND HUMAN RIGHTS
June 15, 2012

I am pleased to submit testimony on the subject of solitary confinement in federal jails and prisons on the behalf of the Campaign for the Fair Sentencing of Youth (CFSY). The CFSY is a national coalition and clearinghouse that coordinates, develops and supports efforts to implement just alternatives to the extreme sentencing of America's youth with a focus on abolishing life without parole sentences for all youth.

The CFSY believes that youth should be held accountable for their crimes in a way that reflects their age and potential for growth. Punishment of youth should be focused on rehabilitation and reintegration into society. This belief extends to ensuring that their safety and human rights are upheld during the duration of their incarceration. While solitary confinement can be harmful for anyone, it is particularly problematic when used on youth.

Prison Conditions of Youth | Solitary Confinement as Protection and Punishment

Conditions in adult jails and prisons exacerbate the already-traumatic experience for youth incarcerated there. According to Human Rights Watch, research proves that youth who enter adult prison while they are still below the age of 18 are "**twice as likely to be beaten by staff and fifty percent more likely to be attacked with a weapon than minors in juvenile facilities.**"[1] Of prisoners in California serving juvenile life without parole, almost everyone surveyed by Human Rights Watch in 2007 reported "witnessing violent acts or being victim to them."[2] Human Rights Watch reports that these abuses included stabbings, rapes, strangulations, beatings, and murder.[3]

In an attempt to deal with this problem, prison officials place youth into solitary confinement. **The long periods of segregation from the general prison population have proven damaging to individuals during a pivotal time of their development.**[4] Youth have described their experiences in segregation as profoundly difficult, causing **long-term emotional and psychosocial distress.**[5] While they are in solitary confinement, youth are unable to engage in normal interactions that contribute to their development as a human being.

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[1] Against All Odds, p. 14.
[2] Against All Odds, p. 18.
[3] Ibid.
[4] Against All Odds, p. 45
[5] Against All Odds, p. 24

The use of solitary confinement as a disciplinary sanction proves just as harmful. Prison officials report from experience that the young age of people serving juvenile life without parole combined with the lack of hope of release causes many newly admitted youth to feel a sense of fear, anxiety, and paranoia.[6] Because of this fear, youth act out, and are punished with solitary confinement.[7]

Effects of Solitary Confinement on Development

Incarcerated youth who have experienced prolonged periods of solitary isolation have described their experiences in segregation as profoundly difficult, causing long-term emotional and psychosocial distress. Their ability to interact with and relate to others in social situations is greatly diminished due to the prolonged periods of time in solitary confinement.[8]

Isolation makes it impossible to participate in programs meant to promote an incarcerated youth's reintegration into society—an opportunity of course not afforded to people serving juvenile life without parole sentences. The chance to participate in GED programs, vocational programs or counseling is greatly inhibited by the lack of access during prolonged solitary confinement, especially for juveniles serving a life sentence without the chance of parole.[9] By limiting their access to these services, youth are not given the chance to learn or grow.

Forcing youth to live for days on end in solitary confinement should never be a part of punishment. The punishment of prison is removal from society, not solitary confinement administered by prison officials with little accountability. Not surprisingly, the suicide rate among adolescents and young adults is higher than the general population, and those that carry out the act of suicide frequently do so when they are confined to their rooms.[10]

Conclusion

Youth should be held accountable for their crimes in an age-appropriate way with a focus on rehabilitation and reintegration into society. As such, they should never be held in solitary confinement where they are susceptible to emotional and psychosocial distress and stripped of opportunities to become rehabilitated.

In order to reduce the risk of youths' exposure to solitary confinement and victimization by older prisoners, youth should never be held in adult jails and prisons.

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[6] Against All Odds, p. 23
[7] Ibid.
[8] Ibid.
[9] Against All Odds, p. 27
[10] U.S. Department of Justice. Characteristics of Juvenile Suicide in Confinement. U.S. Justice Programs: Juvenile Justice and Delinquency Prevention, p. 6.

We urge the introduction and passage of the Juvenile Justice Delinquency Prevention Reauthorization Act which lays out specific protections against victimization of children in prisons. In addition we urge the House Juvenile Justice Accountability and Improvement Act (HR 3305) to be introduced for consideration in the Senate. The bill would end juvenile life without parole in the federal system. This critical step would ensure that young people are held accountable in a way that takes into account their age and potential for rehabilitation and reintegration into society. The Act would ensure hope for young people and reduce chances of disciplinary isolation while incarcerated.

Thank you for the opportunity to submit this testimony.

CAMPAIGN FOR
YOUTH JUSTICE
BECAUSE THE CONSEQUENCES AREN'T MINOR

STATEMENT

Liz Ryan, President & CEO
Campaign for Youth Justice
U.S. Senate Judiciary Committee hearing on Solitary Confinement
June 19, 2012

Background

"What's it going to take for us to make a change? Why do we have to wait for a tragedy? Why does someone like my son have to die before we make a change we know is right?"

-- Diana Gonzalez, a parent of a teen who committed suicide in an adult prison, in public testimony before the Connecticut General Assembly

The Campaign for Youth Justice (CFYJ) is a national organization working to end the practice of trying, sentencing and incarcerating youth in the adult criminal justice system. Every state has laws that require some youth to be prosecuted in adult criminal court. These policies place thousands of young people at risk of facing harmful and irreversible consequences, often for minor mistakes. Despite overwhelming research demonstrating that these policies have failed, statutes that prosecute youth in the adult criminal justice system remain on the books.

Today, we have the benefit of research about the impact of sending kids to the adult criminal justice system that tells us that the vast majority of youth are better served in the juvenile justice system. We now know that youth placed in the adult system are more likely to reoffend, reoffend more frequently, and commit more serious offenses. A 2007 U.S. Centers for Disease Control report found that laws that charge juveniles as adults are counterproductive to reducing juvenile violence and enhancing public safety and "do more harm than good."[i] In 2008, the Department of Justice's Office of Juvenile Justice and Delinquency Prevention released a research bulletin and the findings mirrored those in the CDC report also finding that laws that make it easier to transfer youth to the adult criminal court system have little or no general deterrent effect, meaning they do not prevent youth from engaging in criminal behavior.[ii]

We have also learned a tremendous amount about what works to prevent and reduce juvenile delinquency. From the growing body of research on child and youth development,

the development of the adolescent brain, and effective programs and practice, we now have more evidence about what works in turning these young lives around and correcting their behavior than we did a decade ago.

In the past five years, state policymakers have appeared to be less wedded to "tough on crime" policies, choosing to substitute them with policies that are instead "smart on crime." Given the breadth and scope of the changes, these trends are not short-term anomalies but evidence of a long-term restructuring of the juvenile justice system. In the past five years, nearly twenty states have changed their state policies. Another dozen are actively considering policy reforms. These changes are occurring in all regions of the country spearheaded by state and local officials of both major parties and supported by a bipartisan group of governors.[iii]

Yet much more work still needs to be done as these laws affect thousands of children each year and detrimentally harm their lives.

Youth in Adult Jails and Prisons

"These are the kids who are the least appropriate to place in solitary confinement. Not only are you putting them in a situation where they have nothing to rely on but their own, underdeveloped internal mechanisms, but you are making it impossible for them to develop a healthy functioning adult social identify."

-- University of California Psychology Professor Craig Haney

Researchers estimate that roughly 250,000 youth are prosecuted in the adult criminal justice system every year and on any given day, approximately 10,000 youth are held in adult jails and prisons. Although the federal Juvenile Justice and Delinquency Prevention Act (JJDPA) requires that youth in the juvenile justice system be removed from adult jails or be sight-and-sound separated from other adults, these protections do not apply to youth prosecuted in the adult criminal justice system.

Youth inside adult prisons and jails often experience a variety of inconceivable dangers. These include physical and sexual abuse, mental health erosion, lack of access to any drug treatment, education, and more. The widespread consensus among correctional, mental health and juvenile detention organizations is that adult facilities are simply not equipped to safely detain youth.

When youth are placed with adults in adult facilities, they are at risk of physical and sexual assault. According to the Bureau of Justice Statistics, 21% of all substantiated victims of inmate-on-inmate sexual violence in jails in 2005, were youth under the age of 18 (surprisingly high since only 1% of jail inmates are juveniles)[iv]. Documented abuses include the use of pepper spray, sexual assaults by staff, hog-tying, and subjecting youth to excessive restraint and isolation. According to the latest studies by the Bureau of Justice Statistics, 75% of all deaths of youth under age 18 in adult jails were due to suicide.

The policy of many jails and prisons to "protect" youth from these conditions is solitary confinement. Many children who are placed in isolation experience harmful consequences, for some children this has meant death. Youth are frequently locked down 23 hours a day in small cells with no natural light. These conditions can cause anxiety, paranoia, and exacerbate existing mental disorders and put youth at risk of suicide. In fact, youth housed in adult jails are 36 times more likely to commit suicide than are youth housed in juvenile detention facilities.

Professional Association Positions

"Our ability to effectively manage the juvenile safety is tenuous at best. Most of the time, we are forced to put them in protective custody or some sort of administrative segregation for their own protection. This amounts to additional punishment inasmuch as juveniles are in isolation cells for the majority of the day."

-- Sherriff Gabriel Morgan of New News, VA in testimony before the House Judiciary Committee

Jailers and Corrections officials are faced with a "no win" situation when youth are placed in adult facilities: they simply can't keep youth safe and segregating youth in isolation/solitary confinement creates a different, but equally harmful result.

All of the major national stakeholder associations that deal with juvenile or adult detention or corrections such as American Correctional Association, Council of Juvenile Correctional Administrators, National Juvenile Detention Association, and the American Jail Association all have policies on this issue.

The American Correctional Association's policy states that, "The ACA supports separate housing and special programming for youths under the age of majority who are transferred or sentenced to adult criminal jurisdiction. [The ACA supports] placing people under the age of majority who are detained or sentenced as adults in an appropriate juvenile detention/correctional system or youthful offender system distinct from the adult system."

The Council of Juvenile Correctional Administrators' policy states that, "The juvenile justice system is the most appropriate system to hold youths accountable and receive age-appropriate and effective treatment and rehabilitation opportunities."

Prison Rape Elimination Act

"Youth should not be placed in prison with adults where rape and drugs are the norm."

-- Dwayne Betts, a poet, author and activist who was formerly incarcerated as a youth in adult prison.

Congress unanimously passed the Prison Rape Elimination Act (PREA) in 2003 to stop sexual violence behind bars, and one of its main concerns was the risk youth face when housed in adult jails and prisons. The National Prison Rape Elimination Commission (NPREC), established by the Prison Rape Elimination Act (PREA) in 2003, found that "more than any other group of incarcerated persons, youth incarcerated with adults are probably at the highest risk for sexual abuse" and said that youth must be housed apart from adults.

In response to the U.S. Department of Justice's call for public comments last year, thousands of individuals, and groups in every state across the country, and national organizations and professional associations of every type responded, urging the Attorney General to protect youth in the justice system by banning the placement of youth in adult jails and prisons, and requesting that Congress exercise its oversight responsibilities to ensure the Attorney General protects our young people.

Numerous leading experts in juvenile and criminal justice signed the letter, such as Allen Breed, former Director of the National Institute of Corrections; Todd Clear, Dean of Rutgers University and a former President of the American Society of Criminology; Terence Hallinan, former District Attorney of San Francisco; Ron Angel, Director of the Division of Youth Services for the state of Arkansas; The Honorable Michael Corriero (retired judge); The Honorable Ted Rubin (retired judge); Shay Bilchik, former Administrator of the U.S. Department of Justice's Office of Juvenile Justice & Delinquency Prevention (OJJDP) and current director of the Center for Juvenile Justice Reform at Georgetown University; Professor Charles Ogletree, Harvard Law School; and Eli Lehrer, Vice President of the Heartland Institute. The letter is available online at:
http://www.campaignforyouthjustice.org/documents/ag_youth_in_adult_jails_letter.pdf

Nine years after Congress passed the Prison Rape Elimination Act (PREA) in 2003, 42 U.S.C. 15601 et seq, the Department of Justice finally released the final rule to implement the Act on May 17, 2012. The issuance of these regulations is a historic event since they represent the first time the U.S. government has created national standards to eliminate sexual abuse in prisons, jails, juvenile facilities, community corrections facilities (e.g., halfway houses), and police lockups. The regulations are immediately binding on federal prisons. States will have up to a year to come into compliance with most standards.

For the adult facility standards, the Department adopted a new standard (§§115.14) to protect youth from sexual abuse by limiting contact between youth and adults in adult facilities through three specific requirements:

1. Banning the housing of youth in the general adult population.
2. Prohibiting contact between youth and adults in common areas, and ensuring youth are constantly supervised by staff.
3. Limiting the use of isolation which causes or exacerbates mental health problems for youth.

The regulations go a long way in addressing one of the major human rights violations occurring in the United States today. However, in the effort to eliminate sexual violence

behind bars, the standards unfortunately promote another dangerous practice: solitary confinement for youth in adult jails and prisons. While the purpose of PREA is to protect incarcerated individuals from unfair, unjust, and unconscionable treatment, Congress did not intend for the Department to rely on one dangerous practice in an attempt to eliminate another.

Recommendations

"As a former prosecutor and head of the Office of Juvenile Justice and Delinquency Prevention, I have had the opportunity to witness first hand the impact of trying and sentencing youth as adults. While I once supported these laws, their virtual unbridled use has negatively impacted too many young offenders with whom the juvenile justice system could have done a better job in rehabilitating and promoting public safety and youth development."

-- Shay Bilchik, Director of the Center for Juvenile Justice Reform, Georgetown University

While a number of states have changed their laws to reduce the prosecution of youth in adult criminal court and ensure that fewer youth are charged as adults and detained in adult facilities, thousands of children are still impacted on a daily basis. Congress must take additional action.

Public opinion overwhelming supports major policy reforms to remove youth from automatic prosecution in adult criminal court and placement in adult jails and prisons. In a recent poll conducted by GBA Strategies, it was found that the public supports independent oversight to ensure youth are protected from abuse while in state or local custody (84%); and the public rejects placement of youth in adult jails and prisons (69%).

Therefore, I urge the committee to:

(1) Update the Prison Rape Elimination Act (PREA) and the Juvenile Justice & Delinquency Prevention Act (JJDPA) to ban the placement of youth in adult jails and adult prisons;
(2) Restore federal juvenile justice resources for states and localities to incentivize their use of best practices and evidence-based approaches that rely on the least restrictive setting for youth in conflict with the law; and
(3) Ensure that the U.S. Department of Justice enhances technical assistance to states and localities to assist in the removal of youth from adult jails and adult prisons.

Thank you again for holding today's hearing and focusing on such a critically important issue.

[i] Department of Health and Human Services, Centers for Disease Control and Prevention, Effects on Violence of Laws and Policies Facilitating the Transfer of Youth of From the Juvenile to Adult Justice System p. 8 (2007)

[ii] Richard E. Redding, Juvenile transfer laws: An effective deterrent to delinquency? (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention) (June 2010)

[iii] Arya, Neelum. (2011). State Trends: Legislative Victories from 2005 to 2010 Removing Youth from the Adult Criminal Justice System. Washington, DC: Campaign for Youth Justice.

[iv] Beck, A.J. Harrison, P.M. Adams, D.B. (2006, July). *Sexual Violence Reported by Correctional Authorities*, 2005. Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

CENTER FOR Children's Law and Policy

Testimony of the Center for Children's Law and Policy
for the Subcommittee on the Constitution, Civil Rights, and Human Rights
of the Senate Judiciary Committee

June 15, 2012

Chairman Durbin and Members of the Subcommittee:

This testimony is submitted on behalf of the Center for Children's Law and Policy, a national public interest law and policy organization located in Washington, DC. The Center works to reform juvenile justice and other systems that affect troubled and at-risk children and to protect the rights of children in those systems. Our staff members have decades of experience working to remedy dangerous conditions of confinement – including the misuse of solitary confinement (also described in this testimony as "isolation" and "room confinement") – in facilities that house youth. We have done so through training, technical assistance, administrative and legislative advocacy, litigation, research, writing, public education, and media advocacy.

The Center is widely recognized for our expertise on issues related to conditions of confinement of youth. We drafted the extensive Juvenile Detention Facility Standards used by the Annie E. Casey Foundation in its Juvenile Detention Alternatives Initiative (JDAI), which operates in more than 150 sites across the country. We have provided advice to the U.S. Department of Justice and many state and local agencies on how to improve conditions of juvenile confinement. We have also written about unsafe juvenile conditions in professional and lay publications, including the article, "Juvenile Justice: Lessons for a New Era," 16 Georgetown Journal on Poverty Law & Policy 483, 506-521 (Symposium Issue 2009).

We appreciate the opportunity to contribute to the Subcommittee's review of solitary confinement in U.S. prisons, jails, and detention centers. We submit testimony to address three important questions related to the solitary confinement of children in the juvenile and adult criminal justice systems:

(1) Why is solitary confinement particularly harmful to children?

(2) Why do some juvenile facility administrators and staff rely heavily on solitary confinement, while others use it rarely or do not use it at all?

(3) What are the most effective ways of reducing and eliminating the inappropriate and excessive use of solitary confinement of children?

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Our answers reflect our experience with the solitary confinement of youth in dozens of facilities throughout the country, as well as our efforts to support laws, policies, and practices to reduce its use.

I. Why is solitary confinement particularly harmful to children?

Administrators and staff charged with supervising youth in the juvenile justice system have a fundamental responsibility to ensure the safety and security of the youth in their care. The inappropriate and excessive use of solitary confinement not only undermines that goal, but can result in psychological harm and emotional trauma to youth. In some cases, it has led to serious injury and death.

When we refer to the "inappropriate" use of isolation, we are referring to its use in situations when a youth does not present a serious risk of imminent harm to the youth or others. "Excessive" isolation refers to its use beyond the amount of time necessary for the youth to regain self-control and no longer pose a threat to self or others. These definitions recognize that it may be necessary to briefly isolate youth in certain situations. For example, if a youth is in a fit of rage because of bad news from home, or has gotten into a violent physical confrontation with another youth, it may be necessary to put that youth into his room until he can gain self-control, for his own protection as well as the safety of others in the facility.

Some facilities also use room confinement as a sanction for violating rules, which is different from isolation for out-of-control behavior. In situations involving room confinement, the JDAI Juvenile Detention Facility Standards afford youth a range of due process protections before being placed in room confinement, limit its use to a maximum of three days, and ensure that confined youth have access to services including education, health care, and exercise.

It is our experience, though, that staff often use isolation and room confinement in a much broader range of circumstances. One needs to look no further than recent investigations by the Special Litigation Section of the U.S. Department of Justice's Civil Rights Division to find numerous examples of the inappropriate and excessive use of solitary confinement:

- At the Oakley and Columbia Training Schools in Mississippi, staff punished girls for acting out or being suicidal by stripping them naked and placing them in a cell called the "dark room," a locked, windowless isolation cell cleared of everything but a drain in the floor that served as a toilet.[1]

- At the Indiana Juvenile Correctional Facility, staff isolated youth for consecutive periods of up to 53 days – long stays that the Justice Department characterized as "short-sighted

[1] Findings Letter from Ralph F. Boyd, Jr., Assistant Attorney General, U.S. Department of Justice, Civil Rights Division, to Ronnie Musgrove, Governor, State of Mississippi (June 19, 2003), *available at* http://www.justice.gov/crt/about/spl/documents/oak_colu_miss_findinglet.pdf.

way[s] to control behavior" that "serve[d] no rehabilitative purpose."[2]

- At the W.J. Maxey Training School in Michigan, staff regularly placed youth with severe mental illnesses in the facility's isolation unit because of inadequate staffing and resources to meet youth's needs – a practice that the Justice Department characterized as equivalent to "punish[ing youth] for their disability."[3]

Our experiences in dozens of facilities around the country confirm that these incidents are far from unique. For example, our Executive Director, Mark Soler, successfully litigated against the South Dakota State Training School, which routinely relied on a combination of pepper spray, groups of black-helmeted staff, and extended periods of isolation to manage even minor youth misbehavior. That training school has since been closed. However, we continue to visit facilities that use solitary confinement in inappropriate and excessive ways.

The misuse of solitary confinement in facilities that house youth is particularly troublesome for three primary reasons. First, isolation poses serious safety risks for children, including increased opportunities to engage in self-harm and suicide. A February 2009 report from the Department of Justice's Office of Juvenile Justice and Delinquency Prevention described a "strong relationship between juvenile suicide and room confinement." The study, which reviewed 110 suicides of children in juvenile facilities, found that approximately half of victims were on room confinement status at the time of their death.[4] The Justice Department recently reiterated these safety concerns in its comments accompanying the Prison Rape Elimination Act standards, stating that "long periods of isolation have negative and, at times, dangerous consequences for confined youth."[5]

Second, isolation has particularly negative consequences for youth with mental health needs – youth who are disproportionately represented in the juvenile justice system. In one study, 70% of youth entering juvenile detention met the criteria for a mental health disorder, with 27% of detained youth having a disorder severe enough to require immediate treatment.[6] The use of isolation only exacerbates those conditions. For this reason, many mental health associations advocate against its use. For example, the American Academy of Child and Adolescent Psychiatry opposes the use of solitary confinement in correctional facilities for youth, noting that children are "at a particular risk of . . . adverse reactions" including depression, anxiety,

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[2] Findings Letter from Thomas E. Perez, Assistant Attorney General, U.S. Department of Justice, Civil Rights Division, to Mitch Daniels, Governor, State of Indiana (Jan. 29, 2010), *available at* http://www.justice.gov/crt/about/spl/documents/Indianapolis_findlet_01-29-10.pdf.

[3] Findings Letter from R. Alexander Acosta, Assistant Attorney General, U.S. Department of Justice, Civil Rights Division, to Jennifer M. Granholm, Governor, State of Michigan (Apr. 19, 2004), *available at* http://www.justice.gov/crt/about/spl/documents/granholm_findinglet.pdf.

[4] Lindsay M. Hayes, Juvenile Suicide in Confinement: A National Survey, Office of Juvenile Justice and Delinquency Prevention (February 2009).

[5] U.S. Department of Justice, *National Standards to Prevent, Detect, and Respond to Prison Rape* 96 (May 16, 2012), *available at* http://www.ojp.usdoj.gov/programs/pdfs/prea_final_rule.pdf.

[6] Jennie L. Shufelt & Joseph J. Cocozza, *Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-State Prevalence Study* (Nat'l Ctr. for Mental Health & Juvenile Justice, Delmar, N.Y.), June 2006, at 2.

psychosis, and suicide.[7] Similarly, the American Psychiatric Association has stated that "[c]hildren should not be subjected to isolation, which is a form of punishment that is likely to produce lasting psychiatric symptoms."[8]

Finally, the use of isolation undercuts the primary goal of facility administrators and staff who employ it: preserving the safety and security of an institution. A study from the *Archives of Psychiatric Nursing* noted that a majority of researchers who had studied the effect of isolation and restraint on youth concluded that the practices were "detrimental and anxiety producing to children, and can actually have the paradoxical effect of being a negative reinforcer that increases misbehavior."[9] Relying on isolation as a behavior management tool ignores the existence of less restrictive and more effective alternatives to keeping youth and staff safe.

II. Why do some juvenile facility administrators and staff rely heavily on solitary confinement, while others use it rarely or do not use it at all?

Our experiences with secure facilities confirm that the inappropriate and excessive use of solitary confinement of children is widespread. Our experiences also confirm that the misuse of solitary confinement usually stems from a discrete number of problems:

- **Inadequate staff training on effective de-escalation techniques.** In almost every jurisdiction, staff members receive some type of training on techniques for physically managing disruptive or confrontational behavior. However, those training curricula vary widely and are often weighted heavily toward the use physical restraints and holds, not verbal de-escalation and crisis management. Without adequate training, staff lack the skills to respond to situations without resorting to restrictive interventions such as solitary confinement.

- **Policies that do not limit the use of isolation to short periods and situations that immediately threaten the safety of youth or others.** In our experience, staff tend to gravitate toward the most restrictive intervention available to them when confronted with disruptive behavior. When facility administrators do not place clear limits on the use of solitary confinement, staff will often view it as the "go-to" intervention, even for minor misconduct. Once a child is in isolation, staff do not take care to release the child as soon as the child calms down.

- **Insufficient numbers of direct care staff to adequately supervise youth.** In facilities that are overcrowded, or that suffer from staffing shortages (which amounts to the same thing), staff are under enormous pressure to keep the peace at all costs. In such

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[7] American Academy of Child and Adolescent Psychiatry, Juvenile Justice Reform Committee, *Solitary Confinement of Juvenile Offenders* (Apr. 2012), available at http://www.aacap.org/cs/root/policy_statements/solitary_confinement_of_juvenile_offenders.

[8] Press Release, American Psychiatric Association, Incarcerated Juveniles Belong in Juvenile Facilities (Feb. 27, 2009), *available at* http://www.psych.org/MainMenu/Newsroom/NewsReleases/2009NewsReleases/IncarceratedJuveniles.aspx.

[9] Wanda K. Mohr et al., *A Restraint on Restraints: The Need to Reconsider the Use of Restrictive Interventions*, 12 ARCHIVES OF PSYCHIATRIC NURSING 95, 103 (1998) (citations omitted).

situations, staff members feel compelled to react immediately with force to minor misbehavior, out of fear that a small disturbance will become more widespread. Moreover, staff often feel that they must isolate youth with the highest needs, such as youth at risk of victimization by other youth and children with mental health disorders, because staff cannot provide them with adequate supervision.

- **Too few qualified mental health professionals to meet youths' needs.** Although youth with mental health needs are overrepresented in secure facilities, many officials and agency administrators do not or cannot employ sufficient numbers of qualified mental health professionals. Without regular access to mental health professionals, children with emotional disorders often deteriorate markedly. This prompts staff to rely on solitary confinement as a response to acting out behavior, which can further exacerbate youths' mental health conditions.

- **A failure to incorporate mental health staff in interventions for youth who present challenging behavior.** Secure juvenile justice facilities should not house children with serious mental health disorders. Those children should be served in mental health facilities that can meet their needs. However, mental health professionals can help craft behavior management programs for youth with less serious mental health needs that may nevertheless make a stay in a secure facility particularly challenging. In our experience, staff and mental health professionals often fail to collaborate in this way.

- **Poorly designed behavioral management programs.** Research shows that acknowledging and rewarding compliance is a more powerful tool to change behavior than the use of sanctions alone. Nevertheless, many facility administrators employ behavior management systems focused solely on punishments. Others rely on systems that do not apply sanctions and rewards in a consistent manner, which undercuts the goal of ensuring compliance with facility rules.

- **Few activities to keep youth busy.** Fights in secure facilities often emerge when youth are bored, and many facilities lack programming beyond television and gym time. Without a range of engaging activities, youth may resort to horseplay and other behavior that can lead them to conflicts and ultimately to solitary confinement.

III. What are the most effective ways of reducing and eliminating the inappropriate and excessive use of solitary confinement of children in secure facilities?

Although many facility administrators and staff rely excessively on isolation of children, certain strategies can dramatically reduce or eliminate its use.

First, staff should receive regular, comprehensive training on effective de-escalation techniques. High quality staff training curricula, such as Safe Crisis Management, focus heavily on topics such as verbal de-escalation of confrontations, crisis intervention, and adolescent development. Trainings such as these are essential to build staff members' skills to manage incidents without resorting to solitary confinement or other restrictive interventions.

Second, officials should place clear limits on the use of solitary confinement of children. Federal regulations governing the use of isolation already exist for psychiatric treatment facilities and "non-medical community-based facilities for children and youth" that receive federal funding.[10] The rules, promulgated by the Department of Health and Human Services under the Children's Health Act of 2000, reflect the consensus of professionals and experts from the medical and mental health care communities. Unfortunately, they do not extend to juvenile detention and correctional facilities, despite the fact that substantial numbers of mentally ill youth are housed in those facilities.

Currently, the most detailed "best practice" standards on isolation in the juvenile justice field are in the Casey Foundation's JDAI standards for juvenile detention facilities.[11] Our staff helped develop the standards in 2006 with colleagues from the Youth Center and with input from experts and practitioners from many jurisdictions. They contain over 300 best practices for juvenile detention facilities. The standards limit the use of isolation as a way of controlling disruptive behavior to situations where a youth is threatening imminent harm to self or others or serious destruction of property, and only so long as is necessary for the threat to pass. If youth receive room confinement as a sanction for violating rules in the facility, the standards limit the sanction to a maximum of three days. They also afford those youth due process protections before they are confined, including notice of the alleged offense, an opportunity to challenge the charge and present their own version of what happened, a written decision with a statement of reasons, and the opportunity to appeal. The JDAI standards for room confinement also ensure that youth continue to receive access to education, programming, medical and mental health care, and other services while in their rooms. Limits such as these are consistent with the clear consensus of national correctional standards, juvenile justice experts, social scientists, and practitioners from leading jurisdictions.

Over 150 jurisdictions participate in JDAI, and many have used or are using the standards to reduce inappropriate and excessive isolation in their facilities. The JDAI standards have also influenced other jurisdictions in their efforts to improve conditions of confinement. For example, Louisiana recently established its first mandatory statewide standards for juvenile detention facilities. In doing so, officials relied heavily on the JDAI standards for guidance, incorporating similar limits on the use of solitary confinement.

Third, officials should devote more resources to increasing the number of direct care staff and qualified mental health professionals. As described above, the use of solitary confinement often stems from situations that could have been prevented through increased supervision and opportunities for treatment.

Finally, officials should ensure that there is independent monitoring of facilities that house youth. Independent monitoring systems are entities that are fully autonomous and that have sufficient authority and resources to investigate and remedy harmful conditions. We have recommended various models of independent monitoring in our work to improve conditions of

[10] 24 C.F.R. §§ 483.352-483.376.
[11] Juvenile Detention Alternatives Initiative, Detention Facility Self-Assessment (2006), *available at* http://www.aecf.org/upload/PublicationFiles/jdai0507.pdf.

confinement, including independent ombudsmen, state juvenile justice monitoring units, cabinet-level Offices of the Child Advocate, public defenders based inside juvenile facilities, involvement of Protection and Advocacy offices in juvenile justice, and teams of juvenile justice, medical, mental health, and education professionals and representatives of the community.[12] They serve a critical function by identifying safety and security concerns before they become systemic issues, generating critical information for facility managers and agency officials that can guide improvements to service delivery, and providing insights into needed policy and practice changes. For example, as part of JDAI, we conduct comprehensive trainings of local teams of judges, probation officers, prosecutors, public defenders, parents, physicians, nurses, educators, and mental health professionals to inspect their local juvenile detention facilities. The local teams use the JDAI standards described above to assess every area of operations that affects the welfare of confined children. Jurisdictions throughout the country have used this process to help improve a range of conditions of confinement, including reducing the use of solitary confinement.

Conclusion

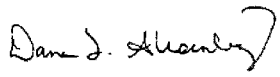
Unfortunately, the inappropriate and excessive solitary confinement of children is not a new phenomenon. In 1970, a federal judge in New York held that confining a 14-year-old girl in a 6' x 9' room for 24 hours a day for two weeks violated the Eighth Amendment's prohibition on cruel and unusual punishment.[13] More than 40 years later, we are still a long way from eradicating this dangerous and ineffective practice.

We urge the Subcommittee to develop ways to support the interventions described above, which can dramatically reduce the solitary confinement of children. We are ready to assist with your efforts in any way that we can.

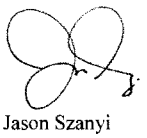
Sincerely,

Mark Soler
Executive Director
Center for Children's Law and Policy

[12] For an overview of models of independent monitoring systems, see Center for Children's Law and Policy, Fact Sheet: Independent Monitoring Systems for Juvenile Facilities (Apr. 9, 2010), *available at* http://www.cclp.org/documents/Conditions/IM.pdf.
[13] *Lollis v. New York State Department of Social Services*, 322 F. Supp. 473 (S.D.N.Y. 1970).



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centerforconstitutionalrights
on the front lines for social justice

Reassessing Solitary Confinement:
The Human Rights, Fiscal, and Public Safety Consequences

Hearing Before the Senate Judiciary Subcommittee on the
Constitution, Civil Rights, and Human Rights
June 19, 2012

Statement of the Center for Constitutional Rights

Chairman Durbin, Ranking Member Graham, and Members of the Subcommittee:

The Center for Constitutional Rights (CCR) would like to thank United States Senator Dick Durbin, Ranking Member Graham, and Members of the Subcommittee for holding this important hearing on the human rights, fiscal, and public safety consequences of solitary confinement in US prisons, jails, and detention centers.

CCR is dedicated to advancing and protecting the rights guaranteed by the United States Constitution and the Universal Declaration of Human Rights. Founded in 1966 by attorneys who represented civil rights movements in the South, CCR is a non-profit legal and educational organization committed to the creative use of law as a positive force for social change.

CCR has a long history of challenging the use of isolation in U.S. prisons, and firmly believes that all people are entitled to dignity, safety, and humane treatment, irrespective of whether and where they are incarcerated. The use of solitary confinement across the U.S. is an assault on these basic human rights principles, and has drawn widespread criticism both domestically and internationally. In *Wilkinson v. Austin*, 545 U.S. 209 (2005), the U.S. Supreme Court unanimously agreed with CCR and the ACLU that the Due Process Clause of the Fourteenth Amendment gave rise to a liberty interest in avoiding solitary confinement in Ohio's Supermax prison. In May 2012, CCR raised a constitutional challenge to prolonged solitary confinement in a federal class action complaint on behalf of prisoners at California's notorious Pelican Bay SHU facility, where prisoners are confined to windowless cells for between 22½ and 24 hours a day, without access to natural light, telephone calls, contact visits, and vocational, recreational, or educational programming.[1] At Pelican Bay, hundreds of prisoners have been held in solitary confinement for over 10 years; 78 prisoners have languished under these conditions *for over 20 years*.

In this Statement, we will address some of the human rights and constitutional implications of solitary confinement, and this kind of prolonged solitary confinement in particular. We sincerely hope that this hearing will result in the fundamental reassessment of the widespread use of solitary confinement in the U.S., and serve as a catalyst to end the brutalizing use of isolation for unconscionable periods of time in U.S. prisons, jails, and detention centers.

[1] Second Amended Complaint, *Ashker et al. v. Brown et al.*, 09-cv-5796 (N.D. Cal.) (Wilken, J.).

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A. Solitary Confinement Is Psychologically and Physically Destructive.

In the early nineteenth century, the U.S. began imprisoning people in solitary cells, without access to any human contact or stimulation, as an experiment in rehabilitation. The results were disastrous: prisoners quickly and predictably became severely mentally disturbed. Describing the devastating effects of solitary confinement in 1890, Justice Miller of the Supreme Court observed that prisoners housed in isolation "fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community."[2] In light of these devastating effects, the use of solitary confinement was all but abandoned in the U.S.

A century later, the use of solitary confinement in U.S. jails, prisons, and detention centers has unfortunately reemerged – with similar ramifications. Today, tens of thousands of prisoners across the country are warehoused in cramped, concrete, windowless cells in a state of near-total solitude for between 22 and 24 hours a day – whether in Special Housing Units (SHUs), in Supermax facilities, or in lockdown. Cells often contain a toilet and a shower, and a slot in the door only large enough for a guard to slip a food tray through. "Recreation" involves being escorted, frequently in handcuffs and shackles, to another solitary cell where prisoners can pace alone for an hour before being returned to their cell. Prisoners in solitary confinement are also frequently deprived of meaningful access to visits and telephone calls home, furthering their isolation and despair and preventing them from maintaining the family and community ties pivotal to their ability to successfully reintegrate into society upon release. As such, prisoners often live for years alone, without any normal human interaction, stimulation, or meaningful programming or vocational opportunities.

The devastating psychological and physical effects of these harsh conditions have been well-documented by psychological experts. Their conclusions are inescapable: the use of solitary confinement results in severe psychological and physical harm. Researchers have demonstrated that common psychological effects of prolonged solitary confinement include a persistent and heightened state of anxiety, and paranoid and persecutory fears. This mindset commonly persists long after prisoners are released from solitary confinement. Other common symptoms experienced by prisoners in prolonged solitary confinement include severe headaches, ruminations and irrational anger, violent fantasies, oversensitivity to stimuli, extreme lethargy, and insomnia. Scientists have also shown that prisoners in prolonged solitary confinement find their ability to concentrate significantly impaired, and experience an extreme state of confusion. A significant proportion of prisoners in prolonged solitary confinement describe hearing voices, and experience hallucinations, perceptual distortions, and frequent bouts of dizziness. Prisoners in prolonged solitary confinement also often suffer from a decreased ability to control their impulses, leading to self-mutilation and violence towards others. Many in prolonged solitary confinement experience severe panic attacks and a sense of an impending nervous breakdown. Even those who withstand the ordeal without succumbing to mental illness or suicide develop a profound sense of emotional and mental "numbness" from years of isolation.

[2] *In re: Medley*, 134 U.S. 160, 168 (1890).

Psychological experts have concluded that the psychological and physical effects of solitary confinement coalesce into a far-ranging and discrete illness in its own right. Prisoners in prolonged isolation are often so debilitated by the experience that they may become unable to live under any other circumstances; the psychological changes they experience may be permanent. Because almost every aspect of these prisoners' day-to-day existence is so circumscribed, they lose the ability to set limits for themselves or control their behavior through internal mechanisms. Prisoners in these conditions sometimes "act out" in a desperate attempt to prove to themselves that they are still alive and capable of eliciting a genuine response from other human beings.

Psychological experts also report that the symptoms they have commonly found in prisoners in prolonged solitary confinement may in fact be worse than they suspect. The extent of these prisoners' psychological dysfunction may not be fully quantifiable until after they return to more normal social settings. This is because these prisoners are minimally functional under conditions of solitary confinement, and so never receive careful and routine psychiatric assessments. And where prisoners have been kept in solitary confinement for years at a time, their symptoms are almost identical to those described in psychological literature about the long-term effects of severe trauma and torture.

In California, the Pelican Bay SHU prisoners report that they experience unrelenting and crushing mental anguish as a result of the years they have spent under these conditions, and they fear that they will never be released from the SHU. Echoing the findings of psychological experts on solitary confinement, prisoners have described their confinement there as "a living nightmare that does not end and will not end." As CCR client Luis Esquivel puts it, "I feel dead. It's been 13 years since I have shaken someone's hand and I fear I'll forget the feel of human contact." And as CCR client Gabriel Reyes wrote in 2011:

> You don't really know what makes [the SHU psychological torture] unless you live it and have lived it for 10, 15, 20 plus years 24/7. Only the long term SHU prisoner knows the effect of being alone between four cold walls with no one to confide in and only a pillow for comfort. How much more can any of us take? Only tomorrow knows. Today I hold it all in hoping I don't explode.

Similarly, CCR client Todd Ashker experiences great feelings of anger at his situation, which he tries to control and suppress, but this just deadens his feelings. He feels that he is "silently screaming" 24 hours a day.

As a result of the severe psychological distress, desperation, and hopelessness that they experience from languishing in the SHU for decades, hundreds of Pelican Bay prisoners engaged in two sustained hunger strikes in 2011. Almost every participant with whom we have spoken reported viewing the possibility of death by starvation as a worthwhile risk in light of their current situation. These prisoners are the survivors of these bleak conditions. It is well known that the incidence of suicides, attempted suicides and the development of mental illness is much higher amongst prisoners in solitary confinement than those held in the general population.

Placing prisoners in these devastating conditions for years at a time – whether at Pelican Bay, or one of the innumerable SHU or Supermax facilities across the country – exposes those prisoners to a significant risk of descending into irreversible mental illness. As CCR contends in *Ashker v. Brown*, the Eighth Amendment to the U.S. Constitution, which forbids the imposition of cruel and unusual punishment, cannot tolerate such a risk. Solitary confinement strips human beings of their basic dignity and humanity, and simply violates contemporary standards of human decency.

But in addition to offending our Constitutional commitments, it offends our dignity as a society to allow tens of thousands of human beings to languish under such severe conditions, slowly losing their grip on sanity and ability to function. Many prisoners who have been held in solitary confinement will ultimately be released into the community. If these prisoners have been broken down to a point of inability to function, we cannot have any hope that they will be successful in their efforts to reintegrate into society, or that the mistreatment to which they have been subjected will ultimately serve the interests of public safety.

B. Solitary Confinement Is Disproportionately Used Against Prisoners of Color, and Other Vulnerable Incarcerated Populations.

A common misperception is that solitary confinement is reserved for the "worst of the worst" – that is, for violent "super-predators" who cannot function in the normal prison environment. CCR firmly believes that no human being should be placed in cruel and inhumane prolonged solitary confinement, irrespective of the circumstances. In reality, however, just as we now know that the prisoners placed in Guantanamo Bay were often not the "worst of the worst" or even terrorists at all, many prisoners warehoused in solitary confinement for many years within the United States have not committed any violent misbehavior in prison. Instead, race, political affiliation, religion, association, vulnerability to sexual abuse, and challenging violations of one's rights all too frequently play a role in which prisoners are sent to solitary confinement.

There are, for example, significant racial disparities in who is sent to solitary confinement. Confinement in isolation units – and therefore the resultant psychological and physical harms that ensue – is disproportionately visited upon African American and Latino prisoners. For example, 85% of the prisoners at the Pelican Bay SHU are Latino. While it is justified by corrections officials as necessary to protect prisoners and guards from violent prisoners, all too often solitary confinement is imposed on individuals, particularly prisoners of color, who threaten prison administrators in an altogether different way. Consistently, jailhouse lawyers and doctors, who administer to the needs of their fellow prisoners, are placed in solitary confinement. They are joined by political prisoners from various civil rights and independence movements. Several African American prisoners in Louisiana known as the "Angola 3" have been held in solitary confinement for over 30 years, and are unlikely to ever be released from solitary confinement, due in large part to their association with the Black Panther Party and their political beliefs. And as one California District Court recently observed in the context of prison officials actions against a Black Nationalist held in the SHU, prison officials "may have taken a race-based shortcut and assumed anything having to [do] with African-American culture could be banned under the

guise of controlling the [Black Guerilla Family]."[3] Solitary confinement and other harsh measures also appear to be applied reflexively in the cases of Muslim defendants being prosecuted for terrorism, many of which rest on material support allegations that raise grave First Amendment concerns.

So too is gender identity, sexual identity, and vulnerability to sexual assault inappropriately used to confine prisoners in solitary confinement, ostensibly for prisoners' own protection. Confining prisoners who are vulnerable to sexual assault (including prisoners who are lesbian, gay, bisexual, transgender, intersex, and/or gender non-conforming, and those who are perceived as such regardless of their identity) in prolonged solitary confinement is inappropriate and harmful. Prison officials must be able to ensure the safety of all prisoners without resorting to placing these prisoners in involuntary solitary confinement. Too often, prisoners with disabilities, young or old inmates, and other inmates targeted for violence are similarly warehoused in solitary confinement.

California is an example of a state that officially imposes prolonged solitary confinement based not on specific acts of violence, but merely on a prisoner's alleged *association* with a prison gang. While California purports to release "inactive" gang members after six years in the SHU, in reality their gang validation and retention decisions (and resulting indefinite SHU placement) are made without considering whether a prisoner has ever undertaken an illegal act on behalf of a gang, or whether they are – or ever were – actually involved in gang activity. CCR client George Ruiz, for example, has been held in the Pelican Bay SHU for 22 years under conditions of extreme isolation based on nothing more than his appearance on lists of alleged gang members discovered in some unnamed prisoners' cells and his possession of allegedly gang-related drawings. His only way out of isolation is to "debrief" to prison administrators (i.e. report on the gang activity of other prisoners). Thus, California prison officials condition release from inhumane conditions on cooperation with prison officials in a manner that places prisoners and their families in significant danger of retaliation, whether or not these prisoners – many of whom have been in solitary confinement for over 25 years – have gang-related information to report.

C. Solitary Confinement and Special Administrative Measures ("SAMs").

Just as states such as California have used overly broad, exaggerated responses to the development of prison gangs or violence within prison to keep thousands of prisoners in inhumane prolonged solitary confinement, the Federal government routinely imposes extremely harsh forms of solitary confinement on persons suspected of or convicted of terrorist-related crimes. In addition to solitary confinement, for example, the DOJ imposes Special Administrative Measures (SAMS) on a number of prisoners in the federal system.[4] These restrictions, imposed at the discretion of the

[3] *Harrison v. Institutional Gang of Investigations*, 2010 U.S. Dist. LEXIS 14944 at *21 (N.D. Cal. 2010).

[4] The DOJ has refused to make virtually any information publicly available about the use of SAMs, including who and how many are subject to the measures, where these individuals are being held, and what the measures entail. The only available official data is from 2009, when DOJ reported that there were 44 prisoners subject to SAMs in Bureau of Prisons ("BOP") facilities. *See* U.S. Dep't Justice, Fact Sheet: Prosecuting and Detaining Terror Suspects in the U.S. Criminal Justice System, June 9, 2009, available at http://www.justice.gov/opa/pr/2009/June/09-ag-564.html.

Attorney General, have been used even in cases where the prisoner has not been convicted of a violent crime, and represent a particularly harsh example of solitary confinement.

While the government has refused to make information publicly available about the nature of the measures themselves, the conditions of a CCR client, Fahad Hashmi, shed some light on the practice. Mr. Hashmi was subject to SAMs for four years while detained at the Metropolitan Correctional Center ("MCC") SHU in New York[5] and the Administrative Maximum ("ADX") facility in Florence, Colorado, where he continues to be held. His SAMs were imposed in addition to solitary confinement, and included provisions expressly prohibiting communication of any kind with other prisoners; expressly prohibiting group prayer, a central tenet of his Islamic faith; restricting all family and social communication to three individuals – his mother, father and brother; severely restricting the frequency of his communication with even those few individuals, including limiting his written correspondence to one three-page letter per week; imposing additional restrictions on his access to reading material; and prohibiting him from all communication with members of the media.[6] The government first imposed Mr. Hashmi's SAMs in 2007 citing his "proclivity for violence," even though he had been detained for a year prior without incident and had never been alleged to have committed an act of violence before or after he was taken into custody.

SAMs, combined with solitary confinement, can be imposed pre-trial, when the debilitating physical and psychological effects of isolation have obvious implications for detainees' ability to effectively assist in their defense. Mr. Hashmi was held under SAMs in the SHU at the MCC for nearly three years pre-trial. They are also shrouded in secrecy. Mr. Hashmi's SAMs, for example, included provisions effectively barring his attorneys and family members from sharing any information received from him with third parties, under threat of criminal sanction. Separate from the implications for zealous advocacy and free speech, these gags, together with DOJ's refusal to provide meaningful information, mean that the public knows very little about a critical aspect of the government's treatment of prisoners in federal custody, and make this hearing all the more urgent.

D. Prolonged Solitary Confinement Is a Form of Torture and Violates Human Rights Standards.

The growing understanding of the destructive effects of prolonged solitary confinement has resulted in international condemnation of the practice. International human rights organizations and bodies, including the United Nations, have decried solitary confinement as a human rights abuse that can amount to torture. In August 2011, for example, the U.N. Special Rapporteur of the Human Rights Council on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment issued a Report on solitary confinement.[7] The report found that prisoners must, at a minimum, have access to windows

[5] For more information on conditions at the MCC, see Amnesty International, *Open Letter to Eric Holder, Attorney General: Special Housing Unit in the Metropolitan Correctional Center*, New York, Feb. 16, 2011, *available at* http://www-secure.amnesty.org/en/library/asset/AMR51/029/2011/en/ca690d55-1476-4d97-8aa6-edf4aff26251/amr510292011en.html.

[6] The SAMs described herein refer to Mr. Hashmi's 2007 SAMs, which are available on the docket sheet for his prior criminal case, *USA v. Hashmi*, No. 06-cr-442 (LAP) (S.D.N.Y.), Dkt. No. 20, Ex. 1.

[7] *See* Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel,

and light, sufficient sanitary fixtures, outdoor exercise and programming, access to meaningful human contact within the prison, and contact with the outside world (including visits, mail, and phone calls from legal counsel, family and friends, and access to reading material, television or radio). The conditions seen in SHUs and Supermax facilities in the United States typically fall well short of these basic standards. The prisoners at the Pelican Bay SHU, for example, are forbidden all access to the outdoors, are deprived of programming, and cannot call their loved ones and family.

The Special Rapporteur also concluded that use of solitary confinement is appropriate only in exceptional circumstances, and where imposed, its duration must be as short as possible and for a definite term that is properly announced and communicated. Prolonged solitary confinement, he found, is prohibited by Article 7 of the International Covenant on Civil and Political Rights (ICCPR) and Article 1 of the Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment (CAT). The U.S. has ratified both the ICCPR and CAT. And yet, the forms of solitary confinement condemned under both continue to proliferate across the U.S. The Special Rapporteur explicitly concluded that, depending on the circumstances, prolonged solitary confinement constitutes either torture or cruel, inhuman or degrading treatment or punishment. Thousands of prisoners have languished in solitary confinement U.S. prisons for years at a time. At Pelican Bay, hundreds of prisoners have been held under these conditions for well over 10 years – over 250 times the amount of time the U.N. has deemed acceptable. Hundreds more are being held in solitary confinement at ADX and have been for years.

Our obligations under these international human rights instruments demand that we seriously re-examine the use of solitary confinement, and bring our practices in line with standards and norms recognized by the international community.

E. Conclusion

With strong leadership, effective policies, and sound practices, U.S. prisons can develop ways to house prisoners in settings that are less restrictive and more humane than solitary confinement, and thereby meet international human rights and Constitutional standards.

States such as Massachusetts, Vermont, and Washington have long limited the length of time a prisoner may be placed in solitary confinement to 15, 30, and 20 days, respectively. Colorado and New Mexico have recently passed legislation to limit or study the effects of solitary confinement, and similar bills have been introduced in Virginia, Pennsylvania, and Texas. Other states, including Maine, Mississippi and Ohio, have significantly reduced their solitary confinement population in the last decade through voluntary changes. To our knowledge, in none of these states did prison violence increase after the use of solitary confinement diminished.

Working to eliminate the use of solitary confinement is to the benefit of everyone – prisoners, staff, and ultimately the communities to which almost all prisoners eventually return. Notable steps have been taken in this direction, but much progress must still be made to eliminate the use of solitary

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Inhuman or Degrading Treatment or Punishment (Aug. 2011).

confinement for all but the most limited periods of time. We hope that today's hearing represents an important step in this direction.



Testimony of Kim Brooks Tandy
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Hearing Before the U.S. Senate Judiciary Subcommittee on the
Constitution, Civil Rights, and Human Rights
Hearing on "Reassessing Solitary Confinement:
The Human Rights, Fiscal, and Public Safety Consequences"

June 15, 2012

Thank you Senator Durbin, Ranking Member Graham, and other members of the Subcommittee for holding this hearing today on solitary confinement. I commend this Subcommittee for its inquiry into this issue, but respectfully request that the Subcommittee do not forget the practice of isolation concerning youth in juvenile detention, correctional facilities, and in the adult system.

My name is Kim Brooks Tandy and I write to you as Executive Director of the Children's Law Center (CLC) in Covington, Kentucky. For over 20 years, CLC has focused on issues involving children in custody and advocated for reducing incarceration rates and ensuring humane and constitutional conditions in locked facilities. The juvenile system, unlike the adult system, is based upon the premise that children are different, and that rehabilitation and treatment are key to making positive changes. However, some youth are prosecuted as adults, and may be placed in adult facilities. In either case, the population of young people in these systems should garner special attention in any discussion about the use of solitary confinement because their age, level of maturity, and social, psychological and moral development warrant a

different approach. In my testimony today, I will focus on conditions for youth in juvenile corrections facilities and how the practice of isolating youth can be detrimental to the youth's development and reintegration into our communities.

Conditions in Juvenile Facilities Nationwide and In Ohio

Although I am primarily a litigator, I learned long ago that litigation does not in and of itself bring about best practices; long term institutional changes need government leadership, collaborative efforts, and research driven practices. Most recently, I have litigated conditions cases on behalf of youth in the juvenile delinquency and adult criminal justice systems for the last eight years in Ohio, where large scale reforms in the juvenile justice system have resulted in reducing institutional placements by two-thirds, down from about 1,800 youth in juvenile corrections facilities in 2008 to about 500 youth today. The state closed four of its eight juvenile corrections facilities, and developed a continuum of care within local communities to keep youth close to home and in less restrictive environments. Decision making has been driven in large part by research-informed and evidenced-based programming that can reduce costs, and provide better outcomes for youth, including an impressive initiative to keep youth who are mentally ill out of institutional placement, where they are more likely to have their condition worsen, and less likely to adapt to institutional rules.

In spite of impressive efforts to keep youth in their local communities, the reality in Ohio, and throughout the country, is that many youth remain in secure correctional facilities that are ill-equipped to rehabilitate and improve the lives of these youth people. The reliance by state and local agencies on incarceration as a means to rehabilitate youth and protect community safety is increasingly being questioned as both counterproductive and costly. Reports of pervasive violence and abuse have been widespread, often resulting in years of litigation. A recent study

commissioned by the Annie E. Casey Foundation showed that 57 lawsuits in 33 states plus the District of Columbia had been filed in response to alleged abuse or otherwise unconstitutional conditions in juvenile corrections facilities.[1] Nearly all of these lawsuits included allegations of systemic problems with violence, physical or sexual abuse by facility staff and/or excessive use of isolation or restraint.[2] An extensive review of recidivism studies compiled from this report suggests that incarceration is no more effective than alternative sanctions, such as probation, in reducing the criminal conduct of youth who have been adjudicated delinquent, and that the use of incarceration actually exacerbates criminality.[3] In spite of the proven success of many community-based alternatives and evidence-based programs in lieu of incarceration, states continue to incarcerate youth in programs that are often poorly designed and ill-equipped to provide effective treatment. Treatment is particularly insufficient for youth with severe mental health conditions, learning disabilities, significant substance abuse problems or other acute needs.[4]

It is against this backdrop that I wish to address the issue of solitary confinement among youth in correctional facilities. I have interviewed dozens if not hundreds of youth in the last eight years who have been held in isolation cells, often devoid of anything other than a toilet and sink, mat, blanket, paper and pencil and a book. Some of these cells lack windows to provide any outside light. By design, they are often stark, cold and lack any positive aesthetic qualities for stimulation. Ohio, like a number of states, uses isolation not only for disciplinary purposes

[1] Mendel, Richard A, No Place for Kids: The Case for Reducing Juvenile Incarceration, The Annie E. Casey Foundation (Baltimore, Maryland) 2011, p. 5.

[2] Id.

[3] Id. at 11. Mendel's research was based on an extensive internet search and literature review in addition to interviews and outreach with state corrections agencies. The research conclusions were based upon recidivism analyses in 38 states and the District of Columbia.

[4] Id at 22.

on a short term basis up to five days, but also operates two special management units that house youth for longer periods – sometimes for years – for more serious behaviors. Not surprisingly, the majority of these youth suffer from mental illness, some severe, before their placement in these units, and then lack adequate programming and services while in isolation. Perhaps also not surprisingly, most of these youth are non-White.

While many youth are isolated in juvenile facilities for shorter periods of time as a disciplinary action, special units can operate to seclude youth for month or even years in environments that fail to provide adequate means for behavioral health, education, recreation, and positive human interactions generally.

My experience over the last twenty years in examining this issue suggests that while there is a significant void in research on the harmful effects that isolation causes in the adolescent population, even for short term use. However, much of what we know about the devastating effects of solitary confinement with adults is likely to apply to youth, and the harm may well be even greater for many reasons.

To understand one of the crucial differences, one need only look at the myriad of research now available on the study of adolescent brain developmentthat has been recognized by the United States Supreme Court to justify abolishment of the juvenile death penalty and life without parole in certain cases. We know that adolescent brain is more moldable, and continues to be shaped by environmental factors sculpted by the youth's interactions with the outside world. The brain's malleability decreases with age, making it more difficult to reduce psychologically damaging experiences. How likely it is, therefore, that the adverse effects of seclusion on youth are potentially irreversible?

Isolation can Exacerbate a Youth's Underlying Mental Health Issues

The Office of Juvenile Justice and Delinquency Prevention's 2010 Survey of youth in the "deep-end" of the system suggests that 70% of youth confined revealed they had "seen someone injured or killed," and 72% had "something very bad or terrible" happen to them.[5] Additional research has also shown that a significant proportion of juvenile offenders have a substantiated history of child or adolescent maltreatment,[6] and that at least three out of four youth in the juvenile justice system have been the victim of traumatic victimization.[7] Such traumatic victimization has been linked to psychological disorders such as Posttraumatic Stress Disorder and can cause the youth to develop ongoing difficulties with oppositional-defiance and aggression.[8] Exposure to trauma also slows down development and can cause disturbances of emotional regulation, relationships, and communication. These youth are prone to engage in the type of defiant behavior and rule breaking that result in their placement in punitive isolation.[9] In addition, research shows that youth who seem aggressive are prone to overreact to actions by correctional officers as a perceived threat, typically because it is reminiscent of past

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[5] Survey for Residential Placement online database, available at http://www.dataxplorer.com/Project/ProjUser/AdhocTableType.aspx?reset_true&ScreenID+40

[6] Swanston, Heather Y, Parkinson, Patrick N., O'Toole, Brian I., Plunkett, Angela M., Shrimpton, Sandra & R. Kim Oates, Juvenile Crime, Aggression and Delinquency After Sexual Abuse: A Longitudinal Study, 43 Brit. J. Crimnol 729 (2003).

[7] Julian D. Ford, John Chapman, Judge Michael Mack & Geraldine Pearson, *Pathways from Traumatic Child Victimization to Delinquency: Implications for Juvenile and Permanency Court Proceedings and Decisions*, Juvenile and Family Court Journal 13, Winter 2006. [hereinafter "Pathways"].

[8] Julian Ford, *Traumatic Victimization in Childhood and Persistent Problems with Oppositional-Defiance*, Journal of Aggression, Maltreatment & Trauma, 6:1, 25-58, p. 26 [hereinafter "Persistent Problems"]

[9] *See* Christopher A Cowles & Jason J. Washburn, *Psychological Consultation on Program Design of Intensive Management Units in Juvenile Correctional Facilities*, Professional Psychology: Research and Practice, Vol 36, No. 1, 44-50, p. 45 (2005). ("Consequently, incarcerated juveniles who are disruptive or violent, regardless of their mental health status, may be relegated to a facility's disciplinary unit.")

victimization.[10] These youth do not see their responses as excessive, because they "have little experience expressing their thoughts and resolving their feelings verbally rather than through aggression," and "may feel helpless about regulating their behavior."[11] Instead of helping youth heal from the victimization that has traumatized them, aggressive juveniles are punished by being placed in isolation for their misbehavior.

Adolescent depression may also cause symptoms that lead to the imposition of isolation. Although several of the symptoms of depression are similar for adults and adolescents, including depressed mood, hopelessness, and helplessness, depression may manifest differently in teenagers.[12] In fact, research indicates that irritability is the most common characteristic of depression in young adults.[13] The level of irritability a depressed youth exhibits increases as the adolescent becomes more depressed.[14] Adolescent depression can also create anger and hostility, which "increases the likelihood that [depressed youth] with provoke angry responses from other youth (and adults)" and "increase[s] the risk of altercations with other youth."[15] These behaviors and attitudes often lead facility officials to respond to such behaviors by placing the youth in isolation rather than treating the underlying causes of the behavior through behavioral health programming.

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[10] Clinical Practice in Correctional Medicine, Michael Puisis, ed. Mosby: Philadelphia, 2006, p. 124. *See also* Persistent Problems at 39, ("[T]hese children's emotions and thought processes reflect a fearful and hypervigilant concern with the possibility of severe danger. It is as if they view their lives as an almost constant effort to be prepared for, and to survive, the reoccurrence of traumatic danger.")

[11] *Id.*

[12] Marie Crowe, Nic Ward, Bronwyn Dunnachie & Morian Roberts, *Characteristics of adolescent* depression, 15 International Journal of Mental Health Nursing, 10-18 (2006), at 15. [hereinafter "Adolescent Depression"]

[13] *Id.* at 10.

[14] *Id.* at 16.

[15] Thomas Grisso, *Adolescent Offenders with Mental Disorders*, The Future of Children, Vol. 18, No. 2, Fall 2008, p 145

Isolation can also be especially agitating for youth with Attention Deficit Hyperactive Disorder .[16] While studies have shown that in the general school population only 2% to 10% of youth have ADHD,[17] anywhere from 19% to 46% of youth in the juvenile justice system are thought to have ADHD.[18] The percentage of youth in isolation with ADHD maybe be higher, since juveniles with this disorder are more likely to engage in the types of disruptive and impulsive behavior that are often sanctioned with seclusion time.[19] We know that patients who suffer with ADHD are unable to tolerate the "restricted environmental stimulation" that is found in an isolation unit.[20] This intolerance may cause an increased susceptibility to psychopathological reactions while in isolation.[21] Due to the prevalence of ADHD in the juvenile justice population, one may question whether a significant number of youth who are subjected to isolation may also face a higher risk of developing a psychiatric disturbance.

The majority of youth I have interviewed in long term isolation have self-reported diagnoses of either ADHD and/or Bipolar Disorder. Often they have expressed concerns over the lack medical therapy, or have questioned the types of medication they are given as ineffective or having adverse effects. I have had youth indicate to me that they have been taken off medication altogether, or that the medication that was working for them to treat symptoms of ADHD or Bipolar Disorder were not available at the institution where they were housed. Youth have reported that they receive psychological services "through their door" by a mental health professional, such that even contact by those most highly trained individuals was impersonal and brief. It is not a coincidence that programs which rely upon seclusion

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[16] Grassian, *supra* note 119, at 11.

[17] Robert B. Rutherford Jr., Michael Bullis, Cindy Wheeler Anderson, and Heather M. Griller-Clark, *Youth with Disabilities in the Correctional System: Prevalence Rates and Identification Issues*, July 2002 at 18.

[18] *Id.* at 19.

[19] *See id.* at 17-18, listing possible symptoms of ADHD.

[20] *Grassian* at 11.

[21] *Id.* at 12.

for behavioral controls in juvenile facilities also often lack adequate mental health and medical services which could address problem behaviors more effectively.

Youth without Mental Health Diagnoses Prior to Isolation May Experience Psychological Harm [22]

Research on the use of isolation on adults suggests that seclusion can cause severe psychiatric harm even when the individual had no history of mental illness.[23] In the most severe cases, adult inmates subject to isolation have displayed "agitation, self-destructive behavior, and overt psychotic disorganization."[24] More than half of the prisoners studied reported an inability to tolerate ordinary stimuli; almost a third heard voices saying frightening things or bizarre noises, and more than half of the inmates interviewed experienced severe panic attacks while in isolation.[25] Many also described having difficulties with thinking, concentration and memory, and almost half of the prisoners complained of "intrusive obsessional thoughts, primitive aggressive ruminations and paranoid, persecutory fears."[26]

Isolation is presumably even more damaging to juveniles because "the adolescent brain is more highly moldable by experience than the adult brain."[27] Adolescence is a unique period of time for human brain development, during which the circuits that coordinate human behavior are remodeled, shaping who youth will become as adults and how their brains function.[28] The majority of this "remodeling" is

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[22] *See generally* S. Grassian, Psychopathological Effects of Solitary Confinement, 140 American Journal of Psychiatry 1450 (1983) [hereinafter "Grassian"]; C. Haney, Infamous Punishment: The Psychological Effects of Isolation, 8 National Prison Project Journal 3 (1993); *and* C. Haney and M. Lynch, Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement, New York Review of Law & Social Change, 23, 477 (1997) [hereinafter "Haney"].

[23] Grassian, *supra* note 119.

[24] *Id.*

[25] *Id.*

[26] *Id.*

[27] Aaron M. White, *The Changing Adolescent Brain*, Education Canada, Canadian Education Association at 5. [hereinafter "Adolescent Brain"]

[28] *Id.* at 6.

"influenced by an individual's interactions with the outside world."[29] In other words, an adolescent's brain is essentially "sculpted by his or her interactions with the outside world."[30] Because adolescence is a critical time in a youth's brain development, using isolation on juveniles may have a profound psychological impact on their entire lives. In fact, because the brain's malleability decreases with age, making it increasingly more difficult to heal, the adverse psychological effects of seclusion on juveniles are potentially irreversible.[31]

Interviews I have conducted with youth in long term seclusion suggest that they lack a sense of hope that they can change or improve their condition. One young person, when asked to tell me something good about himself, replied, "lady, I've been locked up so long, there is nothing good about me anymore." He was 15. Others have expressed to me the fear of being around people and knowing how to interact with them after being secluded for long periods of time. I have witnessed other youth who shut out what little contact they have with the world outside of their room by placing paper on their window because they no longer want to know what happens outside of their room or are fearful. I am not a psychologist or psychiatrist, but having worked with youth in the delinquency system for more than 30 years, there have been few interviews that have affected me so profoundly as those done with youth in long term isolation.

Youth Held is Isolation May Not Receive Adequate Education, Recreation or Necessary Services

Youth in isolation are frequently denied education or other services to which they are entitled. Restricting the ability of youth to participate in education, recreation, group or social skills, programs, or other interactions with youth can have a negative impact on their overall progress in the facility. Requiring youth to miss school or other activities can also increase

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[29] *Id.*

[30] *Id.*

[31] *Id.*

depression and suicidal ideation and attempts.[32]

As with mental illness, the prevalence of learning disabilities and other education disabilities is similarly disproportionate among confined youth.[33] Educational achievement and school success is also lower among youth who are incarcerated, with studies suggesting that these youth perform, on the average, four (4) years below grade level, have a history of being suspended from school, and have frequently been held back at least one grade.[34] A significant percentage of youth in detention and corrections facilities have disabilities that substantially affect their education, and either have or should have been identified for special education. For those youth already identified, up-to-date Individualized Education Plans under the Individuals with Disabilities in Education Act (IDEA)should be in place. A child with a disability does not lose the entitlement for special education and related services, even if excluded from school by being housed in isolation. Nothing in the IDEA excludes from coverage, or diminishes the rights of, children with education-related disabilities who are detained or incarcerated in delinquency facilities. Taking any young person out of school in a detention or long-term incarceration setting is inconsistent with care and rehabilitation, as well as a state statutory right to education.

Yet the reality exists that many youth in isolation do not receive adequate educational programming. Many of my own clients, including a high percentage of those who have learning disabilities or other educational disabilities, have been denied educational services while in seclusion or given paperwork under their door that they were expected to complete on their own

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[32] Clinical Practice in Correctional Medicine, Michael Puisis, ed. Mosby: Philadelphia, 2006, p. 139.

[33] Quinn, Mary Magee, Rutherford, Robert B., and Leone, Peter E., Osher, David, and Poirier, Jeffrey M., "Youth with Disabilities in Juvenile Corrections," Exceptional Children, Vol. 71, No. 3 (2005).

[34] Krezmein, Michael P., Mulcahy, Candace A., & Leone, Peter E, "Detained and Committed Youth: Examining Differences in Achievement, Mental health Needs and Special Education Status, Education and Treatment of Children, Vol. 31, No 4, (2008)

without the assistance of teachers.

Recreation and other services are also more limited or non-existent. Youth clients have expressed to me that "out of room" large muscle activity consists of pushups in their room or being moved to another cell with a push up bar. Physical activity is critical to all individuals who are incarcerated, but it is particularly important for adolescents who are still growing and maturing physically as well as emotionally.

Conclusion

We do not ultimately know how youth are damaged by the unnecessary use of isolation or the extent of this damage. Correctional facilities are not likely to open their doors to researchers to prove the harm caused by practices which are utilized because programming and services are inadequate. This issue has received little attention because youth in juvenile facilities have less of a voice, and they more than likely lack access to counsel that can provide that voice for them.

There are many changes which can be made to policies and practices which can eliminate this harmful practice. Facility closures and "right-sizing" our approach to incarceration – meaning only youth who pose a significant threat to themselves or our community based on an individualized risk assessment – are important steps. However, for those youth who are incarcerated, including those who because of mental illness or other circumstances are more likely to be held in isolation, we need to take steps to eliminate the harmful impact such practices instill. Youth sentences are shorter than adults in most cases. The use of isolation practices neither improves their condition, nor enhances public safety in the communities to which they return.

Thank you on behalf of the young people I represent for your attention and your willingness to examine this important issue.

STATEMENT OF FRED COHEN, LL.B., LL.M

Reassessing Solitary Confinement: The Human Rights, Fiscal and Public Safety Consequences Hearing Before the Senate Judiciary Subcommittee on the Constitution Civil Rights, and Human Rights

Chairman: The Honorable Dick Durbin

My name is Fred Cohen and I am a graduate of the Temple and Yale Law Schools (LL.M. 1961). I have taught at a number of excellent law schools and helped found, then retired from, the S.U.N.Y. at Albany, School of Criminal Justice (2000). I have written a number of articles and books on law and corrections and serve as the Executive Editor of the *Correctional Law Reporter* and the *Correctional Mental Health Report*.

Since 1995 I have served as a federal court monitor, expert witness, and litigation consultant in a number of states with an emphasis on the mentally ill in prison. Most recently, I was appointed as the principal investigator in the case of **Rasho v. Walker**, No. 1:07-CV-1298-MMM-JAG (C.D. Illinois 2011). Our Team spent nine months visiting and observing Illinois' prisons, studying files, interviewing staff and inmates.

I authored a 180-page Report, which issued on March 6, 2012 and made explicit findings about the conditions in Illinois prisons including the hundreds of inmates with serious mental illness (SMI) who are held for extended terms in segregation. The parties to the **Rasho** litigation are now engaged in settlement discussions, as I understand it, with a particular urgency regarding those inmates with SMI held for extended periods of isolation.

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I congratulate this Committee for its historic decision to conduct hearings on the human rights, fiscal and public safety consequences of the extraordinary use of solitary confinement in our penal institutions. The precise number of inmates in solitary confinement is not known but about 82,000 is a reasonable estimate for the state and federal prison systems. *See,* How Many Prisoners Are in Solitary Confinement in the United States? (Solitary Watch, Feb. 1, 2012)

In my experience and based on my studies, the contemporary use of penal isolation is one of the most psychologically damaging, penologically unnecessary, and needlessly expensive correctional measures currently in use. Whether analyzed from a human rights or an empirical perspective, our current practices with penal isolation are properly subject to condemnation and candidates for early reform.

Clearly, some inmates must be separated from each other and staff for legitimate reasons of security. A short-term restriction on movement and loss of amenity can be a useful disciplinary sanction, especially when accompanied by a process that encourages and rewards positive behavior. Inmates may need to be insulated from each other, and for a variety of valid reasons, but insulation (separation) and contemporary penal isolation are quite different concepts and operations. The process of insulation need not lead ineluctably to conditions of extreme social and sensory deprivation.

Being locked down in an archaic, 6' x 9' cell with another inmate for 23 hours a day (or more), seven days a week, with limited showers and exercise opportunities, no congregate meals or other activities is a recipe for madness. Safety is not enhanced by such barbaric, inhumane measures.

An Illinois inmate I recently interviewed and who is subjected to such a regimen concluded with me by saying, "I just don't know who I am anymore." Another such inmate explaining to me why he rejected outdoor exercise in what he (and others) call the "dog run" explained, "They do a full body search going in and out. I'm not going to let them inspect parts of my body I've never seen." He is not alone.

Whether the physical confines of extended penal isolation are the antiseptic sterility of the newer Supermax variety on the medieval-like cells in prisons like Menard, Pontiac, or Stateville in Illinois, the negative impact on the individual appears to be the same. There is a retreat into the recesses of one's psyche and either the "discovery" of a hiding place or of demons so frightening that self-destruction and unimaginable self–abasement emerge. Bodies are smeared with one's own excrement; arms are mutilated; suicides attempted and some completed; objects inserted in the penis; stitches repeatedly ripped from recent surgery; a shoulder partly eaten away.

Even Edward Munch's "The Scream" fails to capture the hidden horrors emerging from some of the men and women in longer-term (over 30 days) penal isolation. Every example I just gave comes from actual cases I have encountered.

It is very expensive to control inmates in a high security classification or segregation. There are two, perhaps three, officers assigned to every such inmate who for whatever reason must leave his or her cell (e.g., a dental or medical appointment, a visit, a disciplinary hearing). I recently observed such prison disciplinary hearings and they moved with the speed of light with each inmate-defendant manacled and a different pair of officers at each shoulder.

There is no enhancement to public safety for our current reliance on penal isolation. Indeed, the anger that is created in these subjects suggest public safety is diminished. For corrections, segregation is an easy response and requires no thinking or planning; no work at changing offenders' behaviors. For some officers, it is an ideal assignment: no real interaction with inmates, nothing but control is on the daily menu.

Officers' unions, not surprisingly, are not opposed to the current use of segregation.

Judicial decisions have brought some relief in this area to juveniles and inmates who are SMI or even especially psychologically vulnerable to extended and right-less confinement. For others, Professor Mushlin correctly writes, "Virtually every court which has considered the issue has held that the imposition of solitary confinement, without more, does not violate the Eighth Amendment. Arguments that isolation offends evolving standards of decency; that it constitutes psychological torture and that it is excessive because less severe sanctions would be equally efficacious, have routinely failed."[1]

In **Austin v. Wilkinson**, 545 U.S. 209 (2005), the Supreme Court did recognize a liberty interest in the avoidance of confinement at Ohio's Supermax (OSP). The due process response is a paper-review type of procedure. Even a more stringent procedural solution than **Austin** to a substantive problem — i.e., the very conditions to be endured — is hardly a solution.

The destructive dimensions of this practice and the magnitude of the problem sit astride a correctional system that either welcomes or condones the practice. Is this a cancer that can be removed without more basic reform; more rehabilitative and educational opportunities, less time served for less serious offenses, for example? Yes, I believe so and if reform undertaken

[1] Michael B. Mushlin, Rights of Prisoners, 92-93 (3rd ed 2002)

here is labeled "mere tinkering" I would insist on a survey of those inmates whose incarcerative lives might acquire the normality of "mere imprisonment."

An Approach

The federal government can play a vital role in affecting change here. First, the government can solicit proposals for a first-rate national study of the number of state and federal prisoners held in penal isolation. It should not be difficult to arrive at criteria for data inclusion on long-term penal isolation and to then survey the states.

Second, the federal government could convene a National Commission to draft national standards for jails and prisons on the use of penal isolation (or whatever term is deemed felicitous). The ABA Standards for Criminal Justice, which I assisted with, Standard 23-3.8, "Segregated Housing" is a good starting reference point.

Federal funding for corrections can be tied to the adoption, oversight, and enforcement of such standards. In this fashion, constitutional minima and constant judicial intervention and oversight might be obviated.

James B. Jacobs and Kerry T. Cooperman in "A Proposed National Corrections College," 38 New Eng. J. on Crim & Civil Confinement 57 (2012), make a very persuasive case for a full-fledged, national-level training and research institution devoted to making our corrections systems as effective and humane as possible. My earlier suggestion for a temporary Commission to create national standards is fully consonant with the more ambitious Jacobs and Cooperman, national academic and training institution.

The National Institute of Corrections (NIC), in my view, is far too invested in nuts-and-bolts, how-to-do-it training to serve as the vehicle for the college these authors propose. There

was a day when the School of Criminal Justice (SCJ) in Albany, N.Y. might have been a "partner" in something like this. Where the NIC is too parochial, the SCJ has evolved into just another school of criminology and ranks high on the opacity scale for many of its research products.

There is a vital role here for the federal government. States have shown some willingness to make changes in penal isolation, particularly where the mentally ill are involved. The whip of judicial intervention, however, typically is the driving force. Governors do not run on a "reform prison segregation" platform. Indeed, we have not heard a word from this presidency on prisons and the segregation crisis.

This committee can be the spark.

— END —

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The following submissions are a representative sample of numerous statements submitted by prison inmates, family members, former prison employees, and others discussing their personal experiences with solitary confinement. For additional statements, please contact the Subcommittee on the Constitution, Civil Rights, and Human Rights.

Statement of Cornelius Dupree who was wrongfully imprisoned for 30 years by the state of Texas before DNA proved his innocence in 2011.

When I first went into prison, I was really upset and stubborn because I was imprisoned for a crime I didn't do. I was getting written up a lot of time for not going to work and for not doing this and that. Around 1980 or 1981, I was working in the fields picking cotton at Cofield Prison. I got into a fight with one of the other inmates. sI was charged with fighting with a weapon, even though I didn't have a weapon and was sentenced to 15 days of solitary.

If you were in solitary, you were only given a full meal every third day. The first day, you would get a spoonful of rice, a spoonful of beans and a roll. It was very dehumanizing. On the third day, you get a full meal but you'd be so hungry and weak that it wasn't enough. Without food for three days , you have to be careful about how fast you eat it because you'll get sick. In the 15 days I was in there, I lost 15 pounds.

I was also very cold from lying on steel. They give you one blanket. It wasn't very long, and you had to ball up in a knot for it cover you. It was very dirty. It was dark. You don't know if it's day or night. You don't get recreation. They called it "the hole." There were no phone calls, there was no visitation. It was the worst thing that they had, and I'll never forget it.

Statement of Robert Dewey who was wrongfully imprisoned for 17 years by the state of Colorado before DNA testing proved his innocence in 2012.

In 2002 or 2003, I got put in the hole because of my own medication. I was on Tylenol 3 because I had undergone back surgery, and they gave me a drug test. I told them I'm on medication, and they said that's okay we can distinguish the difference. But apparently they couldn't because even though I gave them all my medical records, they said I tested positive for opiates and morphine.

When you're in solitary, you sit in the cell 23 hours a day for seven days a week with one hour out for yard. In that hour, you walk around in a concrete area. You really don't even get 60 minutes, because you need at least 15 minutes so you can take your shower.

Everybody likes human contact, so when you first get thrown in there and you're not used to it, you freak out a little bit. Your nerves kick in and you have to go down deep inside yourself and try to fight back against it.

For meals, they give you what they have to give you, no more and usually a lot less. You have to eat with a plastic spork. You lose weight because you don't eat as much, and then you also try to exercise to pass the time.

When you're down in the hole and you need help, you're really out of luck. The guards come by about once an hour, and they act like it's an inconvenience. Medication only comes at a certain time. For me, it was 6 a.m. and then not again until 7 p.m., regardless of what the doctor had prescribed.

Statement of Nicholas James Yarris, former death row prisoner from the state of Pennsylvania who spent 23 years in solitary confinement before his exoneration through DNA testing in 2003

Although I may not appear before you this day, I hope that the following efforts I make in writing can lend to all a clear understanding of what solitary confinement is to a human enduring it long term.

I am, unfortunately, a walking encyclopedic source of information about solitary confinement. Having spent an astounding 8000-plus days locked within a cell 23 hours a day, I have witnessed or understood every form of deprivation or sensory starved confinement one can know.

There are two features to solitary confinement that I wish to address here in this statement.

First, the most degrading mental breakdown to men comes from the physical confinement. In the three decades I spent watching new prisoners come to death row in Pennsylvania, I saw with little variation, the breakdown of the personality of men initially entering death row. This occurs when all structure from your previous life hits full stop and you are left with ordered times for every facet of your care. Combined with intentional cruelty inflicted upon men in maximum-security settings, makes most men break down in their first two years. I entered death row at age 21, being the second youngest man on death row in my home state at the time in 1982.

In the preceding years, I saw death row swell in numbers from 24 in 1982, to 250 in 2004 by the time I was set free. I saw endless processions of men enter death row only to see that within two years each one either committed violence on others, self harmed or had serious mental breakdowns and required long term medications to keep them stable. Of the three men executed by Pennsylvania, two were heavily medicated psychiatric patients with long mental health issues.

I have witnessed numerous suicide attempts and 11 successful suicides. I myself have not only attempted my own suicide at age 21, but later in my incarceration, in 2002, I asked to be executed rather than to continue being held in endless degradation.

It was only because of my asking to be executed that the DNA tests I sought for 15 years had been forced upon the state. I was not let out of solitary confinement until the day I was set free. I was exonerated by DNA in July of 2003 and was not released until January 2004. In the last months I was stripped of all death row privileges and was placed in an administrative/disciplinary housing unit where I was allowed nothing at all in my cell.

I was brought before the prison administration of Green County Prison in Pennsylvania once DNA had been used in court to remove all of my death row convictions. I was told that I posed a threat to the staff because in the years confined within solitary confinement, having my hand crushed by a guard or other things done to me made them fear me. I was told that they feared I would lash out at them because they could not accept that anyone who had been subjected to the things done to me could not want vengeance.

I guess the loudest words of damnation come from the very mouths of those who inflict the hurts they know make them the ones to be feared.

The second aspect of solitary confinement is the detriment of not having any new input. When a man is incarcerated long term his demons are not all around him, it's in every stupid mistake and every memory

of pain his yesterday held.

That is what destroys anyone with decent feelings: The many stupid mistakes we made before that door shut. Every lie we told, every fight we had, every time we were embarrassed or hurt. It all bears down on you like some sick film reel of your life endlessly playing out what WAS your life. Prisoners die a thousand memories a day I was once told. I believe it is true.

Without structure we as humans break down or have our weaknesses magnified to the point of being overwhelmed. We need to have art, literacy and any form of in-cell programming we can if we care about not just erasing humans in cells. We need to understand that there are those who need to be separate from others. We have to look at the form of separation that provides security for staff and handles the burden on the state to care for the prisoner.

I think that the United States Government should seek programming and penal ideals from around the world and attempt to use as many of these as we can to better prisons for both inmates and staff. Although it was not part of this statement in focus we must really be aware that brutal regimens in prison break down the staff in their mental outlook. Prison guards have higher than average rates of suicide and divorce and alcohol abuse because of what they are being made to do to other humans. Solitary confinement is not a cure to violence nor a control to behavior. It is a short term part of what has to be long term strategy.

I now live in the United Kingdom. I hold a steady job and have a loving partner and we plan to marry next year. I have not wasted my time in anger for the many years I spent in solitary confinement. I also thank God for the hard work I spent studying and growing while inside.

I have been in the company of dignitaries, government officials, celebrities and powerful figures in society. I walk around society today no different than anyone else... and yet, I was on the FBI's most wanted list and came as close as 90 days away from being executed.

For all of Pennsylvania's efforts to hold me in solitary confinement because I was so dangerous was, in the end, a facade.

I make this last point not to be facetious, but to point out the reality that every prisoner at some point is going to get out, either on his feet or not. I am able to look at what was done to me and see beyond the draw of anger or pain. Not everyone is going to feel as I do, and they are going to be worse in society than they were before we subjected them to solitary confinement.

Lastly, I wish to add that in no way do I wish to take away from any respect shown to the families of those harmed by men who are placed in solitary confinement and I also wish to acknowledge the few kind and compassionate human beings I met while in prison who rose above the setting and treated me with dignity or respect. Those are the moments I choose to hold onto from my time held within a cell.

Statement of Julie Rea, wrongfully imprisoned for three years by the state of Illinois before her exoneration in 2006

No blanket, underwear or pillow. The lights were on 24/7. And no bed mat either. The metal slab that was my bed was hard. Especially since my weight was down and there was nothing between my hips and it, except for the thin cotton outfit in orange.

I was in solitary so that I wouldn't do anything rash, having been brought in on a charge of murdering my own son. I was considered at-risk of depression because I had been charged, not because anybody realized that I was locked up for something I didn't do. Actually upon entering the jail I felt hopeful that the police would realize before long they had the wrong person and let me go. I was wrong. Dreadfully wrong.

The jail was a dark place where truth wasn't respected highly, and humane behavior was sparse. Guards slammed the door when passing every fifteen minutes. No peace existed while I waited for the error to be righted. But then one doesn't focus on a need for peace when it is so cold. One is chattering and curled up as tightly as one can get for warmth. Still, it added to the discomfort of the experience as a whole.

Finally, trying to lie down and assume a sleep-like position seemed the best effort I could make. Shortly I found out it wasn't. From the audio speaker the guards had access to communicate with me in the cell. There was also a video camera. So they were able to access my person and activities for 'my safety'. Not minutes from lying down, a tape was started, one of a woman being tortured. It took me a bit to realize it was a tape and not someone in the next cell in agony at the moment.

I froze. My God what could I do? What was happening? What was this place?

Then some laughs and a remark from one guard to another, "Look at her, she's playing possum."

"She's gonna be a tough one."

"Do you think she's asleep?"

"No, she's awake alright. She's just stubborn."

In reality I was neither tough, playing possum or stubborn at that point. I was just frozen with fear. I realized that the tape wasn't faked. No one screams like that and is faking it. These were the kind of blood curdling screams that come wrenched from a body that is too exhausted to give them up, but finds them escaping anyway as it jerks and responds to whatever is being done to her. They were real. Very, very real. And if these guards were willing to play this tape and take pleasure in seeing what it did to me to hear it, well, what else were they capable of?

Did they make the tape too?

This was day one and two of my experience in solitary while in a county jail. This was before I was tried and wrongfully convicted. This was the mildest form of abuse these particular guards inflicted on me during the nights I spent in that jail.

After a few months in this county jail and I couldn't lay still without jerking every few seconds even when sleeping, and sleeping didn't occur without someone holding me, when I did get a bond before my first trial. This is not something anyone should go through. I was innocent, but it is wrong no matter what a person may actually be guilty of.

This is a commentary on our sick criminal justice and correctional system. I survived, and have healed and am continuing to heal.

I've studied and read about Philip Zimbardo's work, the growing field of wrongful conviction work, and the history our country and world has that is a dark and sad account of how human nature can fail, even the best of us.

It has left me feeling less alone. But not less violated.

I sometimes wonder who the woman on the tape was. Where she is – as well as a large number of other things that involved other people I came to know during that time period.

My earnest prayer is that the men and women who assaulted my mind, body and spirit during this time will come to know love, joy and forgiveness in goodness, rather than the pleasure of the sick and twisted activities they chose at that time.

And it is my deeper prayer that somehow writing this will place a growing desire in the hearts and minds of those who read it. That they can bring health and change to our jails and prisons and courtrooms and will do so. Ideally, that we neither bring the wrongly charged and torture them trying to get a false confession, nor mistreat any of those in our system any longer. Even if we can save only one person at a time, because that is often the key to changing a whole system.

Statement of Clarence Elkins, Wrongly Imprisoned in Ohio for 6 ½ Years

My name is Clarence Elkins, and I served six and a half years in prison for crimes I did not commit.

When I was in prison in Lucasville, Ohio I had to take drug tests. It was difficult for me to use the restroom in front of so many people. Even thought I gave them a sample and passed the test, the sergeant said that I had refused test and put me in the "hole."

The next time, I was put in solitary because I had been having psychological problems. I was hearing people plotting to kill me. I pretty much lost my mind. I didn't get to talk to anyone—they just put me in solitary until they thought I was OK, and then they let me out and put me right back where I had been. A couple of weeks later, they put me back in solitary.

The last time, I was in solitary for three months. It turned out that the actual perpetrator of the crimes I was convicted of was serving time in the same prison, so they put me in "protective custody" because they thought I might be in danger. I did absolutely nothing wrong, but I was treated the same as everyone else in solitary. I didn't get any assistance from the staff—they would walk right by me like they did see or hear me. I felt neglected and completely invisible. I felt like I didn't mean anything. The noise in solitary is unbearable. Twenty-four hours a day there are inmates hollering and screaming about nothing. I thought I was going to lose my mind one night—I just started screaming too. It's just such a lonely place. It's the worst of the worst. Prison is bad, but solitary is really bad. No visits, no family, limited reading materials, screaming 24-7, terrible food, disgusting showers. Being locked up in a tiny cell that long is cruel and unusual.

When I finally walked out of the prison, some news reporters were out there waiting and someone raised my hand up in the air. I was actually numb. I thought, "OK. This is another day." I didn't think it was real. Coming out of solitary and into society, I just didn't have any feelings when I walked out the door. You don't know what to expect, or what to do. Six years later, I'm still learning how to cope.

Statement of Herman Atkins, Wrongly Imprisoned by California for 11 ½ Years
Before Being Exonerated by DNA Evidence

My name is Herman Atkins, and I spent more than 11 years in prison in California for a rape and robbery that DNA testing ultimately proved I didn't commit. Being wrongly convicted and ordered to prison was a nightmare that I will never completely recover from, but the 16 months that I was forced to spend in solitary confinement was in a league all its own.

Nothing will ever compare to the way I was completely stripped of my humanity while in the "hole." I was confined for 23 hours a day in a small windowless room. A light remained on at all times, allowing the correction officers to watch my every move. I was given one hour for time in the yard and for a shower. But there were many times when if I picked the yard first, I didn't get a shower. If I showered first, I wouldn't make it out to the yard.

In the brief time I was actually allowed out of confinement, I had to contend with constant tormenting from officers who tried to set me off so that they could prolong my sentence.
All of this happened to me, and I was proven innocent. That shouldn't matter though. When you're confined with no ability to read, to exercise, to receive basic medical attention or to develop your mind, it's just inhumane. I saw some people snap. They just lost their sanity.

As a nation, we must do better. When government has the authority to treat people so poorly, it's impossible to hold citizens to a higher standard.

BRIAN NELSON
[redacted]

June 12, 2012

Dear Honorable Senators,

I come before you with the hope that my mere words can express the terrible ordeal I survived. Yet to say I survived does not adequately express the effects of the ordeal which I went through that still torture me daily. I was held at Tamms Correctional Center–Illinois' supermax prison–for 12 years, from 1998 until 2010, when I completed my sentence and went home. While I am no longer physically at Tamms, Tamms is still in my head.

In 1998 Illinois had sent me out of state, and I was housed in the minimum security unit at a prison in Las Cruces, New Mexico. My job was as the institutional tailor. Every day correctional employees dropped off uniforms and other articles of clothing to be repaired, altered, washed and pressed. When the employees dropped off these items, they also dropped off their car keys to me. After each employee's clothing was done I would walk outside the prison to their respective cars and put their clothing in the car, lock the car, then return their keys to them. Many times there were weapons (rifles/guns) in these cars and I was trusted to complete this job unsupervised. My cell door was virtually never locked. I was able to come and go at will. Most of the time carried a pair of scissors with me. I was able to go to the chapel and prayer from 6 am until 9 pm unescorted. I was eligible for conjugal visits outside the main prison's gates in a trailer. I was classified as a trustee.

On March 28, 1998, without warning, instead of going to my tailor job, I was ordered to get dressed, placed in both leg irons and handcuffs with a waist chain. The next thing I knew, we had landed at the Greenville Airbase in Greenville, Illinois. There were approximately 75 correctional officers/state police dressed in full riot gear waiting for me as I was escorted off the plane. Further away, there were sharp shooters pointing rifles at me. I was held by a riot officer on each side, each holding one of my arms. I am an epileptic and had a seizure. The response of the riot officers holding me was to slam, me face down, on the ground in a puddle, holding me down as another riot officer put his combat boot on the back of my neck/head. These riot officers began screaming "WELCOME TO TAMMS!" I was not afforded any medical treatment. I was thrown on the bus and taken to Tamms Supermax in Southern Illinois.

I emphasize that I had not committed any disciplinary infraction in New Mexico, was never served with any disciplinary report, nor was I told why I was being transferred to Tamms. The next thing I knew, I was in Tamms supermax–where I remained for the next 12 years.

Upon arrival at Tamms riot officers again put me face first on the concrete floor and literally cut the clothing off me. I was then left laying naked in a holding area chained up as riot officers made jokes about me having a seizure. When I requested medical attention, the riot officers informed me that if I said anything else, they would gas me. They then stationed a riot officer with a large can of tear gas directly in front of me. After approximately 30 minutes I was taken naked to another holding area where a female counselor, a female nurse and other staff began to ask me questions about what prison I came from, my medical history and who to contact if I died at Tamms. After these people left a TV was placed in front of the holding cell and I was forced to

watch a video about how Tamms supermax prison was run. I was then taken naked to H-pod placed on wing 2 in cell 6. I was issued a jumpsuit, a mattress, a sheet, a towel and a bar of soap. I was not given shoes or underwear.

I point out that prior to Tamms I had been incarcerated16 years and throughout that period I never was treated for any mental illness, nor was I ever under the care of any mental health professionals. When I arrived at Tamms, I weighed approximately 170 pounds. Prior to my incarceration at Tamms, I never attempted to commit suicide, nor even thought about committing suicide.

The cell and wings of Tamms are all gray. The view outside my so called slit window was of a gray wall. I was in the cell alone. To attempt to talk to another prisoner I had to scream loudly. At first, I was not allowed books, T.V., radio or even a BIBLE. After several days left like this I was taken to what was called a "transfer review hearing". Present was a female DOC employee assigned to Tamms as well as an Internal Affairs lieutenant. Rather than explaining what charges had been made that sent me to Tamms, ***they asked me*** why I was transferred to Tamms. This shocked me that the people in charge of Tamms could not tell me why I was transferred from minimum security prison to a supermax. They confirmed that I was not a disciplinary transfer and had no pending charges against me. I was then told that I would be held at Tamms for one year and, if I behaved, I would then be returned to a regular prison. I was then placed back inside the gray box of my cell and left there.

After being at Tamms for several months, correctional officers began making referrals to the mental health department about me. I had begun losing weight, was not eating and according to the reports I have seen since, I spent my time sitting in the corner of the gray box staring at the walls– frankly, I don't remember this period at all; I have blanked it out of my mind. The psychologist at Tamms came to the cell door and after talking for a few minutes said, "From now on you will have to come out to talk with mental health staff". The psychologist's notes also stated that when asked how I was doing, tears ran down my face.

I was in that gray box 24 hours a day, six days a week. One hour per week I was allowed out of the gray box. When I left the gray box I was strip searched, chained hand and foot, then frisk searched. Two riot officers would hold my arms and escort me were ever I was going. Every day, for hours on end, I was locked away alone without any human contact staring at gray walls. I was never allowed a single phone call the entire 12 years I was at Tamms. Days went by where I didn't speak a single word. I had no outside stimuli. The librarian who was supposed to bring books around rarely did. Day after day this went on with only the hope that after one year they would transfer me back to a regular prison. I now realize that I was slipping into severe depression.

After several months, I asked to speak with a mental health care worker who I felt I could trust. When I asked if she could help me deal with the problems I was having concerning solitary confinement, she openly told me she had no idea how to help me. She stated that she knew of no course to teach mental health workers how to relate to the conditions I was forced to endure and did not know how to treat those held in solitary for prolonged periods of time. She went on to say that she was trying to learn from the men being held at Tamms so then someday she would be better able to treat others that are sent to Tamms. Nonetheless, I continued talking to the mental health worker every other week for approximately 6 months. She referred me to the psychiatrist, who prescribed medication for severe depression, anxiety disorder, and adjustment disorder.

During this time, the Assistant Warden came to my cell and informed me that the policy I had been told about when I arrived (do a year and get transferred) was no longer the policy. Instead, he told me about a new "renunciation policy." Under that policy, no matter how well I behaved, I could not be transferred out of Tamms unless I agreed to make a video taped confession/statement of every crime I ever committed and a statement about everyone I knew that ever committed a crime. Further I would have to make this confession and statement without any form of immunity, and without having my lawyer present. This confession/statement would also have to include a description of all Security Threat Group (Prison gang) activity that I knew about. If I choose to make this video I still wouldn't be guaranteed a transfer. The Department of Corrections first had to decide that my video was truthful, helpful and sincere. Otherwise I would remain in Tamms until I either died or was paroled , but there was no other way to leave Tamms. IDOC knew that this placed anyone leaving Tamms life in severe danger–since everyone would know that if you left Tamms, you had to have made this video.

Despite the medication I was prescribed, I developed severe mental problems sitting in the gray box. I started pacing between 15 and 18 hours a day. This became so bad that on numerous occasions a nurse had to cut open blood blisters on the bottom of my feet caused by all the excessive pacing.

In April of 2000, I along with several other men at Tamms came together on a hunger strike to bring attention to the terrible conditions at Tamms. On May 1, 2000, approximately 169 men out of 176 at Tamms declared a Hunger Strike in solidarity or refused their meals. I and three others agreed to go as long as we could to bring awareness and change to Tamms. During the Hunger strike, our outside supporters, the Uptown People's Law Center, the Tamms Committee, and the MacArthur Justice Center, brought our plight to the United Nations Committee on Torture. The Committee in turn condemned the conditions of Tamms.

After 30 something days without eating, I was hospitalized. There were approximately 19 cells in the Tamms infirmary. 18 of those cells were occupied. Two men were naked and strapped to a bed because they attempted suicide. 16 men were stripped naked on suicide watch because they had either cut on themselves or hurt themselves in some other way, such as beating their head against the wall. I was the only prisoner in the infirmary that had a jumpsuit, or blanket. The cells are intentionally keep freezing cold in the infirmary, supposedly to dissuade prisoners from self-harm. This is what passes for mental health treatment at Tamms. About 10 days later an end was called to the strike with the promise from the Associate Director that changes would take place.

I continued my downward spiral, becoming more and more depressed. In 2000, I attempted to hang myself. I made no note nor told anyone, but I was found with rope burns and bruises completely around my neck and barely able to talk. For months I had expressed to mental health staff that I couldn't handle the gray box much longer. When I was found, I was stripped naked and placed in a freezing cold cell that had blood and feces smeared all over the walls in the infirmary. The cell lights remained on 24 hours a day and the only mental health "treatment" was a female mental health employee ordering me to stand up naked in front of the window so she could see me and talk to me. I refused to do this, because I was naked. It was not until a male mental health worker came would I stand up to talk.

At times while I was in Tamms I was held on a wing by myself so that I had no one to scream out to. When Tamms opened there was no separate Mental Health unit, but within a year J-pod was converted into what was labeled the Special Treatment Unit. B-Pod wings 1, 2 and 6, each with ten cells, was also converted into strap down cells, and suicide watch cells. This was due to so many inmates being placed on some sort of Suicide Watch, Psych Watch, or Psych Observation. Please note that the most inmates Tamms has ever held was approximately 300, yet there are almost 60 cells set aside for severely mentally ill prisoners. The Department of Corrections has a written rule that no inmate with mental illness would be housed at Tamms. This rule was ignored beginning the day Tamms opened, and continues to be ignored today.

As the time went by and I remained in the gray box I degenerated even worse. I lost the will to live. I lost hope, even though I was scheduled to be released in a couple years. Depression overwhelmed me. Then a lawsuit was filed over the treatment of inmates with serious mental illness not being properly treated at Tamms. I was named in that suit. In reply, Tamms mental health employees began to harass me and started placing me on suicide watches for no reason. I was given the Minnesota Multi Personality Test. When the results came back, the head psychologist called me to the infirmary had me locked in a bathroom and screamed at me that I was making her look bad. She then ordered officers to strip me naked—which they did, leaving me locked in the bathroom for approximately 10 hours. The psychologist then ordered that my medication be immediately stopped. As part of the case, our lawyer arranged for two doctors to come into Tamms to evaluate me—Dr. Kathryn Burns and Dr. Terry Kupers. Both doctors confirmed that I was severely depressed and the conditions at Tamms exacerbated the depression. Both found that I was actively suicidal. Even though Drs. Burns and Kupers are experts on the conditions of supermax prisons, the Tamms' psychologist refused to initiate any of the therapy they proposed. I got worse. Another serious suicide attempt followed and I lost so much weight that the Deputy Director, after seeing me in the holding cell, ordered that some sort of treatment be started, and immediately had me weighed. I weighed 119 lbs. All the bones in my body protruded. I shuffled instead of walked. I had no appetite and I wanted to die.

Everyday I went to sleep I got down on my knees and prayed that I would die in my sleep, yet God's will was not mine. When I woke up in the night I prayed harder for death. I couldn't sleep, and during this period got no more than 16 hours of sleep *a week*. I went days pacing back and forth like a zombie (a condition now recognized as a sign of severe mental illness when exhibited by animals in zoos—but apparently its okay when people suffer this way). I looked like I was already dead and I had no will to live. Day after day all I saw was gray walls and over time my world became the gray box. I fought hard with my own mind, and I prayed. I copied the Catholic Bible word for word which took me 1 year 9 months and 2 days. I copied the Rule of St. Benedict 3 times and studied with Cisterician Monks and Priests. I watched a friend give up and kill him self at Tamms. Sadly, several minutes before he died, he told the nurse and mental health worker that he was going to commit suicide. They just didn't care and walked away. Marcus Chapman was finally released from the gray box in a black body bag on August 24, 2005.

Another dear friend was the first inmate to arrive when Tamms opened, Mr. Daniel Johnson. Danny too recently succumbed to the torture of the Gray box. In April, 2012, he went to bed at 1:00am with a plastic bag tied over his head. Approx 48 hours later he awoke in an outside hospital with a defibrillator connected to him. Danny was so mad because he thought he would finally be free of the gray box, but instead he was returned to Tamms. Then to hide what happened Danny was

moved to Pontiac Correctional Center. This was so there is no negative publicity as the Illinois Governor considers closing Tamms.

But back to my own ordeal. A settlement was reached in the suit brought on behalf of mentally ill inmates. Strangely that very day I was placed back on medication that was stopped when the suit was filed. I was given treatment that was designed by Doctor Burns and within weeks I was placed on four different types of psychotropic medications. I was seen by a mental health therapist every other week to treat me according to the guidelines set by Dr. Burns. This treatment did not make me well, but it stabilized me. I was prescribed Remeron, Buspar, Prozac and Viseril. By this time I had spent a decade locked alone without human contact in a gray box. What helped me regain some hope was *Westerfer v. Snyder*, a class action case challenging how we were transferred to Tamms; alleging that the conditions at Tamms are so much worse, compared to the other maximum security prisons in Illinois, that Tamms imposes an "atypical hardship." The Uptown People's Law Center (which represented the plaintiffs in *Westefer*) gave us hope in that evil place that some day we could be treated like a human being again. The United States District Court ruled in favor of the inmates in a sweeping opinion which just this month the United States Seventh Circuit Court of Appeals upheld.

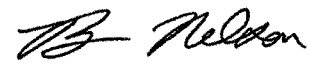
Tamms and the conditions I endured took all hope from me and I gave up on life. I tried to kill myself it was so bad, but the Uptown People's Law Center Executive Director Belinda Belcher and Legal Director Alan Mills took on a fight that saved my life and many others. Ms. Belcher and Mr. Mills against all odds prevailed and helped those that everyone else abandoned. I can not thank them enough.

In 2010 I was scheduled for release on June 29. For months I requested help to prepare me for release. Remember, at this point, I had not been around other people for ***twelve years***. The idea that I was about to be released to the street was terrifying. Twenty-eight days prior to my release I was transferred from Tamms to Menard Correctional Center. Upon arrival at Menard I was placed on a wing—completely alone, even ***more*** isolated than I had been at Tamms. I was denied all personal property, and even denied a shower or shave for 28 days. Upon my release I was sent home without any medication or even a prescription. I received no therapy to help me adjust.

I spent 12 years in solitary confinement and I was never told why I was placed in solitary. I am a human being and every day I still struggle with the trauma being held in that gray box. I wake screaming at night. I can't get it out of my head some days. Solitary confinement in my opinion is worse than being beaten. That I spent twelve years in such conditions in America is appalling.

I thank you for the time you have allowed me and for looking into this matter. Thank you!

Sincerely yours



Brian Nelson N31449

Lois DeMott [redacted]
Co-Founder, Citizens for Prison Reform P.O. Box 80414 Lansing, MI 48909
Association for Children's Mental Health, Administrative Assistant

June 15, 2012

Dear Chairman Durbin and Ranking Member Graham,

I thank you for holding this hearing on the matter of solitary confinement within the U.S. My name is Lois DeMott. I am the mother of a 20-year old son, who has had significant mental illness that became prevalent around age 4. Kevin entered adult prison at the age of 15. I have attached documents and articles to back my testimony.

The judge stated at sentencing that our son "would get the mental health help he needed" in prison. Kevin has received anything but the mental health help he has needed within this system. He has acquired severe Post Traumatic Stress Disorder, among many other new challenges. His minimum sentence was five months to one year. Now, five years later, he remains in prison, due to his mental illness and inability to cope or conform within this system.

Kevin's crime was attempted armed robbery. He had a toy gun and was threatened by drug dealers at the age of 13 to hold up a pizza joint. He ran out scared and took no money, but he was the only one sought out and caught for this crime.

Within seven months of his time in prison he had deteriorated and was waived into the psychiatric prison with the most mentally ill adults. There, because of his age, my lack of knowledge as to his rights, and to my legal rights as his guardian, he spent months caged like an animal. This is what the Michigan Department of Corrections considers "sight and sound protection," yet he could hear and see the adults around him. He was kept in cell for 24 hours a day, including meals, and was frequently without time outside for fresh air or yard break. When he got phone time, he would cry and relay what he was seeing. It was devastating. There was little I had control over but to advocate the best I could.

In this segregated, supposedly safe environment what he and other youth saw was most horrendous. He saw adults who were chained to beds 24/7 for months, allowed up only to use the bathroom. He saw men who had cut open their stomachs and were playing with their intestines, and many other horrendous sights. What he saw and experienced, no 15-year old should ever be exposed to. Nor should this be the treatment of our mentally ill in the United States, nor of any human being, for that matter.

In Michigan, age 17 is the age at which one is considered an adult criminally, but as you well know, children may be sentenced at a much younger age, even to life in prison without the chance of parole. Children are not adults. We need to mandate nationwide change.

The prison where all youthful offenders go in Michigan now has created a "Behavior Modification Unit" for young prisoners. In this unit they are kept in solitary confinement for 30, 60, 90 or more days at a time. They are not allowed a phone, radio, or any positive outlets to cope except for limited materials from their property. They are not allowed contact visits with loved ones. They still are operating under adult policy and procedures, and no consideration is given to their brain development or need for mental health treatment as children. I classify this as cruel and unusual punishment.

Kevin had an extreme breakdown, and was then sentenced into administrative segregation, or long-term solitary confinement. I have his records. He repeatedly states to mental health workers that he is becoming more depressed. The psychologist states he is not coping with solitary confinement. He has severe depression and is suicidal, and cutting himself. Yet it is continually recommended he remain in solitary. His treatment plan states that being kept in isolation is a major stressor for him. Further, it recommends participation in mental health groups. Despite this, he was kept in his cell all but for **three 10 minute showers per week.**

We arrived for one visit to find him suicidal and telling us he could not go on living. He had been "hog-tied" numerous times - on one occasion for 18 hours. He defecated and urinated on the cell floor because he could not get on the toilet. His electricity was shut off, he had no mattress, and he had not gotten his mail in weeks. The list of violations goes on, documented by

the Recipient Right's Specialist. Kevin was punished for banging his head on the wall after going stir-crazy, chained to a cement slab, and was written three tickets from which he is currently serving months of loss of privileges. Prisoners are often given tickets or misconducts for attempting suicide or for hurting themselves. *Would you call this treatment for mental illness?* I question how this method of correcting behavior is making our public any safer upon a prisoner's release back to our communities after receipt of such abuse and neglect.

My son has spent a total of 13 months in solitary in the last 2 years. Because this system is so "walled off "and misuse of power is rampant within - particularly even more so in these segregation units - prisoners are subjected to heaped on abuse and punishment. They frequently go weeks without showers, or a change of clothes (if they even get clothes). Meals are often withheld, and this is proven by my son's 20-25 pound weight loss during both periods of solitary confinement. He is thin. Prisoners are taunted and treated as subhuman. They are denied medical care, necessary medications, live in total darkness and often either in extreme cold or extreme heat with no window, and food slots are kept shut on their steel doors. One of my son's hardest adjustments was to the level of noise around him. He had to be medicated to sleep at times. If they are fortunate, they get three allotted 10-minute showers per week. This is the only other environment they experience. Again, they have no phone contact, and shortened visits through glass talking on a telephone - that is, if they are lucky enough to have anyone visit them at all.

Our family recently experienced having to drive seven hours one way for such a two hour visit, and the phones did not work well. We made sure he got all of his four visits a month, because it was our only way to give him hope, and to learn of his mental state and treatment. I truly believe far too many are dying in these conditions, and it is kept hidden, as they have no one watching out for them. I ask, *how is this system being punished for the way it has dealt with the children and numerous adult prisoners kept in solitary confinement?* As my brother states, "If I were found treating my cattle like this, I would be prosecuted and put in prison."

Recently I had a profound thought cross my mind: "I committed a crime, so you locked me up and then you committed crimes against me."

After seeing my son and many others languish in horrific conditions in solitary confinement for months, family, friends and prisoner families formed Michigan Citizens for Prison Reform in January of 2011. We are working to break the stigma of loving a prisoner, and to get prison families to stand up and be heard, considered and respected. We are working to educate, support and unify families and citizens as to why these methods of treatment are a waste of our tax dollars, and of highest cost within these systems in numerous ways. We are working diligently to bring an end to solitary confinement with our state as it is being used today.

I would like to make a few recommendations:

- Juvenile laws need to be changed, enacted and upheld to protect young children from being put in adult jails and prisons. The recent PREA Act is a step in the right direction, but how will it be implemented and how will accountability brought?
- Restorative Justice practices should be enacted on the forefront, and within the prison system nationwide.
- Prisons should be overseen by commissions, and communities need to be given access to prisons to bring necessary oversight and accountability.
- States need to be required to provide rehabilitation to all prisoners. Warehousing these people at the expense of taxpayers does not make our public any safer upon their release, nor does it help them become successful contributing citizens.
- We must find an appropriate way to care for the mentally ill and severe medically ill, and it is *not* within the prison system.

Thank you for allowing me to share my personal experiences and story of how I learned of this system, and what I have gleaned from this horrific experience. My hope is you will work diligently to bring change to the issue of mass incarceration, and immediately work to bring changes to the use of solitary confinement in the U.S. I thank you for your work and service.

Lois DeMott
Prison Mother and Advocate
Co-Founder Citizens for Prison Reform

June 13, 2012

Senator Dick Durbin, Senator Lindsey Graham and other members of the Senate Judiciary Sub-committee on Constitution, Civil Rights and Human Rights. My name is Barbara Fair and I reside in Connecticut and I want to thank you for the opportunity to come before you and present written testimony on the issues of Solitary Confinement and its fiscal, human rights and public safety consequences. I am elated to witness in my lifetime congressional hearings to address this very serious matter plaguing America. I will not belabor you with statistics and research because I am certain you will receive plenty of data. Many have intellectualized, researched and written on the subject long before this hearing. I joined a Stopmax campaign on the issue at least 10 years ago and addressed it in my state of Connecticut many times. Unfortunately it didn't rise to the level of concern it should have.

I come to you from a different perspective. I come to speak to the experience of a mother whose son was placed at the tender age of seventeen in Connecticut's Northern institution, a super-max facility.

I can't tell how my son endured the psychological torture yet I can tell you about the persistent mental health problems he has experienced since and I can tell you how traumatic it was for me knowing my son was being held like a caged animal in a tomb like cell with no physical interaction with another and no environmental stimulation for the mind. I can tell you that when my son was placed in Northern on his 17th birthday I was a complete wreck and fought with everything that I could think of to get him removed. I can tell you how much pain I was in when I first visited him. He was a mere teen still developing physically , socially and emotionally. He was brought to the visiting room chained like an animal , wrist, feet and belly and then chained to the phone booth while we talked. I wanted to just hug him so he could experience human touch but I couldn't because he was on the other side of plexiglass. It took everything in me to keep the tears from flowing. I didn't want him to feel what I saw. I can tell you how I spent countless nights either lying awake or being awakened in the middle of the night with panic attacks, sweating and having difficulty breathing as a result of knowing my son was being treated in such a cruel manner. I can tell you how I sensed my son sobbing and pleading for me to save him from the torture. I can tell you of the delusional state he was in once released. I can tell you the cruelty included not allowing him pictures of his family which I sent him so he wouldn't lose focus on the fact he had a family on the outside who cared about him. I needed him to know that he had to hang onto his sanity with everything he had in him and I would be doing all that I could to get him released and assure him at some point this torture would end. His siblings never knew what he was going through. I didn't want them in the same kind of pain I was in, wondering how anyone could do this to another human being let alone a young teen and a citizen of this "free" society.

I may never know the true impact of this experience on his developing mind but I do know my son has never been the same. The son who went into prison emotionally sound returned months later with psychiatric problems that persist to this day. Ten years after he continues to suffer serious mental illness which have included multiple hospitalizations. It simply tears me apart. I often question how does a civil and humane society allow this to occur? This is just a glimpse of what solitary confinement can do.

As stated in the beginning I am elated that someone is finally paying attention to this crisis. As an activist for social justice and the founder of a grassroots organization, My Brother's Keeper, I commend you for taking the lead (in Congress) and pray our country will be passionate in ending decades of torture in our prisons and abroad.

In the end society will reap what it sows. Our public safety will always be at risk when we decide it's okay to cage people like animals, turn a blind eye or deaf ear to the consequences of that behavior and at some point release these individuals back into society.

The human cost far outweighs the fiscal cost of doing "business' in this manner and we all can safely conclude that incarcerating people has become a huge business. At the same time we must ask ourselves are we willing to continue to operate as though we do so in a vacuum? Mental illness is far worse in America than other developing countries. I think it's something we can't continue to ignore.

We have a duty to reduce the use of solitary confinement and rid ourselves of super-max prisons altogether. They are nothing less than torture chambers.

Thank you again for the opportunity to be heard on this issue that is very dear to my heart.

[redacted]

The Honorable Durbin, Chairman
U.S. House of Representatives Committee on the Judiciary
2426 Rayburn House Office Building
Washington, DC 20515

Dear Honorable Chairman Durbin: June 12, 2012

We are writing to you on behalf of our loved ones as inmates at Potosi Correctional Center in Missouri who have voiced our concerns about their treatment during their solitary and adult segregation incarceration. Correctional officers have physically abused and intimidated inmates violating their human and civil rights.

They have also utilized several tactics that violate the inmates' rights and constitute criminal behavior. Among the inmates' concerns are the following:

• Inmates have been beaten and physically provoked by correctional officers, yet the officers have failed to report abuse in accordance with Mo. Rev. Stat. § 217.410

• Inmates have been detained in administrative segregation for periods longer than the amount of time they can legally be held in administrative segregation and have not received formal review hearings (a direct violation of Mo. Rev. Stat. § 217.375)

• Inmates have been forced to wear soiled, torn undergarments and clothing which were previously issued to and used by other inmates, instead of receiving needful and necessary clothing in accordance with Mo. Rev. Stat. § 221.140

• Inmates have been denied due process in seeking to address their concerns through the formal resolution process, a direct violation of Mo. Rev. Stat. § 217.370

We the families would like to request a congressional hearing on this matter. We feel this is necessary because Missouri has a history of ignoring abuse within its solitary confinement and adult segregation prison system. As documented in several lawsuits filed against Potosi Correctional Center and the State of Missouri's Department of Corrections. Although these lawsuits revealed that the Department of Corrections failed to enforce Missouri state law and protect the constitutional rights of inmates, they did not provide a permanent solution. There is no independent oversight to ensure that all of Missouri's prisons operate in accordance with state law. An investigation by the Judiciary Committee and a congressional hearing can provide a greater level of accountability for the elected officials in Missouri who we have contacted about resolving this ongoing problem. We can provide documentation as well as testimonies from several families to support our case for the necessity of a congressional hearing to address this matter. We strongly believe that a congressional hearing will serve as a major catalyst toward ending the immoral and illegal treatment of inmates in MO prisons and jails.

Respectfully yours,
Families of Solitary Confinement Prisoners in Eastern Missouri

June 15th, 2012

U.S. Senator Dick Durbin
711 Hart Senate Building
Washington D.C. 2051

Re: Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences

According to the US Bureau of Justice Statistics 2,266,800 adults were incarcerated in U.S. federal and state prisons, and county jails at year-end 2010. My son was one of those statistics, much in part due to his diagnosed mental illness of schizophrenia and Bi-polar disorder. Unfortunately, my son still sits in prison today as a result of his untreated disorders and his constant need to self medicate his mental illness. As his mother, I have spent the last decade of his life battling not only his illness, but an unsympathetic judicial system as well.

My son Shawn's just spent his 30th birthday behind bars and his story spans well over a decade now. I could tell you story after story about my son's rotations between psychiatric hospitals and prisons, much in part due to of his mental illness, but I want to focus on his current incarceration experience. Shawn felt he was doing well and went off his medications. He no sooner had the medicines out of his system and his chronic symptoms returned. As a result, his behaviors began getting more bizarre and he was becoming persistently highly agitated. After much coaxing from his brother and me, Shawn agreed to go back to the hospital. His brother went to pick him up (he was in a very bad part of town) and Shawn got in the car to go, but quickly jumped out, stripped off his clothes down to his boxers and began running down the street screaming.

My older son became afraid; due to Shawn's behavior and the area of town he was in and finally just left. Apparently, someone called the police and Shawn was arrested for disorderly conduct. The police called his father to come get him, but his dad told them Shawn had run out of options and had no where to stay anymore. He would not come get him since he felt Shawn needed long term treatment for his mental illness and addictions. The police decided to let him go and put him back onto the streets. Does this make any sense? Shortly thereafter, that same night, he encountered two undercover police officers. An altercation occurred and they arrested him again but this time with no intervention. The officers sent him straight to the prison. He was combative of course, but what we didn't know was that he had self medicated before his brother came to pick him up. He smoked a marijuana cigarette he was given, but it had been dipped in formaldehyde and this triggered a violent reaction, thus the reason for his combative behavior.

Shawn called the person in charge of the intake of the new prisoners a not so nice name and taking into account his behavior, the decision was made to not to get a doctor to look at him, or put him in a cell to calm down, their answer was to put him in solitary confinement immediately. He was not a rapist or a murderer or anything like that; he was arrested for misdemeanor charges due to his behavior but because he was in full psychotic crisis mode, that behavior landed him right in solitary confinement. He did not spend few days in "the hole" or a couple weeks, but was there for 60 days! I cannot even begin to fathom what my son went through with his untreated schizophrenia, hearing voices in his head and being forced to stay completely alone for 23 out of 24 hours a day. He was frightened, alone, and wondering why his family had abandoned him. Solitary confinement and untreated mental illness is a recipe for mental disaster! It was very apparent that the system that was at one time to be place to not only punish, but rehabilitate had become a system that ignores inmates health and causes more harm by traumatizing them.

When you are in the "hole" (solitary confinement) you have no "rights" to make a phone call. I had no communication with my son in over 3 weeks! This inflicted even more trauma on him (and me as well)! I called the prison and tried to tell them that my son was mentally ill and was off his medications. After several calls I finally came to the prison to try to see my son. I was turned away, again being told it was Shawn's job to tell me the visiting hours. A female guard overheard me begging for information and slipped a number to me and told me to call it. The number was for the Deputy Warden. I called and after explaining what was going on and asking for an assessment, the order for an assessment was made. They also allowed him call me to tell me with the times I could come visit. I was so relieved to get his call, but so upset to hear him cry.

Shawn is 6 foot three about 240 lbs and does not cry at the drop of a hat. When I finally got to see him, I saw a scared little boy who after a month in solitary confinement could not stop rocking himself on the stool and also could not stop crying. My heart ached to hold him and comfort him but he was behind a dirty piece of glass and our only connection was the phone between us. I tried not to cry as I know that would upset Shawn more, but my heart broke to hear him talk about the tiny cell he had been isolated in and what no contact with anyone was doing to him. My son is sick; he is not a hardened criminal and all I wanted to do was tell him it would be alright, but frankly, I had no guarantee! When the lights finally flashed our 45 minutes of time to visit was done. As I stood up telling my son how much I loved him, watching him stand there crying and shaking, he threw his hand up against the glass waiting for me to put my hand on his for even the slightest bit of perceived contact. I looked into his eyes and saw a little boys face that I had comforted after a bad dream so many years ago.

I could not comfort him now and this was not a dream, it was his reality, and mine. I quickly left the prison and the minute I got out of sight, I began to sob uncontrollably. My son was being traumatized and I was powerless to stop it. It is honestly like watching a train come down the track and hit your child and then having someone tie you up and tell you that you cannot do a thing to help them!

I advocated for treatment for my son and finally he was put back on his medications. I saw some improvement and even though he seemed a bit better and the rocking slowed down, but at every visit, the minute the lights flash, his hand goes up on the glass still longing for the comfort of a touch! I am sitting here crying as I write this letter and can visually see my son, the terrified look in his eyes and the longing for me to comfort him as I did when he was a little boy. When I began to notice Shawn was reverting back. I asked him what was going on. He said that they had changed his medications. I called the medical department to tell them what I was seeing in his behavior. I received a note from him cursing at me. My call had sparked the reaction of putting him back in solitary confinement to adjust his medications.

Shawn has less than two months left to serve, but as he has told me "Mom, I am broken now and can't be fixed." As his mother I will hold out hope that his statement is not true. Even though solitary confinement has severely traumatized my son's schizophrenic mind, I choose to hold out hope, that help will be available and he will recover to a degree. I may be bit "Pollyannaish" in my outlook, but I too have been traumatized by all this and I keep going on the premise that there is hope in recovery for my son, once this nightmare has ended.

When I look at the cost of approximately $42,000 (here in Pennsylvania) of housing a prisoner for a year, I know that keeping my son on Medicaid so he can get his regular medications is crucial because this allows him to work, become a productive member of society and pay taxes and that is a lot more cost effective than paying the money to incarcerate, house and traumatize him.

My recommendations below are regarding the budget busting problems of the American prison population regarding the inhumane treatment of solitary confinement for the mentally ill.

- Make prisoner rehabilitation a priority so that treatment would be the first step of action in behavior modification, not providing additional trauma and irreversible damage caused by solitary confinement
- End the use of routine regular use of solitary confinement
- If the end of solitary confinement is not possible, then require that prisoners be given a complete mental health/drug and alcohol assessment before solitary confinement is even considered. It's important that offenders with mental health/addiction issues be provided treatment services, so as to not exacerbated their mental health status

- Require prison staff to be educated about mental illness/addiction and to be trained In the area of de-escalation skills.
- Institute mechanisms to protect the mentally ill. By not protecting prison inmates from each other, we end up releasing people with more coping issues than they came in with. I was told by one of the guards that the mentally ill inmates get harassed. The regular population likes to torment the mentally ill inmates to get them combative so they will be put in the "hole". To those involved in this behavior, it is a game of sport. After being assaulted in these ways, released persons will have a harder time assimilating into mainstream society and it would be a perfectly normal human reaction to lash out in pain of their experience, thus making a non-violent convicted criminal who was only harming himself into a violent released person who is more likely to cause harm to others.

In closing, I wonder what happens to all those mentally ill prisoners who don't have family on the outside to fight for them, because their untreated mental illnesses have exhausted the family. Who does fights for them? You/ we do. I hope my testimony gives you some insight to what the inhumane and traumatizing effects solitary confinement has not only on the prisoner but the family as well.

I want to thank Senator Durbin and the committee for allowing me to provide testimony on this important issue that has deeply affected my family.

Sharon L. LeGore

[redacted]

Angola 3—40 Years of Solitary, 40 Years of Cruel and Unusual Punishment

Dear Chairman Durbin and Ranking Member Graham:

My name is Robert Hillary King. I spent **29** years in solitary before I was freed in 2001 after proving my innocence. Since then I have worked tirelessly speaking and traveling around the world[1] to raise awareness about prison conditions in the US, and to bring attention to the remaining two members of the Angola 3—Herman Wallace and Albert Woodfox—who are still actively fighting to prove their innocence in federal court.[2] Both remain behind solitary bars in Louisiana today after **40** years.

Many people ask me to describe my nearly 3 decades in solitary. Here is an excerpt from my autobiography where I attempted to put these experiences into words:

> "*Solitary confinement is terrifying, especially if you are innocent of the charges that put you there. It evokes a lot of emotion. It was a nightmare. My soul still cries from all I witnessed and endured. It mourns continuously. Through the course of my confinement I saw men so desperate that they ripped prison doors apart and both starved and mutilated themselves. It takes every scrap of humanity to stay focused and sane in that environment. The pain and suffering are everywhere, constantly with you. There's no describing the day to day assault on your body and your mind and the feelings of hopelessness and despair.* [3]

Over a decade ago Herman, Albert and I filed a landmark civil lawsuit challenging the inhumane and increasingly pervasive practice of long-term solitary confinement[4]. Magistrate Judge Dalby describes our almost four decades of solitary as "*durations so far beyond the pale*" she could not find "*anything even remotely comparable in the annals of American jurisprudence.*"[5] The case, expected to go to trial by 2013, will detail unconstitutionally cruel and unusual treatment and systematic due process violations at the hands of Louisiana officials.

To mark the 40th anniversary of Herman and Albert's original placement in solitary, this April Amnesty International delivered a petition with 67,000 signatures from 125 countries to the Governor of Louisiana demanding that Herman Wallace and Albert Woodfox be removed from long term isolation.

> "*Prison records show that neither man has committed any serious disciplinary infraction for decades. Prison mental health records indicate that the men pose no threat to themselves or to others.*
>
> *Woodfox and Wallace are confined to their 6.5 by 9 feet cells for 23 hours a day and allowed out only to exercise alone in a small outdoor cage, or to shower or walk along the cell unit corridor.*
>
> *They have also been denied any meaningful review of the reasons for their isolation. The only reason given for maintaining the men under these conditions has been due to the "nature of the original reason for lockdown."*
>
> *Amnesty International is firm in its belief that conditions for the men in CCR – 23 hour cellular confinement in stark, tiny cells; limited access to books, newspapers and TV; no opportunities for mental stimulation, work and education; occasional visits from friends and family and limited telephone calls - amounts to cruel, inhuman and degrading treatment.*" [6]

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[1] I've spoken before hundreds of universities, the European Parliament, the ANC in South Africa, and even TEDx in California.
[2] In April 2011, Congressman Bobby Scott, John Conyers, and Cedric Richmond all hosted a Congressional Briefing on "*The Abuses of Solitary Confinement in the U.S. Criminal Justice System*" that included a screening of the full length feature documentary film about the A3 civil and criminal cases narrated by Samuel L. Jackson: http://www.inthelandofthefreefilm.com/trailer.aspx.
[3] King, Robert Hillary. *From the Bottom of the Heap.* Oakland: PM Press, 2008. Robert's moving autobiography has received critical acclaim and won The National Council on Crime and Delinquencies 2008 PASS (Prevention for a Safer Society) Award.
[4] http://www.angola3.org/uploads/Angola_8th_A_Summary_Judgment_Decision.pdf
[5] *Wilkerson et all v Stalder*, No. 00-304-C-M3, Magistrate Judge's Report, Civil Action (February 1, 2005).
[6] http://www.amnestyusa.org/news/press-releases/marking-40-years-of-inhuman-solitary-confinement-for-angola-2-prisoners-amnesty-international-set-to and http://www.amnestyusa.org/news/press-releases/marking-40-years-of-inhuman-solitary-confinement-for-angola-2-prisoners-amnesty-international-set-to

They go on to detail the human rights violations involved in such extreme confinement:

> *"In a recent report, the UN Special Rapporteur on Torture condemned prolonged isolation as amounting to torture or inhuman and degrading treatment. He refers to the case of Albert Woodfox and Herman Wallace in his report.*[7]
>
> *The USA has an obligation under international standards to ensure that all prisoners, regardless of their background, are treated humanely and that any security measures that may be necessary conform to this requirement. The prolonged and indefinite isolation of Albert Woodfox and Herman Wallace without meaningful review runs directly counter to this obligation.*
>
> *The USA has ratified the International Covenant on Civil and Political Rights, and the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, both of which prohibit torture or other ill-treatment. The relevant treaty monitoring bodies (the Human Rights Committee and the Committee Against Torture) have found that prolonged solitary confinement an amount to torture or other cruel, inhuman or degrading treatment. Both bodies have expressed concern that the harsh conditions of long-term isolation in some US segregation facilities are incompatible with the USA's treaty obligations.*
>
> *Amnesty International believes their findings are particularly significant in the case of Albert Woodfox and Herman Wallace given that few, if any, other prisoners have spent so long in solitary confinement in recent times.*
>
> *Their treatment also contravenes the UN Standard Minimum Rules for the Treatment of Prisoners. These and other relevant standards emphasize the importance of providing work and educational, recreational, religious and cultural activities for prisoners' mental and physical wellbeing, as well as to prepare individuals for reintegration into society."*[8]

We respectfully submit this statement with the hopes that you can use your legislative powers to put an end to long term solitary confinement. Without uniform standards of the infractions serious enough to merit placement, a meaningful review process with outside oversight and a grievance process, opportunities for socialization and education, and a clear written timeline and detailed action plan for the inmate's release, this form of punishment serves no punitive or reformative purpose. In our view is the very definition of cruel and unusual punishment protected against by our founding fathers.

We believe that only by openly examining the failures and inequities of the criminal justice system in America can we restore integrity to that system. We are grateful for your efforts to do just that today.

Sincerely,

"The Angola 3" - Robert King, Herman Wallace, and Albert Woodfox

[7] http://www.amnesty.org/en/appeals-for-action/wheres-the-evidence
[8] http://www.amnesty.org/en/library/info/AMR51/041/2011/en

UNIVERSITY OF VIRGINIA SCHOOL OF LAW

Thomas L. Hafemeister, J.D., Ph.D.
Associate Professor, University of Virginia School of Law
Associate Professor of Medical Education, University of Virginia School of Medicine

To: Members of the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights

On: "Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences."

From: Thomas L. Hafemeister, Associate Professor of Law, University of Virginia School of Law

Date: June 15, 2012

I was recently informed of the plans of the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights to hold a hearing on June 19, 2012, on the topic "Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences." I applaud this focus.

I also noted that Chairman Durbin is inviting interested advocates and experts to submit written testimony to be included in the hearing record. The following are excerpts from a manuscript by myself and Jeff George entitled "The Ninth Circle of Hell: An Eighth Amendment Analysis of Imposing Prolonged Supermax Solitary Confinement on Inmates with a Mental Illness," which has been accepted for publication in Volume 70, Issue 1, of the *Denver University Law Review* and is scheduled to appear in print by the end of the year. Because of space constraints, the supporting authority provided in the original has been excised from this excerpt. The full manuscript can be found at http://papers.ssrncom/sol3/papers.cfm?abstract_id=2032139. I hope that you will find these excerpts informative.

Abstract

The increasing number of inmates with a mental disorder in America's prison population and the inadequacy of their treatment and housing conditions have been issues of growing significance in recent years. The U.S. Department of Justice estimates that "over one and a quarter million people suffering from mental health problems are in prisons or jails, a figure that constitutes nearly sixty percent of the total incarcerated population in the United States." Furthermore, a person suffering from a mental illness in the United States is three times more likely to be incarcerated than hospitalized, with as many as forty percent of those who suffer from a mental illness coming into contact with the criminal justice system every year and police officers almost twice as likely to arrest someone who appears to have a mental illness. As a result, the United States penal system has become the nation's largest provider of mental health services, a "tragic consequence of inadequate community mental health services combined with punitive criminal justice policies."

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This growth in the number of inmates with a mental disorder, combined with the recent rise of prolonged supermax solitary confinement and the increasingly punitive nature of the American penological system, has resulted in a disproportionately large number of inmates with a mental disorder being housed in supermax confinement. The harsh restrictions of this confinement often significantly exacerbate these inmates' mental disorders or otherwise cause significant additional harm to their mental health, and preclude proper mental health treatment. Given the exacerbating conditions associated with supermax settings, this setting is not only ill-suited to the penological problems posed by the growing number of these inmates, but intensifies these problems by creating a revolving door to supermax confinement for many such inmates who may be unable to conform their behavior within the prison environment.

Housing inmates with a mental disorder in prolonged supermax solitary confinement deprives them of a minimal life necessity as this setting poses a significant risk to their basic level of mental health, a need "as essential to human existence as other basic physical demands . . . .", and thereby meets the objective element required for an Eighth Amendment cruel and unusual punishment claim. In addition, placing such inmates in supermax confinement constitutes deliberate indifference to their needs as this setting subjects this class of readily identifiable and vulnerable inmates to a present and known risk by knowingly placing them in an environment that is uniquely toxic to their condition, thereby satisfying the subjective element needed for an Eighth Amendment claim. Whether it is called torture, a violation of evolving standards of human decency, or cruel and unusual punishment, truly "a risk this grave—this shocking and indecent—simply has no place in civilized society."

. . .

II. A BRIEF HISTORY OF PROLONGED SUPERMAX SOLITARY CONFINEMENT

. . .

The use of prolonged solitary confinement can be traced back at least to the middle ages, [ ] but the modern supermax and its use of extended and total isolation is a relatively recent phenomenon. The

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supermax has its roots in the early part of the nineteenth century, when the use of prolonged solitary confinement became popular as what was perceived to be a new, progressive rehabilitation technique. Eastern State Penitentiary—opened in 1826 in Philadelphia and widely known as "Cherry Hill,"—was the proud prototype of the so-called "Pennsylvania system," which was considered innovative in that it subjected prisoners to complete isolation, much like supermax confinement of today.[ ] However, as one critic put it, "in Philadelphia . . . 'the celebrated system of penitentiary discipline has been abandoned', and in its place solitary confinement is to be substituted, 'the most inhuman and unnatural that the cruelty of a tyrant ever invented.'"[ ]

Implementing a "silent system," Cherry Hill mandated complete silence, and "inmates labored alone in their cells and wore hoods during exercise periods."[ ] The emphasis on social isolation was so strong that prison architects even rearranged sewer pipes to prevent prisoners from communicating between cells.[ ] The underlying rationale for this system was that prolonged isolation and silence would force an inmate into a state of contemplation and moral reflection, thereby making him "the instrument of his own punishment."[ ] As Alexis de Tocqueville reported after a trip to America to view these model institutions, "the solitary cell of the criminal is for some days full of terrible phantoms . . . [but] when he has fallen into a dejection of mind, and has sought labor in relief . . . from that moment he is tamed and forever submissive to the rules of the prison."[ ]

The Pennsylvania model quickly became an "international sensation," with many European visitors coming to inspect prisons like Cherry Hill with the idea of bringing the model back home with them for adoption.[ ] Hundreds of similar prisons utilizing strict solitary confinement were constructed all over Europe, with the Pennsylvania model duplicated in England, France, Germany, Holland, Belgium, Portugal, Norway, Sweden, and Denmark, ushering in the so-called "silent era" of prisons.[ ]

But this era was short lived. The new prisons were exceptionally expensive to build and maintain, and a growing, wide-spread problem of overcrowding in correctional systems made an emphasis on isolation virtually impossible to sustain.[ ] More significantly, the Pennsylvania model was the target of

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increasing criticism from a variety of sources, including critiques based on multiple studies of the effects of prolonged solitary confinement on inmates' mental health.[ ]

Prison officials in the United States and Europe also began to notice the widespread development of serious mental health issues in the prisoners housed in these settings. At Cherry Hill, for example, reports began to materialize as early as the 1830s of inmates with serious mental disorders, "including hallucinating prisoners, dementia, and 'monomania.'"[ ] . . . Officials at Cherry Hill attempted in vain to provide an alternative explanation for the extensive mental illness in its population. . . .

However, prison officials elsewhere were quicker to recognize a connection between the extreme isolation of prisoners at these facilities and mental illness. Millbank Prison in England, for example, introduced the Pennsylvania system of solitary confinement in the late 1830s, but officials at Millbank in an 1841 report complained that "a very extraordinary increase has taken place in the number of insane prisoners in the prison."[ ] The report also suggested a telling course of treatment for them: "prisoners should be placed together and have the privilege of conversation."[ ] Indeed, new 1841 regulations at Millbank reduced confinement periods and allowed prisoners to converse with two or more fellow inmates during exercise hours.[ ] Similar developments took place across the United States as every state, with the exception of Pennsylvania, that tried the Pennsylvania model between 1830 and 1880 subsequently abandoned it within a few years.[ ] By the 1880s, with the exception of Cherry Hill itself which continued to employ the "silent model" until 1913, prisons based on the Pennsylvania model had completely disappeared.[ ] Prolonged solitary confinement as a method of rehabilitation, in other words, was determined to be a profound failure.[ ]

The systematic use of prolonged solitary confinement in correctional systems in the United States remained largely dormant through most of the twentieth century.[ ] Likewise, even the selective use of extended solitary confinement as a means of imposing discipline within relatively traditional prisons began to lose favor.[ ] Authors of a study on prison psychiatry in 1939 declared, perhaps optimistically, that around-the-clock prolonged solitary confinement was no longer practiced by any "civilized nation."[ ] The

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Manual of Correctional Standards produced in 1959 by the American Correctional Association, the largest and oldest correctional association in the world, instructed that solitary confinement should be used only briefly, and only as a last resort.[ ] The manual advised that "no more than fifteen days, and normally a period of a few days [in solitary confinement] is sufficient."[ ] It precluded the use of indefinite isolation and suggested instead a modified segregation for the most difficult prisoners that included therapy and work opportunities.[ ] Excessive solitary confinement, it stated, will "defeat [its] own purpose by embittering and demoralizing the inmate," and it stressed that even inmates in solitary confinement must have daily group or individual therapy to protect their "[m]ental and emotional health."[ ]

The mid-1970s, however, marked the beginning of an unprecedented growth in America's prison population.[ ] While the rate of incarceration had remained largely unchanged from 1925 to 1975, it quintupled over the next quarter century, driven in part by an increase in the crime rate.[ ] The 1970s and 1980s also saw the virtual abandonment of a rehabilitative philosophy in United States prisons, increasingly replaced by a pervasive view that retribution, incapacitation, and deterrence were the primary purposes of incarceration.[ ] It was in this increasingly punitive atmosphere that the supermax prolonged solitary confinement model emerged and flourished.[ ]

Most point to an October 1983 extended lockdown following the killing of two prison guards at the U.S. Penitentiary in Marion, Illinois—a maximum security prison opened in 1963 to replace the infamous prison at Alcatraz—as the nexus of the modern American use of supermax prolonged solitary confinement.[ ] At Marion, a week of inmate rioting had led to a "prolonged emergency lockdown" of inmates that was never lifted, becoming a "large-scale experiment in solitary confinement that continues to this day."[ ] The Marion lockdown "experiment" led corrections departments across the United States to implement their own systematic lockdowns, and a new incarceration paradigm was born.[ ] For example, in 1994, the first federal prison expressly modeled after this approach, called a "super-maximum," opened in Florence, Colorado.[ ] Many states followed suit,[ ] systematically imposing long-term, oftentimes indefinite, administrative segregation in which inmates are placed in virtually total isolation and severely

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restricted in their movements.[ ]

In 1991, the organization Human Rights Watch identified the rise of supermax confinement as "perhaps the most troubling" human rights trend in the United States correctional system, estimating that at least thirty-six states had completed or were developing such facilities at that time.[ ] In 1997, the authors of a study on the use of these facilities concluded: "at no point in the modern history of imprisonment have so many prisoners been so completely isolated for so long a period of time in facilities designed so completely for the purpose of near isolation."[ ] By 2000, [it was] estimated that approximately 20,000 prisoners were confined in supermax facilities across the United States.[ ] A 2004 . . . survey of self-identified supermax wardens determined that forty-four states had at least one supermax facility, collectively housing 25,000 prisoners. [ ] Another study conducted in 2006 concluded that there were now at least fifty-seven supermax prisons or units within prisons in approximately forty states.[ ] A front-page, feature news article published in 2012 asserted that "[a]t least 25,000 prisoners—and probably tens of thousands more, criminal justice experts say—are still in solitary confinement in the United States. Some remain there for weeks or months; others for years or even decades. More inmates are held in solitary confinement here than in any other democratic nation."[ ]

Notwithstanding that prison systems across the United States are increasingly financially strained and overcrowded,[ ] with the U.S. Supreme Court recently taking the extraordinary step of ordering the California correctional system to dramatically reduce its census,[ ] the popularity and use of supermax prisons has continued to grow in spite of their high operating costs.[ ] The increasing popularity of this punitive penological approach and its severe isolation of purportedly dangerous and despicable prisoners proved "politically contagious," as "politicians and prison administrators across the USA and elsewhere have competed to build the most secure, high-tech, fortified isolation prison" possible,[ ] although as a result of their high costs and perhaps influenced by increasing humanitarian concerns, the popularity of supermax prolonged solitary confinement may be beginning to diminish.[ ]

Today, the correctional departments of the various states and the federal government use a variety

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of phrases to describe their own supermax prisons and units within prisons that impose prolonged solitary confinement, . . . [ ] No matter what the phrase, these facilities all share a distinct approach: they "house prisoners in virtual isolation and subject them to almost complete idleness for extremely long periods of time."[ ] A supermax can be a "freestanding facility, or a distinct unit within a facility" that houses specifically selected inmates in an extreme form of long-term administrative segregation emphasizing "separation, restricted movement, and limited direct access to staff and other inmates."[ ]

Although supermax confinement exists in many states, housing both state and federal inmates, its operation and procedures are remarkably uniform. Employing sophisticated designs and technology, the ultimate goal is to limit, as much as possible, environmental and human interaction.[ ] Often referred to as "prisons within prisons,"[ ] inmates are typically confined for twenty-three or more hours per day in cells ranging from sixty- to eighty-square feet in size.[ ] Exercise is limited to one hour per day, in which an inmate is placed, unaccompanied by anyone else, in a designated (often bare) exercise room.[ ] They eat all meals alone in their cells, and no social activity of any kind is permitted.[ ] Inmates are kept under constant surveillance, with "computerized locking and tracking methods [used to] allow their movement to be regulated with a minimum of human interaction."[ ]

Great pains are even taken to reduce an inmate's necessary interactions with prison staff.[ ] Inmates are denied access to all work, rehabilitation, recreational, and other activities and programs, and any services provided are usually delivered through a small portal at their cell front, including mental health services.[ ] Inmates' principle and often sole human interactions are brief encounters with prison staff, which typically consist of muffled speech through a double-paned window or the passing of an object through a tray-sized "cuffport" on the cell door.[ ] For years, their physical contact with other humans may be "limited to being touched through a security door by a correction officer while being placed in restraints or having restraints removed."[ ] The norm is to impose, to the fullest extent possible, complete sensory deprivation and social isolation.

. . .

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IV. THE PROLONGED SUPERMAX SOLITARY CONFINEMENT OF INMATES WITH A MENTAL ILLNESS OR INMATES HIGHLY VULNERABLE TO A MENTAL ILLNESS CONSTITUTES AN EIGHTH AMENDMENT VIOLATION

. . .

The research documenting the harmful psychological effects of prolonged solitary confinement is remarkable for its consistency. As one researcher put it, "there is not a single published study of solitary or super-max like confinement in which nonvoluntary confinement lasting longer than ten days . . . failed to result in negative psychological effects."[ ] . . . [T]he personal accounts, descriptive studies, and systematic research spanning multiple continents over more than a century, is virtually unanimous in its conclusion: prolonged supermax solitary confinement can and does lead to significant psychological harm.[ ]

. . .

[M]odern case studies and descriptive accounts provided by mental health staff employed at modern supermax settings have consistently reported the same adverse symptoms: appetite and sleep disturbances, anxiety, panic, rage, loss of control, paranoia, hallucinations, and self-mutilations—among others.[ ] In addition, direct studies of prison isolation have similarly documented a broad range of adverse psychological symptoms, including, but not limited to, insomnia, anxiety, panic, withdrawal, hypersensitivity, ruminations, cognitive dysfunction, hallucinations, loss of control, irritability, aggression and rage, paranoia, depression, self-mutilation, and suicidal ideation and behavior.[ ] It has also been determined that some of the negative health effects are long term, with

> continued sleep disturbances, depression, anxiety, phobias, emotional dependence, confusion, impaired memory and concentration [lasting] long after the release from isolation. Additionally, lasting personality changes often leave individuals formerly held in solitary confinement socially impoverished and withdrawn, subtly angry and fearful when forced into social interaction[, which] . . . often prevents individuals from successfully readjusting to life within the broader prison population and severely impairs their capacity to reintegrate into society when released from imprisonment.

What is particularly striking about these studies is not the range or nature of these symptoms, but their overwhelming prevalence. Indeed, it appears that an inmate in supermax confinement is virtually

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guaranteed to develop some form of negative psychological effect as a result. . . .

. . .

In addition, [psychologist Craig] Haney[, who assessed 100 inmates, randomly selected, in the Security Housing Unit at Pelican Bay State Prison in California in connection with a lawsuit challenging the conditions there,] noted a number of troubling social pathologies connected to supermax confinement among the inmates. Indeed, the deprivation of social interaction and the absence of external feedback appear to lead even mentally stable inmates to suffer. As Haney explained:

> Because so much of our individual identity is socially constructed and maintained, the virtually complete loss of genuine forms of social contact and the absence of any routine and recurring opportunities to ground one's thoughts and feelings in a recognizable human context leads to an undermining of the sense of self and a disconnection of experience from meaning. Supermax prisoners are literally at risk of losing their grasp on who they are, of how and whether they are connected to a larger social world. Some prisoners act out literally as a way of getting a reaction from their environment, proving to themselves that they are still alive and capable of eliciting a genuine response—however hostile—from other human beings.[ ]

This desperation for external feedback is likely the cause of the high prevalence of feces, urine, and semen throwing that occurs universally in supermax confinement.[ ] One explanation for this behavior is that inmates are so desperate to gain some sort of attention, no matter how negative, they will use the only tools they have—their own bodies and its products.[ ]

. . .

As demonstrated by these studies, the psychological harms produced by supermax conditions clearly constitute a failure to provide a significant minimal life necessity, namely, a reasonable opportunity for mental health as required by the Eighth Amendment.[ ] Further, the psychological harm typically resulting from prolonged supermax solitary confinement has consistently offended standards of decency for more than a century—as evidenced by the outpouring of negative reaction regarding (and eventual rejection of) the Pennsylvania model around the world,[ ] and of today's use of prolonged supermax solitary confinement.[ ]

In addition, research has established that inmates with a mental disorder are particularly vulnerable to suffering adverse psychological effects in this environment.[ ] It has been noted solitary confinement is

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"particularly damaging to those with pre-existing mental illness. For these prisoners, solitary poses a grave risk of psychiatric injury, self-harm, and even suicide. Deprived of the social interaction that is essential to keep them grounded in reality, many prisoners with mental illness experience catastrophic and often irreversible psychiatric deterioration."[ ] A United Nations report determined that:

> Research has shown that with respect to mental disabilities, solitary confinement often results in severe exacerbation of a previously existing mental condition. Prisoners with mental health issues deteriorate dramatically in isolation. The adverse effects of solitary confinement are especially significant for persons with serious mental health problems which are usually characterized by psychotic symptoms and/or significant functional impairments. Some engage in extreme acts of self-mutilation and even suicide.[ ]

This report concluded that "[nations] should abolish the use of solitary confinement for . . . persons with mental disabilities."[ ]

Indeed, just as the Supreme Court in *Helling* found that a tobacco-smoke free environment is a minimal life necessity by contemporary standards, and just as courts today routinely find basic physical conditions such as sanitation,[ ] toilets,[ ] warmth,[ ] and exercise,[ ] to be minimal life necessities, falling within the Eighth Amendment objective component requirement, it is hard to imagine that conditions that almost inevitably lead to a significant deterioration of mental health do not as well, particularly when inmates with a mental illness or inmates who are highly vulnerable to mental illness are involved. Indeed, in the recent landmark decision of *Brown v. Plata*, the Court found adequate mental health care to be a basic need the deprivation of which constitutes a violation of the Eight Amendment.[ ] There, the court compared adequate mental health care to "basic sustenance."[ ] As the court in *Madrid* put it, "it is beyond serious dispute that mental health is a need as essential to a meaningful human existence as other basic physical demands our bodies make for shelter, warmth or sanitation."[ ]

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STATEMENT

Vicky Gunderson

U.S. Senate Judiciary Committee hearing on Solitary Confinement

June 19, 2012

Introduction

Thank you for the opportunity to submit a statement on the issue of solitary confinement. I applaud the committee for holding a hearing and focusing national attention on this crucial issue. I am submitting this statement on behalf of myself and my family. We have been directly affected by solitary confinement as my son, Kirk, committed suicide while in solitary confinement as a teenager in 2005.

Kirk's Story

In 2005, our 17 year old son, Kirk, was held in a county jail for approximately 7 months before dying by hanging in a segregation cell. Alone and 17 yrs old!

While incarcerated, in a county jail with adults, he was targeted due to his youth. Statistics show that youth incarcerated with adults are at high-risk for physical abuse, sexual abuse, and suicide. Our son experienced all of these abuses first-hand.

He was manipulated by the adults in the system to provide them with his canteen, he was physically abused, a convicted sex offender was placed in the same block as Kirk and he was approached by the offender exposing himself and stating "I am going to have you". Upon reporting this situation, Kirk was denied any future programming such as a weekly church service, alcoholics anonymous, and narcotics anonymous because the system did not want to "keep track of Kirk and the sexual offender". Why punish Kirk, by removing programming that may benefit him, for being scared and reporting that he was going to be a victim of a sexual predator if one of them was not removed from the block?

Kirk's survival to the system was suicide. Kirk had a future; Kirk had a family and support system that were ready, willing and able to walk through the challenges he was going to be faced with for years to come. Should the solution to surviving the system be suicide?

Our son wrote a letter to the District Attorney while incarcerated. A few brief statements he wrote, "Correct me if I'm wrong, but isn't the purpose of punishing someone not only about them paying for their actions, but also to rehabilitate them so they don't make the same mistake again. Shouldn't it be the goal of the state for convicted felons to be able to re-enter society as law-abiding citizens and lead productive lives. Therefore, is it in the best interest of every inmate to go to prison?

I understand that you're in a tough situation and that your main responsibility is for the best interest of the community. However, if I truly am a reckless, dangerous person with no care for the law, then what difference would it make if I were to be released next week opposed to twenty years from now. I would still possess those same characteristics only with the education of a criminal who has been through the system.

If I were to be sent to prison, it would be difficult for me to mature into a "normal" adult. Still being in my teenage years I am still developing. I do not want to be influenced by the type of person that resides in the Wisconsin Department of Corrections. Being separated from society, I would be at a disadvantage upon my release as I would not know the ways of a functioning adult in society. I would still be a teenager, just in an adult body with adult situations to be responsible for."

He ended his letter to the District Attorney with "A wise person once told me, "it is not our mistakes in life that define who we are, but rather how we recover from those mistakes"."

In conclusion, does society want to nourish our youth with continued criminal education or do we want to deter our youth with an opportunity to recover from their mistake?

Recommendations

It is crucial that the U.S. Senate Judiciary Committee take action to protect our youth. I urge members of the U.S. Senate Judiciary Committee to spend time, evaluate the risks that a youth being housed with adults, whether in a local, county jail or prison, are exposed to. Seventeen year olds are not adults; they should not be treated as an adult. There is evidence based practices that a youth can be rehabilitated. So why are we spending our dollars to warehouse and not rehabilitate?

I urge the committee to:

(1) Update the Prison Rape Elimination Act (PREA) and the Juvenile Justice & Delinquency Prevention Act (JJDPA) to ban the placement of youth in adult jails and adult prisons;

(2) Restore federal juvenile justice resources for states and localities to incentivize their use of best practices and evidence-based approaches that rely on the least restrictive setting for youth in conflict with the law; and

(3) Ensure that the U.S. Department of Justice enhances technical assistance to states and localities to assist in the removal of youth from adult jails and adult prisons.

June 9, 2012

To: U.S. Senator Dick Durbin
c/o Nicholas Deml

Re: **Solitary Confinement Congressional Hearing**

Dear Senator Durbin,

Thank you for allowing me to express to you my concerns regarding my husband's incarceration in Solitary Confinement for the past 23 years. I feel the California Department of Corrections and Rehabilitation needs oversight and I am very pleased that this hearing will be addressing this issue.

My name is Virginia Gutierrez-Brown. My husband is housed in the Pelican Bay State Prison Secured Housing Unit, called the SHU which is located in Northern California (Crescent City). He's been there (in solitary confinement) since the prison first opened in 1989. That's 23 years and all of them in the SHU. That should be unheard of in the United States of America, but unfortunately, it's not in the State of California.

My husband hasn't been allowed to get any sunlight, walk outside, mingle in the yard with others, or have his picture taken in those 23 years. He lives in a cramped, cement, windowless cell. His only exercise "yard" is a small enclosed cemented area, where inmates are let out for an hour alone.

Until recently, he also could not even have a wall calendar or drawing paper. Those were taken away and when asked why, the answer was always for the safety and security of the prison.

Last July, the inmates had a hunger strike to peacefully protest these barbaric conditions. Those that organized the hunger strike were punished by having their visits and writing privileges taken away.

Inmates sent to Pelican Bay are sent far away from their families. A majority of them living about 700 miles away, making it difficult for families to be afford the trip to see them.

With transportation and lodging expenses, it is impossible for a lot of families to visit their loved ones.

All of this excessive punishment is because he has been labeled an associate of a gang. He has been labeled this without any evidence of such, only by speculation and accusations of unknown informants. They call it validation in the California Prison system.

He doesn't have the right to confront any accusers and is judged and sentenced solely by prison staff. Prison staff can do this as they are not held accountable in a court of law and are free to condemn inmates to the SHU for an indeterminate sentence at will. There is no recourse for inmates to challenge prison authorities.

My husband is not an associate of a gang and does not participate in any gang activity. In fact, he has used his time in a productive manner. He has learned Spanish through college courses when they were allowed and has provided interpretation services for his aunt's church by helping to write church bulletins in Spanish.

My husband is in his late 50's now and spends most of his time reading, writing to me, or studying.

He has spent more than 1/3 of his life in the SHU based on erroneous facts. He was once given an additional 6 years in the SHU for sending a fellow inmate a Christmas card. In California, you cannot have friends in prison or this is looked at as gang affiliation by the prison staff, whether it's true or not.

If something isn't done to change the policy for keeping inmates in the SHU, my husband will probably die there. I can guarantee you

that society is not safer by keeping him in the SHU, not to mention the cost to the State of California for maintaining the SHU. Studies
will show SHU confinement is not cost effective and has not provided the intended results to the California Department of Corrections.

The inmates in the SHU are only asking to do their time in the general population and respectively ask that the SHU at Pelican Bay be shut down and inmates returned to the general population without any retaliation to those men who had to go on a hunger strike in order to bring their plight to the public's attention and to bring about changes to their bleak existence.

In closing, I'd like to ask members of Congress to take a good look at this issue and ask themselves if this is how we want to want to be perceived by others? Is this how the United States of America wants to treat its own people, when if we went to other countries and foreign lands, we would look at this as barbaric, yet we allow our own citizens to wallow away in solitary confinement for decades on end?

Solitary confinement has been deemed "cruel and unusual punishment" by the United Nations and the inmates housed at the Pelican Bay SHU petitioned the United Nations to help stop this torture in March of this year. They had to go to the United Nations as they had no other recourse. They need your help.

Also, on May 31st, the New York-based Center for Constitutional Rights filed a lawsuit on behalf of the SHU inmates stating that the conditions these men are housed in are "cruel and unusual punishment".

I belong to a grass roots organization formed last year after the Hunger Strike at Pelican Bay Prison. It is called *California Families to Abolish Solitary Confinement (CFASC)*. We are family members of inmates house in Pelican Bay SHU and we are committed to bring an end to the inhumane treatment our loved ones receive from the California Department of Corrections and Rehabilitation. We stand in solidarity with our husbands, sons, fathers, brothers, and other loved ones and have spoken at Assembly Meetings here in California in the
-Page 4-

hopes of enlightening lawmakers to the need for change in California's prison system.

I hope my words inspire you to take action and bring long overdue justice to these men.

Respectfully submitted,
Virginia Gutierrez-Brown
Member, *California Families to Abolish Solitary Confinement* (CFASC)

Statement

Grace Warren, Advocate for Juvenile and Adult Criminal Justice

U.S. Senate Judiciary Committee hearing on Solitary Confinement

June 19, 2012

Introduction

After my 17 year old son was convicted and sentenced as an adult in the criminal justice system I became involved in public awareness campaign, I am a member of the Tamms year Ten Campaign, and the Illinois Coalition for Fair Sentencing of Children at Northwestern University. I had the opportunity to give testimony to the Federal Coordinating Council on the importance of family engagement with the juvenile and criminal justice system. I am also a volunteer with the John Howard Association of Illinois who is known as the watchdog of the justice system. We monitor both juvenile and adult facilities.

Solitary Confinement

I can remember almost as if it were yesterday when I was sitting in court with my son as he was tried as an adult. I couldn't believe what I was hearing I wasn't aware they could do this legally I remember feeling like a ton of bricks had just fallen down on me. Prior to my sons' case they sentenced another youth to adult prison he was much smaller in statue than my son and I remember hearing the sheriff saying "oh, they are going to turn him out." I panicked all I could think about was my son being sexually abused by older men. I was devastated. By the sheriff making this comment let me know the courts were aware of the dangers of placing juveniles in prison with adults. I thought this should not be happening and I began my crusade.

During the past 6 years since my son has been incarcerated at Tamms Supermax which is a solitary facility in Illinois. I have had the worst experience of my life. I never knew human beings were treated the way they are treated in solitary confinement family members are not treated too much better. I'll begin with the visiting process you go through to visit your loved one. You

must submit a visitor request form ten days prior to your visit, then wait for three to five days to receive your reply stating you were either approved or denied.

The night before my visit I feel as though I'm having an anxiety attack, I find myself tossing and turning all night. I get up at 3:30 in the morning and I dress very carefully to avoid violating the facility dress code rules that seems to change every other month. I pack extra clothes so I can change if something has changed since my last visit. Rules inside the facility do change frequently and the change without families knowing they are changing so you have to be prepared for any and everything. I'm out of the house by 4:15am allowing myself extra time to ensure that I am not late because of traffic or some other unforeseen problem like a flat tire. I drive 5 ½ to 6 hours to get to Tamms if you are more than 15 minutes late your visit will be denied.

Once I arrive at the facility, I go through a metal detector and am physically searched. Though I completely understand the reason for this tight security and appreciate the administration for their attention to safety that protects my son and all the others, I still feel violated when the staff tells me I have to lift my underwear and shake it. After I get through security, I always feel I a sense of relief that I am going to be able to visit

My son is brought into the visiting area by three guards, one on each side and one in back of him, he's handcuffed and shackled at the feet. They then sit him on a concrete stump and wrap the chain around the stump and that's where he stays for the duration of our visit which is four hours. As we talk through a thick glass that separates us I try to lift his spirits and bring him away from the depressive state I know he's in. I use my entire visit to catch my son up on everything going on at home and hear about how his life is going. I'm constantly watching him for signs of changes in his mental and physical state. I've noticed a twitch beneath his eye at times' this lets me know something is bothering him. I believe it is being in solitary confinement for such a long period is beginning to affect him. Most people have no idea how difficult it is to be cut off from your own child and the level of anxiety it can cause a mother. The truth is I do think people can understand exactly how difficult it can be if it were their own child or a child they loved but, because it's my son and he is in prison somehow it's what he deserves.

I can't begin to explain the hurt, the pain and the depressing state of mind I get when my visit has been denied. Those visits are what keeps' me going and according to research about visits to those behind bars, it is likely what keeps him going as well. So, I take full advantage of every visit I can get, It may be a hardship to me financially but, I need to know that my son is alive and safe. When these visits aren't possible, phone calls become the most important link to our child who is locked up. As a mother of a son who is incarcerated today, I let nothing stand in the way of those calls. I will walk out of Church leave a meeting, or doctor's appointment. It is the only

communication we have in between our face to face visits. I need to hear his voice just as I need food and water. When I don't hear from him I feel anxious, worried and on edge.

Never once have I visited a facility in Illinois that compares to the solitary prison. I thought I would be prepared for the Tamms Supermax prison. After all I had visited other prisons in the past and had always heard oh, Tamms is a new prison and it's really nice. The first part I will agree with, it is a new prison but, nice, not hardly. It is an underground prison. In monitoring other prisons I found some inmates at other facilities have committed the same crimes yet they are in maximum or medium prisons. I see no need to have a solitary prison other than to torture and dehumanize a human being. It is a waste of the tax payer's money.

Solitary is designed for acute sensory deprivation. Inmates are locked in their cells 23 hours out of 24. They never leave their cells except to shower or exercise for one hour in a concrete pen. They never leave their cells except to shower or exercise for one hour in a concrete pen. The guards bring them their meals on dirty trays and push them through a slot in the door that's called a chuck hole. There are no jobs, communal activities, or physical contact. Conditions such as these are cruel, inhumane, and degrading it is actually a form of true torture. I don't get a chance to hug my son on visits, hold his hand or go to the vending machine to purchase snacks.

I have witnessed the drastic changes in inmates from being in solitary confinement. Young men who entered into this prison looked their age and now after several years in solitary they have aged so much hair now is completely gray, they walk slumped over, laugh and talk to themselves. Many inmates have began self-mutilation, attempted suicide and are now dealing with mental, physical, and psychological issues.

In one incident an inmate who was sentenced to seven years for an assault is now serving ninety-nine years for a series of incidents from self-mutilating, throwing urine and feces at the guards and eventually cutting off a body part. This is the result of a youth placed in solitary who otherwise would have been released in 3 ½ years had he spent his time in a regular prison. Instead of treatment for this prisoner they continued to punish him more by adding ninety-nine years to his sentence.

According to psychiatrist Dr. Terry Kupers, of the Wright Institute, a psychology graduate school in Berkeley California and an expert on the effects of long term solitary confinement stated that under conditions imposed by federal court decrees in California someone who is so disturbed that he continually cuts himself, and so bizarre and extreme in his emotional disturbance that he cuts off his body parts is clearly self-harming and should have been permanently removed from solitary.

This is a failure by the department of corrections to connect mental illness to long term isolation, even though a federal court ruling by a judge in East Saint Louis last year made the connection.

Dr. Janis Petzel the former president of the Maine Association of Psychiatric Physicians says prisoners should not be held in isolation longer than forty-five days, "It gets to be a vicious circle – the longer a prisoner is held in solitary the more abnormal their behavior becomes , and the longer they are forced to stay in solitary.

As if solitary is not enough punishment inmates in some cases are put in segregation for not following the rules how much punishment can one person take? If they are placed in segregation they only receive one visit a month. These guys have not had the privilege of touching, hugging, or shaking hands with their love ones for years. One parent stated she has not been able to touch her son in twelve years. This is truly a hardship to families not to be able to hug your child.

Everyone talks about community safety, how safe is it to release people with severe mental illness back into the community not knowing what they might do because of their illness.

I am not advocating that punishing the guilty is wrong what I am saying is that I am against inhumane treatment to any human being. People can change and they should not be defined by a mistake they made as a youth.

As one inmate who has served several years in the Supermax prison in Illinois said "It is like this place (Tamms) is designed to psychologically kill you. How could America be so cruel to its'own people?"

Thank you, for holding this hearing and I hope you will take into consideration the damage solitary has caused to our youth.

Recommendations

I urge the committee to:

(1) Update the Prison Rape Elimination Act (PREA) and the Juvenile Justice & Delinquency Prevention Act (JJDPA) to ban placement of youth in adult prison;

(2) Restore federal juvenile justice resources for states and localities to incentivize their use of best practices and evidence based approaches that rely on the least restrictive setting for youth in conflict with the law; and

(3) Ensure that the U.S. Department of Justice enhances technical assistance in removal of youth from adult jails and adult prisons.

JOHN CONYERS, JR.
14TH DISTRICT, MICHIGAN

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Statement of John Conyers, Jr., for the hearing on
"Reassessing Solitary Confinement: The Human Rights, Fiscal and Public Safety Consequences"
Tuesday, June 19, 2012
Dirksen Senate Office Building, Room 226
10:00 a.m.

Thank you, Senator Durbin, for convening this important hearing on solitary confinement.

I first became involved in this issue several years ago when I learned about the plight of the Angola 3—Robert King, Herman Wallace, and Albert Woodfox—who have served decades in solitary confinement at the Angola State Prison. My concern about this issue, however, goes beyond the Angola 3, which is why I am so pleased that you have called this hearing today and so eager to learn what your distinguished witnesses have to say.

Last April, Congressmen Robert C. "Bobby" Scott (D-VA), Cedric Richmond (D-LA), and I hosted a briefing on the use and abuse of solitary confinement. We learned several important things from our witnesses.

Most importantly, the over-use of solitary confinement is cruel and inhumane. The Angola 3 case provides a good example. Robert King was in solitary confinement from 1972 until his conviction was overturned in 2001. Herman Wallace turns 71 this year, and will begin his 40th year of 23-hour-per-day confinement. Albert Woodfox has been so confined for 37 years, and is 67 years old.

For more than three decades, these prisoners have remained alone in their respective cells measuring approximately 55 to 60 square feet for 23 hours of each day. Further, they do not enjoy privileges generally available to other prisoners, such as reading materials and visitation rights. As Magistrate Judge Docia Dalby observed in her 2007 decision regarding the prisoners' Eighth Amendment challenge to the conditions under which they have been incarcerated, "It is obvious that being housed in isolation in a tiny cell for 23 hours a day for over three decades results in serious deprivations of basic human needs."

Second, while there is no dispute that solitary confinement is a tool that prisons can employ correctly in limited circumstances, there must be both a screening process for the initial placement *and* review of an inmate's ongoing detention in solitary confinement.

But this review must be meaningful. In the case of the Angola 3, every 90 days, Mr. Wallace and Mr. Woodfox go before a review panel of two or three high ranking correctional officers. These officers must determine whether the conduct of these prisoners requires that they remain in closed cell confinement or whether they should be discharged to less confining circumstances.

For the past 40 years, the answer is always the same: they need to remain in closed cell confinement "due to the original offense" that placed them in closed cell confinement. All of their subsequent good behavior has no weight. Clearly, this type of review is not meaningful. What possible justification is there for keeping someone isolated in a cell 23 hours a day for four decades?

Finally, keeping people in isolation for decades can have devastating effects on an individual's mental and physical health, as well as on his or her ability to actually be rehabilitated. These inmates do not have access to drug treatment or other types of prison programs to help them prepare to integrate back into their communities.

Ultimately, well over 90% of prisoners held in solitary confinement will be released to the community. Forty-one percent are released directly from solitary confinement to the streets, after years of total isolation from human contact. We therefore must examine the mental and physical health implications of keeping a prisoner in solitary confinement.

The Angola 3 may very well be the most egregious example of the abusive use of solitary confinement. Nevertheless, there are countless others who are subjected to this cruel and inhumane type of incarceration throughout the country. I hope today's hearing will move forward the conversation about reforming prison policies regarding solitary confinement in a manner that is consistent with the humane treatment of all people.

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June 15, 2012

Senate Judiciary Committee
Subcommittee on the Constitution,
Civil Rights and Human Rights

Dear Chairman Durbin and Honorable Members of the Senate:

Thank you very much for holding the tremendously important and much needed hearing, "Reassessing Solitary Confinement: The Human Rights, Fiscal and Public Safety Consequences." The Correctional Association of New York is grateful to have the opportunity to provide the enclosed written testimony regarding solitary confinement practices, abuses, and reforms in New York State. If there is any additional information that you are interested in receiving from the Correctional Association, please contact me at 212-254-5700 or jbeck@correctionalassociation.org.

Thank you very much for your consideration.

Very truly yours,

Jack Beck
Director, Prison Visiting Project

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Testimony by The Correctional Association of New York Before the Senate Judiciary Committee's Subcommittee on the Constitution, Civil Rights and Human Rights Reassessing Solitary Confinement – June 19, 2012

The Correctional Association of New York (CA) would like to thank the Subcommittee for the opportunity to provide written testimony about New York State's use of solitary confinement, referred to in the state as special housing units (SHU), S-block, and keeplock.[1] Our testimony will document the extensive and expanding abuse of isolated confinement in New York prisons and its devastating impact, particularly on those suffering from mental illness. We will also offer New York as a model for beginning to address the isolation of persons with serious mental illness, while documenting the ongoing challenges and limitations of the New York experience.

Recent History of Advocacy on Solitary Confinement in NYS

The CA is an independent, non-profit organization that has legislative authority to investigate prison conditions in New York and report its findings and recommendations to the state legislature. The CA has long reported on the use and conditions of solitary confinement in New York and advocated for more humane alternatives. Over the last decade, the CA, along with many other advocates in New York, focused on some of the worst abuses imposed by solitary confinement – isolation of those suffering from serious mental illness. In reports published in 2003 and 2004,[2] based on visits to numerous disciplinary housing units in New York, the CA documented the terrible consequences for people with mental illness who are sent to the harsh isolation of the SHU. For example, the CA found people who smeared themselves with feces or lit their cells on fire and/or who were actively demonstrating severe psychological harm. The CA also found long SHU sentences of up to more than a decade, extremely high rates of suicide and self-harm, and people with overwhelming feelings of isolation and sensory deprivation resulting in depression and withdrawal even for those individuals who did not suffer from a mental illness prior to entering the SHU. Subsequent to those reports, based on visits to nine Office of Mental Health (OMH) level 1 or 2 maximum security prisons with SHUs between December 2004 and November 2008, the CA again documented the continued overuse and harmful effects of isolation for the seriously mentally ill. Those visited prisons contained 546 SHU cells and housed 515 individuals, nearly 50% of whom were on the OMH caseload. Several of those prisons had very high numbers of people in the SHU requiring psychiatric hospitalization or transfer to a Residential Crisis Treatment Program (RCTP) due to mental deterioration, such as at Auburn and

[1] SHU units are segregated cellblocks in most maximum- and some medium-security prisons, where individuals must spend 23 hours per day in their cell, are offered one hour per day of recreation, and have meals delivered to their cells. Keeplock refers to individuals confined for 23 hours a day either in their cells or in a separate cellblock. S-blocks are segregated freestanding high-tech lockdown units where individuals are double celled; New York State also has two facilities, Southport and Upstate, which constitute entire prisons made up of these high security lockdown units and eight additional S-blocks at other facilities. Because those individuals confined in double cells are held in isolation with a second person, in this testimony we will use the term "isolated confinement" in place of solitary confinement.

[2] Correctional Association, *Mental health in the House of Corrections*, June 2004 and *Lockdown New York*, Oct. 2003.

Elmira, where people in SHU were 20 to 30 times more likely to require psychiatric hospitalization than those in general population. Moreover, the CA documented the repeated cycling of people between the SHU and RCTPs or hospitalization, as well as the disproportionately high prevalence of suicide and self-harm amongst people with mental illness and/or confined in SHU or keeplock units.[3]

As a result of the intense focus on isolation of the seriously mentally ill by numerous advocates, and through a combination of litigation and legislation, New York implemented historic restrictions on solitary confinement for the seriously mentally ill. The SHU Exclusion Law[4] was passed by the New York State Legislature in January 2008 – expanding upon a 2007 litigation settlement in *Disabilities Advocates, Inc. v. NYS Office of Mental Health* – and took full effect in July 2011. The effect of the settlement and the law has begun to produce positive results for people suffering from serious mental illness. However, significant implementation challenges remain to ensure those protected by the law receive treatment and care. Also, the law does not cover large numbers of people with significant mental illnesses, and has not had any impact on stemming the extensive and expanding use of isolated confinement for the majority of people in NYS prisons. Isolation is routinely used, not primarily to address chronically violent behavior or serious security or safety concerns, but often in response to non-violent prison rule violations, or even as retaliation for questioning authority, talking back to an officer, or filing grievances. Moreover, people often accumulate SHU time while in disciplinary confinement, resulting in long-term isolation, sometimes lasting a decade or more.

New York's Extensive and Expansive Use of Isolated Confinement

Despite a substantial decline in the prison population since 2000, DOCCS continues to discipline an extraordinarily high number of individuals in its prisons, and many of these persons are placed in disciplinary confinement for extended periods of time under harsh conditions.

The DOCCS population reached its maximum of 71,538 in December 1999 and has dropped 23% to its January 2012 level of 55,073 individuals. During this time, the number of DOCCS facilities has been reduced from 70 to 60 institutions. Despite this impressive reduction in the prison population, there has not been a concomitant decline in the population in disciplinary confinement. In fact, the percentage of the population in the most severe isolation, the SHU, has increased during the past ten years. **Table 1 – Summary of DOCCS Population and SHU Confinement,** on page 3, illustrates this unfortunate trend. The most recent data represents a 46% increase in the percentage of the prison population in the SHU compared to the 2003-0 period. It should be noted that during the period 2003-05 there was a significant population in keeplock status in the prisons, generally in the range of 1,500 residents; but even with these figures added to the total, the percentage of individuals in disciplinary confinement during that period was still less than the percentage now in SHU. Further, keeplock is still used by DOCCS, and although we believe it is used less frequently than during 2003-05, we have documented a keeplock census that would appear to exceed 1,000 individuals. It should also be emphasized that keeplock can involve significant periods of isolation. During the 2003-06, annually there were more than 800 individuals sentenced to 90 days or more in keeplock.

[3] According to a DOCS' *Inmate Suicide Report, 1998-2007*, from 1998-2004, 34% of the suicides were in a SHU or disciplinary keeplock unit, and even the slightly decreased percentage of 18% for the period 2005-2007 represented a suicide rate more than twice the rate for the general population. Similarly, 57% of DOCS suicide victims were classified as OMH level 1, 2 or 3 patients at the time even though they represented only 15% of the prison population; and in 2007, just prior to the passage of the SHU Exclusion Law, 11% of the total self-harm unusual incident reports in NYS prisons and 39% of the suicide attempts occurred in a special housing unit.

[4] SHU Exclusion Law of 2008, 2008 N.Y. Laws 1 (codified as amended at N.Y. CORRECT. LAW §§ 137 & 401-a (McKinney 2012) and N.Y. MENTAL HYG. LAW § 45 (McKinney 2012)

Table 1 – Summary of DOCCS Population and SHU Confinement

Population	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Prison Pop	66,745	65,197	63,698	62,732	63,304	62,599	60,081	58,378	56,315	55,073
Total SHU Pop	3,450	3,500	3,500	n/a	4,500	4,504	4,329	4,273	4,331	4,308
SHU % of Pop	5.17%	5.37%	5.49%		7.11%	7.20%	7.21%	7.32%	7.69%	7.82%
S-Block Pop *			1,300	1,280	1,300	1,300	1,250	1,270	1,216	1,446

* Residents in S-Block units, each with capacity for 200 disciplinary prisoners, are included in the SHU census total.

The data presented in **Table 1** illustrates the unusually high rates of isolation employed by DOCCS. According to data presented by the Vera Institute, taken from a DOJ Bureau of Justice Statistics report about the prison population in the United States in 2005, 81,622 individuals were in some restrictive housing in federal and state prisons, representing 5.7% of the entire prison population in the country.[5] New York's 2012 figure is 37% higher than the national average and does not include individuals in keeplock, administrative segregation or some other form of restrictive housing.

The census in the SHU at any one time does not measure the full impact of disciplinary confinement on the NY prison population. Our project surveys incarcerated individuals during prison visits and of the 4,440 individuals who have responded to our survey, 21% stated that they had been in the SHU at the prison at which they were currently confined; at several facilities that figure rose to 28% to 38% of all survey respondents. Since most individuals have been at multiple prisons, this figure would be substantially higher if we asked whether they were ever in the SHU. The only conclusion to draw is that the SHU impacts a large portion of the prison population.

New York's disciplinary population is so high because DOCCS issues a large number of disciplinary actions against its population. Each year, approximately 150,000 violations of the prisons rules are prosecuted by DOCCS. Since approximately 95% of individuals charged with a prison violation are generally found guilty, most of these violations result in some form of punishment. SHU confinement is given for the more serious offenses. The vast majority of SHU sentences are 60 days or more, and in practice most SHU residents spend many months in isolation.

Our project has analyzed DOCCS data for all disciplinary dispositions for the period 2003 through August 2006. During these three and two-third years, each year12,200 SHU sentences were imposed, affecting a total of 22,525 individuals. Of these, approximately 4,500 individuals each year were given six months or more of SHU time, and annually more than 1,600 individuals were given a year or more in the SHU for a single violation. Although these numbers are disturbing, they do not fully present the true impact on these individuals. The 2003-06 data allowed us to link SHU sentences to specific individuals, revealing that a majority of individuals given lengthy SHU sentences were given multiple SHU sentences during this time period. Nearly 80% of people with a six month or more SHU sentence had at least one additional rules violation resulting in additional SHU time. Similarly, nearly 80% of those with a year or more SHU sentence had multiple SHU dispositions. Due to these multiple SHU sentences, many people spend many months and even years in the SHU.

During our prison visits we survey individuals in the SHU and ask about their total disciplinary sentence. Nearly one-quarter of the more than 500 survey respondents reported a cumulative SHU

[5] Browne, Cambier, & Agha, Prisons Within Prisons: The Use of Segregation in the United States. Federal Sentencing Reporter, Vol. 24, No. 1, Sentencing Within Sentencing (October 2011), pp. 46-49; Stephen, James, J, Census of State and Federal Adult Correctional Facilities, 2005 (Bureau of Justice Statistics, U.S. Department of Justice, October 2008).

sentence of one year or more. At certain maximum security prisons a majority of respondents were serving a year or more, and many indicated they were facing multiple years. This accumulation of additional SHU time is particularly prevalent for people already in disciplinary confinement. Although these individuals have very limited opportunity to leave their cell, we find very high numbers of SHU residents receiving additional disciplinary tickets. The SHU becomes a vicious cycle of: isolation, actual or perceived misconduct in the SHU, and additional discipline; many residents surrender to the proposition that they will never be able to leave the SHU until released from prison. Not surprisingly, the despair and anger that results from this hopeless cycle makes getting out of the SHU even more difficult.

General Impact of Isolation

People in the SHU and other forms of isolated confinement are not able to participate in any meaningful programs, jobs, or group interactions, are generally denied such basic "privileges" as making phone calls or purchases from commissary, are allowed a maximum of five books, letter writing supplies, and religious materials, receive food in their cells, and often receive increasingly harsh deprivation orders for rule violations, including restrictions on such basic amenities as food, showers, recreation, and haircuts.[6] The sensory deprivation, lack of normal interaction, and extreme idleness can cause intense suffering and severe psychological debilitation for any person subjected to it, and can have even more devastating impacts on those suffering from mental illness. Incarcerated women face additional special issues related to solitary confinement and its impact on emotional and physical health.[7] For example, isolation can have particularly damaging affects on survivors of domestic violence and abuse, which represents the overwhelming majority of incarcerated women. Extended isolation may trigger symptoms of Post Traumatic Stress Disorder (PTSD) such as flashbacks, self-destructive acts, emotional dissociation, difficulty sleeping, and irritable and aggressive behavior. In addition, isolation can have a devastating affect on women's sense of self-worth and ability to access needed supports, as women often place particular importance on sustaining relationships and community.[8] Moreover, isolation can compromise women's ability to fulfill their particular needs related to reproductive health care, for instance by impeding pregnant women's access to critical obstetrical services, preventing them from getting the regular exercise and movement vital for a healthy pregnancy. Similarly, women in isolation may be dissuaded from requesting care related to sensitive gynecological issues because they are required to inform correction officers about details of their medical problem, may have serious difficulty accessing appropriate medical staff when they do reach out, may be shackled during gynecological appointments that do occur, and will often interact with medical providers in full view of correction officers and/or receive superficial evaluations through closed cell doors.

Mental Health and Disciplinary Confinement in NYS – the SHU Exclusion Law

As noted above, people suffering mental illness face some of the most severe impacts of isolation, and the CA and other advocates have thus far focused their advocacy related to solitary confinement on improving conditions for that population. In part due to the closing of numerous psychiatric

[6] As a particularly harsh deprivation order, individuals are placed on a restricted diet where all meals consist of what is known as "the loaf," a dense, binding, tasteless, one pound loaf of mixed ingredients with a side of raw cabbage.
[7] Bedford Hills and Albion are the only two women's facilities with a SHU – Bedford's unit has 24 cells and Albion's has 48 – and all facilities except Beacon have a Keeplock area.
[8] Barbara Bloom, Barbara Owen, and Stephanie Covington, *Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders*, the National Institute of Corrections

hospitals across New York, and the limited availability of community based treatment options, the state has seen a significant rise in the number of individuals with a mental illness who are confined in correctional facilities. Over the past decade the number of individuals on the prison mental health caseload has soared, reaching a high of 9,067 patients in 2008, before dropping to 7,958 as of January 1, 2011. Individuals with a mental illness are often subjected to disciplinary sentences because of difficulty complying with strict prison rules, and isolation often exacerbates any mental illness, and leads to more behavioral issues and SHU time. The devastating effect of isolation on people with mental illness is particular pressing for incarcerated women as they suffer from mental illness at substantially higher rates than their male counterparts, with more than 42% of women in NY prisons having been diagnosed with a serious mental illness as of January 2007. The SHU Exclusion Law aims to limit some of the worst forms of abuse of isolated confinement for those with serious mental illness, and has made significant progress in improving conditions for these patients. Data, primarily provided by DOCCS and OMH,[9] indicates both that the law has already achieved substantial results and that serious challenges remain in its implementation.

Provisions of the SHU Exclusion Law

The SHU Exclusion Law requires that any individual who suffers from a serious mental illness and is sentenced to a period of disciplinary confinement that could exceed 30 days must be diverted from a SHU or separate keeplock unit to a Residential Mental Health Treatment Unit (RMHTU), except in "exceptional circumstances."[10] RMHTUs must be therapeutic in nature, jointly operated by DOCCS and OMH, and include all NYS Residential Mental Health Units (RMHU), Behavioral Health Units (BHU), Therapeutic Behavioral Units (TBU), Intermediate Care Programs (ICP), and the Intensive Intermediate Care Program (IICP).[11] The law requires that individuals in RMHTUs be offered at least four hours a day, five days a week, of structured out-of-cell therapeutic programming and/or mental health treatment.[12] The law also requires RMHTU residents to "receive property, services, and privileges" similar general population,[13] and places restrictions on discipline in RMHTUs, including prohibiting: restricted diets, misbehavior reports for refusing medication or treatment, and removal to disciplinary confinement absent a significant and unreasonable safety or security risk; as well as creating a presumption against disciplinary charges for acts or threats of self-harm.[14] In addition to the provisions related to diversion, the law requires all new DOCCS staff who will regularly work in programs providing mental health treatment to receive eight hours of training on such topics as types and symptoms of mental illness, treatment goals, suicide prevention, and effective and safe management of individuals with mental illness.[15] The law empowers the NYS Commission on Quality Care & Advocacy for Persons with Disabilities ("CQC") to monitor the quality of mental health care provided to incarcerated individuals, ensure compliance with the law, make

[9] Some of the data analyzed was provided by the Office of Mental Health's (OMH) Central New York Psychiatric Center (CNYPC), which operates a forensic psychiatric wing for patients in prison who require hospitalization. The data analyzed included annual summaries of the services provided both within DOCCS facilities by OMH staff and data about people in DOCCS prisons transferred to the inpatient unit at CNYPC for psychiatric hospitalization. We also reviewed OMH annual reports for specific mental health programs for the periods 2007 through 2011, where such data was available, and system-wide data provided by DOCCS concerning its prison population.

[10] *See* N.Y. CORRECT. LAW § 137.6(d)(i).

[11] N.Y. CORRECT. LAW § 2.21. If a diverted individual is placed in an RMHU or BHU, the time spent in those units will be credited toward any disciplinary sanction that has been imposed.

[12] N.Y. CORRECT. LAW § 2.21. The law carves out an exception to the four hour requirement for the 38 BHU unit beds currently at Great Meadow Correctional Facility, where only two hours of out of cell time are required.

[13] N.Y. CORRECT. LAW § 401.2(b).

[14] N.Y. CORRECT. LAW § 401.2(b), 3, 5(a)

[15] N.Y. CORRECT. LAW § 401.6.

recommendations related to the diversion and removal of individuals with serious mental illness from disciplinary confinement, and have an advisory committee composed of mental health experts, advocates, and family members of incarcerated individuals with serious mental illness.[16]

Positive Outcomes of the SHU Exclusion Law

Although implementation of the SHU Exclusion Law remains in its early stages and thus it is difficult to assess the law's effectiveness, positive outcomes have resulted from the preparation for and implementation of the law. Evidence suggests that a significant number of individuals with serious mental illness have been diverted from the SHU to RMHTUs. New York has expanded the number of treatment beds available for individuals with a serious mental illness sentenced to disciplinary housing, meaning more people receive increased mental health services, the opportunity for disciplinary time-cuts, and the use of non-punitive information reports in response to problematic behavior, instead of discipline that results in additional SHU time. As seen in **Table 2**, in the years leading up to full implementation of the law, and presumably in anticipation of its required implementation, the number of patients with serious mental illness housed in the SHU dropped significantly from 174 in 2007 to 47 in June of 2011, just prior to the law taking full effect. While the total number of people with serious mental illness in disciplinary units has remained fairly constant with a slight decline from 260 patients in 2007 to 241 in 2011,[17] the vast majority of these patients were in a disciplinary mental health treatment program as of June 2011, whereas in 2007, only 35% were receiving intense mental health services. Similarly, the percentage of the SHU population on the OMH caseload has dropped from under 19% to under 14%, indicating that although the total number of OMH patients in some form of disciplinary mental health housing has remained at nearly 800 patients or 18% of those units, a greater number are receiving more intense mental health services.

Table 2 – Disciplinary Confinement for DOCCS Patients with Mental Illness

Disciplinary Units	2003	2004	2005	2006	2007	2008	2009	2010	6/2011
Total SHU Pop	3,450	3,500	3,500	n/a	4,500	4,504	4,329	4,273	4,254
S-Block Pop *			1,300	1,280	1,300	1,300	1,250	1,270	1,216
SHU Patients on OMH caseload	849	798	753	711	660	644	606	561	579
"S" Designated SHU Patients**	n/a	n/a	n/a	n/a	174	166	125	104	47
BHU Patients †	n/a	n/a	76	83	96	90	62	60	78
RMHU Patients††	-	-	-	-	-	-	-	67	88
Total SHU, BHU, RMHU on OMH			829	794	756	734	668	688	792

* S-Block unit residents, each with capacity for to hold 200 people, are included in the SHU census total.
** The number of "S" designated patients in SHU includes patients in the STP and GTP but not the BHU or RMHU.
† BHU census data was obtained from DOCS population data from 7/2005, 9/2006, 6/2007, 9/2008, 6/2009 and 9/2010.
†† RMHU census figures were obtained from DOCCS 9/2010 population data.

[16] N.Y. CORRECT. LAW § 401-a(1), (2), (3).
[17] Prisoners with serious mental illness (SMI), or an "S" designation according to OMH, meet the criteria specified in the SHU Exclusion Law. We have computed this census by adding the patients in the BHU and RMHU to the SHU residents listed as "S" designated. In 2011, it appears STP patients were not included in the listing of "S" designated patients in the SHU, so we added that population of 28 prisoners to the group of SHU, BHU and RMHU patients.

In addition, all individuals with serious mental illness who were previously confined in Special Treatment Program (STP) units – where patients remained in the SHU and participated in two hour group sessions five days a week in caged therapeutic cubicles in which participants were physically separated from each other – were transferred to RMTHUs or non-punitive housing areas and therefore are receiving more treatment in a more therapeutic environment. As an indication of the positive impact, the percentage of patients discharged from the STP to the ICP rose significantly[18] at the same time that, because of the DAI litigation, the number of ICP beds and patients in the ICP both rose more than 35% from 2007 to 2010.[19] To the extent that more individuals have been transferred to the ICP as a result of the DAI litigation and the SHU Exclusion Law, patients receive much more intensive mental health services in a more therapeutic environment, as the vast majority of ICP patients receive 20 hours of therapy per week. Moreover, the feasibility of transitioning disciplinary patients with serious mental illness to non-punitive treatment programs is amply demonstrated by data from 2008 to 2010 whereby discharges from STPs to all non-punitive mental health programs were routine, remained stable at approximately 40%, and constituted the largest single disposition of patients leaving STPs. This increased number of such transfers is a marked change from a decade ago when few disciplinary prisoners left the SHU.

Significant Areas of Concern

1. <u>Individuals Not Protected by the Law and Under-Diagnosis</u>

Although the SHU Exclusion Law has resulted in substantially improved treatment and programs for people with serious mental illness, significant challenges remain. The law has not had an impact on the extensive and expanding use of disciplinary confinement for people in prison without serious mental illness. In addition, people in keeplock, where isolation can be just as devastating, are not afforded the law's protections unless placed in a SHU or separate keeplock unit. Even for those in SHU with some form of mental illness, including diagnoses many would consider serious, the law creates a hard line set by its definition of "serious mental illness," with those who fall above the line receiving intensive mental health treatment and those who fall below receiving little to none. Under the law an individual has a serious mental illness if: a) diagnosed with listed Axis I disorders;[20] b) actively suicidal or engaged in a serious suicide attempt; c) diagnosed with a mental condition, organic brain syndrome, or severe personality disorder with particular characteristics that leads to a significant functional impairment involving acts of self-harm or their equivalent; or d) determined to have substantially deteriorated in isolation to the point of experiencing impairments indicating serious mental illness and involving acts of self-harm or their equivalent. Those not assessed to be in these categories do not receive diversion, treatment, programs, or other protections of the law.

Moreover, the creation of a hard line inherently creates an incentive for OMH and DOCCS to classify people below the line. Diagnoses data over the last few years raises concerns about potential under-diagnosis. For instance, as noted above, the number of patients on the OMH caseload precipitously

[18] The percentage discharged from STPs to ICPs rose from 17.5% in 2008 to 31.5% in 2010; those discharged from STPs to CNYPC dropped from 20.6% in 2008 to 14.3% in 2009 to 8.5% in 2010.
[19] The number of ICP beds increased from 551 in 2007 to 743 in 2010, and the number of patients in the ICP increased from 527 in 2007 to 715 in 2010.
[20] The Axis I diagnoses include: schizophrenia, delusional disorder, schizophreniform disorder, schizoaffective disorder, brief psychotic disorder, substance induced psychotic disorder other than intoxication or withdrawal, psychotic disorder NOS, major depressive disorders, and bipolar disorder I and II.

dropped between 2008 and 2011. While the overall number of individuals incarcerated in New York has also decreased by 6.3% from 2008 to 2011, the number of patients on the OMH caseload has dropped by 12.2%, almost double the decline in the total prison population. More directly related to the SHU Exclusion Law, between 2007 and 2011 the percentage of patients with a primary diagnosis of schizophrenia or another psychotic disorder has significantly decreased while those diagnosed with an anxiety, personality or adjustment disorder has increased.[21] Given that, as discussed above, patients diagnosed with a psychotic disorder automatically qualify for the most intensive mental health services, while those with non-psychotic disorders will only qualify if significant additional criteria are met, and therefore may not receive any protections under the law, this substantial change in diagnoses raises serious concerns about the possibility of under-diagnosis.

2. Punitive Rather than Therapeutic Environment

Serious concerns also remain about the degree to which RMHTUs provide a therapeutic, rather than punitive, environment. Although people with serious mental illness in these units are required under the law to receive two or four hours per day in a therapeutic environment, patients spend the rest of their time in the harsh punitive environment of a disciplinary confinement unit. Prolonged isolation, even in units that provide some mental health services, can have devastating effects, which, for instance, often manifest in incidents of self-harm. Moreover, many individuals with serious mental illness in these units continue to receive large numbers of disciplinary tickets. Recent visits by the CA to the Great Meadow and Attica Correctional Facilities[22] provide examples of the difficult challenges that remain for people in disciplinary units with a mental illness. Attica and Great Meadow are both maximum-security facilities that confine a total of over 3,700 individuals, have SHU and keeplock cells, and subject 350 individuals to some form of isolation. Both facilities have a significant portion of their population on the OMH caseload,[23] are OMH Level-1 facilities,[24] and operate special disciplinary housing units for people suffering from mental illness with a long-term disciplinary sentence.

Great Meadow's BHU[25] exemplifies the tension between RMHTUs as treatment programs and disciplinary units. A distressingly high number of BHU patients reported that it was common for security staff to physically assault patients. One individual shared that before a particular group therapy session began, he was expressing his concerns about security staff to his fellow patients, when a mental health staff person walked in, heard him and immediately reported it to security staff, who promptly removed him from therapy and physically assaulted him on the way back to this cell.

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[21] Between 2007 and 2011, the percentage of patients diagnosed with schizophrenia or psychosis dropped from 21.4% to 17.8%, representing a decline of 16.8%. In contrast, there was an increase in the diagnosis of personality disorders, from 7.2% to 10.1% from 2007 to 2011, a 40% increase. Similarly, there has been a significant increase in the diagnosis of adjustment disorder, rising from 6.6% in 2007 to 11.6% in 2011, representing a 76% increase. Patients diagnosed with anxiety disorders also rose from 9.8% to 10.5% during this four-year period.

[22] PVP visited Attica Correctional Facility in April of 2011 and visited Great Meadow Correctional Facility in 2009 and, due to serious concerns, returned to Great Meadow again in 2010 and 2011.

[23] At Attica, staff estimated that 21% of the entire population was on the OMH caseload; at Great Meadow 24% of the entire population was on the OMH caseload. The number of patients requiring mental health treatment at these facilities is significantly higher than the estimated 14% of prisoners system-wide who require mental health treatment.

[24] OMH designates facilities from Level 1 to Level 6 according to the availability of mental health staff and the treatment provided. Level 6 facilities have no mental health staff and Level 1 have full-time staff and provided the most intensive services.

[25] The BHU operates in three phases, Phase I, which operates at Great Meadow, is the most restrictive, but provides two hours of out-of-cell therapy and incentives to increase positive behavior; Phase II and III, which operate at Sullivan Correctional Facility provide more freedoms, with additional out-of-cell time and decreased physical constrictions.

Similarly, individuals reported that when they expressed concerns regarding self-harm or suicide, they were met with hostility and physical threats. One person reported that when he told security staff he was feeling suicidal and wanted to see mental health staff, the security staff person responded "Just hang up if you want. It would make it easier for us." Moreover, at both the Great Meadow and Sullivan Correctional Facility BHUs, the vast majority of residents continue to receive disciplinary sanctions, and the practice not only persists, but has increased according to the last two years of available data.[26] This frequent use of discipline seriously undermines the therapeutic nature of the units and the ability of patients to progress to less restrictive mental health housing. Similarly, many patients in BHUs are being transferred to another program with significant SHU or keeplock time remaining, which they will be required to serve. According to data from 2010, the average amount of SHU time and keeplock time remaining for individuals released from the BHU were both over one year. In a related manner, the time-cuts individuals should be receiving are insignificant in terms of their disciplinary sentence. The average amount of time cut for people in the BHU was 78 days, which is relatively small for individuals who may be serving years.

Attica's STP, initially established as a disciplinary unit for people with serious mental illness but now no longer recognized as an RMHTU under the SHU Exclusion Law,[27] similarly demonstrates the difficult challenges facing individuals with serious mental illness confined in disciplinary units. Attica STP patients reported long SHU sentences with a median of three years and some reported sentences of up to 10 years. In addition, many of the individuals had been in other residential treatment programs across the state and had received additional SHU time while on those units. Further, although individuals were offered two hours of out-of-cell therapy everyday, a significant percentage of those in the STP refused to participate. As a further indication of the negative psychological impact of prolonged confinement in the harsh environment of the STP, the number of individuals in all STP units across the state requiring psychiatric hospitalization represents a disproportionately large portion of the total admissions to CNYPC,[28] with a rate roughly three times higher than for non-punitive mental health treatment program patients. Also, as in the BHUs, the majority of STP patients continued to receive disciplinary tickets, and were discharged with significant SHU or keeplock time, with less than half of those on the unit receiving a time-cut while in the STP. In 2010, CNYPC reported that 98% of patients discharged from the STP had received a serious disciplinary sanction while on the unit, only 45.5% had received a time-cut, and the average amount of SHU time remaining was just under one year. This data illustrates the continued use of discipline on the unit, the failure of the time cut process to significantly reduce SHU sentences, and a pattern of STP patients leaving the program with substantial time to serve in restricted housing.

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[26] Sixty-one percent of BHU patients with serious mental illness released in 2009 received a serious disciplinary ticket (Tier 3 misbehavior reports), and that figure increased to 71% in 2010.

[27] The Special Treatment Program for disciplinary prisoners with serious mental illnesses was opened at Attica C.F. in 2000 as a treatment program for disciplined people confined to SHU. STP units were subsequently created in the SHUs at Five Points C.F. and Green Haven C.F. The SHU Exclusion Law does not recognize these units as RMHTUs and, therefore, as of July 1, 2011, disciplined persons with serious mental illness could no longer be housed there. Although these units are no longer operational, data analyzing the census and treatment of STP patients is relevant to understand the challenges faced by individuals with serious mental illness in disciplinary units with mental health services, particularly since the STPs at Attica and Five Points were converted into RMHUs. Moreover, although in preparation for full implementation of the SHU Exclusion Law DOCCS began to phase out use of the STP, in 2008 through 2010 there was a substantial increase in STP admissions mostly from the SHU and other disciplinary residential mental health treatment units, demonstrating the continuing need for residential mental health treatment for disciplinary patients.

[28] In CY 2010, STP patients accounted for nearly 5% of all CNYPC admissions even though the STP population is only 1.25% of the patients on the OMH caseload.

Although the SHU Exclusion Law strives to reduce the number of individuals with a mental illness placed in disciplinary confinement, lessen the time served, and limit the use punishment, as demonstrated by data on the BHU and the STP, the practice of continuing to punish and isolate those individuals with a mental illness persists in units across New York State.

3. Suicide and Self-Harm

Self-harm and suicides are perhaps the most devastating manifestation of continued challenges for people with mental illness in isolated confinement. NYS prisons have a comparatively large number of suicides, with a disproportionate number occurring in isolation. The most recent national data for 2001-2004 demonstrates that New York's average annual suicide rate over the past 12 years of 19.7 incidents per 100,000 people in prison is 30% higher than the national average of 15 suicides per 100,000.[29] In 2010, New York's suicide rate of 35 per 100,000 was more than double the national average, and was the highest rate for the past 28 years.[30] Equally disturbing, far too many of the individuals committing suicide are confined in the SHU or keeplock and/or suffer from mental illness. Between 1998 and April 2004, 34% of prison suicides occurred in disciplinary confinement, although prisoners in these units comprised less than 7% of the total prison population.[31] That rate only slightly declined, to 29%, for the period 1998 to 2009.[32] In 2010, although the percentage of suicides in disciplinary confinement dropped to 10%, there is still a concern that many of the individuals who committed suicide had been recently transferred from disciplinary housing.

Suicides can not be viewed in isolation, as they are the devastating final product of often multiple attempts of suicide or acts of self-harm. By analyzing Unusual Incident Reports (UIR) data for 2007-2010,[33] we found a disturbing pattern of destructive behavior indicating that suicides often occurred at facilities that have the highest rates of self-harm. The data also revealed that facilities with the highest incidence of self-harm are facilities with a high percentage of mentally ill patients and large disciplinary housing units, including the two facilities that only confine individuals with long-term disciplinary sentences. Moreover, the rates of self-harm and suicide attempts at the most problematic facilities are five to 10 times higher than the department-wide average.

Conclusion

New York State has begun to make significant progress in addressing the devastating impacts of isolation on people with serious mental illness, and the SHU Exclusion Law can serve as a model for other states still subjecting such patients to solitary confinement. At the same time, any reliance on the New York system must take into account the limitations of the law, the challenges faced in implementation, and the gaps in coverage even for significant numbers of people with debilitating mental illnesses. Moreover, the New York experience demonstrates that providing protections for a particularly vulnerable population is only an initial step in addressing the abhorrent infliction of isolation, with the state remaining one of the worst examples in terms of the frequency and duration of the imposition of disciplinary confinement.

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[29] BJS,US DOJ, *Medical Causes of Death in State Prisons*, at Appendix Table 1, p. 5 (2007).
[30] Pfeiffer, M., *Prison Suicides Rise; Officials Deny Trend*, Poughkeepsie Journal, 12/26/2010 (available at http://www.nyaprs.org/e-news-bulletins/2011/2011-01-04-PJ-Prison-Suicides-Rise-Officials-Deny-Trend.cfm). Mary Beth Pfeiffer is an independent reporter who has been investigating suicides in DOCCS for several years.
[31] Correction Association, *Mental Health in the House of Corrections* at 57 (2004).
[32] Pfeiffer, *supra* note 29.
[33] In New York State, UIRs must be completed after every incident of suicide and self-harm.

VANDERBILT UNIVERSITY

June 9, 2012

Senator Durbin and Honorable Members of the Senate:

I have studied indefinite solitary and supermax confinement since 1996 when I began writing about the Arizona state prison system. My last book, *The Law is a White Dog: How Legal Rituals Make and Unmake Persons* (Princeton, 2011), deals with the suffering of prisoners and the questions of cruel and unusual punishment and due process in such "special management" or "special housing" units (http://press.princeton.edu/titles/9450.html). Relevant recent articles of mine deal with the legal evasion of obvious Eighth Amendment violations (http://bostonreview.net/BR29.5/dayan.php) and the remarkable curtailing of the First Amendment in a case about a Pennsylvania super-max unit (http://bostonreview.net/BR32.6/dayan.php).

Last summer, in June 2011, when the more than 2,000 prisoners in California—some of whom had been in solitary confinement for over 20 years without hope of redress—went on hunger strike, I wrote an op-ed for the NY Times, called "Barbarous Confinement" (http://www.nytimes.com/2011/07/18/opinion/18dayan.html). As I have argued over the years, no matter what claims we make of humane treatment and evolving standards of decency, we are guilty as a nation of the most horrific treatment of prisoners in the civilized world.

Supermax detention is the harshest weapon in the American punitive armory. The severe sensory deprivations of the supermax have been repeatedly condemned since the 1980s by the

United Nations Committee Against Torture, Human Rights Watch, Amnesty International, the American Civil Liberties Union, and the Center for Constitutional Rights. The UN Convention Against Torture (May 2006) and the UN Human Rights Committee (July 2006) documented in detail the torturous psychological effects of this practice. In 2006, as one of its primary recommendations, the bipartisan US Commission on Safety and Abuse in Prisons called for substantial reforms to the practice of solitary confinement. Segregation from the general prison population, it said, should be "a last resort."

As I write, 400 prisoners in California's Security Housing Units, as well as a number of prisoners' rights organizations, have petitioned the UN asking for help. The Center for Constitutional Rights (CCR) has filed a federal lawsuit on behalf of prisoners at Pelican Bay State Prison who have each spent between 10 and 28 years in solitary confinement. Another class action suit in Arizona now challenges inadequate medical and mental care, as well as prolonged solitary confinement.

Once, solitary confinement affected few prisoners for relatively short periods of time. Today, most prisoners can expect to face solitary, for longer periods than before, and under conditions that make old-time solitary seem almost attractive. The contemporary state-of-the-art supermax is a clean, well-lighted place. There is no decay or dirt. And there is often no way out. Prisons in the United States have always contained harsh solitary punishment cells where prisoners are sent for breaking rules. But what distinguishes the new generation of supermaxes are the increasingly long time prisoners spend in them, their use as a management tool rather than just for disciplinary purposes, and their sophisticated technology for enforcing isolation and control.

This is not the "hole" portrayed in movies like *Murder in the First* or *The Shawshank Rdemption.* Under the sign of professionalism and advanced technology, extreme isolation and sensory deprivation constitute the "treatment" in these units. As early as 1995, a federal judge, Thelton E. Henderson, writing about the Special Housing Unit in Pelican Bay, California, conceded that "supermax" confinement "may well hover on the edge of what is humanly tolerable." It is now over that edge. Supermaxes more generally substantially modify inmates' spatial and temporal framework, severely damaging their sense of themselves: a terrible violence against the spirit and a betrayal of our constitutional and moral responsibility to ourselves as a nation and as human beings.

How much can you take away from a prisoner without running afoul of the law? Solitary confinement has now been transmuted from an occasional tool of discipline into a widespread form of preventive detention. Over the last two decades, the Supreme Court has whittled steadily away at the rights of inmates, surrendering to prison administrators virtually all control over what is done to those held in "secure segregation." Since this is not defined as punishment for a crime, it does not fall under "cruel and unusual punishment," the reasoning goes.

Officials claim that those incarcerated in these 23-hour lockdown units are "the worst of the worst." But it is often the most vulnerable, especially the mentally ill, not the most violent, who end up in indefinite isolation. Those who are not mentally ill going in can hardly avoid being mentally destroyed once there. Placement is haphazard and arbitrary; it focuses on those perceived as troublemakers or simply disliked by correctional officers and, most of all, alleged gang members. Often, the decisions are not based on evidence. And before the inmates are

released from isolation into normal prison conditions, they are expected to "debrief," or spill the beans on other gang members.

But how can a prisoner debrief if he is not a gang member? Those in isolation can get out by naming names, but if they do so they will likely be killed when returned to a normal facility. To "debrief" is to be targeted for death by gang members, so the prisoners are moved to "protective custody"—that is, another form of solitary confinement.

More seriously still, though, many of these prisoners have been sent to virtually total isolation and enforced idleness for no crime, not even for alleged infractions of prison regulations. Their isolation, which can last for decades, is often not explicitly disciplinary and therefore not subject to court oversight. Their treatment is merely a matter of administrative convenience.

In the summer of 1996, I visited two "special management units" at the Arizona State Prison Complex in Florence, Arizona. Escorted by deputy wardens, I completed a series of interviews in an attempt to understand this new version of solitary confinement. There, prisoners are locked alone in their cells for twenty-three hours a day. They eat alone. Their food is delivered through a food slot in the door of their eighty square foot cell. They stare at the unpainted concrete, the windowless walls onto which nothing can be put. They look through doors of perforated steel, what one officer described to me as "irregular-shaped swiss cheese." Except for the occasional touch of a guard's hand as they are handcuffed and chained when they leave their cells, they have no contact with another human being.

In this condition of enforced idleness, prisoners are not eligible for vocational programs. They have no educational opportunities, and books and newspapers are severely limited, post and

telephone communication virtually non-existent. Locked in their cells for as many as 161 of the 168 hours in a week, they spend most of the brief time out of their cells in shackles, with perhaps as much as eight minutes to shower. An empty exercise room (twelve feet by twenty feet)—a high-walled cage with a mesh screening overhead, also known as the "dog pen"--is available for "recreation." As an inmate later wrote me, "People go crazy here in lockdown. People who weren't violent become violent and do strange things. This is a city within a city, another world inside of a larger one where people could care less about what goes on in here. This is an alternate world of hate, pain, and mistreatment."

Special Management Unit 1 in Arizona was surpassed by Special Management Unit 2 (SMU 2), completed in 1996. A 768-bed unit, it cost taxpayers $40 million. Given the cost of building supermaxes, one official in Arizona suggested: 'Why don't we just freeze-dry 'em?' In a Special Security Unit there, another officer showed me a sign set above photos of prisoners who had mutilated themselves – row after row of slit wrists, first-degree burns, punctured faces, bodies smeared with faeces, eyes pouring blood. It read: 'Idle Minds Make for Busy Hands.'

Situated on forty acres of desert, SMU 2 is surrounded by two rings of twenty-foot-high fence topped with razor wire, like a nuclear waste storage facility. During my visits there, I learned that those who have *not* violated prison rules—often jailhouse lawyers or political activists—find themselves placed apart from other prisoners, sometimes for what is claimed their own protection, sometimes for what is alleged to be the administrative convenience of prison officials, sometimes for baseless, unproven, and generally unprovable, claims of gang membership.

In choosing to focus on supermax confinement as a punishment worse than death, my argument is against the tendency in our courts and in our prisons to reduce constitutional claims to the most basic terms: bodies emptied of minds, destruction of will, removal of responsibility, and of everything that defines persons as social beings. Designed for basic needs and nothing more, the structure of supermaxes dramatizes the minimal requirements of the courts. Awash in natural light, everything in these units—what can be seen and how, its location and design—coerces in the most unremitting and damaging way possible. These are locales for perpetual incapacitation, where obligations to society, the duties of husband, father, or lover are no longer recognized.

We are proud of our history as citizens of the United States. We are a nation of laws. But what kind of laws? Laws that permit solitary confinement, with cell doors, unit doors, and shower doors operated remotely from a control center, with severely limited and often abusive physical contact. Inmates have described life in the massive, windowless supermax prison as akin to "living in a tomb," "circling in space," or "being freeze-dried." Has the current attention to the death penalty allowed us to forget the gradual destruction of mind and loss of personal dignity in solitary confinement, including such symptoms as hallucinations, paranoia, and delusions? It is to the mind-destroying settings of the supermax penitentiary that I draw your attention, to the "cruel, inhuman, and degrading" treatment that most often bears no relation to crime. I recall the words of former Supreme Court Justice Sandra Day O'Connor warning that prisoners' rights must be considered: "Prison walls do not form a barrier separating prison inmates from the protections of the Constitution." Justice William Douglas put it more starkly: "Prisoners are still 'persons'."

Two centuries ago, Jeremy Bentham came to believe that solitude was "torture in effect." Other nineteenth-century observers, including Charles Dickens and Alexis de Tocqueville, used images of premature burial, the tomb and the shroud to represent the death-in-life of solitary confinement. There are now some 25,000 inmates in long-term isolation in America's supermax prisons and as many as 80,000 more in solitary confinement in other facilities.

We need to ask not only why this torture continues, but how it has been normalized for an ever-larger group of prisoners.

Sincerely,

Colin Dayan
Robert Penn Warren Professor in the Humanities, Vanderbilt University
Member, American Academy of Arts and Sciences

ELLA BAKER
CENTER
HUMAN RIGHTS

She led. So can you.

Statement of Sumayyah Waheed, Esq., Director and Jennifer Kim, Esq., Senior Policy Analyst
Ella Baker Center for Human Rights, Books Not Bars Campaign
On
Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences
Hearing Before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights

June 19, 2012
Washington, D.C.

1970 Broadway, Suite 450, Oakland, CA 94612 **ph**: 510.428.3939 **fax**: 510.428.3940 ellabakercenter.org

On behalf of the Ella Baker Center for Human Rights, we thank Chairman Durbin, Ranking Member Graham and Members of the Committee for holding this historic hearing on solitary confinement in the United States. The Ella Baker Center is based in Oakland, California and organizes people-powered campaigns to transform the state. Through its Books Not Bars campaign, the Ella Baker Center has pursued juvenile justice reforms in California since 2001. Since 2004, Books Not Bars has organized the largest network of families of incarcerated youth to champion alternatives to California's abusive, expensive youth prison system, the Division of Juvenile Justice ("DJJ"). Our advocacy involves sharing the experiences of those directly impacted by the juvenile justice system, crafting and passing cutting-edge policies, and sharing research to support systems reform. We have achieved numerous reforms over the years to benefit incarcerated youth and families impacted by prisons.

We welcome the opportunity presented by this hearing to address the rampant use of solitary confinement on incarcerated youth. As damaging as solitary confinement is to adult prisoners, the damage to young people, whose mental development has not fully matured, is even more severe. Congress has the opportunity to provide leadership to jurisdictions to eliminate this harmful practice, and we provide recommendations for it to do so.

Just this year, Books Not Bars sponsored California's first legislation to reduce the use of solitary confinement for youth.[1] Solitary confinement was a central complaint from families in 2004, which in part led to our campaign against DJJ. Then known as the California Youth Authority, DJJ consistently subjected youth to "23-and-1 lockdown," in which youth are allowed out of their cells for only one hour per day, if at all.[2] Following minimal improvement whereby youth received a still unacceptable three hours out of their cells per day, complaints from families resurged in late 2010 of 23- to 24-hour lockdown. The Ella Baker Center rallied against the practice throughout 2011, leading to an audit of confinement practices and a protest by families, youth, and other supporters at the notorious Ventura Youth Correctional Facility in Camarillo, California.[3] Our advocacy culminated in this year's bill, which is discussed further below.

Narratives of Youth and Family Members

The following accounts from the Books Not Bars membership illustrate the impact of solitary confinement on youth and families.

Maria Sanchez

Maria Sanchez is a mother from Santa Clarita, California. Her son, Jesse, was beaten by guards and

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[1] http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120SB1363&search_keywords=

[2] Krisberg. Barry. General Corrections Review of the California Youth Authority. December 23, 2003. See http://www.prisonlaw.com/pdfs/CYA5.pdf; California, Office of the Inspector General. December 2000. 23 and 1 Program Review. Available at http://www.oig.ca.gov/media/reports/BOA/reviews/23%20and%201%20Program.%20California%20Youth%20Authority%20Facilities.%20Review.pdf

[3] Hoops, Stephanie and Scheibe, John. August 21, 2011. Group protests at Ventura Youth Correctional Facility. Available at http://www.vcstar.com/news/2011/aug/21/group-protests-at-ventura-youth-correctional/.

spent over five months in solitary confinement at the Ventura Youth Correctional Facility. When Maria visited her son, she observed bruises on his face and lesions from repeated pepper spraying. His nose was broken and he needed surgery on his knee, which was not performed due to his heart condition. As he spent months in solitary, Maria witnessed that her son slowly became a shadow of himself.

Jesse could barely hold a conversation with his mother because he was accustomed to staring at concrete walls all day. His speech slowed and in conversation he appeared distant. He received no education or programming. He wasn't even allowed to attend church.

Before Jesse was incarcerated, he was healthy. But 21-hour and sometimes over 23-hour-a-day isolation made him physically deteriorate. When she hugged him, Maria could feel his bones. He suffered from blackouts in his room. To this day, he has not received knee surgery.

Jesse occasionally commented that he'd be better off in adult prison. Earlier this year, his wish was granted: he was transferred to a California adult prison for charges he incurred while at DJJ. Maria now wonders if her son can ever heal from the trauma of juvenile lockup.

David Roldan, Jr.

According to his mother, David Roldan, Jr. was not prepared for what she terms "the gladiator school called DJJ." On his first day, he was beaten by other youth. He witnessed guards assaulting and pepper-spraying youth on a daily basis.

Before entering DJJ, David, Jr. had never presented serious mental health issues. Now he is suicidal: he has attempted to hang himself with a bed sheet, stabbed himself with a fork, and slit his wrist with a razor. He also broke a TV and used the wires to choke himself. In two years, he has attempted suicide six times. Every time David, Jr. attempted suicide, guards stripped him and put him in a small, dirty solitary cell for 21 to 24 hours a day.

After experiencing solitary confinement, violence, and humiliation by guards, David, Jr. suffers from severe depression and hallucinations. David, Jr. was recently transferred from DJJ to a juvenile hall in Los Angeles County. But he is still subject to solitary confinement whenever he is involved in a fight.

Lino Silva

Lino Silva wrote these statements from prison on February 14, 2012:

> My name is Lino Silva #90841. I am 23 years of age. I have been incarcerated within the Division of Juvenile Justice for 7 years and 3 months. I am currently detained in what has been determined by my own experiences as the most notorious, non-transparent youth facility in the state, the "Ventura Youth Correctional Facility." I have been here now for exactly two years, all of which, except for 9 weeks, have been on a Behavior Treatment Program (BTP) unit. These units, better known as "Lock Up" or "The Back" are where the majority of confinement infractions occur. Violations of policy on these units authorized by staff ranging up to the

Superintendent of the facility are well considered the norm on BTP. Refusing wards a decontamination shower, regular shower, education, proper linen, religious services, are all among the many violations. Group punishment, restricting family visits, or the ability to purchase food are constantly used as forms of punishment.

Most recently, on February 1st, 2012, after an isolated incident involving one youth on the unit, the youth allegedly assaulted a staff. Immediately, the youth was moved to another unit. After the incident, based on false pretenses of safety and security, the entire unit (who were locked in their cells during the incident) were put on "lock down" until further notice. I did not receive a shower on this day and was confined to my room for over 38 hours even though I did not have anything to do with any incident, nor did I pose a threat to staff or wards.

Different forms of group punishment, staff decisions clearly based on retaliation, and the manipulative call to uphold safety and security are constant here. And after all that occurred is the fact that not one staff attempted to ask why the youth would assault a staff, instead focusing solely on punishment.

It has become common belief among the wards that adult prison offers a greater chance at going home sooner and certainly offers the chance at escaping such an unbearable situation we have come to find as life in Ventura Youth Prison. I may have the opportunity to be released later this year. I do not advocate for staff assaults or any action that can further incriminate us or potentially prolong our incarceration.

Being in a room over 21 hours a day is like a waking nightmare, like you want to scream but you can't. You want to stretch your legs, walk for more than a few feet. You feel trapped. Life becomes distorted. You shower, eat, sleep, and defecate in the same tiny room. In the same small sink, you "shower," quench your thirst, wash your hands after using the toilet, and warm your cold dinner in a bag. I developed techniques to survive. I keep a piece of humanity inside myself that can't be taken away by the guards. I've learned to play chess with other youth through a six-inch wall to keep myself occupied. But for others, it breaks them, makes them either violent or suicidal. There's no second chance here. We are being institutionalized so that we can't function anywhere other than adult prison.

Dangers of Solitary Confinement

Solitary confinement is not an evidence-based practice that promotes rehabilitation or therapeutic goals; it is a method to control a correctional environment.[4] California has used solitary confinement in its adult Security Housing Units ("SHU") for over 25 years on the premise that it will create a safer environment by reducing gang activity. Yet, California has one of the largest and most dangerous prison systems entrenched with gang culture.

[4] Finke, Linda M., RN, PhD, "Use of Seclusion is not Evidence-Based Practice," Journal of Child and Adolescent Psychiatric Nursing, Oct.-Dec. 2001, available at http://www.findarticles.com/p/articles/mi_qa3892/is_200110/ai_n8993463/print.

Solitary confinement not only exacerbates safety concerns within the prions, it endangers communities when prisoners are released. In a report released by the California Department of Corrections and Rehabilitation in 2011, prisoners who had spent time in isolation in the Security Housing Units had a higher rate of recidivism than those who had not.[5] Solitary confinement debilitates prisoners and severely undermines their ability to transition safely upon their release.

Similarly, solitary confinement does not properly address youth disciplinary issues and more often, it increases these behaviors in youth, especially those with mental conditions.[6] Research has shown the traumatic toll and mental health breakdown that solitary confinement causes in healthy adult prisoners with no mental illness history. Youth who are still in their development stages, who are emotionally and mentally immature, are at an even greater risk of permanent damage caused by isolation. Youth adolescence extends well into the twenties, when youth find themselves caught somewhere between immaturity and accountability.[7] Subjecting them to conditions that interrupt and hinder their healthy development will have a lasting impact well into their adulthood.

Solitary confinement causes psychological trauma and psychopathological symptoms including anxiety, nervousness, headaches, troubled sleep, lethargy, heart palpitations, chronic depressions, violent fantasies, hallucinations and perceptual distortions, social withdrawal, acute agitated psychosis, and random acts of violence.[8] In addition to these dangers, the impact of solitary confinement can result in irreversible consequences. In 1999, the Office of Juvenile Justice and Delinquency Prevention ("OJJDP") released a study on juvenile facilities across the country that found 50% of youth who committed suicide were in solitary confinement at the time of their suicide.[9] Further, over 60% of the suicide victims had a history of isolation.[10]

International Standards

The United States has consistently fallen behind international norms regarding best practices for detained youth. We have six times more youth in secure custody than any other comparable nation.[11] We sentence youth to life without the possibility of parole. And we lock up our youth in cells for 23 hours per day.

While other countries' juvenile justice systems focus on treating the root causes of delinquency, our system focuses on punishment. In 1990, the United Nations ("UN") Guidelines for the Prevention

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[5] California Department of Corrections and Rehabilitation. 2011 Adult Institutions Outcome Evaluation Report. November 2011. http://www.cdcr.ca.gov/Adult_Research_Branch/Research_Documents/ARB_FY_0607_Recidivism_Report_(11-23-11).pdf

[6] Remarks of Steven H. Rosenbaum, Chief, Special Litigation Section, before the Fourteenth Annual National Juvenile Corrections and Detention Forum, May 16, 1999, available at http://www.usdoj.gov/crt/split/documents/juvspeech.htm.

[7] Coalition for Juvenile Justice. Emerging Concepts Brief: What are the Implications of Adolescent Brain Development for Juvenile Justice? 2006. Available at http://www.juvjustice.org/media/resources/public/resource_134.pdf; see also http://www.act4ji.org/media/factsheets/factsheet_12.pdf

[8] Comments by Dr. Stuart Grassian, Dr. Craig Haney, and Dr. Terry Kupers to the April 2, 2012 Hearing of the Illinois Legislature Commission on Government Forecasting and Accountability regarding the proposal to close Tamms Correctional Center.

[9] Hayes, Lindsay M., "Juvenile Suicide in Confinement: A National Survey," National Center on Institutions and Alternatives, February 2004.

[10] Id.

[11] Justice Policy Institute. Finding Direction: Expanding Criminal Justice Options by Considering Policies of Other Nations. April 2011. Available at http://www.justicepolicy.org/uploads/justicepolicy/documents/juvenile_justice.pdf

of Juvenile Delinquency ("The Riyadh Guidelines") prohibited the use of solitary confinement or any other form of punishment that may compromise the physical or mental health of youth. Within the last year, UN Special Rapporteur on torture, Juan E. Mendez, called for an absolute prohibition of solitary confinement against youth and the mentally ill. In his testimony, he stated, "Considering the severe mental pain or suffering solitary confinement may cause, it can amount to torture or cruel, inhuman or degrading treatment or punishment when used as a punishment..."[12]

National Trends

Although solitary confinement has been widely condemned as torture, it is used in almost every correctional environment in the United States. While the number of prisoners in solitary confinement is not officially tracked, it is widely estimated that more than 80,000 individuals are in solitary confinement in the United States.[13] This number fails to account for the youth who are also subjected to solitary confinement.

Youth who are incarcerated in county, regional and state-run facilities are vulnerable to this dangerous practice. The United States is home to over 100,000 such facilities, over 1/3 of the youth are in solitary confinement.[14] In addition, more than 7,500 youth are held in adult lockup facilities on any given day in the United States.[15] In adult facilities, youth are typically held in isolation cells apart from the adult population as a "solution" to laws forbidding jurisdictions from mixing minors with adults.

Nevertheless, some progress is being made. Several states, including Connecticut, Arizona, Maine, Oklahoma, West Virginia, Missouri, and Alaska, prohibit the use of isolation for youth as punishment. Last year, a federal civil rights lawsuit was filed in New Jersey by mentally ill youth placed in solitary confinement. This year, a lawsuit in Mississippi resulted in a consent decree that would prohibit the use of solitary confinement on youth.

On the adult side, Colorado passed legislation in 2011 limiting the use of isolation for its adult prisoners and requiring mental health assessments immediately prior to placement in solitary confinement. In California, following a massive hunger strike to protest excessive isolation and other conditions at secure housing units, prisoners filed a federal lawsuit alleging cruel and unusual punishment in the SHU.[16]

However, despite the growing momentum against solitary confinement, some states have increased and defended its use. In New York, Rikers Island jail has steadily expanded solitary cells where

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[12] Testimony by Juan E. Mendez to the United Nations General Assembly on October 18, 2011. Available at http://www.un.org/apps/news/story.asp?NewsID=40097

[13] http://solitarywatch.com/2012/02/01/how-many-prisoners-are-in-solitary-confinement-in-the-united-states/

[14] Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice. Juvenile Justice Bulletin: Conditions of Confinement. May 2011. Available at https://www.ncjrs.gov/pdffiles1/ojjdp/227729.pdf

[15] Id.

[16] Elias, Paul. May 31, 2012. Rights group joins lawsuit over solitary CA cells. Available at http://www.google.com/hostednews/ap/article/ALeqM5hpxHYVoMPDH7VPm2w9deS8oH1dAQ?docId=ff31e54e7add4628a2e5fde86d39901e.

youth, the mentally ill, and defendants awaiting trial are placed.[17] In Texas, politicians are considering expanding a new block of solitary confinement cells for youth, despite evidence indicating that staffing and structural issues are contributing to the high levels of violence.[18] Given the increased national and international attention to solitary confinement and its harmful effects, and the astounding numbers of youth in solitary confinement in our country, states that insist on and even expand the use of isolation are in dire need of strong leadership in order to abandon this costly, ineffective and harmful practice.

California

In California, as in many other states, solitary confinement of youth occurs under different programmatic titles: temporary detention, separation, isolation, segregation, and behavior treatment program, among others. What they all have in common is that youth can be confined in their cells for over 21 hours per day with little access to education, programming, and meaningful human contact. In California, as in most of the country, youth are placed in solitary confinement for disciplinary issues, mental health concerns, and for suicide watch. In a juvenile justice system where modest estimates indicate that more than 50-75% of youth who are incarcerated have some type of mental condition and more than 90% of the youth are African American or Latino, mentally ill youth and youth of color disproportionately suffer isolation.[19]

Reports at the county level juvenile halls and juvenile camps indicate that some youth are isolated for as many as 23 hours a day. Just last month, a 16-year-old female in a juvenile hall was placed in isolation for three days, after she was stripped of all clothing except her underwear and socks.[20] Because she was on suicide watch, staff put her in a strait jacket that restrained her physical movements.

Ten years ago at DJJ, 16-28% of youth were in solitary units, and the single hour of programming or exercise they received outside of their cells was in steel cages.[21] The prevalence of solitary confinement was one of the driving forces behind *Farrell v. Cate*, a lawsuit resulting in a consent decree that required a complete overhaul of the DJJ. While in solitary confinement, youth are often denied legally mandated education hours, exercise, and access to regular programming. Data obtained from a public records request indicate that in 2004, the average length of stay in a program in which youth are isolated for over 21 hours a day was 42 days.[22] In 2007, that number jumped to 65 days.[23] In 2010, the average was 59 days in one prison, with one youth spending 246 days in isolation.[24] A 2011 internal audit further showed that youth were isolated for 23 or 24 hours a day,

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[17] http://solitarywatch.com/2011/11/21/city-to-sharply-increase-solitary-confinement-cells-on-rikers-island/

[18] http://solitarywatch.com/2012/06/08/controversy-over-kids-in-solitary-confinement-in-texas/

[19] Handle with Care: Serving the Mental Health Needs of Young Offenders, Coalition for Juvenile Justice 2000 Annual Report. Available at http://www.juvjustice.org/media/resources/public/resource_123.pdf

[20] Written communication from youth to Books Not Bars. May 17, 2012.

[21] Krisberg. Barry. General Corrections Review of the California Youth Authority. December 23, 2003. http://www.prisonlaw.com/pdfs/CYA5.pdf. In 2005, the California Youth Authority was renamed the Division of Juvenile Justice.

[22] Data received from a public records request served on May 6, 2011 to the California Department of Corrections and Rehabilitation.

[23] Id.

[24] Id.

with one youth receiving only one hour out of his cell over the course of 10 days. [25] Incredibly, the practices from 10 years ago persist today, as youth languish in windowless 8.5 x 11 feet cells.[26]

As mentioned above, the Ella Baker Center sponsored legislation this year, authored by State Senator Leland Yee, to address these abuses. SB 1363 aimed to create minimum standards to govern the practice of solitary confinement, with the goal of discouraging its use. Among its modest provisions, the bill would require mental health reviews by clinical staff to monitor the condition of the youth placed in solitary confinement, and place limitations on isolation of suicidal youth.[27] Despite the high volume of documented abuses, pressure from the state prison guards' union caused the bill to fail in the Senate Public Safety Committee by one vote.

Recommendations for Congress

This Committee's action is urgently needed in order to address the national epidemic of solitary confinement. We urge the Committee to consult with juvenile justice advocates and adolescent mental health experts to establish and enforce a comprehensive set of policies aimed at eliminating solitary confinement of both youth and adults, and to establish standards that minimize the dangers of solitary confinement. We recommend that the following provisions apply to youth[28] detained in any juvenile or adult facility:

1. Provide a common definition for solitary confinement such as, "The involuntary confinement of a person alone in a room or cell from which the person is prevented from leaving in isolation from persons other than guards, facility staff, attorneys, during hours other than facility sleep hours." Provide that this definition encompass other programmatic titles in which youth are isolated in their cells including, but not limited, to the following: temporary detention, room confinement, segregation, separation, time out, special management programming, behavioral treatment programming, etc.
2. Prohibit solitary confinement in excess of four hours per day, to be applied only after other appropriate, less restrictive methods have been exhausted. This standard is established by the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative ("JDAI").
3. Limit solitary confinement to be used only for the minimum amount of time required to address the safety or security basis for which the youth is placed in solitary confinement, provided that such time does not compromise the mental and physical health of the youth.
4. Require face-to-face assessments by licensed clinicians to manage youths' mental, emotional, and physical health within the first hour of placement in solitary confinement. At a minimum, require hourly check-ins thereafter with licensed clinical staff. Additional guidelines on the treatment of youth placed in solitary confinement can be borrowed from existing federal guidelines for mental health hospitals found in 42 C.F.R. §482 Condition of participation: Patients' rights. Title 42-Public Health.

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[25] California Department of Corrections and Rehabilitation, Office of Audits and Compliance. "Review of Identified Concerns, Ventura Youth Correctional Facility." March 2011.

[26] California Youth Authority Warehouses: Failing Kids, Families & Public Safety. An Issue Briefing form Books Not Bars and The Center on Juvenile and Criminal Justice. 2005.

[27] http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120SB1363&search_keywords=

[28] As states use disparate definitions for "youth," these provisions should apply, at a minimum, to all those under the age of 18, regardless of whether the young person was adjudicated as an adult or a juvenile.

5. If a youth is placed in solitary confinement for suicide risk and the risk is not resolved within 24 hours, require that the youth be moved to a treatment hospital.
6. Prohibit the use of chemical agents against youth in solitary confinement. Any other physical restraints shall be used in accordance with 42 C.F.R. §482 Condition of participation: Patients' rights. Title 42-Public Health.
7. Provide youth in solitary confinement with access to the same meals, clothing, access to drinking water, hygiene, medical treatment, educational services, exercise, visitation, phone and letter privileges, legal assistance, religious services, counseling, time credits, and other rights and privileges that apply to youth in general housing assignments.

Statement of Julie Stewart
President
Families Against Mandatory Minimums

To the Senate Judiciary Subcommittee on the
Constitution, Civil Rights, and Human Rights

On
Reassessing Solitary Confinement:
The Human Rights, Fiscal, and Public Safety Consequences
June 19, 2012

On behalf of the staff, board and over 25,000 members of Families Against Mandatory Minimums (FAMM), I commend Senator Durbin for calling this hearing, the first of its kind, to examine the use of solitary confinement for prisoners incarcerated in the United States. FAMM is a sentencing reform organization, whose membership includes lawyers, judges, criminal justice advocates and above all state and federal prisoners and their loved ones. We concentrate our advocacy on reforming laws so that courts have discretion to fashion sentences that are individualized, proportionate and no greater than necessary to achieve the purposes of sentencing. We have kept in close touch for over twenty years with state and federal prisoners whose "stories" help to inform our advocacy. These stories help us illustrate our points about the impact of unduly rigid sentencing laws on real people.

We cannot help but hear about the conditions of confinement that our members and their loved ones face, including the use of solitary confinement. These stories are hard to hear, told to us by family members who cannot reach their loved one, or by the prisoner him or herself who describes 23 hour a day lockdown situations with infrequent exercise or bathing, and no human contact. When hearing about these experiences, we are always struck by how little this barbaric practice has to do with furthering the purposes of punishment. We have learned that solitary confinement is meted out not only to punish prisoners who misbehave, including violations of administrative rules, but also to separate victims from aggressors, or cooperators from the defendants against whom they testified. We have heard that it is even used to house vulnerable individuals so in fear of their safety from gangs in prison or sexual predators that they resist being placed in general population.

We can think of few if any instances where we would consider solitary confinement warranted, with the extremes of isolation and psychological and physical torment it visits on the prisoner. We suspect that decisions to use solitary confinement, sometimes for years at a time, may be made by prison administration officials ill equipped or unwilling to appreciate the damage it inflicts, though the evidence is right before their eyes.

FAMM evaluates sentencing practices in light of the purposes of punishment: retribution, deterrence, incapacitation and rehabilitation. Incarceration should be the punishment

of last resort, in light of our national birthright of liberty. We can think of no penological purpose served by the additional deprivation of solitary confinement.

For these reasons, we applaud Senator Durbin for calling this hearing and focusing lawmakers' attention on this human rights issue. We thank him and the committee for their commitment to improving our nation's criminal justice system.

Dangerous Overuse of Solitary Confinement in the U.S.

TO: Senate Judiciary Subcommittee on the Constitution, Civil Right

ATTN: Senator Dick Durbin, Chairman

FROM: M.I.S.S. "Solidarity Not Solitary" Mothers of Incarcerated Sons Society, Inc. (M.I.S.S.)

(501(c) 3 Non-Profit)

SUBJ: Dangerous Overuse of Solitary Confinement in the U.S.

Over the last two decades corrections systems have increasingly relied on solitary confinement as a prison management tool – even building entire institutions called "supermax prisons" where prisoners are held in conditions of extreme isolation, sometimes for years or decades. Although supermax prisons were rare in the United States before the 1990s, today forty-four states and the federal government have supermax prisons, housing at least 25,000 people. But this figure does not reflect the total number of prisoners held in solitary confinement in the United States on any given day. Using data from a census of state and federal prisoners conducted by the federal Bureau of Justice Statistics, researchers estimate that over 80,000 prisoners are held in "restricted housing," including prisoners held in administrative segregation, disciplinary segregation and protective custody – all forms of housing involving substantial social isolation.

U.S. Bureau of Justice statistics show that in 2010 there were more than 1.4 million inmates in state prisons. However, there are no official estimates for how many state prisoners are mentally ill or in isolation. But prisoners' rights advocates around the nation say putting mentally ill inmates in long-term solitary confinement amounts to cruel and unusual punishment.

This massive increase in the use of solitary confinement has led many to question whether it is an effective and humane use of scarce public resources. Many in the legal and medical field criticize solitary confinement and supermax prisons as both unconstitutional and inhumane, pointing to the well-known harms associated with placing human beings in isolation and the rejection of its use in American prisons decades earlier.

Indeed, over a century ago, the Supreme Court noted that: Prisoners subject to solitary confinement fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still committed suicide; while those who withstood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community. (re Medley, 134 U.S. 160, 168 (1890))

Other critics point to the enormous costs associated with solitary confinement. For example, supermax institutions typically cost two or three times more to build and operate than even traditional maximum security prisons. Despite the significant costs associated with solitary confinement, almost no research has been done on the outcomes produced by the increased use of solitary confinement or supermax prisons. In the research that has been conducted there is little empirical evidence to suggest that solitary confinement makes prisons safer. Indeed, emerging research suggests that supermax prisons actually have a negative impact on public safety.

Despite these concerns, states and the federal government continue to invest scarce taxpayer dollars in constructing supermax prisons and enforcing solitary confinement conditions. Yet there are stark new fiscal realities facing our communities today and for the foreseeable future. Both state and federal governments confront reduced revenue and mounting debt that are leading to severe cuts in essential public services like health and education. Given these harsh new realities, it is unquestionably time to ask whether we should continue to rely on solitary confinement and supermax prisons despite the high fiscal and human costs they impose.

The American Bar Association has created the following general definition of solitary confinement, which it calls "segregated housing": 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.

People in solitary confinement are also more likely to be subject to the use of

excessive force and abuses of power. Correctional officers often misuse physical restraints, chemical agents, and stun guns, particularly when extracting people from their cells. The fact that the solitary confinement cells are isolated from the general population prisoners makes it more difficult to detect abuse.

Additionally, the idea that "the worst of the worst" are placed in solitary confinement makes it more likely that administrators will be apathetic or turn a blind eye to abuses. New York recently passed a law that excludes the seriously mentally ill from solitary confinement; requires periodic assessment and monitoring of the mental status of all prisoners subject to solitary confinement for disciplinary reasons; creates a non-disciplinary unit for prisoners with psychiatric disabilities where a therapeutic milieu is maintained and prisoners are subject to the least restrictive environment consistent with their needs and mental status; and requires that all staff be trained to deal with prisoners with mental health issues.

The United States uses solitary confinement to an extent unequalled in any other democratic country. But this has not always been so. The current overuse of solitary confinement is a relatively recent development that all too frequently reflects political concerns rather than legitimate public safety needs.

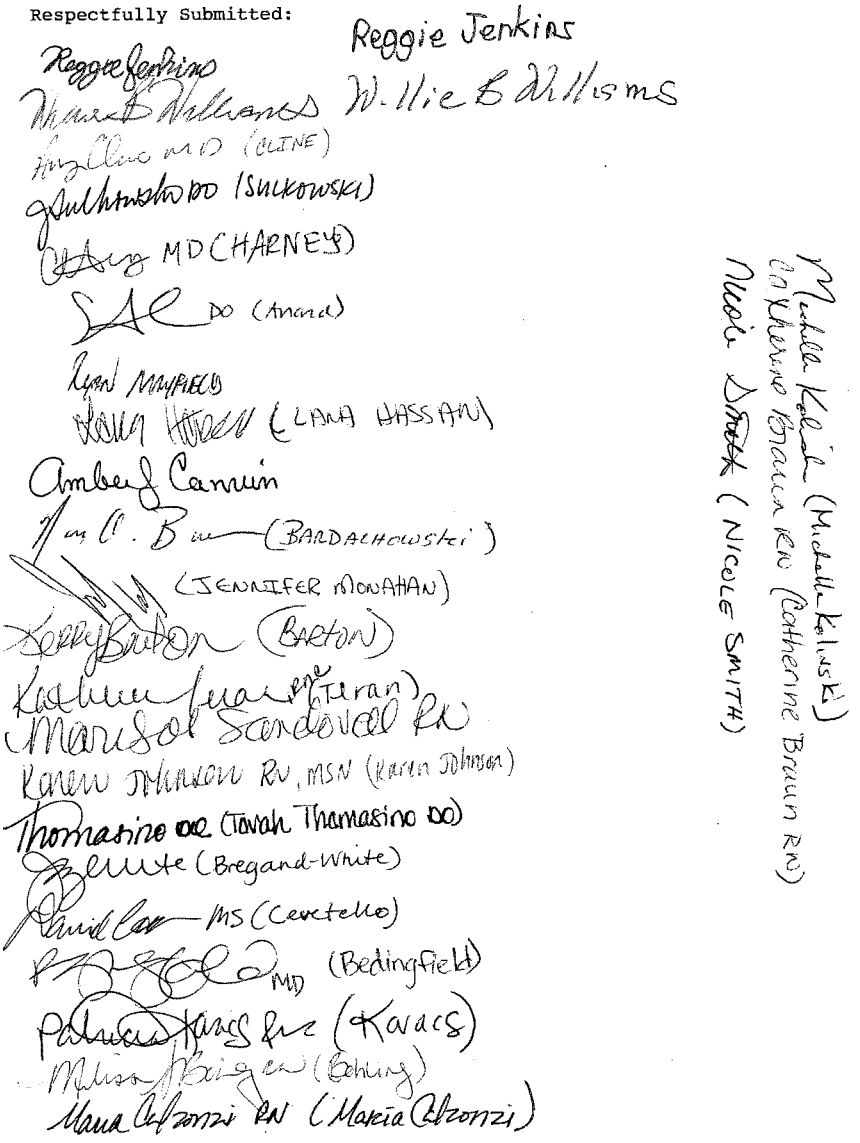
Based on over twenty years of empirical research, we now know that the human cost of increased physiological and psychological suffering caused by solitary confinement, coupled with the enormous monetary cost of its use, far outweighs any purported benefits. Now, in order to build a fair, effective and humane criminal justice system, we must work to limit its use overall and ensure that mentally ill persons are not subject to its deprivations.

Respectfully Submitted:

Lori Fenda ARN CNM (Lori Fender), MISS member and mother of a son found guilty but mentally ill, and the following 26 colleagues (page 4)

(Your Name), Prisoner's Rights Advocate
Mothers of Incarcerated Sons Society, Inc. (M.I.S.S.)
http://www.mothersofinmates.org/
(http://www.mothersofinmates.org/)

Respectfully Submitted:



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Psychiatric Effects of Solitary Confinement

My name is Stuart Grassian, M.D. I am a Board-certified psychiatrist, licensed to practice medicine in the Commonwealth of Massachusetts and was on the teaching staff of the Harvard Medical School continually from 1974 until 2002. I have had extensive experience in evaluating the psychiatric effects of solitary confinement - that is, confinement of a prisoner alone in a cell for all or nearly all of the day, with minimal environmental stimulation and minimal opportunity for social interaction. My conclusions that such confinement can cause severe psychiatric harm have been published in various medical journals and law review articles[1], and have been cited in several federal district and appellate court decisions[2].

1. Psychiatric Effects of Solitary Confinement.

Many of the inmates housed in solitary suffer severe exacerbation or recurrence of preexisting illness, and many who have no prior history of mental illness become severely ill during and as a result of such confinement. In my published works, I described a particular psychopathological syndrome associated resulting from the deprivation of perceptual and social stimulation in such confinement.

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[1] See, for example:
Psychopathological Effects of Solitary Confinement. 140 Am. J. Psychiatry, 1450 (1983).
Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement. 8 Int'l J. Law & Psychiatry 49 (1986)
Psychiatric Effects of Solitary Confinement. 22 Wash. U. J. Law & Policy, 325 (2006).

[2] See, for example:
Davenport v. DeRobertis, 844 F.2d 1310,
Madrid v. Gomez, 889F.Supp.1146.

However, my work does not stand alone. There is in fact an extensive body of literature, including clinical and experimental literature, regarding the effects in a large variety of settings of decreased environmental and social stimulation, as well as specific observations concerning the effects of solitary confinement on prisoners.[3]

It has long been known that severe restriction of environmental and social stimulation has a profoundly deleterious effect on mental functioning; this issue has, for example, been a major concern for many groups of patients including, for example, patients in intensive care units, spinal patients immobilized by the need for prolonged traction, and patients with impairment of their sensory apparatus (such as eye-patched or hearing impaired patients). This issue has also been a very significant concern in military situations and in exploration - polar and submarine expeditions, and in preparations for space travel; the United States Navy and NASA, among others, have sponsored significant research in response to these concerns.

In regard to solitary confinement, the United States was actually the world leader in introducing prolonged incarceration, and solitary confinement, as a means of dealing with criminal behavior; the "penitentiary system" began in the United States in the early 19th century, a product of a spirit of great social optimism about the possibility of rehabilitation of individuals with socially deviant behavior. This system, originally embodied as the "Philadelphia System", involved almost an exclusive reliance upon solitary confinement as a means of incarceration, and also became the predominant mode of incarceration - both for post conviction and also for pretrial detainees - in the several European prison systems that emulated the American model.

The results were catastrophic. The incidence of mental disturbances and the severity of such disturbances were so great that the system fell into disfavor and was ultimately abandoned. During this process a major body of clinical literature developed that documented the psychiatric disturbances created by such stringent conditions of

[3] The Washington University article cited above provides a longer and more detailed discussion.

confinement. The paradigmatic disturbance was an agitated confusional state which, in more severe cases, had the characteristics of a florid delirium, characterized by severe disorientation, confusion, paranoia, hallucinations, and intense agitation with random, impulsive violence - often self-directed.

The psychiatric harm caused by solitary confinement became exceedingly apparent. Indeed, by 1890, in In re Medley, 10 S.Ct. 384, the United States Supreme Court explicitly recognized the massive psychiatric harm caused by solitary confinement: "This matter of solitary confinement is not ... a mere unimportant regulation as to the safe-keeping of the prisoner .... [E]xperience [with the penitentiary system of solitary confinement]demonstrated that there were serious objections to it. A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community." 10 S.Ct. at 386.

The consequences of the Supreme Court's holding were quite dramatic for Mr. Medley. Mr. Medley had been convicted of having murdered his wife. Under the Colorado statute in force at the time of the murder, he would have been executed after about one additional month of incarceration in the county jail. But in the interim between Mr. Medley's crime and his trial, the Colorado legislature had passed a new statute that called for the convicted murderer to be, instead, incarcerated in solitary confinement in the State Prison during the month or so prior to his execution. Unhappily, simultaneously with the passage of the new law, the legislature rescinded the older law, without allowing for a bridging clause which would have allowed for Mr. Medley's sentencing under the older statute.

Mr. Medley appealed his sentencing under the new statute, arguing that punishment under this new law was so substantially more burdensome than punishment under the old law, as to render its application to him ex post facto. The Supreme Court agreed with

him, even though it simultaneously recognized that if Mr. Medley was not sentenced under the new law, he could not be sentenced at all. Despite this, the Court held that this additional punishment of one month of solitary confinement was simply too egregious to ignore; the Court declared Mr. Medley a free man and ordered his release from prison. In short, the Supreme Court held that the addition of a few weeks of solitary confinement to a sentence of death on the gallows was enough to let Mr. Medley get away with murder.

Our jurisprudence has come a long way downhill from there.

Dramatic concerns about the profound psychiatric effects of solitary confinement have continued into the twentieth century, both in the medical literature, and in the news. The alarm raised about the "brainwashing" of political prisoners of the Soviet Union and of Communist China - and especially of American prisoners of war during the Korean War - gave rise to a major body of medical and scientific literature concerning the effects of sensory deprivation and social isolation, including a substantial body of experimental research[4].

This literature, as well as my own observations, has demonstrated that, deprived of a sufficient level of environmental and social stimulation, individuals will soon become incapable of maintaining an adequate state of alertness and attention to the environment. Indeed, even a few days of solitary confinement will predictably shift the EEG (the brain wave pattern) towards an abnormal pattern characteristic of stupor and delirium.

This fact is, indeed, not surprising. Most individuals have at one time or another experienced, at least briefly, the effects of intense monotony and inadequate

[4] Individuals speaking on behalf of Departments of Correction have sometimes asserted that the literature concerning profound sensory deprivation is not relevant to a discussion of the effects of solitary confinement. This is a strikingly naïve and ahistorical assertion. Indeed, the extensive body of laboratory research concerning sensory deprivation was in fact funded by the United States State Department and the Canadian Department of Defense precisely as a model for understanding the effects of solitary confinement and "brainwashing".

environmental stimulation. After even a relatively brief period of time in such a situation, an individual is likely to descend into a mental torpor - a "fog" - in which alertness, attention and concentration all become impaired. In such a state, after a time, the individual becomes increasingly incapable of processing external stimuli, and often becomes "hyperresponsive" to such stimulation; for example, a sudden noise or the flashing of a light jars the individual from his stupor, and becomes intensely unpleasant. Over time, the very absence of stimulation causes whatever stimulation is available to become noxious and irritating; individuals in such a stupor tend to avoid any stimulation, and to progressively withdraw into themselves and their own mental fog.

An adequate state of responsiveness to the environment requires both the ability to achieve and maintain an attentional set - to focus attention - and the ability to shift attention. The impairment of alertness and concentration in solitary confinement leads to two related abnormalities:

First, the inability to focus, to achieve and maintain attention, is experienced as a kind of dissociative stupor - a mental "fog" in which the individual cannot focus attention, cannot, for example, grasp or recall when he attempts to read or to think.

Second, the inability to shift attention results in a kind of "tunnel vision" in which the individual's attention becomes stuck - almost always on something intensely unpleasant - and in which he cannot stop thinking about that matter; instead, he becomes obsessively fixated upon it. These obsessional preoccupations are especially troubling. Individuals in solitary easily become preoccupied with some thought, some perceived slight or irritation, some sound or smell coming from a neighboring cell, or - perhaps most commonly, by some bodily sensation - tortured by it, unable to stop dwelling on it. I have examined countless individuals in solitary confinement who have become obsessively preoccupied with some minor, almost imperceptible bodily sensation, a sensation which grows over time into a worry, and finally into an all-consuming, life-threatening illness.

In solitary confinement, ordinary stimuli become intensely unpleasant, and small irritations become maddening. Individuals in such confinement brood upon normally

unimportant stimuli, and minor irritations become the focus of increasing agitation and paranoia, often resulting in increasing agitation and random violence

Individuals experiencing such environmental restriction find it difficult to maintain a normal pattern of daytime alertness and nighttime sleep. They often find themselves during the day incapable of resisting their bed - incapable of resisting the paralyzing effect of their stupor - and yet incapable at night of any restful sleep. The lack of meaningful activity is far compounded by the effect of continual exposure to artificial light, and diminished opportunity to experience natural daylight. And the individuals' difficulty in maintaining a normal day-night sleep cycle is often far worsened by the constant intrusions on nighttime dark and quiet - steel doors slamming shut, flashlights shining in their face, and so forth.

EEG studies have corroborated these findings. Such studies, using volunteers, have demonstrated that even after a few days of solitary confinement, the EEG will characteristically shift in the direction of stupor and delirium. Moreover, one study from the Balkan conflict demonstrated that even after release from solitary confinement, there are continuing EEG abnormalities; the EEG shows abnormally intense – "spike" - reactions to environmental stimulation. In other words, the "hyperresponsivity to external stimuli" which is found clinically in individuals exposed to solitary confinement, is also seen in EEG recordings, and this disturbance continues for an indefinite period of time after release from solitary.

2. The Safety of the Community.

It has become politically expedient to speak of "getting tough on crime", housing "the worst of the worst" in solitary confinement. In fact, though, inmates whose unruly behavior causes them to be placed in solitary are generally not cold, calculating criminals; instead, they are largely individuals who are impulsive, emotionally labile, often cognitively impaired, and quite often, mentally ill. The incidence of mental illness

among the prison population is demonstrably greater than in the population at large[5], and as one descends deeper into the bowels of the prison system, one encounters more and more individuals who suffer from preexisting mental illness – in some prison studies, over 50% of the inmates in solitary confinement suffered from such illness even prior to incarceration. In short, our solitary confinement cells are not generally housing the worst of the worst; instead, they are often housing the sickest of the sick.

And it is critical to remember that 95% of all inmates will someday be released back into the communities where we all live. What can we expect from these individuals after their release from prison? Solitary confinement breeds long-lasting paranoia, fear, social isolation, anger, impulsivity and major impairment in the individual's capacity to relate in the broader social environment. Even individuals who prior to incarceration were gregarious, comfortable in the social environment, leave prison severely impaired – isolated, paranoid, jumpy, impulsive, and unable to tolerate social interaction or other forms of stimulation. They cannot tolerate the broader environment, and when required to be among others, are jumpy, hypervigilant, angry and fearful. In short, in exposing these inmates to prolonged solitary confinement, we will have succeeded, as much as we possibly could, in leaving them paranoid, impulsive, and incapable of functioning in the broader community.

Many of the prisoners who are housed in long-term solitary confinement are undoubtedly a danger to the community and a danger to the Corrections Officers charged with their custody. But for many, they are a danger, not because they are coldly ruthless, but because they are volatile, impulse-ridden and internally disorganized. But solitary confinement invariably makes it worse. And often, when class-action lawsuits result in such behaviors being reframed as psychiatric problems, no longer punished but now treated, everyone does better – not just the inmate, but also the officers and the mental health providers.

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[5] Survey data indicates that approximately 75% of all prison beds in the United States are occupied by individuals whose committing offense was a product of substance abuse or other addictive disorder, or of other mental illness.

3. Conclusion.

Modern societies have attempted to make a fundamental moral distinction between socially deviant behavior that is seen as a product of evil intent, and that behavior seen as a product of illness. Yet this bifurcation has never been as simple as might at first glance appear. Socially deviant behavior can in fact be described along a spectrum of intent. At one end are those whose behavior is entirely "instrumental" - ruthless, carefully planned and rational; at the other are individuals whose socially deviant behavior is the product of unchecked emotional impulse, internal chaos, and often of psychiatric or neurologic illness.

Too often, the prison system understands behavior only as instrumental and rational. It follows a paradigm that punishment upon punishment will cause that rational mind to choose to change its behavior. But that one paradigm is entirely inadequate, ineffective and, ultimately, cruel.

Thus, it is a great irony that as one passes through the levels of incarceration - from the minimum to the moderate to the maximum security institutions, and then to the solitary confinement section of these institutions -- one does not pass deeper and deeper into a subpopulation of the most ruthlessly calculating criminals. Instead, ironically and tragically, one comes full circle back to those who are emotionally fragile and, often, severely mentally ill. The politics and policies that have established and perpetuated this tragedy deeply offend any sense of common human decency. And they do not succeed in "getting tough on crime". Instead, they succeed only in getting tough on <u>us</u>, on the communities to which these inmates will be returning some day, having ensured that those inmates will be as agitated, impulsively angry, paranoid, and ill-prepared for dealing with demands of life outside of prison as they could possibly achieve.

Dear Chairman Durbin and Ranking Member Graham,

I am an Associate Professor of Philosophy at Vanderbilt University and the author of a forthcoming book on solitary confinement, called *Social Death and its Afterlives: A Critical Phenomenology of Solitary Confinement*, to be published next year by University of Minnesota Press. I also facilitate a weekly reading group with prisoners on death row, each of whom has spent at least one-and-a-half years in solitary confinement, at Riverbend Maximum Security Institute in Nashville, Tennessee. My philosophical perspective on solitary confinement is shaped by my discussions with these prisoners, my correspondence with other prisoners currently in isolation, my research on the psychological, anthropological, and other scholarship on solitary confinement, and my own philosophical training as a phenomenologist.

What is phenomenology ? For me, it is a philosophical method for uncovering the structure of lived experience by describing *what it is like* from a first person perspective. Rather than attempting to prove a set of objective facts, phenomenology tracks the way that a *meaningful* experience of the world emerges for someone in the total situation of their Being-in-the-world. My statement on solitary confinement will demonstrate, from a phenomenological perspective, how prolonged isolation affects the Being-in-the-world of prisoners. Drawing on prisoners' testimony, I will argue that the deprivation of meaningful social relations with others is a form of unacceptable violence against the basic structure of the prisoner's existence, and that it threatens to undermine their capacity to have a meaningful experience of the world. This is damaging, not only for the individual prisoner, but also for society as a whole – both for those who will eventually have to deal with prisoners released from solitary confinement, and for *all of us* as social beings whose Being-in-the-world is affected by the others with whom we share this world. For our own sake, as well as for theirs, we must stop using isolation as an everyday "solution" to disciplinary, security and administrative problems in prisons. If we use solitary confinement at all, it must be as a last resort for protecting prisoners from physical and/or sexual violence, and we must try to balance the damaging effects of physical isolation with other forms of social interaction such as phone calls, access to reading materials, and so forth.

For the sake of brevity, I will focus my analysis on Stuart Grassian's ground-breaking research on the effects of solitary confinement at Walpole Penitentiary.[1] In 1982, Grassian interviewed 14 of the 15 prisoners in Block 10, which was set aside for solitary confinement. The dimensions of each unit were 1.8m x 2.7m (about 6' x 9'). Each cell contained an open toilet, a sink, a bed, and a small steel table and stool fixed in place. The only light sources were a 60-watt light bulb and a small plexiglass window with no view to the outside. Prisoners were held in these cells with no access to TV, radio, or

reading material other than the Bible, for a median length of two months – far shorter than the years, or even decades, currently being served by inmates in supermax prisons. Grassian found that up to 80% of prisoners suffered from perceptual, emotional, cognitive and other disturbances. These findings are consistent with psychiatric research by Craig Haney and others at institutions such as Pelican Bay State Prison.[ii] Grassian later coined the term SHU syndrome (named for the Special Housing Units in which the prisoners were held) to describe a cluster of symptoms including: 1) Hyperresponsivity to External Stimuli; 2) Perceptual Distortions, Illusions, and Hallucinations; 3) Panic Attacks, 4) Difficulties with Thinking, Concentration, and Memory; 5) Intrusive Obsessional Thoughts; and 6) Overt Paranoia.[iii] He notes that this particular configuration of symptoms is "strikingly unique" and that the perceptual disturbances in particular are "virtually found nowhere else."[iv]

These are the facts. But what do they *mean*? To answer this question, we need to listen to how the prisoners themselves describe their experience of isolation:

> I went to a standstill psychologically once – lapse of memory. I didn't talk for 15 days. I couldn't hear clearly. You can't see – you're blind – block everything out – disoriented, awareness is very bad. Did someone say he's coming out of it? I think what I'm saying is true – not sure. I think I was drooling – a complete standstill.
>
> They come by [for breakfast] with four trays; the first has big pancakes – I think I'm going to get them. Then someone comes up and gives me tiny ones – they get real small, like silver dollars. I seem to see movements – real fast motions in front of me. Then seems like they're doing things behind your back – can't quite see them. Did someone just hit me? I dwell on it for hours.
>
> Melting, everything in the cell starts moving; everything gets darker, you feel you are losing your vision.
>
> I can't concentrate, can't read . . . Your mind's narcotized . . . sometimes can't grasp words in my mind that I know. Get stuck, have to think of another word. Memory is going. You feel you are losing something you might not get back.[v]

Deprived of everyday encounters with other people, and cut off from an open-ended experience of the world as a place of difference and change, many inmates come unhinged from reality. Their senses seem to betray them; objects begin to move, melt or shrink of their own accord. Even the effort to reflect on their experience becomes a form of pathology, leading one prisoner to "dwell on it for hours," while another goes into "a

complete standstill." They can't think straight, can't remember well, can't focus properly, and can't even see clearly. What is the prisoner in solitary confinement at risk of losing, to the point of not getting it back?

The prisoner in a control unit may have adequate food and drink, and the conditions of their confinement may meet or exceed court-tested thresholds for humane treatment. But there is something about the exclusion of other living beings from the space that I inhabit, and the absence of even the *possibility* of touching or being touched by another, that threatens to unhinge the subject. We tend to view ourselves as individuals with our own separate, inherent capacity to think and perceive. At the same time, we acknowledge that humans are social animals, and that we need other people in order to live a full and happy life. But the testimony of prisoners in solitary confinement suggests that we are much more deeply connected with and dependent upon other living beings than we tend to assume. We rely on a network of others, not just to survive or to keep ourselves entertained, but also to support for our capacity to make sense of the world, to distinguish between reality and illusion, to follow a train of thought or a causal sequence, and even to tell where our own bodily existence begins and ends.

Think about it: Every time I hear a sound and see another person look towards the origin of that sound, I receive an implicit confirmation that what I heard was something real, that it was not just my imagination playing tricks on me. Every time someone walks around the table rather than through it, I receive an unspoken, usually unremarkable, confirmation that the table exists, and that my own way of relating to tables is shared by others. When I don't receive these implicit confirmations, I can usually ask someone – but for the most part, we don't need to ask because, as Being-in-the-world, our experience is already interwoven with the experience of many other living, thinking, perceiving beings who relate to the same world from their own unique perspective. This multiplicity of perspectives is like an invisible net that supports the coherence of my own experience, even (or especially) when others challenge my interpretation of "the facts." These facts are up for discussion in the first place because we inhabit a shared world with others who agree, at the very least, that there is something to disagree about.

When we isolate a prisoner in solitary confinement, we deprive them of both the *support* of others, which is crucial for a coherent experience of the world, and also the *critical challenge* that others pose to our own interpretation of the world. Both of these are essential for a meaningful experience of things, but they are especially important for those who have broken the law, and so violated the trust of others in the community. If we truly want our prisons to rehabilitate and transform criminal offenders, then we must put them in a situation where they have a chance *and an obligation* to explain themselves to others, to repair damaged networks of mutual support, and to lend their own unique

perspective to creating meaning in the world. When we lock someone in a control unit for breaking prison rules, for being labeled as a gang member, or even for attempting to harm themselves or others, then we are punishing them in a way that blocks the very transformation that we expect of them.

It may sound like I am proposing a "soft" policy that may work for non-violent offenders, but not for murderers, rapists, and other violent criminals. I have seen first-hand in my weekly discussion group with men on death row that this is not the case. These men did not get to the point of working together to create positive change in their unit, in their lives, and in the wider community, by being isolated from one another in solitary confinement; they got there thanks to a levels system that allows even prisoners slated for execution to work their way out of isolation towards what they like to call a "therapeutic community."

We ask *too little* of prisoners when we lock them into control units where they are neither allowed nor obliged to create and sustain meaningful, supportive relations with others. For the sake of justice, not only for them but for ourselves, we must put an end to the over-use of solitary confinement in this country, and we must begin the difficult but mutually-rewarding work of bringing the tens of thousands of currently-isolated prisoners back into the world.

Sincerely,

Dr. Lisa Guenther

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[i] Stuart Grassian, "Psychopathological effects of solitary confinement," *American Journal of Psychiatry* 140:11 (1983), 1450-1454.

[ii] See, for example, Craig Haney, "Mental Health Issues in Long-Term Solitary and "Supermax" Confinement," *Crime Delinquency* 49:1 (2003), 124-156; Craig Haney and Mona Lynch, "Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement," *New York University School of Law Review of Law and Social Change.* 23:4 (1997), 477-570.

[iii] Stuart Grassian, "Psychiatric Effects of Solitary Confinement," *Journal of Law & Policy* 22 (2006), 335-6.

[iv] Ibid., 337.

[v] Grassian 1983, 1452-3.

Statement for the Record

of

Delegate Patrick A. Hope

Presented to the

UNITED STATES SENATE
COMMITTEE ON THE JUDICIARY
SUBCOMMITTEE ON THE CONSTITUTION, CIVIL RIGHTS AND HUMAN RIGHTS

Hearing on

"Reassessing Solitary Confinement: The Human Rights, Fiscal and Public Safety Consequences"

June 19, 2012

Chairman Durbin, Ranking Member Graham and members of the Subcommittee, thank you for holding this important hearing on "Reassessing Solitary Confinement: The Human Rights, Fiscal and Public Safety Consequences." I appreciate the opportunity to share my observations and experiences of the Virginia prison system that I believe present common themes throughout the U.S. prison system.

Last summer, I traveled to the most southwest part of the state to tour Virginia's maximum security prison, Red Onion State Prison (ROSP) in Pound, Virginia. This is where Virginia keeps its most dangerous prisoners or, as sometimes referred to as, "the worst of the worst."

The day started meeting with ROSP corrections officers, mental health staff, and Virginia Department of Corrections (DOC) officials. I asked very direct questions on the treatment of prisoners in segregation, how long they were segregated, and the level of mental health services provided to those with a diagnosis and to those who do not. I was then escorted inside the prison walls to get an up-close view of prison life and came away with a new perspective and offer the following observations.

Too Many Prisoners Are in Segregation For Too Long

Virginia's over 1,700 prisoners in segregation are confined in an 80 square foot cell 23 hours a day, 7 days a week. They typically get one hour a day for recreation five days a week, confined to a 96 square foot chain-linked fence area that can only be described as a cage for a human being. They eat alone in their cells and by design have very little, if any, social interaction with others.

I witnessed over 40 prisoners assigned to the ROSP segregation units living under these conditions. Statistically, a good number of these prisoners have a diagnosed serious mental illness (schizophrenia, bipolar disorder, major depressive disorder) and many more are undiagnosed. While those assigned to segregation have their case periodically reviewed, that doesn't mean prisoners get released into the general population. Some in segregation are there for days, weeks, and even months. But I'm most concerned about the large number of prisoners that are in prolonged segregation for years and decades. I personally spoke to one prisoner who has been in segregation for over 12 years, and have come to be aware of many other prisoners in ROSP's segregation units who have been there for several more years.

One of the most concerning aspect to me was the revelation that many of the prisoners living under these conditions will one day be released directly into the community, without first spending time in the general prison population. That's very alarming that there is no intermediate step within prison from segregation to release into the community. Why? Because statistically segregated prisoners are more likely to reoffend, making the practice of prolonged segregation counterproductive to the idea that prison should serve as rehabilitation of prisoners to then hopefully become productive members of society.

The United States Department of Justice Should Intervene to Limit the Use of Prolonged Segregation

Federal courts have ruled that segregating prisoners, especially those with a serious mental illness, for too long is a violation of the Eighth Amendment's protection against the Cruel and Unusual Punishment. The American Bar Association's Criminal Justice Standards on the Treatment of Prisoners state: "*No prisoner diagnosed with serious mental illness should be placed in long-term segregated housing.*" Similar statements have been made by international treaty bodies and human rights experts, including the Human Rights Committee, the Committee Against Torture, and the U.N. Special Rapporteur on Torture. Unfortunately, the Virginia DOC has no absolute limit on how long an individual with mental illness can be in segregation. Most states do not either.

Therefore, my recommendation requests the United States Department of Justice to take a more active role in assessing how States are using segregation and to urge States to seek ways to limit and minimize its use. The Department should help States adopt uniform standards and guidelines for prison segregation that includes both treatment and duration. The Department must also play an enforcement role to ensure those guidelines are always being met. At its best, I believe prolonged segregation is "cruel and unusual punishment" and at its worst it is torture. The United States has a significant role to ensure States limit the use of prolonged segregation to only extreme circumstances.

Evidence-Based Alternatives Found in Other States

In 2006, Mississippi began to reduce its segregation population and within a year successfully reduced its segregated population by 80 percent through an aggressive reassessment of prisoners and determining more suitable housing. By closing down units and shifting staff they saved over $5 million per year. Maine has also undergone a similar process and reduced its segregated population by 70 percent.

Several states are following the example set by Mississippi and Maine. In the 2012 legislative session, I introduced legislation in Virginia to study the feasibility of limiting the widespread use of segregation for long periods of time, attempting to replicate the experience of Mississippi and Maine. Unfortunately, the legislation was defeated. Fortunately, however, the Virginia DOC has expressed sincere interest in implementing a plan to limit segregation at Red Onion. Only time will tell if Virginia's efforts will be met with the same kind of success found in Mississippi and Maine.

Adequate Mental Health Treatment Needs to Be Assured

If we are going to maintain the use of segregation in the United States – whether we are able to successfully limit its use – we need to ensure that adequate mental health services are always provided to every segregated prisoner. There are very serious consequences to our society if do not at least maintain an understanding of the dangers and risks posed to society by prolonged segregation. Normal human contact is essential for ensuring successful community re-entry and reducing recidivism rates. But long-term segregation and isolation does not facilitate rehabilitation and can in fact create and exacerbate existing serious mental illness. For prisoners with mental illness, years of isolation with minimal face-to-face communication ill equips them for successful community re-entry. For those without a mental illness, the harm from lengthy segregation can be just as damaging.

Therefore, prisoners in prolonged segregation should be regularly evaluated to ensure they are being properly treated and their mental health is not being adversely affected. More psychiatrists and psychologists are needed to regularly assess and interact with segregated prisoners to begin rehabilitation for successful re-entry into the general prison population and, in most cases, re-entry into society. It's clearly in society's best interest to ensure we have adequate mental health treatment in our prison system.

Conclusion

In summary, our goal should be to limit the prolonged use of segregation in all U.S. prisons. Segregation should only be used in extreme circumstances and we should constantly be asking the question: "Does this prisoner really need to be here and what is the best way to transfer this individual into the prison's general population?"

We need to also ensure the prison system serves to rehabilitate prisoners to become productive members of our society. The practice of prolonged segregation has proven to be counterproductive to that goal. Of particular concern is the fact that most prisoners in segregation will one day be released back into our community, so we all have a stake in using proven methods of rehabilitation and successful community re-entry.

Efforts to limit prolonged segregation cuts against the grain of the old way of doing things. Change takes time and we have very well-meaning, professional people in corrections. We need the assistance from the U.S. Department of Justice to help States develop and adhere to uniform standards and guidelines for segregation. We must be willing to take the necessary steps to limit the use of prolonged segregation to only extreme circumstances, and the U.S. Department of Justice has a critical to role to ensure States are in compliance.

Thank you for the opportunity to share with the Subcommittee my views.

Written Statement of
Chad Griffin
President
Human Rights Campaign

To the

Judiciary Subcommittee on
The Constitution, Civil Rights, and Human Rights
Room 226
Dirksen Senate Office Building
United States Senate
June 19, 2012

Mr. Chairman and Members of the Committee:

My name is Chad Griffin, and I am the President of the Human Rights Campaign, America's largest civil rights organization working to achieve lesbian, gay, bisexual and transgender (LGBT) equality. By inspiring and engaging all Americans, HRC strives to end discrimination against LGBT citizens and realize a nation that achieves fundamental fairness and equality for all. On behalf of our over one million members and supporters nationwide, I am honored to submit this statement into the record for this important hearing "Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences".
Today's hearing is a vital step toward evaluating the pervasive use and abuse of solitary confinement in corrections facilities across the country.

Solitary confinement is, by nature, punitive. Traditionally reserved for violent offenders or those who consistently break prison rules, the use of solitary confinement to house LGBT and gender nonconforming inmates has become a default "quick fix" to the systemic violence and abuse of LGBT people in American prisons. Citing safety concerns for the individual, prison authorities routinely place LGBT inmates in this restricted housing, which often entails up to 23 hours in a windowless cell without access to supportive services and programs like job training, education, and enrichment that are available to other inmates. Basic privileges like telephone access, family visitation, and access to legal counsel are also severely restricted and are often only made available in the late hours of the night. Transgender inmates housed in solitary confinement also report limited access to critical medications like hormone therapy and related care. We recognize the unique safety needs of LGBT inmates, however the consistent use of involuntary solitary confinement for the sake of safety must be used only as a last resort—never as a default safe housing option.

Prison rape survivors, who are disproportionately LGBT[1], report being placed in solitary confinement as retaliation for "making trouble." Segregated from the general population, these

[1] *National Former Prisoner Survey: Sexual Victimization Reported by Former State Prisoners, 2008*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Available at: http://www.bjs.gov/content/pub/pdf/svrfsp08.pdf. Finding that compared to their straight counterparts, gay and

survivors are also at a heightened risk for abuse by guards and prison staff. Inmates who are housed in solitary confinement following a sexual assault tend to suffer additional distress including fear, anxiety and heightened trauma. They have decreased access to rape crisis services and are less likely to file a formal complaint or cooperate with any investigation.

If solitary confinement must be used to protect an abused inmate from additional violence, that use must be temporary and strict time restrictions must be put in place. An inmate who has survived abuse or violence should only be placed in such housing until a less restrictive, safe alternative becomes available. Appropriate health care services, access to programs and services, and contact with a rape crisis provider must be made available. The Department of Justice's (DOJ) recently released Prison Rape Elimination Act (PREA) standards meet some, but not all, of these conditions.[2] The PREA standards call on corrections officials to provide survivors with access to services and programs and to move these inmates to less restrictive housing as soon as possible.[3] The standards also mandate the provision of emergency and follow-up medical and mental health care, including contact with support services.[4]

However, these standards fail to place strong limits on the time a survivor may be involuntarily placed in solitary confinement. The PREA standards generally limit involuntary solitary confinement for survivors to 30 days.[5] Placing a victim of sexual abuse in a punitive, highly restrictive, and purposefully isolating environment for a month is unacceptable. A more appropriate time limit would be 72 hours. This would still allow facilities to make other, safe housing available. Although the standards do require ongoing, regularly scheduled reviews of whether a survivor should be kept in solitary confinement beyond 30 days, this review is only required to take place once every 30 days.[6] A more appropriate review schedule would be every 10 days to prevent the victim from needlessly languishing alone after an assault.

Providing safe housing to inmates is the most basic, but vital responsibility of corrections officials. Many corrections officials faced with a particularly vulnerable inmate, believe that solitary confinement is in the best interest of the inmate. Too often, however, solitary confinement is seen as a "quick fix" to the systemic problem of violence and abuse against vulnerable populations. When solitary confinement is the default policy in place to protect LGBT people and other vulnerable populations, little consideration is given to the serious harm caused by this restrictive housing. Rarely are modifications made to correct for the punitive nature of solitary confinement and to ensure that the inmate retains access to programs and services.

In addition to the toll it takes on inmates in the most need, the pervasive misuse of solitary confinement as default housing for vulnerable populations –rather than developing long-term,

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bisexual men are 10 times more likely to be victims of sexual abuse by other inmates. A shocking 34 percent of bisexual men and 39 percent of gay men report being victimized by other inmates, compared to 3.5 percent of straight male inmates. Lesbians and bisexual women also face increased risk of sexual abuse and violence.

[2] The Prison Rape Elimination Act Standards available at www.ojp.usdoj.gov/programs/pdfs/prea_final_rule.pdf (last viewed on June 11, 2012).

[3] *Id.* As an example, see the relevant adult jail and prison standard at 115.43.

[4] *Id* at 115.53, 115.83, and 115.83.

[5] *Id* at 115.68 (referencing 115.43).

[6] *Ibid.*

sustainable solutions—drains the system of vital funding. In a 2009 report, the California Inspector General estimated that, based on needs for increased staffing and greater physical space, the annual costs per inmate in administrative segregation average at least $14,600 more than the annual costs per inmate in general population.[7] The California Inspector General concluded that the overuse of solitary confinement cost the California Department of Corrections and Rehabilitation nearly $11 million every year.[8]

Proactive reinvestment of scarce resources to implement basic policies and procedures aimed at preventing sexual abuse and other forms of violence is vitally important. Engaging the issue of safety, rather than abusing solitary confinement makes sense economically and it makes sense for the individuals who are at the mercy of the corrections system every day. The Human Rights Campaign urges strong leadership and the commitment to developing effective policies that will ensure that all inmates, including LGBT people, have access to safe housing that is not also unnecessarily punitive.

[7] California Office Of The Inspector General, Management of the California Department of Corrections and Rehabilitation's Administrative Segregation Population (2009), available at http://www.oig.ca.gov/media/reports/BOA/reviews/Management%20of%20the%20California%20Department%20of%20Corrections%20and%20Rehabilitation's%20Administrative%20Segregation%20Unit%20Population.pdf (last visited June 11, 2012).

[8] *Ibid*

Human Rights Coalition Pennsylvania – hrcoalition.org

Submission to the Senate Subcommittee

TO: Chairman Durbin and Ranking Member Graham

A Question of Torture

"International law prohibits every act of torture or other cruel, inhuman or degrading treatment or punishment, no matter where, when, or against whom it is perpetrated . . ."[1]

Systemic and severe violations of international human rights law are an endemic—and suppressed—feature of prison conditions in the United States. During the last thirty years the United States has embarked upon a project of race- and class-based mass incarceration unlike anything the world has ever seen. Emerging in this same period has been the regime of super-maximum security prison units, where people are held in solitary confinement between 22-24 hours a day, seven days a week, often for years on end. These units are defined by severe restrictions on visitations, phone calls (which are often prohibited), incoming and outgoing mail, limits on in-cell legal and personal property, and prohibitions on cell decorations. Medical neglect, physical and psychological abuse, food deprivation, racism, and other human rights violations flourish in these conditions, which are effectively hidden from public scrutiny.

The Human Rights Coalition of Pennsylvania (HRC) is a group of current and former prisoners, family members, and supporters working to abolish solitary confinement, mass incarceration, and the political and economic inequalities responsible for systematic, pervasive, and worsening human rights violations inside and outside of the prison walls in the United States. During the past decade we have documented hundreds upon hundreds of instances of torture and other cruel, inhuman and degrading treatment inside the solitary confinement units of Pennsylvania Department of Corrections (PA DOC). The approximately 2,500 prisoners warehoused in solitary by the PA DOC are held in units where physical abuse, psychological deterioration, retaliation for exercising constitutionally-protected rights, food deprivation, extreme social isolation, severely reduced environmental stimulation, theft and destruction of property, obstruction of access to the courts, and racist abuse are normative features. These conditions are not unique to Pennsylvania, and it is long past time that they are exposed and eradicated once and for all.

As described below and in other submissions presented to this subcommittee, the austere, abusive, dehumanizing conditions of solitary confinement fit the legal definition of torture articulated in the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment[2] and are strictly prohibited under international human rights

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[1] Nigel S. Rodley with Matt Pollard, THE TREATMENT OF PRISONERS UNDER INTERNATIONAL LAW 81 (3d Edition 2009).

[2] Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment art. 1(1), Dec. 10, 1984, 1465 U.N.T.S. 85 (defining torture as "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.").

law and the U.S. Constitution. The absolute prohibition on torture is recognized as a *jus cogens*, or peremptory norm of international law that is binding on all governments.[3] No treaty or domestic statute can supersede this prohibition.[4] The prohibition against torture is subject to universal jurisdiction and obligates governments to apprehend and bring to justice perpetrators wherever they are to be found.[5]

The Committee Against Torture, European Court of Human Rights, and Inter-American Court of Human Rights have all stressed that solitary confinement "should be 'an exceptional measure of limited duration' that is subject to strict judicial review both when it is applied and when it is prolonged."[6] This position was endorsed in the Istanbul Statement on the Use and Effects of Solitary Confinement that was adopted in December 2007 at the International Psychological Trauma Symposium, which declared that "[a]s a general principle solitary confinement should only be used in very exceptional cases, for as short a time as possible and only as a last resort."[7] The statement emphasized that when solitary is imposed it should be done in a manner that "raises the level of meaningful social contacts for prisoners" via the provision of meaningful activities in and out of their cells, social interactions with other prisoners, more visits from family and community members, as well as in-depth discussions with psychologists, psychiatrists, and religious personnel.[8]

The United Nations Special Rapporteur on Torture and Other Cruel, Inhuman and Degrading Treatment, Juan Mendez, recently submitted a report to the General Assembly on solitary confinement that resoundingly affirms the position that U.S.-style supermax units are criminal under international law.[9] Noting his opinion "that all human rights standards are subject to the norm of 'progressive development,' in that they evolve in accordance with emerging new features of repression,"[10] the report states that "the social isolation and sensory deprivation that is imposed by some States does, in some circumstances, amount to cruel, inhuman and degrading treatment and even torture."[11] Clarifying just what circumstances rise to the level of a violation of international human rights law, the Special Rapporteur declared that punitive or prolonged solitary confinement constitutes torture or cruel, inhuman or degrading treatment in all instances. When imposed "for the purpose of punishment," solitary confinement "cannot be justified for any reason, precisely because it imposes severe mental pain and suffering beyond any reasonable retribution for criminal behavior," in violation of the CAT.[12] In addition, Mendez found that

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[3] Rodley, *supra* note 1 at 65-66.
[4] *Id.*
[5] *Id.* at 49.
[6] Jules Lobel, *Prolonged Solitary Confinement and the Constitution*, 11 U. Pa. J. Const. L. 115, 129-30 (2008).
[7] Rodley, *supra* note 1 at 407.
[8] *Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, Annex, U.N. Doc. A/63/175 (July 28, 2008).
[9] *Interim Report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment* U.N. Doc. A/66/268 (August 5, 2011) (Defining solitary confinement in ¶ 26 as "the physical and social isolation of individuals who are confined to their cells for 22 to 24 hours a day.").
[10] *Id.* at ¶ 37.
[11] *Id.* at ¶ 20.
[12] *Id.* at ¶ 72 (Noting that "[t]his applies as well to situations in which solitary confinement is imposed as a result of a breach of prison discipline, as long as the pain and suffering experienced by the victim reaches the necessary severity.").

"any imposition of solitary confinement beyond 15 days constitutes torture or cruel, inhuman or degrading treatment or punishment," and called on the international community to adopt such a standard and impose "an absolute prohibition on solitary confinement exceeding 15 consecutive days."[13]

International law, as codified in treaties that are recognized as the Supreme Law of the Land under the U.S. Constitution, mandates that local, state, and federal governments have an affirmative duty to conduct independent, legitimate and transparent investigations and prosecute guards and officials involved in the perpetration or enabling of torture and other cruel, inhuman, and degrading treatment of prisoners. Survivors of torture are entitled to justice and state officials of every jurisdiction are responsible for ensuring the abolition of torture within institutions subject to their control.

Psychological Trauma of Solitary Confinement

Solitary confinement units, by design and intent, inflict immense and predictable psychological suffering and trauma. In 2009 HRC submitted questionnaires to over 75 prisoners throughout the state about conditions in solitary confinement units. Responses to these questionnaires confirmed that a disturbingly large number of prisoners in solitary have experienced one or many of the following symptoms: depression, nervousness, difficulty concentrating, deterioration of social skills, speech impairment, feelings of rage, agitation, inability or difficulty sleeping, fatigue, and mood swings. Prisoners have reported setting their cells on fire, self-mutilation, and attempts to hang themselves. The mandated response from prison staff in these circumstances is to send guards in riot gear into the cell to "extract" the prisoner, often attacking him or her with pepper spray first, and then forcibly transporting the cuffed and shackled prisoner to a psychiatric observation cell where he or she is subjected to even more intensive isolation. Several prisoners have reported being kept in these cells without bedding, a mattress, running water, or clothes for days at a time. This brutality exacerbates and multiplies the incidence of mental health problems inside prisons.

HRC has also received numerous reports of guards encouraging, suggesting, and goading prisoners to commit suicide and not responding to requests for mental health care. When mental health care is provided, it is grossly inadequate to the point of being completely ineffective. Psychotropic drugs are often administered in lieu of necessary counseling, and these prescriptions are sometimes stopped arbitrarily with devastating effects.

On April 24, 2009, Matthew Bullock, a prisoner housed in solitary at State Correctional Institution (SCI) Dallas, Pennsylvania, committed suicide by hanging. In the days and weeks that followed HRC obtained 8 statements from other prisoners testifying that: (1) Bullock was severely depressed as a consequence of conditions in the Restricted Housing Unit (RHU), where he was being held in violation of a judge's sentencing order that he serve his time in a secure mental health institution; (2) Bullock made staff aware of his urge to commit suicide; (3) Bullock was taken off psychotropic medications despite his mindset; (4) guards ignored his plea for help and even encouraged him to kill himself; (5) guards moved him from a cell with a camera to a cell without a camera after Bullock threatened to kill himself; (6) staff then failed to make rounds for at least four hours during which time Bullock killed himself.

On May 6, 2011, John McClellan, a prisoner with a history of mental illness in SCI Cresson's RHU, committed suicide. HRC received four letters stating that prison guard

[13] *Id.* at ¶ 76.

McCullen and Sgt. Bejmovic encouraged McClellan to kill himself after he sought help for his mental condition. Another report indicated that Unit Manager Michelle Houser ignored the warning signs of his mental crisis. Guards then retaliated against prisoners who filed grievances on the staff members who incited McClellan to suicide.

On December 1, 2011 the Department of Justice launched a civil rights investigation into SCI Cresson and SCI Pittsburgh based on reports of human rights violations. The DOJ will investigate SCI Cresson to determine if the prison "provided inadequate mental health care to prisoners who have mental illness, failed to adequately protect such prisoners from harm, and subjected them to excessively prolonged periods of isolation, in violation of the Eighth Amendment to the U.S. Constitution."

Testimony from Christopher Balmer, May, 2011 at SCI Cresson: "I attempted to kill myself over 7 times while at SCI Cresson and destroyed my body with razor blades. The administration ignored my pleas for help, the same administration that is locking me down in the RHU long term (since 2007) with no prospect of release in the near future. They know of my extensive mental health issues and my problems w/ self mutilation and suicide attempts when depressed and severely stressed. As a long term resident in the RHU and as a mental health inmate, the risk of death is high due to the environment of solitary confinement long term increasing the risks of suicide. Since the SCI Cresson administration does not like me for pressing litigation against them in a state court and civil court they are playing hardball and refusing to … help me w/ my problems w/ self mutilation and suicide attempts. I'm not benefiting from sitting in an RHU setting with no mental health treatment. I'm actually getting more depressed stressed out and my hypertension is getting worse due to fear of physical assault by this administration. I was already told by the superintendent that he's going to have guards kill me and cover it up as a suicide. Each day I'm in fear of assault and death."

A Culture of Terror and Abuse

Within this context of social isolation and deprivation, whereby certain people are deemed unworthy and rendered unable to exercise the most basic elements of their human personality, it is unsurprising that brutality flourishes. Instances of staff mistreatment "cannot be characterized as unfortunate but merely occasional incidents to solitary confinement; they are too often an integral part of the experience."[14]

A review of thousands of pages of letters, affidavits, grievances, misconducts, other prison documents, legal paperwork, and conversations with family members and support people has revealed a culture of terror within the solitary confinement units in PA prisons. HRC has spoken and corresponded with survivors of this abuse, people who have been beaten, had their bones broken, been saturated with pepper spray and left in excruciating pain for hours, repeatedly shocked with 50,000-volt charges, had glass, insects, and dirt placed in their food, and who have been subjected to casual and routine use of racist language and images.

A culture of terror is defined as a set of assumptions and practices that divide a community into those with absolute power and those who are absolutely powerless. This dynamic is inherent within the logic of prisons, and is at its most intense in the solitary confinement units. Any attempt to upset this totalitarian balance and its dehumanizing logic is met with remorseless brutality by those in power. The core elements of this culture of terror

[14] Craig Haney and Mona Lynch, *Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement*, 23 N.Y.U. Rev. L. & Soc. Change 477, 531 (1997).

include: arbitrary and biased processes for establishing who is placed in solitary; utilization of fabricated misconducts as a tool of retaliation; systematic denial of prisoner grievances regardless of their merit; the use of violence as a standard technique for enforcing obedience; refusal to engage in constructive dialogue on the part of prison authorities; targeting witnesses of abuse for purposes of intimidation; displays of overt racism as a tool of dehumanization.

Those with power in this culture reinforce their rule through a strict code of silence whereby they refuse to inform on one another to those higher up or outside of the prison hierarchy. Prison guards enforce their rule through threats and use of force, along with deprivations of basic necessities such as food, water, hygienic items, cleaning supplies, clothing, and bedding. Prison administrators and top officials of the PA DOC adopt an informal though strictly enforced policy of turning a blind eye to reports of torture and abuse.

Professor of Corrections and Correctional Law at Minnesota State University, James Robertson, has stated that "Retaliation is deeply engrained in the correctional office subculture; it may well be in the normative response when an inmate files a grievance, a statutory precondition for filing a civil rights action." He also refers to a survey of Ohio prisoners that found "that 70.1% of inmates who brought grievances indicated that they had suffered retaliation thereafter; moreover, 87% of all respondents and nearly 92% of the inmates using the grievance process agreed with the statement, 'I believe staff will retaliate or get back at me if I use the grievance process.'" As Robertson says, guards who retaliate "cannot be regarded as rogue actors. They act within the norm."[15]

At the end of September 2010, prisoners in the solitary confinement units at SCI Huntingdon began a sustained campaign of organized, non-violent resistance. The initial protest occurred on September 29, 2010, when eight prisoners refused to return to their cells from the exercise cages where they are provided one hour of time outside of their cells five days a week. Anthony Allen, Theodore Byard, Vincent Hallman, Rhonshawn Jackson, Kyle Klein, Eric Mackie, Gary Wallace, and Jeremiah Weems staged a peaceful demonstration in protest of the "abuse, racism, retaliation and witness intimidation" they were being subjected to. The prison responded with violence: "we were all sprayed with [pepper spray] and forcibly removed from the exercise yard. We were then brought into our cells with the spray all over our skin which continues to burn until it is properly washed away. Approximately 4 hours later I was burning so bad and my breathing was so hampered that I had to cover my cell door to force a cell removal so that I could receive medical attention." Another of the non-violent protestors stated, "I was then forcibly extracted from my cell taken to an isolation cell where I was stripped naked, with no running water, or working toilet, and left to sleep naked on a concrete slab. As a result my hips were bruised, sore, and I am in extreme pain."

Non-violent protests continued throughout the month. In all, HRC received reports that fourteen men in the solitary confinement unit at SCI Huntingdon were subjected to attacks with pepper-spray and cell extracted in less than one month: Anthony Allen, Theodore Byard, Timothy Everson, Vincent Hallman, Eric Iorio, Rhonshawn Jackson, Jamiel Johnson, Anthony Jones, Kyle Klein, Anthony Martin, Jesse Ring, Naseer Shakur, Gary Wallace, and Jeremiah Weems. Despite the absolute refusal by the prison to address their grievances, many of those involved in the protests refused to be deterred. "Their goal is to stop us from speaking out against them," wrote Kyle Klein, "but it will never work, not a chance in hell, or the hell we are in." He added: "Even when winning is impossible, quitting is far from optional."

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[15] *"One of the Dirty Secrets of American Corrections": Retaliation, Surplus Power, and Whistleblowing Inmates*, 42 U. Mich. J.L. Reform 611 (2009).

Vincent Hallman explained his willingness to engage in non-violent protest and risk certain violence "because your honor of being seen as a human being is at stake and your right to be treated as one is being stripped away from you so you'll take the chances of being hurt in the process cause it's worth it. That's courage."

This cycle of dehumanization and abuse once again turned lethal in Pennsylvania on April 26, 2012, when John Carter, a 32-year-old state prisoner from Pittsburgh, was killed by prison staff during a cell extraction in the solitary confinement unit at SCI Rockview. A cell extraction is a procedure where six guards suit up in riot gear armed with pepper spray, a stun shield and taser, and enter a prisoner's solitary confinement cell and forcibly subdue, handcuff and shackle him. According to witness accounts, prison guards filled Carter's solitary confinement cell with an extraordinary quantity of pepper spray prior to opening his cell door, tasering and assaulting him. One report stated that the incident began after Carter protested being deprived of food. Another prisoner reported that during the cell extraction he could hear Carter say, "Alright, alright, I'm coming out. Let me cuff up." The same report stated that he then heard a guard say, "No, you should've come out when we asked you the first time," and that the guards continued to spray Carter, "turning his cell into a gas chamber."[16]

John Carter had been held in solitary confinement in several different prisons for the last eight to eleven years where he had developed a reputation as a jailhouse lawyer willing to speak out against the rampant and endless cycle of human rights violations in prisons throughout the PA DOC. A fellow prisoner wrote of Carter: "He was a person of integrity. He did not believe in abuse of others, especially the abuse of prisoners from prison guards. If he could help someone in understanding the law, he was there. And he had a lot of patience with others, especially the mentally impaired."

Years and Decades Inside the Prison within the Prison

That John Carter spent approximately one decade in solitary confinement is a fate shared by many others in the PA DOC, although the number of people being held in such long-term solitary confinement is unknown. As of August 2010, the PA DOC confirmed that 85 persons were currently being held on the Restricted Release List (RRL), a form of indefinite, possibly permanent solitary confinement that is subject to an elaborate process for release to general population that must be authorized by the unit staff at the prison, the warden, the regional deputy secretary of the department, and finally the secretary of corrections. Though the PA DOC has refused to release the names of prisoners on the RRL, many prisoners have been individually informed that they are on RRL status. Interviews with these prisoners show that the majority of people on this list are people of color and many have a reputation as jailhouse lawyers or human rights defenders inside the prison.

One person being held in long-term solitary is Russell Maroon Shoats, a 68-year old prisoner who has spent the last twenty-one years in solitary confinement. He has not been issued any misconducts for violating prison rules in more than two decades. Despite this record, prison authorities continue to hold him in 23-24 hour lockdown at SCI Greene, allegedly because he managed to escape from state prisons on two occasions more than thirty years ago. However, during a visit with SCI Greene's warden Louis Folino, a visitor was informed that Maroon is

[16] For coverage of the killing of John Carter see PA Prison Report May 7 (http://hrcoalition.org/node/211); PA Prison Report May 14 (http://hrcoalition.org/node/213); PA Prison Report May 21 (http://hrcoalition.org/node/215).

actually being kept in solitary confinement due in substantial part to his role as an organizer and a political dissident, a straightforward admission that he is being targeted for exercising constitutionally-protected rights.

During the seventies and eighties, Maroon was frequently placed in solitary confinement in order to repress his organizing ability. Maroon was placed in solitary after being elected as president of the DOC-approved lifers organization in 1982. In 1989, after a prisoner uprising at SCI Camp Hill in central Pennsylvania, Maroon was temporarily transferred to the federal penitentiary in Leavenworth, Kansas, although he was not confined at SCI Camp Hill during the uprising and played no role in it. During his eighteen months in federal custody, Maroon was held in the prison's general population without incident. Upon his return to Pennsylvania, he was immediately placed in solitary confinement, where he has remained to this day in violation of his right to be free from torture and other cruel, inhuman and degrading treatment.

Paul Rogers is another prisoner on the RRL. He has spent the last twelve years in solitary confinement after he assaulted a guard in the year 2000. This incident occurred after an earlier period of solitary confinement (which is known to produce anger and lack of impulse control). He has not had a serious disciplinary infraction in the last twelve years, and despite being recommended for removal from the RRL and release into general population, the former Secretary of the PA DOC, Jeffrey Beard, rejected the recommendation without explanation.

Other prisoners, some on the RRL and some not, have been held in solitary confinement for more than five years, many for a decade or longer: Carrington Keys, Andre Jacobs, Damont Hagan; Andre Gay, Jerome Coffey, Hector Huertas, Caine Pelzer, Gary Tucker, Chris Washington, Michael Edwards—these are a handful of the hundreds of people in Pennsylvania who have been forced to survive in an atmosphere dedicated to destroying their humanity.

In addition to being an unconscionable and illegal violation of human rights and constitutional law, solitary confinement fails to achieve its stated objectives of improving prison security and public safety. Counter to the claim that solitary confinement improves security, decreases violence, or produces any significant positive outcomes is that "there are no credible or convincing data" supporting such an assertion.[17] In stark contrast to the "massive body of evidence" documenting the suffering caused by solitary confinement, there is an "absence of documentation" supporting claims that the practice achieves its stated objectives.[18] That there is an absence of any data to support the hypothesis that solitary confinement reduces violence and improves security is further confirmed by the emerging trend in certain states to reduce the solitary population as a cost-saving measure, disproving the fraudulent claims of prison officials that these units are needed to preserve "order" and "security." To the contrary, extant research and analysis strongly suggests that the use of solitary confinement is counter-productive in regard to reducing violence and positively reforming antisocial behaviors.

Prisoner Protest and Leadership in Defense of Human Rights

It is unlikely that a senate subcommittee hearing would have ever been convened to discuss the issue of solitary confinement were it not for the movement of non-violent resistance in solitary units across the nation. In July 2011, a hunger strike in the Security Housing Unit

[17] Haney & Lynch, *supra* note 14 at 534-35; *See also*, Jennifer R. Wynn and Alisa Szatrowski, *Hidden Prisons: Twenty-Three-Hour Lockdown in New York State Correctional Facilities*, 24 Pace L. Rev. 497, 514 (2004).
[18] *Id.* at 536.

(SHU) of Pelican Bay State Prison in California spread to nearly a third of the California Prison system, generating national and international attention. A supporter of the striking prisoners explained the reality of those trapped in the SHU: "They had exhausted the legal process, going through the avenues, no matter how narrow, outlined by the prison administration. They had nothing else besides their bodies to use." Swelling to include 6,600 prisoners, the July strike was the beginning of a renewed struggle against the conditions of solitary confinement in California prisons, and has resulted in a federal lawsuit challenging the use of long-term isolation in California.

California was not the first major hunger strike in the nation or the most recent. Prisoners held in solitary units in North Carolina, Ohio, and Virginia have staged hunger strikes in recent months, and countless others have occurred across the nation. Each strike has focused mainly on the policies that place and keep prisoners in solitary units. In California one of the core policies used to hold people in indefinite solitary confinement is the "gang validation" program, which targets prisoners based on their alleged affiliations with a gang, a determination that is often made on the basis of secret and unreviewable evidence. In order to be released from the SHU, a prisoner has to become a state informant, providing any and all information about the gang, thus placing that person and their family at serious risk of reprisal. In Ohio there are no guidelines for how long a prisoner can be held in the solitary unit and prisoners placed there for whatever reason can expect to stay for at least a year.

Hunger strikes and other extreme means that solitary prisoners have been driven to in order to seek redress for the glaring constitutional and human rights violations they are suffering demonstrate the fundamental inhumanity of the use of solitary. It is prisoners themselves who have taken leadership in speaking out against their own dehumanization and that of their fellow prisoners, and it is they who have been most instrumental in exposing the true nature of prison life in this country. Filing grievances and lawsuits, alerting outside governmental and non-governmental agencies, mobilizing friends and support people are all routine acts of non-violent, constitutionally-protected protest and whistle-blowing. Those who engage in hunger strikes and other individual and collective acts of protest and non-violent resistance do so at great risk to themselves, as prison officials almost uniformly treat attempts to address grievances as acts of subversion to be violently suppressed. It is the efforts of those inside these units fighting to hold onto their sanity and their humanity that have alerted and motivated the growing array of support groups, family members, civil and human rights groups, lawyers, mental health experts, and legislators to begin to recognize the scale of and urgency of their predicament.

Recommendations

While our government purports to be concerned about human rights and the rule of law globally, the unacknowledged human rights crisis inside U.S. prisons indicates that the government is not in a position to lecture others on these subjects. A fundamental change in public consciousness and governmental priorities is long overdue if the U.S. is to begin to bridge the vast chasm between its stated respect for the rule of law and the reality of widespread and normalized torture and other ill-treatment in the prison system.

The United States Congress is profoundly implicated in these widespread and systemic human rights violations. In addition to embarking on a historically and globally unprecedented experiment in race and class-based mass incarceration, the passage of the Prison Litigation Reform Act in 1996 raised deliberate obstacles to prisoners' ability to vindicate their civil rights

in U.S. courts. If this hearing is to be the beginning of a serious, constructive engagement with the urgent and worsening human rights crises inside U.S. prisons, it is imperative that the voices, experiences, and leadership of current and former prisoners and those communities most impacted by solitary confinement and mass incarceration are at the center of reversing this culture of dehumanization. Some recommendations toward the abolition of torture in U.S prisons that can be acted on by the U.S. Congress include:

1. Holding further hearings in Washington, D.C. and in the home districts of individual representatives and senators that feature the testimony of current and former prisoners, their families, civil and human rights organizations, and other relevant experts and advocates. These hearings must directly confront the debilitating psychological impact of solitary confinement and its use as a tool of terror and repression.
2. Creating a commission to investigate torture and other ill-treatment within state and federal prisons. This commission shall be shaped by prisoners and their families and focus on the voices and experiences of those whom have survived solitary confinement torture. The commission must be granted the authority to subpoena government officials and prison officials and records. Periodic progress reports will be mandatory and the commission must be granted the authority to bring criminal charges as soon as the evidentiary threshold for such is met. All records of the commission's investigation shall be made available upon request in order to satisfy the requirements of transparency.
3. Introducing legislation to prohibit torture and other cruel, inhuman and degrading treatment in county, state, and federal prisons, including military prisons. Solitary confinement should be identified as a *prima facie* statutory violation of this law.
4. These recommendations should be construed as part of a broader process of Truth and Accountability that seeks to abolish solitary confinement, other forms of torture, and mass incarceration. This process will only be effective if it is rooted in the leadership of prisoners and communities targeted by policies of mass incarceration.

STATEMENT
OF THE
HUMAN RIGHTS DEFENSE CENTER

Reassessing Solitary Confinement: The Human Rights, Fiscal and Public Safety Consequences

BEFORE THE

UNITED STATES SENATE
COMMITTEE ON THE JUDICIARY

SUBCOMMITTEE ON THE CONSTITUTION, CIVIL RIGHTS AND HUMAN RIGHTS

PRESENTED ON

June 19, 2012

STATEMENT OF THE
HUMAN RIGHTS DEFENSE CENTER

"It's an awful thing, solitary. It crushes your spirit and weakens your resistance more effectively than any other form of mistreatment."

U.S. Senator John McCain, on his treatment as a P.O.W.[1]

Introduction

The Human Rights Defense Center (HRDC) is a 501(c)(3) non-profit organization dedicated to protecting the rights of persons incarcerated in prisons, jails and other detention facilities. HRDC publishes *Prison Legal News* (PLN), a monthly print magazine that reports on issues related to criminal justice and civil rights. PLN has published continuously since 1990 and has extensively covered topics related to solitary confinement and isolation units in the U.S. prison system.

This Statement is not intended as a comprehensive examination of the serious issue of solitary confinement (also referred to herein as segregation); rather, it is intended to provide the Subcommittee with salient points that may be of interest when considering this topic. Other organizations that focus on solitary confinement, including Solitary Watch,[2] the Segregation Reduction Project of the Vera Institute of Justice,[3] the American Friends Service Committee's STOPMAX campaign[4] and the Stop Solitary project of the American Civil Liberties Union,[5] can provide more detailed information.

Solitary Confinement: The Past

Solitary confinement in the U.S. prison system has a lengthy history, dating back to the nation's first prison, the Walnut Street Jail, established in Philadelphia. In 1790, legislation authorized the construction of 16 small, individual cells at the Walnut Street Jail where prisoners were kept in isolation.[6] Under what became known as the Pennsylvania System, prisoners were held in solitary confinement and segregated from each other almost all of the time, including during meals. The Pennsylvania System was intended to induce penitence and reformation by providing prisoners with time alone to contemplate their sins.[7]

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[1] Richard Kozar, *John McCain (Overcoming Adversity)*, Chelsea House Pub. (2001)
[2] http://solitarywatch.com
[3] http://www.vera.org/project/segregation-reduction-project
[4] http://afsc.org/campaign/stopmax
[5] https://www.aclu.org/stop-solitary-resources-advocates
[6] http://www.prisonsociety.org/about/history.shtml
[7] As stated by Alexis de Tocqueville after visiting the Eastern State Penitentiary in Philadelphia in 1831, "Thrown into solitude he reflects. Placed alone in view of his crime, [the prisoner] learns to hate it; and if his soul be not yet surfeited with crime, and thus have lost all taste for anything better, it is in solitude, where remorse will come to assail him." Gustave Beaumont and Alexis de Tocqueville, *On the Penitentiary System in the United States and its Applicability to France* (Edwardsville: Southern Illinois University, 1964) (originally published 1833)

However, problems were noted even during the early years when solitary confinement was used as a form of correctional management, and the Pennsylvania System eventually fell out of favor. When Charles Dickens toured the United States in 1842, he visited the Eastern State Penitentiary in Pennsylvania and commented on conditions at that facility, including the use of segregation. He wrote:

> The system here, is rigid, strict, and hopeless solitary confinement. I believe it, in its effects, to be cruel and wrong. In its intention, I am well convinced that it is kind, humane, and meant for reformation; but I am persuaded that those who devised this system of Prison Discipline, and those benevolent gentlemen who carry it into execution, do not know what it is that they are doing. I believe that very few men are capable of estimating the immense amount of torture and agony which this dreadful punishment, prolonged for years, inflicts upon the sufferers.... I hold this slow and daily tampering with the mysteries of the brain, to be immeasurably worse than any torture of the body: and because its ghastly signs and tokens are not so palpable to the eye and sense of touch as scars upon the flesh; because its wounds are not upon the surface, and it extorts few cries that human ears can hear; therefore I the more denounce it, as a secret punishment which slumbering humanity is not roused up to stay.[8]

A more detailed account of the history of solitary confinement in the U.S. prison system, from its inception to its modern usage, is presented in "The Resistable Rise and Predictable Fall of the U.S. Supermax," by Stephen F. Eisenman.[9]

Solitary Confinement: The Present

According to a 2005 study, an estimated 25,000 prisoners are held in solitary confinement in U.S. prisons, jails and detention facilities.[10] Solitary confinement takes several forms, including placement in isolation units, often called Security Housing Units (SHUs) or Special Management Units (SMUs) but more commonly known in prison vernacular as "the hole." Prisoners may be placed in solitary for a myriad of reasons, including their security custody level, administrative segregation (ad-seg), disciplinary segregation and even protective custody.[11] Thus, the actual number of prisoners held in solitary confinement is likely much higher, and was estimated at more than 81,600 according to a 2005 Bureau of Justice Statistics report.[12]

Supermax facilities are literally built around the concept of solitary confinement. The federal Bureau of Prisons operates the supermax ADX prison in Florence, Colorado, and at least 44 states operate supermax facilities, including Pelican Bay State Prison in California and Red Onion State Prison in Virginia.[13] Some jails (including Rikers Island in New York City), as well as women's prisons and juvenile facilities, also maintain solitary confinement units.[14]

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[8] Charles Dickens, *American Notes for General Circulation*, Chapman & Hall (1842)
[9] https://www.prisonlegalnews.org/23880_displayArticle.aspx
[10] Daniel P. Mears, Urban Institute, "Evaluating the Effectiveness of Supermax Prisons" (2006)
[11] http://solitarywatch.com/faq
[12] http://www.jstor.org/stable/pdfplus/10.1525/fsr.2011.24.1.46.pdf?acceptTC=true
[13] http://solitarywatch.com/faq
[14] *Id.*

Conditions in Solitary Confinement

Solitary confinement is generally defined as isolating prisoners in individual cells for a majority of the time, usually 22-24 hours a day, with minimal contact with other people.[15] Prisoners eat, sleep, use the toilet and live in such conditions for extended periods that last up to decades.[16] When they leave their cells they are usually handcuffed and shackled, even to go shower.

Access to work and education programs, phones, visitation and even reading material is often curtailed (in the latter case, with the approval of the U.S. Supreme Court[17]). According to a 2008 American Friends Service Committee report, "Buried Alive: Long-Term Isolation in California's Youth and Adult Prisons," the lights in segregation cells may be left on 24 hours a day, some solitary confinement cells have no windows, and out-of-cell exercise (30-60 minutes per day) is usually provided in an enclosed "dog-run" or outdoor cage.[18]

While it is far removed from the reality, one way to experience solitary confinement firsthand is to lock oneself in a bathroom – which is the approximate size of an 8x10' cell and contains the same amenities of a toilet and sink – and remain there for a period of several years, with meals being delivered through a slot in the door.

Solitary confinement was described by one U.S. District Court as follows:

> Inmates on Level One at the State of Wisconsin's Supermax Correctional Institution in Boscobel, Wisconsin spend all but four hours a week confined to a cell. The "boxcar" style door on the cell is solid except for a shutter and a trap door that opens into the dead space of a vestibule through which a guard may transfer items to the inmate without interacting with him. The cells are illuminated 24 hours a day. Inmates receive no outdoor exercise. Their personal possessions are severely restricted: one religious text, one box of legal materials and 25 personal letters. They are permitted no clocks, radios, watches, cassette players or televisions. The temperature fluctuates wildly, reaching extremely high and low temperatures depending on the season. A video camera rather than a human eye monitors the inmate's movements. Visits other than with lawyers are conducted through video screens.[19]

Who is Placed in Solitary?

Corrections officials frequently claim that the "worst of the worst" prisoners are held in solitary confinement – those who pose a threat to prison staff, security or other prisoners. While that is true in some cases, other prisoners are placed in segregation because they are perceived as being "troublemakers" due to their religious or political beliefs, or because they exercise their Constitutional right to file grievances and lawsuits,[20] or violate prison rules.

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[15] *Id.*

[16] Federal prisoner Tom Silverstein, for example, has been held in solitary confinement since 1983. Louisiana prisoners Herman Wallace and Albert Woodfox, two of the Angola Three, served 36 years in solitary confinement before being moved to another prison in 2008; the third Angola Three prisoner, Robert King, was released in 2001 after spending 29 years in solitary

[17] http://www.law.cornell.edu/supct/html/04-1739.ZS.html

[18] http://afsc.org/sites/afsc.civicactions.net/files/documents/Buried%20Alive%20%20PMRO%20May08%20.pdf

[19] *Jones'El v. Berge*, 164 F.Supp.2d 1096, 1098 (W.D. Wis. 2001)

[20] Previously, the website for the Tamms supermax prison in Illinois said the facility housed "some of the most litigious inmates in the department's custody." See: https://www.prisonlegalnews.org/20688_displayArticle.aspx

Few if any prison systems have clear, objective standards for placing prisoners in solitary confinement based on the severity of their actual conduct, particularly when they do not pose a threat to prison staff or other prisoners. Corrections officials have almost unfettered discretion in deciding whether a prisoner should be held in segregation, which can lead to arbitrary results.

Also, after spending hundreds of millions of dollars to build and staff supermax prisons, corrections officials may feel the need to keep them full to justify their existence. If there is an insufficient number of violent or dangerous prisoners to fill the supermax beds, then the criteria for placement in segregation are relaxed so that other prisoners can occupy solitary confinement units. Thus, it is not surprising that prisoners are sometimes placed in segregation "for petty annoyances like refusing to get out of the shower quickly enough."[21]

Consider that the California Code of Regulations, Title 15, Section 3315, outlines dozens of "Serious Rule Violations" that may result in "segregation from the general population." Such serious infractions include "possession of five dollars or more without authorization," "tattooing or possession of tattoo paraphernalia," "refusal to perform work or participate in a program as ordered or assigned," "participation in gambling," and "self mutilation or attempted suicide for the purpose of manipulation."[22]

In Virginia, a number of prisoners who practice the Rastafarian religion have been held in segregation for over a decade. Those prisoners were not placed in solitary because they were violent, incited a riot or similar reasons. Rather, they refused – based on their religious beliefs – to cut their hair. Rastafarians let their hair grow in dreadlocks and do not trim their beards, which conflicts with the grooming policy of the Virginia Department of Corrections.[23]

Consequently, Rastafarian prisoners who refused to cut their hair were kept in solitary. According to a June 2010 *Associated Press* article, 48 Virginia prisoners were placed in segregation because they would not follow the prison system's grooming policy.[24] In November 2010, 31 Rastafarian prisoners were released from segregation and transferred to another facility; however, some were returned to solitary confinement several months later after they refused to participate in a program that required them to cut their hair and shave their beards.[25] The use of prolonged segregation to punish Rastafarian prisoners who will not comply with the prison system's grooming policy has been upheld by the federal courts.[26]

Also, in Louisiana, a trio of prisoners known as the Angola Three[27] was held in solitary for up to 36 years, not because they continued to be violent but because in the 1970s they were involved with forming a Black Panther chapter while incarcerated. Angola prison warden Burl Cain said of one of the Angola Three prisoners in a deposition, "He wants to organize. He wants to be defiant.... He is still trying to practice Black Pantherism, and I still would not want him walking around my prison because he would organize the young new prisoners."[28] When asked

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[21] http://www.newyorker.com/reporting/2009/03/30/090330fa_fact_gawande#ixzz1xjz6mWzA
[22] http://www.cdcr.ca.gov/Regulations/Adult_Operations/docs/Title152006Final.pdf
[23] https://www.prisonlegalnews.org/24080_displayArticle.aspx
[24] http://www.firstamendmentcenter.org/va-officials-rastafarian-inmates-no-longer-isolated-because-of-hair
[25] https://www.prisonlegalnews.org/24080_displayArticle.aspx
[26] *McRae v. Johnson*, 261 Fed.Appx. 554 (4th Cir. 2008); *Smith v. Ozmint*, 396 Fed.Appx. 944 (4th Cir. 2010).
[27] Albert Woodfox, Herman Wallace and Robert King; Woodfox and Wallace were convicted of killing a prison guard, while King was convicted of murdering another prisoner (that conviction was later overturned; he pleaded guilty to conspiracy to commit murder and was released in 2001)
[28] https://www.documentcloud.org/documents/207537-burl-cain-deposition-2008.html

whether the Angola Three were political prisoners, Warden Cain responded, "Well, yes. Well, no, I don't like the word political."[29]

It is clear that in some cases, prisoners are held in solitary confinement in U.S. prisons due to their religious and political beliefs, not because they are violent or dangerous. In other cases – particularly in California – prisoners are placed in segregation because they are deemed to be "validated" gang members or are suspected of having ties to prison gangs. "There is no other state in the country that keeps so many inmates in solitary confinement for so long," stated Alexis Agathocleous, a staff attorney with the Center for Constitutional Rights.[30] Around 15,000 prisoners are held in segregation in California alone.[31]

However, the determination by prison officials that a prisoner is a gang member may be incorrect, as was the case with California state prisoner Ernesto Lira, who was "validated" as a gang member and placed in an isolation unit for 8 years. On September 20, 2009, following a four-week trial, a U.S. District Court held that Lira's gang validation was not supported by accurate or reliable evidence and his due process rights had been violated. The court found that as a result of his lengthy stint in solitary, Lira suffered clinical depression and PTSD. His record was expunged and he was awarded over $1 million in attorney fees.[32]

But far exceeding the above examples, one type of offender is "vastly overrepresented" in segregation units: prisoners with mental illnesses.[33]

Solitary Confinement and Mental Health

Because the negative impact of solitary confinement on prisoners' mental health is so well established, it will not be discussed at great length in this Statement. A large body of research has found that solitary confinement results in a plethora of mental health problems;[34] that prisoners placed in segregation are more likely to commit suicide than those not held in such conditions;[35] and that solitary confinement is particularly damaging for people who have pre-existing mental health issues or are otherwise vulnerable, such as juveniles.

As Judge Richard Posner with the U.S. Court of Appeals for the Seventh Circuit put it, "there is plenty of medical and psychological literature concerning the ill effects of solitary confinement (of which segregation is a variant)."[36]

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[29] *Wilkerson v. Stalder*, U.S.D.C. (M.D. La.), Case No. 00-cv-00304-RET-DLD (Docket No. 233), online at: http://www.angola3.org/uploads/Angola_8th_A_Summary_Judgment_Decision.pdf

[30] http://www.huffingtonpost.com/2012/05/31/pelican-bay-state-prison-inmates-lawsuit-solitary-confinement-torture_n_1560175.html

[31] https://www.prisonlegalnews.org/21966_displayArticle.aspx

[32] https://www.prisonlegalnews.org/22316_displayArticle.aspx; www.nytimes.com/2012/03/31/us/battles-to-change-prison-policy-of-solitary-confinement.html?pagewanted=all

[33] https://www.prisonlegalnews.org/18789_displayArticle.aspx

[34] E.g., see: Bruce A. Arrigo and Jennifer Leslie Bullock, "The Psychological Effects of Solitary Confinement on Prisoners in Supermax Units," *International Journal of Offender Therapy and Comparative Criminology* (2008); Craig Haney, "Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement," *Crime & Delinquency* 49, no. 1 (2003); Stuart Grassian, M.D., "Psychopathological Effects of Solitary Confinement." *American Journal of Psychiatry* (1983)

[35] https://www.prisonlegalnews.org/20581_displayArticle.aspx; http://www.usatoday.com/news/nation/2006-12-27-inmate-suicides_x.htm

[36] *Davenport v. DeRobertis*, 844 F.2d 1310, 1316 (7th Cir. 1988); also see: *Madrid v. Gomez*, 889 F.Supp. 1146, 1230 (N.D. Cal. 1995) ("Social science and clinical literature have consistently reported that when human beings are subjected to social isolation and reduced environmental stimulation, they may deteriorate mentally and in some cases develop psychiatric disturbances")

Nor is this a new development. In 1890, the U.S. Supreme Court noted problems with solitary confinement in relation to prisoners' mental health:

> The peculiarities of this system were the complete isolation of the prisoner from all human society, and his confinement in a cell of considerable size, so arranged that he had no direct intercourse with or sight of any human being, and no employment or instruction.... But experience demonstrated that there were serious objections to it. A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community.[37]

Solitary confinement can be accurately described as an effective means of driving the sane insane, while making the insane even more mentally ill. This is in no small part because people are social by nature and need social interaction to maintain a healthy mental state.[38]

As one U.S. District Court stated, "[Solitary confinement] units are virtual incubators of psychoses – seeding illness in otherwise healthy inmates and exacerbating illness in those already suffering from mental infirmities."[39]

It is hard to appreciate the scope and seriousness of mental health problems that result from solitary confinement without reading accounts of prisoners who cut their "arms and legs with chips of paint and concrete," smear themselves and their cells with feces, strangle themselves with their clothes, swallow glass, and cut out their own testicles.[40] Or the Texas prisoner, held in segregation on death row, who gouged out and ate his one remaining eye.[41]

Release from Solitary Confinement

Significantly, many prisoners are in segregation because they have pre-existing mental health problems that make it difficult for them to follow prison rules.[42] Once in segregation they decompensate, which makes it almost impossible for them to "earn" their way out of solitary through good behavior, because that involves following additional rules and regulations. This creates a Catch-22 that keeps mentally ill prisoners in solitary for extended periods of time, although such prisoners could be better managed with mental health treatment.[43]

In other cases, prisoners are not released from segregation unless they become informants for prison officials or complete their sentences and are released – typically known as "snitch, parole or die" policies,[44] as those are the only ways out of solitary confinement. With respect to "validated" gang members, however, prisoners who are erroneously validated and are not in fact

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[37] *In re Medley*, 134 U.S. 160, 168 (1890)
[38] http://www.newyorker.com/reporting/2009/03/30/090330fa_fact_gawande
[39] *Ruiz v Johnson*, 154 F.Supp.2d 975 (S.D. Tex. 2001)
[40] https://www.prisonlegalnews.org/22870_displayArticle.aspx
[41] http://www.reuters.com/article/2009/01/09/us-usa-deathrow-eyeball-idUSTRE50867T20090109
[42] http://www.hrw.org/sites/default/files/reports/usa1003.pdf
[43] https://www.prisonlegalnews.org/18789_displayArticle.aspx
[44] http://solitarywatch.com/2011/09/22/the-truth-about-solitary-confinement-in-california/

gang members cannot snitch ("debrief"), since they are not members of a gang; thus, they too cannot "earn" their way out of segregation. Such was the case with Ernesto Lira.

Don Specter, director of the Prison Law Office in California, noted that although prisoners "identified as gang members are granted periodic hearings, under the current policy they are not allowed to confront their accusers – or even to know who their accusers are. Nor can they cross-examine witnesses, present their own evidence or argue their case before a neutral decision maker, all basic rights afforded to defendants in the outside judicial system."[45]

In short, in many cases there are no specific criteria governing release from segregation. While most prison systems have a formal review process, in which a prisoner's placement in solitary is reviewed on a regular basis to determine whether they should be released (typically every 30-90 days), the review process is usually *pro forma*, with prison staff rubber-stamping decisions to renew terms of solitary confinement *ad infinitum*.

Although the reviews constitute minimal due process for prisoners placed and held in segregation, in practice very little process is due and there is no meaningful, independent review of decisions to keep prisoners in solitary for years or even decades. When such decisions are challenged, the courts typically defer to the "informed discretion of corrections officials."[46]

Solitary Confinement and Public Safety

The vast majority of prisoners, including those in segregation, will one day be released. When they return to the community, prisoners held in prolonged solitary confinement, with little social interaction or ability to participate in education, treatment or other rehabilitative programs, will have a much more difficult time assimilating into society. This translates to higher recidivism rates, which in turn implicate public safety concerns.

According to recidivism data released by the California Department of Corrections in November 2011, the one-year recidivism rate for prisoners held in SHUs was 52.2%, compared with 47.6% for prisoners not assigned to SHUs. At two years, the recidivism rate was 64.9% for prisoners held in SHUs compared with 60.2% for non-SHU prisoners; at three years the rates were 69.8% and 64.8%, respectively.[47]

Further, in a 2006 report, the Commission on Safety and Abuse in America's Prisons warned that "the misuse of segregation works against the process of rehabilitating people, thereby threatening public safety."

This is particularly true for prisoners released directly from segregation units to the community with no post-release supervision (i.e., prisoners who expire their sentences rather than being released on parole). The Commission on Safety and Abuse in America's Prisons stated, "Prisoners often are released directly from solitary confinement and other high-security units directly to the streets, despite the clear dangers of doing so."[48]

The Commission cited "a large study of former prisoners in Washington"[49] that "tracked rearrest rates among people released from prison in 1997 and 1998, a total of 8,000 former

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[45] http://www.nytimes.com/2012/03/31/us/battles-to-change-prison-policy-of-solitary-confinement.html?pagewanted=all

[46] *Turner v. Safley*, 490 U.S. 78, 90 (1987); see also, Sharon Dolovich, "Forms of Deference in Prison Law," *Federal Sentencing Reporter*, Vol. 24, No. 4, p.245 (April 2012)

[47] http://www.cdcr.ca.gov/adult_research_branch/Research_Documents/ARB_FY_0607_Recidivism_Report_(11-23-11).pdf

[48] http://www.vera.org/download?file=2845/Confronting_Confinement.pdf

[49] http://www.son.washington.edu/faculty/fac-page-files/Lovell-SupermaxRecidivism-4-19-04.pdf

prisoners." The study found that prisoners who had spent at least three continuous months in segregation, and often much longer, "were somewhat more likely than the others to commit new felonies. And among the repeat offenders, formerly segregated prisoners were much more likely to commit violent crimes." Further, prisoners "who were released directly from segregation had a much higher rate of recidivism than individuals who spent some time in the normal prison setting before returning to the community: 64 percent compared with 41 percent."[50]

Additionally, in Illinois, the average recidivism rate for adult prisoners for the two years prior to the opening of the Tamms supermax facility in 1998 was 42.5 percent. In the two years after the supermax opened, the recidivism rate averaged 46.2 percent. In the following two years (fiscal years 2000-2001), the average recidivism rate was 54.5 percent. Thus, recidivism rates in Illinois increased by more than 28 percent from 1996 to 2001, despite – or potentially due to – the opening of a supermax in which hundreds of prisoners were placed in segregation.[51]

Solitary Confinement: The Future

According to the 2006 report by the Commission on Safety and Abuse in America's Prisons:

> There is growing consensus that correctional systems should rely less on segregation, using it only when absolutely necessary to protect prisoners and staff – and that further reforms are needed. Keeping people locked down for hours on end is counter-productive in the long run. To the extent that safety allows, prisoners in segregation should have opportunities to better themselves through treatment, work, and study, and to feel part of a community, even if it is a highly controlled community.[52]

Several state prison systems have taken steps to reduce their use of solitary confinement, and have not experienced adverse effects as a result. Unfortunately, in many cases such changes have occurred due to lawsuits and not because prison officials have recognized and voluntarily intervened to remediate the many problems associated with segregation.

In June 2010, as a result of protracted and adversarial litigation, Mississippi agreed to close Unit 32, a supermax unit at the Mississippi State Penitentiary in Parchman. Prison officials had described prisoners held in Unit 32 as the "worst of the worst." Such prisoners "were permanently locked down in solitary confinement with no possibility of earning their way to a less restrictive environment through good behavior."[53]

Following a consent decree entered in 2006, programs were developed whereby prisoners could earn their way out of solitary confinement through good behavior. They were allowed out of their cells, were permitted to eat meals together, and recreational activities and rehabilitative programs were provided.[54] Violence decreased and the population at Unit 32 was reduced from 1,000 to 150 by late 2007.[55]

Mississippi DOC Commissioner Christopher Epps changed his mind about conditions at Unit 32 during the course of the litigation. "If you treat people like animals, that's exactly the

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[50] http://www.vera.org/download?file=2845/Confronting_Confinement.pdf
[51] https://www.prisonlegalnews.org/23880_displayArticle.aspx
[52] http://www.vera.org/download?file=2845/Confronting_Confinement.pdf
[53] https://www.prisonlegalnews.org/22885_displayArticle.aspx
[54] http://www.nytimes.com/2012/03/11/us/rethinking-solitary-confinement.html?pagewanted=all
[55] https://www.prisonlegalnews.org/22885_displayArticle.aspx

way they'll behave," he said. Epps, who is also the president-elect of the American Correctional Association, noted that transitioning prisoners in Unit 32 out of solitary confinement "...worked out just fine. We didn't have a single incident."[56]

In April 2007, the State of New York agreed to settle a lawsuit challenging the placement of mentally ill prisoners in segregation.[57] The settlement requires the state to create "new mental health treatment programs for prisoners with serious mental illness who have SHU and keeplock sentences, and requires the state to provide at least two hours a day of out of cell treatment and programming to all prisoners with serious mental illness remaining in SHU. It requires reviews of disciplinary sentences for inmates with serious mental illness to reduce their sentences and divert them from SHU."[58]

New York subsequently enacted legislation that established safeguards for mentally ill prisoners, including mental health and suicide prevention screening for prisoners placed in segregation; diverting prisoners with serious mental illnesses "from segregated confinement, where such confinement could potentially be for a period in excess of thirty days, to a residential mental health treatment unit"; reviews every 14 days for mentally ill prisoners not diverted from segregation; and staff training on how to deal with mentally ill prisoners.[59]

In Maine, as a result of voluntary action by DOC Commissioner Joseph Ponte, the number of prisoners held in the Maine State Prison's solitary confinement unit has been reduced by more than half. Ponte, who was appointed in 2011, ordered that prisoners not be placed in solitary for more than 72 hours without his approval. He also asked prison staff to impose informal sanctions rather than segregation when prisoners commit rule infractions; removed prisoners from the supermax unit who did not belong there; stopped violent "cell extractions" of uncooperative or unruly prisoners; and instituted other reforms recommended by a panel of corrections officials that had studied solitary confinement-related issues.[60]

In 2007, Indiana agreed to remove seriously mentally ill prisoners from segregation units as part of a settlement agreement in a class-action lawsuit. The court had found that solitary confinement inflicted extreme social isolation and sensory deprivation on mentally ill prisoners; the settlement specified that such prisoners would receive mental health evaluations and treatment, among other provisions.[61]

Additionally, two prisoners at the Pelican Bay State Prison in California, Todd Ashker and Danny Troxell, filed suit in 2009 challenging their lengthy periods of solitary confinement. Both had spent over 20 years in segregation in 8x10' windowless cells. In May 2012, the Center for Constitutional Rights took over representation in the lawsuit and amended it to include hundreds of other prisoners held in solitary confinement.[62] According to statistics released by California prison officials in 2011, 513 prisoners at Pelican Bay have been kept in segregation for 10 years or more; of those, 78 have been held in solitary for 20 years or more.[63] The case remains pending.[64]

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[56] http://www.nytimes.com/2012/03/11/us/rethinking-solitary-confinement.html?pagewanted=all
[57] http://www.nytimes.com/2007/04/25/nyregion/25mental.html
[58] http://www.disability-advocates.org/adv_detail.php?CID=3
[59] N.Y. Correct. Law §§ 137, 401, 401(A)(2008); N.Y. Mental Hyg. Law § 45.07(Z) (2011)
[60] https://www.prisonlegalnews.org/23731_displayArticle.aspx
[61] https://www.prisonlegalnews.org/19179_displayArticle.aspx
[62] http://www.huffingtonpost.com/2012/05/31/pelican-bay-state-prison-inmates-lawsuit-solitary-confinement-torture_n_1560175.html
[63] http://solitarywatch.com/2011/09/22/the-truth-about-solitary-confinement-in-california
[64] *Ashker v. Brown*, U.S.D.C. (N.D. Cal.), Case No. 4:09-cv-05796-CW

Conclusion

Solitary confinement presents a host of problems, especially for prisoners who are mentally ill – although *all* prisoners placed in segregation, whether mentally ill or not, are at risk of adverse effects. There are few objective standards and little meaningful due process when placing and keeping prisoners in solitary confinement. Conditions in solitary, including the inherent lack of social interaction, result in physical and mental harm to prisoners. In some cases, prisoners are placed in segregation not because they are violent or dangerous but rather due to their religious or political beliefs, or because they file complaints or commit minor rule violations. Studies indicate that prisoners held in solitary confinement have higher rates of recidivism following their release from prison, thereby endangering public safety.

Prolonged placement in solitary confinement is constitutionally questionable, and lawsuits have increasingly challenged such practices. As a result of litigation – and voluntarily in some cases – a number of states have taken steps to reduce the use of solitary confinement in their prison systems without negatively impacting institutional security.

For these reasons, solitary confinement should be curtailed and used only in cases where it is essential to ensure the safety of prison staff or other prisoners, and then only for periods of time necessary to meet such safety-related needs. There must be regular, meaningful reviews of continued placement in segregation and clear standards for release from segregation. Further, whenever possible, mentally ill prisoners should not be held in solitary confinement.

This Statement is submitted on behalf of the
Human Rights Defense Center by:

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human rights *first*

Statement of Human Rights First

Hearing Before the Senate Judiciary Subcommittee on the Constitution, Civil Rights and Human Rights

Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences

Tuesday, June 19, 2012

Introduction

Human Rights First commends Senator Durbin (D-IL) and the Senate Judiciary Subcommittee on the Constitution, Civil Rights and Human Rights for holding this important hearing on the use of solitary confinement in U.S. prisons, jails, and immigration detention facilities. Human Rights First is an independent advocacy organization that challenges the United States to live up to its ideals. We press American institutions – including government and business – to respect human rights, seeking to close the gap between values and action. Consistent with this principle, Human Rights First advocates on behalf of refugees and asylum seekers, including by running a legal representation program for detained and non-detained asylum seekers, partnering with law firms in New York, New Jersey, and Washington D.C. to provide pro bono legal assistance to refugees from countries all over the world who are seeking asylum in the United States. For many years, Human Rights First has also pressed the U.S. government to reform its detention practices and to bring the immigration detention system in line with international human rights standards. We have long highlighted our concerns about the detention of asylum seekers and other immigrants in jails and jail-like facilities, the lack of individualized assessments and independent review of the need to detain, the insufficient use of effective and less costly alternatives to detention, and the major challenges that detained asylum seekers and other immigrants face in accessing legal counsel.

Overview of U.S. Immigration Detention

U.S. Immigration and Customs Enforcement (ICE), the interior enforcement agency within the Department of Homeland Security, detains up to 33,400 immigrants and asylum seekers each day – almost 400,000 annually – in 250 jails and jail-like facilities nationwide. These detainees are not being held on criminal charges; they are held pursuant to DHS's authority under civil immigration laws. Their detention is considered civil or administrative in nature. The purpose of immigration detention, according to ICE and DHS, is limited: to ensure that detainees show up for their deportation hearings, and that they comply with deportation orders if necessary. Despite its 2009 reform commitment to move away from a "penal" model of detention, ICE continues to hold a full 50 percent of its daily civil detention population in actual jails. The majority of the remaining 50 percent are held in jail-like facilities.[1] In these facilities, individuals live behind locked doors in thick cement-walled housing units, typically spending 23 hours a day in the same room where they eat, sleep, shower, and use the toilet without privacy. They wear prison uniforms and are often handcuffed or shackled

[1] Human Rights First, "Jails and Jumpsuits: Transforming the U.S. Immigration Detention System – A Two-Year Review," (October 2011), p. 24, available at http://www.humanrightsfirst.org/wp-content/uploads/pdf/HRF-Jails-and-Jumpsuits-report.pdf. [hereinafter "Jails and Jumpsuits"]

when transported. In almost all cases their freedom of movement within the facility is limited to the crowded "pod" where they live. Under minimum requirements, they receive an hour a day of outside recreation, and "outside" may be a room with an opening to the sky. Often, when family members visit, even children, detainees are only allowed to speak to them by phone, looking through a Plexiglas barrier. At an average cost of $122 per person, per day, the U.S. immigration detention system costs taxpayers over $2 billion annually, despite the availability of less costly, less restrictive, and highly successful alternative to detention programs.

Over the years, a range of non-partisan and bipartisan groups have issued reports detailing chronic problems in the immigration detention system, including challenges related to accessing legal counsel and telephones, excessive transfers, noncompliance with existing standards, interference with the open practice of religion, pervasive use of shackles, and overuse of strip searches and solitary confinement.[2] Given that the focus of this hearing is solitary confinement, this testimony is limited to that particular issue. It is worth noting, however, that the challenges related to solitary confinement in immigration detention are part of a larger problem – ICE's flawed paradigm of detention, in which civil immigration detainees are held in jails and jail-like facilities.

Use and Impact of Solitary Confinement in U.S. Immigration Detention

In 2011, the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment submitted a report on the use of solitary confinement to the UN General Assembly. He observed that solitary confinement is often used to punish a detained or incarcerated individual who has violated a facility rule, as well as to separate vulnerable individuals, including LGBT individuals, from the general population.[3] The Special Rapporteur found that "where the physical conditions and the prison regime of solitary confinement cause severe mental and physical pain or suffering, when used as a punishment, during pre-trial detention, indefinitely, prolonged, on juveniles or persons with mental disabilities, it can amount to cruel, inhuman or degrading treatment or punishment and even torture."[4] This statement implicates the U.S. immigration detention system; the segregation of immigration detainees for unspecified periods of time, or for prolonged periods of time ("prolonged" is more than 15 days, according to the report), and the segregation of immigration detainees with mental disabilities, is not uncommon, as detailed below. Moreover, given that the use of segregation can amount to cruel, inhuman, or degrading treatment or punishment and even torture when utilized in the context of pre-trial detention, it would certainly raise these concerns in the context of administrative immigration detention.

The Special Rapporteur noted that solitary confinement can lead to anxiety, depression, anger, cognitive disturbances, perceptual distortions, paranoia and psychosis, and self-harm for any population.[5]

Others have examined the particular negative health effects of solitary confinement for individuals who have already suffered torture or abuse, such as asylum seekers and refugees. In its 2005 study, *Asylum Seekers in*

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[2] U.S. Commission on International Religious Freedom, *Asylum Seekers in Expedited Removal, Volume I: Findings & Recommendations* (Washington, DC: USCIRF, 2005), p. 189; Council on Foreign Relations Independent Task Force on U.S. Immigration Policy, *Independent Task Force Report No. 63—U.S. Immigration Policy* (New York: CFR, 2009), p. 32; Constitution Project, *Recommendations for Reforming Our Immigration Detention System ond Promoting Access to Counsel in Immigration Proceedings* (Washington, DC: Constitution Project, 2009), p. 1.

[3] Interim report to the UN General Assembly of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, A/66/268, Aug. 5, 2011, p. 13. [hereinafter "Special Rapporteur report"]

[4] "Special Rapporteur report" at 2. The Special Rapporteur in fact recommends an end to the use of solitary confinement as a disciplinary measure. (p. 22)

[5] "Special Rapporteur report" at 26-27.

Expedited Removal, the bipartisan U.S. Commission on International Religious Freedom explained that incarceration and a prison-like environment may have the effect of re-traumatizing people who have experienced severe traumas – such as refugees – leading to "disabling psychological reactions and consequences of those earlier damaging experiences."[6] Solitary confinement can be particularly severe and serve to exacerbate the mental anguish of people who have suffered torture or other egregious human right abuses.

The widely respected organization Physicians for Human Rights (PHR) has noted that "[a]lthough both psychiatrists and prison experts have comprehensively documented and acknowledged the detrimental effects of solitary confinement on prisoners and the negative health outcomes that result, prisons and detention centers around the world continue to use solitary confinement as a means of control."[7] PHR observed that asylum seekers and survivors of torture in detention generally experience high levels of stress, depression, and mental health issues. "Much of their anguish relates back to the human rights abuses, including placement in solitary confinement, suffered in their country of origin," PHR explained. "Therefore, reintroduction of this harmful method of control, this time at the hands of U.S. detention center staff, frequently re-awakens their trauma and serves to greatly worsen their mental health issues."[8]

The U.S. immigration detention system is far from immune to this practice. In recent years, several reports have documented widespread misuse and abuse of solitary confinement or segregation in ICE facilities:

- Former DHS Special Advisor Dr. Dora Schriro, a longtime expert on prison systems, expressed significant concern regarding the treatment of detainees with mental illness and ICE's use of segregation cells. In 2009 she reported, "Segregation cells are often used for purposes other than discipline. For example, segregation cells are often used to detain special populations whose unique medical, mental health, and protective custody requirements cannot be accommodated in general population housing."[9] Similarly she found that "[f]ew beds are available for in-house psychiatric care for the mentally ill. Aliens with mental illness are often assigned to segregation, as are aliens on suicide watch."[10] Dr. Schriro recommended that ICE immediately discontinue the use of segregation cells for medical isolation or observation.[11]

- In its 2010 report on protecting the rights of persons with disabilities in immigration detention, Texas Appleseed quoted a detention center nurse stating, "When they are crazy and cannot be managed they go to 'seg' [segregation] when there is not room for them in the short stay unit."[12]

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[6]U.S. Commission on International Religious Freedom, *Report on Asylum Seekers in Expedited Removal,* Vol. I, p. 191 (February 2005).

[7]Physicians for Human Rights, *Dual Loyalties in U.S. Immigration Detention*, pp. 22-23, available at http://physiciansforhumanrights.org/issues/torture/asylum/dual-loyalties-immigration-detention.html (March 2011). [hereinafter "PHR Dual Loyalties"]

[8]Id.

[9]Dr. Dora Schriro had previously run the corrections systems in Arizona and Missouri, and she currently serves as Commissioner of Correction for New York City. See *Immigration Detention Overview and Recommendations* (Washington, DC: Immigration and Customs Enforcement, 2009), p. 26, available at http://www.ice.gov/doclib/about/offices/odpp/pdf/ice-detention-rpt.pdf.

[10]Id.

[11]Id.

[12]Texas Appleseed, Justice for Immigration's Hidden Population: Protecting the Rights of Persons with Disabilities within the Immigration Court and Detention System, p. 21, available at http://www.texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=313&Itemid= (March 2010).

- In 2010, the Inter-American Commission on Human Rights found the condition of basic medical care in U.S. immigration detention centers to be "very alarming," noting, "[It] has learned that various immigrant detainees with mental illnesses spend a significant portion of their time in solitary confinement ("administrative segregation") and are allowed out of their cells for an hour every day. The condition of many of these detainees deteriorates in solitary confinement, which also delays their immigration proceedings due to competency concerns."[13] The Commission's report explained, "[D]uring its visits to the detention centers in Texas and Arizona the IACHR was alarmed to receive information about the use of solitary confinement for mentally ill detainees. The Inter-American Commission must emphasize that solitary confinement takes a terrible mental and physical toll on the person, and would remind the State that solitary confinement must be used as a measure of last resort, for very limited periods of time and subject to judicial review."[14]

- A 2011 report by PHR found that "[d]etainees who complain or act out due to mental conditions beyond their control are frequently sent to segregation units or held down in restraints because staff is unable or unwilling to help them control their behavior. Even those on suicide watch are routinely assigned to segregation in place of receiving necessary psychiatric care. In many cases, security or even medical staff send mentally disabled people to solitary confinement for prolonged periods of time, where they remain without access to mental health professionals or even to other detainees. In these stark conditions, detainees' mental health often degenerates even further because they are starved for human interaction."[15] PHR recommended that health care workers "[r]efuse to participate in any security-focused or non-therapeutic activities (use of restraints, forced medication, segregation, etc.) related to detainees. Health professionals are the guardians charged with ensuring that their patients receive the best care possible, and they are expected, by both society and the law, to adhere to a high code of legal, moral, and ethical considerations."[16] In an earlier report on the U.S. detention of asylum seekers, PHR recommended, "Segregation/solitary confinement should be restricted to cases where it is absolutely necessary for the safety of the asylum seeker or the facility."[17]

- A 2011 report by the ACLU of Arizona reported that "[a] major problem discovered in Arizona facilities affecting LGBT immigrants is the overuse of segregation, either in a Special Housing Unit or isolated cell. LGBT persons are sometimes placed in segregation based on their sexual identity, with the stated reason of protecting the detainee from harassment or threats by other detainees – often called 'protective custody.' While in 'protective custody,' however, detainees are often subjected to prolonged periods of isolation and treated harshly, and their physical and emotional well-being and safety are threatened."[18]

- In April 2011, the National Immigrant Justice Center (NIJC) filed 13 complaints with DHS's Office of Civil Rights and Civil Liberties and Office of Inspector General demanding that the Obama administration investigate abuse allegations and take action to protect LGBT immigrants in ICE custody. The 13 complaints describe violations including sexual assault, denial of medical and mental health treatment,

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[13]Organization of American States, Inter-American Commission on Human Rights, *Report on Immigration in the United States: Detention and Due Process*, OEA/Ser.L/V/II. Doc 78/10, December 30, 2010, ¶ 292, p. 104.
[14]Id.
[15]"PHR Dual Loyalties" at 20.
[16]Id. at 32.
[17]Physicians for Human Rights, *From Persecution to Prison*, p. 19, available at https://s3.amazonaws.com/PHR_Reports/persecution-to-prison-US-2003.pdf (2004).
[18]American Civil Liberties Union – Arizona, *In Their Own Words: Enduring Abuse in Arizona Immigration Detention Centers*, pg 4, available at http://www.aclu.org/blog/prisoners-rights-immigrants-rights/trauma-compounded-plight-lgbt-immigration-detainees (2011).

arbitrary long-term solitary confinement, and frequent harassment by officers and facility personnel.[19] NIJC's complaint included the case of a gay Peruvian asylum seeker who was held in solitary confinement for almost six weeks due to his HIV-positive status. He was not released from solitary confinement until he won his immigration case. The complaint also included an asylum seeker from Mexico who was kept on a daily 22-hour lockdown which one officer allegedly told her was punishment to "teach her not to be transgender."[20]

Conclusion and Recommendations

The conditions and practices of U.S. immigration detention have long been out of step with America's fundamental values and long-standing vision of liberty. In recent years, ICE has taken some steps to address some of the deficiencies in the immigration detention system, but much more needs to be done to improve conditions and to address challenges in the system broadly. To improve its practices related to solitary confinement, ICE should:

- end the use of solitary confinement in place of protective administrative segregation for vulnerable individuals;
- end the use of non-medical segregation cells for medical isolation or observation;
- use solitary confinement or segregation only in very exceptional cases, as a last resort, and for the briefest time possible[21];
- forbid the use of solitary confinement or segregation for mentally ill detainees;
- forbid continuous solitary confinement or segregation for more than 15 days[22];
- ensure that any individual placed in solitary confinement or segregation is afforded the same access to medical and mental health care, telephones, law library, legal presentations, legal visits, and outdoor recreation, as the general population; when an individual is separated for non-disciplinary purposes, he or she should have the same access to all services and privileges as the general population;
- require that every detention facility submit to its Field Office monthly reports detailing the number of individuals in solitary confinement and other forms of segregation, the reasons for their segregation, the length of time they are held, and a demonstration that they have received daily visits from qualified mental health care providers[23]; and
- to prevent the misuse of solitary confinement or segregation for vulnerable populations, expand the use of alternatives to detention and, when detention is necessary, only detain those populations in facilities that can accommodate their unique needs.

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[19]National Immigrant Justice Center (NIJC), "Mass Civil Rights Complaint Details Systemic Abuse of Sexual Minorities in U.S. Immigration Detention," available at http://www.immigrantjustice.org/press_releases/mass-civil-rights-complaint-details-systemic-abuse-sexual-minorities-us-immigration-d (April 2011).

[20]Id.

[21]The American Bar Association's Standard 23-2.6 (a) on the Treatment of Prisoners suggests that "Segregated housing should be for the briefest term and under the least restrictive conditions practicable and consistent with the rationale for placement and with the progress achieved by the prisoner." Available at http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners.htm

[22]The UN Special Rapporteur noted that after 15 days, according to medical literature, "some of the harmful psychological effects of isolation can become irreversible." Special Rapporteur report at 9.

[23]ICE's 2011 Performance-Based National Detention Standards – which have not yet been implemented in any facility holding ICE detainees – require daily visits from "health care personnel." This requirement is not sufficient. The daily visits should be conducted by qualified mental health care providers and include periodic out-of-cell assessments.

At the core of problems related to the misuse and abuse of solitary confinement in ICE facilities is the flawed paradigm of the U.S. immigration detention system. Human Rights First continues to emphasize the following recommendations:[24]

- **Stop Using Prisons, Jails, and Jail-like Facilities, and When Detention Is Necessary Use Facilities with Conditions Appropriate for Civil Immigration Law Detainees.** ICE should end the use of prisons, jails, and jail-like facilities to hold detainees. After an individualized assessment of the need to detain, ICE should use facilities that provide a more appropriate normalized environment. Detainees should be permitted to wear their own clothing, move freely among various areas within a secure facility, access true outdoor recreation for extended periods of time, access programming and email, have some privacy in toilets and showers, and have contact visits with family and friends. ICE should develop and implement new standards not modeled on corrections standards to specify conditions appropriate for civil immigration detention.

- **Prevent Unnecessary Costs by Ensuring that Asylum Seekers and Other Immigrants Are Not Detained Unnecessarily.** ICE should create an effective nationwide system of Alternatives to Detention for those who cannot be released without additional supervision, and Congress should ensure that cost savings are realized in the program's expansion by reallocating part of the enforcement and removal budget to an increase in the ATD budget. Congress should enact legislation to provide arriving asylum seekers and other immigration detainees with the chance to have their custody reviewed in a hearing before an immigration court. Congress should revise laws so that an asylum seeker or other immigrant may be detained only after an assessment of the need for detention in his or her individual case, rather than through automatic or mandatory detention.

- **Improve Access to Legal Assistance and Fair Procedures.** Congress should ensure that detained asylum seekers and other immigration detainees have sufficient access to legal representation, legal information, and in-person hearings of their asylum claims and deportation cases, including by ending the use of facilities in remote locations that undermine access to legal representation, medical care, and family; ensuring that Legal Orientation Presentations are funded and in place at all facilities detaining asylum seekers and other immigration detainees; and ensuring that in-person Immigration Judges and Asylum Officers are available for all detained asylum seekers or other immigration detainees.

[24] "Jails and Jumpsuits" at 42-45.

HUMAN RIGHTS PROJECT FOR GIRLS

Senator Dick Durbin
Chairman, Subcommittee on the Constitution, Civil Rights and Human Rights

Senator Lindsey Graham
Ranking Member, Subcommittee on the Constitution, Civil Rights and Human Rights

Human Rights Project for Girls
1225 Eye Street NW, Suite 600
Washington, DC 20005
Tel. (202) 670-0695

Tuesday, June 19, 2012

RE: SOLITARY CONFINEMENT OF GIRLS IN THE JUVENILE JUSTICE SYSTEM

Dear Chairman Durbin and Ranking Member Graham:

Human Rights Project for Girls is a nonprofit policy and advocacy organization dedicated to protecting the rights of marginalized young women and girls. One of our core areas of focus is girls in the juvenile justice system. We are concerned with the use of isolation methods on girls in the juvenile justice system and advocate against the use of such measures for the reasons outlined below.

CHARACTERISTICS OF JUVENILE JUSTICE INVOLVED GIRLS

According to the Office of Juvenile Justice Delinquency and Prevention, approximately 600,000 girls are arrested in the U.S. annually.[i] Nearly half of these girls are remanded for non-violent offenses such as truancy, running away, loitering, alcohol and substance use, and technical violations to prior court orders for non-violent status offenses. Moreover, evidence suggests that 73% of girls in juvenile detention have previously suffered some form of physical or sexual abuse.[ii] This abuse is often the factor that propelled the child into the juvenile justice system, as it is often the abuse that is the root cause of the girls' running away, becoming truant, substance abuse, etc. Indeed, numerous studies suggest that exposure to traumatic events may be linked to delinquent behavior and that delinquent acts may be a direct or indirect reflection of past victimization.[iii]

It has also been estimated that one in five adolescents involved in the juvenile justice system has a serious mental health condition,[iv] with prevalence rates among girls estimated to be as high as 84%.[v] In one study of detained youth in Cook County, Illinois from 1995 to 1998, study outcomes found that girls had higher rates of psychiatric disorders and rates of depression and anxiety than boys.[vi] Further, the Oregon Social Learning Center found that over 75% of adolescent female study participants met the criteria for three or more DSM IV Axis 1 diagnoses.[vii]

Once girls become system involved, they are forced to maneuver a system that does not address the specific needs of girls or take into account the complex trauma they have endured. Family court judges and detention center staff are rarely provided appropriate trauma training and are unaware of the damaging impact of policies

such as strip searches, physical restraints, and particularly solitary confinement and isolation on survivors of physical and sexual abuse and trauma.

JUVENILE JUSTICE INVOLVED GIRLS AND SOLITARY CONFINEMENT

While girls are sometimes placed in solitary confinement for their own protection, there is a growing body of evidence that demonstrates the severe psychiatric consequences of placing individuals, and particularly children in solitary confinement. Prisoners who have experienced solitary confinement have been shown to engage in self-mutilation at much higher rates than the average population. These prisoners are also known to attempt or commit suicide more often than their counterparts who were not held in isolation. In fact, according to the Campaign for Youth Justice, data shows that juveniles are 19 times more likely to kill themselves in isolation than in general population and that juveniles in general, have the highest suicide rates of all inmates in jails.[viii]

Despite all these facts, when girls in the juvenile justice system express evidence of or the desire to self harm, the typical response is to put them in solitary confinement.[ix] When subjected to isolation, these youth are often locked down for 23 hours per day in small cells with no natural light, causing severe anxiety, paranoia and exacerbation of existing mental trauma.[x] The ACLU has reported that in certain juvenile detention facilities, girls are restrained with brutal force and are "regularly locked up in solitary confinement — a punishment used for minor misbehaviors as well as for girls who express wanting to hurt themselves."[xi] For example, as reported by the ACLU who interviewed a number of girls in juvenile detention in 2010, some of the reasons behind girls' solitary confinement included: (i) giving their crying friend a hug; (ii) singing "Happy Birthday" to their friend; (iii) picking a flower; and (iv) saving a cricket.[xii] The report goes on to say that "[n]ot receiving proper treatment and left alone with their emotions, many girls are driven to cut themselves, bang their heads against the concrete walls, and attempt suicide," which often lead detention facility staff to respond with "physical restraint, pepper spray, and further solitary confinement."[xiii]

In closing, because such a large percentage of girls entering juvenile detention suffer from mental health conditions and have endured sexual and/or physical trauma, we strongly advocate against the use of isolation methods on this vulnerable population of children. Numerous studies show the damaging effects of solitary confinement on children and particularly children with proven histories of mental and physical trauma. Human Rights Project for Girls remains extremely concerned about the use of solitary confinement and isolation techniques on girls in particular and hopes that the information outlined herein can serve as a basis for discontinuing the use of such practices.

cc:
Senator Patrick Leahy, Subcommittee on the Constitution, Civil Rights and Human Rights
Senator Sheldon Whitehouse, Subcommittee on the Constitution, Civil Rights and Human Rights
Senator Al Franken, Subcommittee on the Constitution, Civil Rights and Human Rights
Senator Christopher A. Coons, Subcommittee on the Constitution, Civil Rights and Human Rights
Senator Richard Blumenthal, Subcommittee on the Constitution, Civil Rights and Human Rights
Senator Jon Kyl, Subcommittee on the Constitution, Civil Rights and Human Rights
Senator John Cornyn, Subcommittee on the Constitution, Civil Rights and Human Rights
Senator Michael S. Lee, Subcommittee on the Constitution, Civil Rights and Human Rights
Senator Tom Coburn, Subcommittee on the Constitution, Civil Rights and Human Rights

[i] Office of Juvenile Justice and Delinquency Prevention. Juvenile Offenders and Victims: National Report Series, Juvenile Arrests 2009. Available at: http://www.ojjdp.gov/pubs/236477.pdf

[ii] Sherman FT. 13 Pathways to Juvenile Detention Reform: Detention Reform and Girls – challenges and solutions. The Annie E. Casey Foundation, Baltimore, MD. 2005.

[iii] Caufman E, Feldman SS, Waterman J, Steiner H. Posttramatic Stress Disorder Among Female Juvenile Offenders. Journal of the American Academy of Child Adolescent Psychiatry. 1998. 37(11):1209-1216.

[iv] Cocozza JJ, Skowyra K. Youth with mental health disorders: Issues and emerging responses. Juvenile Justice. 2000. 8(1):3-13.

[v] Wrath C, Ybarra M, Holden EW, Manteuffel B, Santiago R, Leaf P. Female offenders referred for community-based mental health service as compared to other service-referred youth: correlates of conviction. J. of Adolescence. 2003. 26:45-61.

[vi] Sherman FT, 2005.

[vii] Cauffman E, 1998.

[viii] Campaign for Youth Justice. Jailing Juveniles: National *Take Action* Packet. November 15, 2007. Available at: http://www.campaignforyouthjustice.org/Downloads/Jailing_Juveniles_Take_Action_Kit.pdf

[ix] ACLU. "Exposing the 'Secret Punishment' of Incarcerated Children." Available at: http://www.aclu.org/blog/human-rights-prisoners-rights-womens-rights/exposing-secret-punishment-incarcerated-children

[x] Campaign for Youth Justice. Jailing Juveniles: National *Take Action* Packet. November 15, 2007. Available at: http://www.campaignforyouthjustice.org/Downloads/Jailing_Juveniles_Take_Action_Kit.pdf

[xi] ACLU. "Strip Searching and Solitary Confinement of Girls at Texas 'State School.'" Available at: http://www.aclu.org/blog/womens-rights/strip-searching-and-solitary-confinement-girls-texas-state-school

[xii] ACLU. "Not an Isolated Case." Available at: http://www.aclu.org/blog/womens-rights/not-isolated-case

[xiii] ACLU. "Strip Searching and Solitary Confinement of Girls at Texas 'State School.'" Available at: http://www.aclu.org/blog/womens-rights/strip-searching-and-solitary-confinement-girls-texas-state-school



Written Statement of
Human Rights Watch

to

The United States Senate Committee on the Judiciary,
Subcommittee on the Constitution, Civil Rights
and Human Rights

"Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences"

June 19, 2012

Human Rights Watch is grateful for this opportunity to submit a statement for the Committee's hearing on "Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences." Based on years of research and analysis, we are convinced the unnecessary, counter-productive, and devastating use of this harsh form of confinement in many US prisons cannot be squared with respect for human rights.

Human Rights Watch is an independent organization dedicated to promoting and protecting human rights around the globe. Since 1980, we have reported on prison conditions within the United States from a human rights perspective, with a special emphasis on the use of solitary confinement. Over the past 15 years, we have conducted investigations in numerous prisons, including super-maximum security prisons; spoken with officials and inmates about solitary confinement; published many reports and commentaries on the issue; and advocated against its misuse.[1] Most recently, we sent a letter to Governor Pat Quinn of Illinois raising our concerns about the conditions of prolonged solitary confinement at the Tamms Correctional Center.[2] We have also addressed solitary confinement in other nations, such as Tunisia and Japan.[3] This fall, we will be releasing a joint report with the American Civil Liberties Union documenting the prolonged solitary confinement of youth under age 18 in jails and prisons across the United States.

Solitary confinement in US prisons is imposed for different reasons, but most commonly it is used as punishment for breaches of discipline ("disciplinary segregation") or to manage prisoners considered to be particularly difficult or dangerous ("administrative segregation").[4] The increase in solitary confinement in the United States has occurred primarily through administrative segregation, particularly the segregation of prisoners in special super-maximum security facilities built solely for this purpose. Indeed, in our judgment, the proliferation of super-maximum security facilities is the most troubling development in US corrections in recent decades.

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[1] See, for example: Human Rights Watch, *Cold Storage: Super-Maximum Security Confinement in Indiana*, October 1, 1997, http://www.hrw.org/reports/1997/10/01/cold-storage; Human Rights Watch, *Red Onion State Prison: Super-Maximum Security Confinement in Virginia*, May 1, 1999, http://www.hrw.org/reports/1999/05/01/red-onion-state-prison; Human Rights Watch, *Out of Sight: Super-Maximum Security Confinement in the US*, February 1, 2000, http://www.hrw.org/reports/2000/02/01/out-sight-super-maximum-security-confinement-us; Human Rights Watch, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, October 22, 2003, http://www.hrw.org/reports/2003/10/21/ill-equipped-0; Jamie Fellner, "A Corrections Quandary: Mental Illness and Prison Rules," *Harvard Civil Rights-Civil Liberties Law Review*, vol. 41, 2006, http://www.hrw.org/news/2006/07/01/corrections-quandary; "Mental Illness, Human Rights, and US Prisons," Human Rights Watch written statement to the Senate Judiciary Committee Subcommittee on Human Rights and the Law, September 22, 2009, http://www.hrw.org/news/2009/09/22/mental-illness-human-rights-and-us-prisons; Human Rights Watch, *Against All Odds: Prison Conditions for Youth Offenders Serving Life without Parole Sentences in the United States*, January 4, 2012, http://www.hrw.org/reports/2012/01/03/against-all-odds-0.

[2] Letter from HRW to Governor Pat Quinn, March 8, 2012, http://www.hrw.org/news/2012/03/08/illinois-proposed-closure-tamms-supermax-step-right-direction; See also Letter from HRW to Governor Pat Quinn, September 8, 2009; and Letter from HRW to Governor Pat Quinn, May 4, 2009.

[3] See, for example: Human Rights Watch, *Precarious Justice: Arbitrary Detention and Unfair Trials in the Deficient Criminal Justice System of Saudi Arabia*, March 25, 2008; Human Rights Watch, *Tunisia – Long-Term Solitary Confinement of Political Prisoners*, July 7, 2004; Human Rights Watch, *Prison Conditions in Japan*, March 1, 1995.

[4] Corrections officials prefer to use terms such as "segregation" rather than solitary confinement. We consider the terms interchangeable, since both refer to 22- to 24-hour-a-day in-cell confinement, as described below.

Although there are differences between the specific conditions of solitary regimes in different prisons, they share a basic model. Prisoners in solitary typically spend 22 to 24 hours a day locked in small, sometimes windowless, cells sealed with solid steel doors. They lack opportunities for meaningful social interaction with other prisoners; most contact with staff is perfunctory and may be wordless (such as when meals are delivered through a slot in the cell door). Phone calls and visits by family and loved ones are severely restricted or prohibited. A few times a week, prisoners are let out for showers and solitary exercise in a small, enclosed space, sometimes indoors. They often have extremely limited or no access to educational and recreational activities or other sources of mental stimulation, and they are usually handcuffed, shackled, and escorted by correctional officers every time they leave their cells. Assignment to super-maximum security facilities devoted solely to solitary confinement—e.g., Colorado State Penitentiary, Pelican Bay State Prison in California, or Tamms in Illinois—is usually for an indefinite period that often lasts for years.

In some prisons, prisoners in solitary can purchase radios or televisions; participate in educational and skills-enhancing in-cell programs; and access books, newspapers, magazines, and the like. In others, prisoners are denied access to anything more than the basic necessities of survival. The restrictions can exceed the fathomable. In Pennsylvania's most restrictive units, for example, prisoners have all the usual supermax deprivations plus some that seem gratuitously cruel: they are not permitted to have photographs of family members or newspapers and magazines (unless they are religious).[5] In some prison systems, prisoners who follow the rules and who engage in prescribed programs can earn their way out of solitary; in others, prisoners can languish in segregation for years, even decades, with little idea of what—if anything—they can do to be re-assigned to a less harsh form of imprisonment.

Corrections authorities must be able to exercise discretion and professional judgment in choosing where and how to confine inmates, but the exercise of such discretion carries the inherent risk of arbitrariness or error. Because of the extreme nature of solitary confinement, particular precautions are needed to minimize those risks and to ensure that no inmate is unnecessarily sent to or kept in such harsh conditions of confinement.

Unfortunately, in most jurisdictions, the criteria for determining entry to and exit from administrative segregation, particularly in super-maximum security facilities, are so vague that arbitrariness and unfairness are inevitable. Few jurisdictions have careful internal review systems to provide an effective check on unnecessary or unduly prolonged solitary confinement, particularly when imposed as administrative segregation. Moreover, few states have an impartial and independent authority, such as an ombudsman or inspector general, who can monitor supermax conditions and provide inmates with an effective recourse against unnecessary or unduly lengthy solitary confinement.

There is no way, of course, to measure the misery and suffering produced by prolonged solitary confinement. Inmates have described such confinement as akin to living in a tomb. Their days are marked by idleness, tedium, and tension. For many, the absence of normal social interaction, of reasonable mental stimulus, of exposure to the natural world, of almost everything that makes life human and bearable, is emotionally, physically, and psychologically destructive. People suffer grievously in prolonged solitary confinement because human beings are social animals whose

[5] Fred Cohen, "Penal Isolation: Beyond the Seriously Mentally Ill," *Criminal Justice and Behavior*, vol. 35, no. 8, August 2008, http://cjb.sagepub.com/content/35/8/1017.abstract (accessed June 13, 2012).

well-being requires interaction and connection with others as well as mental, physical, and environmental stimulation. As one federal judge noted, prolonged super-maximum security confinement "may press the outer bounds of what most humans can psychologically tolerate."[6]

Prisoners subjected to prolonged isolation may experience depression, despair, anxiety, rage, claustrophobia, hallucinations, problems with impulse control, and/or an impaired ability to think, concentrate, or remember. Some inmates subjected to solitary confinement develop clinical symptoms usually associated with psychosis or severe affective disorders.[7] Solitary confinement is not only extremely painful for many, it can be literally unendurable, as is evident from the high number of suicides that take place in segregation.[8]

For mentally ill prisoners, prolonged solitary confinement can be a living horror; the social isolation and restricted activities can aggravate their illness and immeasurably increase their pain and suffering. Our research indicates that anywhere from one-fifth to two-thirds of prisoners held in solitary confinement have a serious mental illness which was diagnosed or manifested *before* isolation.[9] Persons with mental illness are often unable to handle the stresses of incarceration and to conform to a highly regimented routine. They may exhibit bizarre, annoying, or dangerous behavior and have higher rates of disciplinary infractions than other prisoners. When lesser sanctions do not curb the behavior, officials isolate these prisoners in segregation units, despite the likely negative mental health impact. Once in segregation, continued misconduct, often connected to mental illness, can keep the inmates there indefinitely.[10] While in segregation, inmates with mental illness rarely receive the mental health services that might ameliorate the symptoms of their illness or improve their ability to cope with incarceration.

Youth are also especially vulnerable to the destructive impact of solitary confinement. Unfortunately, youth in some juvenile and adult facilities throughout the country are regularly subjected to prolonged solitary confinement. For our upcoming report on the isolation of youth in jails and prisons in the US, we interviewed scores of youth, including a 19-year-old in New York who spent two periods of time in solitary confinement when he was under 18, once for two months and once for nine months. He would receive one hour of outdoor recreation in a small fenced-in cage, but not every day. He was allowed one six-minute phone call each day and was eligible for only

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[6] *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995).

[7] Human Rights Watch, *Out of Sight: Super-Maximum Security Confinement in the US*, February 1, 2000.

[8] Dr. Jeffrey L. Metzner and Jamie Fellner "Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics," *The Journal of the American Academy of Psychiatry and the Law*, vol. 38, no. 1, 2010, http://www.hrw.org/news/2010/03/22/solitary-confinement-and-mental-illness-us-prisons.

[9] Human Rights Watch, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, October 22, 2003, Chapter XII. Although designed and operated as places of punishment, prisons have nonetheless become *de facto* psychiatric facilities, despite often lacking the needed mental health services. Studies and clinical experience consistently indicate that 8 to 19 percent of prisoners have psychiatric disorders that result in significant functional disabilities, and another 15 to 20 percent require some form of psychiatric intervention during their incarceration. Sixty percent of state correctional systems responding to a survey on inmate mental health reported that 15 percent or more of their inmate population had a diagnosed mental illness. Metzner and Fellner "Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics," *The Journal of the American Academy of Psychiatry and the Law.*

[10] Human Rights Watch, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, October 22, 2003; Fellner, "A Corrections Quandary," *Harvard Civil Rights-Civil Liberties Law Review.*

three short visits from loved ones each week. The only educational programming he received while in solitary confinement was an in-cell study packet that was delivered to him by a corrections officer.

He told us, "The cell was hell.... Can't talk to nobody. At that time I didn't have books or anything. I counted the bricks. There was a bed, a desk, a toilet, a sink and a window.... [The] first thing I thought was, damn, I'm going to be here for 60 days.... I felt like shit. Damn! No contact with anybody for 60 days? I started bugging out in my cell. Started going crazy. [Some]times I wanted to talk to people.... I was talking to myself, 'Why did you do this?' Sometimes I scream really loud. It feels good after a while."[11]

Why Solitary Confinement?

Prisons in the United States have long contained harsh solitary punishment cells where prisoners are sent for breaking prison rules. But what distinguishes the current and expanded use of solitary, particularly in super-maximum security facilities, are the increasingly long terms that prisoners spend in isolation, its use as an inmate population management tool rather than just for disciplinary purposes, and the high-technology methods used to enforce social isolation. No longer a matter of spending a week in "the hole"—prisoners classified as dangerous or disruptive can spend years and even decades in solitary confinement.

The proliferation of super-maximum security prisons is a symptom of profound problems in the nation's prison systems. Beginning in the 1980s, exploding prison populations caused by increasingly lengthy sentences and diminished opportunities for early release, constrained budgets, inappropriately low staff-to-inmate ratios, and punitive correctional philosophies limited the ability of officials to operate safe and humane facilities. Many turned to prolonged solitary confinement in an effort to increase their control over prisoners. A significant impetus for super-maximum security facilities also came from politicians, who found that advocating harsh policies for criminal offenders was politically popular. Reluctant to be accused of "coddling inmates" or being "soft on crime," few politicians have been willing to publicly challenge the expanded use of solitary confinement on human rights grounds.

Some thoughtful corrections professionals have always recognized that the proliferation of solitary confinement was unwise. While they may believe that there will always be a few extremely dangerous or disruptive inmates in a prison population who need to be segregated for extended periods of time, they are also convinced that placing thousands of prisoners in prolonged isolation was neither necessary nor good corrections practice. Reducing the size of prisons, providing increased prison services and programs, and adopting strategies to encourage responsible choice, personal development, and, ultimately, successful re-entry into the community would help address the very problems prolonged solitary confinement was supposed to remedy. Indeed, there is little evidence that the massive imposition of prolonged solitary confinement in expensive super-maximum facilities has improved prison safety, much less improved the skills and competencies of prisoners. To the contrary, prolonged solitary may decrease the ability of prisoners to successfully re-enter their communities upon release from prison.

[11] Human Rights Watch interview with Jacob L. (pseudonym), New York, April 2012.

There has been scant public debate until recently about the justification for prolonged solitary confinement, its high price in terms of the misery and suffering it inflicts, and the likelihood that it reduces an inmate's ability to make a successful transition to society upon release. Judicial scrutiny has been limited by both the courts' tradition of deference to the judgments of prison officials and by jurisprudence that sets an extraordinarily high threshold for finding prison conditions to be unconstitutionally cruel.

This Committee's hearing marks the end of an era of uncritical acceptance of or indifference to the use of solitary confinement in US prisons. It is particularly welcome because of the Committee's recognition that solitary confinement raises serious human rights concerns.

A Human Rights Analysis

All US prisons are subject to human rights standards contained in treaties ratified by the United States and binding on state and federal officials.[12] For example, the United States is a party to the International Covenant on Civil and Political Rights (ICCPR),[13] which requires corrections authorities to respect the inherent dignity of each inmate;[14] prohibits treatment of prisoners that constitutes torture or that is cruel, inhuman, or degrading;[15] and establishes rehabilitation as the primary purpose of imprisonment.[16]

While human rights law does not prohibit solitary confinement in any and all circumstances, prolonged solitary of the type and for the lengths of time imposed in US prisons is inconsistent with respect for inmates' humanity. It can also violate the prohibition on cruel, inhuman, or degrading treatment and, depending on the specific circumstances, may even amount to torture.[17] The

[12] Human Rights Watch, *Out of Sight: Super-Maximum Security Confinement in the US*, February 1, 2000.

[13] International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, ratified by the United States on June 8, 1992.

[14] ICCPR, art. 10 requires officials to treat prisoners "with humanity and with respect for the inherent dignity of the human person."

[15] ICCPR, art. 7. No one "shall be subjected to torture or to other cruel, inhuman or degrading treatment or punishment." The Convention against Torture, to which the United States is a party, contains a similar prohibition. Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture), adopted December 10, 1984, G.A. res. 39/46, annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984), entered into force June 26, 1987, ratified by the United States on October 21, 1994.

[16] ICCPR, art. 10. The "essential aim" of the treatment of prisoners "shall be their reformation and social rehabilitation."

[17] See, for example: UN Human Rights Committee, General Comment 20, Article 7, Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.1 at 30 (1994), para. 6.; UN Human Rights Committee, Consideration of reports submitted by States parties under Article 40 of the Covenant, Concluding observations of the Human Rights Committee, United States of America, UN Doc. CCPR/C/USA/CO/3 (2006); UN Committee Against Torture, Consideration of reports submitted by States parties under Article 19 of the Convention, Conclusions and Recommendations of the Committee Against Torture, United States of America, UN Doc. CAT/C/USA/CO/2, 2006; UN General Assembly, Torture and other cruel, inhuman or degrading treatment or punishment: Note by the Secretary-General, U.N. Doc. A/63/175, July 28, 2008, p. 18-21.

conditions of confinement in solitary are unduly severe and disproportionate to legitimate security and inmate management objectives, impose pointless suffering and humiliation, and disregard the fact that all prisoners—even those who may be deemed the "worst of the worst"—are members of the human community.

International treaty bodies and human rights experts—including the Human Rights Committee,[18] the Committee against Torture,[19] and both the current and former UN Special Rapporteurs on Torture[20]—have concluded that depending on the specific conditions, the duration, and the prisoners on whom it is imposed, solitary confinement may amount to cruel, inhuman, or degrading treatment that violates human rights. They have specifically criticized super-maximum security confinement in the United States because of the mental suffering it inflicts.[21] Human rights authorities are unanimous that it should be an exceptional measure imposed only when necessary, only for so long as necessary, and entailing no more deprivation than is necessary.[22] If legitimate considerations of prison safety and security do necessitate extended periods of separation from other prisoners, the conditions of confinement must be modified to ameliorate the isolation and to recognize the humanity of the person so confined.

Using a human rights framework to assess solitary confinement therefore requires consideration of the length of time it is imposed, the actual conditions, and the reasons for placing the prisoner in them.[23] Each factor must be considered in relation to the others. For example, extreme restrictions and controls that might be considered reasonable in dealing with incorrigibly violent inmates become excessive for inmates who have shown no propensity for violence. Deprivation of sources of stimulation, human contact, and activity that may not be unbearably cruel for some inmates can become torturous when imposed on youth under age 18 or mentally ill inmates. Harsh conditions that might not be unacceptable for a few weeks can become inhuman and degrading when imposed for months or years. A fixed period of solitary may be more tolerable than an indefinite period that in fact lasts the same length of time, because uncertainty regarding the duration of solitary confinement can exacerbate the pain and suffering of those subjected to it.

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[18] UN Human Rights Committee, General Comment 20, Article 7, Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.1 at 30 (1994),

[19] UN Committee Against Torture, Consideration of reports submitted by States parties under Article 19 of the Convention, Conclusions and Recommendations of the Committee Against Torture, United States of America, U.N. Doc. CAT/C/USA/CO/2 (2006).

[20] UN General Assembly, Torture and other cruel, inhuman or degrading treatment or punishment: Note by the Secretary-General, U.N. Doc. A/63/175, July 28, 2008, p. 18-21.

[21] UN Human Rights Committee, Consideration of reports submitted by States parties under Article 40 of the Covenant, concluding observations of the Human Rights Committee, United States of America, UN Doc. CCPR/C/USA/CO/3, (2006); UN Committee Against Torture, Consideration of reports submitted by States parties under Article 19 of the Convention, Conclusions and Recommendations of the Committee Against Torture, United States of America, UN Doc. CAT/C/USA/CO/2, (2006).

[22] In addition to the international authorities cited above, the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has reached similar conclusions regarding solitary confinement. See CPT Standards, para. 56, http://www.cpt.coe.int/en/documents/eng-standards.pdf (accessed June 14, 2012). The CPT was created under the European Convention of the same name to monitor the treatment of prisoners in Council of Europe nations and to recommend measures to strengthen protections from torture or other inhuman or degrading treatment.

[23] Human Rights Watch, *Out of Sight: Super-Maximum Security Confinement in the US*, February 1, 2000.

The most recent analysis of solitary confinement by an international human rights expert is that of Juan Mendez, the current UN Special Rapporteur on Torture. Based on a comprehensive and exacting review, Mendez concluded that prolonged isolation is contrary to article 10, paragraph 3 of the ICCPR, which states that, "The penitentiary system shall comprise treatment of prisoners the essential aim of which shall be their reformation and social rehabilitation."[24] Moreover, "where the physical conditions of solitary confinement are so poor and the regime so strict that they lead to severe mental and physical pain or suffering of individuals who are subjected to the confinement, the use of solitary confinement itself can amount to acts prohibited by article 7 of the International Covenant on Civil and Political Rights, torture as defined in article 1 of the Convention against Torture, or cruel, inhuman or degrading punishment as defined in article 16 of the Convention."[25]

Mendez insists that the use of solitary confinement "can be accepted only in exceptional circumstances where its duration must be as short as possible and for a definite term that is properly announced and communicated."[26] He emphasizes that when "solitary confinement is used in exceptional circumstances, minimum procedural safeguards must be followed. These safeguards reduce the chances that the use of solitary confinement will be arbitrary or excessive, as in the case of prolonged or indefinite confinement."[27] As have other human rights authorities and experts, he calls for a prohibition on the imposition of solitary on youth and persons with serious mental illness because of the especially harmful impact it has on such vulnerable populations.[28]

Recommendations

We commend the Committee for recognizing the importance of human rights scrutiny of the use of solitary confinement in US prisons. We hope this hearing and the testimony delivered to the Committee will convince Congress of the imperative of using its authority to reduce the use of

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[24] ICCPR, art. 10, para. 3.

[25] UN General Assembly, Torture and other cruel, inhuman or degrading treatment or punishment: Note by the Secretary-General, U.N. Doc. A/66/268, August 5, 2011, para. 74.

[26] Ibid., para. 75.

[27] Ibid., para. 89.

[28] UN Committee on the Rights of the Child, General Comment No. 10, Children's rights in juvenile justice, U.N. Doc. CRC/C/GC/10 (April 25, 2007); UN General Assembly, Rules for the Protection of Juveniles Deprived of their Liberty, U.N. Doc. A/RES/45/113 (December 14, 1990); The Istanbul Statement on the Use and Effects of Solitary Confinement, adopted at the International Psychological Trauma Symposium, December 9, 2007, http://www.univie.ac.at/bimtor/dateien/topic8_istanbul_statement_effects_solconfinment.pdf (accessed June 14, 2012). The US has also signed the Convention on the Rights of the Child (CRC) and the Convention on the Rights of Persons with Disabilities (CRPD). **The CRC recognizes that youth have special rights and, when they come in conflict with the law, should be treated in a manner that promotes their reintegration in and contribution to society.** Convention on the Rights of the Child (CRC), adopted November 20, 1989, G.A. Res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989), entered into force September 2, 1990. The United States signed the CRC in 1995 but has not ratified. **The CRPD recognizes that persons with intellectual and psychosocial disabilities must be ensured reasonable accommodation and respect for their difference, including in their treatment when deprived of their liberty.** Convention on the Rights of Persons with Disabilities (CRPD), adopted December 13, 2006, G.A. Res. 61/106, Annex I, U.N.GAOR, 61st Sess., Supp. (No. 49) at 65, U.N. Doc. A/61/49 (2006), entered into force May 3, 2008. The United States signed the CRPD in 2009 but has not ratified.

solitary in the United States, to improve the conditions of confinement when solitary is imposed, to curtail the indefinite imposition of solitary, and to end its use on persons who have mental illness and on youth under 18.

More specifically, we make the following recommendations:

1. Congress should enact legislation that will require the Bureau of Prisons and all federal agencies that operate or contract for confinement facilities to prohibit:

- Prolonged solitary confinement;
- Indefinite solitary confinement; and
- The imposition of solitary confinement on youth or persons with serious mental illness.

2. Because the history of the use of solitary in the US reveals that procedures for evaluating the necessity of its imposition on particular individuals and the duration of its imposition have been lacking, we think it crucial that Congress require the Bureau of Prisons and all federal agencies that operate or contract for confinement facilities to institute meaningful procedures of review and scrutiny—including with the participation of experts external to the agencies—governing the decision to impose and to continue conditions of solitary confinement for more than a two-week period.

3. Congress should enact legislation that will press states to impose similar requirements to bring their use of solitary confinement into conformity with international human rights standards. Congress should condition federal funding for prisons or law enforcement on the states' adoption of the prohibitions and rules noted in recommendation 1, above.

4. Congress should use its oversight and funding authority to insist that the Department of Justice use its powers under the Civil Rights of Institutionalized Persons Act to ensure that states and local jurisdictions do not impose solitary confinement on youth or on persons with mental illness because such confinement is a violation of the Eighth Amendment of the US Constitution as well as of human rights law.

5. In the interest of protecting youth from practices like solitary confinement, the Senate should give its advice and consent to the ratification of the Convention on the Rights of the Child, signed by the US in 1995, and the Convention on the Rights of Persons with Disabilities, signed by the US in 2009. The US government should also withdraw its reservation to articles 10 and 14 of the ICCPR, which allows the treatment of youth as adults in the US criminal justice system.

6. Congress should take steps to improve transparency and accountability in the use of solitary confinement in the United States. Congress should require the Department of Justice to collect data on the use of solitary in federal and state prisons: the characteristics of who was placed in isolation, for what reasons, for how long, and in what conditions. Also, the Department of Justice should report to Congress on the isolation of youth under federal jurisdiction but held by contract in state facilities.

7. Congress should create a national commission of independent experts to undertake a detailed review of solitary confinement in the United States and to propose specific standards governing its use.

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June 14, 2012

Chairman Durbin, Ranking Member Graham, and members of the subcommittee:

Immigration Equality is a national organization that advocates for the rights of lesbian, gay, bisexual, and transgender immigrants. Our legal services team has responded to inquiries from sixty-six transgender immigrants held in immigration detention.

We thank the committee for the opportunity to provide testimony on the critical issue of the overuse and abuse of solitary confinement in immigration detention centers nationwide.

In immigration detention, transgender detainees are too often placed in solitary confinement out of misguided concerns for their own protection. Solitary confinement represents one of the most extreme forms of the neglect that transgender people face in immigration detention. Rather than protecting transgender people, among the most vulnerable to violence in immigration detention, placing them in solitary confinement further victimizes and stigmatizes them. It subjects them to forms of material and emotional deprivation that are largely indistinguishable from torture. Solitary confinement is particularly inappropriate in the context of immigration detention, a non-penal form of civil detention intended primarily as a safeguard to ensure that immigrants appear at their hearings in immigration court.

The overuse of solitary confinement in housing transgender detainees stems from the simple truth that many immigration detention centers do not know how to safely house transgender people. Detention staff will too often rely solely on a person's genitals in deciding whether to house the person in a male facility or a female facility, rather than making an individualized assessment of the person's own needs and safety concerns. At sex-segregated detention facilities, detention staff routinely place transgender detainees in solitary confinement (also referred to as administrative segregation) under the pretext of safety concerns, again without making an individualized assessment of the person's own needs and safety concerns.

For many transgender detainees, solitary confinement can mean being isolated in one's cell for 23 hours a day with only one hour for recreation, bathing, and making phone calls. Transgender detainees in solitary confinement often face barriers to appropriate medical care and legal counsel that are impossible to surmount. The oppressive isolation and lack of outdoor time can create extreme stress, anxiety, and depression. Transgender detainees who express these feelings may be placed on suicide watch, which paradoxically, can mean 24 daily hours of isolation. Further, by limiting a detainee's interpersonal contact to interactions with guards, solitary confinement may actually make detainees more vulnerable to mistreatment by detention staff.

While new detention standards recently issued by Immigration and Customs Enforcement ("ICE") include provisions that limit the use of solitary confinement for transgender detainees, these standards lack effective enforcement mechanisms and do not yet apply to the greater than fifty percent of immigrant detainees nationwide who are housed in local and county jails. At these detention centers, there remains no concrete timeline for implementation of the new standards that recommend that solitary confinement be used only as a housing option of last resort, or at the detainee's request. The Department of Justice's ("DOJ") new Prison Rape Elimination Act ("PREA") regulations include measures

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which would help alleviate this problem far more effectively than the ICE detention standards. However, the new DOJ PREA regulations do not apply to facilities under DHS' jurisdiction.

Transgender immigrants in detention often include asylum-seekers who fear that the government in their home countries will deliberately turn a blind eye to the persecution they encounter as transgender people. In solitary confinement, transgender immigrant detainees can confront forms of isolation in the United States that disturbingly parallel that mistreatment.

Solitary confinement should be used to house transgender detainees only at the request of the detainee. The detainee should be able to end his or her placement in solitary confinement at any time.

Immigration Equality continues to recommend that most transgender detainees should be released from detention under alternative-to-detention programs. These programs, which include measures like curfews, regular check-ins, and electronic monitoring devices, are a more sensible option in light of ICE's inability to find a safe and humane way to house transgender detainees. If transgender immigration detainees, who count among the most vulnerable populations of detainees, must be detained, then their placement should be determined by an individualized assessment of the person's own needs and safety concerns.

Statement of Six People Who Were Wrongly Convicted on Their Experiences in Solitary Confinement

Hearing Before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights

June 19, 2012

Regarding
Reassessing Solitary Confinement:
The Human Rights, Fiscal, and Public Safety Consequences

The Innocence Project, a founding member of the Innocence Network, submits the following six statements of exonerated men and women who have served time in American prisons and jails for crimes they did not commit. These innocent men and women experienced solitary confinement the way that thousands of other Americans have experienced such conditions. Six to thirty years after their original confinement, these individuals were proven innocent. Their experiences are typical of the experience of millions of people who have been confined in institutions that routinely and excessively use solitary confinement as a way to manage incarceration. These six innocent individuals add their voices to the many others that ask the Congress to stop this practice.

We wish to thank Chairman Durbin, Ranking Member Graham, and members of the Subcommittee for understanding the importance of exploring, and hopefully dramatically modifying the use of solitary confinement in this country. While these are the statements of the six exonerees to whom we reached out upon learning of this hearing, we know that there are many others who could attest to the inhumane practice of maintaining people in isolation for extended periods of time. As the Senate Judiciary Committee, and hopefully the Congress, continues to explore and address this issue, we would be happy to reach out to other exonerated men and women to share their experiences with you.

Statement of Julie Rea, wrongfully imprisoned for three years by the state of Illinois before her exoneration in 2006

No blanket, underwear or pillow. The lights were on 24/7. And no bed mat either. The metal slab that was my bed was hard. Especially since my weight was down and there was nothing between my hips and it, except for the thin cotton outfit in orange.

I was in solitary so that I wouldn't do anything rash, having been brought in on a charge of murdering my own son. I was considered at-risk of depression because I had been charged, not because anybody realized that I was locked up for something I didn't do. Actually upon entering the jail I felt hopeful that the police would discover before long they had the wrong person and let me go. I was wrong. Dreadfully wrong.

The jail was a dark place where truth wasn't respected highly, and humane behavior was sparse. Guards slammed the door when passing every fifteen minutes. No peace existed while I waited for the error to be righted. But then one doesn't focus on a need for peace when it is so cold. One is chattering and curled up as tightly as one can get for warmth. Still, it added to the discomfort of the experience as a whole.

Finally, trying to lie down and assume a sleep-like position seemed the best effort I could make. Shortly, I found out it wasn't. From the audio speaker the guards had access to communicate with me in the cell. There was also a video camera. So they were able to access my person and activities for 'my safety'. Not minutes from lying down, a tape was started, one of a woman being tortured. It took me a bit to realize it was a tape and not someone in the next cell in agony at the moment.

I froze. My God what could I do? What was happening? What was this place?

Then some laughs and a remark from one guard to another, "Look at her, she's playing possum."

"She's gonna be a tough one."

"Do you think she's asleep?"

"No, she's awake alright. She's just stubborn."

In reality I was neither tough, playing possum or stubborn at that point. I was just frozen with fear. I realized that the tape wasn't faked. No one screams like that and is faking it. These were the kind of blood curdling screams that come wrenched from a body that is too exhausted to give them up, but finds them escaping anyway as it jerks and responds to whatever is being done to her. They were real. Very, very real. And if these guards were willing to play this tape and take pleasure in seeing what it did to me to hear it, well, what else were they capable of?

Did they make the tape too?

This was day one and two of my experience in solitary while in a county jail. This was before I was tried and wrongfully convicted. This was the mildest form of abuse these particular guards inflicted on me during the nights I spent in that jail.

After a few months in this county jail, I received bond until my first trial. I couldn't lay still without jerking every few seconds even when sleeping, and sleeping didn't occur without someone holding me. This is not something anyone should go through. I was innocent, but it is wrong no matter what a person may actually be guilty of.

This is a commentary on our sick criminal justice and correctional system. I survived and have healed and am continuing to heal.

I've studied and read about Philip Zimbardo's work, the growing field of wrongful conviction work, and the history our country and world has that is a dark and sad account of how human nature can fail, even the best of us.

It has left me feeling less alone. But not less violated.

I sometimes wonder who the woman on the tape was. Where she is – as well as a large number of other things that involved other people I came to know during that time period.

My earnest prayer is that the men and women who assaulted my mind, body and spirit during this time will come to know love, joy and forgiveness in goodness, rather than the pleasure of the sick and twisted activities they chose at that time.

And it is my deeper prayer that somehow writing this will place a growing desire in the hearts and minds of those who read it, that they can bring health and change to our jails and prisons and courtrooms and will do so. Ideally, that we neither bring the wrongly charged and torture them trying to get a false confession, nor mistreat any of those in our system any longer. Even if we can save only one person at a time, that is often the key to changing a whole system.

Statement of Cornelius Dupree who was wrongfully imprisoned for 30 years by the state of Texas before DNA proved his innocence in 2011

When I first went into prison, I was really upset and stubborn because I was imprisoned for a crime I didn't do. I was getting written up a lot for not going to work and for not doing this and that. Around 1980 or 1981, I was working in the fields picking cotton at Cofield Prison. I got into a fight with one of the other inmates. I was charged with fighting with a weapon, even though I didn't have a weapon and was sentenced to 15 days of solitary.

If you were in solitary, you were only given a full meal every third day. The first day, you would get a spoonful of rice, a spoonful of beans and a roll. It was very dehumanizing. On the third day, you get a full meal but you'd be so hungry and weak that it wasn't enough. Without food for three days , you have to be careful about how fast you eat it because you'll get sick. In the 15 days I was in there, I lost 15 pounds.

I was also very cold from lying on steel. They give you one blanket. It wasn't very long, and you had to ball up in a knot for it to cover you. It was very dirty. It was dark. You don't know if it's day or night. You don't get recreation. They called it "the hole." There were no phone calls, there was no visitation. It was the worst thing that they had, and I'll never forget it.

Statement of Robert Dewey who was wrongfully imprisoned for 17 years by the state of Colorado before DNA testing proved his innocence in 2012

In 2002 or 2003, I got put in the hole because of my own medication. I was on Tylenol 3 because I had undergone back surgery, and they gave me a drug test. I told them I'm on medication, and they said that's okay we can distinguish the difference. But apparently they couldn't, because even though I gave them all my medical records, they said I tested positive for opiates and morphine.

When you're in solitary, you sit in the cell 23 hours a day for seven days a week with one hour out for yard. In that hour, you walk around in a concrete area. You really don't even get 60 minutes, because you need at least 15 minutes so you can take your shower.

Everybody likes human contact, so when you first get thrown in there and you're not used to it, you freak out a little bit. Your nerves kick in and you have to go down deep inside yourself and try to fight back against it.

For meals, they give you what they have to give you, no more and usually a lot less. You have to eat with a plastic spork. You lose weight because you don't eat as much, and then you also try to exercise to pass the time.

When you're down in the hole and you need help, you're really out of luck. The guards come by about once an hour, and they act like it's an inconvenience. Medication only comes at a certain time. For me, it was 6 a.m. and then not again until 7 p.m., regardless of what the doctor had prescribed.

Statement of Nicholas James Yarris, former death row prisoner from the state of Pennsylvania who spent 23 years in solitary confinement before his exoneration through DNA testing in 2003

Although I may not appear before you this day, I hope that the following efforts I make in writing can

lend to all a clear understanding of what solitary confinement is to a human enduring it long term.

I am, unfortunately, a walking encyclopedic source of information about solitary confinement. Having spent an astounding 8000-plus days locked within a cell 23 hours a day, I have witnessed or understood every form of deprivation or sensory starved confinement one can know.

There are two features to solitary confinement that I wish to address here in this statement.

First, the most degrading mental breakdown to men comes from the physical confinement. In the three decades I spent watching new prisoners come to death row in Pennsylvania, I saw with little variation, the breakdown of the personality of men initially entering death row. This occurs when all structure from your previous life hits full stop and you are left with ordered times for every facet of your care. Combined with intentional cruelty inflicted upon men in maximum-security settings, makes most men break down in their first two years. I entered death row at age 21, being the second youngest man on death row in my home state at the time in 1982.

In subsequent years, I saw death row swell in numbers from 24 in 1982, to 250 in 2004 by the time I was set free. I saw endless processions of men enter death row only to see that within two years each one either committed violence on others, self harmed or had serious mental breakdowns and required long term medications to keep them stable. Of the three men executed by Pennsylvania, two were heavily medicated psychiatric patients with long term mental health issues.

I have witnessed numerous suicide attempts and 11 successful suicides. I myself have not only attempted my own suicide at age 21, but later in my incarceration, in 2002, I asked to be executed rather than to continue being held in endless degradation.

It was only because of my asking to be executed that the DNA tests I sought for 15 years had been forced upon the state. I was not let out of solitary confinement until the day I was set free. I was exonerated by DNA in July of 2003 and was not released until January 2004. In the last months I was stripped of all death row privileges and was placed in an administrative/disciplinary housing unit where I was allowed nothing at all in my cell.

I was brought before the prison administration of Green County Prison in Pennsylvania once DNA had been used in court to remove all of my death row convictions. I was told that I posed a threat to the staff because in the years confined within solitary confinement, having my hand crushed by a guard or other things done to me made them fear me. I was told that they feared I would lash out at them because they could not accept that anyone who had been subjected to the things done to me could not want vengeance.

I guess the loudest words of damnation come from the very mouths of those who inflict the hurts they know make them the ones to be feared.

The second aspect of solitary confinement is the detriment of not having any new input. When a man is incarcerated long term his demons are not all around him, it's in every stupid mistake and every memory of pain his yesterday held.

That is what destroys anyone with decent feelings: The many stupid mistakes we made before that door shut. Every lie we told, every fight we had, every time we were embarrassed or hurt. It all bears down on

you like some sick film reel of your life endlessly playing out what WAS your life. Prisoners die a thousand memories a day I was once told. I believe it is true.

Without structure we as humans break down or have our weaknesses magnified to the point of being overwhelmed. We need to have art, literacy and any form of in-cell programming we can if we care about not just erasing humans in cells. We need to understand that there are those who need to be separate from others. We have to look at the form of separation that provides security for staff and handles the burden on the state to care for the prisoner.

I think that the United States Government should seek programming and penal ideals from around the world and attempt to use as many of these as we can to better prisons for both inmates and staff. Although it was not part of this statement in focus, we must really be aware that brutal regimens in prison break down the staff in their mental outlook. Prison guards have higher than average rates of suicide and divorce and alcohol abuse because of what they are being made to do to other humans. Solitary confinement is not a cure to violence nor a control to behavior. It is a short term part of what has to be long term strategy.

I now live in the United Kingdom. I hold a steady job and have a loving partner and we plan to marry next year. I have not wasted my time in anger for the many years I spent in solitary confinement. I also thank God for the hard work I spent studying and growing while inside.

I have been in the company of dignitaries, government officials, celebrities and powerful figures in society. I walk around society today no different than anyone else... and yet, I was on the FBI's most wanted list and came as close as 90 days away from being executed.

For all of Pennsylvania's efforts to hold me in solitary confinement because I was so dangerous was, in the end, a facade.

I make this last point not to be facetious, but to point out the reality that every prisoner at some point is going to get out, either on his feet or not. I am able to look at what was done to me and see beyond the draw of anger or pain. Not everyone is going to feel as I do, and they are going to be worse in society than they were before we subjected them to solitary confinement.

Lastly, I would like to add that in no way do I wish to take away from any respect shown to the families of those harmed by men who are placed in solitary confinement, and I also wish to acknowledge the few kind and compassionate human beings I met while in prison who rose above the setting and treated me with dignity or respect. Those are the moments I choose to hold onto from my time held within a cell.

Statement of Clarence Elkins, Wrongly Imprisoned in Ohio for 6 ½ Years

My name is Clarence Elkins, and I served six and a half years in prison for crimes I did not commit.

When I was in prison in Lucasville, Ohio, I had to take drug tests. It was difficult for me to use the restroom in front of so many people. Even though I gave them a sample and passed the test, the sergeant said that I had refused testing and put me in the "hole."

The next time, I was put in solitary because I had been having psychological problems. I was hearing people plotting to kill me. I pretty much lost my mind. I didn't get to talk to anyone—they just put me in

solitary until they thought I was OK, and then they let me out and put me right back where I had been. A couple of weeks later, they put me back in solitary.

The last time, I was in solitary for three months. It turned out that the actual perpetrator of the crimes I was convicted of was serving time in the same prison, so they put me in "protective custody" because they thought I might be in danger. I did absolutely nothing wrong, but I was treated the same as everyone else in solitary. I didn't get any assistance from the staff—they would walk right by me like they didn't see or hear me. I felt neglected and completely invisible. I felt like I didn't mean anything.

The noise in solitary is unbearable. Twenty-four hours a day there are inmates hollering and screaming about nothing. I thought I was going to lose my mind one night—I just started screaming too. It's just such a lonely place. It's the worst of the worst. Prison is bad, but solitary is really bad. No visits, no family, limited reading materials, screaming 24-7, terrible food, disgusting showers. Being locked up in a tiny cell that long is cruel and unusual.

When I finally walked out of the prison, some news reporters were out there waiting and someone raised my hand up in the air. I was actually numb. I thought, "OK. This is another day." I didn't think it was real. Coming out of solitary and into society, I just didn't have any feelings when I walked out the door. You don't know what to expect, or what to do. Six years later, I'm still learning how to cope.

Statement of Herman Atkins, Wrongly Imprisoned by California for 11 ½ Years Before Being Exonerated by DNA Evidence

My name is Herman Atkins, and I spent more than 11 years in prison in California for a rape and robbery that DNA testing ultimately proved I didn't commit. Being wrongly convicted and ordered to prison was a nightmare that I will never completely recover from, but the 16 months that I was forced to spend in solitary confinement was in a league all its own.

Nothing will ever compare to the way I was completely stripped of my humanity while in the "hole." I was confined for 23 hours a day in a small windowless room. A light remained on at all times, allowing the correction officers to watch my every move. I was given one hour for time in the yard and for a shower. But there were many times when, if I picked the yard first, I didn't get a shower. If I showered first, I wouldn't make it out to the yard.

In the brief time I was actually allowed out of confinement, I had to contend with constant tormenting from officers who tried to set me off so that they could prolong my sentence.

All of this happened to me, and I was proven innocent. That shouldn't matter though. When you're confined with no ability to read, to exercise, to receive basic medical attention or to develop your mind, it's just inhumane. I saw some people snap. They just lost their sanity.

As a nation, we must do better. When a government has the authority to treat people so poorly, it's impossible to hold citizens to a higher standard.

Written Testimony of the New York City Jails Action Coalition
Before the Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights,
U.S. Senate
Hearing on "Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences"

Dear Chairman Durbin and Ranking Member Graham:

The New York City Jails Action Coalition ("JAC") is a grassroots collection of activists, including the formerly incarcerated, currently incarcerated, their family members, and other community members, working to promote human rights, dignity, and safety for people in New York City jails. Its members united, in part, to give New York City a local voice in the growing national consensus opposing solitary confinement in jails and prisons. JAC opposes the practice of solitary confinement under all circumstances. Its current advocacy campaign aims to curtail the rapid expansion of solitary confinement beds in New York City jails.

New York represents a case study for the importance of a federal policy on solitary confinement in jails and prisons. Although New York State recently passed legislation to exclude persons with serious mental illness from solitary confinement units in New York State prisons,[1] the law did not apply to local jails, which primarily house pretrial detainees.[2] Thus, although New York State spares many individuals convicted of felonies from the devastating effects of solitary confinement, cities and counties continue to endanger the health and well-being of individuals with mental illness who may never have been convicted of any crime. Such an absurdity is the inevitable result of the patchwork statutory framework governing solitary confinement.

While the New York State legislature moves to curtail solitary confinement in its prisons, New York City plans to expand it in its jails. In fact, by the end of fiscal year 2013, New York City's Department of Correction ("NYC DOC") intends to increase its solitary confinement capacity by 69%, bringing the total number of solitary beds to 1,215.[3] These beds amount to approximately ten percent of the NYC DOC's average daily incarcerated population.[4] Such a rate of solitary confinement far exceeds the national average of between two and four percent. NYC DOC has

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[1] SHU Exclusion Law of 2008, 2008 N.Y. Laws 1 (codified as amended at N.Y. Correct. Law §§ 137 & 401-a (McKinney 2012) and N.Y. Mental Hyg. Law § 45 (McKinney 2012).
[2] *See* N.Y. Correct. Law § 500-K (McKinney 2012).
[3] New York City Department of Correction, *Punitive Segregation: Frequently Asked Questions* 2 (2012), *available at* http://www.nyc.gov/html/doc/html/news/041312_PUNITIVE_SEGREGATION.pdf.
[4] *See* New York City Department of Correction, *DOC Statistics*, http://www.nyc.gov/html/doc/html/stats/doc_stats.shtml.

expanded solitary confinement despite any increase in jail infractions. In the words of DOC Commissioner Dora Schriro, "Jail incidents remain at historic lows."[5]

Solitary confinement places individuals in small cells for 22 to 24 hours a day with little human contact. It comes at a great physical and mental cost to the human beings who must endure it. It deprives individuals of the basic needs of psychological life—productive human interaction and environmental stimulation.[6] As courts have recognized, "isolating a human being from other human beings year after year or even month after month can cause substantial psychological damage, even if the isolation is not total."[7] The psychological harm of solitary confinement is not lost on NYC DOC officers who call solitary confinement "the Bing" because it makes people's "minds go 'bing.'"[8]

Due to solitary confinement's devastating psychological effects, Juan Mendez, Special Rapporteur of the United Nations Human Rights Council, has called for a complete ban on the practice for juveniles and persons with mental disabilities because it constitutes cruel, inhuman, or degrading treatment.[9] States across the nation have recently joined the international consensus opposing solitary confinement. Colorado, Illinois, Maine, Mississippi, Ohio, and Washington have taken steps to reduce their solitary confinement populations. Mississippi reduced both costs and prison violence when it limited the use of solitary confinement.[10]

In the places where it persists, solitary confinement represents a danger to the community. More than one hundred years ago, the Supreme Court recognized that solitary confinement prevented rehabilitation.[11] Today, agencies like the NYC DOC dump thousands of psychologically traumatized individuals directly from solitary confinement cells into the community. These

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[5] Statement to the New York City Council Committee on Fire and Criminal Justice Services and Committee on Finance by Dora Schriro, Commissioner, New York City Department of Correction, March 8, 2012, p. 3.

[6] *See Wilkerson v. Stalder*, 639 F. Supp. 2d 654, 678 (M.D. La. 2007).

[7] *Davenport v. DeRobertis*, 855 F.2d 1310, 1313 (7th Cir. 1988).

[8] *See* Sister Marion Defeis, Op-Ed, *The Crime of Solitary Confinement*, DAILY NEWS (N.Y.), June 4, 2012.

[9] *Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, A/6/268, *available at* http://www.un.org/ga/search/view_doc.asp?symbol=A/66/268.

[10] *See* Erica Goode, *Prisons Rethink Isolation, Saving Money, Lives and Sanity*, N.Y. Times, Mar. 10, 2012, at A1.

[11] "A considerable number of prisoners fell, after even a short [solitary] confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community." In re *Medley*, 134 U.S. 160, 168 (1890).

people can suffer from a range of psychological harms that make it difficult to rejoin productive society and represent a tragic and unnecessary recidivism risk.[12]

Solitary confinement does not decrease violence in New York City jails. Instead, solitary confinement undergirds the culture of official violence perpetuated by the NYC DOC. In addition to the psychological and social harms inherent in solitary confinement, prisoners in New York City's jails face a particular risk of physical abuse. The cellblocks in Rikers Island's Central Punitive Segregation Unit ("CPSU") are places where correction officers can beat incarcerated individuals with impunity. In the 1990s, a successful class action lawsuit brought the brutality of CPSU officers to public light.[13] Today, brutality continues in solitary confinement because the NYC DOC has promoted many of its most notorious officers to positions of authority, where they reinforce a culture of abuse against incarcerated people.[14] Worse, isolation makes it more difficult for those in solitary to access administrative grievance systems, which means that much of this brutality goes unreported. Individuals return to their communities from solitary confinement with broken bodies as well as broken psyches.

Finally, solitary confinement is an extravagant way to deprive prisoners of their rights. Segregation housing can cost as much as two to three times more to build than general population housing and requires substantially greater staffing resources.[15] The NYC DOC plans to accommodate its solitary confinement expansion by adding a new 1,500 bed facility on Rikers Island—even as its number of detainees has steadily declined for the past decade.[16] Solitary confinement simply costs the taxpayers too much money.

JAC's members have suffered and witnessed the ravages of solitary confinement. Some of its members have been forced to live inside "the Bing," and many others have seen its effects on the faces and bodies of family members, friends, and clients.

Conclusion

JAC asks the Subcommittee to adopt federal legislation prohibiting or dramatically limiting solitary confinement. The United States must protect the rights of the people it incarcerates.

Sincerely,

New York City Jails Action Coalition

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[12] *See generally*, Stuart Grassian, *Psychopathological Effects of Solitary Confinement*, 140 Am. J. of Psychiatry 1450 (1983).
[13] *See Sheppard v. Phoenix*, 91 Civ. 4148 (S.D.N.Y. 1998) (order approving stipulation for entry of judgment).
[14] *See* Amended Complaint at 8, 33-35, *Nunez v. City of New York*, No. 11-cv-5845 (S.D.N.Y. May 24, 2012).
[15] Goode, *supra* note 10.
[16] *See* Schriro, *supra* note 5, at 10.

Testimony of
Rabbi Shmuly Yanklowitz, Founder & President
Uri L'Tzedek (Jewish Orthodox Social Justice Movement)

Before the
Senate Judiciary Committee
Subcommittee on the Constitution, Civil Rights and Human Rights
Hearing on Reassessing Solitary Confinement
June 19, 2012

Mr. Chairman, Members of the Subcommittee, thank you for this opportunity to submit testimony on behalf of Uri L'Tzedek concerning the harmful use of solitary confinement in our nation's federal prisons, jails, and detention centers. We are encouraged that a growing number of states across the nation are reassessing this practice and implementing policies to limit its use. In light of the high cost of solitary confinement and its diminishing returns, we are grateful for the Subcommittee's timely review of the federal system's use of isolation today.

Uri L'Tzedek is the Jewish Orthodox social justice movement guided by Torah values and dedicated to combating suffering and oppression.

Across our nation prisoners, inmates, and detainees are being confined in small cells for 22-24 hours per day for weeks, months, even years. Many studies have documented the detrimental psychological and physiological effects of long-term solitary confinement, including hallucinations, perceptual distortions, panic attacks, and suicidal ideation. Considering this severe harm, we strongly believe prolonged solitary confinement is a violation of the inherent God-given dignity in every human being.

In the Talmud, Rabbi Eliezer taught that "Other people's dignity should be as precious to you as your own." (Ethics of the Fathers 2:10). We are inspired by our holy mandate to ensure that all human beings are honored and that each individual created in the image of G-d is treated with basic human dignity.

The use of solitary confinement has increased dramatically in the last few decades. The Commission on Safety and Abuse in American's Prisons noted in their report, *Confronting Confinement*, that from 1995 to 2000, the growth rate of segregation units significantly surpassed the prison growth rate overall: 40% compared to 28%. Rather than a last resort, solitary confinement has become a default management and discipline tool.

The drastic rise in solitary confinement has cost us financially. Super-max prisons are much more expensive than standard facilities to build. Additionally, the daily cost per inmate in a solitary confinement unit far exceeds the costs of housing an inmate in a lower security facility since solitary confinement units require individual cells and significantly more staff.

The success of several states demonstrates that solitary is not the only, or best, option. Several states including Mississippi, Maine, and Colorado have reduced their use of isolation and have proven there are safe alternatives. In an interview with the National Religious Campaign Against Torture, Maine Department of Corrections Commissioner, Joseph Ponte, explained, "Over time, the more data we're pulling is showing that what we're doing now [through greatly reducing the use of solitary confinement] is safer than what we were doing before." Further, we must not neglect the larger public safety impact. The negative effects of prolonged solitary confinement harm our communities. Prisoners who are freed directly from solitary confinement cells are significantly more likely to commit crimes again. Successful reentry of these citizens to our local communities requires preparation for release while they are still incarcerated.

Mr. Chairman, Members of the Subcommittee, Uri L'Tzedek believes strongly that the United States should do everything it can to reverse our nation's harmful and expensive reliance on solitary confinement. We have a moral obligation to uphold the dignity and the mental health of those currently incarcerated. To that end, we would strongly support your leadership in sponsoring legislation that would limit the use and length of solitary confinement. We implore you to immediately take steps to end the use of prolonged solitary confinement. Your hearing today is a very important effort in doing that, and we thank you for the opportunity to contribute to it.



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Written Statement of John Maki, John Howard Association

Hearing on Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences

Before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights

June 19, 2012

Honorable Members of the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights:

The John Howard Association (JHA) is Illinois oldest prison reform group and the only independent organization that monitors the state's juvenile and adult correctional systems. Our mission is to achieve a fair, humane and cost-effective criminal justice system by promoting adult and juvenile prison reform, leading to successful re-integration and enhanced community safety.

Through our regular prison monitoring of Illinois Department of Corrections (IDOC), JHA has documented the effects of long-term isolation in solitary confinement. Based on our work and a growing body of evidence in the fields of criminology, medicine, science, psychology, and sociology linking long-term isolation to the exacerbation and development of serious mental and physical illness, JHA believes that the practice of long-term isolation serves no legitimate correctional purpose. JHA therefore recommends that correctional agencies place strict limits on the use of solitary confinement, including an absolute prohibition against the long-term isolation of mentally-ill inmates.

While IDOC uses long-term isolation throughout its maximum-security facilities, it has one facility, Tamms C-Max, dedicated exclusively to this purpose. In May 2012, JHA published a special report on the facility based on a monitoring visit conducted two months earlier. The following includes relevant selections from our report, "A Price Illinois Cannot Afford: Tamms and the Costs of Long-Term Isolation."

Introduction

Among Illinois' 27 correctional facilities, Tamms C-Max is unique. The facility opened in 1998 as the state's only "supermax" prison in IDOC. It is dedicated to housing "the . . . most disruptive, violent and problematic offenders . . . who have demonstrated an

inability or unwillingness to conform to the requirements of a general population facility."

This mission comes at a high cost to taxpayers. According to IDOC, Tamms' operating budget in fiscal year 2012 was more than $26 million. This means that taxpayers spend almost $65 thousand a year to house an inmate at Tamms, which is three times as much as what it costs to house an inmate at one of Illinois' maximum-security facilities.

The primary reason for Tamms' high costs stems from the fact that the facility was built with the aim of eliminating inmate movement and providing all services in-cell, which requires much higher staffing levels than other prisons. In Tamms, inmates spend 23 to 24 hours a day alone in concrete cells behind perforated steel doors that severely restrict the ability to see or hear anything of the world outside. There are no vocational, educational, religious, leisure, or communal activities in any conventional sense. Exercise consists of an inmate being taken alone to an enclosed outdoor concrete pen to pace. A class consists of an inmate watching pre-recorded instructional tapes in his cell or filling out worksheets. Inmates can be held in these conditions for months, years, or indefinitely in the broad discretion of administrators without oversight by any authority independent of IDOC.

These conditions of confinement are not only expensive to sustain, but they also produce harmful effects that go beyond the legitimate purposes of punishment of incapacitation, deterrence, retribution, or reformation. When Tamms first opened in 1998 at the height of states' enthusiasm for supermax prisons, less was known about the effects of long-time isolation on inmates' physical and mental health and the impact on mentally ill inmates. Since that time, a compelling body of data, literature, study, and research has emerged establishing that long-term isolation can have severely detrimental effects on inmates' physical and mental health, and is particularly hazardous for inmates with preexisting mental illness. Even the courts, which by nature are conservative bodies and usually last to acknowledge consensus on issues of empirical fact, now uniformly recognize that long-term isolation causes grave psychological and physical harm.

The accuracy of these findings was born out during JHA's March 2012 monitoring visit. In observing, visiting, and communicating with Tamms inmates, JHA found evidence of inmates suffering damaging effects to their mental and physical health related to long-term isolation. We found multiple instances of inmates decompensating mentally and physically and engaging in acts of auto-aggression and self-mutilation. We found seriously mentally ill inmates housed in long-term isolation convicted of lower-level offenses who would be more accurately described as the "sickest of the sick" rather than the "worst of the worst."

Observations and Interviews with C-Max Inmates

JHA staff and volunteers had the opportunity to communicate with numerous inmates in C-Max and C-Max's elevated security wings. We found inmates displaying overt symptoms of severe mental illness. We also met inmates with confirmed diagnoses of

severe and enduring mental illnesses, like schizophrenia and major depressive disorder, housed in long-term isolation in elevated security wings.

The weight of evidence obtained in inmate interviews, coupled with our own observations in speaking with inmates and staff, leads JHA to conclude that: (1) Tamms' austere conditions of isolation cause inmates to deteriorate mentally and physically; (2) inmates with serious mental illness are being housed in C-Max, contrary to the minimum treatment standards promulgated by the American Bar Association and the United Nations; and (3) increased training and professional support should be provided to staff to assist them in managing inmates with mental illness, particularly those who engage in self-harming behaviors, and to help staff cope with the stress of working with this difficult population.

Tamms inmates commonly refer to the elevated security wings as the "bug wings" because of the tendency of inmates there to "bug out" and engage in frantic behaviors like self-mutilation and throwing feces and urine. It is well documented that conditions of extreme isolation, like those at Tamms, commonly induce a psychopathological state known as "isolation panic" that is characterized by panic, terror, rage, loss of control, complete breakdown, or fragmentation of self identity. Most C-MAX inmates that JHA spoke with described experiencing symptoms of isolation panic.

The majority of C-Max inmates that JHA interviewed appeared in varying states of mental distress. Some appeared terrified and markedly disordered in their thought processes. JHA received multiple reports of inmates experiencing weight loss, fatigue, weakness, and memory loss. Multiple inmates reported spending two to three days at a time in catatonic-like states of half-sleep. A constant refrain heard from inmates was that they wanted to "hold on" but did not know how much longer they could take it. The vast majority of Tamms inmates JHA interviewed desperately wanted to transfer from the facility.

In conducting inmate interviews, JHA staff and volunteers stood at the cell-fronts.

Communicating with inmates, especially with inmates housed in the plexiglass-covered cells in elevated security, was difficult because of the cell-door design. To be understood, JHA staff and volunteers had to press against the cell doors, yell and repeat ourselves to be heard, as did the inmates inside the cells.

During interviews, Tamms' staff and administrators positioned themselves very nearby and in one instance, an administrator interjected into an interview between a JHA volunteer and an inmate to contest and contradict an inmate's statements. JHA found this level of oversight and scrutiny during interviews to be unusual. Although some of this may reasonably have been attributable to increased safety and security concerns in a supermax facility, it exemplifies the atmosphere of heightened tension and antagonism that JHA encountered on the visit.

In speaking with C-Max inmates and staff, JHA similarly noted unusually high levels of

antipathy between these two groups, even as compared to segregation units in maximum-security facilities. C-Max inmates had a pronounced sense that correctional staff were not simply doing a job but personally "hated" them and wanted them to suffer. Staff and administrators likewise spoke of inmates as incorrigible, unrepentant, and driven solely by destructive motives. Staff and administrators largely discounted that inmates' acts of self-mutilation might be genuine expressions of pain or mental distress, and broadly dismissed these as "malingering" or "manipulation," precluding sympathetic response lest the behavior be encouraged. Inmates, in turn, described staff's responses as infuriating and cruel. In sum, a dysfunctional dynamic of resentment and recrimination seemed evident in interactions between Tamms inmates and staff.

(i) Self-harming Behavior Among C-Max Inmates

JHA encountered a significant number of inmates with scars and wounds from acts of self-mutilation and self-harm. Indeed, at the time of the visit, JHA was unable to tour one of the elevated security wings because administration informed us that an inmate had threatened that he would begin cutting himself when JHA came through the wing. Staff reported that four inmates were actively engaged in cutting and self-harm behaviors, and that the number and frequency of inmates self-mutilating tends to wax and wane. Administration further reported that most inmates who regularly engage in self-mutilation are housed in the elevated security units in C-Max.

Inmates spoke of cutting and self-mutilation as ways to relieve a buildup of pressure and to feel "real" again. An inmate, who currently was not cutting but had deep scars from prior acts of self-mutilation, described to JHA that there was a vicious circle in that when he engaged in self-harm, his cell would be stripped of property, leaving him more deprived and causing the pressure to build again.

JHA also received numerous reports from inmates of being disciplined and penalized for acts of self-harm. Administration reported that acts of self-harm are not themselves penalized, but that any rules broken to effectuate acts of self-harm are penalized. For instance, an inmate who cut himself by using an eyeglass rim or a piece of concrete from his cell could receive a ticket and lose privileges for destruction of state property or possession of contraband. Inmates similarly reported being disciplined for violating "sanitation" rules for engaging in self-mutilation.

JHA believes that attaching punitive sanctions to acts of self-harm and stigmatizing those who self-harm as "manipulative" is unreasonable and counterproductive where these behaviors are typically symptomatic of mental distress and mental illness brought on by long-term isolation. Self-harming behavior is extremely costly in terms of both the danger and damage to inmates and the facility resources required for intervention. However, it is a predictable and well-documented response to conditions of long-term isolation in supermax prisons.

In this environment, self-harm can serve as a morbid but effective form of self-help that brings inmates temporary relief from intense feelings of depersonalization,

disassociation, rage, or fear brought on by extreme isolation. Self-mutilation and self-harm are also often symptoms of deep psychiatric illness and trauma. However, in the economy of the supermax prison, acts of self-harm can also be perversely rational because it is often only through such risky, extreme behaviors that inmates can credibly signal they have urgent, unmet needs, where "cheap" signals like crying or verbal requests for help are routinely discounted or ignored.

Staff noted that inmates sometimes spitefully wait until a shift-change to cut themselves in order to make staff members stay later. Commenting on the specific incident that occurred at the time of JHA's visit, an administrator dismissively commented that the inmate was manipulative and seeking attention and wanted to "put on a show" for JHA. JHA found this administrator's response troubling, but representative of many staff's attitudes towards self-harm that we encountered on the visit.

Staff frustration with inmates who self-harm is understandable, as these inmates tax staff's time and attention and demand a great deal of the facility's resources. Feelings of frustration, distress, anger, anxiety, and a lack of empathy are common and normal reactions to individuals who frequently self-injure. It is critical, however, that staff "[n]ot lose sight of self-injury's function as a response to stress." To do so can "[l]ead to gaps in surveillance, with minor wounds being dismissed rather than being viewed as potential precursors to more severe self-injury."

Staff cannot accomplish this on their own, but need training, strategies, resources, and professional support to assist them in both successfully managing and interacting with mentally ill and self-injuring inmates, and dealing with the tremendous workplace stress and burnout that frequently accompanies dealing with these populations. Absent such training and support, the negative emotions evoked by self-injury may become part of a cyclical pattern. Specifically, self-injuring behaviors tend to illicit negative cognitions and emotions in staff members (*i.e.,* nurses, clinicians, correctional staff) which can lead to a negative interaction between the self-injuring inmate and staff. This interaction can lead to increased negative emotions and cognitions in the person who is at risk for further self-injury and may ultimately trigger another self-injury event.

As previously noted, studies indicate that providing staff with specific training on issues of mental illness, as well as professional and social support leads to much fewer incidents of violence and use of force, creating a safer environment for staff and inmates alike. JHA recommends that regular professional training on issues of mental illness and, specifically, issues of self-injury, be provided to all IDOC staff, and Tamms staff in particular. Dealing with chronic self-injuring behavior can be incredibly stressful for correctional staff, particularly for those who work long term with inmates who repeatedly display this behavior. Without an appropriate theoretical framework on self-injury from which to base interactions and interventions, staff working with self-injuring inmates can increasingly feel overwhelmed and ineffective in working with this population. This adds weight to the possibility of a cyclical interaction between self-injurious behavior and staff behaviors, as staff may unwittingly react in ways that enrage or overwhelm self-harming inmates.

Further, for the reasons already stated, JHA believes that in order to effectively and categorically reduce incidents of self-injury among inmates: (1) the use of long-term isolation should be prohibited with respect inmates who have a history of mental illness, including any history of self-injuring behavior; and (2) that the use of isolation should be strictly circumscribed across the board, and employed with caution, for minimal periods of time, and only when absolutely required to preserve inmates' and staffs' safety.

(ii) Experiences of C-Max Inmates

At the time of our visit, JHA requested that several Tamms inmates be brought to confidential areas to allow JHA to interview them privately. It is a routine monitoring practice for JHA to select and confidentially interview several inmates at the time of a visit, without pre-identifying the inmates to facility administrators ahead of time to prevent potential intimidation or interference with interviewees and ensure the integrity of the interview. JHA's request to privately interview Tamms inmates in this manner was denied on the grounds that we did not seek pre-approval. With the exception of two inmates who were shackled and interviewed by JHA volunteers in multi-purposes rooms with the doors open, all Tamms inmates were interviewed from behind closed cell doors.

A sample of reports JHA received in inmate interviews follows and typifies the experiences of the C-Max inmates we spoke with.

An inmate in one of C-Max's elevated security wing was presented with white bandages wrapped around his legs and arms at the time of JHA's interview. He pressed on the bandages during the interview causing blood to soak through them. The inmate displayed deep scars all over his arms and legs from self-mutilation. He described going through cycles of dark depression where cutting himself was the only relief.

The inmate indicated that he received medical treatment when he cut himself, but that mental health conditions were "bad" in that staff looked for reasons not to provide inmates with mental health treatment. The inmate explained that staff sometimes mocked him and goaded him when he cut himself, telling him that he did not cut deeply enough. During the interview, the inmate's affect verged on frantic at times, and he tended to repeat himself and lose track of his thoughts. When JHA staff explained they had to move on to speak to other inmates, the inmate became very anxious and pleaded that JHA staff stay longer.

Another inmate housed in elevated security described at length how long-term isolation had affected him. He stated: "I feel like I am disintegrating. The isolation has affected my mind. It is like your head is in a vice, with the pressure crushing you. You are isolated from everything that made you who you are. I'm coming apart. I can't connect. It's psychological torture. [Tamms] is worse than any other place I have been because of the depersonalization you go through. The sensory deprivation eats away at your soul. You are not able to interact with another human being. Even if you have a bad cellmate, you interact with another human being." The inmate stated that he would "take Pontiac

[Correctional Center] any day" over Tamms just to have "some contact."

An inmate in elevated security, who was wearing a spit mask, shackled to a stool, and cuffed with his hands behind his back when JHA interviewed him, displayed symptoms of severe mental and physical distress. He appeared wide-eyed, terrified and extremely agitated during the interview. His body and neck were contorted into stiff, unnatural positions, and he writhed around and shook his head from side to side. He spoke in an extremely loud voice and seemed unable to modulate his volume, tone, or affect.

The inmate said he had been in Tamms "sensory deprivation experiment" for over a decade. He called the elevated security wings that "Elevated Security Experiment" and said that the wings were used to house outcast inmates from other facilities because of their psychiatric problems. He was fearful that staff were poisoning and putting bugs in his food. The inmate's level of psychiatric symptoms and mental distress during the interview were so acute that they rendered communication very difficult. The inmate had to be removed from his cell to a multi-purpose room to speak with JHA because we could not enter his housing unit due to another inmate, previously mentioned, who had threatened to begin cutting himself.

Multiple inmates described Tamms as being a "separate world," a "world within a world," a "time warp," or a "time trap." An inmate in elevated security reported to JHA that some inmates howled and screamed all night long. While the inmate had tried to talk to other inmates on the wing, he had since given up because it was impossible to hear.

An inmate in administrative detention reflected that it was a struggle for inmates to remain strong and not lose a grip on reality. He explained that sensory deprivation was hard to withstand, and that he had seen many men "crack" under the pressure of Tamms. The inmate admitted that he had created bad situations and lashed out when he was a young inmate in IDOC, but he had since grown up and his outlook as a middle-aged man had changed. The inmate expressed that the loneliness of Tamms was starting to get to him and had become increasingly hard to bear because he wanted to see his family "so badly."

Another inmate noted that his memory had deteriorated over the years at Tamms, and he could no longer remember things or concentrate long enough to be able to read books. He said that mental health staff occasionally came by the cells to check on inmates and ask how they were doing. He explained that when inmates told staff they were disintegrating and going through "psychological torture," staff would debate them and "think they are faking it." The inmate felt extreme anger, depression, and hopelessness believing that he would never get out of Tamms.

JHA heard reports from some inmates of staff taunting and physically or verbally abusing inmates, particularly inmates in the elevated security units. An inmate explained that inmates in elevated security were especially hated by staff because they were "mental cases." The inmate reflected that poor treatment had instilled inmates with hate and made everyone at Tamms angry and bitter.

An inmate diagnosed with schizophrenia expressed that he had been moved out of the STU because they "don't like me there." The inmate had a history of smearing feces and urine over his cell. During the interview, the inmate began giving a disjointed paranoid account of how he was being poisoned and produced a small piece of rolled-up paper from his mouth as evidence of this. He said that he felt better since leaving the STU because one of the police departments he had written to about his poisoning was finally "on the case." The theme returned to over and over by the inmate was extreme loneliness. During the interview, he became dejected and repeatedly stated, "I'm just so lonely. I'm so lonely all the time."

A large number of inmates made statements to JHA to the effect, "I feel like I am dying," and "I just want to die."



Written Statement of
Just Detention International

Lovisa Stannow
Executive Director

Hearing Before the Senate Judiciary Subcommittee on the
Constitution, Civil Rights, and Human Rights

June 19, 2012
10:00 a.m.
Dirksen Senate Office Building Room 226

Time to End the Overuse and Abuse of Solitary Confinement

Chairman Durbin, Ranking Member Graham, and Members of the Subcommittee:

Just Detention International (JDI) is a health and human rights organization that seeks to end sexual abuse in all forms of detention. JDI was founded more than 30 years ago by survivors of prisoner rape. To this day, it remains the only organization in the U.S. dedicated to ending this type of abuse. JDI was instrumental in developing and securing passage of the Prison Rape Elimination Act (PREA) of 2003 and has since remained at the forefront of the effort to implement this landmark law – including by advocating for strong national standards to prevent and address sexual abuse in detention. The release of standards, mandated by PREA, in May 2012 by the Department of Justice represented a milestone in JDI's work and in the overall effort to end – once and for all – the sexual abuse that plagues U.S. corrections facilities.

Sexual abuse in detention is a nationwide human rights crisis. A recent report from the Department of Justice found that almost one in ten former state prisoners was sexually abused during his/her most recent period of incarceration.[1] The Department of Justice estimates that well over 200,000 men, women, and children are sexually abused in U.S. prisons, jails, and juvenile detention facilities every year. Many more are assaulted in immigration detention facilities, police lock-ups, military prisons, tribal jails, and community corrections facilities. JDI receives about 2,000 unsolicited letters every year from survivors of sexual abuse in detention. Many of them report devastating assaults directly related to inappropriate or abusive solitary confinement.

Survivors of sexual abuse who are placed in solitary confinement (sometimes referred to as administrative segregation or protective custody) tend to suffer significant distress. The same is true for inmates who are placed in solitary confinement simply because they are perceived to be vulnerable to sexual victimization. Today's hearing is a vital step in the effort to do away with the overuse and abuse of solitary confinement in U.S. corrections facilities.

Solitary Confinement is Punitive and Causes Harm to Sexual Abuse Survivors

Solitary confinement is punitive by default; it results in a loss of services and programs, leaves inmates with little or no access to outside support, and cuts the them off from positive human interactions. In many corrections facilities, survivors of sexual abuse are routinely placed in solitary confinement in the aftermath of an assault, ostensibly for their own protection – and frequently against their own will. While there, they tend to suffer significant distress, including fear, anxiety, and heightened trauma.

To make matters worse, the extreme sense of isolation survivors experience in solitary confinement makes them less likely to file a formal complaint about the abuses they have endured or to cooperate with an investigation. As such, solitary confinement is directly linked to the acute lack of accountability for sexual abuse that pervades U.S. corrections facilities. The Department of Justice's study of former state prisoners reveals that about two thirds of survivors abused by another inmate did not report the abuse. Even more alarming, nearly 95 percent of survivors abused by a staff member did not report the abuse.[2] Letters from survivors to JDI make clear that fear of inappropriate use of solitary confinement is a serious contributing factor to these low reporting rates.

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[1] *Sexual Victimization Reported by Former State Prisoners, 2008*, DOJ's Bureau of Justice Statistics, p. 5. Available at: http://bjs.ojp.usdoj.gov/content/pub/pdf/svrfsp08.pdf.

[2] *Id* at Table 17.

One survivor who was abused in a Colorado facility wrote to JDI, "I was treated like the perpetrator. I was thrown in segregation. I felt so humiliated." Many times, sexual abuse survivors are kept in solitary confinement for long periods of time. A survivor raped in a Texas facility wrote to JDI, "I am in lock-up or segregation or whatever it is called. I'm being told I will spend over 100 days here before I'm transferred. You would think that I attacked someone from the way they are treating me." In many cases, the stark physical conditions of solitary confinement further adds to the trauma. A survivor who was abused in Pennsylvania and Florida wrote, "I did not request protective custody. It was imposed on me. I'm in a very small cell with a concrete slab for a bed."

Involuntary Solitary Confinement Should be Used Only as a Last Resort

JDI advocates for basic conditions to be met when involuntary solitary confinement is deemed the only way to protect a survivor of sexual abuse from further attacks. First, strict time limits must be placed on how long a survivor can be held in such punitive housing. The need for continued solitary confinement must be reviewed on a regular basis, and a survivor's wishes to be moved back to general population must be taken seriously. To minimize the negative health consequences of solitary confinement, corrections officials need to provide survivors housed there with health care services, access to programs and services, and contact with a rape crisis counselor.

The Department of Justice's PREA standards reiterate several of these basic requirements, although they do not go far enough.[3] The standards call on corrections officials to provide survivors with access to services and to move them to less restrictive housing as soon as possible.[4] The standards also mandate the provision of medical and mental health care, including contact with support services.[5] However, the standards do not place strong enough limits on the time a survivor may involuntarily be placed in solitary confinement. The PREA standards generally limit involuntary solitary confinement for survivors to 30 days.[6] Taking into account the severely harmful consequences of such housing, JDI believes a more appropriate time limit is 72 hours.

Solitary Confinement is Not Appropriate Housing for Vulnerable Inmates

Like survivors of sexual abuse in detention, inmates who are deemed vulnerable to sexual abuse are frequently placed in solitary confinement. JDI considers such punitive housing assignments inappropriate. Keeping inmates safe is one of the most basic responsibilities of corrections officials. They must be able to ensure the safety of all inmates without resorting to involuntary solitary confinement. Inmates who are most commonly isolated include lesbian, gay, bisexual, transgender, intersex, and/or gender non-conforming inmates and those who are perceived as such regardless of their identity. Too often, inmates with disabilities, young or old inmates, and other inmates targeted for violence are similarly warehoused in solitary confinement.

In some cases, corrections professionals believe that solitary confinement is in the best interest of vulnerable inmates. In other cases, however, officials rely on such housing as a quick fix – moving the "problem prisoners" out of general population. This strategy does not take into consideration the

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[3] The Prison Rape Elimination Act Standards available at www.ojp.usdoj.gov/programs/pdfs/prea_final_rule.pdf (last viewed on June 11, 2012).
[4] *Id.* As an example, see the relevant adult jail and prison standard at 115.43.
[5] *Id* at 115.53, 115.83, and 115.83.
[6] *Id* at 115.68 (referencing 115.43).

serious distress caused by solitary confinement. Indeed, through such housing decisions staff choose to harm inmates rather than doing their jobs properly. In so doing, they allow unsafe conditions to remain unaddressed, ultimately making the facility more dangerous for everyone, inmates and staff alike.

JDI believes that every effort must be made to create institutions in which involuntary solitary confinement is used only as a last resort. To achieve this goal, the policies and culture of corrections facilities must prioritize creating safe, dignified housing for everyone – including sexual abuse survivors and those who are vulnerable to sexual abuse. When solitary confinement is used as a last resort, it must be used in compliance with the strict limitations outlined above.

Solitary Confinement as Retaliation Against "Snitching" or Expression of Homophobia

Many survivors of sexual abuse in detention and other vulnerable inmates are subjected to involuntary solitary confinement as a *de facto* punishment. JDI regularly hears from prisoner rape survivors who, after filing a sexual abuse report are placed in solitary confinement for "causing trouble." One survivor wrote from a Michigan facility, "I have been tasered and raped for the past three years by prison staff. And brutally attacked and confined to segregation for reporting it."

Likewise, many corrections officials use solitary confinement to express contempt toward certain inmate populations. This is particularly true for inmates who are lesbian, gay, bisexual, transgender, intersex, and/or gender non-conforming and inmates whose criminal or medical history is particularly disfavored (such as inmates convicted of child sexual abuse). An inmate in Oklahoma wrote to JDI that "at this maximum security prison they have a policy that if you are homosexual and have HIV they automatically put you in long-term administrative segregation. That policy is so discriminatory."

JDI believes that abusive use of solitary confinement must be taken as seriously as any other form of harm inflicted on an inmate. The perpetrators of such abuse must be held accountable and prosecuted to the fullest extent of the law. Significant pressure should be put on the Department of Justice, state attorneys general, and local district attorneys to investigate and prosecute abusive use of solitary confinement in facilities under their jurisdictions.

Solitary Confinement is a Drain on Resources

Inappropriate or abusive use of solitary confinement drains vital funds that could be used much more effectively. In a 2009 report, the California Inspector General estimated that the annual costs per inmate in administrative segregation averaged at least $14,600 more than the annual costs per inmate in general population.[7] The California Inspector General concluded that the overuse of solitary confinement cost the California Department of Corrections and Rehabilitation nearly $11 million every year.[8]

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[7] California Office Of The Inspector General, Management of the California Department of Corrections and Rehabilitation's Administrative Segregation Population (2009), available at http://www.oig.ca.gov/media/reports/BOA/reviews/Management%20of%20the%20California%20Department%20of%20Corrections%20and%20Rehabilitation's%20Administrative%20Segregation%20Unit%20Population.pdf (last visited June 11, 2012).

[8] *Ibid*

Corrections administrators often cite cost as one reason why facilities are not made as safe as possible. However, the significant funds spent every year on inappropriate and abusive use of solitary confinement could be used to establish and implement basic policies and procedures aimed at preventing sexual abuse and other forms of violence. Such reinvestment of resources would lead to safer, better run corrections facilities. It would also prevent the negative health consequences among inmates who are placed inappropriately in solitary confinement. JDI believes that corrections administrators should begin shifting expenditures in this direction as soon as possible.

With strong leadership, effective policies, and sound practices, prisons, jails, and other confinement facilities can provide all inmates with safe housing that is far less restrictive and far less expensive than solitary confinement. Doing so would fundamentally transform corrections culture, to the benefit of everyone – inmates, staff, and ultimately the communities to which almost all prisoners eventually return.

/end/

JUSTICE & MERCY
SHEDDING LIGHT ON THE ISSUES
PO Box 159 ~ Strasburg, PA 17579 ~ 717-687-7650 ~ www.justicemercy.org ~ jbickmire@justicemercy.org

Thursday, June 14, 2012

The Honorable Dick Durbin
U.S. Congress
711 Hart Senate Building
Washington, D.C. 20510

Dear Chairman Durbin and Ranking Member Graham;

I have attached testimony regarding solitary confinement in the United States correctional system.

Justice & Mercy, as a non-profit organization, has a vision to see justice in the judicial system and to have offenders and victims be made whole in their person, family, and their community through rehabilitation, thereby creating safer communities. We also believe in the innate humanity of every person and, therefore, would promote a process that would correct persons who have done criminal behavior.

We have discussed the negative impact of long segregation with the Pennsylvania Department of Corrections in 2004 and more recently, with newly appointed PA DOC Secretary John Wetzel in establishing a process out of segregation into general population through rehabilitative programs. I am happy to report that Secretary Wetzel was very receptive to the request but I do not know if any plans are yet in place.

Please see the attached testimony on solitary confinement. We appreciate having the chance to be able to present our views to the Congress.

Thank you.

Sincerely,

Jean Bickmire, Legislative Director
Justice & Mercy, Inc.

JMB

JUSTICE & MERCY
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LONG-TERM SEGREGATION UNITS EFFECTS ON INMATES REPORT

By JUSTICE & MERCY, INC.
Written by
Jean M. Bickmire, Legislative Director
2012

Justice & Mercy, Inc., believes long-term segregation units are not helpful in changing negative behavior and, in fact, may be extremely detrimental, not only to the inmates but to prison staff and society as a whole when they are released. We believe intensive treatment programs are required instead of continuing to perpetuate the escalating, futile cycle of violence and punishment.

We propose the use of solitary confinement to a maximum period of 90 days.

REASONS FOR PROPOSAL:
Three main purposes exist for prisons which are:

1. Punishment

2. Deterrence

3. Rehabilitation

Through these purposes, criminals are removed from society for public safety, deterred from committing more crimes through separation from their families and friends as well as from hardships in prison and rehabilitated so they can be productive, tax-paying and law-abiding citizens when they are released. At least, this is the theory.

Unfortunately, the reality is that prisons probably do more harm than good. The recidivism rate is currently 66 – 67%. Inmates need to adapt to prison life which is much different that society. Ways they adapt are:

- Situational withdrawal in which prisoners minimize their interaction with others.

- Prisoners refuse to cooperate with staff and show hostility. Then they are placed in solitary confinement.
- Prisoners become institutionalized to be able to interact with prison staff and inmates. They begin to fit in better in prisons than society.
- Prisoners become what they think correctional officers want them to be.
- Prisoners stay out of trouble so they can eventually get out of prisons as quickly as possible with as little physical and psychological damage as possible. (Haralambos & Holborn, 1995:306)

Inmates may "do time" to avoid any trouble that would lengthen their sentences and make their time as easy as possible. Some may focus on self-improvement. Some inmates may not fit into the niches of other inmates and are disorganized. They tend to be mentally ill or have low IQs and are the most frequent violators of official prison rules. An estimated 16 to 20% of inmates in the state system are diagnosed mentally ill. Experts state that mentally ill prisoners end up in solitary confinement because of rule infractions stemming from their mental illness.

Confinement from society includes the loss of liberty, moral rejection and the fact prisoners are not trusted or respected. Sexual deprivation also places more pressure on inmates and loss of decision-making puts them under the control of prison staff. The circumstances of prison life may lead to a lack of what made them human. (Johnson, 1996).

Officers may have too much power over inmates and exercise it incorrectly and inhumanely. The Stanford Prison experiment showed that normal males became too powerful when they had the role of guards. Some of the group that had the role of prisoners experienced breakdowns. Good governance by correctional officers is the key to the maintenance of good prisons. (DiIulio 1987)

Inmates will get in groups with other inmates to help the pains of imprisonment become less severe. These groups may have a detrimental effect on inmates in which they learn how to be better criminals or develop more hostility toward society.

There are four identified sets of rules that govern prison life:

1. the official administrative rules and regulations (violations result in 30 to 180 days disciplinary action such as segregation or isolation)
2. the convict code (violations result in anything from stares to death by inmates)
3. the color or race code
4. gang membership rules (gangs are said to be responsible for about 85% of all prison violence)

Overcrowding: Pennsylvania has a severe overcrowding issue in the prisons. Studies have shown that increasing the number of inmates in correctional institutions has significantly increased negative psychological effects like stress, anxiety, tension,

depression, hostility, feelings of helplessness and emotional discomfort. (Bartol & Bartol, 1994)

When prisons are overcrowded, the rehabilitative programs are not able to reach all of the prisoners that are assessed as needing them. The Pa. Department Of Corrections agreed that many more people are assessed with needing specific programs than the DOC is able to provide these treatment programs. This is unfortunate since educational programs appear to be the most effective treatment programs. Vocational training programs have mixed results depending on what is being taught. For instance, computer data entry classes are producing higher employment rates for ex-offenders than food service training. Palmer studies (1991) found that counseling or treatment programs can work if they are adequately funded and run properly. However, generally, rehabilitative programs only reach 5% of the inmate population.

Riots can be caused by stressful and oppressive conditions that are exacerbated in overcrowded conditions. (Useem & Kimball 1989). Also, there are theories that the use of a snitch system by correctional officers against inmates is the main cause of violence in prison. (Rolland 1997)

In addition, overcrowding has lead to a shortage of correctional officers and new methods of ascertaining security in prisons which has lead to increased use of units of solitary confinement. They are considered to be cost effective due to technological changes which can make contact between the prison staff and inmates almost nonexistent. Therefore, serious medical conditions can go undetected and untreated and inmates' conflicts are not recognized.

Solitary Confinement:

There are four ways inmates can go to segregation units:

1. disciplinary (the most common)
2. voluntary (known as protective custody)
3. administrative (transfer based on inmate being classified as security risk)
4. medical (for elderly, infirm or seriously ill inmates)

Almost half of segregation units are made up of mentally ill it is estimated by experts. People in supermax cells are not so much the "worst of the worst" but the "sickest of the sick". Two-thirds of the population in segregation units are minorities. Isolation can last for weeks, months or years. In some segregation units, stays are indefinite.

Segregation cells, about 8' x 10', are generally made to cut down on talking and reaching between cells with wire mesh windows about 20" x 30" being covered by Plexiglas spaced about 3" out from the mesh. This is to prevent projectiles directed by some inmates. A few inches below the cell window is a slot for the food tray. The inmate is confined alone in a cell 23 hours per day with little chance for social interaction or stimulation. None of the senses (sight, taste, touch, smell, sound) are stimulated in such a

place. Living conditions are usually harsh with a dim light on all the time, insects crawling and poorly functioning toilets. They are either sparse and cold or extremely hot. The lack of windows prevent air from circulating. In disciplinary segregation, inmates are entitled usually to one hour of outdoor recreation per day and most prisons have small, fenced-in yards like dog kennels. Sometimes, they were forced (per testimony in *Andy Torres v. SCI Pittsburgh Superintendent Phillip Johnson, et.al.* in PA) to choose between recreation or use of the law library. Recreation depends upon an inmate's good behavior. Deputy Attorney General Kemal Mericli said inmates must be shackled and escorted to be taken anywhere. He tried recently to uphold the PA DOC policy of inmates not having reading material in their cells.

Low wattage lights can remain on in cells 24 hours per day. Deprivation of healthy sleep patterns or use of sedating medication increases inmates' propensity for delirium.

Inmates are denied group exercise, work opportunities and corporate religious services. Even religious services have no physical contact with inmates. Holy Communion must come through the food slots. Access to treatment and social services is extremely limited. Inmates only speak to their family and friends during visitation behind Plexiglas windows with guards monitoring their conversations. Their phone calls are also limited.

In addition, according to Judge Colville of the Court of Common Please of Allegheny County, PA, Criminal Division, in the court case *Andy Torres v. SCI Pittsburgh Superintendent Phillip Johnson, et.al.*, inmates were sometimes placed in "alternative housing" which is a 'cell without the inmate's property or clothing, with a smock and no underwear to wear, a mattress and a "security blanket"' in order to punish the inmates. According to the segregation policy, if the inmate used a mattress to barricade himself in his room, the alternative housing cell would exclude a mattress and require the inmate to sleep on a metal bed frame or a concrete slab.

Solitary confinement has been shown through studies to cause adverse psychological effects due to sensory deprivation. Some of the effects are:

- delusions
- dissatisfaction with life
- claustrophobia
- depression (suicidal)
- feelings of panic
- madness
- vivid fantasies and vivid hallucinations
- hyperresponsivity to external stimuli
- cognitive impairment
- massive free-floating anxiety
- extreme motor restlessness
- delirium-like conditions (organic changes in the brain similar to stupor and delirium)
- vision impairment

- headaches
- memory loss
- emotional instability

These symptoms combine to produce chronophobia, a prison neurosis. Symptoms of solitary confinement including hearing voices, seeing ghosts, amnesia and violent psychosis. There are high rates of self-mutilation, head-banging and suicide. Individuals with emotionally chaotic lives are at risk for these psychotic symptoms. Hallucinating is common with inmates feeling like the walls are closing in on them. Inmates are reported to be nervous around people.

Dr. Stuart Grassian, a psychiatrist at Harvard Medical School, found inmates in isolation with these symptoms:

- hearing voices
- increased inability to tolerate ordinary stimuli like noise
- panic attacks
- difficulty in concentration and memory
- mind wanders
- aggressive fantasies of revenge, torture and/or mutilation of guards
- paranoia
- doubts in themselves
- out of touch with reality
- problems controlling impulses (which may lead to random violence)

Dr. Grassian found that more than half of the inmates interviewed who were in solitary confinement reported progressive inability to tolerate ordinary noises and more than half experienced panic attacks. Almost one-third reported hearing voices, often whispers saying frightening things to them.

In the opinion of Judge Colville of the Court of Common Please of Allegheny County, PA, Criminal Division, in the court cases *Andy Torres v. SCI Pittsburgh Superintendent Phillip Johnson, et.al.* and *Americo T. Rivera v. Pennsylvania Department of Corrections, Martin Horn, et. al.*, many of the inmates in long term segregation were described as suffering from mental or emotional illnesses, although the mentally ill are to be housed (theoretically) in a separate unit. The judge said it wasn't clear whether the mental and emotional conditions were caused by long term segregation because of the effects of solitary confinement are the cause of the behaviors that put inmates in segregation. The judge said the petitioners in both cases suffered from depression and other emotional and psychological problems and there was no or little treatment given to them by the Pa. DOC. Judge Colville expressed concern that long term segregation units do not help inmates, staff or society as a whole. The court was glad that the DOC is developing better programming than long term segregation. It cited the lack of psychological care for inmates that need a behavioral modification program, counseling or other help in order to assist them to conform their behavior to prison and the

community at large. The court also said inmates who most need these programs that could assist them in getting out of solitary confinement are excluded from them.

The effects of symptoms depend on the amount of time an inmate may spend in isolation. (Bartol & Bartol, 1994) Social psychologist Craig Haney said it usually takes six months or more for severe symptoms to manifest. The prisoner becomes increasingly depressed and dependent. He may lose many social restraints and begin to soil himself. It takes about four to six weeks to produce degenerate behavior. The mentally ill become sicker under solitary confinement and the psychologically healthy start to exhibit signs of acute mental illness. Haney also said that solitary confinement produces extreme psychological trauma and symptoms of psychopathology in persons subjected to it. Two key functions of the mind affected, said Dr. Grassien, are the ability to focus, which causes difficulty in concentration and memory loss, and the ability to shift attention, in which the inmate become fixated on something and can experience hypersensitivity to certain external stimuli. The inability to shift attention can include obsessive thinking, uncontrollable anger, paranoia, and sometimes, psychotic delirium.

Through simulations of the prison environment, lockups and isolation are shown to dehumanize prisoners by taking away their unique personalities and eventually their identity, and cause ill feelings by prisoners because of their rejection and condemnation by society. The effects also depend of inmates' interpretation of the confinement. If an inmate sees his situation as life-threatening, he is more likely to develop adverse psychiatric reactions. If the situation is perceived as non-threatening, the inmate is more likely to tolerate the circumstances. Mentally ill inmates in isolation are especially vulnerable to the effects. Many inmates in solitary confinement have been diagnosed with mental illness when very young and experience the gamut of the criminal justice system by the time they become adults. They are frequently treated harshly and end up in supermax cells. Many inmates can not handle the extreme conditions and attempt or commit suicide.

Many inmates are likely to suffer permanent harm as a result of being put in solitary confinement. They will begin to have intolerance for social interaction which affects how they can successfully adjust to being released, not only to general prison population, but to our communities as our neighbors. Dr. Grassian said that many prisoners from these segregation units are being released directly into the communities in these violent psychotic states. There's no follow-up since many serve their maximum sentences with no parole oversight. The DOC says it prefers to move these inmates to lower security units before release but this is not a guarantee. Judge Colville in his opinion in the court case *Andy Torres v. SCI Pittsburgh Superintendent Phillip Johnson, et.al.* also stated that letting inmates from long term segregation directly into society without the benefit of psychological or behavioral programs or treatments that can help them is at odds with the rehabilitation mission of the correctional system and is extremely detrimental to society.

Wisconsin Supermax District Judge Barbara Crabb noted in a 23-page ruling in 2001 regarding conditions in Wisconsin's supermax prison that prisoners experienced intensified mental illness including attempted suicides due to severe conditions in these

supermax units. She said some inmates, surprisingly, were still experiencing symptoms of mental illness despite being prescribed medication. In 2001, in fact, Wisconsin lawmakers voted to ask the Department of Corrections to revert the supermax prison back into a conventional prison.

Prolonged confinement can exacerbate mental illness in people who were not previously diagnosed with such an illness. They may cause paranoia, difficulty controlling impulses, agitation and irrational aggression to the prison staff. Social psychologist Craig Haney said inmates in solitary confinement can get fixated on revenge. Therefore, these environments tend to keep a cycle of violence going which is psychologically harmful to inmates, the prison staff and, ultimately, the public. These segregation units teach inmates to hate. Some DOC officers also tend to be inmate haters. Officers that report on their fellow officers for instigating violence against inmates tend to get retribution from the officers. There is an unspoken rule of standing by your fellow officers no matter what.

After repeated exposures, prison staff has become immune to methods of force used to bring inmates into line. Inmates may be subjected to stun guns, pepper spray, batons and violent beatings. It becomes routine and correctional officers ignore the violence. However, inmate insubordination in solitary confinement may be the effect of isolation and psychotic symptoms. To provoke reaction by guards may be a way for inmates to get external stimulation and prove they exist. Correctional officers need to ascertain who is mentally ill and who is just violent.

Many mentally ill prisoners can not understand and, therefore, follow prison rules. They are then more likely to be subjected to one of the most dangerous and violent prison procedures which is the cell extraction. At the minimum, guards use extraction shields, protective vests, helmets with face shields, gas masks, protective gloves, groin protectors, elbow and knee pads along with shin protectors, handcuffs, leg irons and/or flex cuffs OC (pepper)spray and batons.

Lorna A. Rhodes, author of "*Total Confinement: Madness and Reason in the Maximum Security Prison*", said inmates have little chance to earn their way out of these segregation units by good behavior as they are being driven mad by the isolation. Control by prison guards is so severe to limit individual choice. Or inmates lack the ability to make good choices as they are so psychotic. More treatment is necessary, Ms. Rhodes said.

Ms. Rhodes described in her book of a project in a control unit of a maximum-security prison in which officials cleaned up racist graffiti, made renovations so inmates couldn't throw feces at staff members and directed administrators to go to the inmates tiers once or twice per week to talk to inmates and deal with their problems. Educational programs were introduced. Four years later, the unit was experiencing dramatically less violence and use of force on prisoners. Many inmates were able to go back into general population.

Accountability: No one from the outside public has been allowed admittance to witness conditions in today's penal institutions. Psychologists and criminologists used to be allowed access to study the effects of confinement on the inmates. Researchers could study the rigid effects of solitary confinement versus other confinement systems to see which were effective. For instance, in the 1830s, the difference between Philadelphia Prison of rigid confinement and the Auburn system in New York at Auburn and Sing-Sing showed that the Philadelphia Prison had a higher rate of insanity in prisoners than the Auburn system.

In Germany, they documented the effects of solitary confinement and discovered psychosis.

Statistical evidence of many researchers showed that solitary confinement was the cause of very disturbing cases of insanity, physical disease and death.

The 1959 Manual of Standards of the American Correctional Association recommended a few days of punitive segregation for most infractions and a limit of 30 to 90 days for extraordinary circumstances. These limits recognized that solitary confinement has a devastating effect on inmates.

Per a court ruling following legal action, the Pa. DOC now said it tries to get inmates out of the segregation units as soon as possible and mental health services can contact prisoners five days per week. However, with the widespread effects of mental illness on inmates in solitary confinement and their increased propensity for violence as well as social services in prisons being overworked and understaffed due to the increased prison population, it is doubtful that inmates can practically be released into general population any more rapidly.

In October 2003, inmates from SCI Pittsburgh long term segregation unit sued the Pa. DOC for the policy that bans newspapers, magazines and personal photographs in these segregation units. The DOC argued in favor of the policy to the Third Circuit Court of Appeals saying that some inmates abuse them. However, the defense argued that not all the inmates in solitary confinement have abused the reading materials and, thus, it violates their First Amendment rights.

Human Rights Watch recommends bringing greater public scrutiny of prisons including solitary confinement and supermax units and facilities.

More accurate information is needed as more people are going to prison than ever before. We need to study the problem; however, researchers are faced with prison administration denying access for such studies, stating that they are concerned with security. The prisons need to be held accountable to the general public who will be directly affected if such prison programs do not work. The prisons should not monitor its own practices but need oversight. Too much partiality, predisposition and concern on jobs exist in the

prison system to allow psychiatrists paid by this same prison system to effectively and credibly evaluate the current status of the prison population. Research by outside sources can determine if the desired outcomes are being met by prison programs.

Effects on Society:
How many inmates in solitary confinement do not go to general population but straight to society? What is the transition from such a unit to our communities? Do inmates in solitary confinement have the skills to adjust to society after such an experience? Psychiatrist Terry Kupers said that most inmates in solitary confinement are released into society and emerge mentally destroyed and full of rage.

Dr. Lance Couturier retired from the Pa. DOC said as of as of 2004 that only 45% of seriously ill inmates are paroled versus 55% who do their maximum sentences (compared to 82% of inmates not diagnosed with mental illness who get paroled). Therefore, it is supposed that many of the inmates put in solitary confinement are diagnosed with mental illness either caused by solitary confinement or they were put there because they couldn't cope in general population. These inmates will not be able to transition into our communities and have no supervision to help them in their decision-making after leaving these segregation units. Dr. Couturier said in-reach care of case workers to prisons as well as outreach services are important before release of prisoners. These inmates need to be connected to develop life management skills so they don't get into trouble and commit worst, more horrendous crimes. The prison program appears to be set up to fail and thus recidivate these same inmates back into our institutions after causing more crime and more victims.

Justice & Mercy believes that there should be incentives for inmates in solitary confinement to graduate into general population through educational programs and rewards for good behavior. Pa. Deputy Attorney General Mericili, who was against inmates having reading material in their cells due to possible abuse, said that if inmates get few options for discipline, there are very few incentives for good behavior and advocated greater use of disciplinary force. He said the DOC through the use of solitary confinement is trying behavior modification. If that is true, the desired modification seems to be for more and greater negative behavior. Mericili also admitted the opportunities for good behavior for inmates is limited due to their limited contact by prison staff. Therefore, they only learn more violence and retribution and that "model" of behavior will be used when these same inmates are released back into our communities.

Correctional officers assigned to solitary confinement units may only receive the basic training of any correctional officer and perhaps an additional minimal segregation training which involves force and restraints to deal with the difficult inmate population. They may also receive an annual assessment. We believe that these correctional officers should be trained more thoroughly in therapeutic interaction with inmates and mental health issues so they are aware of the differences between inmates mentally ill or becoming mentally ill due to isolation and those inmates who are merely violent. Judge Colville in the court case *Andy Torres v. SCI Pittsburgh Superintendent Phillip Johnson,*

et.al., said that staff at LTSUs have little specialized training in dealing with the mental issues from this population. He recommended that the DOC develop a process to have prisoners from segregation work their way back to general population which could include specialized training for staff that work in this unit. In fact, the judge said that the prison may be feeding inmates' behaviors off each other by the nature of long term segregation units.

We understand that the Pa. DOC is trying to provide alternatives than segregation for mentally ill inmates with a propensity for violence. One of the prisons has a specific unit with a 24-month program for these types of inmates. There are levels in the program after which the goal is to place the inmates into general population or community placement. We advocate healthy alternatives to the current punishment model of behavior and recommend longitudinal studies from an outside source on the effect of such alternatives.

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Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences

Hearing Before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights

Tuesday, June 19, 2012

We are grateful to Senator Durbin and the fellow members of the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights, for this opportunity to present written testimony on the impact of solitary confinement on youth in detention centers, jails and prisons in the United States, including the impact we have observed in Illinois.

US reducing reliance on incarceration, as well as on harsh discipline of youth: The good news is that across the United States there is a rapid shift to deinstitutionalize youth, given the emerging science of adolescent brain development and of the impact of trauma on adolescent brains. States have been rapidly closing juvenile facilities and shifting resources to community based alternatives, based on research documenting better outcomes for positive youth development and for public safety when youth remain at home and are treated within their community.[1] The *Pathways* study concluded that institutional placement actually raised reoffending rates among low-level adolescent offenders. In response, eighteen states have closed over 50 juvenile prisons since 2007.[2]

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[1] *Highlights from Pathways to Desistance, A Longitudinal Study of Serious Adolescent Offenders*, Edward P. Mulvey, March, 20111 [Research funded by the John D and Catherine T. MacArthur Foundation; https://ncjrs.gov/pdffiles1/ojjdp/230971.pdf

[2] *No Place for Kids: The Case for Reducing Juvenile Incarceration*, Annie E Casey Foundation; October, 2011; http://www.aecf.org/OurWork/JuvenileJustice/JuvenileJusticeReport.aspx

This shift away from juvenile confinement in the states includes a shift away from the use of solitary confinement for youth, based as well on the research documenting the impact of trauma on adolescent brains. Adolescent brains are particularly sensitive to the traumatic impact of physical isolation, and even a short stay in a confinement setting can have a long-term deleterious impact on an adolescent.

As a result, states are rapidly limiting/ending their use of solitary confinement for youth. For example, the state of West Virginia recently banned the use of solitary confinement for juveniles based on a lawsuit, and the state of Montana recently reached a settlement limiting the use of solitary confinement. [3] Another recent example is the prohibition of solitary confinement for youth in Mississippi, again as part of a conditions lawsuit settlement.[4]

Staff training essential to end confinement: Illinois officials in the Department of Juvenile Justice have not yet fully eliminated confinement, but have worked to decrease the length and number of incidents of use of solitary confinement in facilities. Officials in the Cook County juvenile detention center, under federal oversight, have also worked to decrease the length and the number of incidents of use of solitary confinement through staff training in adolescent de-escalation techniques and through clear and consistent guidelines on discipline. In both cases, the challenge and lesson learned is that elimination of solitary confinement for juveniles requires adequate staff training on effective juvenile de-escalation techniques. The ongoing staff training utilized in the Division of Youth Services in Missouri is one example of effective and ongoing staff training in appropriate juvenile de-escalation techniques.

A federal mandate to end the use of solitary confinement for youth would greatly benefit the states in the struggle to shift from a punitive prison culture to the more effective treatment model with youth, particularly if it included resources to the states for staff training on effective adolescent de-escalation techniques. The benefits to the states would include enhanced staff and youth safety from positive de-escalation techniques as discipline.

Solitary Confinement and Harsh Discipline Violates International Law: The use of solitary confinement for juveniles violates international law, embodied in the prohibition against inhumane treatment in the Convention on the Rights of the

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[3] http://wvgazette.com/News/201204260017; http://solitarywatch.com/2012/04/18/montana-settlement-limits-solitary-confinement-for-juveniles-and-prisoners-with-mental-illness/

[4] http://www.aclu.org/prisoners-rights/groundbreaking-federal-consent-decree-will-prohibit-solitary-confinement-youth

Child. Article 40 of the Convention on the Rights of the Child urges nations to ensure that measures used are proportionate and appropriate to the youth's circumstances and to the offense.
Specifically, Article 40 urges use of:
A variety of dispositions, such as care, guidance and supervision orders; counselling; probation; foster care; education and vocational training programmes and other alternatives to institutional care shall be available to ensure that children are dealt with in a manner appropriate to their well-being and proportionate both to their circumstances and the offence.[5]

Regular Inspection and Monitoring Essential: Europe has adopted a set of rules for youth in conflict with the law, interpreting the meaning of treaties, including the Convention on the Rights of the Child. [6] In addition to stressing the need for humane facilities when youth are removed from home, these rules include a reminder that regular inspection and monitoring of are *indispensable instruments of control* to ensure humane treatment of youth, especially when particular attention is *paid to the use of force, restraints, disciplinary punishments and other restrictive forms of treatment.*

For these reasons, we urge you to encourage the states to end the use of solitary confinement in juvenile detention, jails and prisons. We further encourage you to urge the states to regularly inspect and monitor juvenile facilities, and to urge the states to ensure staff in juvenile facilities are fully trained on appropriate discipline practices for adolescents.

Thank you for this opportunity to comment on your examination of the critical issue of solitary confinement in the United States. Please let us know if you need further information.

Respectfully submitted,

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[5] http://www2.ohchr.org/english/law/crc.htm#art40

[6] http://www.coe.int/t/DGHL/STANDARDSETTING/PRISONS/Commentary_Rec_2008_11E.pdf

Comments by Dr. Terry Kupers to the June 19, 2012 Hearing Before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights: Reassessing Solitary Confinement - The Human Rights, Fiscal, and Public Safety Consequences

Greetings Hon. Senators:

I regret that because of professional commitments I will not be able to testify in person at this important subcommittee meeting. Thank you for taking on this timely topic. I hope you will consider my written comments. I am a Board-certified psychiatrist, Institute Professor at The Wright Institute, Distinguished Life Fellow of the American Psychiatric Association and recipient of the 2005 Exemplary Psychiatrist Award from the National Alliance on Mental Illness (NAMI). My publications include the book, Prison Madness: The Mental Health Crisis Behind Bars and What We Must do About It (Jossey-Bass/ Wiley, 1999), as well as a professional article about the successful downsizing of a supermaximum facility in Mississippi.[1] I have served as a psychiatric expert in numerous lawsuits involving the psychiatric effects of jail and prison conditions, the quality of mental health treatment in correctional settings and the effects of sexual abuse on prisoners. I am federal court-approved Monitor for Presley v. Epps,[2] concerning the exclusion of prisoners with serious mental illness from the Supermaximum Unit 32 at Mississippi State Penitentiary, and the establishment of a "stepdown" mental health treatment program (see attached article).

In my opinion, an historic wrong turn occurred in American penology in the 1980's. Unprecedented prison crowding (the prison population had multiplied 4 to 6 times in a decade) and forced idleness (rehabilitation programs had been downsized because of concerns about "coddling prisoners") led to rapidly rising rates of violence and psychiatric breakdown in the prisons. Instead of arriving at the obvious correct conclusion (supported by scientific research at the time) that the crowding and idleness caused serious damage and

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[1] "Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs," T.A. Kupers, T. Dronet, M. Winter, et al., Criminal Justice and Behavior, October, 2009.

[2] Presley v. Epps, No. 4:05CV148-JAD (N.D. Mississippi, 2005 & 2007).

needed to be reversed (for example, by removing low level drug offenders from prison and treating them in the community), and educational and training programs needed to be re-instituted and strengthened, corrections authorities instead opted to place the blame for the uncontrollable violence on a new breed of prisoners, "super-predators," and proceeded to place a growing proportion of those they vilified as "the worst of the worst" in round-the-clock solitary confinement.

A major problem with supermax confinement, and a major reason to reverse the trend of recent decades toward long-term isolation, is the effect of long-term isolation and stark idleness on prisoners' mental stability and on recidivism rates, and this is a grave concern even with prisoners who do not suffer from serious mental illness. My views on these matters are based on a careful review of the existing literature on solitary confinement[3] and my own direct observations and analyses of the effects of long-term solitary confinement in work that I have been engaged in for more than three decades. I have toured and inspected numerous "supermax" penal institutions, interviewed and evaluated very many prisoners confined under these severe conditions, and discussed isolation practices and procedures with correctional staff and officials from around the country. I have been asked to render expert opinions in legal cases that focused on whether being housed in supermax facilities constitutes "cruel and unusual punishment," and I have been consulted about the implementation of resultant consent decrees.

You will be hearing testimony from my colleague, Prof. Craig Haney, whose studies of the detrimental effects of long-term isolation are groundbreaking.[4] He found extraordinarily high rates of symptoms of psychological trauma. More than four out of

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[3] For example, see Scharff-Smith, P. (2006). The effects of solitary confinement on prison inmates: A brief history and review of the literature. In M. Tonry (Ed.), Crime and justice (Vol. 34, pp. 441-528). Chicago: University of Chicago Press; and Cloyes, K., Lovell, D., Allen, D., & Rhodes, L., Assessment of Psychosocial Impairment in a Supermaximum Security Unit Sample, 33 Criminal Justice and Behavior 760-781 (2006).

[4] Haney, C., Banks, C., and Zimbardo, P., Interpersonal dynamics in a simulated prison. International Journal of Criminology and Penology, 1, 69-97 (1973); and Haney, C., Reforming Punishment: Psychological Limits to the Pains of Imprisonment. Washington, DC: American Psychological Association Books (2006). Haney, C., and Lynch, M., Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement, 23 New York University Review of Law and Social Change 477-570 (1997); Haney, C., Mental Health Issues in Long-Term Solitary and "Supermax" Confinement, 49 Crime & Delinquency 124 (2003).

five of those evaluated suffered from feelings of anxiety and nervousness, headaches, troubled sleep, and lethargy or chronic tiredness, and over half complained of nightmares, heart palpitations, and fear of impending nervous breakdowns. Equally high numbers reported specific psychopathological effects of social isolation, including obsessive ruminations, confused thought processes, an oversensitivity to stimuli, irrational anger, and social withdrawal. Well over half reported violent fantasies, emotional flatness, mood swings, chronic depression, and feelings of overall deterioration, while nearly half suffered from hallucinations and perceptual distortions, and a quarter experienced suicidal ideation.

Dr. Stuart Grassian has also provided pioneering work on the harmful psychological effects of solitary confinement. In his initial article on the topic, Dr. Grassian reported on 15 prisoners kept in isolation for varying amounts of time at a Massachusetts prison.[5] Dr. Grassian described a particular psychiatric syndrome resulting from the deprivation of social, perceptual, and occupational stimulation in solitary confinement. This syndrome has basically the features of a delirium, and among the more vulnerable population, can result in an acute agitated psychosis, and random violence – often directed towards the self, and at times resulting in suicide. He has also demonstrated in numerous cases that the prisoners who end up in solitary confinement are generally not, as claimed, "the worst of the worse"; they are, instead, the sickest, most emotionally labile, impulse-ridden and psychiatrically vulnerable among the prison population.

Two-thirds of the prisoners Dr. Grassian initially studied had become hypersensitive to external stimuli (noises, smells, etc.) and about the same number experienced "massive free floating anxiety." About half of the prisoners suffered from perceptual disturbances that for some included hallucinations and perceptual illusions, and another half complained of cognitive difficulties such as confusional states, difficulty concentrating, and memory lapses. About a third also described thought disturbances

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[5] Stuart Grassian, Psychopathological Effects of Solitary Confinement, 140 American Journal of Psychiatry 1450-1454 (1983). See also, Stuart Grassian and Friedman, N., Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement, 8 International Journal of Law and Psychiatry 49-65 (1986).

such as paranoia, aggressive fantasies, and impulse control problems. Three out of the fifteen had cut themselves in suicide attempts while in isolation. In almost all instances the prisoners had not previously experienced any of these psychiatric reactions.

I have toured and inspected numerous "supermax" penal institutions, interviewed and evaluated numerous prisoners confined under these severe conditions, and discussed isolation practices and procedures with correctional staff and officials from around the country, Europe and Africa. In other words, I have been studying the plight of mentally ill prisoners for decades.[6] I have written extensively about the harm that long-term isolated confinement causes in prisoners, especially those suffering from serious psychiatric conditions. As one stunning index of the magnitude of this harm, national data indicate that fully half of the suicides that occur in a prison system occur among the 3% to 8% of the prisoners who are consigned to segregation or isolation.

An alarmingly large proportion of prisoners who have been consigned to supermaximum security isolation in recent decades suffer from serious mental illness. It is stunningly clear that for them, time served in isolation and idleness exacerbates their mental illness and too often results in suicide. This is the main reason that federal courts have ruled that prisoners with serious mental illness must not be subjected to long-term isolation.[7] For other prisoners, those who do not suffer from an obvious mental disorder, time in isolation brings about the disturbing symptoms Drs. Haney and Grassian have enumerated, and has the effect, on average, of worsening recidivism rates.

Recently I have been asked by attorneys to investigate the effects of very long term solitary confinement (over a decade) upon prisoners who do not exhibit an obvious serious mental illness. These are individuals who do not participate in mental health treatment, who have refused to inform on other prisoners as a condition of release from supermaximum confinement, and many of them have long ago become eligible for parole but parole boards have told them that because they remain in isolated confinement they cannot be paroled. The referral question I am asked is whether their continuing isolated confinement causes

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[6] For example, see: T. Kupers, Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It. San Francisco: Jossey-Bass/Wiley (1999).

[7] Madrid v. Gomez, 889 F Supp. 1146 (N.D. Calif., 1995); Jones 'El v. Berge, 164 F. Supp. 2d 1096 (W.D. Wis. 2001); Presley v. Epps, No. 4:05CV148-JAD (N.D. Mississippi, 2005 & 2007).

additional psychiatric harm. My preliminary answer (my investigation is ongoing) is that very long-term isolation and idleness has produced in these prisoners, on average, disabling symptoms beyond those reported by Haney, Grassian and others (whose studies mostly involved prisoners who had been in solitary confinement for a matter of months or a few years). Those disturbing symptoms continued and worsened over ensuing decades, but additionally, these prisoners have become severely cut off from their own feelings and have turned inward so they hardly engage in any social activity at all, even considering their very limited options within the isolation unit. The damage is cumulative and severe.

Then, too often, a certain number of prisoners are released straight out of solitary confinement to the community at the end of their prison sentence (this is called "maxing out o the SHU"). This creates huge problems for them in adjusting to community life, and needless to say the recidivism and parole violation rates for the group who "max out of the SHU," as well as for those who spent considerable time in isolation, is extremely dire. Whether or not prisoners are permitted to "max out of the SHU," the period of isolation and idleness has very negative effects on their chances of succeeding at "going straight" after being released.

By now there is a growing national trend away from the use of long-term solitary confinement in corrections.[8] Of course, there are compelling economic justifications that partially explain this trend. Supermax prisons, where prisoners are confined in their cell nearly 24 hours per day and take part in few if any growthful activities, are very expensive to operate. In addition, however, there are the important mental health concerns and public safety justifications mentioned above. Because this kind of confinement is not only painful but also potentially damaging — and, for some prisoners, irreversibly so — it is a cruel and singularly inappropriate form of punishment. Beyond doing more to debilitate than rehabilitate the prisoners who are subjected to it, solitary confinement undermines the ability of many of them to succeed in the

[8] Erica Goode, Prisons Rethink Isolation, Saving Money, Lives and Sanity, New York Times, March 10, 2012 [available at: http://www.nytimes.com/2012/03/11/us/rethinking-solitary-confinement.html?pagewanted=all]

community after their eventual release from prison.[9] This evidence—that it appears to increase rather than reduce recidivism—raises public safety concerns.

Moreover, supermax prisons do not reliably reduce violence or disciplinary infractions within the larger prison systems in which they function; in some instances they appear to make it worse.[10] Nor do they alleviate the problem of prison gangs. The California Department of Corrections has aggressively pursued the use of long-term solitary confinement for more than 20 years and the state prison system is now plagued with perhaps the worst gang problem in the nation.

Recently, I served as an expert witness, and then as a court-approved monitor, in litigation in Mississippi that required the Department of Corrections (Mississippi DOC) to ameliorate substandard conditions at the super-maximum Unit 32 of Mississippi State Penitentiary at Parchman, remove prisoners with serious mental illness (SMI) from administrative segregation, providing them with adequate treatment, and re-examining the entire classification system. Pursuant to two federal consent decrees, the Mississippi DOC greatly reduced the population in administrative segregation and established a step-down mental health treatment unit for the prisoners excluded from administrative segregation. After 800 of the approximately 1,000 prisoners in the super-maximum security unit were transferred out of isolated confinement, there was a large reduction in the rates of misconduct and violence, not only among the prisoners transferred out of supermax, but in the entire Mississippi Department of Corrections.[11]

Thus, long-term solitary confinement places prisoners at grave risk of psychological harm without reliably producing any tangible benefits in return. There is no hard evidence that supermaximum security facilities actually ever reliably reduced system-wide prison violence or enhanced public safety. Fears that a significant reduction in the supermax population or the

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[9] For example, see: Lovell, D., Johnson, L., & Cain, K., Recidivism of Supermax Prisoners in Washington State, 53 Crime & Delinquency 633-656 (2007); Mears, D., & Bales, W., Supermax Incarceration and Recidivism, 47 Criminology 1131 (2009).

[10] Briggs, C., Sundt, J., & Castellano, T., The Effect of Supermaximum Security Prisons on Aggregate Levels of Institutional Violence, 41 Criminology 1341-1376 (2003).

[11] See T. Kupers, T. Dronet et al, Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs, 36 Criminal Justice and Behavior 1037-1050, October, 2009, attached.

outright closure of a facility will result in heightened security threats and prison violence have not been born out by experience. In fact, as the example cited above makes clear, recent experience in Mississippi found exactly the opposite—that a drastic reduction in the supermax population was followed by a reduction in prison misconduct and violence.

As prison populations slowly decline, and the nation's correctional system re-dedicates itself to program-oriented approaches to positive prisoner change, the resources expended on long-term solitary confinement should be redirected to more cost-effective solutions. In Mississippi and elsewhere, supermax prisons are beginning to be seen as an expensive anachronism. I urge the Subcommittee to promote legislation that will reduce reliance on supermaximum security facilities, reduce the abuses that have accompanied the trend toward long-term prisoner isolation, and require effective rehabilitation for prisoners. I would be happy to help the Subcommittee in its work.

Thank you for considering these comments.

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Testimony of

The Legal Aid Society, Prisoners' Rights Project

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To the Senate Committee:

The Legal Aid Society thanks Chairman Durbin, Senator Graham, and Members of the Subcommittee for the opportunity to submit this written testimony on the issue of solitary confinement in New York prisons.

My name is Sarah Kerr. I am a staff attorney at the Prisoners' Rights Project ("PRP") of the Legal Aid Society. PRP has been a leading advocate for constitutional and humane conditions of confinement for prisoners incarcerated in the New York City and New York State correctional systems since it was established by the Legal Aid Society in 1971. The Prisoners' Rights Project has participated in several federal lawsuits that address the inappropriate use of solitary confinement of prisoners with mental illness. Along with others we were counsel in the state-wide lawsuit, *Disability Advocates, Inc. v. New York State Office of Mental Health*, 02 CIV 4002 (S.D.N.Y.) *("DAI v. OMH")*, which sought to improve mental health services in the prisons including in the solitary confinement settings in New York prisons.[1]

I offer this testimony based on ongoing contact with and advocacy on behalf of prisoners of the State of New York, knowledge of the New York State Department of Corrections and Community Supervision (DOCCS) and the New York State Office of Mental Health (OMH) through litigation and other advocacy, as counsel for the plaintiff, Disability Advocates, Inc., in the litigation *DAI v. OMH* and as counsel in prior litigation concerning the solitary confinement of prisoners with serious mental illness at several New York State prisons.

Introduction:

My comments will focus on the significant progress made in providing for mental health treatment in the New York State prisons including limiting the placement of prisoners with serious mental illness in solitary confinement settings, taking mental illness into account during disciplinary hearings, creating and expanding residential mental health treatment settings in the prisons and the importance of the Special Housing Unit (SHU) Exclusion Law passed by the New York State Legislature. In addition to barring prisoners with serious mental illness from harmful solitary confinement, recommendations for providing for prisoners with mental illness include the need for external oversight, training, and a full range of programs and services.

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[1] *Disability Advocates, Inc. v. New York State Office of Mental Health*, No. 1:02-cv-04002 (S.D.N.Y. 2007) was brought by Disability Advocates, Inc., the Prisoners' Rights Project of the Legal Aid Society, Prisoners' Legal Services of New York, and the law firm of Davis Polk & Wardwell. A similar case was recently settled in Massachusetts. *Disability Law Center, Inc. v. Mass. Dept. of Correction, et al.*, Civ. No. 07-10463 (U.S.D.C. Mass.). Nina Loewenstein, from Disability Advocates, Inc. ("DAI") and Karen Murtagh from Prisoners' Legal Services of New York ("PLS"), co-counsel in the state-wide litigation, also expect to submit written testimony to Congress.

Progress did not occur overnight. At the end of a two-decade course of litigation, the primary lesson is that the humane treatment of prisoners with mental illness – which includes keeping them out of solitary confinement settings – must be addressed as part of the overall mental health program of the prison system.

Efforts to Improve Mental Health Treatment for Prisoners in New York:

Eng v. Goord, Civ 80-385S (W.D.N.Y.) and *Anderson v. Goord*, 87 CV 141 (N.D.N.Y.):

A little more than twenty years ago I went to Attica Correctional Facility to speak to prisoners who were housed in solitary confinement at that prison. I was just beginning to monitor a settlement agreement in *Eng v. Goord* that was supposed to result in the removal of prisoners with serious mental illness from solitary confinement at that one prison. I spoke with many prisoners over several days. A shocking number of the prisoners I spoke with had been in solitary confinement for years, many with long sentences yet to be served. Some never expected to be let out of solitary confinement and many were in fact correct that their sentence to solitary confinement exceeded their criminal sentence. They were scheduled to be released from solitary confinement to the street (a practice that continues to occur). Some of the prisoners were extremely psychiatrically deteriorated at the time of my interviews. Attica staff informed me that some of the prisoners on my list "never come out of their cells and will likely refuse to see you." I was informed by a DOCCS Supervisor that one of the individuals that I was hoping to see "believed that he was Jesus Christ and was from another planet." The staff member who informed me of this told me that this prisoner would refuse the interview — she had *never* seen him come out of his cell over a period of many years in solitary confinement.

Many prisoners did come to speak to me in the attorney visit area. I had written to them indicating when I would come and many entered the interview area eager to share their experiences. I spoke with prisoners who had scars up and down their arms from acts of self-harm committed while in solitary confinement. Some said cutting relieved the stress of isolation, others appeared depressed and offered no explanation for their self-harming acts. Some spoke of the lack of visits from their family: because they had been in prison too long, were too far from home, or because they asked them not to come because they didn't want them to see them "like this" – referring to the non-contact visit room where some prisoners in solitary confinement were permitted family visits in small booths behind metal grates covered in Lexan.

The prisoner who believed he was Jesus Christ from outer space did come to speak to me. Staff told me they were shocked that he had agreed to the interview. He was disheveled but calm, gentle seeming and completely delusional. He spoke of outer space, and of being the Savior and made no logical sense during our exchange. Although he was known by everyone (security and clinical staff at Attica) to be delusional, he was not removed from solitary confinement despite his obvious treatment needs and despite the language of the settlement agreement that I was there to enforce. According to Attica clinical staff he was "functioning adequately" in solitary confinement.

The last prisoner I spoke with on the last day told me of his lack of hope, his depression, the desperation that he felt daily. When he began to weep quietly sitting across from me, I opened the window to let more of the spring breeze in. I told him that I could stay until the end of the shift when my visit time was to end. We sat there for another half hour, he weeping quietly and I trying not to join him and feeling inadequate. It was at this time that the Prisoners'

Rights Project began to understand the scope of the problem of solitary confinement of prisoners with mental illness in New York and to consider how the situation could be improved.

At Attica, despite a settlement requiring removal from solitary confinement for prisoners with serious mental illness who were "known to be at substantial risk of serious mental or emotional deterioration," prisoners were deemed by OMH clinical staff "functioning adequately" unless they deteriorated to the point of requiring crisis intervention. The settlement provision was interpreted to be coterminous with the prisoner requiring hospitalization due to being a danger to self or others. There was in effect a revolving door between SHU and psychiatric hospitalization: prisoners who psychiatrically deteriorated due to isolation in solitary confinement were hospitalized, stabilized, and sent back to solitary confinement, where they predictably deteriorated and were hospitalized again.

Further litigation in *Eng v. Goord* resulted in an amended settlement agreement and the creation of the first solitary confinement mental health treatment program in New York. At Attica, prisoners with serious mental illness in solitary confinement received two hours of out-of-cell treatment five days a week. However, the reforms developed in *Eng* were inadequate to address the scope of the problem. Prisoners with mental illness were moved from Attica to solitary confinement in other prisons where there was no treatment program and no settlement; the program worked for some prisoners but did not provide sufficiently individualized treatment to accommodate others with varied mental health treatment needs. Prisoners who succeeded in the program and were released from solitary confinement often returned to solitary soon thereafter. Moreover, the treatment program simply did not address the root problem of prisoners with mental illness violating prison rules due to the symptoms of their illness.

One other case predated our filing of a state-wide claim. *Anderson v. Goord* was litigation about treatment and due process rights of prisoners in solitary confinement at two New York prisons It resulted in improved state-wide regulations concerning disciplinary hearings that required that mental illness be considered when determining culpability as well as mitigating and determining an appropriate penalty, and regulations requiring that security and mental health staff meet to consider time cuts and discuss problems or consider other ameliorative interventions for prisoners with serious mental illness in solitary confinement.[2] The changes in the disciplinary hearing regulations began to address the root problem concerning discipline for symptomatic behavior yet there remained limited treatment opportunities and limited residential mental health treatment units.

Disability Advocates, Inc. v. New York State Office of Mental Health ("DAI v. OMH") & the SHU Exclusion Law:

DAI v. OMH was brought with the goal of improving the entire prison mental health treatment system state-wide in New York.[3] We had learned in the prior litigation that keeping prisoners with mental illness out of solitary confinement required comprehensive reform of the mental health treatment system as well as aspects of the disciplinary system. We knew we had to improve mental health treatment at the front door to the prison, as well as at the door to the

[2] 7 N.Y.C.R.R. §§ 251.2, 254.6, 254.7 and 310.

[3] *Disability Advocates, Inc. v. New York State Office of Mental Health*, No. 1:02-cv-04002 (S.D.N.Y. 2007). The case was brought by Disability Advocates, Inc., the Prisoners Rights Project of the Legal Aid Society, Prisoners Legal Services of New York, and the law firm of Davis Polk & Wardwell.

solitary confinement housing areas. The *DAI v. OMH* complaint reflected our understanding that one of the results of inadequate mental health treatment was that prisoners with mental illness became trapped in the disciplinary process and ended up in solitary confinement settings, where they deteriorated psychiatrically. The grossly disproportionate numbers of suicides that occurred in solitary confinement demonstrated the tragic consequences of the failure to intervene and remove prisoners with serious mental illness from solitary confinement. The settlement reflected our understanding that to keep prisoners with mental illness out of solitary confinement, it is necessary to create other places to keep them. Many prisoners with mental illness simply cannot be housed in the general prison population consistent with their own safety and the safety and good order of the prison.

DAI v. OMH went to trial in 2006 and after the initial phase of testimony was presented, the parties – encouraged by the judge who had heard the testimony of prisoners and psychiatric experts and who had toured three prisons with the parties – entered negotiations. These resulted in a private settlement agreement (PSA) which included among its provisions a *minimum* of two hours per day of out-of-cell treatment or programming for prisoners with serious mental illness in solitary confinement, universal and improved mental health screening of all prisoners upon admission to the state prison system, creation and expansion of residential mental health programs including creation of a regional mental health unit (RMHU) where prisoners with serious mental illness who would otherwise have been held in solitary confinement would receive at least *four* hours per day of out-of-cell treatment or programming. The PSA required and improved suicide prevention assessments upon admission to solitary confinement, improved treatment and conditions for prisoners in psychiatric crisis in observation cells, and directed further modifications to the disciplinary process e.g. restricting charges for acts of self-harm and barring certain restrictive punishments. The result of the litigation is that there is now an array of residential and non-residential mental health treatment programs available to New York State prisoners in need. There are medium security prisons with sufficient mental health treatment staff so that prisoners with serious mental illness may be housed there. (Previously, only the maximum security prisons had full-time psychiatric coverage, which meant that prisoners with serious mental illness were housed in maximum security prisons regardless of whether there was an actual security need for them to be in those harsher conditions.) A stated goal of the agreement was to treat rather than isolate and punish prisoners with serious mental health needs.

Simultaneous to the *DAI v. OMH* litigation efforts, a broad coalition of prisoner and mental health advocates, ex-offenders, and family members created a coalition to end the use of solitary confinement for offenders with mental illness. The coalition, Mental Health Alternatives to Solitary Confinement ("MHASC"), participated actively in community organizing and lobbying efforts to educate the public and politicians about the problems experienced by offenders with mental illness incarcerated in solitary confinement settings.[4] Members of MHASC assisted legislators in drafting state legislation to end solitary confinement for offenders with mental illness in New York State prisons altogether.

[4] On several occasions New York State legislators held public hearings about mental health care in the state prisons. *DAI v. OMH* counsel, psychiatric experts, ex-prisoners and MHASC family members testified about their knowledge of problems with the overuse of solitary confinement by NY DOCCS and its deleterious effect on offenders with mental illness.

That legislation passed in modified form in 2008.[5] The SHU Exclusion Law does not completely bar the use of solitary confinement for prisoners with serious mental illness. It expanded on some of the provisions of the *DAI v. OMH* PSA and adopted other PSA provisions without modification. It defines "serious mental illness," and provides for prisoners with serious mental illness to be diverted or removed from segregated confinement to RMHUs where they will receive a minimum of *four* hours of out-of-cell mental health treatment or programming. The law provides that confidential meetings with qualified mental health staff are offered more frequently than every 90 days in solitary confinement at OMH level one and two facilities (*i.e.* those holding prisoners with more serious mental health treatment needs) and are offered on a routine basis by qualified clinical staff. The SHU Exclusion Law provides that a state agency, the Commission on Quality of Care and Advocacy for Persons with Disabilities, has oversight responsibilities to ensure that the SHU Exclusion Law is followed. CQCAPD must publicly report findings to the New York State Legislature on compliance with the SHU Exclusion Law each year. The passage of the SHU Exclusion Law expanded upon and made permanent the improvements to the New York prison system.

For many prisoners with serious mental illness the changes have been extremely beneficial. Overall, the increase in available treatment opportunities has, for many prisoners with serious mental illness, greatly improved their periods of stability and we have witnessed improved clinical response to relapse by OMH clinical staff in the prisons. Some prisoners with serious mental illness have succeeded in moving out of solitary confinement into less restrictive housing areas. However, not all are able to maintain sufficient psychiatric stability to remain free of new disciplinary charges.

For some prisoners with serious mental illness the changes in the disciplinary process have led to lower penalties at disciplinary hearings and in some cases substantial time cuts by treatment teams or Joint Case Management Committees ("JCMC") in the RMHUs. However, it is not our experience that time cuts and consideration of mental illness at disciplinary hearings have been effective for every prisoner with serious mental illness or that the process is consistent. Many prisoners with serious mental illness are now serving long sentences to solitary confinement in the RMHUs where they receive four hours per day of out-of-cell treatment and programming. The RMHU is substantially less isolating than solitary confinement but some prisoners remain unable to succeed and move on to general population or to the less restrictive residential mental health treatment units.

We continue to witness ongoing problems with treatment and discipline of prisoners with mental illness including under diagnosis, failure to identify and designate inmate-patients with serious mental illness and overly punitive disciplinary sanctions imposed against some prisoners with mental illness. Most of these reflect failure to follow the requirements of the *DAI v. OMH* settlement, the SHU Exclusion Law, and the agencies' own policies. Several recent suicides in New York prisons illustrate the tragic outcomes that can accompany failure to fully remedy these problems and to identify and remove from solitary confinement prisoners with serious mental illness. Suicide investigation reports conducted by the New York State Commission on Correction or by CQCAPD reflect inconsistent assessments, failures to accurately diagnose and identify inmate-patients with serious mental illness and unchecked punitive response to symptomatic behaviors. The redacted CQCAPD and SCOC Reports on the 2009 and 2010

[5] Most of the provisions of the statute appear as amendments to N.Y. Correction Law §§ 137 and 401.

suicides of A.W.; G.P. and A.H. described below raise serious concerns about the failure of OMH to provide a continuum of care to the prisoners in their care, and failure to comply with OMH policy and procedure, the *DAI v. OMH* settlement and cognate provisions of the SHU Exclusion Law.

Suicides of A.W., G.P. and A.H.

The redacted SCOC Report on the suicide of A.W. on March 12, 2010, demonstrated failures of the prison risk assessment, suicide screening and mental health reception screen and evaluation of A.W.. A.W. was re-admitted to prison on February 9, 2010 as a parole violator. In accordance with the policies in effect pursuant to the *DAI v. OMH* settlement, he should have received an initial suicide screen upon admission, a complete mental health reception screen within 14 days of admission, and given his history (the report indicates that A.W. was designated as having a serious mental illness while incarcerated from August, 2007 to October, 2009), an in-depth mental health evaluation following the screening. Instead, he was inexplicably designated as not in need of OMH services. SCOC noted a clear failure to follow the reception screening and evaluation policy by examining and responding to the extensive documentation of his mental health treatment history.

The redacted SCOC Report on the suicide of G.P. on September 22, 2009, identifies problems with providing adequate treatment and a continuum of care; the report characterizes his treatment history as "inattentive case management with multiple changes in treatment regime at a distance without clinical encounters."

The reports about the suicide of A.H. in solitary confinement at Great Meadow on June 20, 2010 are far too reminiscent of the failures in treatment and unchecked punitive responses to symptomatic behaviors that led us to file *DAI v. OMH.* A redacted CQCAPD investigation notes changes in diagnosis, mental health level, medications, failure to provide trauma treatment and numerous failures to properly document his mental status. The failure to communicate about his condition led to a failure to conduct a mental health assessment when he was transferred between SHUs prior to his suicide. The redacted SCOC Report includes disturbing changes in treatment from entries that stated a "need for psych meds on permanent basis" to discontinuance of psychiatric medications without explanation. A discharge plan from the state forensic hospital recommending that A.H. be placed into a Transitional Intermediate Care Program was not followed by OMH prison staff. The SCOC concluded "[i]n the case of A.H., as his mood and behavior became increasingly unstable, punitive responses to those behaviors led to further decompensation, while treatment interventions decreased." The repeated punitive responses to A.H. as he psychiatrically deteriorated in solitary confinement exemplify the importance of vigilance and monitoring, and the need for diversion from harmful solitary confinement.

The inexplicable change from a designation of serious mental illness to an OMH level 6 "not in need of services" and the "multiple changes in treatment regime", changes in OMH level, medications and diagnoses described in these reports unfortunately mirror problems identified throughout the *DAI v. OMH* litigation and intended to be cured by the Private Settlement Agreement ("PSA"). The parties negotiated the PSA requirement that reception screening would be conducted by OMH clinical staff after plaintiff's psychiatric experts systematically identified

inappropriate diagnoses and changes in diagnoses of inmate-patients throughout the DOCCS population.[6]

Another example is a prisoner with serious mental illness now housed in an RMHU who was transferred there from solitary confinement at Southport where he accumulated multiple additional disciplinary infractions and solitary confinement sentences prior to being identified as having a serious mental illness. Even with the added protections in place (periodic confidential mental health assessments with a clinician), this prisoner had deteriorated in solitary confinement at Southport to the point of requiring crisis treatment by mental health staff before any effective action was taken. This prisoner has now been assessed as having a serious mental illness and has been diverted from Southport to an RMHU pursuant to the SHU Exclusion Law.

Persistent failures by DOCCS and OMH staff to adequately diagnose and detect mental illness, and to adequately accommodate serious mental illness during the disciplinary process, despite concerted efforts at reform over the past decades, demonstrate that the difficult task of improving mental health treatment and disciplinary systems is not finished and requires continued oversight. Prison systems resist reform even under the best of circumstances.

Recommendations:

- Prisoners with Serious Mental Illness Must Not be Housed in Solitary Confinement. Prisoners who suffer from serious mental illness should not be housed in solitary confinement in prisons or jails. This restriction should not be limited to so-called "Supermax" facilities, and we should reconsider the over-reliance on solitary confinement for *all* prisoners whether diagnosed with a serious mental illness or not. When Judge Lynch[7] approved the *DAI v. OMH* PSA he stated:

> [G]reater attention should probably be paid to the problem of extremely lengthy SHU confinement even to those who are not mentally ill. As we learned during the trial, New York does not have a formal Supermax prison, but when numerous lengthy disciplinary sanctions of SHU confinement are made to run consecutively, prisoners in effect are kept in conditions at least as rigorous and perhaps even more so than in any official Supermax facility perhaps without as carefully thought about consequences as would exist in more official decision to relegate a prisoner to a formal Supermax institution. Tr. p. 9, 4/27/07.

- Definition of Serious Mental Illness. The obligation to provide mental health treatment to prisoners in need is not limited to a rigid diagnostic criteria. Any prisoner, regardless of diagnosis or lack of diagnosis, who develops a serious mental health need while incarcerated must be provided with needed treatment. Criteria for exclusion from harmful solitary confinement should take this into consideration and be inclusive of functional impairments including e.g. acts of self-harm and suicidality.

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[6] *DAI v. OMH*, Supplemental Report of Terry Kupers, M.D., M.S.P., November 29, 2005, pp. 27-28, Trial Exhibit 3; *DAI v. OMH*, Report of Terry Kupers, M.D., M.S.P., June 1, 2005, pp. 23-29, 38-41, 105-130, Trial Exhibit 2.

[7] Judge Gerard E. Lynch, then of the United States District Court for the Southern District of New York, now serving on the United States Court of Appeals for the Second Circuit.

- Periodic Confidential Mental Health Assessments (of all prisoners housed in solitary confinement) by Qualified Clinical Staff. Humans, whether diagnosed with a serious mental illness or not, fair poorly in solitary confinement. "Walking rounds" of solitary confinement housing are wholly inadequate to enable clinical staff to identify and intervene when prisoners deteriorate due to the conditions of isolation in solitary confinement. It is simply not enough to walk through a solitary confinement housing area glancing into cells or briefly speaking with the prisoners. The need for vigilance to detect signs of mental illness for prisoners in solitary confinement requires periodic mental health assessments by qualified clinical staff in a confidential setting, if tragic consequences are to be prevented.

- Qualified Staff and Periodic Training. Effective treatment with positive outcomes requires qualified, experienced, trained clinical staff. The requirement of qualified and licensed clinical staff is extremely important in the closed setting of a prison where there is no choice of treatment, where access to advocates and family is limited, and where the population is often extremely impaired.

- Outside Monitor. Institutions – especially closed institutions like prisons which are not subject to public scrutiny – cannot be relied on to police themselves, especially where there is a long history of bad choices and bad policy that the institution must put behind it. There must be external review of the performance of prisons in managing and treating these difficult patients.

- Stop the Revolving Door: Prison systems must critically examine and end the continued punitive response to symptomatic behaviors of prisoners with mental illness in their care. Prisoners who deteriorate in solitary confinement must be diverted into alternative settings which provide out-of-cell treatment and programming to end the pattern of repeated punitive responses, psychiatric deterioration in solitary confinement and the need for crisis intervention.

- Quality Assurance. Implement a quality assurance system that measures effectiveness of treatment and provides evidence-based outcome measures to improve clinical practices. For example, information that should be tracked includes but is not limited to: frequency of changes from a diagnosis that qualifies as a serious mental illness to one that does not, frequency of changes to diagnosis in general, frequency of medication changes and medication discontinuance, and need for crisis intervention. By tracking information on changes in treatment regimes and outcomes, a system will be able to identify personnel and facilities which require performance improvement resources and will be able to improve the continuity of care for their inmate-patients and prevent tragic outcomes.

- Open Communications. Encourage open communications between agencies involved in providing mental health treatment and security to the vulnerable population of prisoners with serious mental illness – information that will assist in understanding the symptoms and nature of mental illness can reduce confrontations between staff and prisoners. Advocates for prisoners and family members of prisoners should also have the ability to communicate with security and treatment personnel concerning prisoners in their care.

- Reduction of Solitary Confinement. Sentences to disciplinary solitary confinement and solitary confinement in administrative segregation should not be long-term placements. Systems that house prisoners for months, years and decades rather than days and weeks should reconsider their practices and find alternatives to harmful solitary confinement.
- Other Alternatives. New York has implemented reforms for prisoners with serious mental illness with some notable success. These programs which include time cuts, incentives and programming with increased out-of-cell activities can be models for prisoners without serious mental illness as well. Introduction of shorter time periods in solitary confinement can also include reductions in the isolating aspects of this form of confinement. For example, periodic phone calls to family, access to television or other media, educational programs and substance abuse treatment programs can be made available.

Conclusion:

Prisoners with mental illness may have little or no ability to advocate for themselves within the prison. Inadequate mental health care in prison and the hostile and punitive reaction of prison staff, officials and other prisoners to the behaviors caused by their illnesses make coping with prison extremely difficult for prisoners with mental illness. When prisoners with mental illness are not adequately treated, they become increasingly incapable of conforming to institutional rules of conduct and, as a result, often are charged with disciplinary infractions.[8] As a result, solitary confinement cells in prisons are disproportionately, and inappropriately, filled with the prisoners who suffer from a mental illness.[9] Under the stringent restrictions of solitary confinement, prisoners with mental illness frequently receive additional disciplinary charges, prolonging their confinement in prison[10] and in the environment of solitary confinement that aggravates their illnesses and further isolates them from the limited mental health treatment available in prison. Many of the most seriously disabled prisoners end up in the "revolving door" between a solitary confinement setting and a state forensic psychiatric facility or crisis observation unit.[11] An expert in the effects of solitary confinement on prisoners with mental illness, Dr. Stuart Grassian, aptly termed this particular revolving door the "misery-go-round."[12]

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[8] Many disciplinary infractions against prisoners with mental illness reflect conduct which is symptomatic of their mental illness. For example, prisoners with mental illness are often punished for committing unhygienic acts, for flooding their cells, damaging property, being untidy, and for committing acts of self harm. More serious conduct can also be the product of mental illness, such as charges of violent conduct, harassment, arson and assault.

[9] In *Eng v. Goord*, Civ 80-385S (W.D.N.Y.), the N.Y. DOCS *Mental Health Services Plan for Special Housing Unit Patients at Attica Correctional Facility*, reported that between 30-40% of prisoners housed in the Attica SHU were on the active OMH caseload. Contrast this to the of 10-15% of the total prison population generally estimated to have mental illness. See, USDOJ Special Report, July 1999, *Mental Health and Treatment of Inmates and Probationers.*

[10] Prison disciplinary sanctions lead to lengthier prison terms. Discipline may result in the loss of good time and/or parole authorities may look at a lengthy disciplinary history as a reason to deny release.

[11] For example, one prisoner with schizophrenia was admitted to the state forensic hospital on more than 20 occasions since his incarceration in the late 1970s; he was housed continuously in some form of 23 hour solitary confinement for at least the period from early 1991 through May 2000.

[12] *Perri v. Coughlin*, 1999 WL 395374 (N.D.N.Y. 1999).

The harmful effects of isolation in solitary confinement on prisoners with mental illness and on other prisoners is well known and well documented. Steps can and must be taken to ameliorate the effects of solitary confinement for prisoners with mental illness and we must also take steps to reduce the current over-reliance on solitary confinement in America's prisons.

Improvements in prison mental health treatment are important not only for prison management but also for re-entry. The opportunities and services available in jail or prison, and the conditions under which prisoners are held, directly affect the skills, problems and needs prisoners will have at the time of their release. If mental health programs are unavailable, ineffective or oppressive in prison and jail, the released offender will be less likely to seek and participate in necessary treatment after release. Prisoners with mental illness who are not treated and who psychiatrically deteriorate in prison are less likely to be able to cope with prison, and are more likely to be punished for symptomatic behaviors that may violate prison rules. Discipline in prison may result in denial of parole, lengthening the period of expensive incarceration, placement into solitary confinement housing which may in turn cause additional psychiatric deterioration including acts of self harm (including a disproportionate number of prison suicides), additional rule breaking and more discipline. The end result of such neglect is that offenders are released to the community who are psychiatrically unhealthy, have been restricted from developing skills (including daily living and coping skills), and who may have developed a strong distrust for mental health treatment staff and the correctional and criminal justice systems for failing to intervene and assist them during their incarceration.

New York has been taking steps to improve its treatment of prisoners with serious mental illness who are disciplined with solitary confinement in its prisons. The progress towards reform in New York has taken many years, has been significant, but has also been slow and inconsistent. The improvements to policies and expansion of mental health treatment options in New York are thoughtful and can be looked to as a model for other systems with the understanding that implementation of changes in policy requires more than re-writing the policies. To implement change, there must be leadership, supervisory staff and line staff willing to work to make a change. If they are, they will see the difference I see between those first hopeless and despairing prisoners I interviewed at Attica and the condition and expectations of prisoners I interview today.

I thank the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights for attention to the important issue of solitary confinement in our prisons. I appreciate the opportunity to provide this written testimony.

Dated: June 15, 2012

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Testimony of
Rev. Jill Job Saxby, Executive Director
Maine Council of Churches
Before the
Senate Judiciary Committee
Subcommittee on the Constitution, Civil Rights and Human Rights
Hearing on Reassessing Solitary Confinement
June 19, 2012

Mr. Chairman, Members of the Subcommittee, thank you for this opportunity to submit testimony on behalf of the Maine Council of Churches concerning the harmful use of solitary confinement in our nation's federal prisons, jails, and detention centers. We are encouraged by the remarkable progress made here in Maine by our own Department of Corrections and that a growing number of states across the nation are reassessing this practice and implementing policies to limit its use. In light of the high cost of solitary confinement and its diminishing returns, we are grateful for the Subcommittee's timely review of the federal system's use of isolation today.

The Maine Council of Churches is a 74 year old, statewide ecumenical association of Maine's Evangelical Lutheran, Episcopal, Presbyterian Church (USA), Religious Society of Friends (Quakers), Roman Catholic, Swedenborgian, United Church of Christ, United Methodist and Unitarian Universalist denominations, representing over 500 congregations. Our mission is to "unite people of faith in good works that promote a culture of justice, compassion and peace."

While the Maine Council of Churches has a long history of advocacy for prison reform and restorative justice, for the past two years we have specifically focused these efforts on reducing the use of solitary confinement in Maine's prisons. We have worked with a coalition of organizations such as the National Religious Coalition Against Torture and local prison reform advocates to advocate for changes to state laws. While the law we advocated for in 2010 (which would have, among other things, reduced the use of solitary to no more than 45 days) did not pass, the legislature did order a working group to study the issue. The resulting in-depth report provided a set of guidelines for addressing the mental health and human rights concerns we and many others share for those who are confined to small cells for indefinite periods for 23 hours a day.

In 2011 and 2012, Commissioner Joseph Ponte of the Maine Department of Corrections has introduced new practices, standards, training and expectations about the use of solitary that, together, address many of the issues raised in the working group's report. As a result, there has been a significant decrease in the use of solitary confinement in our two prisons with special management units, the Maine State Prison and the Maine Correctional Center.

The Maine Council of Churches has sponsored three visits to these two prisons for clergy and other lay leaders over the past year and a half. Those of us who attended all three visits noticed not only a significant decrease in the use of the solitary cells but perhaps just as importantly, a change reported by management and staff in the approach to situations which might in the past have resulted in a prisoner being confined to solitary for long periods. At the Maine State Prison we were told on a recent visit that the use of the "special management unit" had been reduced by more than 50%. At the Maine Correctional Center, a recent report showed the solitary units for women had not been used at all in 2012.

Staff training in de-escalation techniques, the institution of treatment plans and the use of behavioral therapy techniques that incentivize appropriate behavior have all made a noticeable difference, as has what seems to be an attitudinal shift to thinking of the use of "segregation" or "special management" as a last resort and something to be avoided if at all possible.

While the changes are not yet codified into state law, we have observed here in Maine that significant changes to the use – and cultural acceptance in the corrections community – of solitary confinement as a routine prisoner management technique are possible, and within a very short period of time, with the right leadership from the top, with changes in training, and with outside advocates expressing their concern.

As faith leaders in Maine, our reasons for opposing the routine and prolonged use of solitary confinement are rooted in our shared moral values which derive from the Hebrew and Christian scriptures. In the words of Jesus to his disciples in Matthew 25:44-45: "Then they also will answer, 'Lord, when was it that we saw you hungry or thirsty or a stranger or naked or sick or in prison, and did not take care of you?' Then he will answer them, 'Truly I tell you, just as you did not do it to one of the least of these, you did not do it to me."

Our moral opposition to the prolonged and widespread use of solitary confinement, with all its attendant ill effects, is rooted in this understanding of who God is, but also in our understanding of God's will for human community and in the idea of the common good and our duties to one another. When society decides it must imprison a human being because of his or her crimes, that person's basic human needs and welfare become part of our collective responsibility.

Too often, the use of solitary as a punishment not only fails to meet the basic standards of human rights, it fails as a tool for managing the behavioral problems and/or underlying mental illness that caused it to be used in the first place. Many studies have documented the detrimental psychological and physiological effects of long-term solitary confinement, including hallucinations, perceptual distortions, panic attacks, and suicidal ideation. Considering this severe harm, we strongly believe prolonged solitary confinement is a violation of the inherent God-given dignity in every human being.

The use of solitary confinement has increased dramatically in the last few decades. The Commission on Safety and Abuse in American's Prisons noted in their report, *Confronting Confinement*, that from 1995 to 2000, the growth rate of segregation units significantly surpassed the prison growth rate overall: 40% compared to 28%. Rather than a last resort, solitary confinement has become a default management and discipline tool.

The drastic rise in solitary confinement has cost us financially. Super-max prisons cost much more expensive than standard facilities to build. Additionally, the daily cost per inmate in a solitary confinement unit far exceeds the costs of housing an inmate in lower security facility since solitary confinement units require individual cells and significantly more staff.

Our experience here in Maine has shown that solitary is not the only, or best, option and that there are safer – and we believe, more moral, alternatives. In an interview with the National Religious Campaign Against Torture, Maine Department of Corrections Commissioner, Joseph Ponte explained, "Over time, the more data we're pulling is showing that what we're doing now [through greatly reducing

the use of solitary confinement] is safer than what we were doing before." Further, we must not neglect the larger public safety impact. The negative effects of prolonged solitary confinement harm our communities. Prisoners who are freed directly from solitary confinement cells are significantly more likely to commit crimes again. Successful reentry of these citizens to our local communities requires preparation for release while they are still incarcerated.

Mr. Chairman, Members of the Subcommittee, the Maine Council of Churches believes strongly that the United States should do everything it can to reverse our nation's harmful and expensive reliance on solitary confinement. We have a moral obligation to uphold the dignity and the mental health of those currently incarcerated. To that end, we would strongly support your leadership in sponsoring legislation that would limit the use and length of solitary confinement. We implore you to immediately take steps to end the use of prolonged solitary confinement. Your hearing today is a very important effort in doing that, and we thank you for the opportunity to contribute to it.

Hearing: June 19th, 2012
Written Statement: Commissioner Joseph Ponte, Maine Department of Corrections

Solitary Confinement

Summary of Corrections Work:
I began my career as a Corrections Officer with the MA DOC in 1969 working up to the position of Assistant Deputy Commissioner in charge of five facilities on the Bridgewater Campus. Retiring from the MA DOC in 1991, I accepted the position of Assistant Director with the Rhode Island DOC.

Since then, I have worked at various levels within private corrections, first with Cornell Corrections and most recently with Corrections Corporation of America.

Several times during my career, I have been asked to take on organizations in need of major change, including state prisons, county jails and private corrections organiztaions. Prior to becoming the Commissioner with the Maine DOC, I have worked in eight states either in public or private corrections.

I earned an Associate's Degree in Business Management from Fisher College, Boston, MA and a Bachelor's Degree in Political Science from Bridgewater College, Bridgewater, MA.

Approach to Implementing Reforms:
The Maine Department of Corrections took the following steps to implement reforms to the segregation process:

1. Established a committee of key people within the department to review the current practices. This committee was lead by a Director of one of the Juvenile facilities who had been through a similar change to the juvenile system. The Committee members were purposefully chosen to represent all levels of prison management and prisoner oversight within the system and included: line officers, mental health providers, caseworkers, warden, deputy warden, captains, unit manager, commissioner, associate commissioner and representatives from prisoner advocacy groups such as the NAACP, Maine Prisoner Advocacy Coalition (MPAC) and the Board of Visitors. The diversity of this committee was critical to the success of the effort.
2. The Committee examined the numbers of prisoners going to segregation and the reasons why. The length of time a prisoner would spend in segregation was also reviewed and found to be problematic. Reasons for the long stays in segregation varied from prisoners not wanting to return to general population, to a lack of bed space in general population and safety issues.
3. Identified policy that played a part in placing prisoners in segregation. Policies were identified and revised.
4. The Committee agreed on a new set of criteria that would review prisoners for placement in segregation. Not all prisoners are placed in segregation pending the

review as a new status was implemented as a precursor to segregation placement called 'observation status' which allows staff the flexibility to observe a prisoner for a period of time up to 72 hours to determine if segregation placement is absolutely necessary. Once the decision to place a prisoner in segregation is made approval must be obtained by the Warden and Commissioner. These steps were written into new policy.

5. New policies were written, staff received training and new practices put into place.
6. Ongoing oversight and accountability of segregation placements happen through weekly meetings at the facility level and calls to the Commissioner.
7. Quarterly meetings take place on a quarterly basis to ensure ongoing success of reforms.

Having an awareness of what the current body of research tells us about changing prisoner behavior is the first step in determining how a system may be doing with regard to reforming prisoner behavior. Reducing segregation takes careful consideration of the risks prisoners may present in general population. A sound process for assessing prisoner risk is critical and requires investigation and input from the unit team to include security staff and program staff. Additionally, Unit Staff's approach to managing their prisoner population is at the center of the decisions made to send prisoners to a segregation unit. Knowing the prisoner population and having ongoing communication with them about how they are doing could be the difference between sending a prisoner to segregation and keeping him in his/her living area.

The Disciplinary policy also factors into the number of prisoners a system may have in the segregation unit. Articulating the goal or mission of the Department, facility or unit can set the tone for the culture of the facility which will in turn drive the way in which staff treat prisoners. Is the goal to punish or to teach/role model pro-social skills?

Observations about Reforms:

The MDOC has been able to keep one segregation pod closed for the last year. There has not been an increase in violent incidents as a result. Efforts to improve the unit management approach are still underway as the culture shifts from punitive responses to more positive responses. Shifting thinking among staff is challenging and takes time and education. As positive outcomes are seen and experienced, staff buy-in increases. Accountability and follow-up is critical to the success of such a change or staff will fall back into old practices. Top administrators need to lead and model thinking that support the mission and moves the organization toward practices that are proven to work with changing offender behavior.

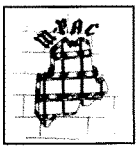
Suggestions for Other Corrections Officials:

- Surround yourself with strong leaders who share your vision and have the skills to carry it out.
- Be clear about your organizations mission and monitor outcomes
- Stay aware of best practices as new research emerges
- Identify training needs staff may have

- Review disciplinary policy to ensure that it does not drive placements in segregation.
- Identify a clear set of criteria to determine who really needs placements in segregation
- Have a plan for monitoring the changes with ongoing outcome measures.

Maine Statistics on Reductions in Segregation:

The MDOC had two segregation pods each holding 50 prisoners. On 5/16/11 one pod was closed as a result of a careful review of each prisoner and what risks were associated with returning him to general population. What resulted was the redistribution of the staff that covered that pod to other areas of the facility ultimately reducing the overtime rates. The population of prisoners in segregation was reduced by more than half.



Maine Prisoner Advocacy Coalition (MPAC)

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June 15, 2012

***Testimony presented to*:**
Senator Dick Durbin and Members of the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights

From: **James Bergin of Blue Hill, Maine, Co-Coordinator, Maine Prisoner Advocacy Coalition (M-PAC)**

As Co-Coordinator of Maine Prisoner Advocacy Coalition (M-PAC, www.maineprisoneradvocacy.org) in the state of Maine, I am pleased to testify on the experience of M-PAC in helping move the Maine Department of Corrections (MDOC / DOC) to adopt a Policy restricting the use (and abuse) of solitary confinement (Special Management Unit) as a means of punishment and control. Thank you for accepting this testimony on this most important occasion.

In working as a volunteer Prisoner Advocate with my wife and colleague Judith Garvey, for the last twelve years, at the county level (Volunteers for Hancock County Jail Residents www.jailvolunteers.org), we had become increasing alarmed about the long term deleterious effects, in terms of psychological trauma and recidivism, as a direct consequence of severe sensory deprivation from being placed in solitary confinement.

We don't need to list here the types of destructive behaviors that are manifested as a result, but only to say that the use of solitary confinement actually creates, and stimulates, the dysfunctional behaviors it is supposed to "correct." In

addition, despite its failure to alter behavior in a positive way, housing a prisoner in a solitary confinement unit doubles or triples the costs to the taxpayers. And what we get for our money is what Senator John McCain described as the worst form of torture he experienced as a POW in North Vietnam.

As this Committee is aware, the use of solitary confinement is going on all across the United States, where it has nothing to do with rehabilitation: rather it causes anti-social behavior that, as we have seen, manifests itself in prison and in the community upon a prisoner's release. Solitary confinement is now a structural part of almost all prisons, and the Policy du jour in dealing with aberrant behavior.

And so it was in Maine, under the previous MDOC administration of Commissioner Martin Magnusson, and a Board of Visitors, under the chairmanship of Jon Wilson, that adhered to the status quo, despite protestations on the part of Prisoner Advocates. With an entrenched bureaucracy, a Board of overseers unwilling to initiate change, and the lack of transparency overall, the only recourse left to Advocates, outside of ongoing protests, was to propose legislation at the State level that would seek to limit and control the use of solitary at MSP.

This process was begun in 2009 through a Maine State Representative, James Schatz (D), and composed of a committee of Advocates who were soon joined by the ACLU of Maine, NAACP-Portland, Solitary Watch, CURE, Maine Council of Churches, Immigrant Legal Advocacy Coalition, and numerous other organizations, forming the Coalition "Mainers against Solitary Confinement," which later became Maine Prisoner Advocacy Coalition (M-PAC).

The resulting Bill – LD 1611 – was modest in that given the DOC's intransigence, Advocates were not optimistic in gaining a major transformation. It established necessary limits to the use of solitary based on the current research findings on

this form of deprivation, presumably before the point where severe psychological damage can take place. Advocates also wanted to ensure that each prisoner in solitary would be checked at regular intervals for mental and physical deterioration by a trained mental health practitioner. We also hoped to enforce an end to "cell extractions," "restraint chairs," and other so-called "tools." With this Bill, it seemed that we were not pushing the envelope too far, and that our legislation would be viewed as moderate and politically capable of passing through the state legislative process successfully, despite views to the contrary on the part of Maine's DOC.

With the great resources of the ACLU of Maine, M-PAC mustered a large group of volunteers, organizations, and experts on sensory deprivation to testify on behalf of LD 1611 in front of the Criminal Justice and Public Safety Committee of the Maine State Legislature. At the same time the MDOC, under then-Commissioner Martin Magnusson, turned out a veritable army of staff correction officers, administrators, and the Chairman of the Board to Visitors, Jon Wilson, to testify on the use of Solitary Confinement as an important "tool" that was necessary for the security of the prisons and the community.

"Security," as used by the MDOC, is a term common throughout the entire criminal justice system used to justify many forms of behavior, or policy, whether abusive, inhumane, or not. As it pertains to Maine's SMU, solitary was said to be for "the worst of the worst" from whom the rest of the Inmate population and staff needed protection. This is a common old saw which was repeated over and over at the LD 1611 Hearing as a way of perpetuating the stereotype of the out-of-control prisoners who need to be confined.

This argument gained some resonance with members of the Criminal Justice Committee who had backgrounds in law enforcement, while others on the Committee waffled from the somewhat intimidating display of uniformed force to the explanations of medical and psychological harm. The expert witnesses and

legal testimony, as well as Clergy who testified in support of the legislation gave pause for thought on the part of the committee. As a result, the Legislation, after numerous rewrites, was sent to the floor of the Legislature for a vote, where the Bill LD 1611 sustained one of the longest floor debates in recent legislative memory.

Finally, when the vote was taken the Bill did not pass; however, all was not lost. In response to the testimony, and the near majority of Legislators in favor of prison reform, a *Resolve* to study the use of solitary confinement and recommend changes was agreed to by legislators. The *Resolve*, while not the passage of the Bill Advocates had fought for, was critically considered as a move in the correct direction, pending the findings and recommendations of the committee selected to undertake the study. (For info on the process and history of Maine LD 1611: http://www.maineprisoneradvocacy.org/solitaryconfinement.html)

After months of anticipation, the *Report* coming from the *Resolve*, authored by Dr. Steven Sherrets and others, was issued, and much to advocates' surprise contained recommendations which, to a certain extent, reflected some of the reforms M-PAC advocated for, including a more humane and carefully monitored use of the SMU, citing in the *Report* the destructive effect of solitary confinement on Prisoners as the basis for these recommendations. The *Resolve*, subsequent *Report*, and the appointment of the new MDOC Commissioner, Joseph Ponte, created a "perfect storm" for reform of Maine's prisons, of the SMU, the Mental Health Unit (MHU), and other units in the prisons, to be enacted through *Policy* changes, the underpinning of which was now viewed by the MDOC as rehabilitation instead of punishment.

To do this, Commissioner Ponte formed a Working Committee to revise existing *Policy* and to advise on training of Staff that would stress different, more efficient forms of grievance resolution between Staff and Inmates. The purpose of this training is to provide Staff with new "tools" as a means of control, as opposed to

relying on the threat, and use, of an Inmate being thrown in the "hole" (solitary) for any transgression deemed unacceptable by Staff.

This Working Committee had weekly meetings through a year, meeting at Maine State Prison in Warren, Maine, and consisted of MDOC Administrative Staff, the Commissioner, Prison Warden Patricia Barnhart, Dr. Steven Sherrets, author of the *Report*, various prison Staff, Board of Visitors Chair John Wilson, and for the sake of transparency, two independent Advocates, Rachel Talbot-Ross, President of the Maine NAACP-Portland, and Jim Bergin, Co-Coordinator of the Maine Prisoner Advocacy Coalition (M-PAC). The presence of the two Advocates on the Committee, at the suggestion of Commissioner Ponte, was a radical innovation for the MDOC that was in marked contrast to the previous MDOC Administration for which "transparency" was a dirty word, and M-PAC was a problem that wouldn't go away.

The combination of Advocates and MDOC Administrators on the Committee made for an interesting dynamic for the former adversaries during the Legislative hearing for LD 1611, and on a multitude of actions by Advocates against MDOC for its overall treatment of Prisoners. The role of Advocates, as part of the Working Committee, evolved from quiet observation to a proactive role of representing Prisoners' concerns and objecting to certain policies that hinted of the same old way of doing business. With Advocates' presence at the table, a dialogue took place that energized the Committee's work and resulted in creating a "sea change" at Maine State Prison and throughout Maine's prison system that is still in process. Sitting at the table with MDOC was a constant balance for Advocates of continuing to speak strongly for change while not alienating those working for the MDOC. The concern was to avoid being "co-opted" by relationships formed with those who control the lives of Prisoners. This goal was successfully met.

As the meetings progressed, it became apparent that MDOC Administrators had suddenly, and seemingly miraculously, become transformed and were now speaking the language of reform under the guidance of the Committee Chair, Rod Bouffard, Director of Maine's Long Creek Juvenile Center, which was now being used as a model of reform having successfully been in the vanguard of eliminating the use of solitary confinement for its Juvenile Inmates. The Advocates almost immediately found common ground with Mr. Bouffard and offered him support and suggestions for his proposed policy changes to the other MDOC administrators on the Committee.

The subtext to the SMU Policy changes is ideally based on the potential of all but eliminating the use of solitary, and charting a gradual means through Policy changes and data collection to get there. The data collection is used as a means to measure the success or failure of the Policy changes, and where necessary to "tweak" the changes to effect the desired results. This process is referred to by the MDOC as evidence-based change, and is now reviewed by ongoing quarterly meetings of the Working Committee, which to date has met three times.

The participation of Prisoner Advocates at these Policy Meetings, and in subsequent MDOC committees dealing with aspects of prison life, is a major transformation toward transparency in the MDOC and speaks well for Maine's State Legislators taking the initiative of commissioning a *Resolve* to examine the Correctional system, and Commissioner Ponte, in response to this *Report*, having the experience and perspective to effect major changes in concert with Advocates. However, this is just a beginning, since longer range problems, some of which are beyond the range of Policy changes, still persist.

While Policy can be changed with the stroke of a pen, so to speak, the Staff on the floor with Prisoners, some of whom have been there for over thirty years, do not change so easily and are sometimes unwilling to leave their comfort zone in response to Policy. The culture of Prisons will take time to change, but it has to

start somewhere, and to that end enlightened leadership, along with involved Prisoner Advocates and citizens, is a good start. M-PAC in its distinct role of Prisoner Advocacy continues to independently monitor the effects of these Policy changes on the day-to-day lives of Inmates in terms of their treatment by correctional staff, healthcare providers, rehabilitative programs, and ultimately whether, upon release, they are equipped to readjust as productive members of their communities.

In looking to the future, M-PAC, ACLU-Maine, and the NAACP will be meeting in June with The Sentencing Project, the Chief Justice of Maine, Chairs of the Criminal Justice and Public Safety Committee of the Maine Sate Legislature, Commissioner Joseph Ponte, and others to discuss initiating a review of Maine sentencing guidelines as a hopeful prelude to enacting sentence reform. As M-PAC moves forward members are optimistic that the established collaboration in corrections reform between the MDOC and Prisoner Advocates will encourage an atmosphere for constructive change in the Criminal Justice System here in Maine and the rest of the country.

In sum, solitary confinement units throughout the USA must be closed as quickly as possible to protect the mental and physical health of prisoners, public safety in our communities, and financial security for states. Maine's Prisoner Advocates stand ready to assist other Advocacy groups on advocacy procedures used in Maine to greatly limit use of the "Special Management Units" in Maine's prisons.

Respectfully submitted,

James F. Bergin, Co-Coordinator
Maine Prisoner Advocacy Coalition (M-PAC)
www.maineprisoneradvocacy.org
207-374-3608

Mental Health America Statement for Senate Hearing on:

Reassessing Solitary Confinement:

The Human Rights, Fiscal, and Public Safety Consequences

Senate Judiciary Subcommittee on the

Constitution, Civil Rights, and Human Rights

Position Statement 56: Mental Health Treatment in Correctional Facilities

Policy

"Over the past 50 years [America has] gone from institutionalizing people with mental illnesses, often in subhuman conditions, [in state mental health hospitals] to incarcerating them at unprecedented and appalling rates—putting recovery out of reach for millions of Americans.... On any given day, between 300,000 and 400,000 people with mental illnesses are incarcerated in jails and prisons across the United States, and more than 500,000 people with mental illnesses are under correctional control in the community." 1 MHA supports effective, accessible mental health treatment for all people in adult or juvenile correctional facilities or under correctional control who need it. However, persons with mental health and substance use conditions also need an effective classification system to protect vulnerable prisoners and effective protection of their human rights. 2 Notwithstanding their loss of their liberty, prisoners with mental health and substance use conditions retain all other rights, and these must be zealously defended.

Background

The most important contemporary civil rights issue for persons with mental health and substance use conditions is the increasing use of criminal sanctions and incarceration to compel consumers to accept treatment, replacing the state mental hospitals with much more drastic curtailment of personal liberty and preclusion of community integration and community-based treatment. 3 Prisoners with mental health conditions are especially vulnerable to the difficult and sometimes deplorable conditions that prevail in jails, prisons and other correctional facilities. Overcrowding often contributes to inadequacy of mental health services and to ineffective classification and separation of prisoner classes. It can both increase vulnerability and exacerbate mental illnesses. For these and other reasons, Mental Health America supports maximum reasonable diversion.4

Nevertheless, America is locking up more and more people with mental health conditions. 5

MHA believes that placing prisoners with mental health conditions in institutions, especially correctional facilities, imposes special obligations on society. Jails, prisons and other correctional facilities have a duty to provide medical services, including mental health services, and to provide protection from harm. These services are basic human rights of every prisoner with a mental illness or an addictive disorder. Correctional facilities must exercise special vigilance in dealing with every prisoner with a mental illness or addictive disorder because his or her ability to assert these human rights may be impaired. Mental Health America believes that these treatment obligations are greater than the treatment rights currently enforced by the courts as a matter of American constitutional law. 6

Additionally, MHA recognizes the nation must acknowledge and address the forces that contribute to the disproportionately high involvement of persons from ethnic and racial minority

communities in the criminal justice system. A system that continues to incarcerate so many people of color with inconsistent lengths of incarceration when compared to others is inherently unjust.

Treatment During Confinement

When prisoners in need of mental health treatment must be confined in correctional facilities, certain principles should be observed:

1. All prisoners should be screened upon admission by trained personnel for mental health and substance abuse problems. When the screening detects possible mental health or substance use conditions, prisoners should be referred for further evaluation, assessment and treatment by mental health professionals. 7 Prisoners who are already receiving treatment before they enter should be assisted in continuing treatment. All prisoners should have behavioral, mental health and substance abuse evaluations completed promptly following admission by qualified mental health staff. 8
2. Delivery of mental health services to prisoners in correctional facilities is the responsibility of all professionals at a facility, including psychiatrists, psychologists, social workers, nurses, correctional counselors, correctional officers, and facility administrators. Correctional facilities must be sufficiently staffed with mental health professionals. Correctional facilities that do not employ mental health staff should have written arrangements with local medical or mental health facilities for providing emergency medical and mental health care. 9
3. Mental health services should be available to prisoners 24 hours per day, seven days per week. Treatment should be provided in an atmosphere of empathy and respect for the dignity of the person. It should be strengths-based and recovery-oriented. A reasonable array of mental health interventions should be available, including the full range of available medications. The type of intervention should be tailored to meet the prisoner's needs, with family consultation unless the prisoner rejects it, and should be delivered by qualified mental health staff who are trained to deal with crises as they arrive. When medications are used, they should be consistent with the treatment plan and monitored by a qualified mental health professional. 10 Psychotropic medications should never be used as a form of "chemical restraint" for prisoner control. 11
4. Special treatment should be available to prisoners who are sexually abused, who have substance abuse problems, health problems, educational problems, histories of family abuse or violence, and who are sex offenders. Programming in facilities should be appropriate to the person's age, gender and culture. Linguistically and culturally appropriate therapy should be provided. Under no circumstances should a prisoner be penalized for seeking, receiving or declining mental health treatment.
5. Correctional facilities should train staff to use behavior management techniques that minimize the use of intrusive, restrictive, and punitive control measures. MHA supports elimination of seclusion and restraints in therapeutic facilities. 12 It is particularly important to maintain facilities other than seclusion for the protection of vulnerable prisoners, including those with serious mental health conditions. 13 In any event, facilities should follow written guidelines for the use of seclusion, room confinement, and restraints. These guidelines should be made clear to persons in custody. Distinctions

should be made between the use of seclusion and restraints for custodial-administrative purposes and those made for therapeutic purposes. When restraint must be used to prevent injury to self or others, there should be stringent procedural safeguards, limitations on time, periodic reviews and documentation. Generally, these techniques should be used only in response to extreme threats to life or safety and after other less restrictive control techniques have been tried and failed.

6. Under no circumstances should prisoners be subjects of research without proper ethical review and informed consent. 14
7. Prisoners should have a discharge plan prepared when they enter the correctional facility in order to integrate them back into the family and the community. This plan should be updated in consultation with the prisoner's family (as appropriate) and community treatment facilities before the prisoner leaves. It should include the continuation of treatment, therapy and services begun in the facility. Correctional facilities should take an active role in promoting continuity of treatment for those released. 15
8. Prisoners who suffer from acute mental disorders or who are actively suicidal should be placed in or transferred to appropriate medical or mental health units or facilities and returned to general population only with medical clearance. Facilities should have a suicide prevention plan that includes appropriate admission screening, staff training and certification, assessment by qualified mental health professionals, adequate monitoring, referral to appropriate mental health providers or facilities, and procedures for notification of the prisoner's family (unless refused). 16
9. Facilities need to identify and treat co-occurring disorders, and particularly substance abuse, and to provide support in the facility and in the transition to the community. 17
10. Many states and the federal government have created a class of prison referred as "supermax." Supermax prisons are intended to reduce violence within prison systems by creating an extremely harsh environment which includes extreme isolation and sensory deprivation. Mental Health America shares the concerns of most prison reform groups that supermax prisons may constitute cruel and unusual punishment for all inmates and may induce mental illnesses in those prisons who were previously healthy. 18 However, we are specifically opposed to placing any person diagnosed with a serious mental illness in a supermax prison.

Specific Rights

Mental Health America affirms the specific rights of people with mental illness confined in correctional facilities listed here because they have the most potential to be abridged in correctional settings:

- The right to adequate medical and mental health care, to protection from harm including staff abuse, and to a facility in which the vulnerable can be protected: a safe, sanitary and humane environment
- The right to informed consent to treatment. Staff should discuss with the prisoner the nature, purpose, risks, and benefits of types of mental health treatment.
- The qualified right to refuse treatment, including psychotropic medications, on the same basis as any other person. 19

- The right to the least restrictive environment and the least intrusive response to an apparent need for mental health services.
- The right to be confined in a place that can provide the treatment needed.
- The right to confidentiality in the delivery of mental health services and in mental health and related facility records.
- The right to have regular and timely access to medical and mental health staff who are culturally competent and qualified to provide adequate treatment and supervision.
- The right to be transferred to an appropriate medical or mental health facility or unit when conditions warrant.
- The right to be free from corporal punishment, chemical restraints, and sexual abuse or coercion.
- The right to assert grievances, to have grievances considered in a fair, timely and impartial manner, and to exercise rights without reprisal.
- The right to an individualized written treatment plan, to the treatment specified in the plan, to periodic review and revision of the plan based on the prisoner's needs. The family should participate in the development, review, reassessment and revision of both the treatment plan and the discharge plan, unless the prisoner refuses such participation.

Call to Action

MHA and its affiliates should work to inform members of law enforcement and correctional groups, judges and attorneys, mental health professionals and advocates, prisoners and their families, the community and the media about the excessive number of persons with mental illnesses and addictive disorders in prisons and jails and the inherent difficulties involved in providing decent and humane care to such persons in these settings and should develop and advocate for effective strategies addressing these problems.

Effective Period

The Mental Health America Board of Directors approved this policy on June 13, 2010. It is reviewed as required by the Public Policy Committee.

Expiration: December 31, 2015

1. "Ending an American Tragedy: Addressing the Needs of Justice-Involved People with Mental Illnesses and Co-Occurring Disorders," by the National Leadership Forum on Behavioral Health/Criminal Justice Services (September, 2009).
2. National Commission on Correctional Health Care, Standards for Mental Health Services in Correctional Facilities, Standards MH-E-02, MH-E-03, MH-E-04, (2009).
3. "Ill-Equipped: U.S. Prisons and Offenders with Mental Illness," Abramsky & Fellner, Human Rights Watch (2003). http://www.hrw.org/reports/2003/usa1003/
4. MHA Position Statement Number 50, "In Support of Maximum Diversion of Persons with Serious Mental Illnesses from the Criminal Justice System" (2008).
5. "From the Asylum to the Prison: Rethinking the Incarceration Revolution," Harcourt, B., 84 Texas Law Review 1751 (2006)
6. In *Estelle v. Gamble*, 429 U.S. 97 (1976), the Supreme Court held that a prison was not liable under the United States Constitution for failing to provide adequate health care to an inmate unless the inmate could prove that the prison was "deliberately indifferent" to the inmate's medical needs. This standard has been applied to the provision of mental health services in prisons and jails. *Conn v. City of*

Reno, 591 F.3d 1081 (2010). MHA believes that this standard does not sufficiently protect the rights of inmates and that confinement in a correctional facility should not entail the loss of the basic right to non-negligent health care, including mental health care that meets ordinary standards of professional care.

7. National Commission on Correctional Health Care, Standards for Mental Health Services in Correctional Facilities, Standard MH-E-02 and MH-E-03 (2008).
8. *Id.*, Standard MH-E-04.
9. *Id.*, Standards MH-D-05, MH-E-09, MH-G-01 through 06.
10. *Id., Standard MH-D-02.*
11. *Washington v. Harper, 490 US 210 (1990).*
12. *MHA Position Statement Number 24, "Use of Restraint Techniques and Seclusion" (2006).*
13. *"Commentary: Evolving Toward Equivalence in Correctional Mental Health Care—A View from the Maximum Security Trenches," Vlach & Daniels, 35 J. Am. Acad. Psychiatry & Law. 436 (2007)*
14. *National Commission on Correctional Health Care, Standards for Mental Health Services in Correctional Facilities, Standard MH-I-05 (2008).*
15. *Id., Standard MH-E-10.*
16. *Id., Standard MH-G-04.*
17. *Id., Standard MH-G-05.*
18. *"Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement," by Craig Haney, University of California, Santa Cruz. Published in Crime & Delinquency, Vol. 49, No. 1, pp.124-156 (2003); "Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics", Metzner & Fellner, 38 J. Amer. Acad. Psychiatry & Law 1 (2010).*
19. *In Washington v. Harper, 494 U.S. 210 (1990), the Supreme Court held unanimously that a prisoner had a Constitutional right not to be medicated against his will unless, as a result of serious mental illness, the prisoner was dangerous to himself or others and the treatment was in the prisoner's best interest. MHA shares the view expressed in Justice Stevens's concurring opinion that prisoners should be afforded review of involuntary medication decisions by a judicial decision-maker or, at a minimum, by someone not employed by the prison.*

Midwest Coalition for Human Rights

Advocating for fairness and human dignity

Written Testimony of the Midwest Coalition for Human Rights
Hearing Before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights
"Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences"
Tuesday, June 19th, 2012

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ABOUT THE MIDWEST COALITION FOR HUMAN RIGHTS

The Midwest Coalition for Human Rights (Coalition or Midwest Coalition) is a network of 56 organizations, service providers, and university centers, that work together to promote and protect human rights in our Midwest region. Through collaboration in the Heartland, we advocate, educate and take action with a strong regional voice on national and international human rights issues.

POSITION STATEMENT

The Midwest Coalition for Human Rights calls for an end to prolonged solitary confinement in excess of 15 days, any period of solitary confinement of juveniles and persons with mental disabilities, and the use of solitary confinement as a form of punishment. The Coalition finds that these practices violate basic human rights and human dignity.

OVERVIEW: SOLITARY CONFINEMENT ACROSS THE NATION

Solitary confinement is used extensively throughout the United States penitentiary system. It is manifested in "supermax prisons," short for super maximum security prisons, as well as specific units within regular prisons. These specific units may be referred to as segregation, administrative segregation, control units, security housing units (SHU), special management units (SMU), or "the hole". A review of a census of state and federal prisoners conducted by the federal Bureau of Justice Statistics reveals that over 80,000 prisoners are held in some form of solitary confinement in this country.[1] Approximately 25,000 of those individuals are in supermax prisons, facilities devoted exclusively to prolonged solitary confinement.[2]

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[1] Angela Browne, Alissa Cambier, Suzanne Agha, *Prisons Within Prisons: The Use of Segregotion in the United States*, 24 FED'L SENTENCING REPORTER 46 (2011)

[2] Sharon Shalev, *Supermax: Controlling Risk Through Solitary Confinement*, Willan Publishing, 2009; Daniel P. Mears, *Evaluoting the Effectiveness of Supermax Prisons*, Urban Institute Justice Policy Center, March 2006, https://www.ncjrs.gov/pdffiles1/nij/grants/211971.pdf

CONDITIONS OF CONFINEMENT

Inmates held in prolonged solitary confinement throughout the U.S. face extreme social isolation, severely restricted environmental stimulation, limited movement, and harsh punishment for problematic behavior sometimes caused by mental illnesses. Activities that are common in most prisons, such as educational and rehabilitative programs, jobs, religious services, outdoor exercise, and visits from family or friends are greatly reduced for these inmates.[3]

The harsh nature of prolonged solitary confinement is exemplified in Tamms Correctional Center's Closed Maximum Security (CMAX) facility located in Southern Illinois. Inmates in Tamms are locked alone in 7x12 foot cells for 23 or 24 hours each day.[4] Many have been held there for extended periods of time, often ten years or more.[5] They are severely deprived of human interaction and environmental stimulation. For example, at least one inmate did not have reading materials in his cell for a number of years until a lawyer intervened on his behalf.[6] Recreation is limited to one-hour sessions (alone) in concrete or metal cages featuring at most a handball or pull-up bar.[7]

Guidelines for placement of inmates in supermax facilities are vague and sometimes non-existent. Non-threatening individuals or inmates with mental illness are frequently held in these facilities.[8] Inmates are typically placed in supermaxes for indefinite periods of time,[9] and inadequate and illegitimate review proceedings can make it very difficult for them to transfer out. [10]

In the extremely isolated confines of supermax detention facilities, abuse and excessive force by prison guards is relatively common and often overlooked.[11] Management in these facilities frequently fails to enforce a prison policy that rejects abuse. Prison guards use excessive force including cell extractions and the discharge of electronic stun devices, stun guns, chemical sprays, shotguns with rubber pellets, and guns loaded with lethal munitions.[12]

PSYCHOLOGICAL EFFECTS OF SOLITARY CONFINEMENT

Solitary confinement can have harmful and irreversible psychological effects.[13] Individuals held in solitary confinement experience anxiety, depression, anger, cognitive disturbances, perceptual distortions, paranoia and psychosis, and self-harm.[14] A number of men in Tamms CMAX have reported experiencing these symptoms as a result of their confinement. One Tamms prisoner has engaged in self-mutilation hundreds of times since first entering the facility seven years ago,

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[3] Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax" Confinement*, Crime & Delinquency, January 2003, vol. 49 no. 1, at 124-156.
[4] Gary Marx,"A Look Inside Illinois' Only Super-Max Prison," Chicago Tribune, February 27, 2009.
[5] George Pawlaczyk & Beth Hundsdofer, *Trapped in Tamms: In Illinois' only Supermax Facility, Inmates are in Cells 23 Hours a Day*, The Belleville News Democrat, October 2010, *available at* http://www.bnd.com/2009/08/02/865377/trapped-in-tamms-in-illinois-only.html.
[6] *Id.*
[7] *Id.*
[8] Vera Institute of Justice, *Confronting Confinement : A Report of the Commission on Safety and Abuse in America's Prisons*, 2006, *available at* http://prisoncommission.org/pdfs/Confronting_Confinement.pdf.
[9] ACLU, *Abuse of the Human Rights of Prisoners in the United States: Solitary Confinement,*, February 2011, *available at* http://www.aclu.org/human-rights-prisoners-rights/abuse-human-rights-prisoners-united-states-solitary-confinement.
[10] Human Rights Watch, *Out of Sight: Super-Maximum Security Confinement in the United States*, February 2000, *available at* http://www.hrw.org/reports/2000/02/01/out-sight-super-maximum-security-confinement-us.
[11] ACLU, *supra*
[12] Human Rights Watch, *supra*
[13] Craig Haney, "Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement, Crime and Delinquency", vol. 49, No1, pp. 124-156.
[14] Sharon Shalev, *A Sourcebook on Solitary Confinement* (London, Manneheim Centre for Criminology, 2008), pp. 15-17.

frequently requiring hospitalization.[15] What's more, the effects of solitary confinement on mental health, personality, and social behavior are long-term. This impairs individuals' ability to reintegrate into society when released from imprisonment and damages relationships, families, and communities.[16]

Solitary confinement is particularly damaging to individuals with mental illness. The extreme conditions of confinement can exacerbate preexisting mental illness or provoke a reoccurrence of mental illness.[17] Individuals with mental illness are disproportionately represented in supermax facilities.[18] For example, prison officials in the Secured Housing Unit (SHU) at the Wabash Valley Correctional Facility in Indiana stated that "well over half" of the prisoners in the unit were mentally ill.[19] Prison administrators respond to uncooperative behavior caused by mental illness with punishment such as a withdrawal of privileges and lengthening their term in isolation, perpetuating their illness and delaying recovery.[20]

Juveniles are also among the more vulnerable individuals subjected to solitary confinement. Juveniles placed in solitary confinement, due to their developmental vulnerability, "...are at particular risk of adverse reactions," including depression, anxiety and psychosis.[21] In fact, the majority of suicides in juvenile correctional facilities occur when the individual is completely isolated or held in solitary confinement.[22] Recognizing the inherent psychiatric risks of prolonged solitary confinement for juveniles, the American Academy of Child & Adolescent Psychiatry issued a policy statement in April 2012 concurring with the United Nations position[23] opposing the use of solitary confinement in correctional facilities for juveniles.[24]

U.S. COURTS CONFIRM DEVASTATING EFFECTS OF SOLITARY CONFINEMENT

U.S. courts have concurred that prolonged solitary confinement has devastating effects. In 1988, the Chicago-based U.S. Court of Appeals for the Seventh Circuit observed that "isolating a human being from other human beings year after year or even month after month can cause substantial psychological damage, even if the isolation is not total."[25] In 2001, a Wisconsin federal court found that "many prisoners are not capable of maintaining their sanity in such an extreme and stressful environment; a high number attempt suicide" in addressing the use of solitary confinement.[26] Most recently, an Illinois federal court found in 2010 that "Tamms imposes drastic limitations on human contact, so much so as to inflict lasting psychological and emotional harm on inmates confined there for long periods."[27]

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[15] George Pawlaczyk & Beth Hundsdofer, *supra*

[16] UN General Assembly, Interim report prepared by the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman, or degrading treatment or punishment, Juan E. Mendez: *Torture and other cruel, inhuman, or degrading treatment of punishment*, sixty-sixth session, 5 August 2011, pp.20, line 72.

[17] Human Rights Watch, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, October 2003, *available at* http://www.hrw.org/en/reports/2003/10/21/ill-equipped.

[18] *Id.*

[19] Howard Greninger, *Suit targets Carlisle Prison*, Terre Haute Tribune-Star, Feb. 4, 2005.

[20] Human Rights Watch, *supra*

[21] Grassian, Stuart. "Psychiatric Effects of Solitary Confinement," Journal of Law and Public Policy, (2006): 325-383.

[22] Mitchell, Jeff, M.D. & Varley, Christopher, M.D. "Isolation and Restraint in Juvenile Correctional Facilities," J.Am. Acad. Child Adolesc. Psychiatry, 29:2, March 1990.

[23] Section 67 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty, approved by the General Assembly in December 1990, and supported by the United States, states, "All disciplinary measure constituting cruel, inhuman or degrading treatment shall be strictly prohibited, including corporal punishment, placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned."

[24] American Academy of Child & Adolescent Psychiatry, Policy Statement, "Solitary Confinement of Juvenile Offenders," April 2012, *available at* http://www.aacap.org/cs/root/policy_statements/solitary_confinement_of_juvenile_offenders.

[25] *Davenport v. DeRobertis*, 844 F.2d 1310, 1313 (7th Cir. 1988).

[26] *Jones 'El v. Berge*, 164 F. Supp. 2d 1096, 1102 (W.D. Wis. 2001).

[27] *Westefer v. Snyder*, 725 F. Supp. 2d 735, 769 (S.D. Ill. 2010).

INTERNATIONAL HUMAN RIGHTS COMMUNITY DENOUNCES SOLITARY CONFINEMENT

Prolonged solitary confinement is contrary to international standards and conflicts with U.S. obligations under the International Covenant on Civil and Political Rights and the Convention against Torture.[28,29]

In a report delivered at the United Nations General Assembly in August, 2011, UN Special Rapporteur on Torture Juan Méndez stated that "Solitary confinement, when used for the purpose of punishment, cannot be justified for any reason, precisely because it imposes severe mental pain and suffering beyond any reasonable retribution for criminal behavior."[30] Additionally, he finds that solitary confinement is "contrary to one of the essential aims of the penitentiary system, which is to rehabilitate offenders and facilitate their reintegration into society."[31] Mr. Méndez urged states to prohibit the imposition of solitary confinement as punishment, calls on countries to abolish the use of solitary confinement for juveniles and persons with mental disabilities, and recommends that prolonged solitary confinement, in excess of 15 days, should be subject to an absolute prohibition.

Upon reviewing the use of prolonged isolation in the United States in 2006, the U.N. Committee Against Torture expressed concern "about the prolonged isolation periods detainees are subjected to, the effect such treatment has on their mental health, and that its purpose may be retribution, in which case it would constitute cruel, inhuman or degrading treatment or punishment". The Committee called on the United States to "review the regime imposed on detainees in 'supermaximum prisons', in particular the practice of prolonged isolation."[32] Since then the Committee has taken a stronger position on this issue, recommending (in a 2007 review of Denmark) that solitary confinement only be used as a measure of last resort and for as short a period of time as possible. The Committee also recommended that cases remain under strict supervision with the possibility for judicial review.[33]

CONCLUSION & RECOMMENDATIONS

The Midwest regional and the international human rights communities remain deeply concerned about the United States' use of solitary confinement. The United States must respond to domestic and international calls for reform by ensuring full compliance with both the United Nations Standard Minimum Rules for the Treatment of Prisoners[34] and the recommendations made by the U.N. Special Rapporteur on Torture in his August, 2011 report on solitary confinement.[35] The guidelines and recommendations set forth in these documents include, but are not limited to, the following:

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[28] UN General Assembly, *Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment,* 10 December 1984, United Nations, Treaty Series, vol. 1465, p. 85.
[29] UN General Assembly, *International Covenant on Civil and Political Rights* (Article 7), 16 December 1966, United Nations, Treaty Series, vol. 999, p. 171.
[30] UN General Assembly, Interim report of the Special Rapporteur on Torture, 4 August 2011.
[31] Ibid., pp. 22, line 79.
[32] U.N. Comm. Against Torture, 36th Session, Consideration of Reports Submitted by States Parties Under Article 19 of the Convention: Conclusions and Recommendations of the Committee Against Torture: United States of America, U.N. Doc. CAT/C/USA/CO/2, at ¶ 36 (May 18, 2006).
[33] *See, e.g.,* U.N. Comm. Against Torture, Consideration of Reports Submitted by States Parties Under Article 19 of the Convention: Denmark, ¶ 14, U.N. Doc. CAT/C/DNK/CO/5 (July 16, 2007).
[34] United Nations, Standard Minimum Rules for the Treatment of Prisoners, 30 August 1955, available at: http://www.unhcr.org/refworld/docid/3ae6b36e8.html [accessed 14 June 2012]
[35] UN General Assembly, Interim report of the Special Rapporteur on Torture, 4 August 2011, available at: http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N11/445/70/PDF/N1144570.pdf?OpenElement [accessed 14 June 2012]

1) Prolonged solitary confinement, in excess of 15 days, should be absolutely prohibited.[36]
2) Solitary confinement should never be used for juveniles or persons with mental disabilities.[37]
3) Solitary confinement should not be used as a form of punishment, either as a part of a judicially imposed sentence or a disciplinary measure.[38]

The Midwest Coalition for Human Rights urges Congress to demonstrate its commitment to human rights and human dignity by insisting on U.S. compliance with these guidelines.

[36] Ibid., pp 23, line 88
[37] Ibid., pp 23, line 86
[38] Ibid., pp 22, line 83.

M.I.S.S.
Mothers of Incarcerated Sons Society, Inc

TO: **Senate Judiciary Subcommittee on the Constitution, Civil Right**

ATTN: **Senator Dick Durbin, Chairman**

FROM: **M.I.S.S. "Solidarity Not Solitary" Mothers of Incarcerated Sons Society, Inc. (M.I.S.S.) (501(c) 3 Non-Profit)**

SUBJ: **Dangerous Overuse of Solitary Confinement in the U.S.**

Over the last two decades corrections systems have increasingly relied on solitary confinement as a prison management tool – even building entire institutions called "supermax prisons" where prisoners are held in conditions of extreme isolation, sometimes for years or decades.

Although supermax prisons were rare in the United States before the 1990s, today forty-four states and the federal government have supermax prisons, housing at least 25,000 people. But this figure does not reflect the total number of prisoners held in solitary confinement in the United States on any given day. Using data from a census of state and federal prisoners conducted by the federal Bureau of Justice Statistics, researchers estimate that over 80,000 prisoners are hel! d in "restricted housing," including prisoners held in administrative segregation, disciplinary segregation and protective custody – all forms of housing involving substantial social isolation.

U.S. Bureau of Justice statistics show that in 2010 there were more than 1.4 million inmates in state prisons. However, there are no official estimates for how many state prisoners are mentally ill or in isolation. But prisoners' rights advocates around the nation say putting mentally ill inmates in long-term solitary confinement amounts to cruel and unusual punishment.

This massive increase in the use of solitary confinement has led many to question whether it is an effective and humane use of scarce public resources. Many in the legal and medical field criticize solitary confinement and supermax prisons as both unconstitutional and inhumane, pointing to the well-known harms associated with placing human beings in isolation and the rejection of its use in American ! prisons decades earlier.

Indeed, over a century ago, the Supreme Court noted that: Prisoners subject to solitary confinement fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community. In re Medley, 134 U.S. 160, 168 (1890).

Other critics point to the enormous costs associated with solitary confinement. For example, supermax institutions typically cost two or three times more to build and operate than even traditional maximum security prisons.3 Despite the significant costs associated with solitary confinement, almost no research has been done on the outcomes produced by the increased use of solitary confinement or supermax prisons. In the research that has been conducted there is little empirical evidence to suggest that s!

olitary confinement makes prisons safer. Indeed, emerging research suggests that supermax prisons actually have a negative impact on public safety.

Despite these concerns, states and the federal government continue to invest scarce taxpayer dollars in constructing supermax prisons and enforcing solitary confinement conditions. Yet there are stark new fiscal realities facing our communities today and for the foreseeable future.

Both state and federal governments confront reduced revenue and mounting debt that are leading to severe cuts in essential public services like health and education. Given these harsh new realities, it is unquestionably time to ask whether we should continue to rely on solitary confinement and supermax prisons despite the high fiscal and human costs they impose.

The American Bar Association has created the following general definition of solitary confinement, which it calls "segregated housing": The term "segregated housi! ng" 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.

People in solitary confinement are also more likely to be subject to the use of excessive force and abuses of power. Correctional officers often misuse physical restraints, chemical agents, and stun guns, particularly when extracting people from their cells. The fact that the solitary confinement cells are isolated from the general population prisoners makes it more difficult to detect abuse.

Additionally, the idea that "the worst of the worst" are placed in solitary confinement makes it more likely that administrators will be apathetic or turn a blind eye to abuses. New York recently passed a law that excludes the seriously mentally ill from solitary confinement; requires periodic assessment and monitoring of the mental s! tatus of all prisoners subject to solitary confinement for disciplinary reasons; creates a non-disciplinary unit for prisoners with psychiatric disabilities where a therapeutic milieu is maintained and prisoners are subject to the least restrictive environment consistent with their needs and mental status; and requires that all staff be trained to deal with prisoners with mental health issues.

The United States uses solitary confinement to an extent unequalled in any other democratic country. But this has not always been so. The current overuse of solitary confinement is a relatively recent development that all too frequently reflects political concerns rather than legitimate public safety needs.

Based on over twenty years of empirical research, we now know that the human cost of increased physiological and psychological suffering caused by solitary confinement, coupled with the enormous monetary cost of its use, far outweighs any purported benefits.&nb! sp; Now, in order to build a fair, effective and humane criminal justice system, we must work to limit its use overall and ensure that mentally ill persons are not subject to its deprivations.

Respectfully Submitted:

(Rhonda Robinson),

Prisoner's Rights Advocate

Founder
Mothers of Incarcerated Sons Society, Inc. (M.I.S.S.)
http://www.mothersofinmates.org/

"Reassessing Solitary Confinement: The Human Rights, Fiscal and Public Safety Consequences"

Hearing Before the Senate Judiciary Subcommittee on the Constitution Civil Rights, and Human Rights

Chairman: The Honorable Dick Durbin
Ranking Member: The Honorable Lindsey Graham

June 19, 2012

Testimony of Michael B. Mushlin

Thank you for holding this important hearing and inviting testimony. My name is Michael B. Mushlin. I am a Professor of Law at Pace Law School in White Plains, New York. I am the author of *Rights of Prisoners*,[1] a four volume treatise, and a member of the American Bar Association's Task Force on the Legal Status of Prisoners. I am also a co-chair of the American Bar Association, Subcommittee on Implementation of the ABA Resolution on Prison Oversight,[2] and have served as chair of the Committee on Correction of the New York City Bar Association, the Correctional Association of New York and the Osborne Association, an organization that provides training and support programs for people in jail and prison or who are being diverted from imprisonment. Currently, I am a vice chair of the Correctional Association of New York, a 168 year old organization endowed by New York law with the authority to visit New York State Prisons with the responsibility to report on their condition to the New York state legislature. With colleagues, including Prof. Michele Deitch of the University of Texas, I participated in the

[1] MICHAEL B. MUSHLIN, RIGHTS OF PRISONERS (4th ed. 2012).
[2] I co-chair that committee with Prof. Michele Deitch of the University of Texas.

organization of two national conferences on prison reform, the first *Prison Reform Revisited: The Unfinished Agenda* held at Pace Law School and the second, *Opening Up a Closed World: What Constitutes Effective Prison Oversight* held at the University of Texas. Both conferences drew together professionals from all segments of the criminal justice and corrections fields to discuss improvement to the operation and oversight of the American prison system. For seven years, I was staff counsel and then the Project Director of the Prisoners' Rights Project of the Legal Aid Society. I also served as staff counsel with Harlem Assertion of Rights Inc., and was the Associate Director of the Children's Rights Project of the American Civil Liberties Union. For the 2012/13 academic year, I will be a Visiting Professor of Law at Brooklyn Law School.

I first confronted conditions in solitary confinement units over thirty years ago when I served as trial counsel in a federal civil rights case involving Unit 14, the solitary confinement unit at Clinton prison in upstate New York close to the Canadian border. What I saw there was deeply disturbing. Inmates were locked for 23 hours each day into small windowless cages for months and years on end. No programs or activities were provided to them. Without access to any meaningful activity, they were separated from one another spending almost all of their time entirely by themselves. During that one precious hour per day when a Unit 14 inmate could leave his cell there was only one place to go: a small space directly behind his cell called a "tiger cage." The tiger cage was a small empty space with a barren floor surrounded on all sides by high concrete walls which were not covered by a roof. An inmate could walk only a few steps in one direction before turning. If he looked up he could glimpse a bit of the sky but nothing else of the outside world.[3]

Working on that case I witnessed firsthand the awful consequences of subjecting human beings to solitary confinement. I will never forget looking into the eyes of those inmates

[3] *See Frazier v. Ward*, 426 F. Supp. 1354 (N.D.N.Y. 1977).

struggling to maintain a foothold on reality and sanity. Afterwards, when visiting other solitary confinement units, no matter where, I see that same pained, desperate stare. I have seen it so often, and in so many different places, that I have come to recognize it instantly as the gaze of a tortured person.

In the years since the Unit 14 case I have witnessed the growth and expansion of solitary confinement in prisons, in New York and nationally, through the emergence of "supermax" confinement and the expanded use of "administrative segregation units." I have watched what I saw in Unit 14 three decades ago repeated throughout the nation as massive numbers of people—many of whom are mentally ill, young, and those deemed too dangerous or vulnerable to be placed in the general prison population even though they have not violated any prison rules—have been placed into solitary confinement. Even teenagers have been thrown into solitary. Not long ago I was shocked to read a Justice Department Report describing how children 16 years old were being held for up to a full year in solitary in an adult jail in Westchester County, New York, a mile or two from my office on the campus of Pace Law School.[4] I have heard estimates that the number of people held in solitary on any given day ranges from 25,000 to 85,000, but the truth is no one really knows how many people are held in these units. I suspect that the true number of confined souls is higher than even the highest reported figures.

Solitary units provide fertile soil for mistreatment and abuse of prisoners. As one observer put it, "[b]ecause of the absence of witnesses, solitary confinement increases the risk of

[4] CRIPA Investigation of Conditions at Westchester County Jail (Dep't of Justice, Civil Rights Division, Nov. 19, 2009) *available at* http://www.justice.gov/crt/about/spl/documents/Westchester_findlet_11-19-09.pdf (reporting that half of the inmates placed in the jail's Special Housing Unit -- where inmates are placed in isolation as a result of disciplinary infractions -- are between 16 and 18 years of age. Many of these minors are facing an average term of 365 days in isolation. One 16 year old was given a sanction of 360 days for an infraction.); *See also Troy D. v. Mickens*, 806 F. Supp. 2d 758, 764 (D.N.J. 2011).

acts of torture or other cruel, inhuman or degrading treatment or punishment."[5] I recently wrote an article about abuses that occur in solitary confinement units.[6] In the article I recount the story of Tyron Alexander and Kevin Carroll, inmates who were involved in a fight with two prison guards while being held in a jail awaiting their court appearance. Apparently no one was seriously injured, but as a result Alexander and Carroll were placed together in an isolation cell.[7] Aptly named the "the hole," this isolation cell, which was a "sparse" 64 square foot space meant to contain only one person, had no running water, and no toilet.[8] At first, Alexander and Carroll were stripped fully naked though they were later given only boxer shorts but nothing else to wear. Instead of a toilet the cell had a grate-covered hole in the floor which could only be flushed by prison officials from outside the cell.

Carroll became nauseated soon after being confined in the cell and was forced to defecate into the drain, after which he was allowed only one sheet of toilet paper for cleaning purposes. Afterwards, the drain became obstructed with feces. Alexander and Carroll tried to clear the obstruction but were unsuccessful. No one helped them. When they had to urinate, urine splattered from the clogged drain onto the cell floor. The smell nauseated Carroll, who then vomited into the drain. When the guards finally decided to do something they were unable to flush the drain. Nevertheless, rather than release Carroll and Alexander from the contaminated cell, the guards kept them confined. The guards then instructed an inmate to spray water into the

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[5] SPECIAL RAPPORTEUR OF THE HUMAN RIGHTS COUNCIL, INTERIM REPORT ON TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT, U.N. Doc. A/66/268, 19 (Aug. 5, 2011) (by Juan E. Méndez); *See also*, Lena Kurki & Norval Morris, *The Purposes, Practices and Problems of Supermax Prisons*, 28 CRIME AND JUSTICE, A REVIEW OF RESEARCH 385, 385 (Michael Tonry ed., 2001); *See* COMM'N ON SAFETY & ABUSE IN AMERICA'S PRISONS, CONFRONTING CONFINEMENT 14 (2006) ("There is troubling evidence that the distress of living and working in this environment actually causes violence between staff and prisoner.").

[6] MICHAEL B. MUSHLIN, *Unlocking the Courthouse Door: Removing the Barrier of the PLRA's Physical Injury Requirement to Permit Meaningful Judicial Oversight of Abuses in Supermax Prisons and Isolation Units*, 24 FEDERAL SENTENCING REPORTER 268 (2012).

[7] *Id.* at 268 (citing *Alexander v. Tippah County*, Miss., 351 F.3d 626, 628 (5th Cir. 2003)).

[8] *Alexander v. Tippah County*, 351 F.3d. at 628-629. All the facts recounted about this case are drawn from this published opinion..

cell through an opening at the bottom of the cell door, which served only to further spread the waste across the floor. Desperate, Carroll and Alexander requested a mop to clean the mess, but it was denied. To make matters worse, Carroll and Alexander could not wash their hands because the cell had no running water and they were not allowed out. In this contaminated cell filled with urine, feces and vomit, prison officials served Carroll and Alexander lunch and dinner without utensils. The isolation cell did not have a bed—only a concrete protrusion from the wall with space for just one person. No mattress or sheets or blankets were provided even though the men were clothed only in boxer shorts that winter evening. That night in the cold Carroll and Alexander tried to sleep by sharing the small concrete slab. Incredibly, despite the enormous degrading treatment and abuses they endured, the federal court to which they turned for relief dismissed their case because the conditions did not result in "physical injury," which is a requirement for relief under the Prison Litigation Reform Act.[9]

In solitary confinement units across the nation, abuses, which differ only in detail from those inflicted on Carroll and Alexander, occur daily.[10] Where but in a fictionalized horror story would one learn of places where "bodies are smeared with one's own excrement; arms are mutilated; suicides attempted and some completed; objects inserted in the penis; stitches repeatedly ripped from recent surgery; a shoulder partly eaten away."?[11]

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[9] *Id.* at 631 (citing 42 U.S.C. § 1997e(e) (2006)).

[10] These abuses, which include subjecting inmates to degrading, humiliating and unnecessary suffering, often do not cause physical injury. Even though constitutional rights are violated by these acts, federal courts have often failed to provide relief to victims of these abuses. The reason is that the Prison Litigation Reform Act (PLRA) deprives federal courts of the ability to provide relief from degrading and even torturous behavior if there is not physical injury.

[11] Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences: Hearing Before the S. Jud. Subcomm., 112th Cong. 3 (June 13, 2012) (Statement of Fred Cohen, LL.B., LL.M.).

Seven years ago, commenting on solitary confinement, I said in a *New York Times* Op-Ed that, "there is never justification for prison conditions that cause mental torture."[12] I went on in that Op-Ed to observe that since most inmates will someday return to our communities, "it is a mistake to think that these kinds of conditions do not directly affect us."[13] A conversation with a correction officer I had several years ago during a visit to Southport prison in upstate New York near Elmira drove this point home for me. Southport prison at the time of my visit housed hundreds of men, all in solitary confinement. The officer told me of his concern for law-abiding people whenever a Southport prisoner is released from solitary directly back on to the streets. He recalled the times he saw inmates, most of whom are from the New York City metropolitan areas and have been in solitary confinement for months or even years, released from the prison front gate with a suit of clothes, $40 and a bus ticket to the Port Authority Bus Station in midtown Manhattan. I, too, feel apprehension when I consider that I or my wife and children might encounter a person on the street who has just released directly from a solitary confinement unit.

Prisons must be safe and humane and they can be without solitary confinement. There are alternatives. As others will no doubt describe in detail, in Colorado, Maine and my home state of Mississippi, recent efforts led by talented corrections officials and prison reformers have dramatically decreased the use of solitary confinement with savings to the taxpayers, without compromising security, and with untold benefits in terms of the decrease in mental abuse and suffering. These alternatives and others, when implemented, will reduce the numbers of people in isolation to a tiny fraction of those currently held, will improve the conditions in which those who are isolated are held, and will make prisons safer for prison staff, the public and for prisoners.

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[12] Michael B. Mushlin, *Breeding Psychotics,* N.Y. TIMES, March 27, 2005, *available at* http://query.nytimes.com/gst/fullpage.html?res=9802E6DE173FF934A15750C0A9639C8B63.
[13] *Id.*

These changes are consistent with the standards on the treatment of prisoners which have been recently adopted by the ABA.[14] I served on the Task Force comprised of a wide variety of experts from across the spectrum which drafted these standards. Drawing on examples of good corrections practice, the standards prohibit isolation of the mentally ill or juveniles,[15] and even for those who must be isolated the standards absolutely prohibit "[c]onditions of extreme isolation . . .regardless of the reasons for a prisoner's separation from the general population."[16] The animating idea behind these standards is the one that my colleague Fred Cohen put so well in his testimony to this subcommittee:

> Inmates may need to be insulated from each other, and for a variety of valid reasons, but insulation (separation) and contemporary penal isolation are quite different concepts and operations. The process of insulation need not lead ineluctably to conditions of extreme social and sensory deprivation.[17]

For all these reasons I add my voice to those who will testify before you about the damaging physiological effects of solitary confinement and the awful pain and suffering it causes, and the urgent need for reform. I call upon you to take action that will responsibly address this American problem.

Recommendation

Just as it has addressed the scourge of prison rape,[18] Congress should mandate reform of solitary confinement. With the Prison Rape Elimination Act, Congress called for the establishment of a national commission, a study and survey of existing levels of sexual abuse of prisoners, and the promulgation of national standards for the prevention of sexual abuse with

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[14] ABA, CRIMINAL JUSTICE SECTION STANDARDS, STANDARDS ON TREATMENT OF PRISONERS (2010); *ABA* STANDARDS FOR CRIMINAL JUSTICE: TREATMENT OF PRISONERS (3rd ed. 2011),
[15] *Id.* at Standard 23-2.8.
[16] *Id.* at Standard 23-3.8.
[17] Statement of Fred Cohen, *supra* note 11 (emphasis in original).
[18] 42 U.S.C.A. § 15607 (West 2003).

federal funding tied to compliance with the adoption, oversight, and enforcement of these standards.[19] That law, passed on a bipartisan basis, has been the catalyst for important fundamental change. Similarly, a law addressed to solitary confinement would lay the foundation for essential reform. Lastly, for the reasons I have set out in my article cited earlier, Congress should also amend the Prison Litigation Reform Act to allow federal courts to remedy the most serious unaddressed abuses occurring in solitary confinement units. [20] Stories like Alexander's and Carroll's must become a remnant of the past.

[19] *See, e.g., Id.;* Statement of Fred Cohen, *supra* note 11 (I agree with the Statement of Fred Cohen advancing a similar position).
[20] MUSHLIN, *supra* note 6.



Statement of Ron Honberg, J.D.
Director of Policy and Legal Affairs
NAMI (National Alliance on Mental Illness)
Before the
United States Senate
Committee on the Judiciary
Subcommittee on the Constitution, Civil Rights and Human Rights

June 15, 2012

Dear Chairman Durbin and Ranking Member Graham:

This testimony is submitted on behalf of NAMI (National Alliance on Mental Illness), the nation's largest grassroots organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, supports and research and is steadfast in its commitment to raising awareness and building a community of hope for all of those in need. NAMI's members include countless families and friends of persons living with serious mental illness who are incarcerated or otherwise involved with the criminal justice system.

In recent years, concerns have increased about the extensive use of solitary confinement and other forms of administrative segregation in both adult and juvenile correctional facilities. For NAMI, this is an issue of particular concern, because a significant percentage of individuals incarcerated in correctional facilities suffer from pre-existing serious mental illnesses, such as schizophrenia, bipolar disorder, major depression, post-traumatic stress disorder (PTSD) and other serious psychiatric disorders.

A recent study concluded that 16.9 percent of inmates in jails suffer from serious mental illness and the U.S. Department of Justice estimates that 24 percent of all state

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prisoners in the U.S. are diagnosed with these illnesses.[1] The prevalence of youth with serious mental health disorders in juvenile justice facilities is even higher. According to the National Center for Mental Health and Juvenile Justice, 70 percent of youth in the juvenile justice system have one or more psychiatric disorders, with 20 percent of these youth having a serious mental illness that significantly interferes with their day-to-day functioning.[2]

Veterans with post-traumatic stress disorder (PTSD), traumatic brain injuries (TBI) and other severe cognitive or mental disorders that have been called "invisible wounds of war" are also disproportionately represented in the criminal justice system. Although current estimates are not available, an earlier study conducted by Rosenheck, *et. al.*, documented that 15.7 percent of all male users of VA mental health services had been incarcerated at some point between 1994 and 1997, and these rates were substantially higher among veterans between the ages of 18 and 39.[3] Since users of VA mental health services have increased significantly in recent years, it is very possible that these rates are even higher today.

Inmates with Mental Illness are Frequently Placed and Kept For Long Periods of Time in Solitary Confinement

Despite the high prevalence of serious mental illness among incarcerated individuals, correctional systems often lack the expertise and resources to effectively respond to individuals experiencing symptoms of their illness, such as delusions or

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[1] H.J. Steadman, F.C. Osher, et. al., "Prevalence of Serious Mental Illness Among Jail Inmates," *Psychiatric Services* 60: 761-765 (2009); James, D. and Glaze, L., "Mental Health Problems of Prison and Jail Inmates, U.S. Department of Justice, Bureau of Justice Statistics, (2006)

[2] Skowyra K. & Cocozza, J. (2007). *Blueprint for change: A comprehensive model for the identification and treatment of youth with mental health needs in contact with the juvenile justice system.* Accessed at www.ncmhjj.com.

[3] R.A. Rosenheck, S. Banks, J. Pandiani, et. al., "Bed Closures and Incarceration Rates Among Users of Veterans Affairs Mental Health Services," *Psychiatric Services,* 51: 1282-1287, 2000.

hallucinations. Behaviors resulting from these symptoms are resulting in excessive and inappropriate placements of individuals in segregated settings within correctional systems, such as supermax prisons, locked down special housing units, or other forms of solitary confinement.

The reasons for the excessive placement of persons with mental illness in solitary confinement are multiple, including for purposes of discipline, protection from other inmates, or because their psychiatric symptoms are so severe that they are unable to function in the general prison setting. Whatever the reason, these placements are highly inappropriate and cause extreme suffering and often long term damage. Placing individuals with severe psychiatric symptoms in solitary confinement is akin to pouring gasoline on a fire. It is an almost sure fire guarantee to lead to a worsening of symptoms.

Human Rights Watch, in an important report issued in 2003 on individuals with mental illness in U.S. prisons, provided documentation of this trend in a number of states.[4] For example:

- Indiana reported that between one-half and two-thirds of the inmates in its segregated Special Housing Unit in the Wabash Valley Correctional Unit were mentally ill.
- Dr. Dennis Koson, retained as an expert to review mental health treatment in New Jersey prisons, reported that inmates with mental illnesses were three times more likely to be found in solitary confinement or other forms of administrative segregation, than in the general population of the prison.

[4] S. Abramsky and J. Fellner, *Ill Equipped: U.S. Prisons and Offenders with Mental Illness,* Human Rights Watch (2003), 147-148

- The New York State Correctional Association reported that 23 percent of all inmates in special housing units were on the mental health caseload and among these individuals, nearly one-third had previous psychiatric hospitalizations.

These trends have continued and even worsened in recent years. Many states acknowledge that they frequently confine inmates with mental illness for long periods of time in solitary confinement.

- Officials with the Michigan Department of Corrections acknowledge that there are probably more inmates with mental illness in segregation than in the general population. And, once these individuals are placed in solitary, they stay there. Some stay in segregation for years.[5]
- In Illinois, some inmates with mental illness have been confined in the Tamms supermax facility for more than 10 years. The extreme isolation and social isolation characteristic of this facility has only led to a worsening of symptoms, which in a perverse catch 22 scenario, has led to even longer confinement. One inmate with a history of mental illness was placed in a strip cell as "punishment" for cutting off a piece of his own genitalia.[6]

Incredibly, solitary confinement is even used for juveniles, particularly as a way to protect youth under age 18 who are placed in adult correctional facilities. The damaging effects of solitary confinement on juveniles whose brains are still developing can be

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[5] Jeff Gerritt, "Mentally Ill get Punishment Instead of Treatment," *Detroit Free Press,* February 5, 2012, accessed at http://www.freep.com/article/20120205/OPINION02/202050442/PUNISHMENT-INSTEAD-OF-TREATMENT-Hundreds-of-Michigan-s-mentally-ill-inmates-languish-in-solitary-confinement-lost-in-a-prison-system-ill-equipped-to-treat-them

[6] G. Pawlaczyk and B. Hundsdorfer, "Inmate Wants out of Tamms; Attorney Says Years of Solitary Confinemente have Harmed his Mental Health," *Belleville News-Democrat,* August 29, 2011, accessed at http://www.bnd.com/2011/08/28/1837463/inmate-wants-opportunity-to-get.html

permanent. Juveniles placed in solitary confinement are particularly vulnerable to suicides. According to the Campaign for Youth Justice, data shows that juveniles are 19 times more likely to kill themselves in isolation than in general population.[7]

Solitary Confinement Worsens Psychiatric Symptoms and Causes Extreme Suffering

Placement in segregated units, whether in supermax facilities or in other forms of solitary confinement, is characterized by extreme isolation and social deprivation. Typically, inmates in these units spend 23 to 24 hours a day in small cells with no social contact. They are also deprived of books, radios, or any other form of activity to divert their minds from their horrendous living circumstances.

The negative effects of solitary confinement on inmates with mental illness have been well documented. These negative effects include worsening of psychiatric symptoms such as paranoia, extreme anxiety and depression, increased suicides and suicide attempts, sleep disturbances, hallucinations, and self-mutilation. Craig Haney, a psychologist and leading expert on the psychological effects of solitary confinement, has stated that "there are few if any forms of imprisonment that appear to produce so much psychological trauma and in which so many symptoms of psychopathology are manifested" as with supermax facilities and other forms of solitary confinement.[8]

For some individuals, the damage caused by these placements can be permanent and irreversible. In his seminal 2003 article in *Crime and Delinquincy*, Dr. Haney documents the loss of functionality that frequently occurs among those placed in long

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[7] Campaign for Youth Justice, "Key Facts: Youth in the Justice System," April 2012, accessed at http://www.campaignforyouthjustice.org/documents/KeyYouthCrimeFacts.pdf

[8] C. Haney, "Mental Health Issues in Long-Term Solitary and "Supermax" Confinement," *Crime and Delinquincy* 49: 125 (2003).

term segregation. He describes adverse functional consequences such as chronic apathy, inability to begin or complete mundane tasks, inability to maintain concentration and attention, and extreme difficulties in interacting with others.[9]

Long-term placement in solitary confinement inevitably has an adverse impact on a person's capacity to successfully reenter society, an important factor since many individuals with serious mental illness who are in solitary confinement have been convicted of relatively minor crimes and will eventually be released into the community without any meaningful help to successfully make this transition.

Positive Reforms are Underway in Some States

In recent years, a number of states have begun moving away from supermax facilities and the regular use of solitary confinement in corrections. This trend reflects recognition both of the high costs of supermax facilities and other forms of solitary confinement and understanding that long term segregation and isolation is counter-productive, costly, and very likely worsens psychiatric symptoms and decreases the chances of recovery and successful community reentry.

For example, in 2008, New York State enacted a law imposing significant limits on the use and duration of confinement of inmates with serious mental illness in segregated housing units (also called "special housing units") and alternatively established residential mental health treatment units for these individuals.[10]

Recently, Colorado announced that it will eliminate 316 solitary confinement beds in its Centennial Correctional Facility. This cost-saving measure was followed a

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[9] Haney, Id at 140.
[10] Consolidated Laws of New York, Mental Hygiene Law, Article 45, Sect. 45.07

gradual decrease in the use of solitary confinement in Colorado's prisons, coupled with efforts to establish mental health alternatives to solitary confinement in these prisons.[11]

Mississippi, a state that was notorious in the 1990's for the large numbers of inmates in supermax units at Parchman State Penitentiary, has reduced the number of supermax prisoners by more than three-quarters in recent years. It did so by investing in a number of alternative programs, including enhanced mental health treatment programs, crisis response training for its correctional officers and mental health step down units as an alternative to solitary confinement.[12] These steps have proven to be beneficial in multiple ways, including reductions in violence and savings of $5.6 million a year, according to Emmitt Sparkman, Deputy Commissioner of the Mississippi Department of Corrections.[13]

In 2011, Maine cut its population of inmates in the state prison supermax unit by more than 50 percent and is implementing many other reforms designed to reduce the use of supermax even further. Many of these reforms focus on improving responses to inmates with mental illnesses. For example, the state is looking at moving the mental health unit out of the supermax to another part of the prison system.[14]

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[11] Maes, D., "Victory in Colorado: Closing Solitary Confinement Unit Good for Budget and Public Safety," https://www.aclu.org/blog/prisoners-rights/victory-colorado-closing-solitary-confinement-unit-good-budget-and-public, accessed 3/31/2012.

[12] A. Brown, A. Cambier, and S. Agha, "Prisons within Prisons: The Use of Segregation in the United States," *Federal Sentencing Reporter,* Vol. 24, No. 1, pp 46-49, http://www.jstor.org/stable/pdfplus/10.1525/fsr.2011.24.1.46.pdf?acceptTC=true, accessed 3/31/2012.

[13] Vera Institute of Justice, "Mississippi DOC's Emmitt Sparkman on Reducing the Use of Segregation in Prisons," http://www.vera.org/blog/mississippi-docs-emmitt-sparkman-reducing-use-segregation-prisons, accessed 3/31/2012.

[14] Lance Tapley, "Reform Comes to the Supermax," The *Portland Phoenix,* May 25, 2011, http://portland.thephoenix.com/news/121171-reform-comes-to-the-supermax/?page=5#TOPCONTENT

Additional states, such as California, are implementing or considering measures to reduce the use of solitary confinement.[15] States that have gone down this path have reduced costs significantly, freeing correctional resources for other purposes. Violent incidents among inmates formerly in supermax have decreased as well.

Recommendations

Steps can be taken at the federal level to address the need to reduce or eliminate the use of solitary confinement in federal and state prisons.

First, Congress should mandate meaningful reforms and reductions in the use of solitary confinement by tying federal funding of prisons to good faith efforts by states to establish alternatives to the use of solitary confinement and to document reductions in the numbers of individuals placed in solitary confinement. And, Congress should make it clear that the use of solitary confinement with prisoners who have mental illnesses in federally funded prisons is prohibited.

Second, the Prison Litigation Reform Act (PLRA) should be amended to more effectively permit federal courts to remedy abuses occurring in solitary confinement units. Currently, the PLRA serves as a restriction on the ability to seek federal remedies for these aversive practices.

Third, the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA) and other federal programs intended to support alternatives to incarceration for juveniles and adults with mental illness and/or addictions disorders, including those who are veterans, should be fully funded.

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[15] Erica Goode, "Fighting a Drawn Out Battle Against Solitary Confinement," *New York Times,* March 30, 2012.

NAMI appreciates the opportunity to provide testimony on this important issue. Please contact me, Ron Honberg, at (703) 516-7972 or RonH@nami.org, if we can be of further assistance.

Respectfully Submitted,

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Lisa Monet Wayne
President

June 18, 2012

The Honorable Dick Durbin
711 Hart Senate Bldg.
Washington, DC 20510

Dear Senator Durbin:

On behalf of the National Association of Criminal Defense Lawyers (NACDL), I write to thank you for scheduling a hearing for the purpose of "**Reassessing Solitary Confinement: The Human Rights, Fiscal and Public Safety Consequences.**" The National Association of Criminal Defense Lawyers (NACDL) is the preeminent organization in the United States advancing the mission of the nation's criminal defense lawyers to ensure justice and due process for persons accused of crime or other misconduct. NACDL believes that safe and humane prisons must be the highest priority of any correctional system.

The NACDL opposes the use of long-term solitary confinement in our prison systems for the following reasons:

(1) Solitary confinement results in greater prison violence.
- Solitary confinement increases the risk of torture, excessive force and other forms of physical abuse, because there is an absence of witnesses and many detainees have been held in solitary confinement for years.
- Long-term segregation has been shown to increase prisoner-on-staff and prisoner-on-prisoner assaults.

(2) Solitary confinement endangers the psychological health of inmates.
- Research shows that people who experience long periods of isolation in prison often experience serious and sometimes lasting deterioration in mental and physical health.
- Prisoners with mental illness are significantly overrepresented in supermax prisons and similar solitary confinement facilities, and once subjected to the extreme social and sensory deprivations of solitary confinement, many mentally ill prisoners deteriorate dramatically.
- Direct studies of the effects of prison isolation have documented a wide range of harmful physiological and psychological effects including increases in negative attitudes and affect, insomnia, anxiety, panic, withdrawal, hypersensitivity to external stimuli, ruminations, cognitive dysfunction, perceptual distortions and hallucinations, loss of control, aggression, rage, paranoia, hopelessness, lethargy, depression, emotional breakdowns, self-mutilation, suicidal impulses, heart palpitations, appetite loss and weight loss, and lower levels of brain function, including a decline in EEG activity.

(3) Solitary confinement undermines prisoner reentry and public safety.
- Studies show that prisoners who are released form segregation directly to the community reoffend at higher rates than general-population prisoners.
- Although there is no compelling evidence that solitary confinement "works," in general or for any particular type of inmate, alternative approaches to handling violent prisoners are proven to both reduce levels of institutional aggression and decrease recidivism among such prisoners upon release.

Aside from the overwhelming weight of research demonstrating the dangers and ineffectiveness of solitary confinement, there is the issue of fiscal responsibility. The cost of confining prisoners in segregation is astronomical. Supermax cells cost on average 50% more than general population cells. In Illinois, it costs $92,000 per year to hold an inmate in solitary confinement at Illinois's Tamms Correctional Center. That figure is two to three times higher than the cost of keeping an inmate at the state's other maximum-security prisons.

The solitary confinement practices of the US detention system are far below the basic minimum standards for treatment of prisoners under international law. Adopted by the United Nations, the Standard Minimum Rules for the Treatment of Prisoners ("Standard Rules"), recognize solitary confinement and prolonged segregation as appropriate only in exceptional circumstances, to be used sparingly. In an October 2011 report by the UN's special rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez urged all countries to ban the solitary confinement of prisoners except in very exceptional circumstances. UN rapporteur Méndez also called on the international community to agree to impose an absolute prohibition on solitary confinement exceeding 15 consecutive days because 15 days is the point at which solitary confinement becomes prolonged, as a practical matter and as a conservative assessment of when, based on his survey of medical research, the harm suffered by individuals held in solitary confinement constitutes torture or cruel, inhuman, or degrading treatment or punishment.

Once again, the NACDL would like to thank you for presiding over a much needed hearing on solitary confinement. After hearing from the witnesses, NACDL strongly encourages you to consider Congress' potential role in limiting the use of solitary confinement in state, local and federal detention facilities.[1] We look forward to working with you on this important issue.

Sincerely,



Lisa Monet Wayne
President

cc: Members of the Senate Judiciary Committee

[1] It is our understanding that at the federal level, the use of pure solitary confinement (one man, one cell) is less common than placement in Special Housing Units (SHUs), defined by the BOP as "housing units in Bureau institutions where inmates are securely separated from the general inmate population, and may be housed either alone *or with other inmates*." SHU conditions raise many (if not all) of the same concerns as pure solitary confinement, and the BOP's reliance on these units warrants scrutiny during the hearing.

nae national association of Evangelicals
COOPERATION WITHOUT COMPROMISE

Statement on the Use of Solitary Confinement in Prisons and Jails

Submitted to the Senate Judiciary Committee
Subcommittee on the Constitution, Civil Rights, and Human Rights

by

Galen Carey, Vice President for Government Relations
National Association of Evangelicals

June 15, 2012

The National Association of Evangelicals (NAE), representing 40 denominations with 45,000 congregations, as well as evangelical organizations, schools, and ministries with millions of constituents, commends Chairman Durbin, Ranking Member Graham, and the Subcommittee members for holding this important hearing on solitary confinement.

The NAE has long advocated for the humane treatment of prisoners. We recognize that all people, including prisoners, are created in God's image and must therefore be treated with human dignity (Genesis 1:27). Fifteen years ago the NAE issued a resolution titled "The Church's Responsibility to Prisoners." This statement, which continues to guide evangelical engagement in prison ministry, recognizes that prisoners are human beings with the capacity for emotional and spiritual growth and transformation.

> "Incarcerated believers who make up the 'church-behind-the-walls' have the same need as believers in the 'outside world' for instruction, for living by example, and for being equipped to do ministry. Local churches can play an important role not only in sharing the gospel with incarcerated non-believers, but also in supporting, teaching and equipping saints in the incarcerated church for ministry in their environment."

Evangelicals embrace the biblical mandate to visit those who are in prison. Jesus taught his followers that when we visit prisoners, we minister to Christ himself. (Matthew 25:36) Through our prison ministries, we bring encouragement to prisoners and their families, and promote rehabilitation and reconciliation.

A substantial body of research indicates that prolonged solitary confinement is psychologically harmful to inmates. Most prisoners come from troubled backgrounds, and experience further trauma due to the prison experience. Since most prisoners will one day be released into society, it is in everyone's interest to minimize further damage to the human spirit and to maximize opportunities for rehabilitation. Solitary confinement precludes prisoner access to most educational and social programs aiming at preparing inmates for reentry.

External volunteers can also play an important role in prisoner rehabilitation. Prisons that adopt widespread use of solitary confinement, whether for punishment or for protection, limit volunteer access to those who are behind bars. This is counterproductive and wasteful of both human and financial resources.

We recognize the terrible toll caused by sexual violence in America's prisons. The NAE strongly advocated for the Prison Rape Elimination Act and continues to push for implementation of the recently promulgated standards aimed at fully protecting all prisoners and detainees from rape and sexual abuse. However, solitary confinement as a protective strategy should be used only in rare circumstances and for short periods of time. It should never be the default option.

We understand that some prisoners are prone to violence and must be carefully watched. Wherever possible, this should be done in a way that does not rely on solitary confinement. There is no substitute for effective prison administration that combines security with respect for human dignity.

Prison violence is affected by overcrowding. Overcrowding limits access to recreation, religious services, and other activities that promote rehabilitation, while exacerbating tensions. As the Subcommittee explores potential legislative remedies to the overuse of solitary confinement, please also consider sentencing reforms, including appropriate use of alternatives to incarceration, that could address overcrowding without requiring the construction of additional facilities.

Evangelicals believe that human beings were created to live in community. Friendship and social engagement are basic human needs, not optional extras. In our nation's best prisons, inmates have the opportunity to work, study and prepare themselves for the day when they are given a second chance to establish healthy, productive lives in the community.

Please be assured of our prayers as you consider new federal standards on the use of solitary confinement that promote humane treatment of prisoners while improving security in our communities by maximizing the prospects for effective prisoner rehabilitation and reentry.

NASW
National Association of Social Workers
...the power of social work

Written Testimony
Submitted by
Melvin H. Wilson, MSW
Manager
Department and Social Justice and Human Rights
National Association of Social Workers (NASW)
For the

Hearing Before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights

Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences

Chairman Durbin, Ranking Member Graham, and members of the Committee, on behalf of the National Association of Social Workers (NASW) and its 145,000 members, I commend you for holding this hearing on the vastly important and often overlooked issue of excessive use of solitary confinement in the nation's prisons and jails. As the Committee has pointed out, the United States has witnessed an explosion in the use of solitary confinement for federal, state, and local prisoners and detainees. Also, as you have so aptly stated, there is a significant and long-lasting psychological and psychiatric impact on inmates that experience extended periods of solitary confinement. For example, according to Solitary Watch, "An estimated 20 percent of all inmates in the nation's prison and jails are seriously mentally ill. To compound the problem, psychiatric resources are scarce in the overcrowded prison system.... The inadequacy of prison system to deal with mental illness, results in a cycle wherein emotionally troubled inmates enter solitary confinement, anger builds as a result of isolation, and eventually the inmate may lash out, resulting in an extended term in solitary."
(Solitary Watch. (http://solitarywatch.files.wordpress.com/2011/06/fact-sheet-psychological-effects-of-solitary-confinement3.pdf).

The social work profession has a long history of both responding to issues that impact social justice and human rights, as well as being providers of mental health services to vulnerable and low-income members of our society. Therefore, our concern that excessive use of solitary confinement as a disciplinary tool contributes to severe acute and long-term mental illness is based on NASW's values, and the clinical experience of its members in treating persons with mental illness.

The Bureau of Justice Statistics reports that, in 2005, more than half of all prison and jail inmates had a mental health problem, including 705,600 inmates in state prisons, 78,800 in federal prisons and 479,900 in local jails. These estimates represented 56 percent of state prisoners, 45percent of federal prisoners, and 64 percent of jail inmates. More than two-fifths of state prisoners (43 percent) and more than half of jail inmates (54 percent) reported symptoms that met the criteria for mania. About 23 percent of state prisoners and 30 percent of jail inmates

reported symptoms of major depression. An estimated 15 percent of state prisoners and 24 percent of jail inmates reported symptoms that met the criteria for a psychotic disorder (Bureau of Justice Statistics (http://bjs.ojp.usdoj.gov/content/pub/pdf/mhppji.pdf).

NASW is a strong advocate for the expansion of mental health assessments and treatment for individuals incarcerated in the nation's prisons and jails. For example, NASW has actively supported continued funding of Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA). We feel that the Federal Bureau of Prisons, state Departments of Corrections, and County/City jail officials should be proactive in ensuring that all individuals in their custody receive in-depth mental health assessment using evidenced based clinical assessment tools and administered by qualified mental health professionals. NASW additionally feels that any inmate that is documented to have had a recent history of, and/or is actively exhibiting symptoms of, bi-polar disorders, clinical depression and severe psychosis should never be placed in isolation for disciplinary purposes. NASW recognizes there are situations when a given inmate's behaviors may pose a danger to himself or others, thereby requiring segregation from the general prison population. However, clinically monitored segregation is much different than the unmonitored isolation to which far too many mentally ill or at-risk for mental illness inmates are subjected.

Finally, we would be remiss if we did not mention the problem of the use of disciplinary isolation/solitary confinement in facilities in the Juvenile Justice system. It should be obvious to everyone that subjecting young people who are still developing cognitively and emotionally to extended periods of isolation is unacceptable.

Again, on behalf of NASW, I want to thank the Chairman, the Ranking Member, and the rest of the Committee for holding these important hearing on reassessing the use of solitary confinements in prisons, jails, and juvenile facilities.

NCLR NATIONAL CENTER FOR LESBIAN RIGHTS

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June 15, 2012

The Honorable Richard Durbin, Chairman
Senate Judiciary Subcommittee on the Constitution,
Civil Rights and Human Rights
224 Dirkson Senate Office Building
Washington, D.C. 20510
Via email to: Nicholas_Deml@judiciary-dem.senate.gov

Statement of the National Center for Lesbian Rights
Before the United State Senate
Committee on the Judiciary
Subcommittee on the Constitution, Civil Rights and Human Rights
Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety
Consequences (June 19, 2012)

Dear Chairman Durbin, Ranking Member Graham, and members of the subcommittee:

The National Center for Lesbian Rights (NCLR) is grateful for this opportunity to submit testimony on the human rights and public safety concerns posed by the use of solitary confinement in U.S. prisons, jails, and detention centers. As a national organization committed to advancing the rights of lesbian, gay, bisexual, and transgender (LGBT) people and their families, NCLR is aware of the devastating impact that solitary confinement has on the mental health of prisoners. LGBT prisoners and detainees are particularly vulnerable to abuses, including serious physical and psychological risks, resulting from overreliance and abuse of solitary confinement.

NCLR has received numerous complaints from LGBT people held in solitary confinement and we write today to bring some of those stories to your attention. We very much appreciate your efforts to shine a light on this extremely important human rights issue and the June 19, 2012 hearing is a vital step in the effort to stem the overuse and abuse of solitary confinement in U.S. correctional and detention facilities.

Introduction

Survivors of sexual abuse in detention who are placed in solitary confinement (sometimes referred to as administrative segregation or protective custody) tend to suffer significant distress. The same is true for prisoners who are placed in solitary confinement simply because they are perceived to be vulnerable to sexual abuse, whether because they identify as LGBT, are gender nonconforming, or for other reasons. In recognition of the severely negative impact of solitary confinement on these prisoner populations, some corrections systems have sought to limit its use. However, significant work still needs to be done to create detention environments nationwide where staff is willing and able to keep survivors and other vulnerable prisoners safe from abuse

without having to place them in restrictive, punitive housing that has been shown to be detrimental to their mental health.

This statement provides an overview of the ways that LGBT prisoners are particularly impacted by the use of solitary confinement, with an emphasis on the use of solitary confinement for survivors of sexual assault, for vulnerable prisoners, and as punishment for being associated with a disfavored group. NCLR recommends that solitary confinement not be used for this population, except in the most extreme circumstances, and that when it is used, it is used for the shortest possible time (with frequent administrative reviews of the placement) and that prisoners be provided substantial access to programming, exercise, and work and educational opportunities on par with the general population.

Solitary Confinement Is Punitive

Segregation and isolation are usually reserved for prisoners with particularly egregious disciplinary issues. In all material respects, conditions in administrative segregation and protective custody are the same as those in disciplinary segregation. Examining a challenge to administrative segregation, the Supreme Court noted: "The reasons for placing one inmate in administrative and another in punitive segregation may be different, and the periods of confinement may vary, but the Court properly assumes for purposes of this case that the conditions in the two types of confinement are substantially identical."[1]

Segregation typically confines prisoners to their cells for all but approximately one hour per day of exercise and one or two showers per week.[2] Other prisoner privileges such as using the library, interacting with other prisoners socially, and accessing laundry facilities are extremely limited or denied to prisoners in administrative segregation or isolation.[3] Prisoners are also deprived of communal dining, as well as work and educational opportunities. The 7th Circuit has held that "prisoners confined in protective custody have no right of equal access to the same vocational, academic and rehabilitation programs as those in the general prison population."[4]

In addition to losing vocational, academic, and rehabilitative programming when in solitary confinement, some prisoners also face limited access to medical care when housed away from the general population. S.L., a gay prisoner living with AIDS in a New York facility faced death threats from other prisoners in the general population because the guards informed the prisoners that he was gay and HIV-positive.[5] When he was moved to solitary confinement for his

[1] Hewitt v. Helms, 459 U.S. 460, 479-480 (U.S. 1983) (internal quotation marks omitted).
[2] *See, e.g.*, Ally Windsor Howell, *A Comparison of the Treatment of Transgender Persons in the Criminal Justice Systems of Ontario, Canada, New York, and California*, 28 BUFF. PUB. INT. L.J. 133, 192 (2010).
[3] *Id.*
[4] Meriwether v. Faulkner, 821 F.2d 408, 416-17 (7th Cir. 1987) (*citing* French v. Owens 777 F.2d 1250, 1256 (7th Cir. 1985)).
[5] Letter from S.L., received 2/27/2012.

protection from dangers posed by other prisoners, he stopped receiving necessary HIV medication.[6]

In *Tates v. Blanas*, Sacramento County Jail's administrative policy of housing transgender prisoners in "total separation" or "T-sep" came to light.[7] The Jail "automatically classifies all biologically male transgender inmates as T-sep, regardless of their behavior, criminal history, whether they pose a danger to others, or any other characteristic. . . . [T]here is no possibility that the Jail will change their classification."[8] The court in *Tates* found that "T-sep inmates are . . . forbidden to have any contact with other inmates or even to be in the same room as them. . . . T-sep inmates are subject to many burdens and restrictions not shared by other inmates."[9] After discussing safety considerations weighted against the overwhelming evidence of harm caused by isolation, the court found that classifying prisoners solely on the basis of their transgender status was inappropriate.[10]

Regardless of what it is called, solitary confinement is punitive by default. As such, involuntary solitary confinement aimed at protecting the safety of a prisoner must be used only as a last resort. This type of restrictive housing results in a loss of services and programs, leaves prisoners with little or no access to outside support, and cuts them off from human interactions essential for mental health.

Use of Solitary Confinement for Survivors of Sexual Abuse

Sexual abuse survivors placed in solitary confinement in the aftermath of an assault tend to suffer significant distress, including fear, anxiety, and heightened trauma. In addition to these negative health consequences, the extreme sense of isolation survivors experience in solitary confinement often makes them less likely to file a formal complaint of the abuse or to cooperate with an investigation.

When solitary confinement must be used to protect a survivor of abuse from further attacks, it should be used for as short a period as possible and with substantial protections in place. Strict time limits should be placed on how long a survivor can be housed in such punitive housing. The need for continued solitary confinement should also be reviewed on a regular basis (preferably every 15 days), and a survivor should be moved to less restrictive housing as soon as possible. To minimize the negative health consequences of solitary confinement, corrections officials should provide the survivor with appropriate health care services, access to programs and services, and contact with a rape crisis provider.

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[6] *Id.*
[7] Not Reported in F.Supp.2d, 2003 WL 23864868 at *3 (E.D.Cal. 2003).
[8] *Id.*
[9] *Id.*
[10] *Id.* at 4, 11.

The Department of Justice's (DOJ) recently released Prison Rape Elimination Act (PREA) standards meet some, but not all, of these conditions.[11] The PREA standards call on corrections officials to provide survivors with access to services and programs and to move these prisoners to less restrictive housing as soon as possible.[12] The standards also mandate the provision of emergency and follow-up medical and mental health care, including contact with support services.[13] However, the standards do not place strong enough limits on the time a survivor may involuntarily be placed in solitary confinement. The PREA standards generally limit involuntary solitary confinement for survivors to 30 days.[14] A more appropriate time limit is 72 hours. The standards do call for ongoing, regularly scheduled reviews of whether a survivor should be kept in solitary confinement beyond 30 days. However, this review is only required to take place once every 30 days.[15] A more appropriate review schedule would be every 10 days.

Use of Solitary Confinement for Vulnerable Prisoners

Like survivors of sexual abuse in detention, prisoners who are LGBT or seen as vulnerable to sexual abuse are frequently placed in solitary confinement, ostensibly for their own protection. Such punitive housing assignments are inappropriate. Keeping prisoners safe is one of the most basic responsibilities of corrections officials. They must be able to ensure the safety of all prisoners without resorting to involuntary solitary confinement of those who are the most vulnerable to abuse. This includes prisoners who are lesbian, gay, bisexual, transgender, intersex, and/or gender non-conforming and those who are perceived as such regardless of their identity. Too often, prisoners with disabilities, younger or older prisoners, and other prisoners targeted for violence are similarly warehoused in solitary confinement.

A transgender prisoner in a Texas facility explained that she believed "[a]bout 90% of the [transgender] girls in here . . . are in segregation. I expect that, before too long, I will be in there too."[16]

In some cases, corrections professionals believe that solitary confinement is in the best interest of the vulnerable prisoners. In other cases, however, officials rely on such housing as a quick fix, not taking into consideration the serious harm caused by solitary confinement. In so doing, they tend to allow unsafe conditions in the rest of a facility to continue unchallenged, making the facility more dangerous for everyone, prisoners and staff alike.

When Krystal, a transgender girl in Louisiana, was 13 or 14, the bullying and violence became so bad in her juvenile detention facility that staff placed her in protective custody, where she

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[11] The Prison Rape Elimination Act Standards available at www.ojp.usdoj.gov/programs/pdfs/prea_final_rule.pdf (last viewed on June 11, 2012).
[12] *Id.* As an example, see the relevant adult jail and prison standard at 115.43.
[13] *Id* at 115.53, 115.83, and 115.83.
[14] *Id* at 115.68 (referencing 115.43).
[15] *Id.*
[16] STOP PRISONER RAPE & ACLU NATIONAL PRISON PROJECT, STILL IN DANGER: THE ONGOING THREAT OF SEXUAL VIOLENCE AGAINST TRANSGENDER PRISONER, 5 (2005), available at http://www.spr.org/pdf/stillindanger.pdf.

remained for a month.[17] But even after the abuse that she endured in the dorm, including finding urine and saliva in her shoes, lockdown was so painful that she requested to be returned to the dorm.[18] "Sending LGBT victims of violence into isolation, instead of punishing their attackers, is common practice across the country, even though . . . the American Psychological Association opposes it."[19]

A gay man in Attica was unexpectedly transferred into a two-person cell with a homophobic cellmate.[20] He refused to sign a waiver indicating that he would remain with that cellmate and was transferred into the Special Housing Unit for thirty days.[21] After he had finished those thirty-days, he was again assigned to double-bunk with a homophobic cellmate and was placed in Special Housing for an additional 45 days when he refused to sign the waiver.[22] With three years remaining on his sentence, he believed that he would be in the Special Housing Unit until his release because guards were unwilling to find safe housing for him in the general population.[23]

J.T., a transgender woman faced sexual abuse, harassment, and discrimination due to her gender identity while in prison.[24] Despite her repeated requests to be moved away from a dangerous cellmate, no action was taken to protect her in the general population.[25] She found herself with no other option than to request administrative segregation.[26] The facility likely lists her administrative segregation as "voluntary" despite the failure of the prison guards to acknowledge or investigate her earlier requests for safer housing.

In *Meriwether v. Faulkner*, the 7th Circuit applied its precedential standard that prisoners in administrative segregation are not entitled to the same access to programs to a transgender woman who was at high risk of sexual assault in the general population and who challenged the prospect of spending the entirety of her thirty-five-year sentence in segregation.[27] The court found it "troubling to extend that holding" to a prisoner who, through no misconduct, "is required to serve a thirty-five-year sentence in segregation."[28] Ultimately, the court left Meriwether's housing determination to the wardens, because the court thought there was likely no "feasible alternative" to housing Meriwether in administrative segregation to prevent continued sexual assault in the general population.[29]

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[17] Daniel Redman, *'I Was Scared to Sleep': LGBT Youth Face Violence Behind Bars*, The Nation (June 21, 2010) http://www.thenation.com/article/36488/i-was-scared-sleep-lgbt-youth-face-violence-behind-bars.
[18] *Id.*
[19] *Id.*
[20] Letter from S.K., received 1/30/2012.
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] Letter from J.T., mailed 5/21/2012.
[25] *Id.*
[26] *Id.*
[27] 821 F.2d at 416-17.
[28] *Id.*
[29] *Id.* at 417.

Every effort must be made to create institutions in which involuntary solitary confinement is used only as a last resort. To achieve this goal, the policies and culture of confinement facilities must prioritize creating safe, dignified housing for everyone—including sexual abuse survivors and others who are vulnerable to sexual abuse. When solitary confinement is used as a last resort, the need for continued solitary confinement should be reviewed on a regular basis (preferably every 10 days), and a vulnerable prisoner should be moved to less restrictive housing as soon as possible. To minimize the negative health consequences of solitary confinement, corrections officials should provide prisoners in solitary confinement access to appropriate health care services, programs, activities, exercise time, and services.

Use of Solitary Confinement as Punishment

Many survivors of sexual abuse in detention and vulnerable prisoners are subjected to involuntary solitary confinement as a de facto punishment. In far too many cases, however, prisoner rape survivors who report their abuse are placed in solitary confinement as retaliation for "making trouble." Likewise, many corrections officials use solitary confinement to express animus toward certain prisoner populations. This is particularly true for prisoners who are lesbian, gay, bisexual, transgender, intersex, and/or gender non-conforming and prisoners whose criminal history is particularly disfavored (such as prisoners convicted of child sexual abuse).

This type of abusive use of solitary confinement must be taken as seriously as any other form of harm inflicted on a prisoner. The perpetrators of such abuse must be held accountable and prosecuted to the fullest extent under the law. Significant pressure should be put on the Department of Justice, state attorneys general, and local district attorneys to investigate and prosecute abusive use of solitary confinement in facilities under their jurisdictions.

A.D. was 17-years-old when he was adjudicated for second-degree robbery and committed to the California Youth Authority (CYA).[30] Even though he was never accused of or charged with a sex offense, CYA automatically placed him in a sex offender unit solely because he was bisexual.[31] Because A.D. lived in the sex offender unit and was known to be gay, other wards expected that he would service them sexually. This was exacerbated by staff who called him homophobic names, made sexualized references toward him in front of the other wards, and refused to take any steps to protect him from sexual harassment and assault. Whenever A.D. refused to comply with sexual demands made by other residents, the other residents physically attacked him.[32] On one occasion when A.D. defended himself, facility staff responded by placing him in solitary confinement.[33] In a particularly severe assault, another youth slashed A.D. in the face with a razor blade, creating a wound that required hundreds of stitches to close and will leave him permanently scarred.[34] After this attack, staff placed A.D. in solitary confinement while he

[30] Katayoon Majd, et al, *Hidden Injustice: Lesbian, Gay, Bisexual, and Transgender Youth in Juvenile Courts*, 127 (2009).
[31] *Id.*
[32] *Id.*
[33] *Id.*
[34] *Id.*

recovered and then prohibited him from leaving his unit for the remaining six months of his confinement.[35] A six-month confinement in isolation for a 17-year old drastically limits the rehabilitative measures that juvenile detention is designed to provide. Additionally, A.D.'s experience of both sexual assault and isolation was avoidable had staff not exacerbated the situation themselves.

One transgender girl incarcerated in a New York male juvenile jail was strip searched and told to remove her women's underwear and discard it.[36] She removed her underwear but refused to discard it because it was only pair of gender-appropriate underwear she possessed.[37] Upon that refusal, she was told to face the wall.[38] She was then beaten by four prison officials, verbally harassed, and placed in 24-hour lock down.[39]

Prisoners who advocate in favor of safer prisons and improved conditions are also punished for their efforts. R.W., a bisexual man who has served 25 years of a 40 years-to-life sentence in a California prison has tried to bring attention to the dangers transgender women and gay men face in confinement.[40] He has been placed in administrative segregation for these efforts several times.[41]

The procedural safeguards of frequent reevaluation of solitary confinement should apply to disciplinary segregation as well. Increasing the frequency of these evaluations will help ensure that discipline is appropriate to the misconduct, that it is not abusively applied to disfavored groups, and that it is not imposed unjustly at the expense of prisoners' mental health.

Use of Solitary Confinement in Immigration Detention Facilities

Through NCLR's immigration and asylum work, we also frequently encounter LGBT detainees in U.S. Immigration and Customs Enforcement (ICE) facilities. Many of those people seek asylum in this country based on persecution and physical violence, including sexual violence that they have suffered in their home countries on the basis of their sexuality or gender identity. In our experience, LGBT detainees, and particularly detainees who are transgender, are frequently placed in solitary confinement for months on end while they await decisions in their asylum or deportation cases. Such placements are devastating to the medical and mental health of those detainees. Immigration detention is not supposed to be a form of punishment—many people held in ICE facilities are asylum seekers fleeing desperate conditions, as well as older adults, people with failing health, and family members of U.S. citizens. Yet these detainees are subjected to conditions on par with the harshest conditions found in correctional institutions. It is essential

[35] *Id.*
[36] Letter from S.B, mailed 6/3/2011.
[37] *Id.*
[38] *Id.*
[39] *Id.*
[40] Letters from R.W, received 6/22/2011, 8/25/2011, and 3/22/2012.
[41] Letter from R.W., received 3/22/2012.

that all of the protections against the abusive use of solitary confinement be extended to detainees in ICE facilities as well.

Solitary Confinement Drains Resources

Inappropriate or abusive use of solitary confinement drains vital funds that could be used much more effectively. In a 2009 report, the California Inspector General estimated that, based on needs for increased staffing and greater physical space, the annual costs per prisoner in administrative segregation average at least $14,600 more than the annual costs per prisoner in general population.[42] The California Inspector General concluded that the overuse of solitary confinement cost the California Department of Corrections and Rehabilitation nearly $11 million every year.[43]

Looking at the problem on a national level, estimates indicate that housing prisoners in solitary confinement or supermax isolation costs between 145% and 200% of the cost of housing a prisoner in the general population.[44] "[K]eeping an inmate in a supermax prison costs roughly $50,000 per year compared with $20,000 per year for inmates kept in the general population."[45] Despite the increased cost of solitary confinement and its documented overuse, the number of people housed in solitary confinement is increasing. Though precise figures are unavailable, in 2000, approximately 60,000 prisoners (4.4% of the total prison population of the U.S.) were subjected to solitary confinement.[46] In 2005, a Bureau of Justice Statistics census reported there were 81,622 people held in restrictive housing.[47]

These figures do not take into account the cost of building and maintaining prisons designed to house prisoners in single cells. "Basic economics demonstrates that maintaining these prisons below their population capacities increases [the] cost differential even further."[48] This perverse incentive encourages prison administrators to expend funds on solitary confinement where isolation is unnecessary for staff or prisoner safety. For example, one year after a supermax prison opened in Wisconsin, "the number of inmates in solitary confinement was three times

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[42] California Office of the Inspector General, Management of the California Department of Corrections and Rehabilitation's Administrative Segregation Population (2009), available at http://www.oig.ca.gov/media/reports/BOA/reviews/Management%20of%20the%20California%20Department%20of%20Corrections%20and%20Rehabilitation's%20Administrative%20Segregation%20Unit%20Population.pdf (last visited June 11, 2012).

[43] *Ibid*

[44] An Urban Institute study found that, in Ohio, "it costs $149 per day to house a supermax prisoner, $101 per day to house a maximum-security prisoner and $63 per day to house the average nonsupermax prisoner;" and in Texas "ad seg [administrative segregation] units cost an average of $61.63 per prisoner per day in 2002—45 percent more than general population units' average cost of $42.46 per prisoner per day" http://www.urban.org/UploadedPDF/411326_supermax_prisons.pdf

[45] Tracy Hresko, *In the Cellars of the Hollow Men: Use of Solitary Confinement in U.S. Prisons and Its Implications Under International Laws Against Torture*, 18 PACE INT'L L. REV. 1, 14 (2006).

[46] *Id.* at 3.

[47] Angela Browne, et al., *Prisons Within Prisons: The Use of Segregation in the United States*, 24 FED. SENTENCING REP. 46 (2011).

[48] Hresko, supra note 48 at 14-15.

what it had been before, even though the criteria for solitary confinement use had remained the same."[49]

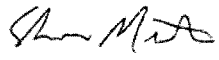
Corrections administrators often site cost as one reason why facilities are not made as safe as possible. However, funds spent on inappropriate and abusive use of solitary confinement could be used to establish and implement basic policies and procedures aimed at preventing sexual abuse and other forms of violence. Such reinvestment of scarce resources would lead to all around safer, better run confinement facilities. It would also prevent the negative health consequences among prisoners who are placed inappropriately in solitary confinement. Corrections administrators should be encouraged to begin shifting expenditures in this direction as soon as possible and should utilize various correctional experts, including James Austin,[50] who has assisted prison facilities to successfully do this.

Conclusion

With strong leadership, effective policies, and sound prison practices, prison officials can provide survivors of sexual abuse and vulnerable prisoners with safe housing that is far less restrictive than solitary confinement. Achieving this goal would fundamentally transform the culture within a facility to the benefit of everyone—prisoners, staff, and ultimately the communities to which almost all prisoners eventually return. Notable steps have been taken in this direction but much more work is required to severely restrict the use of solitary confinement, to review that use frequently and on a regular basis, and to ensure extensive programming for prisoners who are housed in solitary confinement in extreme cases.

We again thank the committee for their work on this urgent human rights and mental health issue.

Sincerely,



Shannon Minter, Esq.
Legal Director
National Center for Lesbian Rights

[49] *Id.* at 15.

[50] James Austin is the President of JFA Institute, a non-profit corrections consulting firm that works in partnership with federal, state and local government agencies to implement more effective criminal justice policies. He has served as an expert or consultant to various federal courts and correctional systems throughout the United States, including as an expert in the recent California prison overcrowding case that went to the United States Supreme Court.

Testimony of the National Center for Transgender Equality

For the Hearing:
Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences
Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights
United States Senate
Dirksen Senate Office Building Room 226

June 19, 2012

Chairman Durbin, Ranking Member Graham, and members of the subcommittee:

National Center for Transgender Equality

The National Center for Transgender Equality (NCTE) is a social justice organization, founded in 2003 and dedicated to advancing the equality of transgender people through advocacy, collaboration and empowerment. When we speak of transgender people, we refer to an umbrella term for people whose gender identity, expression or behavior is different from those typically associated with their assigned sex at birth. All of these people face the threat of disrespect, discrimination, violence, and sexual assault because of their real or perceived gender identity or expression. Sexual violence is among the greatest dangers and most serious challenges faced and feared by transgender people on a day-to-day basis. For this reason, transgender prisoners are often kept in solitary confinement or protective custody, a form of involuntary segregation with devastating mental and emotional effects.

Restrictive, segregated, isolated custody is by its very nature punitive and damaging; placing transgender inmates in solitary protective custody amounts to punishing them for their transgender status. The use of solitary confinement as a means of protecting transgender inmates absolutely must be limited. It is not acceptable to trade the violence and cruelty of prison rape for the violence and cruelty of long-term solitary confinement. Today's hearing is an important step in doing away with the overuse and abuse of solitary confinement for transgender inmates in U.S. correctional facilities.

BACKGROUND

Hundreds of transgender inmates are incarcerated in U.S. prisons. Because of systemic discrimination that prevents transgender people from accessing and maintaining employment, limits educational opportunities, and disrupts support networks and emergency services, transgender people are more likely than the general population to be homeless and are more likely to participate in street economies. Transgender inmates are much more likely to be in prison because of property crimes, are less likely to be identified as gang members, and are more likely to have low security classifications. Transgender inmates are categorically low-threat, but they are very likely to be confined in isolation.

The use of involuntary protective custody prevents many vulnerable inmates from accessing essential programs and work assignments. The isolation that vulnerable inmates endure, purportedly "for their own good," can destroy their mental health and ability to function, with consequences that will continue to affect them for the rest of their lives. In addition, the programs that vulnerable inmates are routinely prevented from participating in are incredibly important both during and after incarceration. They are usually the only means for inmates to earn money, which can allow them to buy basic products like shampoo and to pay debts that they owe as a result of their convictions. Without successful completion of programs, it is also difficult or impossible to obtain parole or conditional release, so inmates who are not permitted to participate in programming spend more time in prison than others. Programs also interrupt the deadening boredom of incarceration by providing some level of meaningful activity. Programs can also help inmates develop skills critical for successful reintegration into the community upon release, improving their lives and those of others in American communities.

Transgender inmates are vulnerable to sexual abuse for reasons other inmates are not. Transgender women housed in male detention facilities face many of the same dangers other women would face in a men's prison. It is for this reason that solitary confinement is often called protective custody. However, we must be critical of that system: isolation does not protect people from harm, only from a specific kind of harm. It is our position that transgender inmates can be protected by far less traumatizing and punitive means.

SOLITARY CONFINEMENT IS PUNITIVE

By its nature, involuntary solitary confinement is punitive. It removes people from common human contact, from even the comfort of conversation. It is a constraint on those who are already constrained, a prison within a prison. Transgender inmates who suffer solitary confinement as protective custody solely on the basis of their transgender status are, by definition, being punished for being transgender. Being transgender is not a crime, but transgender people suffer imprisonment beyond their sentences because of who they are. Policies that involuntarily confine victims of sexual assault that occurred during incarceration are even more onerous, and ultimately punish transgender rape victims for their assault.

TRANSGENDER INMATES AS SURVIVORS OF SEXUAL VIOLENCE

In many prisons, transgender inmates are automatically placed in involuntary solitary confinement to protect them from sexual violence. Sometimes they are placed in solitary confinement because they have been raped.

Survivors of sexual abuse suffer distress, anxiety, fear, and other forms of emotional trauma. Solitary confinement can make these feelings worse due to isolation and the inability to be

comforted by other people. Isolation has deep psychological impacts on all people; it compounds the trauma suffered by those who have been abused.

The fear of solitary confinement and the trauma of isolation make abuse survivors less likely to report their abuse, making it harder for them to escape ongoing abusive situations. For example, Laura, a transgender woman we know of was forcibly raped by another inmate while in a men's prison. When she reported the attack, she and her rapist were both placed in segregation. She was placed in a different form of segregation than he was, where she actually had far less time out of her cell, less contact with other inmates, and far more severe and total restrictions on "privileges" such as group religious worship, recreation, and phone calls than her assailant did. She felt that instead of getting help, she got punished, even more severely than the person who raped her.[1] The prospect of protective custody in solitary confinement forces prisoners to make the untenable choice between rape and isolation.

When solitary confinement is necessary to protect an inmate from further sexual abuse, that confinement absolutely must be of minimal duration and solely for the purpose of safety. There must be severe time limits on the duration of involuntary isolation, and the need for that isolation must be reevaluated regularly. Abuse survivors should be able to live in the least restrictive environment possible, have access to all the programs and services they otherwise would receive, and must have access to a certified rape crisis counselor. Solitary confinement must be a last resort and a very temporary solution to sexual violence.

The Prison Rape Elimination Act (PREA) guidelines are not sufficient to ensure that rape survivors experience the least restrictive environment and least duration in isolation necessary for their safety. The standards provide no concrete rules for the maximum duration of isolation and the circumstances under which transgender inmates may be safely housed either in or out of solitary confinement. PREA requires that facilities document the services and programs inmates have been denied as a result of isolation, but it does not mandate that these services and programs be made available. Prisons must only list the freedoms a rape survivor has been denied because of being a rape survivor.

The PREA standards[2] call on corrections officials to provide survivors with access to services and programs and to move these inmates to less restrictive housing as soon as possible.[3] The standards also mandate the provision of emergency and follow-up medical and mental health care, including contact with support services.[4] However, the standards do not place strong enough limits on the time a survivor may involuntarily be placed in solitary confinement. The PREA standards generally limit involuntary solitary confinement for survivors to 30 days.[5] A more appropriate time limit is 72 hours. The standards do call for ongoing, regularly scheduled

[1] Client interview on November 30, 2007 (notes on file with authors).
[2] The Prison Rape Elimination Act Standards available at www.ojp.usdoj.gov/programs/pdfs/prea_final_rule.pdf (last viewed on June 11, 2012).
[3] *Id.* As an example, see the relevant adult jail and prison standard at 115.43.
[4] *Id.* at 115.53, 115.83, and 115.83.
[5] *Id.* at 115.68 (referencing 115.43).

reviews of whether a survivor should be kept in solitary confinement beyond 30 days. However, this review is only required to take place once every 30 days.[6] A more appropriate review schedule would be every 10 days.

The PREA Standards incorporate several critical protections that should be used instead of solitary confinement to protect transgender inmates from abuse. These include staff training on working with transgender people and providing transgender individuals the opportunity to shower separately from other inmates. Most importantly, under the Standards each individual must receive individualized screening for vulnerability to abuse and this screening must be used to make individualized housing and classification decisions. For transgender people, this must include a case-by-case evaluation of whether the individual would be more safely and appropriately housed in a men's or women's facility; this decision may not be made automatically based on the individual's anatomy or assigned sex at birth. Appropriate placements will vary by individual circumstances; however, in some cases it will be safer and more appropriate to house an individual consistent with their gender identity rather than their assigned sex at birth. These individualized determinations are a more effective, appropriate, and constitutional means of ensuring inmate safety than prolonged solitary confinement.

While many agencies have already implemented these approaches, others will require guidance, technical assistance, and oversight to ensure effective implementation. For example, agencies will need to develop appropriate procedures and guiding principles for making individualized housing determinations for transgender people.

TRANSGENDER INMATES IN PROTECTIVE CUSTODY BECAUSE THEY ARE VULNERABLE

Like survivors of sexual abuse in detention, inmates who are vulnerable to sexual abuse are frequently placed in solitary confinement, ostensibly for their own protection. Such punitive housing assignments are inappropriate. Keeping inmates safe is one of the most basic responsibilities of corrections officials. They must be able to ensure the safety of all inmates without resorting to involuntary solitary confinement of those who are the most vulnerable to abuse. This includes inmates who are lesbian, gay, bisexual, transgender, intersex, and/or gender non-conforming, and those who are perceived as such regardless of their identity. Too often, inmates with disabilities, young or old inmates, and other inmates targeted for violence are similarly warehoused in solitary confinement.

In some cases, corrections professionals believe that solitary confinement is in the best interest of the vulnerable inmates. In other cases, however, officials rely on such housing as a quick fix, not taking into consideration the serious harm caused by solitary confinement. In so doing, unsafe conditions in the rest of a facility are allowed to continue unchallenged, making the facility more dangerous for both inmates and staff.

[6] *Id.*

Every effort must be made to create institutions in which involuntary solitary confinement is used only as a last resort. To achieve this goal, the policies and culture of confinement facilities must prioritize creating safe, dignified housing for everyone – including sexual abuse survivors and others who are vulnerable to sexual abuse. When solitary confinement is used as a last resort, it must be used in compliance with the restrictions outlined above.

SOLITARY CONFINEMENT AS PUNISHMENT

Because solitary confinement is by itself punitive, corrections officials sometimes use it as a means of punishing inmates. Rape survivors may be placed in solitary confinement as retaliation for reporting their rapist; in the worst examples, inmates assaulted by corrections staff may be placed in solitary confinement for reporting the abuse. Officials sometimes place transgender inmates in solitary confinement simply because they do not like the inmates or their gender non-conforming status. This type of confinement is abuse and must be taken as seriously as any other form of inmate abuse. Perpetrators must be prosecuted, and procedures must be in place in advance to ensure that accusations of this kind of abuse can be fully investigated. Standards for timely, neutral evaluation must be in place; the short timeline we advocate would help to ensure that if transgender inmates are being housed involuntarily in solitary confinement for abusive reasons, discovery and resolution of the matter would occur immediately.

COSTS TO PRISONS

The mental and emotional costs of solitary confinement to inmates are severe, and the financial cost to prisons is also greater than necessary. We advocate procedures for assessing the necessity of solitary confinement and for the constant reassessment of that necessity. The cost of these procedures would not outstrip the current costs of solitary confinement itself.

In a 2009 report, the California Inspector General estimated that, based on needs for increased staffing and greater physical space, the annual costs per inmate in administrative segregation averaged at least $14,600 more than the annual costs per inmate in the general population.[7] The California Inspector General concluded that the overuse of solitary confinement cost the California Department of Corrections and Rehabilitation nearly $11 million every year.[8]

Corrections administrators often cite cost as one reason why facilities are not made as safe as possible. However, funds spent on inappropriate and abusive use of solitary confinement could be used to establish and implement basic policies and procedures aimed at preventing sexual

[7] California Office Of The Inspector General, Management of the California Department of Corrections and Rehabilitation's Administrative Segregation Population (2009), available at http://www.oig.ca.gov/media/reports/BOA/reviews/Management%20of%20the%20California%20Department%20of%20Corrections%20and%20Rehabilitation's%20Administrative%20Segregation%20Unit%20Population.pdf (last visited June 11, 2012).

[8] *Ibid*

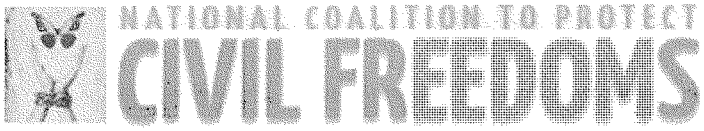
abuse and other forms of violence. Such reinvestment of scarce resources would lead to confinement facilities that are better run and safer all around. It would also prevent the negative health consequences among inmates who are placed inappropriately in solitary confinement. Corrections administrators should be encouraged to begin shifting expenditures in this direction as soon as possible.

INVOLUNTARY SEGREGATION AS A DUE PROCESS CONCERN

The kind of isolation discussed here brings to mind a normative procedural due process consideration: solitary confinement deprives inmates of liberty they otherwise would have. There must therefore be adequate procedures in place to assure that this deprivation does not exist unless it is absolutely necessary, all other avenues have been exhausted, and its use is constantly reevaluated to make sure that it is the only possible means of serving the needs of the inmate and the institution.

CONCLUSION

Solitary confinement is expensive and dangerous. It does not create safer prisons or better behaved or mentally stable inmates. It keeps inmates from being released early, costing the prison system more money for the duration of the incarceration and more money for the type of incarceration for that duration. Solitary confinement is damaging to inmates' mental health and can act as a deterrent for reporting sexual assault. Transgender inmates are disproportionately affected by involuntary segregation compared to the rest of the prison population, and they are forced into solitary confinement often on the basis of their gender identities alone. Less restrictive housing and greater availability of assessment resources would not only be less expensive than solitary confinement, it would also be better for the health and safety of inmates. Solitary confinement should only be used when there are absolutely no other means of housing an inmate; its gross overuse at present is expensive, cruel, prejudicial, and unnecessary.



www.CivilFreedoms.Org

Date: June 14, 2012
TO: Senate Judiciary Committee,
Subcommittee on the Constitution, Civil Rights, and Human Rights
ATTENTION: Nicholas Deml, Nicholas_Deml@judiciary-dem.senate.gov
RE: Subcommittee Hearings on Solitary Confinement

Dear Members of the Subcommittee:

The National Coalition To Protect Civil Freedoms (NCPCF) is a coalition of twenty civil rights, advocacy, and Muslim organizations focused on ending preemptive prosecution, profiling, and prisoner abuse, including solitary confinement. Information about NCPCF and our member organizations can be found on our website at www.CivilFreedoms.Org. We wish to address the subcommittee with respect to its hearings on the abuse of solitary confinement.

NCPCF is Opposed to All Forms of Prolonged Solitary Confinement

Solitary confinement appears in state and federal prison systems under a variety of names and purposes:

Protective Custody (PC): to protect the inmate from violence by other inmates.

Special Administrative Measures (SAMs): to restrict the inmate in some specific way from communicating with others because of particular dangers that might result from such communication.

Special Housing Unit (SHU): to discipline inmates for violations of prison rules.

Communication Management Unit (CMU): to hold certain prisoners in prisons isolated from contact with the outside world so that the voices and ideas of the inmates will be heard as little as possible outside the prison.

Supermax prisons: high-security prisons designed to hold all inmates in solitary confinement.

Two reasons commonly cited by the Bureau of Prisons (BOP) for imposing solitary confinement are prison security and disciplinary punishment. In practice, the courts give wide latitude to prison authorities to provide for their own security and prisoner punishment, and in the past have generally not interfered with decisions to impose solitary confinement on these bases.[1] As a result, the rationale to impose solitary confinement is often contrived. Before trial, an inmate can be placed in solitary confinement for protective custody and then have SAMs added, supposedly for prison security reasons; then be placed in the SHU for disciplinary reasons; and then after conviction be placed in a CMU or a Supermax supposedly for security reasons. However, solitary confinement is often imposed arbitrarily or for improper reasons, such as to break a defendant down to prevent his testimony at trial, or to interfere in defense preparation, or to prevent legitimate communication, or to force the defendant's cooperation in other cases.

It has been well established that prolonged solitary confinement is detrimental to mental health and can cause permanent mental health damage. It is considered a form of torture. For this reason, Juan Mendez, UN Special Rapporteur on Torture, concluded in an October 2011 report that "whatever the name, solitary confinement should be banned by States as a punishment or extortion technique," adding that "the practice could amount to torture." He also stated that "[i]ndefinite and prolonged solitary confinement in excess of 15 days should also be subject to an absolute prohibition...citing scientific studies that have established that some lasting mental damage is caused after a few days of social isolation."[2] As a form of torture, solitary confinement is also prohibited by numerous treaties and laws.

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[1] The Constitutional framework for considering solitary confinement is set forth in *Turner v. Safley,* 482 U.S. 78 (1987), in which the Supreme Court held that courts can consider prison regulations that place a "burden on fundamental rights." The courts must first examine whether the regulation in question (solitary confinement) is "reasonably related" to legitimate penological objectives, or whether it represents an "exaggerated response" to those concerns; second, whether there are alternative means for the prisoner to exercise the fundamental right at issue; third, the impact that the desired accommodation will have on guards, other inmates, and prison resources; and fourth, the absence of "ready alternatives." (*Turner* at 87–91.) Where the prisoner is being held in solitary confinement before trial, an additional consideration is that the due process clause of the U.S. Constitution prohibits the inmate from being punished for the crime before being convicted of it. Punishment is a legitimate objective of solitary confinement only after conviction. *Bell v. Wolfish,* 441 U.S. 520, 537 n. 16 (1979). However, the *Turner* court also held that in conducting a review, the courts must give great deference to the Bureau of Prisons' determination because the courts are "ill-equipped to deal with the increasingly urgent problems of prison administration and reform." (*Turner* at 84–85.) As a result, few courts have overturned BOP decisions.

Notwithstanding the clear illegality of the practice, the last decade has seen torture and solitary confinement gain acceptance in military, penal, and law enforcement practices, both in the U.S. and through secret renditions abroad. Prolonged solitary confinement is now probably the most widely practiced method of torture in the U.S. Numerous studies, and the testimony of those who have experienced prolonged solitary confinement, establish how powerful a form of torture it is to experience the intense pain, disorientation, confused thinking, loss of speech, paranoia, and induced insanity that accompanies prolonged solitary confinement.[3] As psychologist Craig Haney of the University of California-Santa Cruz, an expert on long-term solitary confinement, has stated:

> [Solitary confinement] is itself a painful and potentially harmful condition of confinement...[I]t has historically been a part of torture protocols. It was well documented in South Africa. It's been used to torture prisoners of war... it is a very painful experience....It's certainly profoundly damaging if people lose hold of their own sanity. For some people their sense of themselves changes so profoundly and so fundamentally that they are unable to regain it.[4]

The use of torture and solitary confinement does enormous damage to the United States of America. It destroys our moral authority; undermines due process and the rule of law; infects our legal system with coerced statements and false pleas of guilty; impairs our relationship with other countries and cultures that abhor torture; and makes them question how they can cooperate with such a system without themselves becoming complicit.

Torture is so clearly illegal that the U.S. government has made elaborate efforts to conceal its illegal torture activities, establishing hidden "black" sites and secret illegal rendition agreements with other countries. Transparency and accountability have been lost. With no clear purpose or

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[2] "Solitary confinement should be banned in most cases, UN expert says," UN News Centre, http://www.un.org/apps/news/story.asp?NewsID=40097

[3] "Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement" by Craig Haney and Mona Lynch, *23 N.Y.U. Review of Law and Social Change* 477, 531 (1997).

[4] "Solitary Confinement: The Invisible Torture" by Brandon Keim, *Wired Science*, April 29, 2009, http://www.wired.com/wiredscience/2009/04/solitary confinement/

policy in place, the treatment of inmates has been left to whatever sadistic or vengeful motives may inhabit the authorities in charge. Thus NCPCF opposes all forms of prolonged solitary confinement not only because it is torture, but because it is also bad prison policy. It damages the prisoner's mental health and fails to prepare them for eventual release. Why would the U.S. deliberately damage prisoners' mental health, only to release them back into society? It makes no sense.

With so many reasons to reject torture and solitary confinement, why is the practice increasing? There are general reasons for this, including the increased use of private prisons, the warehousing of prisoners, and the abandonment of attempts to "correct" or "reform" prisoners' behavior. However, one significant reason seems to be the increased reliance by American law enforcement officers on coerced statements and cooperation from inmates to obtain information and convictions. Solitary confinement is thought to "soften" inmates up and make them more susceptible to giving up information. As with any form of torture, solitary confinement may become so painful that inmates will agree to cooperate, but there is no guarantee that this cooperation will provide truthful information. Solitary confinement induces mental confusion, disorientation, and the inability to think clearly, though interrogators believe that it can give them an advantage in planting ideas in an inmate's mind and extracting information that law enforcement officers want to hear.

As David Hicks stated about his experience with solitary confinement:

> Talking becomes difficult, so when conversations do take place you cannot form words or think...[C]oherent sentences become elusive and huge mental blanks become common, as though you are forgetting the very act of speaking. Everything you think and know is dictated by the interrogators. You become fully dependent with a childlike reliance on your captors...It was a constant struggle not to lose my sanity and go mad. It would have been so easy just to let it go; it offered the only escape.[5]

Because interrogation under such circumstances is inherently coercive and brainwashing, there is great danger that testimony or information obtained in this manner will be unreliable or false.

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[5] "David Hicks: One of Guantanamo Bay's First Detainees Breaks His Silence" by Jason Leopold, *Truthout*, February 16, 2011, http://www.truth-out.org/exclusive-an-interview-with-former-guantanamo-detainee-david-hicks67818

Specific Objections Based on NCPCF's Mission

NCPCF would like to focus this statement on two aspects of solitary confinement that are of particular concern to its mission:

1. Pre-trial Solitary Confinement, Protective Custody, and Special Administrative Measures (SAMs)

In the last decade, there has been a great increase in the use of prolonged solitary confinement for defendants awaiting trial at a time when the defendants, by law, are presumed innocent. In national security (terrorism) cases especially, federal prisons tend to place defendants in pre-trial solitary confinement for security reasons based solely on the allegations of the charges (which are often based on questionable sting operations), disregarding the possibility that the defendant may be factually innocent or entrapped, and disregarding often substantial evidence that the defendants are only marginally involved and are not dangerous. To avoid the appearance that the defendants were placed in pre-trial solitary confinement as punishment (before having been found guilty, which would be illegal), prisons often claim that the charges by themselves establish how dangerous the defendant can be—that solitary confinement is necessary for security reasons and not as punishment for crimes yet untried. A recent terrorism case in Kentucky is a good example of this. Of two co-defendants, one has been held pre-trial in solitary confinement for a year, while the other pleaded guilty and has been moved to general population and allowed to socialize, watch TV, and participate in recreation. "When asked if federal authorities were trying to coerce a guilty plea…by putting [his client] in solitary confinement, [defense lawyer Jim] Earhart said he…found the differing circumstances…curious. 'It seems more than coincidental,' Earhart said. 'The only difference I can see between them is one pleaded guilty and one hasn't.'"[6]

Until recently, the courts have shown little inclination to interfere with such BOP determinations even when these claims are patently ridiculous. However in *U.S. v. Viktor Bout* (USDC, SDNY, 2012), a Court held on February 24, 2012 that a defendant was improperly held in solitary confinement in the SHU for fourteen months (before and after conviction), notwithstanding that

[6] "Attorney: Terror suspect isolated for a year" by Brett Barrouquere, Associated Press, June 11, 2012, http://www.timesunion.com/news/article/Attorney-Terror-suspect-isolated-for-a-year-3625138.php

he was found guilty of terrorist-related charges for conspiring to supply arms to kill American citizens. Prison authorities claimed that the defendant had to be held in solitary confinement because of the serious nature of the charges, the defendant's vast resources and connections with violent criminal associates, his leadership abilities with both the inmates and people who might try to rescue him from outside, and his general ability to "control and influence people." (The prison also noted that the case had received "broad publicity, which could place [the defendant] at risk and abuse by other inmates"—thus invoking the Protective Custody rationale described above.) Notwithstanding these concerns, the Court directed that the defendant be returned to the general population of the prison, stating "There is no valid rational connection between the BOP's decision to keep Bout in the SHU for more than fourteen months and any legitimate governmental interests put forth to justify it." The BOP failed to give any particularized explanation about why the defendant was a security risk who required such drastic measures. The judge also noted that "[i]t is well documented that long periods of solitary confinement can have devastating effects on the mental well-being of a detainee." (Decision, page 9.)

Notwithstanding the *Bout* decision, many defendants, especially those charged in national security cases, are placed in solitary confinement from the moment they are charged, based solely on the allegations of the criminal complaint. Defendants awaiting trial must focus their attention on cooperating with their lawyers to prepare a defense and on preparing themselves to testify at their trial; solitary confinement is a substantial burden on both these activities. Solitary confinement dulls the ability of many prisoners to think and communicate; words are hard to form, ideas become difficult to express, speech is impaired, and it becomes difficult to communicate with lawyers about possible defenses. Moreover, some defendants under prolonged solitary confinement experience panic attacks and paranoia. This paranoia may be directed against the lawyer. The defendant may think, "If my lawyer was really working on my behalf, why am I still in solitary confinement? Perhaps my lawyer is working against me." The trust necessary between the client and the lawyer is undermined.

Moreover, at trial the defendant may find it impossible to speak articulately or to express thoughts in a way that the jury can understand. Solitary confinement can destroy a defendant's ability to communicate, which may preclude the defendant from testifying on his own behalf. As a result, the longer defendants are held in solitary confinement, the greater the pressure to plead guilty to avoid a trial for which defendants are ill-prepared; they may become so disoriented and unable to testify that they feel they have no alternative but to plead guilty. Even

if they decide to go to trial, such defendants often do not testify on their own behalf. Prolonged pre-trial solitary confinement and the torture inherent in it amounts, in many cases, to a denial of counsel, of a fair trial, of an opportunity for the defendant to testify in his or her own defense, and of due process.

For example, in *U.S. v. Mohammed Warsame,* the government held the defendant in solitary confinement for five and a half years until he asked to plead guilty to something so that he could escape the torture of solitary confinement. When he was finally allowed to plead guilty, he was released soon afterwards. Before he pled guilty, however, the BOP claimed that he was so dangerous by virtue of the charges against him that he could not safely be allowed to interact with anyone else—but once he pled guilty and served a few more months in jail, the government was willing to release him. This case, and many others like it, reflects the hypocrisy and unfairness of the government in falsely claiming that a defendant is dangerous based on the charges alone. The purpose of solitary confinement was obviously to pressure the defendant into cooperating or pleading guilty to a charge that the government was not prepared to prove.

The problems of preparing a defense are multiplied when the defendant is placed under Special Administrative Measures, or SAMs. SAMs were originally created to prevent organized crime figures from running their crime empires from jail, or from threatening witnesses into not testifying; the SAMs were focused on specific security restrictions and were no more restrictive than necessary to meet the specific dangers presented. Today, however, SAMs have evolved into a system to subvert the defense. SAMs now typically require that people who have spoken to the defendant are prohibited from speaking to other people about the conversation—including the defendant's own lawyer. If the defendant's family becomes concerned about the defendant's mental condition, they cannot speak about it to the lawyer. If lawyers want to talk to witnesses, they cannot refer to things the defendant has told them. After consulting with the client, the lawyer cannot event communicate information to members of the defense team. SAMs destroy zealous representation and the trust between attorney and client. How can a client have any trust in a lawyer who is so restricted and controlled by the prosecution that if the lawyer publicly mentions anything that the client spoke about, the lawyer can be prosecuted and given a long prison sentence. (See *U.S. v. Lynne Stewart* for an example of a lawyer who made one public statement about a conversation with a client who was under SAMs, and was given a ten-year prison sentence.)

2. Post-Trial Solitary Confinement: Supermaxes and CMUs

After trial, defendants can be given years in prison in solitary confinement. Although the decision as to whether the defendant must serve the sentence in solitary is one of the most important aspects of the sentence, the courts have no control over it. Only the BOP decides where a sentence will be served, and if it will be served in a Supermax or other prison where solitary is the norm. It is astonishing that this decision—whether a defendant will be potentially tortured for the rest of his life in solitary—is completely out of the control of the courts. NCPCF believes that prolonged solitary confinement should be abolished in all its forms, but that if any such issues remain, solitary confinement should be imposed only on approval of the courts after a full due process hearing at which all sides can be heard. Allowing the BOP and the Department of Justice to determine whether prisoners should serve their sentence under solitary confinement gives the prosecution an enormously unfair advantage and a method of pressuring defendants into pleading guilty or giving false testimony in a deal to escape the torture of solitary confinement.

In December 2006, the Bush Administration quietly—and in violation of the Administrative Procedure Act of 1946—opened a special prison in Terre Haute, Indiana to hold predominantly Muslim prisoners. Called a Communication Management Unit, or CMU, this Muslim prison was designed to restrict communication between the inmates and the outside world in what might be described as collective or group solitary confinement. The BOP opened the prison without complying with legal requirements, and in 2010, in *Aref et al. v. Holder et al.,* some inmates sued to close the CMU because it was illegally opened. In March 2011, a judge permitted the case to go to trial on a number of due process issues, including the arbitrary way that prisoners are assigned to the CMU. A trial date is expected soon.

There are now two CMUs: one at Terre Haute, Indiana and one at Marion, Illinois. The prisons were apparently designed to prevent prisoners who have ideologies abhorrent to the government from allowing their ideas to disseminate throughout the prison system and the general public. In fact, however, the restrictions on communication seem designed to prevent the prisoners from demonstrating the unfairness of their convictions and their unjust treatment by the government. The restrictions on communication put a tremendous burden on prisoners' families. Moreover, locating both prisons in the middle of the United States makes it very difficult for families from the coasts of the U.S. to visit their loved ones. A round trip by car from either coast can require as much as a week.

The two CMUs in some ways resemble the prison at Guantanamo Bay, Cuba. At Guantanamo, hundreds of Muslim prisoners were incarcerated for years under conditions amounting to torture, although it is now known that approximately 80 percent of the prisoners there were innocent and that the government knew they were innocent. In the same way, the CMUs now house dozens of Muslim prisoners, most of whom are innocent of real terrorism charges or grossly overcharged. Like the Guantanamo prison, the primary purpose of the CMUs seems to be to harass and abuse the prisoners because of their Muslim faith. For example, although the two CMUs have a majority of prisoners who are Muslim, the CMUs refuse to serve the inmates halal (religiously approved) meals, although in other prisons, other faiths receive meals appropriate for their religious beliefs.

Recently Marion CMU Muslim prisoners complained that the guards refuse to allow them to pray together. Other faiths can pray together; only Muslims cannot. Marion's Muslim prisoners are allowed recreation and exercise in groups, but not congregational religious prayer, although that is a basic requirement of the Islamic faith. The prisoners have reported to us that the guards also routinely show disrespect for them and their faith by regularly throwing the holy Qur'an on the floor and by making insulting comments about Prophet Mohammed and Islam. Although all other religious groups get special meals and consideration on religious holidays, the guards at Marion do not provide special meals on the two Muslim religious holidays, and they don't accommodate Muslim prisoners who voluntarily fast, although they do accommodate them during Ramadan (when prisoners must break their fast and thus eat only after sundown). In a prison in which a majority of prisoners are Muslim, there is simply no excuse for such disrespect. The Marion CMU prisoners became so upset over the continual harassment and insults from the guards and from Warden Wendy Roal that they went on a hunger strike, and were joined in solidarity by the non-Muslim inmates. Communication with the prisoners has since been cut off by the CMU administration, perhaps reflecting the real communication that the prisons seek to "manage": that the prison is denying the prisoners their constitutional right to practice their religion, and that the CMUs perpetuate segregation and racism in the U.S.

To the extent that the CMUs are America's second ethnic prisons (the first being the internment camps for the Japanese during World War II), they are a disgrace that flaunts the equal protection clause of the Constitution and the freedom of religion clause of the Bill of Rights. To the extent that they are ideological prisons designed to repress dissidents, they violate the right of

people, including prisoners, to speak freely. CMUs serve no purpose other than to discriminate offensively, and they should be closed.

Recommendations

1. Prolonged solitary confinement should be prohibited as torture. Prisoners should not be subjected to solitary confinement for more than fifteen days, and only for disciplinary punishment after following proper due process requirements. High-security Supermax prisons should no longer use solitary confinement as a standard method of housing inmates.

2. Pre-trial solitary confinement should be prohibited. SAMs should be imposed only by the courts after a particularized showing of special circumstances as to why some restrictions of confinement are necessary. The court should be required to impose only the least-restrictive conditions that will meet the particular needs proved by the government after a due process hearing. Since the defendant is entitled to the presumption of innocence, little or no weight should be given to the seriousness of the charges. Rather, the issue should be what particular facts outside the charges require that restrictions be placed on the confinement of the defendant.

3. Congress should require that the CMUs be closed. Although a court trial is presently being scheduled as to whether the CMUs were illegally constituted, an eventual court decision may be inconclusive or a long way off. Congress should exercise its independent power now to close these two ethnic prisons that serve no purpose other than to allow guards to harass and abuse Muslims for observing their faith.

4. Protective custody should be imposed only with the consent of the inmate.

Respectfully Submitted,

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Testimony of Organizations Supporting LGBT Equality

Senate Judiciary Subcommittee on the
Constitution, Civil Rights, and Human Rights

June 19, 2012

Mr. Chairman Durbin and Members of the Judiciary Committee:

We thank Chairman Durbin and the Judiciary Committee for holding the first Senate hearing to consider the extensive human rights, fiscal, and public safety consequences of solitary confinement in U.S. prisons, jails, and detention centers. The undersigned organizations working to secure policies that benefit the lives of lesbian, gay, bisexual, and transgender (LGBT) people urge the Committee to not only consider the detrimental consequences of solitary confinement for the general prison population, but to also consider the especially severe effect on LGBT prisoners and LGBT immigrant detainees.

Solitary confinement is overused and abused by many correctional facilities in the U.S. at the high cost of the psychological, physical, and emotional well-being of those confined. Solitary confinement should only be used as a last measure to ensure inmate welfare and not as a routine procedure, as is so commonly the case across the United States. As this historic hearing will demonstrate, the effects of solitary confinement are devastating and far-reaching, as prison officials corral more vulnerable inmates into confinement rather than working to ensure a safer general population. This is especially true for transgender inmates.

We urge the Committee to not only seriously consider solitary confinement's consequences to the general prison population, but also the especially severe consequences for transgender prisoners. Transgender inmates are already at higher risk for discrimination and violence in the prison setting and are often placed in solitary confinement because prison officials deem them more vulnerable to sexual abuse. However, placing transgender prisoners in solitary confinement causes excessive harm by denying inmates services and programs, external support systems, and human interactions upon which they rely for survival. The Committee's timely hearing will demonstrate the dire need for U.S. correctional facilities to better protect inmates from the long-term damage caused by solitary confinement.

Transgender Inmates are Disproportionately Housed in Solitary Confinement

Though data on the experiences of transgender people in prison and jails is limited, recent data from the groundbreaking report *Injustice at Every Turn: A Report from the National Transgender Discrimination Survey*, conducted by the National Gay and Lesbian Task Force and the National Center for Transgender Equality, found that transgender people are more likely to be imprisoned than non-transgender people. Of the 6,450 transgender people surveyed, 16% reported being sent to jail or prison "for any reason," with rates of incarceration at 47% for Black respondents and 30% for American Indians. Comparatively, a 2003 Department of Justice report

shows that 2.7% of the general population is imprisoned at some point in life. Because transgender people are incarcerated at higher rates than the general population, they likely represent a larger percentage of the prison population.

Solitary confinement has become U.S. correctional facilities' quick fix for "protecting" transgender inmates from the unsafe conditions of the general prison population that remain unaddressed, effectively punishing inmates for their identities and for being victims of abuse. According to data from the U.S. Department of Justice, inmates placed in male prisons who are smaller in stature, display feminine traits or features, or are known to be gay are at a higher risk for physical and sexual assault.[1]

Injustice at Every Turn found that 16% of transgender people in prisons or jails were physically assaulted and 15% were sexually assaulted.[2] For black transgender respondents, 34% reported sexual abuse while in prison or jail.[3]

Because nearly all transgender inmates are placed into sex-segregated facilities based on their sex assigned at birth and not on their gender identity, transgender women are frequently placed in men's facilities, and transgender men are frequently placed in women's facilities.[4] When prison officials make these incongruous placements, inmates are singled out for scrutiny, harassment, and abuse by other inmates and prison staff.

The impact of placing transgender inmates in facilities inconsistent with their gender identity is seen in the data as well. *Injustice at Every Turn* found that 21% of transgender women housed in men's facilities reported experiencing physical abuse and 20% reported incidents of sexual abuse while in prison or jail. For transgender men, 11% of those placed in women's facilities reported physical abuse, and 6% reported sexual abuse. In addition transgender men are more often in danger of assault *by prison staff* than their transgender female peers.

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[1] Ally Windsor Howell, A Comparison of the Treatment of Transgender Persons in the Criminal Justice Systems of Ontario, Canada, New York, and California, 28 Buff. Pub. Int. L.J. 133, 151 (2010)

[2]Grant, Jamie M. et. al. Injustice at Every Turn: A Report of the National Transgender Discrimination Study. Available at http://www.endtransdiscrimination.org/PDFs/NTDS_Report.pdf

[3] Id.

[4]Ally Windsor Howell, A Comparison of the Treatment of Transgender Persons in the Criminal Justice Systems of Ontario, Canada, New York, and California, 28 Buff. Pub. Int. L.J. 133, 145 (2010) citing Amnesty Int'l USA, Stonewalled: Police Abuse and Misconduct Against Lesbian, Gay, Bisexual and Transgender People in the U.S. 59-63 (2005), *available at* http://www.amnestyusa.org/outfront/stonewalled/report.pdf; Stop Prisoner Rape & the National Prison Project of the ACLU, Still in Danger: The Ongoing Threat of Sexual Violence against Transgender Prisoners (2005), *available at* http://www.justdetention.org/pdf/stillindanger.pdf; Human Rights Campaign Found., Transgender Americans: A Handbook for Understanding 44-46 (2005), *available at* http://www.hrc.org/documents/Transgender_handbook.pdf. For examples of anecdotal evidence, see Oliver Libaw, *Prisons Face Dilemma with Transgender Inmates: Inmates Who Look Like Women, Housed with Men*, ABC News (Jan. 22, 2005), *available at* http://abcnews.go.com/US/story? id=90919&page=1 (last visited May 1, 2010); Cosmo Garvin. *What's she doing in the men's jail?* News Review, Feb. 13, 2003, http:// www.newsreview.com/sacramento/content?oid=14229. See also: Interview with anonymous inmate, Female-to-male Transsexual Prisoner, Gender Coalition meeting in Albany, N.Y. (Mar. 25. 2006) (notes on file with author) [hereinafter March 25 Interview].

As transgender inmates are at higher risk for physical and sexual assault because of their identities, they are disproportionately placed in solitary confinement "for their safety." While solitary confinement can protect inmates from the unaddressed dangers of the general prison population, it exposes them to assault by prison staff and generally tends to exacerbate their fear, anxiety, and isolation by depriving them of community based support, resources and programming available to inmates in the general prison population.

Treatment of Transgender Inmates while in Solitary Confinement

Solitary confinement severely restricts the movements and privileges of transgender inmates on the basis of their marginalized identities. Like other inmates who are placed in solitary confinement, transgender inmates are allowed at most an hour outside of their cell per day, with some inmates reporting as little as five to ten minutes each day.[5] If inmates are fortunate, they may be able to shower once a week, but often times, showers are less frequent.[6] While in solitary confinement, inmate access to prison programming, such as educational classes, laundry, the prison library, and other prison facilities, is severely restricted or denied altogether.[7] Necessary medical care is also sometimes altogether denied while in solitary confinement.[8]

The denial of medical care that is often inherent in use of solitary confinement may have additional disturbing consequences for transgender people. Twelve percent (12%) of transgender respondents surveyed in jail or prison reported being denied routine non-transition related healthcare and 17% report being denied hormone treatment. Transgender people of color also reported higher rates of denial of hormone treatment with American Indians reporting 36% denial and Black respondents at 30% denial.[9] The general denial of necessary medical treatment for inmates in solitary confinement compounded with the rates of medical care denial for transgender inmates in the general prison population implies there may be even more dire consequences for transgender inmates.

While solitary confinement arguably "protects" transgender prisoners from assault perpetrated by the general population, it increases inmates' risk for assault and harassment by prison staff, a documented source of abuse for transgender inmates.[10] As confirmed by *Injustice at Every Turn*, of respondents who went to jail and/or prison, 37% reported they were harassed by correctional officers or staff. Respondents of color experienced higher rates of officer/staff harassment than

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[5] Ally Windsor Howell, A Comparison of the Treatment of Transgender Persons in the Criminal Justice Systems of Ontario, Canada, New York, and California, 28 Buff. Pub. Int. L.J. 133, 191-92 (2010)

[6] Id.

[7] Id.

[8] Estelle v. Gamble, 429 U.S. 97, 109 (1976)

[9] Grant, Jamie M. et. al. Injustice at Every Turn: A Report of the National Transgender Discrimination Study. Available at http://www.endtransdiscrimination.org/PDFs/NTDS_Report.pdf

[10] Christine Peek, Breaking Out of the Prison Hierarchy: Transgender Prisoners, Rape, and the Eighth Amendment, 44 Santa Clara L. Rev. 1211, 1240 (2004) citing Schwenk v. Hartford, 204 F.3d 1187, 1192 (9th Cir. 2000) (transsexual plaintiff alleged attempted rape by a Washington state prison guard); Darren Rosenblum, "Trapped" in Sing Sing: Transgendered Prisoners Caught in the Gender Binarism, 6 Mich. J. Gender & L. 499, 525 (2000) (citing Meriwether, 821 F.2d at 410). See also James Robertson, A Clean Heart and an Empty Head: The Supreme Court and Sexual Terrorism in Prison, 81 N.C. L. Rev. 433, nt. 101, at 446 (2003). "Because transsexuality and homosexuality are often conflated, officials may also consider transgender inmates appropriate targets."

their white peers, with Latinas/os at 56%, black respondents reporting 50%, and multiracial individuals reporting 44%. Transgender male inmates experienced officer/staff harassment at higher incidence (44%) than their transgender female (40%) peers.[11]

These practices and experiences reflect the punitive nature of solitary confinement and demonstrate that while the intent may be to protect transgender inmates from some general population risks, forced solitary confinement often results in undeserved punishment that causes more harm to already vulnerable inmates.

Effects of Solitary Confinement on Transgender Prisoners

In addition to transgender inmates experiencing the punishing restrictions of solitary confinement and heightened risk of physical and sexual abuse by prison staff, the mental and emotional effects of solitary confinement are severe and long-lasting. Prisoners in solitary confinement develop psychopathologies at higher rates than those in the general population (28% v. 15%),[12] and have been found to engage in self-mutilation at rates higher than the general population.[13] In an extensive study of the Pelican Bay State Prison in Del Norte, California, researcher Dr. Stuart Grassian found that prisoners who had been in solitary confinement had "high anxiety, nervous-ness [sic], obsessive ruminations, anger, violent fantasies, nightmares, trouble sleeping, as well as dizziness, perspiring hands, and heart palpitations."[14]

For all prisoners in solitary confinement, but especially for transgender prisoners who are more vulnerable to sexual assault by prison officials or staff, the mental and emotional impact of solitary confinement impacts inmates' lives beyond their prison sentences.

Recent data suggests a correlation between solitary confinement and suicide attempts. A recent study from 2005 of the 44 inmates who committed suicide in the California prison system showed that 70% were housed in solitary confinement.[15] Another study from 2007 on suicide attempts in prison documented that solitary confinement is a major factor in suicidal ideation and suicide attempts.[16]

Given the overuse of solitary confinement as placement for vulnerable transgender inmates and the prevalence of suicide attempts among the transgender population, the correlative data on suicide and solitary confinement is especially troubling. Data from *Injustice at Every Turn*

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[11] Grant, Jamie M. et. al. Injustice at Every Turn: A Report of the National Transgender Discrimination Study. Available at http://www.endtransdiscrimination.org/PDFs/NTDS_Report.pdf

[12] Andersen, H. S., Sestoft, D. D., Lillebæk, T. T., Gabrielsen, G. G., Hemmingsen, R. R., & Kramp, P. P. (2000), —A Longitudinal Study of Prisoners on Remand: Psychiatric Prevalence, Incidence and Psycho-pathology in Solitary vs.Non-Solitary Confinement.l *Acta Psychiatrica Scandinavica*, 102(1), 19.

[13] Haney, C., & Lynch, Mona. (1997), —Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement.l *New York University Review of Law and Social Change* 23: 477-570.

[14] Rodriguez, Sal. Fact Sheet: Psychological Effects of Solitary Confinement. Solitary Watch. (available at http://solitarywatch.files.wordpress.com/2011/06/fact-sheet-psychological-effects-of-solitary-confinement2.pdf) last accessed June 14, 2012.

[15] Thompson, Don. Convict Suicides in State Prison Hit Record High. Associated Press, January 3. (2006).

[16] Suto, I. Inmates Who Attempted Suicide in Prison: A Qualitative Study. School of Professional Psychology. Paper 46 (2007).

reflects that a staggering 41% of transgender people had attempted suicide, compared to 1.6% of the general population. Suicide attempts were even higher for transgender people of color, with rates at 56% for American Indians and 54% of multiracial people.

Of all transgender people who were incarcerated at some point, the suicide attempt rate rises to 52%. However, for those who were incarcerated 3-5 years, the suicide attempt rate is 60%. For those that are incarcerated for five or more years, 70%. It is possible that the over-usage of solitary confinement during imprisonment contributes to the increased suicide attempts.

Solitary Confinement of Transgender Immigrant Detainees

While placements of transgender inmates in solitary confinement within prisons, jails, and correctional facilities around the U.S. are generally unwarranted and create lasting detrimental consequences, transgender immigrant detainees placed in solitary confinement in detention facilities also experience negative outcomes.

Many of the approximately 32,000 immigrant detainees being held in the United States have not committed any criminal offense, but are awaiting a judge's determination of deportation proceedings.[17] Despite the fact that Immigration and Customs Enforcement detention is not designed to be punitive, many of the detainees are treated as criminals. Transgender immigrant detainees are no exception to this practice and are often treated far worse; they may be placed in solitary confinement for the same reasons as transgender inmates: convenience for prison officials, consequences of housing placements based on sex assigned at birth, and refusal to address safety issues in the general detainee population that make transgender detainees more vulnerable to physical and sexual assault.

Cases of transgender immigrant detainees experiencing sexual assault at the hand of detention officers, and denial of health care have been reported.[18] A recent complaint from the National Immigrant Justice Center details mistreatment of more than a dozen LGB and transgender detainees in California, Pennsylvania, Texas and other states. The complaint details a sexual assault against a transgender detainee while being transported to an immigration hearing, as well as accounts of prison officials' ignorance, or in some cases total indifference, to the needs and vulnerable status of transgender detainees. [19]

In another appalling recent account, Victoria Arellano, a 23-year-old HIV-positive transgender undocumented immigrant was detained at a traffic stop. While in detention for two months, Arellano's health quickly deteriorated, and she was not sent to the infirmary until her fellow

[17] Harmon, Andrew "Eight Months in Solitary" The Advocate. May 7, 2012. Available at http://www.advocate.com/news/news-features/2012/05/07/transgender-detainees-face-challenges-broken-immigration-system?page=0,0

[18] Restore Fairness. *A transgender detainee speaks out.* Breakthrough TV; 2009. Available at: http://vimeo.com/7551045.

[19] Harmon, Andrew "Eight Months in Solitary" The Advocate. May 7, 2012. Available at http://www.advocate.com/news/news-features/2012/05/07/transgender-detainees-face-challenges-broken-immigration-system?page=0,0; citing "Stop Abusing of LGBT Immigrants." National Immigrant Justice Center available at http://www.immigrantjustice.org/stop-abuse-detained-lgbt-immigrants.

detainees, who had been caring for her, staged a protest. When she finally was taken to a hospital two days later, her symptoms were too far gone and she died of an AIDS-related infection. Her family filed a wrongful death lawsuit in federal court.[20]

This is just one example of the horrific experiences of transgender detainees in immigrant detention facilities, and being in solitary confinement can worsen their ability to get help when needed. The Committee's consideration of the effects of solitary confinement on transgender people must include an analysis of the consequences for the most vulnerable and voiceless transgender people in immigration detention.

Conclusion

Solitary confinement affects many people incarcerated in U.S. jails, prisons, and detention facilities, but none so significantly as transgender inmates and immigrant detainees involuntarily confined not because of their actions, but because of their identities. A full review of the inhumane practice of solitary confinement and its far-reaching consequences cannot ignore the experiences of this extremely vulnerable group of people.

The United States must discontinue the discriminatory use of solitary confinement for housing transgender inmates and immigrant detainees . Prison officials and staff must commit to changing the dangerous and abusive conditions of the general prison population, rather than punishing transgender inmates and detainees for their very existence. By creating prison environments sensitive to the experiences and identities of transgender inmates and detainees, sexual abuse reporting and enforcement becomes transparent.

We applaud the Committee taking the first important step by holding this historic hearing. However, important work still remains to ensure that transgender inmates and detainees are exposed to solitary confinement only in extreme and rare circumstances.

Sincerely,

Lambda Legal
National Center for Lesbian Rights
National Center for Transgender Equality
National Gay and Lesbian Task Force Action Fund
National Latina Institute for Reproductive Health
Transgender Law Center

[20] Hernandez, Sandra. A lethal limbo. *Los Angeles Times.* 2008. Available at: http://articles.latimes.com/2008/jun/01/opinion/op-hernandez1.



National Immigrant Justice Center

Testimony by Mary Meg McCarthy,
Executive Director, Heartland Alliance's National Immigrant Justice Center

Submitted to the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights
Hearing on Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences

June 19, 2012

Heartland Alliance's National Immigrant Justice Center (NIJC) applauds Senator Richard Durbin for initiating the first congressional hearing on solitary confinement. NIJC appreciates the opportunity to submit this statement for the record to document the misuse of solitary confinement in immigration detention.

Since its founding 30 years ago, NIJC has safeguarded the rights of non-citizens, particularly those held in immigration detention. Each year, NIJC and its unparalleled network of 1,000 *pro bono* attorneys provide legal counsel and representation to nearly 10,000 individuals. NIJC also conducts regular "Know Your Rights" presentations in immigration detention facilities, operates a detention hotline, and responds to correspondence from detainees throughout the country. In each capacity, NIJC encounters individuals who have been held in solitary confinement for prolonged periods of time with weak or no justification.

As co-chair of the Department of Homeland Security (DHS)/Nongovernmental Organization (NGO) Enforcement Working Group, NIJC facilitates regular dialogue between the federal government and 100 human rights organizations, legal aid providers, academics, and immigrant rights groups on issues of immigration enforcement and detention. NIJC is also a leading voice within the Midwest Coalition for Human Rights, a network of 56 organizations, including human rights groups, service providers, and academic institutions, that promote and protect human rights in the Midwest. In these and other coalitions, NIJC elevates our clients' stories to press for systemic policy change.

Today, we call on Congress to hold DHS accountable for the misuse of solitary confinement in immigration detention. NIJC offers the following recommendations, described in detail below:

1. Congress should require DHS to implement legally enforceable regulations to govern the use of solitary confinement.
2. DHS must track the use of solitary confinement to assess the extent to which non-citizens are held in solitary confinement and prevent future abuse.
3. DHS must regularly inspect facilities and monitor compliance with regulations. Failure to comply with regulations must be a basis to end contracts.
4. DHS should end the inappropriate use of solitary confinement, particularly for individuals with mental health and chronic medical conditions, LGBT detainees, and other vulnerable populations.
5. Congress should encourage DHS to give meaningful consideration to alternatives to detention for vulnerable populations who would be held in isolation.
6. DHS must require immigration detention facilities to properly investigate accusations against detainees before placing individuals in disciplinary segregation. DHS must also require facilities to afford detainees an opportunity to confront the evidence against them.

Background

Immigration detention is the fasting growing incarceration system in the United States.[1] Each year, DHS detains nearly 400,000 men, women, and children in a patchwork of 250 facilities, including county jails and prisons operated by private corporations. Individuals are held in civil custody for immigration violations. They are not being punished for criminal conduct, so they are not afforded procedural protections such as a right to appointed counsel. Even without procedural protections, however, immigrant detainees are subject to the same detention policies as criminal detainees, including policies that govern the use of solitary confinement.

In April 2011, NIJC filed a mass complaint with DHS' Office of Civil Rights and Civil Liberties (CRCL) on behalf of 13 detained LGBT immigrants who were targeted for physical, sexual, and emotional abuse in immigration detention.[2] In October 2011, four additional DHS detainees joined the civil rights complaint. Many of these individuals were inappropriately held in solitary confinement, often for months at a time without formal determinations of the necessity of solitary confinement and without an appeals process.

NIJC continues to represent dozens of clients who have been improperly isolated from other detainees. We continue to receive letters from non-citizens who are languishing in detention. Yet we can only reach a small fraction of the 400,000 people in immigration detention each year. DHS can and must take steps to proactively track and oversee the use of solitary confinement.

Lack of Regulations and Data

- **DHS detention standards are not legally enforceable.**

  This year, DHS released long-awaited Performance-Based National Detention Standards (PBNDS) to address critical human rights concerns in the system. While the release of the PBNDS acknowledges the need for reform, the administration can only ensure humane and fair treatment of detained individuals by issuing legally enforceable regulations.

- **DHS has failed to track solitary confinement policies and procedures.**

  If asked today, DHS would be unable to describe when, how often, and why any immigrant detainee is placed in solitary confinement. Without statistics from DHS, it is impossible to accurately assess the scope of this problem.

- **DHS detention standards are not uniformly implemented, so solitary confinement policies and procedures vary greatly.**

  No facility has taken steps to become compliant with 2011 PBNDS. Rather, immigration detention facilities are inspected against older versions of DHS detention standards, either from 2000 or 2008. These standards vary dramatically. As a result, local jails and private prison companies often adhere to inconsistent policies and procedures. It is not clear that

[1] *See "Lost in Detention,"* PBS Frontline (October 18, 2011), available at: http://www.pbs.org/wgbh/pages/frontline/race-multicultural/lost-in-detention/map-the-u-s-immigration-detention-boom/.

[2] *See* http://immigrantjustice.org/sites/immigrantjustice.org/files/OCRCL%20Global%20Complaint%20Letter%20April%202011%20FINAL%20REDACTED.pdf

DHS reviews these policies or inspects facilities for compliance with national detention standards for solitary confinement. It is clear, however, that contracted facilities have no incentive to create non-punitive conditions. DHS does not issue financial penalties nor does it terminate contracts with facilities that routinely perform below standards.

Misuse of Segregation in Immigration Detention

Immigration detention facilities distinguish between administrative segregation and disciplinary segregation. Administrative segregation is a "non-punitive" status to ensure the safety of an individual and/or security of the facility. Disciplinary segregation is a punitive status that stems from a violation of facility rules.

NIJC has identified several disturbing trends in the use of administrative and disciplinary segregation in immigration detention.

- **Administrative segregation can be indefinite and without review.**

  For many individuals in immigration proceedings, detention is indefinite. As a consequence, individuals in administrative segregation do not know how long they remain isolated. Moreover, because non-citizens do not have a right to counsel, they can easily lose contact with the outside world and become even more vulnerable to abuse.

  José (pseudonym), a gay Mexican national, was held in solitary confinement for four months. Officers told him that he was being isolated because of his "feminine appearance" and "for his own protection." José became increasingly confused when he found out that other gay men were living in the general population. Three people in José's isolation unit tried to commit suicide while he was there. These individuals had been isolated for many months, and José feared that he would also become suicidal. He repeatedly asked to be put on work detail to keep his mind and body busy but he was denied. Officers told him that he had no right to be with anyone else.

- **Administrative segregation is used as a substitute to mental health and medical treatment.**

  Solitary confinement is often used in lieu of proper mental health services for detainees with severe mental illness and for those who become suicidal as a consequence of their isolation. Isolation is also used as a substitute for proper medical treatment. The Inter-American Commission on Human Rights has held that the use of solitary confinement as part of a person's mental health rehabilitation plan can rise to the level of "inhuman and degrading treatment."[3]

  NIJC represents Adan (pseudonym), a refugee from Eritrea whose competency to be in proceedings is being evaluated. Adan has been in DHS custody since February 2012. He is not receiving proper treatment for his mental illness and he is frequently placed in segregation. Adan has told NIJC that he prefers to be in the general population, but without his medication, it is difficult for him to remain among other detainees.

[3] Inter-American Commission of Human Rights, *Rosario Congo v. Ecuador*, Report 63/99, Case 11.427 of April 13, 1999 at 59; *See also Keenan v. the United Kingdom*, European Court of Human Rights, April 3, 2001, Application No. 27229/95 at 113.

Martin (pseudonym) is a young man from Guatemala who has bipolar disorder and requires a series of medication and regular therapy. He spent nine months in detention last year while pursuing relief under the Convention Against Torture. While in detention, he did not receive correct dosages of his medication and he did not have consistent access to a psychiatrist. Instead of providing him proper treatment, jail staff regularly placed him in administrative segregation.

- **LGBT immigrants are inappropriately held in "protective custody."**

Administrative segregation is disproportionately used against the most vulnerable populations in immigration detention, such as LGBT individuals. Juan Méndez, Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, notes that "Although segregation of [LGBT] individuals may be necessary for their safety, lesbian, gay, bisexual and transgender status does not justify limitations on… access to recreation, reading materials, legal counsel, or medical doctors."[4]

Jessica (pseudonym) is a transgender woman from Mexico. She languished in DHS custody for nearly two years before obtaining legal protection. Jessica was placed in solitary confinement for the first month of her detention because officers insisted she be separated for her own protection. Jessica repeatedly asked facility staff and DHS to move her to the general population. While in isolation, Jessica received reduced quantities of food and was prohibited from communicating with others. She was unable to access religious services, the library, or other recreation areas. When she was allowed out of her cell, she was handcuffed. The only time Jessica could bathe or make phone calls was during the one hour she was allowed out of her cell per day, which was supposed to be reserved for recreation and exercise.

NIJC recognizes that disciplinary segregation may be appropriate in rare, exceptional circumstances. However, absent uniform detention standards and DHS oversight, detention facilities may interpret protocols in drastically different and harmful ways.

- **Disciplinary segregation is used for minor, frivolous infractions.**

A survivor of domestic violence, Helena (pseudonym) was detained for 11 months while her U visa application was pending. On separate occasions, she was placed in disciplinary segregation for having an extra blanket, bra and pair of socks; placing her shampoo bottle on the windowsill; and possessing newspaper articles in her cell. She spent weeks in isolation as punishment for her "offenses."

- **When officials do not properly investigate, false accusations can justify placement in disciplinary segregation.**

A Mexican national named Laura (pseudonym) was placed in disciplinary segregation for 49 days after she was accused of having sex with other inmates. Laura vehemently denied the accusation and no evidence was ever produced. Laura was never told how long she would remain in disciplinary segregation or that she could appeal the decision. Instead, Laura was regularly harassed by guards, causing her to fear leaving her cell.

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[4] *See* Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment at 19 (August 5, 2011) (available at: http://solitaryconfinement.org/uploads/SpecRapTortureAug2011.pdf)

- **Disciplinary segregation is used to retaliate against detainees who exercise their civil and religious rights.**

  Farid (pseudonym), a young man from Yemen, was detained for three years while he appealed his asylum claim. Farid was observing Ramadan when he was brought into custody. Farid explained to officers that he would fast for 30 days and requested that he be excused from meals. Instead, officers placed him in disciplinary segregation for the remainder of Ramadan. He could not appeal the decision. Later, Farid was placed in disciplinary segregation after he tried to advocate on behalf of another Muslim detainee who could not speak English well. When Farid inquired about the charges against him, officers did not respond. Farid spent approximately 30 days in isolation for his "offense." Each day, the warden would ask Farid if he was "broken" yet. On yet another occasion, Farid went on a hunger strike because the jail administrators decided to suspend his kosher meals after a kitchen employee falsely accused him of eating non-kosher food. Farid spent 10 days in segregation until he could demonstrate that the allegation was false.

The Costs of Solitary Confinement

Over the past decade, states have started to assess the costs of solitary confinement. For example, it is estimated that the state of California spends $77,740 annually for each inmate in administrative segregation in its Pelican Bay State Prison. Annual costs for inmates in the general population are estimated to be $58,324 per inmate.[5] The state of Colorado spends roughly $20,000 more per inmate per year to hold an individual in solitary confinement.[6] By comparison, when Mississippi ended its use of solitary confinement in super-maximum-security facilities, it saved more than $5 million.[7] Several other states have since followed Mississippi's lead.

Similar expenses exist in the immigration detention system. Last year, the government spent approximately $166 per detainee per day at a capacity of 33,400 detention beds.[8] Congress appropriated a budget of $2.75 *billion* for DHS' Detention and Removal Operations in Fiscal Year 2012, $184 million more than the previous year and enough for DHS to keep 34,000 immigrants detained at any one time.[9] A similar Detention and Removal budget is being considered for Fiscal Year 2013.[10] Before Congress expands the budget for DHS operations, it must demand that DHS account for its spending on solitary confinement.

Conclusion

Congress can and must take immediate steps to remedy the pervasive misuse of solitary confinement in immigration detention. DHS detention standards offer only weak guidelines for the operation and oversight of a vast detention system. Congress must require DHS to issue uniform, legally enforceable standards. In addition, detention facilities that fail to meet standards should not be detaining immigrants. Finally, Congress must encourage DHS to use alternatives to detention, particularly for vulnerable populations who will be held in isolation. With these steps, we will not only protect the fundamental rights of immigrant detainees but save limited government resources.

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[5] *See* http://www.cdcr.ca.gov/COMIO/Uploadfile/pdfs/Pelican_Bay.pdf

[6] *See* "The High Cost of Solitary Confinement," ACLU of Colorado (available at http://www.cslc.org/sujy-f0001-sac/supporting_documents/Leg_fact_sheets/co_solitary_fact_sheet.pdf)

[7] *See "Prisons rethink Isolation, Saving Money, Lives, and Sanity,"* New York Times (March 10, 2012).

[8] *See "The Math of Immigration Detention: Runaway Costs for Immigration Detention Do Not Add Up to Sensible Policies,"* National Immigration Forum (August 2011) at 1. (Hereinafter "NIF Report")

[9] *See* NIF Report at 1.

[10] *See* HR 5855, FY13 Homeland Security Appropriations Act.



NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE HEALTH

June 15, 2012

Senate Judiciary Subcommittee on the
Constitution, Civil Rights, and Human Rights

Chairman Durbin, Ranking Member Graham, and members of the subcommittee:

National Latina Institute for Reproductive Health is the only national organization working on behalf of the reproductive health and justice of the 20 million Latinas, their families, and communities in the United States through public education, community mobilization, and policy advocacy.

We thank the committee for the opportunity to provide testimony on the critical issue of solitary confinement. We are particularly concerned about the use of solitary confinement in immigration centers with transgender immigrant detainees.

Nearly half of all immigrants in the United States are Latinos, and currently there are over 11 million undocumented immigrants in the United States.[i] With deportations at an all-time high and evidence that deportation rates will continue, [ii, iii] the treatment of immigrants in immigration detention facilities is an increasing concern to the Latina community. Particularly for transgender and gender non-conforming Latina/os, solitary confinement within immigration detention is a pressing human rights and social justice issue.

LGBTQ immigrants—particularly those who are transgender or gender non-conforming—face a disproportionate risk of deportation. Discrimination in legal areas of employment means that people must engage in "survival crimes" such as sex work, drug transactions, theft, etc., which increase the likelihood that LGBTQ immigrants will be detained and deported, even if they do have legal status. Additionally, employment eligibility verification programs such as E-verify have high error rates often associated with changes in legal documents, such as name changes or changes in legal sex. All these factors mean that transgender and gender non-conforming immigrants are disproportionately likely to end up in immigration detention.

Once in immigration detention, transgender and gender non-conforming people are subject to harms specifically due to their gender identity and presentation. As with any gender segregated institution, immigration detention centers can be extremely dangerous places for transgender and gender-nonconforming immigrants. It is well-known amongst immigrant rights advocates that a very common approach to housing transgender detainees is to place them in solitary confinement to "keep the piece" or for "safety" reasons. Because immigration officials rarely (if ever) allow transgender and gender non-conforming detainees to choose housing in the barracks of the gender where they feel safest, these detainees are placed instead solitary to prevent the violence and sexual assault they are vulnerable if placed in barracks where the detainee feels unsafe.

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Though data on transgender prison life is sparse, a recent study found that 21% of transgender women housed in male facilities reported experiencing physical abuse, and 20% reported incidents of sexual abuse while in jail; or transgender men, 11% of those placed in women's facilities reported physical abuse, and 6% reported sexual abuse.[iv] Because of this risk of violence, transgender and gender non-conforming individuals disproportionately are sent to solitary confinement.

Empirical research on solitary confinement has consistently and unequivocally documented harmful mental health consequences, coming from sources as varied as personal accounts, descriptive studies, and systematic research.[v] In fact, research demonstrates that the clinical effects of even relatively short periods of isolation can be similar to that of physical torture.[vi]

The recent story of a transgender woman named Kripcia is a perfect example: failure to pay cab fare had landed Kripcia in immigration detention, where she was held in "administrative segregation" – i.e. solitary confinement – for eight months.[vii] For Kripcia, this meant a minimum of 22 hours per day in a tiny cell, with little access to recreation or any other human contact. Of course, for every story that we've heard, we know that there are countless that go untold. The National Latina Institute for Reproductive Health urges the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights to consider the issues of transgender immigration detainees and to act quickly to put limits to this harmful practice.

Sincerely,

Jessica González-Rojas
Executive Director
National Latina Institute for Reproductive Health

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[i] Pew Hispanic Center: *Unauthorized Immigrant Population :National and State Trends, 2010* http://www.pewhispanic.org/2011/02/01/unauthorized-immigrant-population-brnational-and-state-trends-2010/

[ii] Fox News Latino: *Deportations Reach a New All-Time High*, October 18, 2011. http://latino.foxnews.com/latino/politics/2011/10/18/us-deportations-reach-new-record/

[iii]

[iv] National Center for Transgender Equality & National Gay and Lesbian Task Force: *Injustice At Every Turn* http://www.thetaskforce.org/reports_and_research/ntds

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[v] Haney, Craig: *Mental Health Issues in Long-term Solitary and "Supermax" Confinement* (2003), Crime & Delinquency, vol. 49, no. 1

[vi] American Civil Liberties Union: *Stop Solitary – Mental Health Resources* https://www.aclu.org/prisoners-rights/stop-solitary-mental-health-resources

[vii] The Advocate: Eight months in Solitary, May 07, 2012. http://www.advocate.com/news/news-features/2012/05/07/transgender-detainees-face-challenges-broken-immigration-system?page=0,0

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Testimony of
Linda Gustitus, President, and Rev. Richard Killmer, Executive Director,
National Religious Campaign Against Torture,
Before the
Senate Judiciary Committee
Subcommittee on the Constitution, Civil Rights and Human Rights
Hearing on Reassessing Solitary Confinement
June 19, 2012

Mr. Chairman, Members of the Subcommittee, thank you for this opportunity to submit testimony on behalf of the National Religious Campaign Against Torture (NRCAT) concerning the harmful use of solitary confinement in our nation's federal prisons, jails, and detention centers. Due to the negative fiscal and public safety consequences of solitary confinement, NRCAT is encouraged that a growing number of states across the nation are reassessing the practice and implementing policies to limit its use. The Subcommittee's consideration of this issue at the federal level is opportune and urgent. It is due time that we learn from the states' successful reforms. We are confident that a transparent evaluation of the impact of the federal system's use of solitary confinement on prisoners, correctional staff, our budget, and society at large, will lead you to conclude that the pervasive use of prolonged solitary confinement is wrong both morally and economically.

The National Religious Campaign Against Torture is a coalition of religious organizations joined together to ensure that the United States does not engage in torture or cruel, inhuman or degrading treatment of anyone, including U.S. prisoners, inmates, and detainees. Since its formation in January 2006, more than 300 religious organizations have joined NRCAT, including representatives from the Catholic, Protestant, Orthodox Christian, evangelical Christian, Buddhist, Hindu, Quaker, Unitarian, Jewish, Buddhist, Muslim, and Sikh communities. NRCAT member organizations include denominations and faith groups, national religious organizations, regional religious organizations, and congregations.

The faith-based members that belong to NRCAT do not question whether individuals convicted of certain crimes deserve to be sent to prison. Rather, we are united in opposing treatment that is so severe that it violates our values as a nation, as people of faith, and as fellow human beings. This opposition has inspired us, along with people of faith and religious leaders across the nation, to participate in a 23-hour fast, symbolizing the 23 hours per day that tens of thousands of prisoners, inmates, and detainees, are warehoused in solitary confinement. As we have seen in recent prisoner hunger strikes in California and Virginia, refusing food is one of the few means prisoners

have to protest their conditions in solitary confinement. We are fasting for change on their behalf, asking for divine intervention that "drives out fear." Today at noon, we will break bread together immediately after your hearing and pray that this will not be the end of your efforts to evaluate and reform this inhumane and destructive practice.

The 2006 Commission on Safety and Abuse in America's Prisons (hereinafter "the Commission"), co-chaired by Nicholas Katzenbach, former Attorney General under President Lyndon Johnson, and John Gibbons, former Chief Judge for the 3rd Circuit Court of Appeals, produced a report that described life in a supermax prison like this:

> Conditions in segregation vary across the country. In the most severe conditions—which are more likely to occur in disciplinary segregation units and super-max prisons—individuals are locked down 23 or 24 hours a day in small cells between 48 and 80 square feet with no natural light, no control over the electric light in their cells, and no view outside of their cells. They have no contact with other prisoners—even verbal—and no meaningful contact with staff. They may be able to spend up to an hour every other day alone in a concrete exercise pen. Though there are some exceptions, access to books and writing materials is limited; radio and television are often banned; calls to and visits with family are very infrequent, when permitted at all.[1]

The faith groups and member organizations of NRCAT believe that solitary confinement is not only inhumane, but that in certain circumstances, it can rise to the level of torture.

As you already know, the universally recognized definition of torture is in the United Nations Convention Against Torture and Cruel, Inhuman or Degrading Treatment adopted by the UN General Assembly in 1984 and signed by the United States in 1988 and ratified by the U.S. in 1994. It defines torture as any act by which,

> . . . severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.[2]

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[1] COMM'N ON SAFETY AND ABUSE IN AMERICA'S PRISONS, VERA INSTITUTE OF JUSTICE, CONTRONTING CONFINEMENT at 57 (2006), http://www.vera.org/download?file=2845/Confronting_Confinement.pdf [hereinafter *Commission*].

[2] Convention Against Torture and Other Cruel, Inhuman, and Degrading Treatment or Punishment, art. 1(1), Dec. 10 1984, 1465 U.N.T.S. 85.

In a 2011 report, the United Nations Special Rapporteur on Torture, Juan Mendez, cited 15 days or more of solitary confinement as "prolonged solitary confinement," noting that some of the psychological effects caused by isolation become irreversible at that point.[3] The severe pain and suffering caused by solitary confinement is clearly documented throughout history within literary, scientific, and legal sources.

Many Americans don't realize that the harm of solitary confinement is, unfortunately, a lesson we have to relearn. In 1829, the Eastern Pennsylvania Penitentiary opened.[4] It was called a penitentiary because the enlightened voices of the day, including Dr. Benjamin Rush, Benjamin Franklin, and key Quaker leaders, wanted inmates to spend time in isolation so they could think deeply about their crimes and become penitent.[5] However, instead of becoming remorseful while in solitary confinement, the prisoners developed serious mental health problems, with many going insane. In 1842, Charles Dickens visited the Eastern Pennsylvania Penitentiary and wrote, "The system here is rigid, strict and hopeless solitary confinement. I believe it . . . to be cruel and wrong. I hold this slow and daily tampering with the mysteries of the brain, to be immeasurably worse than any torture of the body."[6] Recognizing this severe psychological harm, the Quakers apologized for devising solitary confinement cells.

Unfortunately, today, the same "daily tampering with the mysteries of the brain" that Dickens referenced is painstakingly evident in the countless letters sent to friends, family members, and organizations like NRCAT, from the tens of thousands of prisoners held within solitary confinement cells. Describing the impact of solitary confinement, one prisoner wrote:

> [P]rolonged isolation tears at my soul, mind, and ability to cope. The cell collapses on top of me. I don't breathe. I can't breathe from crushing anxiety, literally. I utilize all coping mechanisms I know, and some conjure up to no avail. The end result is self-mutilation to escape or an attempt on my life. I can do fine for five, six or eight months. Then all hell inside my head breaks loose. I'm not choosing to be suicidal. It's an unseen force which compels me to try to escape by any means.[7]

Many studies have documented the detrimental psychological and physiological effects of long-term segregation.[8] Nationally recognized expert Dr. Stuart Grassian was

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[3] The Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman, and degrading treatment or punishment, *Interim Report*, ¶ 15, delivered to the General Assembly, U.N. Doc. A/66/268 (Aug. 5, 2011).

[4] Laura Sullivan, *Timeline: Solitary Confinement in U.S. Prisons*, NATIONAL PUBLIC RADIO, July 26, 2006, http://www.npr.org/templates/story/story.php?storyId=5579901.

[5] *Id.*

[6] CHARLES DICKENS, AMERICAN NOTES 146 (Fromm Int'l 1985) (1842).

[7] Citing a letter from a prisoner during video interview by Steve Martin, Board Member, National Religious Campaign Against Torture, with Shaheed Omar in Roanoke, VA (January 10, 2012).

[8] *See e.g.*, Stuart Grassian & Nancy Friedman, *Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement*, 8 INT'L J.L. & PSYCHIATRY 49 (1986); Craig Haney & Mona Lynch, Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement, 23 NEW YORK

one of the pioneers in researching the harmful psychological effects of solitary confinement in super-max prisons in the early 1980s.[9] In a statement submitted to the Commission, Dr. Grassian documented that nearly a third of the prisoners he evaluated experienced perceptual distortions, in which objects appear to change size or form.[10] This is particularly alarming, he noted, since this symptom is more commonly associated with neurological illnesses, such as brain tumors, than with primary psychiatric illness.[11]

Additionally, Dr. Craig Haney, social psychologist and Professor of Psychology at the University of California, Santa Cruz, who will address the Subcommittee today, found extraordinarily high rates of symptoms of psychological trauma among prisoners held in long-term solitary confinement in his systematic analysis of prisoners held in super-max prison.[12] More than four out of five of those evaluated suffered from feelings of anxiety and nervousness, headaches, troubled sleep, and lethargy or chronic tiredness, and over half complained of nightmares, heart palpitations, and fear of impending nervous breakdowns.[13] Nearly half suffered from hallucinations and perceptual distortions, and a quarter of them experienced suicidal ideation.[14]

In 2011, the United States Supreme Court stated that "[p]risoners retain the essence of human dignity inherent in all persons. Respect for that dignity animates the Eighth Amendment prohibition against cruel and unusual punishment."[15] United States case law has specifically recognized solitary confinement's clear harm[16] and in certain circumstances, has declared the practice as a violation of the Eighth Amendment.[17]

Due to the overwhelming evidence that solitary confinement causes severe mental pain and suffering, NRCAT believes prolonged solitary confinement is a violation of the inherent God-given dignity in every human being. We concur with the Supreme Court that this inherent dignity does not end at the prison gates.

Dr. Atul Gawande, surgeon and staff writer for the *New Yorker*, asked in his 2009 article, "Hellhole," "If prolonged isolation is—as research and experience have

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UNIVERSITY REVIEW OF LAW AND SOCIAL CHANGE 477-570 (1997); Craig Haney, Mental Health Issues in Long-Term Solitary and "Supermax" Confinement, 49 CRIME & DELINQ. 124 (2003).

[9] See e.g., Stuart Grassian, *Psychopathological Effects of Solitary Confinement*, 140 AM. J. PSYCHIATRY 1450 (1983).

[10] Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 JOURNAL OF LAW AND POLICY 325, at 335 (2006), http://law.wustl.edu/journal/22/p325grassian.pdf.

[11] *Id.* at 338.

[12] Haney, *supra* note 8.

[13] *Id.* at 133.

[14] *Id.* at 134.

[15] Brown v. Plata, 131 S.Ct. 1910 (2011).

[16] *See In re* Medley, 134 U.S. 160, 168 (1890) (noting that prisoners held in isolation became violently insane and suffered some irreparable mental damage).

[17] *See, e.g.*, Jones'El v. Berge, 164 F. Supp. 2d 1096 (W.D. Wis. 2001) (finding that placing mentally ill prisoners in solitary confinement constitutes an Eighth Amendment violation); Madrid v. Gomez, 889 F. Supp. 1146, 1265 (N.D. Cal. 1995) (equating placing mentally-ill inmates in solitary confinement to placing asthmatics in a room with insufficient air); Ruiz v. Johnson, 37 F. Supp. 2d 855, 915 (S.D. Tex. 1999).

confirmed for decades—so objectively horrifying, so intrinsically cruel, how did we end up with a prison system that may subject more of our own citizens to it than any other country in history has?"[18]

We believe that responding in fear, rather than objectively evaluating evidence-based best practices, is how we ended up here. Following an attack on two correctional officers in 1983, Marion Prison in Illinois instituted a permanent lockdown of its entire facility, in which all inmates were confined alone in their cells for 23 hours per day.[19] The use of solitary confinement has increased dramatically since then. In 1989, California built Pelican Bay Prison to house prisoners exclusively in solitary confinement cells. Today, there are more than 40 super-max prisons across the country, including one federal facility, the Administrative Maximum Facility ("ADX"), located in Florence, Colorado.

The Commission noted that from 1995 to 2000, the growth rate of segregation units significantly surpassed the prison growth rate overall: 40% compared to 28%.[20] Long-term isolation has become a default management tool, not only as a response to violent behavior, but exceedingly as routine practice for minor rule infractions, involuntary protection, and as a means of managing difficult inmates, particularly those with mental illness. Walter Dickey, former secretary of the Wisconsin Department of Corrections, testified before the Commission that his state's super-max prison was filled with the wrong people, "the young, the pathetic, the mentally ill."[21] Similarly, psychiatrist Stuart Grassian told the Commission, "Many of these people who are said to be the 'worst of the worst' are simply the wretched of the earth. They're sick people."[22]

The notion that prolonged solitary confinement is a necessary evil to maintain safety in our prisons, jails and detention centers, is not rooted in evidence. A study evaluating the impact of segregating prisoners in super-max facilities on prison violence in three different states found that segregation did not decrease prisoner-on-prisoner violence in any of the states and had divergent results on prisoner-on-staff assaults.[23]

The demonstrated success of reducing the use of solitary confinement is evident among several states that have proven that not only are there safe alternatives, but there are more cost-effective options.[24] For example, Mississippi experienced a decline in violence within its prisons after it drastically reduced its use of solitary confinement by

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[18] Atul Gawande, *Hellhole*, NEW YORKER, March 30, 2009, http://www.newyorker.com/reporting/2009/03/30/090330fa_fact_gawande.

[19] Sullivan, *supra* note 4.

[20] Commission, *supra* note 1, at 53.

[21] Commission, *supra* note 1, at 54.

[22] Commission, *supra* note 1, at 60.

[23] Chad Briggs, et al., *The Effect of Supermaximum Security Prisons on Aggregate Levels of Institutional Violence*. 41 CRIMINOLOGY 1341 (2003).

[24] Erica Goode, *Prisons Rethink Isolation, Saving Money, Lives and Sanity*, NEW YORK TIMES, March 10, 2012, http://www.nytimes.com/2012/03/11/us/rethinking-solitary-confinement.html.

85 percent in one super-max unit; Mississippi eventually closed the facility all together.[25] "The [segregated housing] environment . . . actually increases the levels of hostility and anger among inmates and staff alike," Donald Cabana, former Mississippi Warden, told the Commission.[26] Maine and Colorado also have recently made significant reductions in the use of solitary confinement without jeopardizing prison safety.[27] Maine Department of Corrections Commissioner Joseph Ponte explained, "Over time, the more data we're pulling is showing that what we're doing now [through greatly reducing the use of solitary confinement] is safer than what we were doing before."[28]

The daily cost per inmate of solitary confinement far exceeds lower security facilities because individualized cells and increased correctional staff are required, and prisoners do not contribute to the ongoing maintenance of the facility, such as cleaning, cooking, and laundry. Indeed, Mississippi has reportedly saved $5 million by closing its super-max unit.[29] Thanks to the transfer of more than 400 prisoners out of solitary confinement in the past year, the Colorado Department of Corrections plans to close its super-max unit, Centennial Correctional Facility, by 2013, which will result in savings of $4.5 million.[30] Other states, strapped for cash, are taking note. Illinois Governor Pat Quinn recently announced a proposal to close Illinois' super-max prison, Tamms Correctional Center, projecting annual savings of $21.6 million in the upcoming fiscal year and $26.6 million each year thereafter.[31]

Not only do these states demonstrate that limiting the use of solitary confinement can save taxpayer dollars and does not come at the cost of safety within prisons, we can not sit idly by and neglect a much larger public safety concern. The effects of prolonged solitary confinement impact all of us. In a recent interview about why Colorado reduced its reliance on solitary confinement, Colorado Department of Corrections Executive Director Tom Clements pointed out that 47 percent of those held in solitary confinement

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[25] Terry A. Kupers, et al., *Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs*, 36 CRIM. JUST. & BEHAV. 1037, 1041 (2009); John Buntin, *Exodus: How America's Reddest State – And Its Most Notorious Prison – Became a Model of Corrections Reform*, 23 GOVERNING 20, 27 (2010).

[26] Commission, *supra* note 1, at 54.

[27] Lance Tapley, *Reform Comes to the Supermax*, PORTLAND PHOENIX, May 25, 2011, http://portland.thephoenix.com/news/121171-reform-comes-to-the-supermax/; COLORADO DEPARTMENT OF CORRECTIONS, REPORT ON THE IMPLEMENTATION OF ADMINISTRATIVE SEGREGATION PLAN 1-2 (2012), available at https://www.aclu.org/prisoners-rights/report-co-docs-implementation-administrative-segregation-plan.

[28] Video interview by Richard Killmer, Executive Director, National Religious Campaign Against Torture, with Joseph Ponte. Maine Department of Corrections Director, in Augusta, Maine (October 4, 2011).

[29] Erica Goode, *Prisons Rethink Isolation: Saving Money, Lives and Sanity*, NEW YORK TIMES, March 10, 2012, http://www.nytimes.com/2012/03/11/us/rethinking-solitary-confinement.html.

[30] Kristen Wyatt, *Colorado Closing Canon City Prison*, The Gazette, March 19, 2011, http://www.gazette.com/articles/colorado-135471-denver-prison.html.

[31] Dave McKinney & Andrew Maloney, Editorial, *Governor Pat Quinn: Close Super-max Downstate Tamms Prison*, CHICAGO SUN-TIMES, February 21, 2012, http://www.suntimes.com/news/politics/10785648-418/gov-pat-quinn-close-super-max-downstate-tamms-prison.html.

are eventually released directly to the community.[32] This lack of transition from solitary confinement straight to society is alarming, considering prisoners who are freed directly from solitary confinement cells are significantly more likely to commit crimes again.[33]

Mr. Chairman and members of the Subcommittee, we hope that your leadership on this issue will extend beyond this hearing. To that end, we would strongly support your leadership in sponsoring legislation that would limit the use and length of solitary confinement. We urge Congress to pass legislation that would:

- prohibit the placement of the most vulnerable populations, including persons with mental illness and juveniles, in solitary confinement;
- provide adequate training to all correctional officers concerning signs of mental illness and effective behavior management techniques for this population;
- ensure that prisoners, inmates, and detainees held in solitary confinement receive routine and meaningful mental health evaluations and divert individuals exhibiting signs of mental illness from isolation to mental health treatment units that provide habilitative care;
- designate solitary confinement as a last resort by narrowing the types of conduct that qualify prisoners, inmates, and detainees to be involuntarily placed in solitary confinement to include only active and serious safety concerns, such as escape attempts and severe violent behavior;
- require that prisoners, inmates, or detainees who voluntarily request and are granted placement in solitary confinement have the right to request immediate reintegration into the general prison population;
- improve the due process guarantees provided to prisoners, inmates, and detainees recommended for placement in solitary confinement, including providing the prisoner, inmate, or detainee with the written reasons for his or her recommended placement in isolation and ensuring meaningful hearing by an objective panel;
- provide prisoners, inmates, and detainees placed in solitary confinement with individualized plans specifying the specific behaviors they must demonstrate in order to increase their privileges within isolation and eventually be granted release from solitary confinement;
- ensure that the resources and opportunities to reach those behavior benchmarks are accessible;
- provide recognition of and incentives for correctional staff who successfully utilize alternative behavior management techniques that prevent prisoners, inmates, and detainees from entering solitary confinement;

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[32] Kirk Mitchell, *Colorado Prisons Turn Away from Heavy Use of Solitary Confinement*, DENVER POST, June 4, 2012, http://www.denverpost.com/news/ci_20775290/colorado-prisons-turn-away-from-heavy-use-solitary.

[33] *See, e.g.*, Lovell, et al., *Recidivism of Supermax Prisoners in Washington State*, 53 CRIME AND DELINQ. 633, 633-56 (October 2007).

- disincentivize the use of solitary confinement by holding the correctional officer who refers a prisoner, inmate, or detainee to solitary confinement accountable for assisting that individual in meeting the behavior benchmarks in his or her individualized plan;
- establish more frequent and meaningful due process guarantees for those who remain in solitary confinement to demonstrate whether or not they have met the expectations listed in their individualized plans, including additional review and approval by higher level correctional officials in order for prisoners, inmates, and detainees to remain in solitary confinement beyond designated lapses in time;
- require that prisoners, inmates, and detainees in solitary confinement be reintegrated into the general prison population at least six months prior to being released to the general public;
- establish an absolute maximum amount of time any prisoner, inmate, or detainee may be held in solitary confinement; and
- provide regular and independent oversight bodies with authority to access and inspect solitary confinement units in all jails, prisons, and detention centers; such bodies should not depend on corrections agencies for funding and should have the authority to issue public reports, to make recommendations, and to compel implementation of those recommendations.

Mr. Chairman, Members of the Subcommittee, the National Religious Campaign Against Torture believes strongly that the United States should do everything it can to reverse our nation's reliance on solitary confinement. The United States has from its inception tried to live up to the vision of its role in this world as the "shining city on the hill." That luster has been dimmed by the destructive, counterproductive, and immoral use of solitary confinement. We need to immediately take steps to clearly and emphatically end the use of prolonged solitary confinement. Your hearing today is a very important effort in doing that, and we thank you for the opportunity to contribute to it.

Testimony of

Rev. Steven D. Martin, Executive Director

New Evangelical Partnership for the Common Good

Before the

Senate Judiciary Committee

Subcommittee on the Constitution, Civil Rights and Human Rights

Hearing on Reassessing Solitary Confinement

June 19, 2012

Mr. Chairman, Members of the Subcommittee, thank you for this opportunity to submit testimony on behalf of the New Evangelical Partnership for the Common Good concerning the harmful use of solitary confinement in our nation's federal prisons, jails, and detention centers. We are encouraged that a growing number of states across the nation are reassessing this practice and implementing policies to limit its use. In light of the high cost of solitary confinement and its diminishing returns, we are grateful for the Subcommittee's timely review of the federal system's use of isolation today.

The New Evangelical Partnership for the Common Good (NEPCG) is an organization headed by Rev. Richard Cizik and made up of thousands of young evangelical Christians who hear the gospel speaking to the great challenges we face today including nuclear proliferation, war and peace, immigration, interfaith relations, family planning, and prison reform. The organization came into being as young evangelicals responded negatively to the old culture-wars paradigm of their parents and sought to solve problems rather than simply fight about them. We seek to do the same.

As the Executive Director of a lean organization with a small staff, one of my responsibilities is to develop various media for the organization. We were charged by our partner organization, the National Religious Campaign Against Torture, with developing a 15-minute video educating viewers on the problem of prolonged solitary confinement. My remarks will be personal in nature, describing how I was deeply affected by the knowledge I gained, the people I met, and the process of learning about what I now understand as an abhorrent practice that goes mostly unnoticed in American life today. I will describe how I moved from being indifferent toward the use of prolonged solitary confinement to being active in working to end it.

Working regularly on such difficult issues brings enthusiasm to some, indifference to others. When I was approached about producing a short video on prolonged solitary confinement, I felt that I had little emotional capacity to give to the project. I believed that one can only care about a finite number of things, even one one places compassion above all other virtues. I felt that I did not have energy to give to this issue even though I had already encountered it close to home.

Prisoner Abuse and the Cub Scouts

My first encounter with some of the practices I would later come to know as associated with prolonged solitary confinement occurred one evening on a field trip with our local Cub Scouts den. The leaders of our den thought it would be both interesting and sobering to our kids if a field trip was made to the Anderson County Jail, located in east Tennessee, where I reside. Three of my four children are triplets, and my two younger sons were on this field trip where they were shown the jail's maximum security facility.

The visit to the jail made an impression on these then-nine-year-old boys. They got to stand in the secure guard tower above the cell unit where they saw the male prisoners end their recreation time and enter their cells to be locked up for the night. After this occurred a young prisoner was asked to stand in the center of the common area and address the cub scouts. He was serving a life sentence for murder (and I'm not clear about why he was serving this part of that sentence in the county jail) and made an inspiring speech to the boys about the need to stay clean and stay off drugs. He returned to his cell after the speech and our kids went to another part of the jail to hear from the guards.

The guards then gave the boys a show-and-tell presentation about tools they use to control the prisoners. The showed them a large plexiglass shield that, when picked up, would cover a guard from above the head to just below the belt. The two handles one would use on the inside of the shield to firmly hold the device also contained a trigger that sent thousands of volts of electricity between two probes located on the outside of the shield. They showed how the plexiglass that formed the largest part of this particular shield was cracked and broken (yet was still in use), and then pulled the trigger inside. To the delight of the boys, the bright blue stream of electrical current jumped from the metal probes down the length of the cracks in the shield and jumped in every direction. The breaks in the shield seemed to direct the current in abnormal ways.

The guard then told the boys how the shield is used to protect them against prisoners during what I came to know later as a cell extraction, a particularly brutal method of subduing a prisoner as part of disciplinary action. This delighted the young Cub Scouts, but horrified me, as I wondered what effect these thousands of volts sent ripping through the cracks in this shield into the muscles of a defenseless prisoner might be. The demonstration left a great impression on both me and the boys, but most likely a different kind.

Then the guards pointed to a large black fiberglass form, with straps and buckles, situated on the floor before them. This, they said, was the restraint chair. It is used whenever a prisoner becomes unruly and unmanageable. The prisoner is forcibly placed in this device that completely restrains all movement and kept there until the prisoner "gets the message" (their words). Later I came to understand that, while use of the chair itself may not be considered prisoner abuse, often prisoners are placed in the chair and forgotten about for long periods of time, sometimes urinating or defecating on themselves as a result.

We left the jail that night with me wondering what the Cub Scout leaders were hoping to accomplish. My boys accepted the visit at face value. I discovered later that I had just been exposed to practices that, if abused, could be considered torture.

Three Days in Maine

Years later, in the fall of 2011, I was hired by the National Religious Campaign Against Torture (NRCAT) to produce a 15-minute video to educate religious people on the problem of prolonged solitary confinement. I provided videography and editing services to NRCAT, who wrote the script and provided logistical support for three days of interviewing experts and persons who had been subjected to solitary

confinement for years at a time. This testimony is to give you a glimpse into my own mindset, reminding you that prior to this period I was indifferent to the problems of life in modern prisons. I was completely unaware that a Supermax prison contains only solitary confinement cells, and that prisoners are intentionally prevented from any form of human contact or sensory stimulation except for one hour per day for "recreation" that a prisoner spends in a confined space outside his or her cell, still kept apart from any form of human contact. I was also unaware that the UN Special Rapporteur on Torture called for an absolute ban on placing juveniles or the mentally ill in solitary confinement or holding anyone in solitary confinement for more than 14 days (which he defined as "prolonged solitary confinement"). As the United States is a signatory to the UN Convention Against Torture, torture is illegal in the United States. Therefore prolonged solitary confinement is a breach of both domestic and international law. And all of that did not matter very much to me, as I worked passionately on other human rights issues.

While making this kind of video, the camera operator and interviewer are met face-to-face with the knowledge and experience of the interviewee. There is always interaction that the viewer of the final video never sees, always on a very human, personal level. As I listened to Michael, a young man who had spent over two years in solitary confinement in a Maine prison, I wondered if his stammer was a result of his prison experience. I heard him describe in detail how he developed delusions and hallucinations as a result of his being deprived of not only human contact, but of a sense of time, of night and day, and any other sensory stimulation whatsoever. I listened as he told how he sensed his ability to concentrate slipping away, and noticed in his interview how he still demonstrated this inability to focus.

Most disturbing was an interview with another man named Michael who was a patient in the Maine State Mental Hospital. He had been taken there after winning a court case after spending nine years of an eighteen-year sentence, much of which in solitary confinement. He was well-known within his prison as a mentally-ill inmate who experienced as many as five violent cell extractions per day for a period of months and years.

A cell extraction, I discovered, can be performed without any kind of due process; one can take place simply because a guard decides it is in order. Once the order is given a group of men dressed in helmets and riot gear, wielding tasers and shields similar to the one I had seen on the Cub Scouts field trip, descend on the prisoner's cell, electrocuting and violently beating the prisoner, shouting "do not resist," even when the prisoner is unable to resist due to the temporary paralysis that comes with electrocution. The prisoner is then bound and carried out to be placed in a small cell with no furnishings other than a cot with no mattress and a toilet, and no windows. Thus begins an indefinite period of sensory deprivation and loss of human contact. Extractions often, but do not always, result in placement in solitary confinement. But most often, extraction and solitary confinement are used together as a form of extreme disciplinary action against prisoners.

To hear from Michael of his experience of hundreds of these violent cell extractions, and then of his months spent in solitary confinement while already diagnosed as suffering from mental illness, was profoundly disturbing to me. How far away was this, I wondered, from the stories I have read from prisoners in Dachau or Sachsenhausen?

Sarah Shourd

A few weeks later we gained an opportunity to interview Sarah Shourd, which led me to meet her in Birmingham, Alabama, for an interview. Sarah is one of the three hikers that accidentally crossed the

Iran-Iraq border in northern Kurdistan. She spent 14 months in solitary confinement and was released many months before her companions found freedom.

I found Sarah to be a remarkable, articulate young woman. She went into great detail about her experience which alarmingly matched those of other interviewees. She described how she lost track of night and day and of the amount of time she spent in her cell. She told of feeling as though her mind was slipping away, of how she became obsessed with wondering how her mother was doing and of having no way to clear her mind of these worries, and of how she began screaming uncontrollably and beating at the walls of her cell until her knuckles bled, so much so that the guards had to come and calm her down. While she was screaming, she reported, she believed she was only dreaming, unaware that her screams and blood were real. She, too, told of a loss of ability to concentrate, the lasting effects of which are evidenced in the interview footage. I found quite unbelievable the similarities between the experiences of prisoners in the United States and of this young woman tortured in a prison cell in Iran.

In Conclusion

The experience of interviewing these people was profoundly disturbing and ultimately transformative. I could no longer ignore the practice of placing human beings in a prolonged state of solitary confinement, a practice which destroys the minds of prisoners for no reason that I could fathom. To come to terms with the practices that occur on a daily basis in US prisons is to understand that prolonged solitary confinement is cruel, unusual, and if continued for more than 14 days, is considered to be torture by domestic and international law. I cannot, and will not, tolerate this inhuman practice as something I don't have the time or inclination to care about, and I will be working to shine light on this issue among the rising tide of young evangelicals that my organization works with.

Mr. Chairman, Members of the Subcommittee, The New Evangelical Partnership for the Common Good believes strongly that the United States should do everything it can to reverse our nation's harmful and expensive reliance on solitary confinement. We have a moral obligation to uphold the dignity and the mental health of those currently incarcerated. To that end, we would strongly support your leadership in sponsoring legislation that would limit the use and length of solitary confinement. We implore you to immediately take steps to end the use of prolonged solitary confinement. Your hearing today is a very important effort in doing that, and we thank you for the opportunity to contribute to it.

PJDC
PACIFIC JUVENILE DEFENDER CENTER

Ensuring excellence in juvenile defense and promoting justice for all children

VIA EMAIL

June 15, 2012

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The Honorable Richard Durbin, Chairman
Senate Judiciary Subcommittee on
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RE: Statement of the Pacific Juvenile Defender Center (PJDC)
Reassessing Solitary Confinement: The Human Rights, Fiscal and Public Safety Consequences
June 19, 2012 Hearing Before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights

Dear Chairman Durbin and Members of the Subcommittee:

The Pacific Juvenile Defender Center (PJDC) thanks the Subcommittee for holding this hearing on the use of solitary confinement in the prisons, jails, and juvenile halls of the United States. We write to offer our insight on the profound and permanently negative effects of solitary confinement upon children.

PJDC is the regional affiliate for California and Hawaii of the National Juvenile Defender Center based in Washington, D.C. PJDC works to build the capacity of the juvenile defense bar, and to improve access to counsel and quality of representation for children in the justice system. Collectively, PJDC's membership of more than 400 juvenile attorneys represents tens of thousands of children in California and Hawaii's delinquency and dependency courts.

Extensive research by mental health and medical professionals has shown that solitary confinement of adults is the most extreme form of criminal punishment besides death, and only should be used in the most limited of circumstances. (C. Haney, "Mental Health Issues in Long-Term Solitary and Supermax Confinement," 49 Crime & Delinquency 124 (2003).) When used with children, its effects are even more devastating. Anyone who has spent time with a child realizes that their conception of time is very different from that of adults, and an hour is an eternity. The negative impacts seen in adults after a month in solitary can be seen in children after brief periods of solitary. (S. Simkins, M. Beyer, L. Geis, "The

Harmful Use of Isolation in Juvenile Detention Facilities: The Need for Post-Disposition Representation," 38 WASH. U. J. OF L. & POL'Y 241 (2012).) The U.S. Supreme Court has repeatedly held that children *are* different than adults, and as a result they deserve different punishment. *Roper v. Simmons*, 543 U.S. 551 (2005); *Safford Unified School Dist. v. Redding*, 557 U.S. 364 (2009); *Graham v. Florida*, 560 U.S. ___, 130 S.Ct. 2011 (2010); *J.D.B. v. North Carolina*, __ U.S. __, 131 S.Ct. 2394 (2012).

Most youth who are isolated in solitary confinement at juvenile detention facilities have histories of abuse, trauma, and mental illness. However, even for children without mental illness or abuse histories, being isolated for 23 to 24 hours a day and denied the most basic of human contact induces grave and permanent results. Children in solitary confinement often are denied education or substance abuse and mental health treatment, rehabilitative services that would do the most good to prepare them for a successful return to their families and community.

One of the most common justifications for isolating youth in solitary confinement is that they are at risk of self-harm or suicide. Isolating these vulnerable children for days or weeks on end, rather than providing them appropriate mental health treatment, exacerbates their conditions. This practice flies in the face of extensive research by mental health and criminal justice experts. Furthermore, federal courts have found that prisons may not isolate seriously mentally ill adults; such reasoning surely applies to mentally ill children. *Madrid v. Gomez*, 889 F.Supp. 1146 (N.D. Calif., 1995); *Jones 'El v. Berge*, 164 F.Supp.2d 1096 (W.D. Wis. 2001); *Presley v. Epps*, No. 4:05CV148-JAD (N.D. Mississippi, 2005 & 2007). Isolating mentally ill children or children in crisis does nothing but compound their trauma.

A recent national study of suicides in juvenile detention facilities published by the U.S. Department of Justice found that half of all youth who killed themselves in custody were subjected to isolation in disciplinary confinement, and that 75% of juvenile suicides were children who were confined to single-occupant cells. (L. Hayes, "Characteristics of Juvenile Suicides in Confinement," OJJDP Juvenile Justice Bulletin, Feb. 2009).

The federal government has taken steps to end the practice of "seclusion" of children in mental health institutions because of the permanent physical and mental harms that occur. The Children's Health Act of 2000 required Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare & Medicaid Services (CMS) to develop regulations governing use of restraint and seclusion in health care facilities receiving federal dollars and in non-medical, community-based facilities for youth. CMS has established standards that prohibit hospitals and residential psychiatric treatment facilities for people

under age 21 from using restraint and seclusion except for very brief periods of time to ensure safety during emergencies. SAMHSA's goal is to end the use of seclusion (and restraints) on children in mental health institutional settings. (http://www.samhsa.gov/samhsanewsletter/Volume_18_Number_6/EndSeclusionRestraint.aspx).

Not all states isolate their children in juvenile detention facilities. For example, through programs such as the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative, jurisdictions are moving away from using punitive solitary confinement and replacing it with positive behavior support programs. As a result of litigation, the California Department of Juvenile Justice (DJJ) has reduced its overreliance on isolation in its juvenile prisons, and has turned to using evidence-based therapeutic interventions with youth. These facilities have seen a decrease in violence, and the changes allow staff to focus on rehabilitation and education of children.

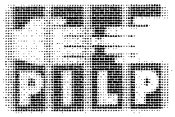
The work by SAMHSA and CMS in mental health institutions provides a roadmap for how to end the use of solitary for children. Congress can require juvenile detention facilities and jails to adhere to the strict requirements for "seclusion" now imposed on mental health treatment facilities. Congress can similarly enact legislation that requires the Department of Justice (and other agencies) to promulgate standards, professional education, and technical assistance to end the isolation of children. Congress also should reauthorize the Juvenile Justice and Delinquency Prevention Act (JJDPA) to condition federal funding to the states on the elimination of solitary confinement of children.

Thank you for your consideration of our comments on the issue of solitary confinement for children.

Sincerely yours,

PACIFIC JUVENILE DEFENDER CENTER

/s/ Jonathan Laba	*/s/ Corene Kendrick*
Jonathan Laba	Corene Kendrick
Deputy Director	Board of Advisors



PENNSYLVANIA INSTITUTIONAL LAW PROJECT
Angus R. Love, Esq., Executive Director

June 15, 2012

Dear Senator Durbin, Senator Graham, and members of the Subcommittee:

Thank you for holding this hearing and for providing this opportunity to submit testimony on the issue of solitary confinement. We are a non-profit legal services organization dedicated to providing civil legal services to people incarcerated in Pennsylvania. Through advocacy and litigation for the past twenty years, we have helped prisoners whose civil rights have been violated. We regularly hear from and represent prisoners held in various forms of solitary confinement in Pennsylvania. Their descriptions of conditions in solitary confinement, how and why they came to be placed in solitary confinement, and their repeated failed efforts to be released are disturbing.

In Pennsylvania, solitary confinement usually occurs in specially designed housing units within the prison, known variously as "Restricted Housing Units" or "Special Management Units." Whatever they are called by administrators in the various prison systems, our clients universally refer to these "housing units" as "the hole." A review of the conditions supports the use of that label.

Although the size of the cells in the different prison systems varies, the cells in "the hole" are always small – usually measuring approximately 8 by 10 feet. Prisoners are kept in these spaces for 23 hours per day. The cell door is usually solid metal and has a narrow slot through which meal trays are passed. Some institutions have cells with two cell doors and a small space in between them, further limiting the necessity for staff to interact with the prisoner. The

prisoner eats his or her meals alone in the cell. There is a small window in the cell door with a limited view to the cell block. Conversations with prison staff are minimal and only done through the cell door. Security "checks" on the prisoner by prison staff are conducted through the cell door. In many institutions, even mental health "checks" are conducted through the cell door and confidential mental health information is conveyed, in a necessarily loud conversation, through the crack in between the door and the wall, destroying any semblance of privacy.

In "the hole," conversations with other prisoners are almost impossible, as the narrow gaps in between the cell doors and the cell walls connect only to the walkway and not to the adjoining cell. In some institutions, a cell light is kept on all the time, making normal sleeping impossible. Depending on the custody status of the person kept in solitary, there is limited or no access to radio, books and other reading material, television, or other input or stimuli from the outside world. Access to programs, including religious services and rehabilitation classes, is similarly restricted for prisoners in "the hole." Prisoners can only have non-contact visits and only a limited number of visits. A "non contact" visit means that the prisoner and the visitor are separated by glass and must speak to each other through a telephone or through a narrow opening in the glass. During a "non contact" visit, even though there is glass separating the prisoner from the visitor and even though the prisoner is in a locked room, the prisoner is sometimes kept in handcuffs and leg shackles during the visit. There is no opportunity for normal social interaction or basic human contact in "the hole."

One hour per day, during Monday through Friday, a prisoner is offered the opportunity to leave his or her cell in the "the hole" and go to a cage outdoors which is about the same size as the cell for exercise. On the weekends, during holidays and lock down periods, however, exercise is not offered and the prisoner remains in the cell. Three times per week, showers are

offered to prisoners in the hole. The prisoner is handcuffed and shackled to and from the shower.

In the Pennsylvania state prisons, prisoners can be kept in solitary confinement – in conditions described above - for periods ranging from days to years and, in some case, decades.

The negative mental health effects caused by prolonged solitary confinement have been amply documented through published studies and reports and will undoubtedly be conveyed to you by others submitting testimony. The accounts we hear from prisoners throughout Pennsylvania echo the findings of those studies and the accounts of other prisoners across the country. Two examples offer good illustrations of how this punishment works and its effects.

Paul Rogers is 41 years old. He has been in solitary confinement in the Pennsylvania Department of Corrections system for twelve years, after being found guilty of one assault on staff. Mr. Rogers has suffered from intense feelings of depression, rage, and anger from the extended deprivation of human contact and environmental stimuli. Over the course of the past twelve years, he has noticed his thinking becoming negative and irrational and his social skills deteriorating – he has trouble maintaining eye contact or holding conversations. During his time in solitary, he has had episodes of paranoia and has heard voices, neither of which he had experienced before. It has been extremely difficult for him to maintain his family ties while in solitary; his family must travel long distances to see him and when they do, their visits are "non contact" through glass. The negative impact extends beyond the prison walls as well. Mr. Rogers' mother recently related to us her grief at not being able to give her son a hug for twelve years.

Mr. Rogers has not incurred any serious disciplinary infractions in twelve years and has maintained an overall positive behavior record. While he has completed various prison programs

successfully and received positive recommendations for release from the RRL from staff, he has not been approved for release from solitary. Indeed, although he has asked on numerous occasions how he can "earn" his way out of solitary, he has never been given a clear answer. Not surprisingly, there is little reason for hope, or good behavior, in these conditions. Unfortunately, this story is not unique, and we have heard from many other prisoners who have been held in these conditions for similar lengths of time, some even longer.

Another one of our clients held in solitary confinement was in Pennsylvania's "SMU," a program where prisoners can theoretically "move up" through the levels into general population. The reality is that this client spent years in the bottom level without any reading materials, hygiene products such as deodorant, or contact visits. Even worse, he was denied mental health treatment while in solitary. Instead of recognizing this prisoner's acts of self-harm as manifestations of his mental illness and desperate cries for help, prison officials blamed the prisoner for these acts, considered them to be "misconduct" and responded with continued punishment in solitary rather than with mental health treatment. He never received the treatment he needed and was released to the community after only a brief stay in general prison population. Sadly, but perhaps not surprisingly, he has since been rearrested.

We have heard from numerous prisoners that their mental illness and its behavioral manifestations were not taken into consideration in the disciplinary process, resulting in prolonged time in solitary confinement. If any mental health treatment is provided to the prisoners in solitary confinement, it is insufficient. In the worst cases, individuals successfully commit suicide.

Examples such as these, where solitary confinement is imposed in lieu of mental health treatment, are unfortunately prevalent in the Pennsylvania system. Indeed, the Department of

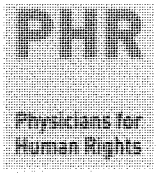
Justice has recently undertaken an investigation into the use of solitary confinement at SCI Cresson, a DOC institution in the Western part of the state.

In addition to the psychological effects of solitary confinement, prisoners' physical safety is at much greater risk in isolation, as there are fewer witnesses to individual acts of violence on the part of staff.

Thank you again for holding this important hearing and considering this testimony.

Sincerely,

Jennifer J. Tobin
Staff Attorney



Using science and medicine to stop human rights violations

Statement for the Record from Physicians for Human Rights

Senate Judiciary Committee, Subcommittee on the Constitution, Civil Rights and Human Rights

"Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences"

June 19, 2012

Dear Chairman Durbin, Ranking Member Graham, and distinguished Members of this Committee:

Physicians for Human Rights (PHR) appreciates this opportunity to join in the growing chorus of calls to end the use of solitary confinement in America's prisons, jails, and detention facilities. As an independent organization that uses medicine and science to stop severe human rights human violations, PHR firmly believes that the well-documented psychological and physiological effects of even a brief period spent in solitary confinement are so detrimental that the practice must be prohibited, except when it is absolutely necessary to protect the lives or safety of others. Mr. Chairman, we applaud your leadership on this important human rights issue and look forward to your continued efforts to curb the use of solitary confinement.

In 1842, Charles Dickens visited the newly-constructed Philadelphia Prison, which kept all of its inmates in solitary confinement for the entire period of their incarceration. After touring this facility, which many held up as a model for prisons across the country, Dickens wrote that an inmate in solitary confinement "is a man buried alive ... dead to everything but torturing anxieties and horrible despair."[1]

[1] Charles Dickens, "Philadelphia, and Its Solitary Prison," *American Notes* (1842), *available at* http://www.victorianweb.org/authors/dickens/pva/pva344.html.

Dickens' observation remains true 170 years later. American prisons, jails, and detention facilities use solitary confinement now more than ever, despite overwhelming evidence that it is ineffective, counterproductive, and causes severe mental and physical suffering. While the separation of dangerous or vulnerable inmates from the rest of the prison population is sometimes necessary to running a safe facility, our country's current widespread use of solitary confinement veers far outside the realm of the necessary into the purely punitive.

As the title of this hearing acknowledges, the use of solitary confinement implicates human rights, fiscal, and public safety concerns. But the mere fact that solitary confinement violates fundamental human rights that apply to all individuals – including those in prisons, jails, and detention facilities – is alone enough to warrant an end to the practice in virtually all cases. In the way in which it is used in the United States today, solitary confinement constitutes torture and/or cruel, inhuman, or degrading treatment, in violation of both international law and America's founding principles.

While clearly detrimental to the approximately 25,000 inmates held in isolation in prisons and jails, we note that the use of solitary confinement is particularly inappropriate for detainees in immigration detention facilities and national security detention facilities. Unlike prisons and jails, these detention facilities are used to detain people for administrative purposes – not as punishment for having been convicted of a crime. Many detainees in these facilities have been tortured in the past or suffer from mental illnesses, making them particularly susceptible to the harmful psychological effects of solitary confinement. And oversight and avenues for judicial review in these facilities are sorely lacking, leaving detainees with few options for challenging their placement in solitary. We urge Congress to hold additional hearings to examine the use of solitary confinement in these settings.

Given Physicians for Human Rights' medical and scientific expertise, we will focus our testimony on the psychological and physiological effects of solitary on inmates and detainees. These effects are well-documented, pervasive, and uniformly negative across all populations held in solitary.

Psychological Effects

Almost since solitary confinement was first used in the early 19th century, its harmful psychological effects have been well-documented. In fact, shortly after solitary confinement was established in the United States as a means of incarceration, the high rates of severe mental disturbances resulting from solitary confinement caused it to fall into disuse.[2] Early observers noted that even among prisoners with no prior history of mental illness, those held in solitary confinement exhibited "severe confusional, paranoid, and hallucinatory features," as well as "random, impulsive, often self-directed violence."[3] For those who entered prison with a

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[2] Stuart Grassian, "Psychiatric Effects of Solitary Confinement," *Washington University Journal of Law and Policy* 22:325-383 (2006), at 328.
[3] Id.

preexisting mental illness – as a disproportionately large portion of today's incarcerated population do – solitary confinement exacerbated those conditions.[4]

Recent research has confirmed that solitary confinement often results in a syndrome described as "prison psychosis," the symptoms of which include anxiety, depression, anger, cognitive disturbances, perceptual distortions, paranoia, psychosis, and self-harm.[5] Dr. Stuart Grassian, a noted expert on the psychological effects of solitary confinement, has identified a group of symptoms associated with solitary confinement:

- Hyperresponsivity to external stimuli;
- Perceptual distortions, illusions, and hallucinations;
- Panic attacks;
- Difficulties with thinking, concentration, and memory;
- Intrusive obsessional thoughts;
- Overt paranoia;
- Problems with impulse control, including random violence and self-harm.[6]

This combination of symptoms – some of which Grassian notes are found in virtually no other psychiatric illnesses – together form a unique psychiatric syndrome resulting exclusively from solitary confinement.[7]

While the mental health effects of even a short, defined period of time in solitary confinement can be disastrous, many individuals are held in solitary for prolonged or indefinite lengths of time. These individuals "are in a sense in a prison within a prison,"[8] and the effects on mental health are correspondingly severe. The effects of prolonged solitary confinement, which the UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment defines as solitary confinement lasting longer than 15 days,[9] include symptoms of post-traumatic stress such as flashbacks, chronic hypervigilance, and hopelessness; and continued intolerance of social interaction after release.[10]

Furthermore, the deleterious effects of solitary confinement can be even more pronounced among the high proportion of inmates and detainees in American prisons and detention facilities who suffer from preexisting personality disorders or other mental health

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[4] Id. at 329.
[5] Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, ¶62, U.N. Doc. A/66/268 (August 5, 2011) (*prepared by* Juan Mendez) (*hereinafter* "Mendez Report"), *available at* http://www.ohchr.org/EN/Issues/Torture/SRTorture/Pages/SRTortureIndex.aspx.
[6] Grassian, "Psychiatric Effects of Solitary Confinement," at 335-36.
[7] Id. at 337.
[8] Mendez Report at ¶ 57.
[9] Mendez at ¶ 79.
[10] Grassian, "Psychiatric Effects of Solitary Confinement," at 353.

problems.[11] Indeed, such inmates are the most likely to develop psychoses after being placed in solitary confinement.[12] But even inmates with histories of relatively strong psychological functioning suffer severe psychological trauma as a result of solitary confinement.[13]

Moreover, the negative mental health effects of solitary confinement often continue after an inmate is released, as most eventually are. One notable study found that the symptoms of prison psychosis last long after release from solitary confinement, while lasting personality changes resulting from solitary can permanently impair social interaction.[14] This not only inhibits an inmate's ability to adjust to life in the general prison population – where maladjustment often leads to disciplinary infractions, which in turn lead to more solitary confinement – but severely impairs a released inmate's ability to safely and successfully reintegrate into general society, effectively defeating any purported rehabilitative component of incarceration.[15] Instead of curing antisocial behavior, solitary confinement exacerbates it, perpetuating a cycle that results in more incarceration and more solitary confinement.

In interviews of inmates who were released from prison after spending time in solitary, many report having difficulty interacting with their families. One describes how he "curls up in a corner of his apartment, blinds drawn, alone," while another gave himself a black eye while on parole.[16] Eighteen months after being released back into society from solitary confinement, Brian Nelson describes how he feels every day: "People ask me what hurts. I say the box, the gray box. I can feel those walls and I can taste them every day of my life. I'm still there, really. And I'm not sure when I'm ever gonna get out."[17]

The potential for this cycle is particularly worrisome for immigration and national security detainees, the vast majority of whom are released back into society. Indeed, such detainees are held with the intention of temporary detention and the presumption of future release. Safe reintegration into society is imperiled when these detainees are isolated in solitary confinement.

In short, the lack of social interaction that is the defining feature of solitary confinement causes severe psychological impairment in inmates and detainees that is severely disproportionate to almost any possible reason for their placement in solitary.

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[11] Id. at 348.
[12] Id. at 349.
[13] Id. at 354.
[14] Sharon Shalev, "A Sourcebook on Solitary Confinement" (2008) (*hereinafter* "Sourcebook") at 13, 22, *available at* http://www.solitaryconfinement.org/sourcebook..
[15] Grassian, "Psychiatric Effects of Solitary Confinement," at 332-33.
[16] Susan Greene, "The Gray Box: An Investigative Look at Solitary Confinement," January 24, 2012, *available at* http://www.dartsocietyreports.org/cms/2012/01/the-gray-box-an-original-investigation/.
[17] Id.

Physiological Effects

Solitary confinement also results in a number of serious and well-documented physiological effects as a result of both the physical manifestations of psychological problems, as well as common features of solitary confinement such as lack of access to fresh air and sunlight, and long periods of inactivity.[18]

Inmates and detainees held in solitary for even a short period of time commonly experience sleep disturbances, headaches, and lethargy. In one study, researchers found that over 80% of the isolated inmates in the study suffered from all three of these ailments, while more than half suffered from dizziness and heart palpitations as well.[19] Inmates in solitary confinement often suffer from appetite loss, weight loss, and severe digestive problems, sometimes resulting from their inability to tolerate the smell or taste of food in an environment of near-total sensory deprivation. Other common signs and symptoms include heart palpitations, diaphoresis, back and joint pain, deterioration of eyesight, shaking, feeling cold, and aggravation of pre-existing medical problems.[20] Moreover, as a result of the psychological trauma common to inmates in solitary confinement, self-harm and suicide are more common in solitary than among the general prison population.[21]

Because inmates in solitary confinement are often kept in separate wings of prisons and detention facilities and are, by definition, separated from other inmates, they are more likely to be subjected to excessive force and other physical abuse by corrections officers and guards.[22] And because they have more limited access to medical services, both pre-existing illnesses and illnesses resulting from time spent in solitary confinement often go untreated.

Conclusion

The physiological and, especially, psychological harm caused by even a relatively short period in solitary confinement is indisputable. A review of the medical literature on solitary confinement by Dr. Craig Haney concludes that "there is not a single published study of solitary or supermax-like confinement in which nonvoluntary confinement lasting for longer than 10 days, where participants were unable to terminate their isolation at will, that failed to result in negative psychological effects."[23] There is no question that the harm caused to an inmate or detainee kept in solitary confinement outweighs any benefit in all but the most extreme cases.

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[18] Shalev, "Sourcebook" at 15.
[19] Id. at 11.
[20] Id. at 15.
[21] Craig Haney and Mona Lynch, "Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement," *New York University Review of Law and Social Change* 23:477-570 (1997), at 525.
[22] Leena Kurki and Norval Morris, "The Purposes, Practices, and Problems of Supermax Prisons," *Crime & Justice* 28:385-424 (2001), at 409.
[23] Craig Haney, "Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement," *Crime & Delinquency* 49:124-156 (2003), at 132.

Social interaction is neither a right nor a privilege – it is a fundamental human need. "Simply to exist as a normal human being," writes Atul Gawande, "requires interaction with other people."[24]

Physicians for Human Rights urges members of Congress to work towards ending the use of solitary confinement in all facilities under federal jurisdiction, including federal prisons, immigration detention facilities, and national security detention facilities, in all but the most extreme cases. PHR believes that solitary confinement should never be used as a means of controlling mentally ill inmates and detainees, and that any use of solitary confinement should conform to the recommendation contained in the Istanbul Statement on the Use and Effects of Solitary Confinement: "As a general principle solitary confinement should only be used in very exceptional cases, for as short a time as possible and only as a last resort."[25]

While PHR firmly believes that solitary confinement should be used only in the rarest cases and only as a last resort, we recognize that it will continue to be used in prisons, jails, and detention facilities in the near future. Given the extremely harmful psychological and physiological effects of even a short period of time in solitary confinement, we emphasize that inmates and detainees held in solitary confinement must have the same or greater access to medical and mental health care as the general incarcerated or detained population. Individuals held in solitary must receive daily assessments from qualified medical and mental health professionals, whose ethical obligations are to their patients, not to the detaining authority.

We thank you for the opportunity to submit testimony for this important hearing, and we at PHR stand ready to engage with all congressional leaders to begin a serious dialogue focused on ending the use of this dangerous and counterproductive practice.

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[24] Atul Gawande, "Hellhole," *The New Yorker* (March 30, 2009), *available at* http://www.newyorker.com/reporting/2009/03/30/090330fa_fact_gawande.

[25] The Istanbul Statement on the Use and Effects of Solitary Confinement (December 9, 2007), *available at* http://www.solitaryconfinement.org/istanbul.

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Hearing Before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights

TESTIMONY OF PRISONERS' LEGAL SERVICES OF NEW YORK

July 19, 2012

INTRODUCTION

Prisoners' Legal Services of New York (PLS) would like to thank Senator Durbin, Chair of the Senate Judiciary Subcommittee on the Constitution, Civil Rights and Human Rights and Senator Graham, as well as the other members of the committee, for holding the first-ever Congressional hearing on solitary confinement, and for the opportunity to submit written testimony on this critical issue. The explosion in the use of solitary confinement in the United States prisons, jails and detention centers over the past thirty years demands an in-depth look into the human, moral, fiscal, and public safety consequences of such confinement, and we applaud this committee's foresight and courage in initiating a public discussion of this topic.

PLS is a nonprofit legal services organization that provides civil legal services to indigent prisoners in New York State correctional facilities on issues associated with their conditions of confinement. PLS was established in 1976 in response to the Attica uprising, a three-day siege that culminated on September 13, 1971, when then-Governor Rockefeller ordered state law enforcement agents to forcibly retake control of the Attica prison.[1] The events at Attica forced public attention on the inhumane treatment and living conditions of New York State prisoners and, as a result, many of those conditions improved. We learned a great deal from "Attica," but with respect to the issue of prolonged solitary confinement, we have lost sight of the most important lesson of all: the need for our criminal justice system to continually assess the effects of the conditions of confinement on prisoners and to consider those effects in light of our evolving standards of decency.

[1] That day has come to be known as the day when "the bloodiest prison confrontation in U.S. history" occurred. As a result of the uprising, a special state Commission (the McKay Commission) was created to investigate and report on the incident. After dozens of hearings and thousands of pages of testimony, the McKay Commission issued a report chastising New York State prison authorities for: failing to provide adequate programming and education for prisoners; the lack of any procedures for prisoners to air or resolve their grievances; poor conditions in the prisons; and the overall mistreatment of prisoners.

The sordid history of the use of solitary confinement should inform our analysis.[2] This history together with the current, almost daily, reports, across the country, about the effects of prolonged isolation on individual prisoners, requires us to examine whether our evolving standards of decency have brought us to a place where we can no longer tolerate such punishment. This hearing is the first step in that process.

SOLITARY CONFINEMENT IN NEW YORK

In New York, prisoners can be disciplined for a host of prison rule violations ranging from failing to have an identification card, to being out of place, to drug charges of various types, to creating a disturbance, fighting and assaults as well as many others. If a prisoner is charged with such misconduct, a disciplinary hearing is held against him. Although prisoners have some limited rights at these hearings, such as notice of the charges and the right to call (but not cross-examine) witnesses, for prisoners facing disciplinary hearings, there is no right to counsel.

The punishment for violating a prison rule can range from 'counsel and reprimand' to placement in solitary confinement, loss of visits with family, recommended loss of good time and loss of packages, phone and commissary privileges. Although New York State's Department of Corrections and Community Supervision (DOCCS) has internal "guidelines" for imposing solitary confinement,[3] these "guidelines" are applicable only to a few offenses, are not mandatory, and are often exceeded. In fact, there is no limit to the length of time a prisoner in New York State can be placed in solitary confinement.[4] Whether DOCCS follows its existing guidelines, however, is not really the issue; the research on the effects of solitary confinement on humans demonstrates that even the application of DOCCS' existing guidelines can result in conditions of confinement that jeopardize the physical and mental health of people so confined. And yet, in New York State, the number of individuals subjected to solitary confinement and the length of the terms of solitary

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[2] *See* Exhibit A for a brief history of solitary confinement.

[3] For instance, DOCCS' guidelines for an assault without a weapon and minor or no injury has a guideline range of 3 to 9 months in solitary confinement and 3-6 months loss of good time; an assault with a weapon with serious injury has a guideline range of 12-24 months in solitary confinement and 12-24 months loss of good time.

[4] Due to litigation by PLS, Prisoners' Rights Project and Disability Advocates, Inc., and legislative efforts by various advocacy groups, there has been a movement in New York State to reduce the amount of time a mentally ill prisoner might face in solitary confinement, but there is no such limit for other prisoners. In 2008, New York passed what is referred to as the SHU Exclusion law (McKinney's Correction Law §137), a law that requires that inmates diagnosed with serious mental illness be removed from segregated confinement and placed into residential mental health treatment units (RMHTU). The passage of the SHU Exclusion Law recognized that the percentage of individuals in DOCCS' custody who require mental health care is growing –10% in 2000, 11% in 2003, 13.9% in 2009, 14.5% in 2011 – and that these individuals should be provided treatment for their mental illness rather than punished for conduct that is a result of that mental illness. The SHU Exclusion Law, which expands on reforms that occurred due to extensive litigation on this issue, helps to ensure that inmates with serious mental illness will not languish in segregated confinement, but instead be provided proper therapeutic care.

confinement have increased, rather than decreased, over the past thirty years.

In 1983, the New York State prison population was 33,000 and there were 32 adult prisons. Solitary confinement, or what is referred to as "the special housing unit" (SHU) or "the box" was used as punishment, but a typical box term was 30 to 60 days. A 90 day term was given out for relatively serious misbehavior, a 6 month box term was for very serious misbehavior and a year or more in the box was, for the most part, unheard of. There were no facilities that were built solely to house prisoners in solitary confinement. Eighteen years later, in 2001, there were approximately 70,000 prisoners and 70 prisons. The average box term had increased from 2 months to 5 months and 6.7 percent of the prison population was being held in solitary confinement.

Today the prison population has actually decreased to 55,000, but box terms have continued to increase with 18 months to 2 year box terms being far from uncommon. Over 4,300 prisoners, or 7.6% of the prison population, are currently being held in solitary confinement.

CASE STUDIES

Each year, PLS receives and responds to more than 12,000 requests for assistance and many of those requests involve issues associated with prisoners being held in solitary confinement for prolonged periods of time. Some of those prisoners suffered from mental illness when they were initially placed in solitary confinement, while others develop mental illness as a result of the prolonged isolation. Very few are able to tolerate prolonged isolation without suffering some damage to their physical, emotional or mental health.

The steady increase in the amount of box time that is imposed for various misbehaviors appears to have resulted in desensitization to the purpose and effects of solitary confinement by hearing officers and DOCCS officials. Because of this, prisoners are often given months or years of time in solitary confinement without any regard to whether such prolonged isolation will have any positive effect on prison security or the individual's future conduct. Below are a few cases that we have recently reviewed at PLS that demonstrate the lengthy solitary confinement sentences presently being imposed by DOCCS.

Case No. 1

Our client was charged with drug use based on a positive urinalysis test for "cannabinoids." The hearing officer found him guilty and found that the prisoner's prior guilty dispositions for drug use in 2007, 2009 and 2010 "displays a propensity for illegal drug use and blatant disregard of NYS rules." Rather than ordering participation in a drug treatment program, the hearing officer imposed a penalty of **12 months solitary confinement** and 36 months loss of other privileges.

Case No. 2

Our client was charged with drug use based on a positive urinalysis for cannabinoids. He pled not guilty, but stated that he is addicted to cannabinoids and he was on a waiting list for the Alcohol and Substance Abuse Treatment (ASAT). While acknowledging that our client was on the waiting list, the hearing officer noted that the ASAT manual states that inmates with 12 months to earliest release date will be given preference." Our client, who was more than 12 months before his earliest release date, was given **18 months solitary confinement** and loss of privileges.

Case No. 3
Our client was given **one year in solitary confinement** and one year recommended loss of good time for Misleading/False Information and Interference with Employee. Our client claimed she was assaulted by another inmate who coerced her into making a false statement, alleging sexual misconduct, by a Correction Officer.

Case No. 4
Our client was given **15 months solitary confinement** and 15 months recommended loss of good time for possessing a cell phone.

Case No. 5
Our client, with significantly below average intellectual capacity, assaulted another prisoner who died as a result of the assault. Our client attempted to explain that he was being forced to smuggle drugs into the facility through extortion and threats against his family but his limited intellectual capacity made it difficult for him to present this defense. He was given **99 months in solitary confinement** and recommended loss of good time.

Case No. 6
Our client was in a work release program at a DOCCS facility. He and other inmates were drinking alcohol with the knowledge and consent of the dorm officer. Our client claimed that the officer gave him and another inmate permission to leave the facility, as long as they were back in time for the 9:30 p.m. count. The officer did not dispute this. The two prisoners left the facility and went bar-hopping. Our client got drunk, fell in a ditch, and apparently passed out. Documents show that the state police apprehended him at about 10:45 p.m. He was charged with escape, temporary release violation, leaving assigned area, causing a miscount and alcohol. At the hearing he pled guilty to alcohol and to temporary release violation, but not guilty to the other charges because he insisted that a CO allowed him to leave. He was found guilty of all of the charges and given a penalty of **87 months solitary confinement** and 87 months recommended loss of good time. We appealed and the penalty was administratively reduced to 43 months SOLITARY CONFINEMENT.

Case No. 7
Our client is transgender and has been held under the label of 'involuntary protective custody' **in solitary confinement for over 7 years.** She has mentally deteriorated in solitary confinement and has attempted self-castration.

JUVENILES IN SOLITARY CONFINEMENT

The Supreme Court categorically presumes juveniles to be less culpable for their actions than adults[5] and has recognized at least two fundamental differences between adults and juveniles that support a finding of diminished juvenile culpability.[6] First, a lack of maturity and an underdeveloped sense of responsibility are more typical of youth than adults. Second, juveniles are more vulnerable or susceptible to negative influences and outside pressures, including peer pressure, than are adults.

Current scientific research suggests that juveniles should not be held culpable for their conduct to the same degree that adults are because juveniles lack fully developed frontal lobes required for impulse control[7] and because their brain structure is fundamentally and significantly different from that of adults.[8] General principles of child development show that adolescents process thoughts, feelings and information in qualitatively different ways than adults do and that they are psychologically very different from adults. Because juveniles lack a developed frontal lobe, they tend to process emotional decisions in the limbic system, the part of the brain responsible for instinctive (and often impulsive) reactions.[9] An adult's fully developed frontal lobe typically allows the adult to curb impulsive decisions coming from other parts of the brain such as the limbic system.[10] As such, the average juvenile cannot be expected to demonstrate the same level of maturity, judgment, risk aversion or impulse control that we expect from the adult.[11] This is particularly true in stressful situations, where juvenile brain circuitry is not sufficiently established to sustain adult-level cognitive control of their behavior in the face of heightened states of affect or motivation.[12]

In the correctional setting, there is no harsher punishment than solitary confinement. Imposing solitary confinement on a child is particularly cruel. Because of how they experience time, juveniles subjectively perceive the duration of a sanction as lasting longer than an adult would experience a sanction of the same duration.[13] In practical terms, sentencing juveniles to prolonged isolation is harsher than an equivalent sentence is for an adult.

Moreover, from a developmental point of view, prolonged isolation is problematic because juveniles are undergoing developmentally important phases of life in an institutional setting with idiosyncratic demands particular to that setting.[14] Depriving them of normal developmental opportunities, such as social contact, physical exercise and intellectual stimulation for prolonged

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[5] Roper v. Simmons, 543 U.S. 541, 570 (2005).
[6] Id.
[7] *Principles of Child Development and Juvenile Justice – Information for Decision-Makers,* David A. Arredondo, M.D., Journal of the Center for Families, Children & the Courts, 2004, p. 129.
[8] Tracy Ritmer, *Arrested Development: Juvenile's Immature Brain's Make Them Less Culpable Than Adults*, 9 Quinnipiac Health L.J. 1, (2005) p. 4.
[9] Arrendondo at p.129
[10] Ritmer at p.24
[11] Ritmer at p.23
[12] Ritmer at p.27
[13] Arredondo at p.131.
[14] Arredondo at p.132.

periods of time, will irreparably damage any prospect they may have for normal development. Punishing a child whose brain is not fully developed by placing him in solitary confinement for any length of time clearly violates our contemporary standards of decency as evidenced by a plethora of data on child development.

In New York State, juveniles between the ages of 16 and 18 who have committed certain offenses will be house in adult correctional facilities. As of December 2010, there were 689 individuals in DOCCS custody between the ages of 16-18 and 2,064 between the ages of 19 and 20. The State has recognized the vulnerable stage of development of the adolescent by establishing standards for the treatment of juveniles in detention which include a prohibition on the use of solitary confinement in the discipline of children,[15] but those rules do not apply to adult facilities. The American Correctional Association (ACA) standards for juvenile justice detention facilities limit the isolation of juveniles to a maximum of five days. These prohibitions and limits are in place because both New York lawmakers and the major national correctional organization in the U.S. recognize the unique physical and developmental status of juveniles and their related needs.

In addition, the U.S. Department of Justice, Chief of the Special Litigation Section, Civil Rights Division has remarked that "the wholesale adoption of many adult practices without taking adequate account of the relevant differences between adults and adolescents, has often resulted in operational difficulties and violations of juvenile's federal rights. The use of extended isolation as a method of behavior control, for example, is an import from the adult system that has proven both harmful and counterproductive when applied to juveniles. It too often leads to increased incidents of depression and self-mutilation among isolated juveniles, while also exacerbating their behavior problems."[16]

Below are two examples describing the placement of juveniles in isolation:

Case No. 1

Our client is a **16 year old youthful offender who was sentenced to three years in solitary confinement** and loss of privileges for running away from a "shock" facility. He claimed he ran away because he was being abused by corrections officers – abuse that included being locked in a janitor's closet overnight for the three nights prior to his attempt to run away. We appealed the disposition and received a decision from DOCCS reducing the solitary confinement time from three years to six months.

Case No. 2

Our client is **17 year old and was given 4 years in solitary confinement** with 4 years loss of good time, phones, packages and commissary for allegedly assaulting a corrections officer. The standard at disciplinary hearings is "substantial evidence" which means "some evidence." He

[15] Title 9 N.Y.C.R.R. §180.9(c)(10)(iii), Discipline of Children.

[16] Remarks of Steven H. Rosenbaum, Chief, Special Litigation Unit, Civil Rights Division, United States Department of Justice, before the Fourteenth Annual National Juvenile Corrections and Detention Forum at Long Beach , California, May 16, 1999.

will spend from age 17 to age 21 confined to a small cell for 23 hours per day, 7 days per week.

Based upon the scientific evidence regarding a juvenile's brain development, the regulations in NYS that prohibit the use of solitary confinement for juveniles detained in juvenile detention facilities, the ACA standards for juvenile justice detention facilities, the U.S. Department of Justice Civil Rights Division's position on the use of solitary confinement when dealing with juveniles and our own contemporary standards of decency, we should immediately prohibit the use of solitary confinement in cases where the individual is under 21 years old.

SOLITARY CONFINEMENT AND SENSORIALLY DISABLED INDIVIDUALS

In New York State, DOCCS places both deaf and blind inmates who engage in misconduct in solitary confinement for significant lengths of time without consideration of how their disability may affect their ability to cope with solitary confinement. Below is one example of such a case:

> Our client is an intelligent, humorous man who has been profoundly deaf since birth. **He has already spent a total of over seven years in solitary confinement** for disruptive behaviors of many kinds. He has significant difficulty communicating with DOCCS' staff and the lack of competent translation services leads to his frustration and resulting disciplinary charges. As a result he continues to receive additional solitary confinement penalties. **Presently he is scheduled to be held in solitary confinement until 2017.** The time he has spent in solitary confinement has caused severe mental deterioration and as a result he has engaged in self-harming behaviors.

One can only imagine the profound isolation that our client, and others like him, experience. As with juveniles who engage in misconduct while in prison, the specific issues associated with disabled prisoners cry out for the use of a different prison management tool.

EVOLVING STANDARDS OF DECENCY

In May of 2000, the U.N. Committee against Torture issued a report expressing concern over "[t]he excessively harsh regime of the 'supermaximum' prisons" in the United States.[17] In 2008, U.N. Special Rapporteur to the Human Rights Council noted that "the use of prolonged solitary confinement may amount to a breach of article seven of the International Covenant on Civil and Political Rights,"[18] and that it "should be strictly and specifically regulated by law."[19] Presidential hopeful John McCain talked about his experience in solitary confinement as a prisoner of war in

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[17] U.N. Comm. against Torture, *Report of the Committee against Torture*, Supp. No. 44, U.N. Doc. A/55/44, May, 2000, at 32, *available at* http://www.un.org/documents/ga/docs/55/a5544.pdf.
[18] *See* NYCBA COMM., *supra* note 12, at 18.
[19] *Id.*

Vietnam where he spent five and a half years in isolation in a fifteen-by-fifteen-foot cell.20 He stated: "It's an awful thing, solitary.... [i]t crushes your spirit and weakens your resistance more effectively than any other form of mistreatment."[21]

In Europe, solitary confinement has rarely been used since a 1982 decision from the European Commission stated that "[c]omplete sensory isolation coupled with total social isolation, can destroy the personality and constitutes a form of treatment which cannot be justified by the requirements of security or any other reason."[22] Conditions at supermax facilities in the United States have also allowed prisoners to successfully resist extradition to the United States from foreign nations.[23] Unfortunately, international treaties, most notably the ICCPR and CAT, have had little effect on prison litigation in the United States, due in part to the reservations adopted by the United States upon ratifying both treaties.[24]

Legal organizations in America have also begun to adopt stances critical of solitary confinement and supermax facilities. In 2011, the New York City Bar Association Committee on International Human Rights (NYCBA), recognized that the state of the law is increasingly critical of solitary confinement, and took a strong stance against it:

> The policy of supermax confinement, on the scale which it is currently being implemented in the United States, violates basic human rights. We believe that in many cases supermax confinement constitutes torture under international law according to international jurisprudence...[t]he time has come to critically review and reform the widespread practice of supermax confinement.[25]

The authors of the NYCBA report took note of the Constitutional dimensions as well:

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[20] Most, if not all, of New York's single isolation cells are much smaller than this.

[21] Antul Gwande, "Hellhole," *New Yorker*, March 2009. "And this comes from a man who was beaten regularly; denied adequate medical treatment for two broken arms, a broken leg, and chronic dysentery; and tortured to the point of having an arm broken again. A U.S. military study of almost a hundred and fifty naval aviators returned from imprisonment in Vietnam, many of whom were treated even worse than McCain, reported that they found social isolation to be as torturous and agonizing as any physical abuse they suffered."

22 *Id.* at 20 (quoting) Krocher v. Switzerland, 34 Eur. Comm'n H.R. Dec. & Rep. 24, 53, P 62 (1982); *see, e.g.*, Elizabeth Vasiliades, *Solitary Confinement and International Human Rights: Why the U.S. Prison System Fails*, 21 AM. U. INT'L L. REV. 71, 93-94 (2005).

23 NYCBA COMM., *supra* note 12, at 20–21 ("In the 1989...the European Court refused extradition to the United States based on the extreme psychological effects of confinement on death row.... The European Court is also considering whether supermax conditions in US prisons violate Article 3 of the European Convention, which prohibits the extradition to a state where the prisoner is at risk of inhuman and degrading treatment. Babar Ahmad, a British citizen, and three others, were indicted in the US on terrorism charges. The Court blocked the extraditions and as of July 2011 was considering whether the defendants' post-trial confinement to the federal supermax prison amounts to a violation of Article 3 of the European Convention.") (internal citations omitted).

[24] *Id.* at 19.

[25] *Id.* at 2 (quoting Rhodes v. Chapman, 452 U.S. 337, 349 (1981); Estelle v. Gamble, 429 U.S. 97 (1976) (internal citations omitted)).

> Although the Constitution "does not mandate comfortable prisons," it does require humane prisons that comport with the Eighth Amendment's prohibition against punishments that are "incompatible with 'the evolving standards of decency that mark the progress of a maturing society" or which "involve the unnecessary and wanton infliction of pain."[26]

Other professional organizations, as well as numerous advocacy groups, both secular and religious, have followed suit.[27] Meanwhile, public opinion on the issue of solitary confinement has become decidedly negative, with numerous commentators from various backgrounds speaking out against it with greater frequency in recent years.[28] These groups, taken together with the international law regarding the use of solitary confinement, as well as the customs of other civilized nations, make

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[26] *Id.* at 5.

[27] *See, e.g.*, Nat'l Commc'n Assoc., Resolution Regarding Extended Solitary Confinement and Torture, Nov. 2010, *available at* http://www.natcom.org/uploadedFiles/About_NCA/Leadership_and_Governance/Public_Policy_Platform/PDF-PolicyPlatform-Resolution_Regarding_Extended_Solitary_Confinement_and_Torture.pdf; NAT'L RELIGIOUS CAMPAIGN AGAINST TORTURE (NRCAT), *Statement Against Prolonged Solitary Confinement* (last visited Mar. 15, 2012), http://www.nrcat.org/index.php?option=com_content&task=view&id=546&Itemid=396; Tanya Greene, *ACLU To United Nations: Solitary Confinement Violates Human Rights*, AMERICAN CIVIL LIBERTIES UNION (Mar. 5, 2012), http://www.aclu.org/blog/prisoners-rights/aclu-united-nations-solitary-confinement-violates-human-rights.

28 In addition to works already cited, *see, e.g.*, Locke Bowman, *Gov. Quinn's Proposal to Close Tamms Supermax Prison Got It Right*, HUFFINGTON POST (Mar. 13, 2012, 4:28 PM), http://www.huffingtonpost.com/locke-bowman/gov-quinns-tamms-supermax-prison_b_1342135.html (condemning conditions at Tamms Prison in Illinois); Bill Quigley, *Bradley Manning, Solitary Confinement, and Occupy 4 Prisoners*, HUFFINGTON POST (Feb. 23, 2012, 3:43 PM), http://www.huffingtonpost.com/bill-quigley/bradley-manning-solitary-_b_1296141.html (referring to solitary confinement of Bradley Manning as "torture"); James Ridgeway, *Bradley Manning's Tortuous Treatment Met by Growing Resistance*, MOTHER JONES (Mar. 18, 2011, 9:02 AM), http://motherjones.com/mojo/2011/03/bradley-mannings-solitary-confinement-meets-growing-resistance (describing protests against Bradley Manning's conditions of confinement); Susan Greene, *The Gray Box: An Investigative Look at Solitary Confinement*, DART SOCIETY (Jan. 24, 2012, 9:53 PM), http://www.dartsocietyreports.org/cms/2012/01/the-gray-box-an-original-investigation/; *The Abuse of Private Manning*, N.Y. TIMES (Mar. 14, 2011), http://www.nytimes.com/2011/03/15/opinion/15tue3.html?_r=1; Stephen F. Eisenman, *The Resistable Rise and Predictable Fall of the U.S. Supermax*, MONTHLY REVIEW (Nov. 2009), http://monthlyreview.org/2009/11/01/the-resistable-rise-and-predictable-fall-of-the-u-s-supermax (noting that some prisoners intentionally hurt themselves in order to be taken out of their isolation cells); Joseph B. Allen, *Applying Graham v. Florida to Supermax Prisons*, 20 WM. & MARY BILL RTS. J. 217 (2011) (seeking to expand the scope of the Eighth Amendment protection offered to prisoners in solitary confinement); Kiilu Nyasha, *America's Supermax Prisons do Torture*, OPEDNEWS.COM (Nov. 22, 2009, 9:52 PM), http://www.opednews.com/articles/America-s-Supermax-Prisons-by-Kiilu-Nyasha-091122-501.html; *Supermax: A Clean Version of Hell*, CBS NEWS (Oct. 14, 2007), http://www.cbsnews.com/stories/2007/10/11/60minutes/main3357727.shtml?tag=contentMain;contentBody; Laura Sullivan, *As Populations Swell, Prisons Rethink Supermax*, NPR (July 27, 2006), http://www.npr.org/templates/story/story.php?storyId=5587644 (mentioning warden of Oregon State penitentiary); Maria Godoy, *Q&A: Solitary Confinement and Human Rights*, NPR (July 27, 2006), http://www.npr.org/templates/story/story.php?storyId=5586937 (interviewing Jamie Fellner of Human Rights Watch); Julia Dahl, *Is it Time to Ban Solitary Confinement?*, THE CRIME REPORT (Oct. 12, 2009), http://www.thecrimereport.org/archive/is-it-time-to-ban-solitary-confinement/#; Lance Tapley, *Torture in Maine's Prison*, Portland Phoenix (Nov. 11, 2005), http://www.portlandphoenix.com/features/top/ts_multi/documents/05081722.asp.

a compelling case that long term solitary confinement no longer falls within the ambit of "evolving standards of human decency that mark the progress of a maturing society."[29] Furthermore, it is becoming increasingly clear that long term solitary confinement is not only unnecessary, but counterproductive as a means of maintaining institutional protection, discipline and safety in correctional facilities.[30] As such, the continued use thereof constitutes an "unnecessary and wanton infliction of pain," which ought to be rejected, both in law and morality.

RECOMMENDATION

The known effects of solitary confinement on an individual's mental and physical health, mandate congressional reform. That reform should identify solitary confinement as the most extreme form of punishment that should only be used in the most extreme circumstances, for people who pose an active and ongoing threat to the safety of prison staff and other prisoners. Even then, prisoners should be regularly evaluated to ensure that they are being properly treated and that their mental health is not being adversely affected, and there should be systems in place for prisoners to earn their way out of solitary confinement.

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[29] *Gamble*, 429 U.S. at 102.
[30] Erica Goode, *Rethinking Solitary confinement*, N.Y TIMES, Mar. 11, 2012, at A1. This article is available online under the title, "*Prisons Rethink Isolation, Saving Money lives and Sanity*," *available at* http://www.nytimes.com/2012/03/11/us/rethinking-solitary-confinement.html?pagewanted=all.

EXHIBIT A

A BRIEF HISTORY OF SOLITARY CONFINEMENT

The origins of solitary confinement in the United States are often placed in the early nineteenth century, as an outgrowth of the prison reform movement led by Pennsylvania Quakers.[31] However, examples of solitary confinement in America range at least as far back as 1787.[32] Advocates for solitary confinement originally thought it was rehabilitative in nature.[33] The reasoning was that a prisoner, left alone with only their conscience and a Bible, would have time to reflect on their bad deeds, and come to see the nature of their crimes; after which the prisoners would voluntarily reform themselves into normal, law-abiding citizens.[34]

Over time, experience contradicted the conviction of the reformers. Jurists in the late 18th century came to recognize solitary confinement as a "greater evil than certain death."[35] Indeed, reformers in 18th century Britain believed that solitary confinement provided "the most terrible penalty short of death that a society could inflict,"[36] while at the same time being the most humane.[37] It was reported in late 18th century American newspapers that prisoners housed in solitary confinement "[begged], with the greatest of earnestness, that they be hanged out of their misery[.]"[38] Similar results were had in Britain: the "rigid system of perfect order and perfect silence" in operation at Pentonville prison in London resulted in "twenty times more cases of mental disease than in any other prison in the country."[39] In the Netherlands, solitary confinement fared no better:

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[31] Christine Rebman, *The Eighth Amendment and Solitary Confinement: The Gap in Protection from Psychological Consequences*, 49 DEPAUL L. REV. 567, 574 (1999).
[32] *See* In re Medley, 134 U.S. 160, 168 (1890) (describing conditions in a Philadelphia Penitentiary circa 1787).
[33] *Id.*
[34] *See* SHARON SHALEV, A SOURCEBOOK ON SOLITARY CONFINEMENT 2 (2008); *see, e.g.*, Craig Haney & Mona Lynch, *Regulating Prisoners of the Future: A Psychological Analysis of Supermax and Solitary Confinement*, 23 N.Y.U. REV. L. & SOC. CHANGE 477, 481—82 (1997).
[35] *Id.* at 483. Haney & Lynch also note that "[e]arly modern judges had fewer scruples about meting out physical punishments, but they found solitary confinement an unbearable torment." *Id.* at 482 (quoting DARIO MELOSSI & MASSIMO PAVARINI, THE PRISON AND THE FACTORY: ORIGINS OF THE PENITENTIARY SYSTEM 150 (Glynis Cousin trans., Barnes & Noble Books) (1981)).
[36] Haney & Lynch, *supra* note 4, at 482.
[37] *Id.*
[38] *Id.*
[39] *Id.* at 481; *see, e.g.*, Martha Grace Duncan, *In Slime and Darkness: The Metaphor of Filth in Criminal Justice*, 68 TUL. L. REV., 725, 788 (1994); Christopher Hibbert, THE ROOTS OF EVIL: A SOCIAL HISTORY OF CRIME AND PUNISHMENT 160 (1963).

"[a]gain and again reports of insanity, suicide, and the complete alienation of prisoners from social life seriously discredited the new form of punishment."[40] Prison reformers in Auburn, New York, who implemented their own "rigid system," encountered similar failures. The account of Beaumont and Tocqueville, who traveled to the prison as observers, was especially damning:

> This experiment, of which the favourable results had been anticipated, proved fatal for the majority of prisoners. It devours the victim incessantly and unmercifully; it does not reform, it kills. The unfortunate creatures submitted to this experiment wasted away. . . .[41]

Additionally, Charles Dickens, in 1842, described conditions of prisoners under solitary confinement in Pennsylvania: "[T]here is a depth of terrible endurance in it which none but the sufferers themselves can fathom . . . this slow and daily tampering with the mysteries of the brain [is] immeasurably worse than any torture of the body."[42] The nearly universal consensus of observers that solitary confinement was both inhumane and ineffective as a corrections tool led to its general abandonment in America for at least a century.[43]

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[40] Haney & Lynch, *supra* note 4, at 482 (quoting Herman Franke, *The Rise and Decline of Solitary Confinement: Socio-Historical Explanations of Long-term Penal Changes*, 32 BRIT. J. CRIMINOLOGY 125, 128 (1992)).
[41] Haney & Lynch, *supra* note 4, at 483. Another commenter observed that the prison reforms at Auburn, New York were a "hopeless failure that led to a marked prevalence of sickness and insanity on the part of the convicts in solitary confinement." *Id.* at 484.
[42] NEW YORK CITY BAR ASSOC., COMM. ON INTERNAT'L HUMAN RIGHTS, SUPERMAX CONFINEMENT IN U.S. PRISONS 6 (2011) (hereafter 'NYCBA COMM.').
[43] *Id.*

Testimony of Rabbi Rachel Kahn-Troster, Director of North American Programs
Rabbis for Human Rights-North America
Before the Senate Judiciary Committee
Subcommittee on the Constitution, Civil Rights and Human Rights
Hearing on Reassessing Solitary Confinement
June 19, 2012

Mr. Chairman, Members of the Subcommittee, thank you for this opportunity to submit testimony on behalf of Rabbis for Human Rights-North America concerning the use of solitary confinement in our nation's federal prisons, jails, and detention centers. It is reassuring that a growing number of states across the nation are reassessing this practice and implementing policies to limit its use. We are grateful for the Subcommittee's timely review of the federal system's use of isolation today.

Rabbis for Human Rights-North America is an organization of rabbis from all streams of Judaism that acts on the Jewish imperative to respect and protect the human rights of all people. Grounded in Torah and our Jewish historical experience and guided by the Universal Declaration of Human Rights, we advocate for human rights in Israel and North America. We were founding members of the National Religious Campaign Against Torture, and our mission to end the use of prolonged solitary confinement in the United States is an outgrown of our anti-torture campaign.

At the beginning of Genesis, we read: "It is not good for a human to be alone." (Genesis 2:18) From the very beginning of human existence, there is an awareness that people are social creatures, designed to be in community with others. Genesis also teaches us that every human being – no matter what their behavior might be – is created in God's image, *b'tzelem elohim*. Therefore, to intentionally torture, humiliate or degrade another human is akin to degrading the divine.

If we take our belief in God seriously as people of faith, then we cannot be silent when more than 80,000 people every day in the United States are subject to degrading conditions of incarceration. As Gabriel Reyes (a prisoner and former hunger striker at the Pelican Bay State Prison) recently described to the San Francisco Chronicle: "Unless you have lived it, you cannot imagine what it feels like to be by yourself, between four cold walls, with little concept of time, no one to confide in, and only a pillow for comfort - for years on end. It is a living tomb."

There is an increasing consensus that prolonged solitary confinement of prisoners leads to profound and often irreversible psychological impairments without making anyone safer (whether other prisoners, guards, or the public at large), and that it constitutes a form of torture. By ignoring the needs of prisoners for normal human contact and basic standards of living, it does not treat the incarcerated as they are created in the divine image. Long-term solitary confinement goes against the values of humane punishment that Judaism holds dear. The Torah prohibits degrading and excessive punishment by saying, "lest your brother be degraded before your eyes." (Deuteronomy 25:3)

Jewish tradition also emphasizes the need for human companionship. Commenting on the death of a man who had outlived his friends and study partners, the rabbis of the Talmud commented: "Either companionship or death." (Babylonian Talmud Ta'anit 23a) Many of those held in

prolonged solitary confinement have been deprived of community for months or even years. The impact on their physical and mental health may be irreversible.

We believe that the moral voice of rabbis is critical in ending this endemic violation of human rights. Rabbis play a crucial role in teaching our communities about the importance of restorative justice, rather than punitive and damaging punishment. In our system of justice, being sent to prison is the punishment, not horrific conditions while in prison, of which isolation is the extreme end. As a nation, our goal for those incarcerated should be rehabilitation and repentance. Jewish tradition teaches us that the gates of repentance are always open, and that God suffers over the pain of sinners and righteous alike.

Mr. Chairman, Members of the Subcommittee, Rabbis for Human Rights-North America believes strongly that the United States should do everything it can to reverse our nation's harmful and expensive reliance on solitary confinement. We have a moral obligation to uphold the dignity and the mental health of those currently incarcerated. To that end, we would strongly support your leadership in sponsoring legislation that would limit the use and length of solitary confinement. We implore you to immediately take steps to end the use of prolonged solitary confinement. Your hearing today is a very important effort in doing that, and we thank you for the opportunity to contribute to it.

Statement of Keramet A. Reiter, J.D., Ph.D.
Before the
United States Senate
Committee on the Judiciary
Subcommittee on the Constitution, Civil Rights and Human Rights

Submitted via e-mail to: Nicholas_Deml@judiciary-dem.senate.gov
Cc to: solitarywatchnews@gmail.com

June 15, 2012

Dear Chairman Durbin and Ranking Member Graham,

My name is Keramet Reiter. I am an Assistant Professor in the Department of Criminology, Law and Society at the University of California, Irvine (as of July 1). I am an expert in the history and uses of solitary confinement in U.S. prisons; I have been researching and writing about this topic for nearly ten years.

In this testimony, I will discuss, in turn, three aspects of solitary confinement in the United States on which I have a particular expertise: (1) the history of the practice as an administrative (rather than legislative or judicial) innovation, (2) the lack of evidence that the practice promotes safety, either in prisons or in communities; and (3) the unprecedented scale of the practice – in terms of both numbers of people confined and durations of confinement.

(1) Solitary Confinement & Supermaxes: An Administrative Innovation

In 1890, the U.S. Supreme Court noted that solitary confinement as a punishment "was found to be too severe" and had been eliminated across the United States. The case concerned a condemned prisoner who had been held in isolation for one month prior to his execution; the Court ordered Medley's release from prison.[1] And yet, more than a century later, there are tens of thousands of U.S. citizens being held in solitary confinement, from California to Maine. Moreover, these prisoners are spending not days or months in solitary confinement, but years and decades. In the United States today, 41 states and the federal prison system have at least one entire prison dedicated to confining people in long-term solitary confinement. These prisons range in size from a few dozen beds to more than 1,000 beds. Why did the United States return to this practice, so roundly condemned centuries earlier?

The answer lies at the intersection of mass incarceration and insufficient prison oversight. Between 1970 and 2010, the number of people in American prisons increased one-thousand-fold, from just over twenty thousand to just over two million.[2] Today, the United States has more people in prison than any other nation in the world (the closest second is China) and the highest *rate* of incarceration of any nation in the world (the closest second is Russia). Indeed, there are more people under correctional supervision in the United States today than there were in Stalin's

[1] *In re: Medley*, 134 U.S. 160, 168, 161, 175 (1890).
[2] *See* Franklin E. Zimring and Gordon E. Hawkins, *The Scale of Imprisonment* (Chicago: University of Chicago Press, 1991), at Table 5.1; Heather C. West. & William J. Sabol, *Prison Inmates at Midyear 2008 - Statistical Tables* (Bureau of Justice Statistics, NCJ 225619, Mar. 2009).

gulags.[3] As the U.S. prison population rose throughout the 1980s and 1990s, states and the federal government built new prisons – often as fast as they could – to house this growing prisoner population.

During these prison-building years, forty-one of the fifty United States, as well as the federal prison system, built at least one *supermax* institution. Supermax prisons are explicitly designed to keep prisoners in solitary confinement, indefinitely. Arizona built the first supermax in 1986, and California built two more in 1988 and 1989. In both states, prison administrators, including wardens and high-level bureaucrats, collaborated with architects to design a new kind of prison. In both states, legislators had delegated control over prison design, location, and financing to correctional bureaucrats, as a means to expedite prison building.[4] In California and Arizona, prison administrators, not legislators or governors or judges, designed a newly punitive supermax prison, which reinstituted a policy that had been largely abandoned in the United States by the late nineteenth century.

Not only were the first supermax institutions designed by correctional administrators, but supermax institutions across the United States today are operated at the discretion of correctional administrators, with little judicial oversight. Judges do not assign prisoners to long-term solitary confinement in supermaxes; prison guards do. A prisoner in a supermax has either (a) been found guilty, in an in-prison administrative hearing, of breaking a prison rule or (b) been labeled a dangerous gang member through an in-prison, administrative evaluation process. A prisoner labeled as a dangerous gang member is usually sent to a supermax indefinitely – either for the duration of his prison sentence, or until he consents to "de-brief," sharing incriminating information about other gang members.[5]

In reviewing the constitutionality of supermax prisons, federal courts have generally further expanded the discretion that correctional administrators have had to design supermaxes, and to assign prisoners to these institutions. Specifically, courts defer to administrators' safety-and-security justifications for the institutions, with little evidence that these institutions actually promote safety and security.[6] In sum, the administrative discretion underlying the design of

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[3] Adam Liptak, "U.S. Prison Population Dwarfs that of Other Nations," *New York Times*, Apr. 23, 2008; Adam Gopnik, "The Caging of America," *The New Yorker*, Jan. 30, 2012.

[4] *See* Mona Lynch, *Sunbelt Justice: Arizona and the Transformation of American Punishment* (Stanford: Stanford University Press, 2010); Keramet Reiter, *The Most Restrictive Alternative: The Origins, Functions, Control, and Ethical Implications of the Supermax Prison, 1976 – 2010*, University of California, Berkeley dissertation (Spring 2012).

[5] For further discussion of this process, *see* Keramet Reiter, "Parole, Snitch, or Die: California's Supermax Prisons and Prisoners, 1997-2007," under final review at *Punishment & Society* (available from author upon request).

[6] *See, e.g.*, *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995) (finding the concept of California's supermax prisons to be fundamentally constitutional); *Austin v. Wilkinson*, 545 U.S. 209 (2005) (holding that placement in supermax prisons raises a liberty interest for prisoners, but is not unconstitutional).

supermax prisons has only been expanded over the last twenty years of supermax operation and burgeoning uses of solitary confinement across the United States.

(2) There is Little Evidence that Solitary Confinement and Supermaxes Promote Public Safety

Correctional administrators justify extended uses of solitary confinement as necessary to maintain safety and security throughout a given state's prison system. However, there is little evidence that either extended solitary confinement or supermax institutions promote safety and security, either within a given state prison system, or within our communities.

Only a small handful of studies have looked at the potential relationship between supermaxes and violence (in Arizona, Illinois, Minnesota, and Utah), and these studies have found no effects on inmate-on-inmate assaults, and minimal decreases in inmate-on-staff assaults.[7] Indeed, many states do not even systematically collect data about violence in-and-out of solitary confinement units or post-release recidivism statistics.

On the other hand, many studies have documented two serious, detrimental impacts of long-term solitary confinement on in-prison violence and public safety, more broadly: unconstitutional prisoner abuse and permanent mental health deterioration. First, the harsh conditions in supermax prisons and the extreme discretionary control prison administrators have over supermax prisoners often open the door to unconstitutional abuses – clear violations of human rights – in these institutions. As a result, especially when supermax prisons first open, serious prisoner abuses often occur. In California, at Pelican Bay State Prison, one supermax prisoner was dipped in scalding water until his skin peeled off. Also in California, at Corcoran State Prison, supermax prisoners from rival gangs were set-up to fight to the death, in "gladiator" fights on small exercise yards.[8] Similar incidents of abuse following supermax openings have been documented by journalists and federal courts alike, in Arkansas, Colorado, Connecticut, Florida, and Virginia, to name just a few examples.[9]

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[7] Chad S. Briggs, Jody L. Sundt, and Thomas C. Castellano, "The Effect of Supermaximum Security Prisons on Aggregate Levels of Institutional Violence," *Criminology*, Vol. 41 (2003): 1341-1376; Jody L. Sundt, Thomas C. Castellano, and Chad S. Briggs, "The Sociopolitical Context of Prison Violence and Its Control: A Case Study of Supermax and Its Effect in Illinois," *The Prison Journal*, Vol. 88.1 (2008): 94-122.

[8] *See* "Former Inmate at Pelican Bay Wins Judgment Against State," *San Francisco Chronicle*, March 1, 1994: A-18; Matthew Heller, "They Shoot Prisoners, Don't They?" *Independent*, Jan. 28, 2001.

[9] *See* Andy Davis, "State settles pepper-spray suits: Ex-inmate at Varner Supermax Unit to get $4,000 for '05 cases," *Arkansas Democrat-Gazette*, Feb. 17, 2011, available online at: http://epaper.ardemgaz.com/webchannel/ShowStory.asp?Path=ArDemocrat/2011/02/17&ID=Ar00902 (last acessed 20 Feb. 2012); *U.S. v. LaVallee*, 269 F. Supp. 1297 (D. Colo. 2003) and *U.S. v. Verbickas*, 75 Fed. Appx. 705 (10th Cir. 2003) (detailing gruesome abuses of prisoners at the federal supermax facility in Colorado officers were sentenced to three-plus years in prison); American Civil Liberties Union, "ACLU Sues CT Corrections Chief Over Abuse of Prisoners

Second, the harsh conditions in supermax prisons can cause severe mental health problems, or can exacerbate existing mental health problems. Indeed, prisoners are often sent to solitary confinement *because* they have mental health problems that preclude their adjustment to standard prison life. Once in solitary confinement, these problems often worsen. And prisoners who did *not* have pre-existing mental health problems often start to experience problems – from hallucinations, to suicidal ideation, to suicide itself – the longer they spend time in isolation. The testimony of Dr. Craig Haney at this hearing, as well as the statements of many former prisoners and advocates, further document these mental health impacts.

These two problems inherent to supermax confinement lead to a third, with devastating social implications: prisoners are often released *directly* from solitary or supermax confinement onto parole, or to the streets. In California, between 50 and 100 prisoners *per month* are released directly from supermax institutions onto parole.[10] Colorado, Connecticut, Florida, Indiana, Massachusetts, and Pennsylvania, to name just a few documented examples, also release prisoners directly from long-term solitary confinement onto the streets.[11] Given the documented mental health challenges these prisoners are likely to face, the potential public safety challenges of these policies can well be imagined, though little research has investigated the recidivism statistics of this particular former prisoner population.

In sum, although solitary confinement and supermaxes are often justified as necessary safety and security measures in a given state or federal prison system, there is almost no evidence that the practice of solitary confinement or the institution of the supermax provides this benefit. There is, however, abundant evidence that supermax institutions facilitate abuse of prisoners, cause or exacerbate mental health problems, and then export these abused and ill prisoners back into

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Housed at Notorious Virginia 'Supermax,'" Press Release, Feb. 7, 2001, available online at: www.clearinghouse.net/chDocs/public/PC-CT-0001-0002.pdf (last accessed 22 Feb. 2012); *Osterback v. Moore*, Case No. 97-2806-CIV-HUCK (S.D. Fl.), Defendants Revised Offer of Judgment, Oct. 20, 2003, available online at: www.clearinghouse.net/chDocs/public/PC-FL-0011-0002.pdf (last accessed 23 Feb. 2012);

[10] Reiter, *supra* note 5.

[11] Bonnie L. Barr, Chuck R. Gilbert and Maureen L. O'Keefe, *Statistical Report: Fiscal Year 2010* (Colorado Department of Corrections, Feb. 2011), available online at: http://www.doc.state.co.us/opa-publications/97 (last accessed 20 Feb. 2012); Connecticut Department of Correction, "Northern Correctional Insitution Admnistrative Segregtion Program," at 4, 6, available online at: www.ct.gov/doc/lib/doc/pdf/northernascc.pdf (last accessed 21 Feb. 2012); *Osterback v. Moore*, Case No. 97-2806-CIV-HUCK (S.D. Fl.), Second Report of Craig Haney, at para. 25 (on file with author); Jamie Fellner and Joanne Mariner, *Cold Storage: Supermaximum Security Confinement in Indiana* (New York: Human Rights Watch, 1997); Bruce Porter, "Is Solitary Confinement Driving Charlie Chase Crazy?" *New York Times Magazine*, Nov. 8, 1998: 52 (discussing Massachusetts supermax release policies); Terry Kupers, *Prison Madness: The Mental Health Crisis behind Bars and What We Must Do about It* (San Francisco: Jossey-Bass, 1999): 35 (discussing Pennsylvania supermax release policies).

society, significantly less adapted to healthy societal participation than they were before entering prison.

(3) The Scale of the Use of Solitary Confinement in the United States is Unprecedented

In California, prisoners released from solitary confinement or supermax prisons have spent an average of approximately two years in isolation. Many more California prisoners serving life sentences expect never to be released from solitary confinement. As of this writing, more than 500 prisoners in the state have each spent more than 10 years in continuous isolation.[12] Individual prisoners' challenges and journalistic investigations in states like Colorado, New York, and Virginia suggest that prisoners in other states spend comparably long periods – years to decades – in total solitary confinement.[13] Many states, however, do not even collect data about average lengths of stay of state prisoners in solitary confinement, so more systematic national data is simply not available.

By contrast, in New York in the 1820s, the experimental practice of solitary confinement was abandoned completely after 18 months, because so many prisoners suffered such obvious deterioration.[14] And in legal challenges to short-term solitary confinement in the 1970s, federal courts across the United States noted that prisoners usually only spent a few days, to a month at most, in solitary confinement.[15]

Not only do American prisoners today spend unprecedentedly long periods of time in solitary confinement, but there is an unprecedentedly large number of prisoners being held in these

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[12] Reiter, *supra* note 5; Julie Small, "Under Scrutiny, Pelican Bay Prison Officials Say They Target Only Gang Leaders," 89.3 KPCC Southern California Public Radio, Aug. 23, 2011.
[13] James Austin, and Emmitt Sparkman, *Colorado Department of Corrections Administrative Segregation and Classification Review*, Technical Assistance No. 11P1022 (Washington, D.C.: NIC Prisons Division, Oct. 2011), available online at: http://www.aclu.org/prisoners-rights/colorado-department-corrections-administrative-segregation-and-classification (last accessed 14 Feb. 2012): 18 (documenting average length of stay in Colorado supermax of 24 months, or two years); *Lockdown New York: Disciplinary Confinement in New York State Prisons* (The Correctional Association, Oct. 2003), available online at: www.correctionalassociation.org/publications/download/pvp/issue_reports/lockdown-new-york_report.pdf (last accessed 14 Feb. 2012) (documenting average length of stay in one New York solitary confinement facility as 37 months, or more than 3 years); Adam Ebbin, Charniele Herring, and Patrick Hope, "Why All Virginians Should Care about the Overuse of Solitary Confinement," *The Washington Post*, Jan. 20, 2012 (noting prisoners had been in solitary confinement as long as 12 years).
[14] Peter Scharff Smith, "The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature," *Crime & Justice*, Vol. 34 (2006): 441-528, at 457.
[15] Keramet Reiter, "The Most Restrictive Alternative: A Litigation History of Solitary Confinement in U.S. Prisons, 1960-2006," *Studies in Law, Politics and Society*, Vol. 57 (2012): 69-123.

conditions. Whereas in the 1970s, prior to the American prison-building boom, a small handful of prisoners in the highest security prisons might have been held in solitary confinement, today thousands of prisoners in nearly every state are held in solitary confinement. All but nine states have a supermax unit or prison, with at least a few dozen, if not a thousand, beds dedicated to total, long-term solitary confinement in each of these states. Today, there are more than 20,000 prisoners being held in more than 50 supermax prisons across the United States. And an additional 50,000 prisoners, or more, are being held in solitary confinement or segregation in shorter-term, smaller facilities scattered throughout state prison systems.[16]

Both the long terms prisoners spend in solitary confinement in the United States and the large number of prisoners being held under these conditions deserve further scrutiny and oversight. Are these conditions constitutional, effective, or necessary? The answer to this question is, at the very best, that we do not know.

In sum, I applaud the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights for hosting a hearing on solitary confinement in U.S. prisons. The use of solitary confinement in U.S. prisons is largely invisible, unchecked, and brutal. Congressional attention raises visibility, and will facilitate efforts to decrease the prevalence of civil and human rights violations in U.S. prisons.

Sincerely,



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University of California, Irvine

[16] These numbers are based on the author's own unpublished research. For published estimates of the numbers of prisoners in segregation, solitary confinement, and supermaxes across the United States, *see* Chase Riveland, *Supermax Prisons: Overview and General Considerations* (U.S. Department of Justice, National Institute of Corrections, January 1999), available online at: http://www.nicic.org/pubs/1999/014937.pdf (last accessed 13 Feb. 2012); Alexandra Naday, Joshua D. Freilich, and Jeff Mellow, "The Elusive Data on Supermax Confinement," *The Prison Journal*, Vol. 88 (1): 69-92 (2008).

UNIVERSITY OF DENVER
Sturm College of Law
Clinical Programs

Written Testimony of Professor Laura Rovner
Before the Senate Judiciary Committee,
Subcommittee on the Constitution, Civil Rights, and Human Rights
Hearing on Reassessing Solitary Confinement:
The Human Rights, Fiscal, and Public Safety Consequences

June 15, 2012

Chairman Durbin, Ranking Member Graham and Honorable Committee members,

My name is Laura Rovner and I am an Associate Professor of Law and Director of Clinical Programs at the University of Denver Sturm College of Law, where I also founded and teach in the Civil Rights Clinic. The lawyers and students in the Civil Rights Clinic have represented a number of prisoners held in solitary confinement in state and federal prisons in Colorado, including several men confined in the federal "supermax" prison ("ADX").[1] Those cases involved claims that the conditions at ADX violate the Eighth Amendment's prohibition against cruel and unusual punishment[2] and that prolonged and indefinite confinement at ADX violates due process.[3] Additionally, I have provided several declarations to the European Court of Human Rights regarding the conditions of confinement at ADX.[4]

I want to begin by thanking the Committee for holding this important hearing. The American public is entitled—and perhaps obligated as a matter of civic responsibility—to be informed about the state of our prisons. As Justice Kennedy eloquently stated in his 2003 address to the American Bar Association, "[w]hen the door is locked against the prisoner, we do not think about what is behind it."[5] Justice Kennedy urged "a greater responsibility…as a people, we should know what happens after the prisoner is taken away." Prisons are part of our justice

[1] Additionally, separate from my employment with the University of Denver Civil Rights Clinic, I, along with co-counsel, represent two prisoners who have been held at the ADX for nearly a decade, some of that time under Special Administrative Measures (SAMs). *Ayyad v. Holder, et al.*, 05-cv-02342-WYD-MJW (D. Colo). SAMs are prisoner-specific confinement and communication rules, imposed by the Attorney General but carried out by the Federal Bureau of Prisons, that severely restrict a prisoner's communication and increase his isolation.
[2] *Silverstein v. Bureau of Prisons, et al.*, 07-cv-02471-PAB-KMT (D. Colo.) (lawsuit claiming that BOP's confinement of prisoner in extreme isolation for 28 years constitutes cruel and unusual punishment).
[3] *See Saleh, et al. v. Bureau of Prisons*, 05-cv-02467-PAB-KLM (D. Colo.); *Rezaq v. Nalley*, 07-cv-02483-LTB-KLM (D. Colo.). These cases were consolidated on appeal. *Rezaq v. Nalley*, 677 F.3d 1001 (10th Cir. 2012).
[4] *Babar Ahmad and Others v. the United Kingdom*, Application Nos. 24027/07, 11949/08 and 36742/08; *Bary and Al'Fawwaz v. the United Kingdom*, Application Nos. 66911/09 and 67354/09.
[5] Anthony M. Kennedy, Assoc. Justice, Supreme Court of the U.S., Address Before the American Bar Association Annual Meeting 2 (Aug. 9, 2003).

system, and public awareness of what goes on inside them is crucial to the transparency that is a central value of that system.

This transparency is particularly important – and elusive – in the context of ADX, the nation's only federal supermax facility. BOP officials have repeatedly denied requests from human rights organizations and the media to tour the ADX and interview prisoners held there,[6] which has resulted in a dearth of publicly available information about the nature of the conditions at ADX and the effects of those conditions on the men who are held there.

For that reason, I wish to devote my testimony to the use of solitary confinement in the Federal Bureau of Prisons, particularly at ADX. Others will testify in detail about the harmful psychological effects of solitary confinement,[7] as well as provide empirical data about the increased costs associated with supermax confinement[8] and the lack of evidence demonstrating that the use of solitary confinement has significantly reduced the levels of violence in prisons.[9] Through my testimony, I seek to share some of the information about ADX that our legal clinic learned in the course of working with men who are held there, with the hope that this can serve as a basis for further investigation and oversight by the Committee.

Conditions of Confinement at ADX

ADX is the Bureau of Prisons' only designated supermax facility, though the BOP holds people in segregation in the Special Housing Units of its other prisons for both disciplinary and "administrative" reasons.[10] ADX is the most restrictive prison in the federal system. All of the

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[6] According to a Freedom of Information Act response provided in 2007, BOP officials denied "every single media request for a face-to-face interview with ADX prisoners from January 2002 through May 2007." Alan Prendergast, "Fortress of Solitude," *Westword*, Aug. 16, 2007, available at http://www.westword.com/2007-08-16/news/fortress-of-solitude/. One exception to this was a tour given to Human Rights Watch in 2007, which resulted in an eight-page single-spaced letter to the Director of the BOP detailing extensive and serious concerns about the conditions of confinement at the ADX, the vast majority of which still exist today. Ltr from J. Fellner & J. Daskal, Human Rights Watch, to Harley G. Lappin, Dir. of the Fed. Bureau of Prisons (May 2, 2007).

[7] *See, e.g.*, Craig Haney, *The Social Psychology of Isolation: Why Solitary Confinement is Psychologically Harmful*, 181 PRISON SERVICE JOURNAL 12 (2009); Stuart Grassian, *Psychopathological Effects of Solitary Confinement*, 140 AM. J. OF PSYCHIATRY 1450 (1983); Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax" Confinement*, 49 CRIME & DELINQUENCY 124 (2003); HANS TOCH, MOSAIC OF DESPAIR: HUMAN BREAKDOWN IN PRISON, (Am. Psychol. Ass'n. 1992).

[8] *See, e.g.*, Jeffrey Ross, *Supermax Prisons*, 44 SOCIETY 3 (March/April 2007), available at http://www.convictcriminology.org/pdf/jross/SupermaxPrisons.pdf (estimating average cost increase of $50,000 to house inmate in supermax confinement rather than general population).

[9] Terry A. Kupers, et al., *Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs*, 36 CRIM. JUST. & BEHAV. 1037, 1041 (2009) (describing Mississippi's experience of reducing solitary confinement population from 1200 to 150, resulting in reduction of prison violence levels by 70%).

[10] According to one report, there are 11,000 people in some form of segregation in BOP facilities. Stephanie Chen, "Terrible Tommy" Spends 27 Years in Solitary Confinement," CNN, Feb. 25, 2010: http://articles.cnn.com/2010-02-25/justice/colorado.supermax.silverstein.solitary_1_solitary-confinement-federal-prison-system-cell?_s=PM:CRIME.

prisoners in ADX are in solitary confinement. In an interview with "60 Minutes," a former ADX warden described it as "a clean version of hell."[11]

ADX has been criticized by Amnesty International and Human Rights Watch for its inhumane conditions.[12] In the main unit of ADX,[13] prisoners are in solitary confinement for twenty-two hours a day, five days a week and twenty-four hours a day for the other two days, in cells that measure 87 square feet. Each cell contains a poured concrete bed and desk as well as a steel sink, toilet, and shower. ADX prisoners eat all meals alone inside their cells, within arm's length of their toilet. Each cell has a small window to the outside; however, the only view is of the cement "yard." Prisoners at ADX cannot see any nature—not the surrounding mountains or even a patch of grass.

The only time prisoners are regularly allowed outside of their cells is for limited recreation, which occurs either in an indoor cell that is empty except for a pull-up bar, or in an outdoor solitary cage. The outside recreation cages are only slightly larger in size than the inside cells and are known as "dog runs" because they resemble animal kennels. The warden can (and does) cancel recreation for any reason he deems appropriate, including weather, shakedowns, or lack of staff. Some prisoners are required to undergo a strip search as a precondition to any out-of-cell exercise. Accordingly, ADX prisoners sometimes go for days without ever leaving their cells.

Direct contact with others is rare. The prison was specifically designed to limit all communication among the people that it houses. Accordingly, the cells have thick concrete walls and two doors, one with bars and a second made of solid steel. The only "contact" ADX prisoners have with other inmates in the main unit is attempted shouting through the thick cell walls, doors, toilets, and vents. All visits are non-contact, meaning the prisoner and visitor are separated by a plexiglass barrier. Most ADX prisoners remain shackled at their hands and feet throughout the non-contact visits.

Formal opportunities for rehabilitation are extremely limited. All educational programming occurs via closed-circuit television in the prisoners' cells. "Classes" consist of broadcasting shows such as "World of Byzantium," "Parenting I and II," and "Peloponnesian War I and II," with the prisoner filling out a short quiz. There is no interaction with an educator or other students.

While in the main, the BOP does not dispute that these are the conditions at ADX, some of its officials have repeatedly taken the position, as a semantic matter, that solitary confinement does

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[11] *See* CBS News – 60 Minutes, "Supermax – A Clean Version of Hell," June 9, 2009, http://www.cbsnews.com/stories/2007/10/11/60minutes/main3357727.shtml.

[12] Ltr. from HRW, to Harley G. Lappin, *supra* note 6; Amnesty International, "United States of America, Cruel and Inhuman: Conditions of Isolation for Detainees at Guantanamo Bay," AI Index: AMR 51/051/2007, April 2007.

[13] This main unit is described by the BOP as "general population," though all of the prisoners held there are in solitary confinement. It is, therefore, completely unlike regular "general population" or "GP" units where prisoners are permitted to be out of their cells for a number of hours each day, to hold jobs, and to have regular interaction with other people.

not exist in its facilities – including ADX.[14] For example, when Dr. Donald Denney, Regional Psychology Director for the BOP's North Central Region (which includes ADX), was asked about solitary confinement in a deposition, the following exchange ensued:

Q: What do you understand the term "solitary confinement" to mean?
A: And are you referring to the Bureau of Prisons or in general?
Q: First, with the Bureau of Prisons.
A: I'm not aware that the Bureau of Prisons has a policy related to solitary confinement.
Q: Do you have a general understanding of what the term "solitary confinement" means?
A: And again, we're not talking about the Bureau of Prisons, correct?
Q: Correct. Your own personal understanding.
A: I would have my opinions about what that would mean, yes.
Q: Can you explain to me what those are?
A: Well, solitary confinement—"confinement," if we break the words into pieces, would mean that a person was confined in a space. And "solitary" would mean by himself, absent of all other engagements.
Q: Can you explain to me what you mean by all other engagements?
A: Human contact, the ability to see others, lacking – basically being alone.[15]

The case in which Dr. Denney was deposed is *Silverstein v. Bureau of Prisons*, in which our client, Thomas Silverstein, has asserted that the BOP's confinement of him in extreme isolation for twenty-eight years violates his constitutional rights.

The effect of solitary confinement conditions, particularly when they are endured for long periods of time, can be psychologically devastating. As Dr. Craig Haney observed in a

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[14] Instead, BOP officials speak in euphemisms such as "single-occupancy cells" and state that they have no definition of or reference for the term "solitary confinement" in the context of the BOP. For example, in a deposition given by then-ADX Warden Wiley in 2008, he testified as follows:

> Q: Do you consider the ADX general population to be solitary confinement?
> A: I do not. . . . I don't have a definition of solitary confinement. I just know what I see on TV. And when they say solitary confinement on TV, they generally have a person in a place that's dark and no contact with anyone. And they open a little slot and slide in a tin plate or something with bread and water or something like that. That's my only frame of reference for solitary confinement. So based on that, my only knowledge of it, at the ADX, those are the differences.
> Q: So you have no personal basis, apart from watching television, for the definition of solitary confinement?
> A: I do not.[14]

Deposition of Warden R. Wiley, *Saleh et al., v. BOP*, 05-cv-2467 (D. Colo) at 248-49.

[15] Deposition of Dr. Donald Denney, *Silverstein v. BOP*, 07-cv-2471 (D. Colo) at 22-23. Unlike the BOP, the federal courts have no problem recognizing that ADX is solitary confinement. *See, e.g., Jordan v. Sosa,* 654 F.3d 1012, 1015 (10th Cir. 2011) ("Plaintiff-Appellant Mark Jordan was incarcerated in solitary confinement at the administrative maximum security facility in Florence, Colorado (ADX)"); *Sattar v. Holder,* 2012 WL 882401, *1 (D. Colo. 2012) ("At ADX, inmates are housed in solitary confinement and are subject to highly restrictive conditions.").

declaration he provided in Mr. Silverstein's case, "the overwhelming consensus among persons who have actually conducted research on the effects of solitary confinement is clear: severe and prolonged isolation—the deprivation of meaningful social contact and the other deprivations that commonly occur in conjunction with it—is psychologically painful and can have harmful psychological consequences." As described by Dr. Haney, some of those consequences include:

> appetite and sleep disturbances, anxiety, panic, rage, loss of control, paranoia, hallucinations and self-mutilations. Moreover, direct studies of prison isolation have documented an extremely broad range of harmful psychological reactions. These effects include increases in the following potentially damaging symptoms and problematic behaviors: negative attitude and affect, anxiety, withdrawal, hypersensitivity, ruminations, cognitive dysfunction, hallucinations, loss of control, irritability, aggression, and rage, paranoia, hopelessness, a sense of impending emotional breakdown, self-mutilation and suicidal ideation and behavior.[16]

Some prisoners in ADX find the conditions of prolonged solitary so devastating that they protest in one of the few ways available to them: hunger strikes. Some of these men have refused food for upwards of three months, resulting in even greater suffering, risk of organ damage, and being subjected to painful force-feeding while restrained.[17]

Many Federal Prisoners Are in Solitary Confinement for Years

Especially troubling is the extraordinary length of time that some federal prisoners have been held in solitary confinement at ADX (and, in some cases, elsewhere). Perhaps the most extreme example of this is Mr. Silverstein, on whom the BOP imposed a "no human contact" order in 1983 and who has been held in solitary confinement ever since. But while Mr. Silverstein's solitary confinement in the BOP is the longest period of which I am aware, there are many others who have spent years—and decades—in isolation in federal custody.

The BOP has been resistant to efforts to obtain data about the duration of prisoners' confinement at ADX, even from the European Court of Human Rights which made repeated requests for this information in connection with litigation seeking to stop the extradition to the United States of several men charged with terrorist crimes on the grounds that the conditions at ADX could be in violation of the European Convention on Human Rights.[18] Consequently, attorneys and others have been forced to conduct their own research to obtain information as best they can. One attorney explained his methodology like this: "I sent letters to 130 prisoners who I had identified as being housed at ADX. The survey did not include every prisoner at ADX, and there may be prisoners who have spent long periods of time at ADX whom I have not identified. As you might expect, my letters to prisoners under SAMs were returned, and so their data is not included in the results. We received a total of 61 results." Even with this admittedly small and imperfect

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[16] Expert Report of Dr. Craig Haney, *Silverstein v. BOP*, 07-cv-2471 (D. Colo.), at 8-9.

[17] Human Rights Watch has documented that such force-feeding is done in a manner that is unnecessarily punitive and painful, and that hunger-strikers are often moved to "dry cells" with no mattress, clothes or basic hygiene products as punishment for the strike. Letter from J. Fellner and J. Daskal, Human Rights Watch, to Federal Bureau of Prisons, May 2, 2007, *supra* note 6.

[18] *See* note 4, *supra*.

sample (the ADX generally holds approximately 400 prisoners on any given day), this attorney found that "at least 43 prisoners have been locked down at ADX and Marion for over 8 years."[19]

There is No Meaningful Process Governing How–or Whether-Prisoners are Removed from ADX

Compounding the lengthy periods of time that some prisoners are held at ADX is the fact that most of these men do not know when – or whether – they will ever be removed from solitary confinement. Unlike prisoners who are put in solitary confinement for disciplinary reasons, most prisoners at ADX have been placed there for administrative reasons, pursuant to a "classification decision" made by the BOP. In other words, these men are not at ADX for a set period of time, but are there for as long as the BOP determines is appropriate. There is nothing to prevent the BOP from keeping these men in solitary confinement for the rest of their lives, and in some cases that appears to be the plan of the Bureau. This can be so even where a prisoner – such as Mr. Silverstein – has demonstrated *decades* of clear conduct.

As Dr. Haney has observed, "[r]esearch indicates that the negative effects of general environmental stress are moderated by perceived control. That is, when people come to believe that they cannot control the psychologically or physically threatening conditions to which they are exposed, the resulting stress is intensified. This general, common sense proposition applies to prisons in general and to conditions of solitary confinement in particular. Prisoners who do not know whether or when they will be released experience the pains of this kind of isolated confinement more acutely."[20]

Not only does the lack of guidance about what they can do to be released from solitary confinement exacerbate the mental health effects of isolation, there is empirical evidence that it *negatively* impacts institutional safety. There are studies that demonstrate, in the context of incarceration, prisoners will be more likely to comply with prison rules and less likely to recidivate if they perceive authority is exercised in a fair, transparent, and unbiased manner. As noted by amici in *Rezaq v. Nalley*, "[t]he classification and program assignment procedures currently in place at ADX do not appear to include any opportunity for inmates to state their case to a neutral third party, fail to ensure consistency of treatment across cases, do not evince respect for inmates' dignity, and are unlikely to foster trust in prison authorities."[21]

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[19] Ltr. From M. Donatelli to [redacted] ADX prisoner, Mar. 23, 2011.

[20] Haney report, supra note 16 at 49.

[21] Brief of Behavioral Scientists, Social Psychologists, Criminologists and Former Correctional Officials as *Amici Curiae*, *Rezaq v. Nalley*, 11-1069, U.S. Court of Appeals for the Tenth Circuit, at 12-13. *Amici* further explain:

> Beliefs about the fairness of institutions influence the legitimacy of those institutions and individuals' propensity to cooperate with their authority. *See, e.g.,* Jason Sunshine & Tom R. Tyler, *The Role of Procedural Justice and Legitimacy in Shaping Public Support for Policing*, 37 L. & SOC'Y REV. 513, 530-34 (2003) (finding that public perceptions of procedural fairness "impact people's compliance with law, their willingness to cooperate with and assist the police, and whether the public will empower the police"). Conversely, research suggests "that unjust situations and outcomes lead to frustration and strain, which can ultimately cause crime and delinquency." Eric G. Lambert et al., *The Relationship among Distributive and Procedural Justice and Correctional Life Satisfaction, Burnout, and Turnover Intent: An Exploratory Study*, 38 J. CRIM. JUSTICE 7 (2010). When people perceive that they have been treated fairly, they are

At ADX, the criteria for progression to and through the one program that provides the potential for leaving are so vague as to provide the prisoner with no meaningful notice of what, if anything, he can do to progress. These criteria include: "the institution's safety and security needs; the safety and security needs of the inmate; the safety and security needs of other inmates; and the safety and security needs of the public."[22] While the BOP is rightfully permitted some discretion in who should be segregated, correctional experts urge that their discretionary decisions be based on objective data. One such expert in the *Silverstein* case has opined that "sound correctional practice, as well as fundamental notions of fairness and due process, requires providing prisoners with notice of the reason for their conditions, an explanation of what must be done to change those conditions, and giving them some ability to do so."[23] The current regime at ADX does not provide any of these fundamental hallmarks of due process in any meaningful way.

The Extreme Nature of the Conditions at ADX Impacts America's International Credibility on Human Rights Issues

Harold Koh, legal advisor to the State Department, has described the United States as the world's indispensible force for human rights. Yet solitary confinement conditions like those at ADX are inconsistent with international human rights standards[24] and have been roundly condemned, including by the United Nations Special Rapporteur on Torture at the 19th session of the U.N Human Rights Council. At that session, the Special Rapporteur on Torture called on all countries to ban the use of solitary confinement, except in very exceptional circumstances, as a last resort, and for as short a time as possible. The Special Rapporteur concluded that solitary confinement is a harsh measure that may cause serious psychological and physiological adverse effects. He found that solitary confinement can amount to cruel, inhuman or degrading treatment or punishment and even torture. He recommended both the prohibition of solitary confinement and the implementation of alternative disciplinary sanctions. He also called for increased safeguards from abusive and prolonged solitary confinement, the universal prohibition of solitary confinement exceeding 15 days.[25]

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more likely to accept "the need to bring their behavior into line with the dictates of an external authority." TOM R. TYLER, WHY PEOPLE OBEY THE LAW 25 (1990).

[22] ADX Institution Supplement FLM 5321.06J(1), General Population and Step-Down Unit Operations, Nov. 21, 2011 at 10.

[23] Decl. of Correctional Expert Steve Martin in Support of Plaintiff's Response to Defendants' Motion for Summary Judgment, *Silverstein v. BOP*, 07-cv-2471-PAB-KMT (D. Colo), Ex. 10 at ¶ 31.

[24] The U.S. has ratified the International Covenant on Civil and Political Rights (ICCPR) and the Convention against Torture, both of which prohibit torture or other cruel, inhuman or degrading treatment or punishment. Article 10 of the ICCPR further requires that "all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person". The UN Human Rights Committee, the ICCPR treaty monitoring body, has further emphasized that the absolute prohibition of torture or cruel, inhuman or degrading treatment under international law "... relates not only to acts that cause physical pain but also to acts that cause mental suffering ..." and that prolonged solitary confinement may amount to torture or other ill-treatment.

[25] Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, delivered to the General Assembly, U.N. Doc. A/66/268 (Aug. 5, 2011).

While the U.S. is dismissive of international criticism of its own prison conditions, in judging other countries' human rights records, the U.S. State Department has regularly treated the use of prolonged solitary confinement as a human rights violation.[26] If the U.S. is to continue to hold itself out to the world as a standard-bearer of human rights, we must look closely at the use of solitary confinement here at home, including and especially in our federal prisons.

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[26] Glenn Greenwald provides a powerful summary of this tendency:

> [T]he U.S. Government routinely condemns similar acts—the use of prolonged solitary confinement in its most extreme forms and lengthy pretrial detention—when used by other countries. See, for instance, the 2009 State Department Human Rights Report on Indonesia ("Officials held unruly detainees in solitary confinement for up to six days on a rice-and-water diet"); Iran ("Common methods of torture and abuse in prisons included prolonged solitary confinement with extreme sensory deprivation . . . Prison conditions were poor. Many prisoners were held in solitary confinement . . . Authorities routinely held political prisoners in solitary confinement for extended periods . . ."); . . . Israel ("Israeli human rights organizations reported that Israeli interrogators . . . kept prisoners in harsh conditions, including solitary confinement for long periods"); Iraq ("Individuals claimed to have been subjected to psychological and physical abuse, including . . . solitary confinement in Ashraf to discourage defections"); Yemen ("Sleep deprivation and solitary confinement were other forms of abuse reported in PSO prisons . . .").

U.N to Investigate Treatment of Bradley Manning, SALON (Dec. 23, 2010, 5:24 AM), http://www.salon.com/2010/12/23/manning_4/singleton/.

UNIVERSITY OF DENVER
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June 20, 2012

Senator Richard Durbin
711 Hart Senate Bldg.
Washington, DC 20510
Via e-mail to Mara_Silver@Judiciary-dem.senate.gov

Dear Senator Durbin, Ranking Member Graham, and Honorable Committee members,

Thank you for the opportunity to attend the Hearing on Reassessing Solitary Confinement convened by the Senate Judiciary Subcommittee on the Constitution, Civil Rights and Human Rights. It was an honor to be present for this historic event and I am grateful to Senator Durbin and the other members of the committee for their concern about these issues.

In listening to the testimony, there were responses to two areas of questions by Bureau of Prisons Director Charles Samuels that I found particularly striking because they differ significantly from representations the BOP has made in other contexts. I send this brief note as a follow-up to my written testimony so that the Committee has this information in the event it seeks to conduct additional investigation into the BOP's use of solitary confinement, especially at the ADX.

Mentally ill prisoners at ADX

On the question of whether prisoners with serious mental illnesses are confined at ADX, the following exchange ensued:

DURBIN:
So, Mr. Samuels, let me ask you a couple of questions. First, it's my understanding that those who are seriously mentally ill are not supposed to be assigned to supermax facilities, like Florence, Colorado. Is that true?

SAMUELS:
You are correct. Our policy prohibits any inmate who suffers from a serious psychiatric illness to be placed in that confinement.[1]

Yet in a declaration given to the European Court of Human Rights in November 2010, ADX psychologist Paul Zohn stated:

> Many inmates with bipolar affective disorder, schizophrenia, post-traumatic stress disorder, and depression are managed successfully in mainline institutions. Each of the facilities at FCC Florence are equipped to manage mentally ill inmates, including those with affective bipolar disorder, schizophrenia, depression, and post-traumatic stress

[1] Hearing Tr. at 8.

disorder. A diagnosis of bipolar affective disorder, depression, schizophrenia, or post-traumatic stress disorder would not preclude a designation to the ADX. These disorders can typically be successfully managed at the ADX. Conditions of confinement are largely determined by security needs and would be modified based on mental illness only if the inmate's mental status warranted such a change (e.g., if his mental status deteriorated).[2]

Length of confinement at ADX

DURBIN:
So let's look at the numbers. We asked bureau prisons how much time people spend in isolation. Here's what they said. "The average amount of time an inmate spends at supermax, ADX facilities, 531 days in isolation." Roughly a year and a half that we're talking about here. "The average amount of time in special management units," which I assume would be in other prisons where people are put in a segregated or isolated circumstance, 223 days, which would be over seven months, seven and a half months, the average amount of time in special housing units, 40 days.[3]

In a deposition given by an ADX staff member acting as a representative of the BOP, different figures were offered:

Q: Warden Wiley said in his deposition that ideally, the ADX program is three years: one year in the general population, six months in intermediate, six months in transitional, one year in DB. Does this match your understanding of the step-down program?
A: Yes.
Q: What percentage of inmates go through this quickly?
A: I have no idea.
Q: More than 50 percent?
A: That go through that quickly?
Q: Uh-huh.
A: No.
Q: More than 10 percent?
A: More than 10 percent go through that quickly?
Q: Uh-huh.
A: No. I would not think so.
Q: More than 5 percent?
A: No. Maybe up to 5 percent.
Q: So –
A: No more.
Q: -- 5 percent or fewer?

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[2] Decl. of Paul Zohn, Ph.D., *Babar Ahmad and Others v. United Kingdom*, European Court of Human Rights, App. Nos. 24027/072, 11949/08, 36742/08, Nov. 5, 2010, at ¶ 8.
[3] Hearing Tr. at 15.

A: No more than that.[4]

The source documents cited above are somewhat long so I have not attached them; I am happy to provide them if you wish. I have attached a copy of a declaration I submitted last year to the European Court of Human Rights in the Matter of *Babar Ahmad and Others v. the United Kingdom*, Application Nos. 24027/07, 11949/08 and 36742/08; *Bary and Al Fawwaz v. the United Kingdom*, Application Nos. 66911/09 and 67354/09, which sets forth some additional information regarding the use of solitary confinement at the ADX.

Thank you again for your interest and work on these important issues.

Sincerely,

Laura Rovner,
Director of Clinical Programs
Director, Civil Rights Clinic
Associate Professor of Law

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[4] Deposition of Mark Collins Pursuant to FRCP 30(b)(6), *Saleh, et al., v. BOP*, 05-cv-2467-PAB-KLM, Oct. 24, 2008, at 84-85.

ROBERT C. "BOBBY" SCOTT
3RD DISTRICT, VIRGINIA

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SUBCOMMITTEE ON THE CONSTITUTION

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Statement of Robert C. "Bobby" Scott for the briefing on
"Reassessing Solitary Confinement: The Human Rights, Fiscal and Public Safety Consequences"
Tuesday, June 19, 2012
Dirksen Senate Office Building, Room 226
10:00 a.m.

Thank you, Senator Durbin, for convening this hearing on Reassessing Solitary Confinement. The use and abuse of solitary confinement is an important issue that warrants careful examination, and I thank you for calling this hearing and for inviting written statements.

Last April, Congressmen John Conyers, Jr. (D-MI) and Cedric Richmond (D-LA) and I hosted a briefing that examined the detrimental impacts of the abusive use of solitary confinement, including its disproportionate impact on inmates of color, the appropriateness of its use on mentally ill inmates, and other concerns about its use by correctional facilities.

At the briefing, witnesses discussed the fact that each day, tens of thousands of prisoners in the U.S. are held in solitary confinement. Usually in isolation for at least 23 hours a day and denied human contact, these inmates are subject to a range of other restrictive conditions. There is no doubt that solitary confinement is a necessary tool for prisons in certain instances. Solitary confinement is employed for different reasons: to protect an inmate from other inmates, to protect an inmate from him or herself, or as a sanction for rules violations. Witnesses raised concerns that prisons do not distinguish among these types of segregation, especially when it is employed for an inmate's own protection and through no fault of his or her own. In addition,

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witnesses highlighted the issue of the manner and length of time that prisons impose solitary confinement, particularly when it is improperly employed against mentally ill inmates and disproportionately against inmates of color.

We know that the mentally ill are over-represented in solitary confinement in state prisons. For example, in Colorado, according to the Department of Corrections, 37% of those in administrative segregation or solitary confinement are either developmentally disabled or mentally ill. In Indiana, the Department of Corrections stated that "well over half" of those in one solitary confinement unit were mentally ill. While we do not have national figures, it is estimated that nationwide, between one-third and one-half of those in solitary suffer from mental illness. These numbers are even more troubling in light of the fact that medical science tells us that solitary confinement can make mental illness worsen and can even put people at a substantial risk of descending into mental illness. In addition, some federal courts have ruled that the detention of mentally ill prison inmates in solitary confinement violates the cruel and unusual punishment clause of the Eighth Amendment.

There is also a lack of transparency in the use of solitary confinement and the characteristics of inmates placed in solitary confinement. While no official estimate exists for the number U.S. prisoners held in solitary confinement, a conservative count is 80,000. At this time the Department of Justice does not collect data on the use of solitary confinement in federal and state prisons. Also, no standardized reporting mechanism exists for states to report solitary confinement data or an agreed upon standard to what constitutes as solitary confinement.

Solitary confinement is also expensive. According to Bureau of Prisons ("BOP") figures, it cost $28,284 to house a federal prisoner in general population in fiscal year 2010, and it costs 60% more than that to house an inmate in solitary confinement. Being more selective about who

truly requires such segregation, and segregating those inmates only for limited periods of time, will go a long way toward reducing prison costs at this time when states and the federal government are facing severe budgetary challenges.

Based on these concerns, I have requested that the Government Accountability Office ("GAO") conduct a study into BOP's use of segregated housing. The GAO is examining the costs, length of stay, what is known about the impacts of extended placement in segregated housing, and BOP's compliance with requirements for reviewing decisions to place and keep inmates in segregated housing. That report should be completed in March 2013.

I look forward to hearing the information that your distinguished panel of experts has to share regarding solitary confinement, and I thank you for calling this hearing.

Dear Chairman Durbin and Ranking Member Graham.

My name is Dr Sharon Shalev. I am a researcher at the Centre for Criminology at Oxford University, a Fellow of the Mannheim Centre for Criminology at the London School of Economics and Political Science, and an Associate of the International Centre for Prison Studies (ICPS).

I have been researching the use of solitary confinement for almost two decades and have written extensively on the subject. In the course of my work I have conducted research on, and published a book about, the American Supermax prisons. I have asked for a copy of the book, titled: "Supermax: controlling risk through solitary confinement" (Willan, 2009) to be sent to you. As my book demonstrates, I am of the view that supermax prisons are excessive, expensive, and extremely harmful to prisoners' health and well being. I also found little evidence that these prisons succeed in reducing prison violence and I believe that they may in fact contribute to increased violence which can be directed both towards others and internally in the form of self harm and suicide.

This is evidenced in a large body of literature, stretching back to the 19th century. I have reviewed this literature, international law standards and regulations and case law and proposed some safeguards in a resource titled "A sourcebook on solitary confinement" which was published in 2008 and is freely available online at: www.solitaryconfinement.org/sourcebook.

For your convenience I enclose an executive summary of the Sourcebook, which I hope you will find illuminating and useful. I would be delighted to offer further information and any assistance that you may need and look forward to reading the Sub committee's findings.

Yours sincerely,

S. Shalev

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A sourcebook on solitary confinement: Executive Summary

Dr Sharon Shalev Mannheim Centre for Criminology, LSE (2008)

About the Sourcebook

The sourcebook, available in full at www.solitaryconfinement.org, provides a single reference point for those concerned with the practice of solitary confinement, particularly when it is imposed for prolonged periods of time. Its purpose is to a) inform prison operational staff, health professionals, and policy makers of the human rights position regarding solitary confinement, of ethical and professional standards and codes of practice relating to prisoner isolation, and of research findings on the health effects of solitary confinement, and b) propose safeguards and best practice in light of the above. More broadly, it aims to raise awareness of the potential consequences of prolonged solitary confinement.

Solitary confinement – an introduction

For the purpose of the Sourcebook, solitary confinement is defined as a form of confinement where prisoners spend 22 to 24 hours a day alone in their cell in separation from each other. An old and enduring prison practice, first widely and systematically used on both sides of the Atlantic in the 'separate' and 'silent' penitentiaries in the 19th century, recent years have seen an expansion in the large scale use of solitary confinement in the form of 'supermax' and 'special security' prisons, particularly in the USA.

The health effects of solitary confinement

There is unequivocal evidence that solitary confinement has a profound impact on health and wellbeing, particularly for those with pre-existing mental health disorders, and that it may also actively cause mental illness. The extent of psychological damage varies and will depend on individual factors (e.g. personal background and pre-existing health problems), environmental factors (e.g. physical conditions and provisions), regime (e.g. time out of cell, degree of human contact), the context of isolation (e.g. punishment, own protection, voluntary/ non voluntary, political/criminal) and its duration.

Notwithstanding variations in individual tolerance and environmental and contextual factors, there is remarkable consistency in research findings on the health effects of solitary confinement throughout the decades. These have mostly demonstrated negative health effects, in particular psychological but also physiological. Attested symptoms include anxiety; depression; anger; cognitive disturbances; perceptual distortions, and; paranoia and psychosis. Studies reporting no negative health effects from solitary confinement are few and far between, and virtually no study reports positive effects. The personal accounts of prisoners held in solitary confinement show a striking similarity and consistency with these research findings.

Each of the three main factors inherent in solitary confinement - social isolation, reduced environmental stimulation and loss of control over almost all aspects of daily life - is potentially distressing. Together they create a potent mix, especially when applied to what studies of psychiatric morbidity indicate is a particularly vulnerable population.

Both the duration of solitary confinement and whether the prisoner has prior knowledge of how long the period in solitary confinement will last are important determinants of the adverse health effects. All studies of prisoners who have been detained involuntarily in solitary confinement in

regular prison settings for longer than ten days have demonstrated some negative health effects but for shorter periods the evidence is more equivocal. Other studies have shown that uncertainty as to the length of time in solitary confinement promotes a sense of helplessness and increases hostility and aggression.

While some of the adverse health effects of solitary confinement will subside on its termination, others may persist. Unable to regain the necessary social skills for leading a 'normal' life, some of those held in solitary confinement in prison may continue to live in relative social isolation after their release. In this sense, solitary confinement operates against one of the main purposes of the prison which is to rehabilitate offenders and facilitate their reintegration into society.

The decision to place prisoners and detainees in solitary confinement

Where prisoners and detainees are held in solitary confinement, whether in an especially designed free-standing isolation unit or in a designated segregation wing in a general population prison, this is typically on the grounds of: punishment; protection; prison management; national security; pre-charge and pre-trial investigation, or; lack of other institutional solutions.

As solitary confinement is a harsh measure with potentially harmful consequences for the prisoner involved, the decision to place a prisoner in solitary confinement must always be made by a competent body, transparently and in accordance with due process requirements. Human rights bodies view solitary confinement as an undesirable prison practice which can only be justified in extreme cases, must only be used for the shortest possible time, and which, in certain circumstances, may be in violation of international law.

The isolation of those who have not yet been convicted of any crime is particularly problematic, as it inflicts punitive and potentially harmful conditions on people who are innocent until proven guilty, and serves to coerce them. There is consensus amongst observers, experts and, increasingly, the courts, that the mentally ill and those at risk of self harm should not be held in solitary confinement

Whilst the European Court of Human Rights has shown a willingness to accept that solitary confinement may be justified in exceptional cases, particularly those involving offences against the State, the Court has also found that placement in solitary confinement has breached a prisoner's human rights in other circumstances.

Putting aside any legal considerations, studies suggest that, whilst it may be a convenient tool in the short term, solitary confinement is not effective for managing those defined a 'problem' or 'difficult' prisoners in the long term and may even be counter-productive – potentially fragmenting prisoner solidarity an and creating a legitimacy deficit and leading to increased violence.

Design, physical conditions and regime in solitary confinement units

Since prisoners in solitary confinement spend at least 22 hours a day alone in their cells, physical conditions assume particular importance. The United Nations Standard Minimum Rules (globally) and the European Prison Rules (in Europe) set out minimum requirements in respect of physical conditions and, along with other international instruments prescribe minimum requirements in respect of the prison regime.

Those standards simply set a minimum baseline, which notwithstanding the constraints of a solitary confinement regime, which prison administrations should strive to improve upon. Decent facilities,

in-cell provisions, meaningful human contact and access to purposeful activities are likely to mitigate the harmful effect of solitary confinement. Regimes which increase opportunities for social interaction between prisoners and between prisoners and staff, provide for direct supervision of prisoners by staff, and which communicate a more positive message about the prison and the prisoners themselves, are cited as positively influencing behaviour and wellbeing in research.

The extreme nature of solitary confinement and its potential health effects give rise to special human rights concerns, and its use is subjected to close scrutiny by the courts and monitoring bodies. In particular, the physical conditions in which prisoners are held, the regime provisions they enjoy and the degree of human contact they have whilst isolated are assessed on a case by case basis to determine whether it has violated the prohibition against torture, inhuman or degrading treatment or punishment.

The role of health professionals in segregation units

Health professionals working in prisons and other places of detention face some particular challenges which stem from the inherent tension between the role of the prison as a place of punishment through deprivation of liberty, and their role as protectors and promoters of health. The ethical challenges are especially acute when the question of the involvement of health personnel in disciplinary measures arises, and nowhere is this more contentious than in their role, if any, in segregation units.

Prison health staff will almost inevitably be faced with situations where their 'dual loyalty' to a patient and the prison administration conflicts, but they remain bound by the usual established principles of medical ethics that make clear that their duty to the patient takes precedence over any other obligation. The courts have upheld prisoners' rights to appropriate medical care and the normal principles around the confidentiality of medical information continue to apply.

The question of whether health professionals have any role in certifying a prisoner 'fit' to undergo, or continue to be subject to, disciplinary measures, including solitary confinement, is a particularly contentious one, but given the substantial evidence of it adverse health effects, the argument that, in line with the World Health Organisation's guidance, they should not, is persuasive.

Where the use of solitary confinement is abusive and may amount to torture or other forms of ill-treatment, health staff have a duty to report and denounce such acts to the appropriate authorities and professional bodies.

Recommendations

Procedural safeguards

- Inform prisoners, in writing, of the reason for their segregation and its duration.
- Allow prisoners to make representations on their case at a formal hearing.
- Undertake regular reviews of placement – substantive and at short intervals.

These safeguards apply to all forms of solitary confinement.

Placement in solitary confinement

- When used as punishment for prison offences, solitary confinement must only be used as a last resort, and then for the shortest time possible, lasting days rather than weeks or months.

- The use of prolonged solitary confinement for managing prisoners is rarely justified, and then only in the most extreme of cases.
- Those suffering from mental illness must not be placed in solitary confinement and under no circumstances should the use of solitary confinement serve as a substitute for appropriate mental health care.
- The use of solitary confinement for pre-charge and pre-trial detainees must be strictly limited by law and must only be used in exceptional circumstances, with judicial oversight, for as short a time as possible, and never for more than a matter of days.
- Solitary confinement must not be imposed indefinitely, and prisoners should know in advance its duration.
- The use of solitary confinement as a means of coercing or 'softening up' detainees for the purpose of interrogation should be prohibited.

Physical conditions and regime:

- Provide decent accommodation (as per established standards discussed in chapter 4), reflecting the fact that prisoners will spend most of their day in their cell.
- Provide educational, recreational and vocational programmes.
- Provide these activities, wherever possible, in association with others.
- Allow in-cell reading, hobbies and craft materials.
- Ensure that prisoners have regular human contact; encourage informal communication with staff.
- Allow regular and open family visits.
- Enable prisoners a degree of control of their daily lives and physical environment.
- Include a progressive element.

Health

- Health staff must maintain the same standards of care and ethical behaviour as those which apply outside the prison, in particular the right to health care and to privacy and confidentiality.
- Health staff must not participate in the decision to impose or the enforcement of any disciplinary measure.
- Provide mental health training for custodial staff

Federal Bureau of Prisons Responses to Information Request

- **Policies for determining which inmates are placed at ADX, in SHUs, and in SMUs and**
- **To what extent are there subsequent reviews of placement?**

Special Housing Units (SHU)

SHUs house two broad categories of inmates: (1) inmates who are in disciplinary segregation status, and (2) inmates who are in administrative detention status. An inmate can submit a formal grievance challenging his or her placement in the SHU through the Administrative Remedy Program, outlined in 28 Code of Federal Regulations, part 542.

Disciplinary segregation (DS) is a sanction for an inmate's commission of a prohibited act in a correctional facility. Prohibited acts include assault, possession of contraband, fighting, and refusing direct orders from staff.

Administrative detention (AD) is not punitive, rather inmates are generally placed in AD status for three reasons: 1) for investigation of potential misconduct, 2) for protection of themselves or other inmates until appropriate steps can be taken to transfer them to another facility, or 3) until further information is available about their background that allows us to determine a safe and appropriate facility to house them.

Within seven days of placement in AD or DS, the inmate's status is reviewed at a hearing the inmate can attend. Inmates who are being protected from the general population can request another hearing at any time if they feel their placement in the SHU as a protection case is unnecessary. After these initial reviews, every inmate in both AD and DS receives recurring seven day reviews to ensure basic necessities are met, including sufficient recreation, meals, and showers. Every thirty days the inmate's status is reviewed at a hearing the inmate can attend.

Psychology staff makes weekly rounds in SHU and examine each inmate in a personal interview every 30 days of continuous placement in a SHU, or more often as needed or requested for the inmate.

Special Management Unit (SMU)

In fiscal year 2008 the Bureau began converting some existing bed space to Special Management Units (SMUs). These units are part of a 4 stage program lasting 18-24 months, which is designed to assist inmates in modifying behavior that has proven to be confrontational, resistant to authority and disregardful of institution rules. Many of these inmates have participated or had leadership roles in gang-related activity and therefore, present unique security and management concerns.

Inmates are referred for consideration for placement in SMU after a review by the institution warden and the Regional Director. A trained Hearing Administrator notifies the inmate prior to the SMU placement hearing and provides the inmate with specific evidence (unless such information would jeopardize the safety and security or endanger staff or others). The inmate has the opportunity to be present during the hearing, make an oral statement, and present documentary evidence to the Hearing Administrator. The inmate may also have a staff representative to compile evidence and witness statements for the hearing. Following the hearing, the Regional Director

makes the final determination regarding whether or not the evidence supports the appropriateness of SMU placement. The inmate is informed of the decision and his right to appeal the designation through the Bureau's Administrative Remedy Program.

Following completion of the four phase SMU program, inmates may be considered for redesignation to a less restrictive facility. To qualify for consideration, the inmate must have, for a period of 12-18 months, abstained from gang-related activity, serious or disruptive misconduct, and group misconduct that adversely affect the orderly operations of the prison. The inmate must also demonstrate a sustained ability to coexist with other inmates and staff. Upon meeting those qualifications, the Unit Team, with the concurrence of the warden, submits a request for redesignation to another facility. If the inmate is not deemed appropriate for redesignation after 24 months of SMU placement, the Regional Director must approve continued SMU housing for that inmate.

U.S. Penitentiary – Administrative Maximum (ADX) in Florence, Colorado

All inmates who are designated to the ADX receive a due process hearing prior to their placement at the facility. In order to be considered for placement in a less restrictive environment, inmates must maintain clear conduct, participate in a variety of programming opportunities, and demonstrate an overall positive institutional adjustment.

This institution has three types of housing units: *General Population, Special Security, and Control Unit.*

General Population (ADX GP)

An inmate may be referred to the ADX GP because their placement in other correctional facilities creates a risk to the institutional security, or staff, inmate, or public safety, or because their status before or after incarceration precludes their safe housing at another institution. ADX GP is a four phase program, and during the final two phases the inmates are housed in the less restrictive environment of the USP where staff can monitor their adjustment prior to transferring them to another facility.

Inmates are referred for consideration for placement in ADX GP after a review by the institution warden and the Regional Director. Central Office (Bureau headquarters) staff then conducts a preliminary review of the case, and if it appears the inmate may be appropriate for ADX GP, a trained Hearing Administrator conducts a hearing where the inmate may be present, make an oral statement, and present documentary evidence. The inmate may also have a staff representative compile evidence and witness statements for the hearing. The hearing report and recommendations are provided to the inmate, and forwarded to the National Disciplinary Hearing Administrator. The Assistant Director of the Correctional Program Division within Central Office makes the final placement determination. The inmate is informed of the decision and his right to appeal the designation through the Bureau's Administrative Remedy Program.

Control Unit Program:

Within the ADX, the Control Unit houses inmates who are the most disruptive individuals within the Federal prison system. Inmates are designated to the unit as a disciplinary sanction that is the result of serious misconduct during service of their sentence (e.g., murdering an inmate with high risk for a repeat offense, murder of a staff member, extraordinarily extreme flight risk).

Designation to the Control Unit requires approval by the Regional Director and Assistant Director of the Correctional Programs Division.

The Control Unit referral procedures are similar to the ADX GP referral procedures described above, but must include a psychologist's review of the inmate's mental status. Inmates currently suffering from active significant mental disorders or major physical disabilities are not referred to the Control Unit. As with other ADX referrals, the inmate may be present and provide evidence at the hearing, is informed of the final decision, and may appeal the decision through the Administrative Remedy Program.

Once transferred to the Control Unit, inmates are evaluated by a psychologist every thirty days. The Control Unit team also meets with the inmate and makes an assessment of his progress every thirty days. At least once every 60-90 days, the Regional Director and Assistant Director review the status of the Control Unit inmate to determine the readiness for release from the unit. The inmate is normally interviewed in person.

Only the Regional and Assistant Director may authorize an inmate's release from the Control Unit. In making this decision, they consider involvement in work, recreation, and program assignments, interactions with others (inmates and staff), adherence to policy, personal grooming and cleanliness, and quarters' sanitation.

Special Security

The Special Security Unit houses up to 64 offenders (with an additional 32 cells available) who have Special Administrative Measures (SAMs) imposed by the Attorney General. The referral process is similar to the other ADX referral procedures.

- **How many BOP inmates are currently in each type of housing above, and what percentage of BOP inmates spend at least some time in each of the above?**

  SHU = 11,458 (May 2012 Key Indicators); 5.2% of the population.
  SMU = 1,711 (May 25, 2012 SENTRY data run); 0.8% of the population.
  ADX = 431 (June 18, 2012 report from Warden Berkebile); 0.2% of the population.

- **Demographics for each type of housing, including race, age, gender?**

	BOP	ADX	ADX SSU	SHU	SMU
Asian Pacific Is.	1.64%	1.17%	6.06%	0.97%	0.25%
Black	41.77%	40.18%	21.21%	39.49%	47.79%
American Indian	1.78%	1.47%	0.00%	3.53%	5.56%
White	54.81%	57.18%	72.73%	56.01%	46.40%
18 to 29 Years	18.64%	4.11%	3.03%	27.05%	23.83%
30 to 40 Years	63.47%	63.64%	60.61%	63.90%	70.61%
50 to 60 Years	15.50%	26.10%	24.24%	8.40%	5.25%
65 Years and Older	2.39%	6.16%	12.12%	0.65%	0.32%

All are male; only 2.05% of female population (235) is currently in segregated housing.

- **What are the conditions and restrictions for each type of housing?**

SHU - SHU units are supervised by correctional officers who are present in the SHU 24 hours per day and who monitor inmates every thirty minutes. Additionally, correctional staff is available to meet with SHU inmates when requested by the inmate.

Inmates are not only visited by correctional officers, but also by unit team staff and programming staff. A unit team staff visits with the inmates on their caseload once per day. Programming staff visit with inmates for recreation, education, and chaplaincy needs. Every morning and evening all SHU inmates receive a visit from a health services staff member to ensure any medical needs are promptly addressed. Emergency medical care is always available and inmates can take prescribed medications in a SHU. Additionally, mental health and psychology staff makes weekly rounds in SHU and examine each inmate in a personal interview every 30 days of continuous placement in a SHU, or more often as needed or requested for the inmate. All inmates in a SHU receive the opportunity to exercise outside their cells at least five hours per week. This usually occurs in five one-hour periods throughout the week, and a SHU inmate generally shares the recreation area with at least one other inmate

SMU - Conditions of confinement for SMU inmates is more restrictive than for general population inmates. An inmate's individual conditions are limited as necessary to ensure the safety of others, to protect the security or orderly operation of the institution, or protection of the public, but all inmates continue to have access to Bureau reentry programming, including drug treatment, medical and mental health care, education, religious services, legal, recreation, commissary, correspondence, social visiting, and telephone privileges. While privileges are initially limited (e.g., less personal property, less commissary), inmates may gradually earn more privileges and are allowed to interact with one another based on their involvement in educational and counseling programs as well as their adherence to institution rules and regulations. Because of the extra supervision SMU inmates require, additional psychologists, counselors, and correctional officers are assigned to the units. The additional staff not only increase security, but also improves the chances of successfully modifying the inmates' behavior.

ADX-GP - ADX GP inmates receive up to 10 hours of out-of-cell exercise weekly, and are able to converse with other inmates in adjoining recreation areas. They also receive two monitored 15-minute telephone calls monthly. If an inmate maintains clear conduct, positive adjustment, and successful programming (generally for a minimum of 12 months), he is eligible for placement into the institution's step-down component of the general population program.

Inmates assigned to the Step-Down component are afforded up to 15 hours out-of-cell exercise weekly, and three 15-minute telephone calls monthly. Inmates who adhere to these provisions for six months may progress to the Transitional phase of the step-down component. Both the transitional phase and the final pre-transfer phase occur at the USP.

The transitional phase allows inmates increased out-of-cell time and four telephone calls per month. Inmates who adhere to the programming requirements for six months may be moved to the Pre-Transfer phase.

The Pre-Transfer phase is the final phase of the step-down component. Ordinarily, this is the final program requirement prior to transfer out of the ADX to the GP of another high security facility. Inmates in this phase are allowed to utilize common recreation areas and barbering

facilities, and are provide 300 minutes per month for telephone calls. Inmates in this phase are usually required to remain in this unit for 12 months before being considered for transfer to another institution. During this 12-month phase, staff can sufficiently monitor each inmate's adjustment in the least restrictive environment within the institution prior to transferring him to another facility.

ADX-Control - Control Unit inmates are afforded individual recreational opportunities up to seven hours a week and receive one 15-minute telephone call monthly. When moved outside of their cells, these inmates are restrained and escorted by three staff. The period of time an inmate is assigned to the Control Unit is determined based on the severity of the misconduct that caused his placement in the unit.

ADX-SSU - The Special Security Unit houses offenders who have Special Administrative Measures (SAMs) imposed by the Attorney General. SAMs restrict access to mail, media, telephone, and/or visitors, depending upon the specific risk factors. The referral process is similar to the other ADX referral procedures.

- **How many hours are spent in "isolation," or restraint, for each?**

Restraint is very rarely used within the Bureau and only when absolutely necessary for the safety of the inmate (e.g., engaging in extreme self-harm). However, it is not coded in our database in a searchable manner.

- **To what extent do these conditions involve single-inmate housing?**

Single-inmate housing is used only at the ADX. Inmates in SHUs and SMUs are almost always double-bunked except in extremely rare occasions when safety and security require the use of a single cell (for example, the inmate has demonstrated a risk of violence toward cellmates). And even in those cases, we work diligently to return the inmate to double-bunk status. Our level of crowding precludes the use of single-cell housing except in the most extreme cases.

- **What is the mean and median length of stay in each? Is there a maximum limit?**

There is no maximum limit set in policy for these designations. However, we recognize that GP is generally the best and most efficient housing option in terms of both inmate programming and staffing costs. Our staff work diligently with these offenders to assist them in modifying their behavior and programming appropriately so that they can move back to GP as quickly as possible.

ADX: Mean = 531.43 days (FY '12)

SMU: Mean = 223.06 days (FY '12)

SHU: Mean = 39.84 days (FY '12)

- **What is the cost for each of the above, also as compared with the average daily cost of less restrictive confinement?**

The BOP does not have separate budgets or a mechanism in place to trace all costs associated with the operation and management of various housing units within each facility or correctional complex. Each facility or complex has one budget for salaries and operations and each discipline/program area supports all units within the facility or complex. Costs are tracked for each discipline/program area, but are not tracked down to the unit level. However, staff salaries represent 2/3rds of our costs. In units where we have higher levels of staffing – with the ADX being the most extreme, costs are much higher.

- **Data on the number of inmates requiring medication for mental health conditions?**

This data is not readily available. Although we can search our medical records by type of medication, psychotropic medications may also be prescribed for non-psychiatric conditions, (e.g., pain management), thus we cannot determine this number without conducting an individual file review.

- **Data on the number diagnosed with mental retardation?**

This data is not readily available in our Psychology database. The diagnosis field is a text entry field that is not searchable.

- **Data on the number of suicides? (FY 2006 – 2012 Totals)**

ADX:	3
SMU:	3
SHU:	47
ALL OTHERS:	63
BOP TOTALS:	116

- **Data on the number of attempted suicides/those placed on suicide watch?**

This data is not encoded in the Psychology database in such a way that it can be searched by specific housing unit type. Rather, it is encoded by institution. Since most of the SMU beds exist as a unit within an institution, it was not possible without an individual file review to determine SHU or SMU suicide watch numbers except at USP Lewisburg, Pennsylvania because that entire facility functions as a SMU.

LEW SMU Suicide Watches.

2010 15
2011 17
2012 18 (to present)

ADX Suicide Watches.

2009 9
2010 8
2011 13
2012 10 (to present)

- **Data on the number of instances of self-harm?**

Self harm data is not encoded in the Psychology Services database as a separate, identifiable entry. We could only determine this number by conducting an individual file review on every inmate housed within ADX, SHUs, and SMUs.

- **Data on the instances of required forced feeding?**

Similar to self harm, this data is not encoded in the medical database as a separate, identifiable entry. We could only determine this number by conducting an individual file review on every inmate housed within ADX, SHUs, and SMUs.

- **Data regarding the amount of time between placement in these types of housing and release?**

This data is not encoded in our SENTRY system in a readily searchable manner.

- **Is placement at the above types of housing intended to be a permanent designation or is it only for a temporary period?**

All of these placements are intended to be temporary. We recognize that GP is generally the best and most efficient housing option in terms of both inmate programming and staffing costs. Our staff work diligently with these offenders to assist them in modifying their behavior and programming appropriately so that they can move back to GP as quickly as possible.

- **Comparative statistics for attacks on BOP officials in the types of housing listed above versus the general population.**

Guilty Findings for Assault and Weapon Prohibited Acts for SMUs and Highs – May 2012



ADX	462.58	2	4.32	3	6.49	11	23.78
HIG	19565.67	297	15.18	59	3.02	2416	123.48
SMU	79.00	0	0.00	0	0.00	3	37.97
FY 2008 Total		**299**		**62**		**2430**	

Fiscal Year=2009

ADX	428.25	1	2.34	1	2.34	14	32.69
HIG	19412.83	338	17.41	57	2.94	2708	139.50
SMU	413.00	29	70.22	10	24.21	73	176.76
FY 2009 Total		**368**		**68**		**2795**	

Fiscal Year=2010

ADX	413.08	2	4.84	1	2.42	13	31.47
HIG	18651.58	239	12.81	47	2.52	2019	108.25
SMU	1148.83	31	26.98	13	11.32	390	339.47
FY 2010 Total		**272**		**61**		**2422**	

Fiscal Year=2011

ADX	418.00	2	4.78	0	0.00	9	21.53

HIG	18489.17	223	12.06	29	1.57	1705	92.22
SMU	1279.42	35	27.36	5	3.91	302	236.05
FY 2011 Total		**260**		**34**		**2016**	
Grand Total		**1199**		**225**		**9663**	

- **Can inmate in one of these designations move back to general population? What is the policy for this process?**

Yes, inmates in all three categories can move back to GP and that is our primary goal for these offenders. We recognize that GP is generally the best and most efficient housing option in terms of both inmate programming and staffing costs. Our staff work diligently with these offenders to assist them in modifying their behavior and programming appropriately so that they can move back to GP as quickly as possible.

- **Can an inmate challenge assignment to these types of housing, and what is the procedure for doing so?**

SHU - Within seven days of placement in AD or DS, the inmate's status is reviewed at a hearing the inmate can attend. Inmates who are being protected from the general population can request another hearing at any time if they feel their placement in the SHU as a protection case is unnecessary. After these initial reviews, every inmate in both AD and DS receives recurring seven

day reviews to ensure basic necessities are met, including sufficient recreation, meals, and showers. Every thirty days the inmate's status is reviewed at a hearing the inmate can attend. The inmate has the right to pursue his placement, seek redress of complaints, and have a formal review of his/her concerns through the Bureau's Administrative Remedy Program.

SMU - Inmates are referred for consideration for placement in SMU after a review by the institution warden and the Regional Director. A trained Hearing Administrator notifies the inmate prior to the SMU placement hearing and provides the inmate with specific evidence (unless such information would jeopardize the safety and security or endanger staff or others). The inmate has the opportunity to be present during the hearing, make an oral statement, and present documentary evidence to the Hearing Administrator. The inmate may also have a staff representative to compile evidence and witness statements for the hearing. Following the hearing, the Regional Director makes the final determination regarding whether or not the evidence supports the appropriateness of SMU placement. The inmate is informed of the decision and his right to appeal the designation through the Bureau's Administrative Remedy Program.

ADX-GP - Inmates are referred for consideration for placement in ADX GP after a review by the institution warden and the Regional Director. Central Office (Bureau headquarters) staff then conducts a preliminary review of the case, and if it appears the inmate may be appropriate for ADX GP, a trained Hearing Administrator conducts a hearing where the inmate may be present, make an oral statement, and present documentary evidence. The inmate may also have a staff representative compile evidence and witness statements for the hearing. The hearing report and recommendations are provided to the inmate, and forwarded to the National Disciplinary Hearing Administrator. The Assistant Director of the Correctional Program Division within Central Office makes the final placement determination. The inmate is informed of the decision and his right to appeal the designation through the Bureau's Administrative Remedy Program

ADX-Control Unit - The Control Unit referral procedures are similar to the ADX GP referral procedures described above, but must include a psychologist's review of the inmate's mental status. Inmates currently suffering from active significant mental disorders or major physical disabilities are not referred to the Control Unit. As with other ADX referrals, the inmate may be present and provide evidence at the hearing, is informed of the final decision, and may appeal the decision through the Administrative Remedy Program.

ADX-SSU – These inmates have SAMs put in place by the Attorney General. The referral process is similar to the other ADX referral procedures and these inmates have the same Administrative Remedy appeal opportunities.

- **Who does mental health assessments for BOP? What kind of mental health staff does BOP have? How many part- and full-time psychologists and psychiatrists are on staff?**

All institutions are staffed with a doctoral level, license eligible, chief psychologist. The staffing complement of the department is based on the institution's specific mission, size, and any specialty programs. Most institutions have a core staffing complement of a chief psychologist, drug abuse program coordinator, 1-3 staff psychologists, a drug treatment specialist, and an administrative support staff member (part-time or full-time).

In the field, there are 402 doctoral level psychologists whose primary mission is to provide mental health services (assessment, management, and treatment). There are an additional 67 bachelors and masters level clinicians working in specializing treatment programs for mentally ill inmates. These numbers include Challenge Program staff who have a dual mission of mental health and substance abuse treatment. These numbers do not include drug treatment staff working in dual diagnosis RDAPs. In addition, the BOP provides training for students pursuing doctoral degrees in psychology through its formal pre-doctoral psychology internship programs. At present, the BOP provides this training for 45 interns, who provide mental health services for BOP inmates under the supervision of licensed BOP psychologists.

The above numbers refer to allocated positions, not filled positions. Due largely to budget constraints, a number of positions are vacant. As of pay period 10, 18% of Psychology Services positions were vacant.

Mental health evaluations, such as forensic examinations, suicide risk assessments, and segregation reviews, are all conducted by doctoral level BOP psychologists.

Approximately 70% of BOP psychologists are fully licensed; all BOP psychologists must be license eligible



News from a Nation in Lockdown
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June 12, 2012

Dear Chairman Durbin and Ranking Member Graham,

Thank you for the opportunity to comment on the issue of solitary confinement that has come before the subcommittee. Our names are James Ridgeway and Jean Casella and we are the editors of Solitary Watch, a web-based project aimed at bringing the widespread use of solitary confinement and other forms of torture in U.S. prisons out of the shadows and into the light of the public square. Solitary Watch's mission is to provide the public—as well as practicing attorneys, legal scholars, law enforcement and corrections officers, policymakers, educators, advocates, and prisoners—with the first centralized source of background research, unfolding news, and original reporting on solitary confinement in the United States.

The use and abuse of solitary confinement in U.S. prisons is one of the most pressing domestic human rights issues in America today—and also one of the most invisible. Part of the mission of Solitary Watch is to provide prisoners a chance to relate their own experiences in solitary, through a feature called "Voices from Solitary." In that connection, we have received hundreds of letters from prisoners in segregation, many of them eager to share their stories. Some wish their words to be published under their own names, while others prefer to remain anonymous to prevent retaliation. What follows is a small selection of writings by prisoners in solitary confinement in U.S. prisons and jails.

Pennsylvania state prisoner in solitary for two years: "I sit in solitude alone in my cell, with thoughts of freedom running wild in my head like a child in a walker, I shiver from the bitter cold that these concrete walls give off, I can't do nothing but lay in the corner on the cold floor naked the only light enters through the bottom of the steel door—I'm so cold—hunger sets in as as the only food I will be eating is some stale bread and if I'm lucky a piece of rotten fruit. I scratch the days into my skin with hopes of being released from these psychological confines of this concrete jungle, with no windows, no lights, no bed no running water, just a toilet that doesn't work with the strong smell of years of urine, this is sure to make any man lose his mind. This is the reality of a man in prison with the support of no one, do you think he hurts?"

California state prisoner subjected to additional punishment for disciplinary problems while in solitary: "For 30 days.... I was placed in a tiny isolation cell in the middle of a desolate hallway by itself. It was the only cell in the entire hallway. The cell was only large enough to accommodate a bunk, sink and toilet. There was only room to take about two steps. I couldn't even flush the toilet myself; I had to wait for an officer to pass by so I could ask them to push the bottom outside my cell to flush it. It was humiliating. I was not allowed any personal property, not even writing, reading or hygiene products. I couldn't even receive my mail. The only items I was allowed to possess were a blanket, sheets, a t-shirt, boxers, socks and toilet paper (if I was lucky). I was fed a brick diet twice a day which consisted of different foods smashed together in a ball."

Oregon state prisoner who spent 12 years in solitary: "I've learned, from other prison psychiatrists that PTSD is common in prisoners who have spent many years incarcerated. It is akin to serving several tours in a war zone. People become hypersensitive and you can literally feel the stress and tension on people. I've known it for years but didn't know it was PTSD. I startle easily. If a pen rolls off my desk and hits the floor…even that small sound can throw me into fear. If the officer knocks on the cell door or shuts the cuff port hard, a door slams, an odd sound…every one of them can throw me into fear…I have recurring nightmares."

Texas state prisoner, now age 30, who has been in solitary almost continuously since the age of 16: "Being subjected to years of solitary confinement is a terribly unique experience; quite unlike any other form of time, one of the things in life that you've kind of either been through or you haven't. However mentally tough you may be, years of sensory deprivation, total isolation, lack of mental/physical stimuli, and otherwise enduring the struggle that is a part of it all, takes a tremendous toll. Nearly without fail it instills a bitterness and hatred in you. After a number of years it often becomes difficult to do any other type of time; being around people in typical or normal [environments] becomes uncomfortable and even unbearable…Any time you leave your cell you're handcuffed with a dog leash attached (they refer to it as a 'tether' I believe) and otherwise treated like a straight up animal. I've often compared it to having a dog in a kennel or cage and keeping him there for years, while poking sticks at him, playing vile games against him, making him go periods without water or food, etc…and when you eventually loose that dog, do you really expect anything other than pure aggression, hatred, anti-social, etc?"

Nevada state prisoner placed in medical solitary after several escape attempts: "[They] put me in this cell [in the infirmary] where I have been locked away, and it seems they have thrown away the key, I have no shoes of any kind. No clothes except a pair of underwear and a T shirt. I have a blanket and a mattress. That's it. They won't even let me keep a toothbrush and toothpaste in my cell. I have to use it and give it right back to the guard. There is no window to the outside. And they painted everything in this cell Orange…It's like I live in an orange box. It seems like I am stuck in some weird room in the Willy Wonka factory. They posted a "No Communication" notice on the outside of my door. The regular COs are not allowed to talk to me or even come into the vestibule outside my cell. When they feed me a sergeant or lieutenant has to be present. And they feed me using this box that they put my food in, then they lock it. Then open the inside part, sliding it open so I can reach in and pick up my tray. They treat me like Hannibal Lector and I've never once acted aggressive towards any staff."

New York state prisoner with mental illness who tried to kill himself by burning down his solitary cell, and was given an additional six years for arson: "It's hard in here for me. I feel like killing myself most of the time like I said but end up cutting myself to relieve the pain or just do things that help me relieve pain. Cutting myself seems the best way but one day I'm going to really cut myself and not tell noone so I can bleed out. That's how I am feeling nowadays. My life's gone down the drain."

Louisiana state prisoner: "We are even forced to have all sick call visits and psychiatric visits while we are in our cells in the hearing range of all the other inmates and guards. Social workers, psychiatrists, nurses etc. stand in the hall (on the cat walk) in front of our cells. Our cells have only one opening. This is the equivalent of no treatment at all with people being mocked and ridiculed by what they say."

Missouri state prisoner: Since I've been in this demoralizing place I've seen people go absolutely insane...They have got people that talk to themselves all day. They got people who curse people out all

day. They got people the attempt suicide for stupid reasons. They got people that eat or play with their own bodily wastes. Human beings don't do this. Animals do. Uncivilized people do. Staff here created an environment that makes a person uncivilized. When I say uncivilized, I'm talking about stripping away their humanity. First, they say to the person "I don't know if you will ever get out of the hole." They make the person lose hope for anything. Then they don't give the person much to exercise his mind. They only provide us with one reading book a week ...While in the hole, we can't order magazines or newspaper ourselves, [and] they forbid us from passing along these items so the ones that are fortunate to get magazine or newspaper subscriptions from people helping them on the outside, they can't even let someone else read it. Making matters worse, we stay in our cells 24/7 unless we need to get medical, attend classification hearings, or visits...We stay in these cells day after day, month after month, year after year. We want ad seg reform. We need ad seg reform. Help us obtain ad seg reform.

Washington State prisoner: A question rises in my mind..."I am still alive, aren't I?" And as ridiculous as the question seems, it holds my attention because it's hard for me to be certain of anything in this place anymore. I haven't spoken in months. What do I actually have to verify that I am still alive? A heartbeat? It strikes me that someone dead may still perceive his heart as beating. Breath? Dead people probably think they're breathing too.

I look at the heavy steel cell door beside me. That is something—what keeps me sealed inside this concrete box, this IMU cell. If I am no longer alive, would it still do this to me?...The thought scares me. Deepens despair. Hell, in my mind, not the fiery nether world of Christianity. How can I adopt an abstract when I know something worse, a thousand times more concrete?

Focus. I redirect my mind, aware that it is necessary to keep it on a short leash here, to rein it in when I feel it slipping, or run the risk of it leaving altogether. Strange things happen to minds in this place—things, I suspect, people in the free world know nothing about. Weak minds break quickly. Strong ones, later on.

Utah state prisoner: Go to your bathroom door and kick a hole in it. Now lock yourself in tight. Throw all your hygiene items, except a tooth brush and toothpaste tube, out the hole. Everything. Now go to your tub and flip it over. This is where you'll sleep. Now sit. The light switch disappears and the shower spigot. A little speaker replaces them. It listens and sometimes speaks to you. Laughs at you. Taunts you. Tells you your suffering is entertaining. You can't shut off the light with no switch and you'll have to shower using the sink...

A day passes this way. "My god," you say, "what have I done to deserve this?"

A week passes. You cry.

A month. You attempt suicide but your vein closes up before death.

A year. You are now talking to yourself and running around naked. You are convinced the food you seldom receive, that's halfway edible, is poisoned. As you eat the rotten "meat" your beard and mustache get in the way of the teeth chewing. You couldn't cry if your life depended on it. And it used to. But you've forgotten why.

Two years. You can't remember. You've forgotten. Forgotten what? You don't know. The "squatter enemies" come around and you look at them. They look at you. They laugh. You start to laugh too. You forgot why. But you do.

Three years. You sleep 20 hours a day. You can't help it. But your floor is clean. You keep it spotless. You don't know why. But you do. You're skinny. You've lost an easy 60 lbs. Your skin is turning yellow and your legs cramp up and atrophy. You don't want to die anymore. Why bother? You'd rather sleep and dream. The dreams are so vivid. More real than these walls.

Five years. You go home, you leave your bathroom, this year. They tell you that. But why? Where do I go? I don't want to leave now. I like my tub and sink...

Federal prison in the U.S. Penitentiary in Lewisburg, Pennsylvania: In a hole, within a hole, inside a prison is where I dwell--the Special Management Unit at USP Lewisburg. Days to nights, nights to dawn. I roll out my rack to the sight of nothing…

The tiny space I call home allows me a few feet before I am at my door peeking out of a rectangular shaped window that permits a view to a blank tier and adjoining cells. This particular prison was constructed in 1932. Its concealed conditions are inhumane and utterly unpleasant. Anywhere but here, yet this it…

Wall to wall- hardly enough room to shape my physical–I push up as if the weight of the world rests heavily upon my shoulders. When I can go no more, I go further, harder. The associated matters, which modify my course of development provoke me to exert the force within. One of the few positive pushes permissible and, for now, it's this or staring at the walls in effort to impede the ever-tightening grip of this unilluminated dungeon.

From down the tier I hear the cries of another inmate. Although I can place no face–"LET ME OUT!", he wailed. His sanity gone forever. What he was going through I know so well. Had I not been afraid of my cries falling on deaf ears, I too would holler LET ME OUT!!!

Federal prisoner in the U.S. Penitentiary, Administrative Maximum (ADX) in Florence, Colorado: The moment you set your eyes on it it's a mixed ball of emotions and feelings that hit you...The psychological intimidation starts without even setting one foot into the ADX and the remoteness also adds a touch that you are no longer to be a part of the world the moment you arrive you realize you've reached a level of solitary living that is specifically designed to keep you totally separated from human contact–it's a chilling feeling.

The sensory deprivation starts from the moment you arrive into the intake, the deadly silence adds to the reality that you're not in a normal prison…what was normal was the humiliating experience of becoming a new inmate. After the intake process I was shackled and box-cuffed and escorted by a number of corrections officers with black batons at hand and ready to beat me down if I made a wrong move.

I was escorted down a series of never ending, lengthy wide and tall hallways that were painted an off white and were at a downhill angle which make your ears pop as you move down them. It's just another drop added to the emotional and psychological design and purpose of solitary life. I was then housed in the famous D-Unit…The confined space that you are housed in is a 7-by-9 foot sound proof cell that comes with a concrete slab and a thin mattress for a bed, a shower within the cell with a timer to conserve water and prevent flooding, a sink with no taps, just touch buttons…a toilet with a valve that shuts off the water after two flushes automatically for an hour, an immovable concrete desk and concrete stool, a polished steel mirror riveted to the concrete wall and a thirteen inch black and white television encased in plexiglass to prevent tampering.

I have been to many different prisons and none can compare to ADX's conditions. Of course I'm not taking away the fact that the animalistic treatment isn't the same when it comes down to the beatings, torture, and psychological abuses…These places are designed to drive you crazy, you can feel the madness closing in on you. You can feel it eating away at you and there is nothing you can do to stop it…you can slow it down by writing and reading but that's all it does, slow down the process of mental madness.

TAMMS YEAR TEN
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June 14, 2012

U.S. Senator Dick Durbin
Chair, Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights
c/o Nicholas Deml
Nicholas_Deml@judiciary-dem.senate.gov

Dear Senator Durbin:

Thank you for your interest in supermax prisons, especially their psychological and psychiatric impact on prisoners. As you know, Illinois contains one such facility, Tamms C-MAX, located in southern Illinois. This letter is written on behalf of the members of Tamms Year Ten, a coalition of concerned citizens, faith groups, mental health advocates, law and public policy clinics and prison reform and reentry organizations who have come together to educate the public about the misguided and inhuman policies at Tamms C-MAX.

Members of our group have been interested in Tamms since the prison opened. One of us (Ms. Snyder) was lead counsel in a lawsuit challenging the housing of seriously mentally ill prisoners at Tamms, *Rasho v. Snyder*, 00-528-DRH (S.D. Ill.). Between the three of us, we have visited the prison dozens of times from June 1998 and March 2012 and corresponded with hundreds of men housed at the facility.

Federal review of supermax prisons such as Tamms is long overdue. Our country's extensive use of supermaxes has for years been criticized by the United Nations, first in 2000 by its Committee Against Torture, and most recently in 2011, by U.N. Rapporteur on Torture Juan E. Méndez. Certainly, it is time for the federal government to take a serious look.

In Illinois, Governor Patrick Quinn recently proposed closing Tamms C-MAX; but opposition from the public employees' union and legislators from southern Illinois has left the closure plan in doubt. For this reason, Tamms Year Ten recently asked U.N. Special Rapporteur Juan Méndez to investigate Tamms. Mr. Méndez has announced his strong interest in doing so, and he will shortly decide whether to seek permission from the U.S. State Department to investigate the solitary confinement used at Tamms C-MAX. (Please see "*Does solitary*

confinement at Tamms meet definition of torture? U.N. panel seeks probe," by George Pawlaczyk and Beth Hundsdorfer, Belleville News-Democrat, June 10, 2012, attached hereto.)

Yet, the United Nations would not need to act if we in the U.S. would on our own curtail the routine use of long-term supermax confinement. Some states have already taken the initiative: Maine, Colorado, and Mississippi have all closed their supermaxes or considerably reduced their supermax population, and have done so with success. We hope that Illinois will follow suit. Positive action by the Senate Judiciary Subcommittee can help built a national trend to close supermaxes.

Seriously mentally ill men are housed at Tamms C-MAX

Built in 1998, Tamms C-MAX is a free-standing facility specially designed to house prisoners in an atmosphere of social isolation and extreme restrictions. When it opened, the announced aim was to manage and control violent or seriously disruptive inmates by housing them at Tamms for up to a year. Instead, many prisoners are sent to Tamms in retaliation for filing grievances and lawsuits or for arbitrary reasons, and are not told when they will leave. In practice prisoners are housed there for years and years; some of the men transferred to Tamms in 1998 are still there today, 14 years later.

It is now generally accepted that the harsh, isolating conditions of a prison like Tamms C-MAX can cause or exacerbate mental illness; and that is the reality at Tamms. The Illinois Department of Corrections does not bar seriously mentally ill men from being sent to Tamms or from continuing to be housed there, and so the prison is populated with men who have serious pre-existing mental illnesses or who became seriously mentally ill after their prolonged stay at the supermax.

Conditions at Tamms C-MAX

Undeniably, the conditions at Tamms constitute the "excessively harsh regime" that has been condemned several times by the United Nations' Committee Against Torture. At Tamms, control is exercised through extreme social isolation, severely restricted movement, and an environment that denies sensory stimulation. A centralized control booth operates all lights and doors and the water supply, video cameras provide visual surveillance, and intercoms provide communication without human contact while also allowing guards to eavesdrop on prisoners.

Tamms C-MAX consists of eight self-contained cell blocks, called pods, each holding six wings of ten cells. To restrict the movement of prisoners, each pod is a self-contained living unit that holds an exercise area, showers, a small law library, a nurses' station, a "multipurpose room" used by the medical and mental health staff, and a central control booth for corrections staff. Movement between the pods is through an underground tunnel. At Tamms, each inmate spends 23 to 24 hours a day, seven days a week, in a single 80-square-foot concrete cell. Each cell contains only a concrete bed, a stainless steel combination sink and toilet, a mirror, a shelf

that serves as a desk, and (for some inmates) two boxes for storing personal property. Each cell has a narrow window placed high up on the wall, making it possible to say that the cell has natural light but impossible for the inmate to see anything unless he stands on his bed. The door to the cell is made of heavy gauge steel perforated with dime-sized holes that are difficult to see through. Each door contains a slot for food, called a chuck hole. The prisoners' view through the perforated steel mesh is of a raw concrete wall and the occasional corrections employee who passes by; prisoners cannot see each other.

Five wings have been converted to "elevated security" wings to house some inmates on disciplinary segregation status. Each such cell has a Plexiglas shield covering the perforated steel door and a "food box" affixed to the door. The food box permits correctional staff to pass items to and receive items from the inmate without the possibility of contact during the exchange. In addition, mirrors have been removed, light fixtures are reinforced, and special drains have been installed outside of the cells on the gallery so that the cells can be cleaned more easily, and some cells have a special "prime coat" covering the concrete walls, which makes them easy to hose down. The Plexiglas shield and attached food box muffle sounds and impede communication even more than with the regular cells, making the elevated security wings especially isolating. Many men whose out-of-bounds conduct is caused by mental illness are housed in these elevated security wings.

One pod has been set aside as a "Specialized Treatment Unit" for seriously mentally ill prisoners, although not all seriously mentally prisoners are housed here. The Unit holds approximately 10 prisoners, who reside in cells resembling those on the elevated security wings. The additional benefit for those in the Treatment Unit is up to an hour a day of "group therapy," which consists of a session where all participating prisoners are placed in the same room, each encased in a Plexiglas booth like a telephone booth, where they can shout out to the therapist and to each other.

Throughout Tamms C-MAX, prisoners do not leave their cells for meals, which are served on plastic trays pushed through the chuck hole; the trays and utensils must be placed back in the chuck hole within 30 minutes. Prisoners do not leave to visit with other prisoners; such contact is forbidden. They do not leave for communal religious services, educational programs, or jobs, none of which exist at Tamms except for "correspondence courses," a rudimentary non-contact form of educational program. Those who can read (many prisoners at Tamms have only rudimentary reading and writing skills) may keep some books in their cells.

Most prisoners cannot listen to the radio or watch television, which are provided only for the prisoners who have advanced to a high behavioral level, which is not possible for many of the prisoners who are mentally ill. Prisoners cannot see or socialize with other prisoners, except by yelling into the wing, where the extreme echoing effect makes it hard to hear and understand. On nearly every wing, one or two prisoners scream and bang on cell walls throughout the day and night, so that other prisoners often cannot sleep.

Prisoners regularly leave their cells only to exercise or take a shower one to five times a week – or not at all if privileges have been taken away from them for disciplinary reasons. Occasionally, they visit the satellite law library or go to the multipurpose room to see a social worker; only rarely do they travel outside the pod to the Health Care Unit or the Visitors' Room. At no time, are two or more prisoners on a wing allowed outside their cells at the same time.

Whenever an inmate leaves his cell for any purpose except exercise and shower, and each time he returns, he must submit to a full body cavity search. First he removes his clothes and hands them to the guard. Standing naked, he must display his ears, feet, hands. Then he must bend over, his back to the guard, and spread his buttocks. He must raise his penis so the guards can examine his testicles. He may be ordered to expose the underside of the glans penis, or, if he is not circumcised, to pull back the foreskin.

After dressing, he is handcuffed and then, kneeling or lying on the floor, his legs are shackled by guards wearing latex or leather gloves. If he is moving outside his pod he is surrounded by two or three guards, who place their arms on his chest and shoulders, and his movements may be tracked by a guard who has access to a semi-automatic rifle. These punitive and humiliating exchanges are the only times a Tamms inmate feels another person's touch, except when he is examined by a doctor, which usually takes place while the inmate's legs are shackled and his arms are held by guards.

Exercise takes place in concrete "yard," about 15 by 30 feet in diameter, located at one end of each pod. The yard contains no basketball hoop, no drinking fountain, and no toilet. The only equipment is a small rubber ball available to prisoners who purchase it. A stainless steel plate covers one-half of the yard; the remaining half gives the inmate his only glimpse of natural light and the outside world, except what he can see through his cell window. Yet many seriously ill prisoners go for weeks without going to the yard because their privileges have been removed for disciplinary reasons or because their mental illnesses make them fearful of leaving or too depressed to move.

The inmate's contact with family and friends outside prison is infrequent, uncomfortable, and without physical contact. Visits are cumbersome, expensive, short, and inhospitable. Except for visits by lawyers, each visit must be arranged weeks in advance for a specific time and is forfeited if the visitor is late. Most visitors must make an overnight car trip, since Tamms is 370 miles from Cook County, where the families of two-thirds of the prisoners reside. A thick glass shield separates the visitor and the inmate, who talk through a microphone that distorts voices and cuts off a conversation if one person talks or laughs while the other is talking. All conversation (except between attorney and client) is recorded. The prisoner's legs are shackled and chained to a bolt in the floor. If the prisoner is in segregation status, he wears handcuffs attached by a short chain that makes it difficult for him to gesture or even to scratch his face. In addition, prisoners whose behavior qualifies them, are allowed one or two 10- or 15-minute calls to immediate family per month.

Three Tamms prisoners

The three men described below came to Tamms soon after it opened in March 1998. They have been housed there for all or most of the time since then, and they reside there today.

Faygie Fields: Faygie Fields is a 54-year-old man from Cook County, who has been incarcerated since 1986. Faygie came to prison on a charge of murder; while in prison he's been convicted on three criminal charges based on in-prison conduct, one of which occurred at Tamms, where he has been housed continuously since it opened. Currently he is scheduled to be released from prison in 2039.

Faygie has a long history of serious mental problems dating back to pre-adolescence, when he was diagnosed with schizophrenia. That diagnosis was confirmed several times throughout his stay at Tamms by psychiatric experts who examined him when he was a plaintiff in *Rasho v. Snyder*. Prison doctors do not consider Faygie to be seriously mentally ill and believe he is malingering. Nevertheless, they agreed to provide mental health treatment for him as part of the settlement of the lawsuit, so that in 2005, for the first time he received medication and therapy for his deteriorated schizophrenia. Initially Faygie improved, but after the settlement agreement ended, his improvement declined and he was transferred out of the Treatment Unit. Now he resides on a elevated security wing, where the mental health team writes him off as a malingerer.

For Faygie, the intense isolation at Tamms has intensified the delusions and feelings of persecution that typify schizophrenia. In the years that we have known him, the number one issue on his mind is trying to deal with the poisoned food and drugs he believes that prison staff are offering to him. His complaints are always accompanied by descriptions of symptoms of the poisoning and often supported by bits of string or chalky substances which he hides in his mouth and serves up as examples of the poisons that he would like to have tested. He files hundreds and hundreds of grievances about the poisoning and sends letters to lawyers, law enforcement officials, and court personnel to complain and seek relief. Because of his delusions, he regularly tries to harm himself or his surroundings, actions which bring punishment that further increases his sense of isolation.

Robert Boyd. Bobby Boyd is a 37-year-old man from Cook County. He has been incarcerated in IDOC since 1993 when at age 19 he was convicted of stealing a car. Thanks to a series of convictions based on in-prison conduct, he now has an out date of 2051.

Bobby had an extensive psychiatric history that includes multiple suicide attempts, treatment with numerous psychotropic medications, and a year-long psychiatric hospitalization at the Illinois State Psychiatric Institute when he was a teenager. Bobby's current diagnoses include major depressive disorder, recurrent with psychotic features; borderline personality disorder; and a cognitive disorder likely caused by multiple, serious head trauma.

Bobby was transferred to Tamms shortly after it opened in March 1998. He immediately began displayed signs of serious mental illness such as hallucinations, paranoia that others were conspiring to kill him, severe self-mutilation and multiple suicide attempts. He screamed and talked to imaginary people in his cell, once explaining to staff that he was busy having a party; another time, describing to them demons he saw crawling out of his toilet and walls. Staff did not acknowledge that he was seriously mentally ill until he became a plaintiff in the *Rasho* lawsuit. Even so, from the get-go he was treated with heavy-duty psychotropic drugs and placed in "therapeutic restraints" while being forcibly medicated. In 1999 Bobby left Tamms. He did well when he was housed in Dixon Correctional Center, the Department of Corrections' dedicated mental facility but not elsewhere, in part because his Tamms experience had made him fearful of being around other prisoners. Eventually his distorted fears of other prisoners caused him to act violently toward another prisoner, and in 2003 he was returned to Tamms for good.

The Department of Corrections now acknowledges that Bobby is seriously mentally ill, and he was housed on the Specialized Treatment Unit upon his return to Tamms. But eventually he was transferred to an elevated security wing, where he resides today.

The extreme isolation and social deprivation at Tamms have intensified Bobby's mental problems. His hallucinations and paranoia continue; he continues to injure himself and to threaten and engage in suicide attempts, and he occasionally engages in violent and destructive behavior. Two years ago he wrote, "I'm going out of my mind. . . I'm very sick medically and mentally. And [I] got no one! [W]hat can I do? Can you help me? I need help. I'm wanting help." When two of us visited him this spring he said essentially the same thing; we still have no remedy for him.

Anthony Gay Anthony Gay came to prison in 1994 following a conviction for a robbery that occurred when he was 19. When Tamms opened in 1998, he was one of its first residents, and he has been housed there for most of his incarceration. To cope with the isolating conditions at Tamms, Anthony has become a "cutter," a prisoner who responds to the stress of isolation by mutilating himself.

Using self-injury as a mechanism for dealing with his emotional instability, Anthony compulsively cuts his body over and over. The cutting began at Tamms, he says, when he saw another prisoner receive care and compassion from the staff after injuring himself. Now Anthony cannot stop; sometimes the Tamms staff place him in "therapeutic restraints" and inject him with strong tranquilizers to halt the cutting, and sometimes he even asks to be bound in restraints for that purpose. The only time he has stopped cutting himself for longer than a few weeks was during a four-month stay at Dixon.

Now Anthony has multiple cuts on his arm, neck, thighs, penis, and testicles. In prison lingo, he is a "cutter," one of nearly a dozen such men at Tamms. Anthony, like most of the other cutters, is housed on a elevated security wing and is not considered by staff to be seriously mentally ill.

Anthony also engages in out-of-bounds conduct such as throwing urine or feces at the correctional officers. He is continually punished for his self-mutilation and his actions toward officers, by such methods as removing the minimal privileges he otherwise would be allowed and by serving him only a foul-tasting concoction called a meal loaf instead of a regular meal. He also has been prosecuted numerous times for such things as throwing a liquid substance at a correctional officer, so that his initial seven-year sentence has morphed into one lasting 101 years.

Conclusion

We appreciate the opportunity to tell you about Tamms supermax. We hope that the Senate Judiciary Subcommittee will seriously address the problem of our country's routine use of prolonged solitary confinement in supermax facilities such as Tamms C-MAX.

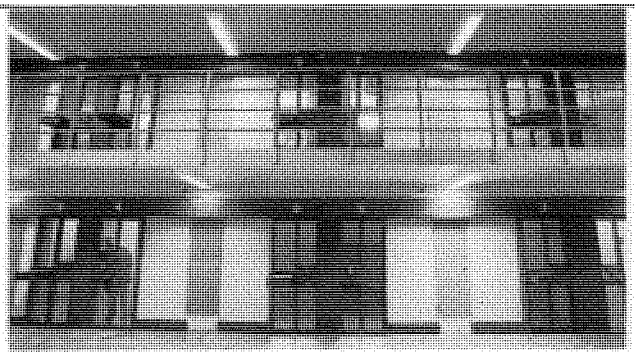
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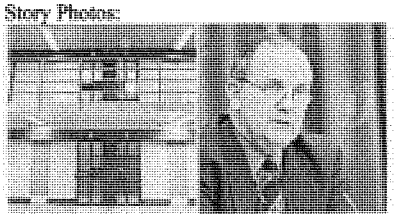
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- Story Photos:
- 
  - Juan E. Mendez, the special rapporteur on torture for the U.N.

Does solitary confinement at Tamms meet definition of torture? U.N. panel seeks probe

Published: June 10, 2012

By GEORGE PAWLACZYK AND BETH HUNDSDORFER — News-Democrat

Despite uncertainty about whether the Tamms Correctional Center will continue to operate, a United Nations committee is expected to make a decision this week about whether to seek permission from the U.S. State Department to investigate solitary confinement at the supermax prison to see if it meets the international definition of torture.

Many Tamms inmates, including the mentally ill, have been held in isolation at the relatively small 180-prisoner lockup for more than a decade. More than a dozen have been held in solitary since the prison opened in 1998.

Juan E. Mendez, the special rapporteur on torture for the U.N., said Saturday that his staff in Geneva, Switzerland, is going ahead with an assessment of Tamms to determine if it should be investigated. The assessment began about two weeks ago in response to a written request by the Tamms Year Ten Committee, a Chicago-based alliance of mental health advocates, citizens and religious groups concerned with prison reform. The group has opposed the supermax on humanitarian grounds for more than a decade.

"Communications with the U.S. government are still being prepared but it is going to go forward unless we have drastic changes in the situation," Mendez said Saturday.

An attorney from Argentina, who was himself tortured in the 1970s in his own country, Mendez has been involved with international human rights groups for decades. He has taught human rights at colleges and universities in the United States and at the University of Oxford in the United Kingdom.

Mendez said that even if Gov. Pat Quinn goes ahead with his earlier announced intention of closing Tamms for budgetary reasons, the U.N. is still likely to seek the go ahead to launch a study.

"Whatever happened in the past is also part of my concern. So, we will have to see. I'm obviously following the situation closely. It will have an effect on what I ask the government to allow us to do but not necessarily whether I ask them," Mendez said.

Jean Maclean Snyder, an attorney and member of the Tamms Year Ten Committee, said, "Mr. Mendez' swift and serious attention to the human rights concerns posed by prolonged incarceration at the Tamms supermax should be a wake-up call for Gov. Quinn. More is at stake than providing jobs for downstaters."

Quinn's spokesman could not be reached for comment.

The Illinois Department of Corrections, long a supporter of Tamms, has since stated that if the prison closes, even its most troublesome inmates can be held safely in isolation units at other maximum security prisons.

But several groups including the American Federation of State, County and Municipal Employees have urged that Tamms remain open to act as a safety valve for the entire 45,000-

inmate system. Anders Lindall, spokesman for AFSCME, has said fear of being transferred to Tamms has resulted in less violence at other prisons.

However, following weeks of testimony, long-term solitary confinement at Tamms was found harmful in 2010 by a federal judge sitting in East St. Louis.

"Tamms imposes drastic limitations on human contact, so much as to inflict lasting psychological and emotional harm on inmates confined there for long periods," wrote U.S. District Court Judge G. Patrick Murphy in his decision stating that inmates must have a hearing before being transferred to the supermax. That decision is under appeal.

Controversy about Tamms increased in 2009 following the publication of an investigative reporting series "Trapped in Tamms" by the Belleville News-Democrat. The newspaper's findings questioned long-held beliefs by the Illinois Department of Corrections that only the "worst of the worst" were sent to the lockup, located in Alexander County in the southernmost part of Illinois.

The BND reported that many inmates were held in the most restrictive portion of the prison for throwing body waste at guards and other acts that could be attributed to mental illness exacerbated by solitary confinement.

Mendez said he welcomed what is being called the first ever congressional hearing on solitary confinement in U.S. prisons, which is set for June 19 and will be headed by Illinois Sen. Dick Durbin, assistant majority leader and chairman of the Senate Judiciary Committee. It is titled, "Reassessing solitary confinement: The human rights, fiscal and public safety consequences."

It is actually the second committee hearing involving solitary confinement and prisons.

In September 2009, several weeks after the newspaper series ran, Durbin issued a statement that he would hold a hearing about mentally ill prisoners in solitary, which was in response to the BND articles about Tamms. But about two months later, Durbin made a 90-minute tour of the prison and later told reporters that he thought its 12-prisoner mental health unit was the best in the country.

That finding brought criticism from members of the Tamms Year Ten Committee who stated that the main concern was the hundreds of inmates driven to mental illness by the lengthy solitary confinement.

Contact reporter George Pawlaczyk at gpawlaczyk@bnd.com or 239-2625. Contact reporter Beth Hundsdorfer at bhundsdorfer@bnd.com and 239-2570.

Testimony of
Bill Mefford
Director of Civil and Human Rights
United Methodist Church, General Board of Church and Society
Before the
Senate Judiciary Committee
Subcommittee on the Constitution, Civil Rights and Human Rights
Hearing on Reassessing Solitary Confinement
June 19, 2012

Mr. Chairman, Members of the Subcommittee, thank you for this opportunity to submit testimony on behalf of the United Methodist Church, General Board of Church and Society concerning the harmful use of solitary confinement in our nation's federal prisons, jails, and detention centers. We are encouraged that this committee has chosen to focus a hearing solely on reassessing the use of solitary confinement, the first hearing of its kind. This comes at a time when a growing number of states across the nation are also reassessing this practice and implementing policies to limit its use. We believe that this committee will find that solitary confinement is a moral failure as well as an unnecessary financial burden on the federal and state governments.

The United Methodist Church is the third largest denomination in the United States and has over 11 million members worldwide. The General Board of Church and Society is tasked with bringing "the whole of human life, activities, possessions, use of resources, and community and world relationships into conformity with the will of God. It shall show the members of the Church and society that the reconciliation that God effected through Christ involves personal, social, and civic righteousness."

Across the United States inmates and detainees are being confined in a small cell for 22-24 hours per day for weeks, months, even years at a time. The United States leads the world in its use of solitary confinement, a dubious distinction. Some estimates claim that at least 80,000 people in the U.S. criminal justice system are held in solitary confinement. The 2006 Commission on Safety and Abuse in America's Prisons issued a report, Confronting Confinement, stated that from 1995 to 2000, the growth rate of segregation units significantly surpassed the prison growth rate overall: 40% compared to 28%.

There have been numerous studies that have shown the harmful psychological effects of long-term solitary confinement. Some of these effects include hallucinations, paranoia, panic attacks, and even suicidal ideation. The 2006 Commission on Safety and Abuse in America's Prisons noted that among the dozens of studies on the use of solitary confinement conducted since the 1970s, there was not a single study of non-voluntary solitary confinement lasting more than 10 days that did not document negative psychiatric symptoms in its subjects.

The United Methodist Church believes that every person is created in the image of God. Considering the severe harm done to individuals through the use of solitary confinement its use must be condemned. Scriptures are clear that we must regard the inherent value of each person as sacred. Jesus is so protective of the sacredness of each person that he identifies with those who are incarcerated and the failure of his followers to acknowledge and protect their sacredness when he states, "Truly I tell you, just as you did not do it to one of the least of these, you did not do it to me" (Matthew 25:45). The early Church was instructed to continue Jesus' high regard for the sacredness of each individual as it is written, "Remember those in prison as though you were in prison with them; those who are being tortured, as though you yourselves were being tortured" (Hebrews 13:3).

The United Methodist Church has long held the importance of recognizing and protecting the sacred worth of each individual, especially among those who are incarcerated. We work and advocate for "the creation of a genuinely new system for the care and restoration of victims, offenders, criminal justice officials and the community as a whole." (*2008 United Methodist Book of Discipline*) Solitary confinement is not restorative, but rather is retributive and does not recognize or protect the sacred worth of each individual.

According to Article I of the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which states in part, "the term 'torture' means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person." The United Methodist Church stands unequivocally against the use of torture. "Mistreatment or torture, and other cruel, inhumane, and degrading treatment or punishment of persons by governments for any purpose violates Christian teaching and must be condemned and/or opposed by Christians and churches wherever and whenever it occurs." (*2008 United Methodist Book of Discipline*) Solitary confinement is a form of torture and must be ended.

Moreover, solitary confinement is a financial drain on society. Super-max prisons are much more expensive to build than other housing facilities. Additionally, the daily cost per inmate in a solitary confinement unit far exceeds the costs of housing an inmate in lower security facility. The 2006 Commission on Safety and Abuse in America's Prisons found that housing inmates in solitary confinement can double the normal cost of incarceration since solitary confinement units require individual cells and significantly more staff. Some experts believe that this can run as much as $50,000 more annually compared to general population housing.

Further, solitary confinement has a negative impact on the re-entry of returning citizens to their communities and thus, can be a detriment to public safety. Inmates who have been held in solitary confinement are significantly more likely to recommit crimes than those who have been held in the general prison population. For example, the 2006 Commission on safety and Abuse in America's Prisons cited a Washington state study of over 8,000 former prisoners. The study found that people who were released directly from solitary confinement had a much higher rate of recidivism than individuals who spent some time in the general prison population before returning to the community. Public safety is best enhanced when those who are currently incarcerated are given access to educational classes and social programs to prepare them for a successful re-entry to society and with their families.

Mr. Chairman, Members of the Subcommittee, the United Methodist Church believes strongly that the United States should do everything it can to reverse our nation's harmful and expensive reliance on solitary confinement. This is a profound moral issue and we have a moral obligation to uphold the sacred worth of each person currently incarcerated. To that end, we would strongly support your leadership in sponsoring legislation that would dramatically limit or end entirely the use and length of solitary confinement. We implore you to immediately take steps to end the use of prolonged solitary confinement. Your hearing today is a very important effort in doing that, and we thank you for the opportunity to contribute to it.

Statement of the

Uptown People's Law Center

Reassessing Solitary Confinement

BEFORE THE
UNITED STATES SENATE
COMMITTEE ON THE JUDICIARY
SUBCOMMITTEE ON THE CONSTITUTION, CIVIL RIGHTS AND HUMAN RIGHTS

PRESENTED ON
June 19, 2012

Recommendation

The Law Center recognizes that segregating some prisoners, for severe misconduct and for limited periods of time, is a necessary tool for corrections professionals. However, solitary confinement must be limited to short terms (less than 90 days), with clear criteria on why men will be placed in solitary, and what they have to do to be released. Mentally ill prisoners must not be punished by being held for decades in solitary; they must receive treatment.

The use of highly restrictive solitary confinement has now vastly outgrown its origins. There is no evidence based rationale for keeping approximately 80,000 prisoners in this country in conditions of isolation for decades. The over-use of these isolation units is particularly troubling when applied to juveniles and the mentally ill—which make up a huge portion of the population of these units. A national Commission to establish limitations on the use of these isolation units is long overdue.

The Uptown People's Law Center thus calls on Congress to establish a Commission to produce recommendations on the use of solitary confinement in prisons and jails receiving federal funds throughout the country. This Commission should be modeled after the Commission established by the bipartisan and highly successful, Prison Rape Elimination Act. PREA has led to an increase in awareness of prison rape by public officials, and a renewed commitment to ending this terrible blight which has infected our prisons for all too many decades.

Constitutional Violations Are Rampant in Solitary Confinement

The Uptown People's Law Center has represented prisoners in solitary confinement in Illinois' maximum security prisons since 1982 (see, for example, *Walters v. Edgar*, 163 F. 3d 430 (7th Cir. 1998). More recently, the Law Center has represented the men confined to Illinois' supermax prison (Tamms Correctional Center) since the day it opened in March 1998.

During the course of our work, we have exchanged letters with every prisoner at Tamms, most for many years. We have had dozens of in-person visits with men at Tamms. We have spent time with their mothers, fathers, sisters, wives and children. More recently we have spent

significant time with prisoners who have been released from prison having completed their sentences, now living in our communities, after having spent years, and in many cases more than a decade, in the profound isolation imposed on prisoners at Tamms. We can say, without reservation, that Tamms has profoundly damaged the mind of every prisoner who has been punished by being sent to live in solitary confinement there, especially those men who have never been told why they are in Tamms.

The culture of control and isolation which is inherent in supermax prisons sets the stage for a wide variety of human rights violations, in addition to violations of the most sacred rights guaranteed by the Constitutional of the United States.

The courts have repeatedly found that officials at Tamms supermax have violated fundamental constitutional rights of the prisoners housed there. These findings include the denial of the right to practice one's religion (*Nelson v. Miller*, 570 F.3d 868 (7th Cir. 2009)); retaliation for filing grievances (*Pearson v. Welborn*, 471 F.3d 732 (7th Cir. 2006)); and unwarranted censorship of outgoing mail (*Arnett v. Markel*, 363 Ill.App.3d 1136, 845 N.E.2d 752(5th Dist. 2006)).

The Law Center has also filed three class action cases relating to conditions at Tamms. Two remain pending. In *Rasho v. Godinez*, pending in the United States District Court of the Central District of Illinois, we allege that prisoners with mental illness throughout the state of Illinois are not properly treated. One of the central points of that case is that Illinois continues to confine seriously mentally ill prisoners at Tamms, for years on end, without meaningful mental health treatment, and watches as these men continue their descent into madness. The second pending class action case is *Almodovar v. Snyder*, pending in the Circuit Court of Sangamon County, in which we allege that prisoners at Tamms are not given meaningful review of their continued placement at Tamms–in violation of both Illinois' own laws and in violation of the due process guarantees of the Fourteenth Amendment to the Constitution of the United States.

The principle case we have pursued relates more directly to who is at Tamms and why. In *Westefer v. Snyder*, 735 F.Supp.2d 735 (S.D.Ill. 2010), we alleged that prisoners had been sent to

Tamms in violation of their right to due process—prisoners were not provided notice of the reason for their transfer, a hearing at which they could contest those reasons, or a meaningful decision explaining the outcome of the hearing. Instead, an all too typical "hearing" consisted of a prisoner being brought into a room with no advance notice of why he was there, then being asked why *he* thought that he had been sent to Tamms. The due process claims were certified as a class action on behalf of all prisoners transferred to Tamms.

In addition, we brought claims on behalf of individual prisoners who claimed that their transfer to Tamms was retaliatory punishment for the filing grievances and lawsuits. In the Fall of 2009, a federal jury in southern Illinois found that four of the individual plaintiffs had, as we alleged, been sent to Tamms to punish them for exercising their First Amendment rights, and that there was no legitimate reason for them to have ever been sent to Tamms in the first place. Unfortunately, by the time the jury rendered this verdict, those four men had spent a total of more than 30 *years* in profound isolation. The damage had been done. Under the Prison Litigation Reform Act, since none of them had suffered any *physical* injury, they were only entitled to $1.00 as compensation for having had their mental health severely damaged.

In June 2010, the District Court found in favor of the *Westefer* plaintiff class. Under the applicable law (*Sandin v. Conner*, 515 U.S. 472 (1995)) the court had to determine whether a transfer to Tamms imposed an "atypical and significant" hardship on prisoners. The Court answered that question with a resounding "yes."

The Court began its discussion with a reminder of how Tamms was initially conceived:

> Even before the supermax prison at Tamms was opened in 1998, the 1993 final report of the Illinois Task Force on Crime and Corrections, which recommended the construction of the supermax prison, cautioned,
>
> > Reputable human rights organizations . . . have expressed legitimate and serious concerns about practices in existing super-maximum security facilities. The Task Force recommends that our Super-Max facility be required by statute to conform to certain requirements concerning constitutional and humanitarian safeguards. Since *these highly restrictive environments, if misused, can create conditions tantamount to long-term isolation*, the Department of Corrections will have to establish clearly defined rules and regulations to govern the admission and release of inmates from the Super-Max facility and to monitor its operation and administration

> closely. Illinois Task Force on Crime and Corrections, Final Report, at 87-88 (1993) (Plaintiffs' Exhibit 19)(emphasis added). As the Court hopes will be apparent from its discussion of the evidence in this case, including the Court's first-hand observation of conditions at Tamms during a tour of the facility in the company of IDOC officials and counsel for the parties to this case, the Task Force's concerns about confinement in the supermax prison at Tamms becoming an experience of long-term isolation for IDOC inmates were and are well-founded.

The Court went on to make findings of fact based on the extensive evidentiary record regarding the impact of long term isolation on the mental health of prisoners:

> Strickland * * * testified that while he was at Tamms he began experiencing auditory hallucinations or "hearing voices" and suffered delusions that correctional personnel at the supermax prison were poisoning his food. Id. at 10. Ultimately Strickland was transferred out of Tamms to the Psychiatric Unit of the Dixon Correctional Center, where he remained for approximately a year before being transferred to Pontiac.

Another prisoner intentionally created a fake escape attempt to relieve some of the isolation he experienced at Tamms:

> Rodney Guthrie testified that he had no history of psychiatric disorders before being transferred to Tamms and that, following his transfer to the supermax prison, he fell into a severe depression caused by the isolation at Tamms that ultimately prompted him to have himself classified as an escape risk in a desperate bid to escape from that isolation.

Based on the testimony of a dozen prisoners, the Court found:

> [T]he intense deprivation of human contact at Tamms exacts a toll on the psychological well-being of the inmates of the supermax prison.

Last week, the United States Court of Appeals for the Seventh Circuit found that the injunction entered by the District Court Judge to remedy these constitutional violations was overly detailed. However, the Seventh Circuit did not disturb any of the factual findings entered by the District Court, and reaffirmed that prisoners sent to Tamms were entitled to a due process hearing—because the restrictions imposed at Tamms were so severe compared to those imposed, even at other maximum security prisons.

Conclusion

Segregating some prisoners, for severe misconduct and for limited periods of time, is a necessary tool for corrections professionals. However, that is not what Illinois, nor most of the other supermax facilities throughout the country, does. Rather, the use of solitary in Illinois has metastasized. Not only does Illinois confine over 100 men at the Tamms supermax, but there are several *thousand* men confined in segregation, under extreme conditions, at the State's century old maximum security prisons—Menard, Pontiac, and Stateville. With the increasing use of months long lockdowns at these older prisons, conditions begin to approach the isolation of a supermax, with prisoners locked in their cells 24 hours a day. However, Tamms presents a special case.

The Governor of Illinois has now proposed closing Tamms supermax prison in its entirety. In the course of public hearings on the Governor's proposal, the Director of the Department of Corrections has admitted that there are less than 25 men at Tamms who need enhanced security. The remainder can be housed, without any security concerns, in Illinois' maximum security prisons. We believe the numbers are the same in every state in the country. Mississippi reduced its segregation population by 90%, saving millions of dollars—and saw the incidence of violence drop dramatically.

We urge Congress to take action on this issue at the national level. Evidence based policies must be applied to solitary confinement. There must be clear criteria for assignment to solitary, clear limits on how long prisoners can be kept in solitary, and clear goals prisoners can meet to win their release from solitary. Juveniles and those with mental illness should never be placed in solitary. The federal government should take the lead in ensuring that corrections systems are smart on crime, and make efficient use of taxpayer dollars, inflicting punishment only under carefully controlled circumstances, through fully transparent mechanisms.



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"Reassessing Solitary Confinement:
The Human Rights, Fiscal and Public Safety Consequences"
Senate Judiciary Committee
Subcommittee on the Constitution, Civil Rights and Human Rights

June 19, 2012

Written Testimony of
Jennifer J. Parish, Director of Criminal Justice Advocacy
Urban Justice Center / Mental Health Project

Dear Chairman Durbin and Members of the Subcommittee:

I commend you for convening this hearing and urge you to take action to end the overuse of solitary confinement in the United States. For the last decade, the Urban Justice Center's Mental Health Project has collaborated with other organizations, family members, and formerly incarcerated individuals in opposing the placement of people with mental illness in solitary confinement in the New York State prisons. We recently began organizing a similar effort in response to the expanded use of solitary confinement in New York City jails.

We submit this testimony to highlight the particularly noxious effects of punishing people with mental illness by isolating them in a barren cell without social contact and meaningful activity for 22 to 24 hours a day. While we support restricting the use of solitary confinement generally because of its damaging psychological effects, we are particularly opposed to the placement of people with mental illness in such a toxic environment.

I am confident that you will receive persuasive testimony from academics, attorneys, and physicians documenting the horrendous consequences of placing people in solitary confinement. But the personal accounts of the effects of solitary confinement from those who have experienced it and their family members establish beyond question the immediate need for Congressional action. To relate these experiences, we have enclosed excerpts from "Faces of the SHU," a collection of testimonials about the "Special Housing Units" ("SHU") in New York State prisons.

The Urban Justice Center's Mental Health Project has advocated on behalf of people with mental illness in the criminal justice system since 1998. Our work includes successful class action litigation to require New York City to provide discharge planning to individuals receiving mental health treatment in the city jails, legislative advocacy in support of a law limiting the placement of people with serious mental illness in solitary confinement (known as the SHU Exclusion Law), and grassroots organizing in support of alternatives to incarceration for people with mental illness. Through this work, we are deeply familiar with the difficulties people with mental

illness experience within correctional facilities and in accessing services upon release.

We currently have a public health crisis in the U.S. – jails and prisons have become the insane asylums of the 21st century. Our jails and prisons treat more people with serious mental illness than hospitals. Rikers Island in New York City and the Los Angeles County jail are the two largest psychiatric facilities in the country. According to a 2010 study by the Treatment Advocacy Center and the National Sheriffs' Association, there are more than three times as many people with serious mental illness in jails and prisons than in hospitals. As many as 40 percent of people with serious mental illnesses have been in jail or prison at some point in their lives.

Fundamentally jails and prisons are not designed to provide for the needs of people with psychiatric disabilities. They are strict, militaristic, closed systems which are designed to punish and control. And people with mental illness face enormous difficulties while incarcerated there. Many are unable to conform to the rigid requirements of prison life. Untreated mental illness leads to behavior that violates prison rules and results in disciplinary charges. For instance, a person with schizophrenia may hear voices demanding that he respond, making it difficult or impossible for him to remain silent or stand still when ordered to do so by a correction officer. The punishment for violating prison rules is often placement in solitary confinement, where the person is locked in a cell for 23 hours a day, deprived of social contact and basic amenities.

This isolation further exacerbates symptoms of mental illness and makes people with mental illness extremely vulnerable to psychiatric decompensation. In turn their symptomatic behavior can lead to additional disciplinary charges and greatly prolong their period of solitary confinement. People with psychiatric disabilities spend disproportionately longer periods in solitary confinement than the general prison population. According to the Correctional Association of New York's 2004 report, the average disciplinary confinement sentence of individuals with mental illness was 38 months – six-and-a-half times longer than prisoners generally.

Moreover, in New York there is no limit to the amount of time that a person can spend in solitary confinement. Before the enactment of the SHU Exclusion Law, people with mental illness could accumulate years of disciplinary confinement. In fact, some individuals received solitary confinement sentences that lasted beyond their maximum release date from prison. In these cases, the person could be released directly from solitary confinement to the community.

Individuals who continue to act out while in solitary confinement are subjected to further punishments. For example, in New York State prisons, such punishment can include the imposition of a restricted diet, known as "the loaf," a dense mixture of flour, potatoes, and carrots served three times a day along with a portion of raw cabbage. Although the SHU Exclusion Law limits when a person with mental illness can be placed on a restricted diet, it still allows the diet to be imposed in exceptional circumstances.

In solitary confinement, people with mental illness are at increased risk of suicide. Between 2007 and 2010, about one-third of the suicides in New York State prisons occurred in solitary confinement units although only about six percent of the prison population was housed there.

Inadequate mental health treatment in prison is one reason that people with mental illness end up in solitary confinement. Upon admission to prison, many people do not receive thorough psychiatric assessments, so their mental illness goes untreated. Other people receive inadequate mental health treatment – psychiatric medications are changed or discontinued and little to no therapeutic interventions are provided other than medication.

In addition, the stigma of mental illness leads some incarcerated people to refuse psychiatric treatment. Being identified as a person with mental illness can make someone a target of abuse from other prisoners and correction officers. Generally psychiatric medication is distributed in a public manner, so receiving mental health treatment confidentially is not an option for most incarcerated people.

The detrimental effects of being in solitary confinement do not end when the person walks out through the prison gates. Many people report lasting psychological damage as a result of the time spent in isolation. People with mental illness face enormous obstacles rejoining the community upon release. For those even further traumatized by periods of solitary confinement, the possibility of reintegration is slim indeed.

As a society, we should strive to ensure that people with mental illness receive adequate mental health treatment and supportive services in the community so that they avoid the criminal justice system all together. But to the extent that people with mental illness are incarcerated in jails and prisons, they should be categorically excluded from placement in solitary confinement.

The faces on the following pages reveal the humanity of those labeled "prisoner." I encourage you to look at them and hear their stories. We must not countenance correctional policies which we know to inflict emotional distress on people who have mental disabilities.

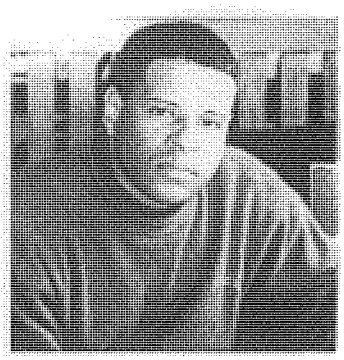
I urge you to take action to end this practice in the United States.

Sincerely,

Jennifer J. Parish
Director of Criminal Justice Advocacy
Mental Health Project

Enclosure

Robert



My godson Robert was diagnosed with bipolar disorder at age twenty-one and hospitalized many times. He had to drop out of college because his disability made him too unstable to continue. He fell through the cracks of the mental health system and ended up in prison with a very severe sentence for minor acts.

Prison is the last place on this earth that a person with a psychiatric disability needs to be. If you want to do the worst possible thing to a person with a bipolar condition put them in SHU when they're in a state of mania (which is usually the case when they go in to SHU) without treatment and without human contact. ***In SHU they are cut off in a nine-by-six-foot cell all alone with a racing mind. This is the ultimate abuse for someone who is suffering.***

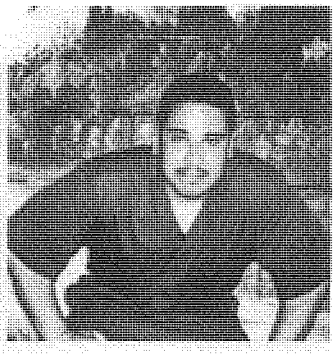
Robert has been in Central New York Psychiatric Center four times. More than once, he was sent back to prison, still unwell, and immediately his symptomatic behavior led to SHU tickets. ***I was crying on the phone, pleading with them to keep him in the hospital.*** They still sent him back to prison. Almost immediately a counselor noticed that he was "racing" and he was placed in the mental health observation unit for ten hellish days until he was sent back to the hospital.



Robert's depression was extreme after his second SHU time. He didn't want to see anyone any longer and he didn't write me or call and he lost a lot of weight. ***Robert told me, "When I went in to SHU I knew it was all over for me. Don't think about me as the person that you knew, because I'll never be the same man again." These words were painful for me to hear because I knew what a fun-loving free spirit Robert use to be.*** He has trophies from his dirt bike–racing days, he was in *Ripley's Believe It or Not*, and he was such a good dancer that as a teenager he starred in a Burger King ad.

Prison is a nightmare for Robert. He was moved from facility to facility, experiencing abuse from guards and other inmates and he was given inadequate mental health care. As often happens, this led to attacks by the guards. ***Robert has experienced three major assaults, resulting in severe pain and trauma.*** I was always calling the prison to tell them how ill Robert was. Nobody understood what I was trying to convey about the patterns of his illness and the constant changes in his condition and how he was in need of consistent treatment. ***As a family member it's so painful to see the suffering that you're powerless to prevent. You're just watching your loved one deteriorate and experience violence and brutality that is unimaginable.***

—Leah, Robert's godmother

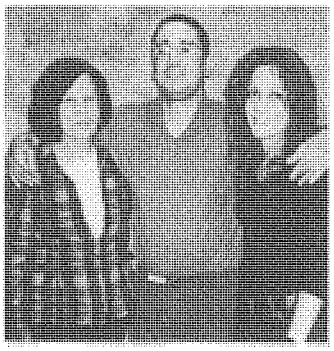


My brother Alberto has been diagnosed with schizophrenia and an anxiety disorder. I want to make palpable the grave inhumanity and suffering inflicted on individuals and families who have experienced what it means to do time in the SHU.

Alberto has been a victim of excessive physical violence used as a safety measure or protection for the prison officials. He has been denied phone calls home, monthly care packages, access to recreational and educational programs, and a television and radio. He has lost significant amounts of weight. He has to hold up his pants to prevent them from falling down. He has been denied a transfer to a facility with a residential treatment center.

My mother, cousins, and I are devastated by the deterioration of my brother's mental state. ***His affect is flat. He has a glazed look in his eyes. He has lost touch with reality.*** He can no longer engage in a coherent or relevant conversation or even play a simple game of cards. His letters are incoherent. Every letter is the same, with the same twenty sentences.

Alberto becomes easily agitated during our visits. He comes in shackled. I can't even give him a hug. They treat him like he is a caged animal. It's like he is a dog on a leash being restrained. He's behind bars already, there's no need to shackle him too. When we were entering the facility to visit Alberto, an officer asked me who I was going to visit and when I told him he said, "Oh, my God, why are you going to visit him?"



He was at Central New York Psychiatric Center for about six months. Right from CNYPC he went to keeplock before he was transferred to Upstate. During our last visit he asked to go to the bathroom and the officer said no and he had to wait for the entire visit to use the bathroom. He got beaten after we left on that visit.

He is no longer making plans for what his life will be outside of prison. Instead—with only four months left until his release—he is talking about appealing his case. This wish of his shows his irrational state. The psychologists have said, "He seems fine, at least when I speak with him."

Of the nine years that he's been in prison, he has spent seven years in the SHU.

I am very fearful for what life outside of prison will be like for Alberto. ***He has not been rehabilitated to function in society. He's been set up to fail. He's coming back needing to be resocialized.***

—Lissette, Alberto's sister

Mark

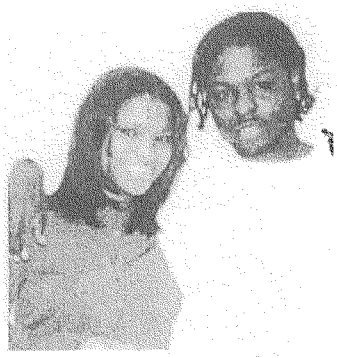


My brother Mark was officially diagnosed with depression when he was a teenager. He hears voices, is paranoid, and shakes a lot. He wasn't getting adequate treatment in the community prior to his incarcerations. He's been in and out of jails and prisons since he was twelve years old. He's been incarcerated for the past eight years.

His demeanor is very quiet and isolated. On the street people tested him because he is withdrawn. The same thing has happened to him in prison. He told me he couldn't be in general population because people continuously bother him. ***In prison, if you seem like a person who can be beaten up or bothered, then the guards and inmates target you.***

For the first years of this incarceration he wasn't connected to any mental health treatment. That's when he would run in to problems. On this bid he has been hospitalized five to ten times.

He'll either respond to threats or try to hurt himself. He has recently tried to put a sheet around his neck to choke himself. He has tried to starve himself to death on other occasions. He's lost a lot of weight because of this and also because he thinks that the COs are poisoning his food. ***He has told me that he didn't want to live anymore.***



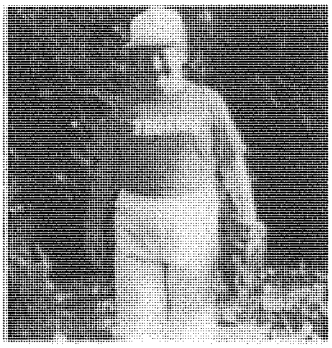
The COs have been taunting him, trying to get him riled up to do something. They continually frisk him and touch him inappropriately. They do this in an attempt to demean him and break him.

They hit him with sticks when he went out for rec, but he is too afraid to file a grievance. ***He's too afraid to take his one hour of out of the box per day because he's afraid that the guards would hurt him, so he stays in his cell for twenty-four hours a day.*** The only time he comes out of his cell is to see mental health staff once every two weeks.

He's been in SHU for two years. He's going to be there for almost another year still to come. ***Since he's been transferred to a new facility he's already tried to kill himself, and it's been less than a month. The prison staff won't tell me anything. This is inhumane.***

—Karen, Mark's sister

Dennis



My son Dennis was diagnosed with attention deficit and hyperactivity disorder at seventeen years old. His doctors have said that he may also have a mood disorder. ***His symptoms have definitely gotten worse since he was locked up—he's incredibly hyperactive.*** He was first locked up at fifteen years old, and since them he has been in and out of jails and prisons. He is now thirty years old, and he has at least another two years on this bid. He feels trapped, and is only getting more and more agitated.

I know him as a caring and sweet person. He always use to be very generous. He used to buy me flowers and mail me cards, but now he holds on to things as if they could be taken away from him. When he last came out of prison, he was very angry and frustrated.

He told me the other day, "They're going to keep locking me up, Mom." He is getting more and more agitated, and I am afraid for him. He yells and screams and punches the bars even though it hurts his hands, to dispel some of his agitation.

This is not the place for him to be rehabilitated. He is not given adequate treatment for his disability. I just feel like they're going to make an animal out of a person that they treat like an animal. He's never going to be normal again.



He has been in and out of SHU and keeplock for many insignificant, nonviolent reasons. He is frequently tormented by guards, who threaten to plant weapons on him. He was given three months in keeplock for not having his sweater tucked in enough.

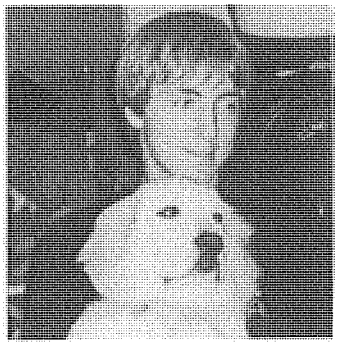
Dennis has suffered from sexual abuse, and from being tormented by guards.

On his last bid they would humiliate him when they would take him to shower. He was forced to walk in compromising positions. The guards went out of their way to humiliate him.

I was just cleaning the house today and I looked up and there was his picture, and it breaks my heart—I just don't know what to do, I just worry so much, and know that he is only getting worse in there.

—Sue, Dennis's mother

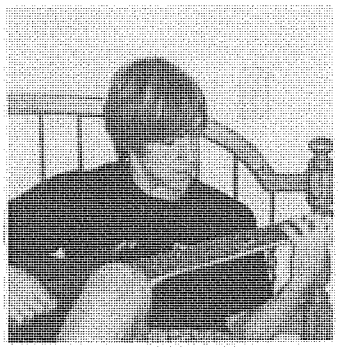
Seth



My son Seth was fifteen when he was diagnosed with depression. He was put on medication and hospitalized four times in three years. ***Just after his nineteenth birthday he became very, very sick.*** He was diagnosed as having a bipolar disorder with "psychotic and paranoid features." Instead of being hospitalized, he was incarcerated. At first he was taken to Central New York Psychiatric Hospital, very manic. All I wanted to do was to just hold him. They allowed a hug at the beginning, but it was timed and they pulled us apart after a few seconds. After a few weeks, Seth was moved to another facility.

Seth spent the first eight months of his incarceration in solitary confinement. He was placed in SHU because he asked a guard, "Why are you being so mean?" At another time, he was given SHU time for defending himself against a rapist in the shower. I visited him every week. ***He was suicidal, talking about killing himself, saying that he couldn't stand it.*** All this time the staff refused to give him his medication. Seth wanted to see a psychiatrist. He asked, but they refused. He was still in SHU. He was only nineteen years old.

Seth was classified as Mental Health Level II and given only a low dose of antidepressant. ***The guards who escorted him to where he was given his medication made fun of the mentally ill inmates. They would say, "You buggy people, you're all insane."*** Seth seemed agitated when I would visit. He was in solitary confinement.



Then he was in a mental health observation room, and no one would tell me why. He was in solitary confinement for twenty-four hours a day, no recreation time, no letters, and no phone calls for two weeks. During this time he had no water for fifty-two hours. He had to pound on the glass to get someone's attention because he needed water. Finally someone threw in a bag of ice. The toilet didn't flush. He found a plastic bag in his cell to cover up the stench. He had nothing to do, nothing to read.

He said, "I am one thread away from being insane, Mom, I can't hold on much longer." ***After I inquired about his placement in SHU, the superintendent told me, "I don't know what to do with your son—he slipped through the cracks." He also told me, "Your son's going to be disciplined, because he has a Mental Health Level II classification."***

Seth is a good musician and loves to play the guitar. But he refuses to be given a guitar because he says the guards will simply break it, especially when they put him in the SHU. He says he is practicing for SHU life by just sitting and doing nothing.

—Jennifer, Seth's mother

Carlos



I've suffered from mental illness all my life. Not understanding my condition led me to prison on several occasions and while in prison, due to my condition not being understood, I always was subjected to being placed in solitary confinement. ***Being in SHU always caused my condition to get worse, with hatred and frustration for not being understood and not being assisted with the services that could've been provided.***

While in SHU, treatment is rarely administered. The environment itself is not structured to assist people like me, being overwhelmed with mental illness. Oftentimes, I sought to escape the tormenting thoughts that ran through my mind, but couldn't. At times visions came to me so real that I thought there was no gaining any vestige of sanity back.

I felt hopeless, I was made to believe I had nothing to lose, no one is helping me, no one understands what I'm going through, and no one wants to stop the punishment I was receiving due to being mentally ill and leading to my placement in solitary confinement. I was so tired of going through the same routine over and over again, not being heard, understood, assisted in getting well. I was just getting worse, every time I was placed in solitary confinement. Being in solitary confinement with a mental illness, with nothing to do, receiving inadequate treatment, wanting to get better, not being allowed, being subjected to that punishment, that hostile environment, that disregard.

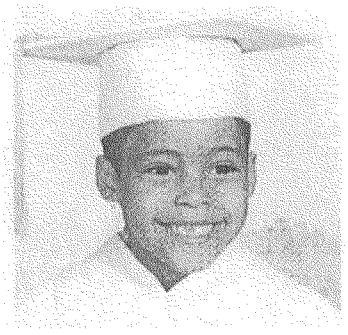
My hopes were diminished and I wanted to end it all. Suicide was my only option and I failed at that due to officers not letting the last breath escape from out of my lungs. Forced to continue life in torture, carrying that anger and frustration from not being understood and helped, foreseeing the cycle of my life, I always thought, "What do I have to live for?"

I've been made worse than I ever was before I entered prison, through being subjected to continuous placement in special housing unit as punishment. I am always searching and carrying the burden of what I've been made to become.

No one should be subjected to such a tormenting situation. ***If only the opportunity was afforded to others while in prison, the opportunity to actually receive the help they need in understanding their mental illness. If only an environment other than "special housing unit" was available.***

—Carlos

Ron



My son Ron suffered from a traumatic brain injury. He has a lot of difficulty following commands. It takes him time to process information. He can be extremely paranoid. His affect is mostly withdrawn. Much of his mood swings have to do with his being in SHU for years and years. Prison isn't a suitable place for him. He isn't getting any therapy or cognitive stimulation. He just gets tickets and SHU time. The Department of Correctional Services isn't prepared to take care of his condition.

Ron wasn't capable of testifying at his trial. When I first started to visit him I would have to repeat my questions to him. He would ask me the same questions over and over. He has trouble concentrating. I can tell that he is overwhelmed just by talking to him. He looks frightened after all this time in prison. Ron has been incarcerated for twelve years.

Because of Ron's psychiatric disability he is frequently abused by the correction officers. They pick on him and give him SHU tickets. They give him tickets for walking slowly—he is partly paralyzed and has a metal plate in his leg. The COs call him "stupid," "dumb," or "slow." This hurts him deeply. He's not dumb, he has a brain injury. Ron would have gotten better treatment if he hadn't been sent to prison.



Ron has been in SHU for almost his entire incarceration. He has been sent there for fictitious charges. He is targeted for his disability. While he's been in SHU he's experienced beatings, starvation, being called mentally "sick," and being ignored. He tells me he's very sad, very cold, and is not given changes of clothing. The COs steal his blankets. The staff says he is "bad."

Ron was transferred to a facility where he went straight to SHU. I wasn't getting any letters from him. I would call and they were telling me he was OK and meanwhile they were starving him to death. They were threatening to kill him. ***He said, "Mom, they're starving me. I'm not eating." He was so hungry he ate paint chips off the wall. He looked like he was dying.***

I kept begging them to send him to Central New York Psychiatric Center. He was decompensating more and more.

I can't begin to count the number of times that Ron has been sent to CNYPC. If I was to make an estimate I would say 30 to 40 times.

—Kathy, Ron's mother

Written Testimony of Michael Jacobson
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June 19, 2012

Thank you, Chairman Durbin, Ranking Member Graham, and members of the Subcommittee for holding this hearing on the human rights, fiscal, and public safety consequences of solitary confinement in United States prisons, jails, and detention centers. My name is Michael Jacobson and I serve as President and Director of the Vera Institute of Justice. Vera is an independent, nonpartisan, nonprofit center for justice policy and practice, with offices in New York City, Washington, D.C., and New Orleans. Since 1961, Vera has combined expertise in research, technical assistance, and demonstration projects to help develop justice systems that are fairer, more humane, and more effective for everyone. One of the ways Vera works toward these goals is through its Segregation Reduction Project, which partners with states to decrease safely the number of people held in segregation (also called solitary confinement), provides recommendations tailored to the states' specific circumstances and needs, and offers assistance as states plan and implement changes.

A. Background on Use of Solitary Confinement/Segregation in U.S. Prisons

Since the 1980s, prisons in the United States have increasingly relied on segregation to manage difficult populations in their overcrowded systems. According to the U.S. Department of Justice's Bureau of Justice Statistics (BJS), the number of people in restricted housing units nationwide increased from 57,591 in 1995 to 81,622 in 2005.[1] Segregation was developed as a method for handling highly dangerous prisoners. However, it has increasingly been used with prisoners who do not pose a threat to staff or other prisoners but are placed in segregation for minor violations that are disruptive but not violent, such as talking back (insolence), being out of place, failure to report to work or school, or refusing to change housing units or cells. In some jurisdictions, these prisoners constitute a significant proportion of the population in this form of housing.

Conditions within "supermax" units and facilities and in segregation units throughout the country have also become increasingly harsh. Evidence now suggests that holding people in isolation with minimal human contact for days, years, or—in some instances—decades is exceptionally expensive and, in many cases, counterproductive. Long-term isolation can create

[1] James J. Stephan, *Census of State and Federal Correctional Facilities* (Washington, DC: U.S. Bureau of Justice Statistics, National Prisoner Statistics Program, 2008, NCJ 222182). BJS requests information on individuals being held in "restricted housing units," but does not provide definitions for restricted housing units or for different types of segregation for respondents. As a result, the "restricted housing" category may include prisoners held in protective custody and death row units, as well as special needs and mental health units. For this and other reasons, BJS statistics may not accurately capture the numbers of prisoners in segregated settings. The BJS census includes both state and federal prisons, but excludes military facilities, local detention facilities, Immigration and Customs Enforcement facilities, and facilities that only house juveniles.

or exacerbate serious mental health problems and assaultive or anti-social behavior, result in negative outcomes for institutional safety, and increase the risk of recidivism after release.[2]

In the United States, segregation or solitary confinement is used most commonly: (1) to punish prisoners for rule violations; (2) to remove prisoners from the general prison population who are thought to pose a risk to security or safety; and (3) to protect prisoners believed to be at risk in the general prison population. Other reasons include ensuring the safety of prisoners under investigation, awaiting hearings, on death row, and addressing special needs, such as mental health. Although the terms used to refer to those held in solitary confinement or segregation vary tremendously across systems, the following examples are typical of the ways that state systems use segregation:

- ***Disciplinary segregation*** for violation of rules;
- ***Administrative segregation*** for those who are thought to pose a risk to safety or security and not necessarily in response to a specific violation;
- ***Protective custody*** for prisoners believed to be at risk in the general prison population;
- ***Temporary confinement*** for use when a reported incident is being investigated; and
- ***Supermax*** or ***closed maximum-security prisons***, which may hold both disciplinary or administrative segregation prisoners.[3]

Prison officials fear that moving prisoners out of segregation will lead to violence and other serious violations. Two states—Ohio and Mississippi—have tested that concern. In the mid-2000s, Ohio and Mississippi reduced their supermax populations by 89 percent and 85 percent, respectively. Mississippi went from 1,000 to 150 prisoners in segregation; Ohio went

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[2] David Lovell, "Patterns of Disturbed Behavior in a Supermax Population," *Criminal Justice and Behavior* 35 (2008): 9852; David Lovell, L. Clark Johnson, and Kevin C. Cain, "Recidivism of Supermax Prisoners in Washington State," *Crime and Delinquency* 53 (2007): 633-656; and David Lovell and Clark Johnson, "Felony and Violent Recidivism Among Supermax Inmates in Washington State: A Pilot Study" (University of Washington, 2004).

[3] In greater detail, these uses of Segregation can be described as follows: 1) ***Disciplinary segregation*** is a form of punishment for violations of prison rules. For example, a prisoner may be sentenced to a year in segregation for assault or possession of contraband, or for a period of months for violation of a direct order; 2) ***Administrative segregation*** removes prisoners from the general prison population who are thought to pose a threat to safety or security or who are believed to have information about an incident under investigation. For example, a gang leader believed to be coordinating gang activities within the prison may be placed in administrative segregation even if that individual has not violated any rules. Administrative segregation usually lasts for an indeterminate period of time and, for those considered a threat to safety and security, may be of long duration. In some systems, prisoners are not told the reason for their transfer to administrative segregation, and options for reevaluation or release back to the general prison population may be few; 3) ***Protective custody*** provides safety for prisoners believed to be at risk in the general prison population, such as a prisoner who provides information to correctional staff about violations committed by others, or someone considered at risk due to physical characteristics or other individual factors. Although segregated for their own protection, restrictions on human contact and programming for prisoners in protective custody can be as severe as for prisoners in disciplinary or administrative segregation; 4) ***Temporary confinement*** uses segregation while a reported incident is being investigated; it usually lasts for a short period and begins immediately after a rule violation is identified but before a hearing is conducted; and 5) ***Supermax*** (or closed maximum-security) ***prisons*** may hold both administrative and disciplinary segregation prisoners. All prisoners in supermax facilities are held in high levels of confinement, typically for long periods of time. Architecturally, supermax prisons are built to restrict visual and tactile contact with others. Educational and programmatic activities are greatly restricted.

from 800 to 90 prisoners.[4] Mississippi not only reduced the number of people held in segregation but also saw an almost 70 percent decrease in prisoner-on-prisoner and prisoner-on-staff violence; and use of force by officers in the unit plummeted.[5]

B. Vera's Segregation Reduction Project

Prompted by the success of Ohio and Mississippi, Vera launched its Segregation Reduction Project (SRP) in February 2010. The first project of its kind, SRP works with state prison systems to safely reduce the number of prisoners held in segregation by facilitating policy changes that: (a) reassess the violations that qualify a prisoner for segregation and (b) recalibrate the length of stay in segregation, especially for minor violations. SRP also focuses on improving conditions of confinement in segregation and enhancing programming and support for safe transitions back to the general prison population. SRP's overall goal is to develop a national model that can be adapted for use in many jurisdictions.

Currently, SRP is partnering with the Illinois Department of Corrections and the Maryland Department of Public Safety and Correctional Services to help each:

- Develop criteria to determine who should be held in segregation and who could be moved safely to the general prison population;
- Assess disciplinary sentences and lengths of stay in segregation;
- Enhance programs to transition prisoners out of segregation;
- Improve conditions of confinement for those who remain; and
- Track the effects of moving prisoners from segregation to other levels of security.

The project is also collaborating with the Washington State Department of Corrections to assess its segregation policies and practices, analyze the effects of its use of segregation, and make recommendations for handling its protective custody, disciplinary, and intensive management populations. Vera is in the process of adding a fourth state in the Southwestern United States.

With this project, Vera aims to demonstrate that states can reduce the numbers of prisoners they hold in segregation without jeopardizing institutional or public safety, as well as to create a replicable model that can be adapted for use in other jurisdictions. Based on observations and analyses so far, it seems clear that segregated populations in U.S. prisons can be safely and dramatically reduced with no reduction of staff positions and with cost savings.

I. Bringing About a Culture of Change

SRP works with prison systems' administrators and key operations personnel, conducting site visits to all supermax and other facilities with significant segregation populations, reviewing policies and practices related to the use of segregation, providing comprehensive data analyses of

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[4] Terry Kupers et al., "Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs," Criminal Justice and Behavior 36 (2009): 1037-50.

[5] Ibid.

a state's use of segregation and the outcomes of that use, and—in consultation with corrections administrators and staff—recommending strategies to safely reduce the use of segregation and improve conditions of confinement for those who remain. Close collaboration at the agency and facility level and attention to a state's unique challenges encourage statewide adoption of changes. For example, in the Illinois Department of Corrections (IDOC), Vera and IDOC administrators presented SRP's recommendations to all 27 wardens, and changes are now being implemented in all IDOC facilities.

II. Progress Updates from SRP Partner States

Vera's partner sites have provided updates regarding their progress below.

1. Illinois Department of Corrections (IDOC)

"In January 2011, the Illinois Department of Corrections kicked off its Long Term Segregation and Administrative Detention project, informed by the work of Vera Institute of Justice. In the latter part of 2010, Vera visited each of the Department's Maximum Security prisons as well as our Closed Maximum facility, Tamms. Vera partnered with the Department's Planning and Research Unit to provide statistics, which drove the direction of the project. At project kick-off, the Department had 2,204 segregation inmates with 2.8 years as an average length of stay in segregation. Vera analyses also revealed that 85 percent of the segregation population were in disciplinary segregation for less severe types of infractions. Since it was also found that those who spent less time in segregation were not more likely to commit new violations during the first twelve months of release into general prison population, we were on our way to identify areas of improvement.

"The project has several layers of effort. We committed to changing the culture of discipline in our facilities by utilizing progressive discipline, rather than providing literal interpretation of the disciplinary code violation chart, thus resulting in less time in segregation and more appropriate and effective sanctions. This effort will help reduce the number of new disciplinary segregation inmates. In the instances where we had inmates serving years of segregation time, we instituted a Long Term Segregation Incentive Program to assist in behavioral modification through a tiered approach. This has been positively received by both staff and inmates. For the 200 inmates serving "Dead Time," the Department is reviewing the offenders' original segregation charges and the behavior exhibited while in segregation to consider time cuts, since they are currently serving time past their original date for release from prison.

"The mantra of the program has been to determine if we are mad at the offender or scared of them when making recommendations for segregation time and transfer. Taking the personal element out of the applied discipline has been a benefit to the Wardens in their constant review of the segregation time applied. To date we have seen improvements in the behavior of the inmates serving segregation time, which lessens the safety concerns to our staff. At some facilities, the segregation unit has seen a drop in numbers so that the cells can be used for general population. A full analysis has not yet been conducted, but anecdotal updates from our professionals have found the modified

approach with the buy-in of staff is making this project a success for the Illinois Department of Corrections."

2. Washington State Department of Corrections (DOC)

"In May 2011, we asked Vera to come assess our Intensive Management Units (IMUs) and give us recommendations for improvements. A prison system can largely be judged by how it operates its highest-custody units. Due to budget cuts, we were losing a partnership with the University of Washington that helped us assess and examine use of long-term segregation, and we wanted to reach out to an independent organization on a national level.

"Based on the Segregation Reduction Project's review and recommendations, a committee of administrators, mental health staff, and managers of WA DOC's segregation units are now developing plans to implement some of Vera's recommendations, including providing more resources to mentally ill offenders in segregation and creating programming in group settings for offenders in segregated living units.

"Today, we are working on expanding our Intensive Transition Program (ITP): a program designed to gradually introduce IMU offenders back into general population. The ITP at Clallam Bay in northern Washington has an 80 percent success rate and enhances staff and public safety by having fewer offenders return to their communities directly from segregation units. Since our involvement with Vera, we have committed more dollars to this successful ITP program and have doubled it in size. We are also seeking ways to expand mental health treatment into more IMUs around the state. In November 2011, we also permanently closed a 100-bed segregation unit at the Washington State Penitentiary and have safely reduced the number of segregated prisoners by 170 at a time when the incoming offender population was becoming more violent. Only about 2.7 percent of the 16,000 beds in the Washington prison system are now housed in Intensive Management Units."

3. Maryland Department of Public Safety and Correctional Services (DPSCS)

Vera began partnership with Maryland in April 2011. Since that time, Vera has conducted site visits and is currently analyzing data on their segregation populations. These analyses will examine DPSCS's use of segregation and alternatives to segregation, violations resulting in segregation time, length of the segregation "sentences," and types of prisoners housed in segregation. Recommendations will be made for policy and practice changes.

C. Fiscal Impact of Prison Segregation

Significant fiscal costs are associated with housing people in segregation. In the Ohio State Penitentiary—Ohio's supermax—in 2003, it cost $149 a day to house a prisoner, compared with $101 per day for a maximum-security prisoner and $63 per day for an average general-population prisoner.[6] The majority of the higher costs come from the need for additional staff to monitor segregation units. For example, the supermax required one corrections officer for every 1.7 prisoners; maximum-security housing required one officer for every 2.5 prisoners.[7]

Mississippi provides a clear example of the fiscal benefits of reducing the use of segregation. Deputy Commissioner Emmitt Sparkman described the changes as follows: "In 2007, we had nearly 1,300 inmates in long-term segregation and were spending hundreds of thousands of dollars on litigation and maintaining the physical plant. Once we reduced segregation to 335 inmates, we were able to [permanently] close Unit 32. We moved staff to other locations and there was attrition; we saved approximately $5.6 million a year and were able to avoid layoffs and furloughs."[8]

In Illinois, Governor Pat Quinn has proposed closing eight IDOC facilities, including the Tamms supermax prison. It costs Illinois' taxpayers more than $26 million a year to hold approximately 180 maximum-security and 180 minimum-security prisoners at Tamms. This translates into almost $65,000 per year per prisoner—the highest cost of any IDOC facility.[9]

Given the current fiscal crisis, many more jurisdictions now are looking for new and effective paths forward, away from reliance on this expensive form of incarceration. States can no longer afford these costs. Illinois—with approximately 46,000 men and women in state prisons in February 2010—provides one example of why it is important to reassess the use of segregation in the nation's prisons. Although only about 5 percent of the prison population was in segregation on any given day, more than half (56 percent) had spent some time in segregation during their current prison stay. Reducing the use of segregation and improving conditions of confinement can affect thousands in that one state alone and greatly alter per person costs of prison housing.[10]

D. Public Safety Impacts of Segregation

A study of correctional systems in Illinois, Arizona, and Minnesota found that segregating some prisoners in supermax facilities did little or nothing to lower overall violence

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[6] Daniel P. Mears "Evaluating the Effectiveness of Supermax Prisons" (Urban Institute Justice Policy Center, 2005). Available at https://www.ncjrs.gov/pdffiles1/nij/grants/211971.pdf

[7] Ibid.

[8] Vera Institute of Justice Blog, "Mississippi DOC's Emmitt Sparkman on Reducing the Use of Segregation in Prisons," October 11, 2011, http://www.vera.org/node/5313 (accessed June 13, 2012).

[9] John Maki, "It's Time for Illinois to Close Tamms Supermax," *The Huffington Post*, May 23, 2012, http://www.huffingtonpost.com/john-maki/tamms-prison-closure_b_1539255.html (accessed June 14, 2012).

[10] Angela Browne, Alissa Cambier, and Suzanne Agha, "Prisons Within Prisons: The Use of Segregation in the United States," *Federal Sentencing Reporter* 24, no. 1 (2011): 46-49.

across the system.[11] Prisoner-on-prisoner violence did not decrease in any of the three states. Prisoner-on-staff assaults dropped in Illinois, staff injuries temporarily increased in Arizona, and there was no effect in Minnesota.[12] Releasing prisoners directly to the community from solitary—a not uncommon practice—poses significant dangers to the public as well, as people housed in segregation for long periods may have difficulty dealing with the company of others, whether in the general prison population or in the community. A rigorous quantitative study of recidivism after release from prison for prisoners held in solitary confinement found that those released directly from supermax to the community had significantly higher felony recidivism rates and committed new offenses sooner than prisoners who spent three or more months back in the general prison population before release to the community.[13]

There also is some evidence that officers who work in SHUs are more likely to be assaulted. For example, one study found that 57 percent of serious assaults on staff occurred in a control unit that housed less than 10 percent of the facility's prisoners.[14] It may be that segregated prisoners, some of whom have histories of violence, pose a greater threat to officers than prisoners in the general population. However, the harsh living conditions in segregation and, at times, the harsh treatment received there may also exacerbate tendencies toward violence.

E. Conditions in Solitary Confinement/Segregation

Prisoners may stay in segregated housing for years without the opportunity to engage in the types of interactions, treatment, and education experiences that would help them adjust when reentering either the general prison population or society. Segregated prisoners are typically taken out of their cells for only one hour out of every twenty-four for recreation or a shower. However, in some systems, prisoners are released once a week for a total of five hours. Before being released from their cells, prisoners are cuffed and may be shackled at the waist and placed in leg irons. Recreation times may occur anytime from 7:00 a.m. until 3:00 a.m. Typically recreation takes place in either an open cage outdoors (called a yard) or an indoor area, sometimes with an open barred top. Because many exercise areas are exposed to the weather, prisoners must choose whether to use them during extreme weather conditions or remain in their cells. Extreme weather may greatly reduce the amount of time prisoners are out of the cell, particularly when recreation periods are offered in five-hour blocks.

Except when overcrowding requires double celling, face-to-face human contact with individuals other than corrections officers is virtually eliminated in segregation. Officers deliver meal trays through a slot in the door, and counselors and mental health staff conduct visits

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[11] This section is excerpted from the Commission on Safety & Abuse in America's Prisons, *Confronting Confinement* (New York: Vera Institute of Justice, 2006).

[12] Chad S. Briggs, Jody L. Sundt, and Thomas C. Castellano, "The Effects of Supermaximum Security Prisons on Aggregate Levels of Institutional Violence," *Criminology* 41 (2003): 1341-76.

[13] David Lovell, L. Clark Johnson, and Kevin C. Cain, "Recidivism of Supermax Prisoners in Washington State," *Crime and Delinquency* 53 (2007): 633-656; and David Lovell and Clark Johnson, "Felony and Violent Recidivism Among Supermax Inmates in Washington State: A Pilot Study" (University of Washington, 2004).

[14] Peter C. Kratcoski, "The Implications of Research Explaining Prison Violence and Disruption," Federal Probation 52 (1988): 27, 28.

through the cell door. Segregation prisoners typically are not allowed contact with other prisoners, and visits with family members are curtailed or may be prohibited for a year or more. When visits are allowed, they usually are conducted by speaker or telephone through a thick glass window, precluding the opportunity for human touch.[15]

F. The Prevalence of Mental Illness in Prison

The prevalence of mental illness adds complexity to managing the confined population. The closure of most of the psychiatric institutions in the US over the last 50 years, and increasing reliance on community-based psychiatric care, have led to dramatic increases in the number of people with mental illness entering jails and prisons. A recent study found three times as many people with serious mental illnesses in the country's jails and prisons as in its hospitals.[16] Another study documented that 14.5 percent of male and 31.0 percent of female jail prisoners had current, serious mental illnesses, rates much higher than in the general U.S. population.[17] Research conducted by Vera's Substance Use and Mental Health Program (SUMH), using administrative data from government agencies, found that 19 percent of the sample of people who were booked into New York City jails and stayed for at least 72 hours required psychiatric services.[18] The study also found that people with mental illness stay in jail an average of 40 days longer than similar individuals without mental illness in the general jail population. In another study, SUMH found that 33 percent of people arrested in Washington, D.C. had some indication of mental health needs based on existing criminal justice and mental health agencies' data.[19]

G. Recommendations

I. Strategies to Reduce Segregated Populations

The progress of SRP partner states and other jurisdictions demonstrates that prison systems can effectively and safely reduce the use of segregation, improving conditions of confinement for prisoners and leading to sometimes dramatic cost reductions for facilities and taxpayers. Proven methods for reducing segregation include:

1. ***Reduce intakes to segregation by using alternative sanctions for all but the most serious violations.*** Alternative sanctions may include restrictions of privileges like visitation, programs, commissary, and recreation time; restrictions on movement (referred to in some systems as "confined to cell" or "keep locked"); or transfers to a

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[15] Angela Browne, Alissa Cambier, and Suzanne Agha, "Prisons Within Prisons: The Use of Segregation in the United States," *Federal Sentencing Reporter* 24, no. 1 (2011): 46-49.

[16] E. Fuller Torrey et al., More Mentally Ill Persons Are in Jails and Prisons than Hospitals: A Survey of the States, http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf (accessed September 27, 2011) (Treatment Advocacy Center and the National Sheriff's Association, 2010).

[17] H.J. Steadmean, F.C. Osher, P.C. Robbins, B. Case, and S. Samuels, "Prevalence of Serious Mental Illness Among Jail Inmates," *Psychiatric Services*, 60, no 6 (2009).

[18] Naomi Sugie and Jim Parsons, *From Risk to Resiliency: Part 1 Analysis* (Vera Institute of Justice, 2010).

[19] Jim Parsons and Talia Sandwick, *District of Columbia Forensic Health Project: Technical Report,* (Vera Institute of Justice, 2012).

different facility or level of security.

2. ***Limit the violations for which segregation is a sanction, and reduce segregation time for certain categories of violations.*** For violations such as talking back (insolence), being out of place, failure to report to work or school, or refusing to change housing units or cells, alternative sanctions or reductions in segregation time should be considered.

3. ***Review currently segregated population.*** Conducting individual case reviews will allow policy changes, such as fewer violations that result in segregation and reduced segregation time, to apply to the currently segregated population. Such reviews would include assessments of the violation leading to segregation time, behaviors while in segregation, and potential for safe release to the general prison population.

4. ***Provide tiered incentives to reduce segregation time for sustained good behavior.*** Providing incentives in the form of reductions in segregation helps encourage good behavior and gives facility management flexibility to manage behavior.

5. ***Separate special populations into "missioned" housing.*** Administrators can create or expand dedicated housing units where programming, procedures, and other conditions are tailored to the needs of populations, while still ensuring safety.

    a. In many systems, prisoners needing protection are held in the same units and subjected to the same harsh conditions as those serving sentences for rule violations or considered a threat to safety and security. Instead of using disciplinary segregation as the default housing option for prisoners in protective custody (PC), they can be housed in dedicated units with opportunities for congregate activities and programming to help them return to the general non-PC population (if appropriate). These units help systems reserve scarce security resources for ensuring the safety and security of all populations, creating potential cost savings.

    b. Severely mentally ill prisoners unable to function in the general population without violations are better served in general population housing tailored to their needs. For example, Wisconsin's Special Management Units allow severely mentally ill prisoners to receive specialized treatment and programming in a safe, secure environment.

6. ***Increase programming for prisoners in segregation.*** Programming should include opportunities for gradual resocialization to prepare prisoners for return to the general prison population and congregate activities for prisoners serving long terms in segregation.

II. Other National Recommendations

1. ***Mandate Gathering of National Data on Segregation.*** A major challenge with existing national-level data on segregation is a lack of clarity on types of segregation. For example, to date there are *no* reliable national statistics on populations in different forms of segregation. Additionally, the current BJS census does not include segregated populations in jails or Immigration and Customs Enforcement detention centers, so the size of this population is completely unknown. The BJS census also is conducted only once every five years. A more comprehensive census, completed more regularly and with more precise definitions, is vital to inform decision-making and legislation on the use of segregation in the United States.

2. ***Conduct a National Study on the Impact of Segregation.*** Expert studies should be funded to assess the costs of the use of (different types of) segregation compared to housing in the general prison population, and costs associated with incarceration in prison overall. In 2011, Vera's Cost Benefit Analysis Unit (CBAU) developed a sophisticated methodology to calculate prison costs and conducted a survey to collect this data. While this survey did not include specific information on segregation, it could be used as a model for this type of data collection.

3. ***Create National Standards.*** National standards on the use of segregation would encourage the field to adopt best practices for these settings. Vera has experience supporting this kind of work, having staffed the privately funded Commission on Safety and Abuse in America's Prisons (the subject of a 2006 Subcommittee Hearing on Corrections and Rehabilitation).[20] Additionally, Vera assisted the congressionally mandated National Prison Rape Elimination Commission in developing national standards to address sexual abuse in confinement settings. Creation of national standards governing the use of segregation would build on the work already undertaken by many states and this Subcommittee.

Concluding Statement

In closing, I would like to thank the Chairman and Ranking Member for holding the first federal hearing on solitary confinement, and I look forward to continuing our dialogue on this important issue.

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[20] *The Findings and Recommendations of the Commission on Safety and Abuse in America's Prisons: Hearing Before the Subcomm. on Corrections and Rehabilitation of the S. Comm. on the Judiciary*, 109th Cong. (2006).

VERA
INSTITUTE OF JUSTICE

Additional Background and Statistics on Prisoners in Segregation
Vera Institute of Justice
233 Broadway, 12th Floor
New York, NY 10279
June 19, 2012

A major challenge in assessing the use of segregation in the United States is the lack of reliable statistics.

National Segregation Figures
The best national-level source of information on segregation is the "Census of State and Federal Adult Correctional Facilities," sponsored by the Bureau of Justice Statistics and conducted every five to six years.[1] ***According to the 2005 census, there were 81,622 people held in restricted housing units in the United States.*** These are the most recent data available.

The BJS census ***includes*** adult correctional facilities operating under state or federal authority and private and local facilities that primarily house inmates for federal or state correctional authorities. It ***excludes*** detention centers, Immigration and Customs Enforcement facilities, Bureau of Indian Affairs facilities, U.S. Marshals Service facilities, military facilities, and facilities that house only juveniles. Although useful for many purposes—including counts and characteristics of facilities and prisoners—it poses challenges in describing the use of segregation in the United States. Some limitations include:

1. ***Lack of clarity on types of segregation.***
   There is tremendous variation across state systems—and between facilities in the same state system—in the terms used for various types of segregation. The census uses the term "restricted housing units," but does not provide a definition for this term. Although it does ask about some categories of segregation (disciplinary, administrative, protective custody), it does not provide definitions for these categories for respondents to follow. This sort of guidance is critical for obtaining reliable data.

2. ***Inconsistency in reporting.***
   It is standard practice for systems to provide estimates when actual figures are unavailable, but analysis of census data indicate important inconsistencies in facilities reporting (a) whether they have restricted housing units, and (b) whether they are providing actual counts or estimates. Some facilities or systems provide inconsistent responses (for example, reporting no restricted housing units, at the same time as providing the actual number of prisoners in a particular category of restricted setting), increasing the potential for error.

[1] The 2005 census included data from all Federal facilities and 49 state facilities.

3. ***Reporting of segregation findings.***
   For each census the BJS traditionally publishes a report summarizing key findings, providing details on the methodology, and including several data tables. These reports typically do not include information on counts of prisoners in segregation, requiring interested parties to download and analyze the data individually. While these data are publically available, their analysis requires substantial experience and expertise.

Information on the costs of and impact of segregation are also critical for informed decision making and policy. Unfortunately, the data required to calculate costs and savings are not included in the BJS census, and we are not aware of any national-level data on the costs of segregation.[2]

State-level Data

In the absence of national-level data on segregation, state-level data provides valuable information. Estimates of segregated populations based on state-level data cannot substitute for national-level data and should not be interpreted as representative of the nation as a whole. State-level systems vary significantly in the type and quality of data they collect and the kinds of analyses they conduct. Below are highlights of state-level figures that have been published in journals, collected by Vera researchers, or calculated by state agencies.

1. ***Population Figures***
   - **Illinois DOC.** In February 2010, 4.8% of the prison population (or 2,272 of 46,006 prisoners) was in segregation.[3]
   - **Washington DOC.** In 2012, about 2.7% of 16,000 beds (about 432 beds) is in the Intensive Management Unit (segregation unit).[4]
   - **Maryland DPSCS.** In May 2011, 7.8% of the prison population (or 1,720 of 22,094 prisoners) was in segregation.[5]

2. ***Costs***
   - **Mississippi DOC.** Quote from Emmitt Sparkman, Department of Corrections Deputy Commissioner: *"....[R]educing segregation saves money. In 2007, we had nearly 1,300 inmates in long-term segregation and were spending hundreds of thousands of dollars on litigation and maintaining the physical plant. Once we reduced segregation to 335 inmates, we were able to close Unit 32. We moved staff to other locations and there*

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[2] The approach required to accurately assess these types of costs and savings is complex. In 2011, Vera developed a sophisticated methodology to calculate prison costs and conducted a survey to collect this data. While this survey did not include specific information on segregation it could be used as a model for this type of data collection. *See* C. Henrichson, R. Delaney, *The Price of Prisons: What Incarceration Costs Taxpayers* (New York, NY, Vera Institute of Justice, 2012).

[3] Includes disciplinary segregation and administrative detention, Vera analysis.

[4] *Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences: Hearing Before the Subcomm. on the Constitution, Civil Rights, & Human Rights of the S. Comm. on the Judiciary*, 112th Congress (2012) (testimony of Vera Institute of Justice).

[5] Includes disciplinary and administrative segregation, Vera analysis.

was attrition; we saved approximately $5.6 million a year and were able to avoid layoffs and furloughs."[6]

- **Ohio DOC.** In 2003 in the Ohio State Penitentiary, Ohio's supermax, it cost $149 a day to house a prisoner, compared with $101 per day for a maximum-security prisoner and $63 per day for an average general-population prisoner.[7] The majority of these higher costs come from the need for additional staff to monitor segregation units. For example, the supermax required one corrections officer for every 1.7 prisoners; maximum-security housing required one officer for every 2.5 prisoners.[8]

3. Examples of Impact

- **Washington DOC.** Prisoners released directly from supermax to the community had significantly higher felony recidivism rates and committed new offenses sooner than prisoners who spent three or more months back in the general prison population after release from supermax and before release to the community.[9]
- **Washington DOC.** Long-term isolation can create or exacerbate serious mental health problems and assaultive or anti social behavior.[10]
- **Mississippi DOC.** Mississippi reduced the number of people held in segregation by 85 percent. Internal data suggest that these changes were associated with an almost 70 percent decrease in prisoner-on-prisoner and prisoner-on-staff violence and large declines in use of force by officers in the unit.[11]
- **Colorado DOC.** A study conducted by the research department at Colorado DOC concluded that prisoners with mental illness in administrative segregation did not deteriorate more quickly than prisoners without mental illness in administrative segregation.[12] Study methodology and findings are controversial.

Recommendations for National-Level Data on Segregation

1. Population

The Bureau of Justice Statistics brings considerable experience and expertise to national-level data collection, and their Census of State and Federal Correctional Facilities provides a solid

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[6] Vera Institute of Justice Blog, "Mississippi DOC's Emmitt Sparkman on Reducing the Use of Segregation in Prisons," October 11, 2011, http://www.vera.org/node/5313 (accessed June 13, 2012).

[7] Daniel P. Mears "Evaluating the Effectiveness of Supermax Prisons" (Urban Institute Justice Policy Center, 2005). Available at https://www.ncjrs.gov/pdffiles1/nij/grants/211971.pdf.

[8] Ibid.

[9] David Lovell, L. Clark Johnson, and Kevin C. Cain, "Recidivism of Supermax Prisoners in Washington State," Crime and Delinquency 53 (2007): 633-656; and David Lovell and Clark Johnson, "Felony and Violent Recidivism Among Supermax Inmates in Washington State: A Pilot Study" (University of Washington, 2004).

[10] David Lovell, "Patterns of Disturbed Behavior in a Supermax Population," *Criminal Justice and Behavior* 35 (2008): 9852.

[11] Terry Kupers et al., "Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs," Criminal Justice and Behavior 36 (2009): 1037-50.

[12] O'Keefe, Maureen et al. (2010) "One Year Longitudinal Study of the Psychological Effects of Administrative Segregation" (State of Colorado Department of Corrections).

foundation. With appropriate and adequate funding dedicated to this purpose, this effort can be expanded to gather critical data and provide a more complete picture of segregation in the United States. Below are several recommendations to enhance the current census, which represent a fairly significant and important undertaking.

- Provide clear definitional guides for all categories of segregation and a mechanism for census respondents to ask questions as they complete the census form. The data cannot be interpreted without definitions.
- Include local jails, ICE detention centers, and other types of facilities currently excluded from the census.
- Include internal survey mechanisms to identify inconsistent responses, spot-check all submitted forms for inconsistency, and create a follow up mechanism to clarify and correct inconsistent responses.
- Include findings on segregation in the BJS report summarizing census findings. The report does not currently include such findings.
- Increase the frequency of the census to every three years.

2. Costs

Expert studies should be funded to assess the costs of the use of (different types of) segregation compared to housing in the general prison population, and costs associated with incarceration in prison overall. In 2011, Vera's Cost Benefit Analysis Unit (CBAU) developed a sophisticated methodology to calculate prison costs and conducted a survey to collect this data. While this survey did not include specific information on segregation, it could be used as a model for this type of data collection.

3. Impacts

Until population and costs are better understood, researchers will not have sufficient basis for evaluating the national impacts of segregation. In the longer term, however, research should be supported that examines the safety, psychological, and recidivism impacts of segregation.

Testimony of
The Rev. Jonathan M. Barton, General Minister
Virginia Council of Churches
Before the
Senate Judiciary Committee
Subcommittee on the Constitution, Civil Rights and Human Rights
Hearing on Reassessing Solitary Confinement
June 19, 2012

Mr. Chairman, members of the Senate Judiciary Subcommittee on the Constitution, Civil Rights and Human Rights, my name is Jonathan Barton and I am the General Minister for the Virginia Council of Churches, thank you for this opportunity to submit testimony on behalf of the Council concerning the harmful use of solitary confinement in our nation's federal prisons, jails, and detention centers. I would like to express my appreciation to Senator Durbin for his leadership in convening this, the first-ever Congressional hearing on solitary confinement. We are encouraged that a growing number of states across the nation are reassessing this practice and implementing policies to limit its use. In light of the high cost of solitary confinement and its diminishing returns, we are grateful for your timely review of the federal system's use of isolation today.

The Virginia Council of Churches brings together thirty six governing bodies of eighteen different Catholic, Protestant, and Orthodox denominations within the Commonwealth of Virginia. During our sixty eight-year history we have always stood for fairness, justice and the dignity of all peoples. We stand here today in faith, grounded in our history and our values. We believe and value the inherent dignity of all human beings, the Divine image in which we have all been created.

Across our nation prisoners, inmates, and detainees are being confined in a small cells for 22-24 hours per day for weeks, months, even years. Many studies have documented the

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detrimental psychological and physiological effects of long-term solitary confinement, including hallucinations, perceptual distortions, panic attacks, and suicidal ideation. As reported by the New Yorker, electroencephalogram tests since the 1960s have shown that solitary confinement causes significant slowing of brain waves after even only a week of isolation. The Commission on Safety and Abuse in America's Prisons, a national bipartisan taskforce established in 2006, noted that among the dozens of studies on the use of solitary confinement conducted since the 1970s, there was not a single study of non-voluntary solitary confinement for more than 10 days that did not document negative psychiatric results in its subjects.

The severe consequences of isolation are not surprising from a faith perspective. "And God said, 'It is not good for a man to be alone.'" Human beings are meant to live in community with others is the message of this passage from Genesis 2. Jewish, Christian and Muslim scriptures all affirm that human beings need each other physically, mentally and spiritually. The mental harm caused by solitary confinement severely damages prisoners' capacity to think critically and to consciously opt for a new way to live. Considering this severe harm, we strongly believe prolonged solitary confinement is a violation of the inherent God-given dignity in every human being.

The use of solitary confinement has increased dramatically in the last few decades. The Commission on Safety and Abuse in American's Prisons noted in their report, *Confronting Confinement*, that from 1995 to 2000, the growth rate of segregation units significantly surpassed the prison growth rate overall: 40% compared to 28%. Rather than a last resort, solitary confinement has become the cruel and usual default management and discipline tool, tarnishing the integrity of the Eighth Amendment of the Constitution.

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The widespread use of solitary confinement is evident in my home state of Virginia, where we have seen a recent hunger strike by inmates at Red Onion State Prison, Virginia's supermax prison, located in Wise County, VA. As reported by the Washington Post, prisoners at Virginia's Supermax prison, Red Onion State Prison, have been kept in solitary confinement from anywhere between two weeks and seven years, with an average length of stay of 2.7 years. In addition Virginia prison officials reported that over a third of the individuals placed in solitary confinement at Red Onion State Prison are mentally ill. These individuals' illnesses are often dramatically magnified when held in solitary confinement. Ironically, the mental effects of solitary confinement can prevent the good behavior often required to move back into the general prison population.

In September 2011, members of our General Assembly led by Delegate Patrick Hope of Arlington County, had the opportunity to visit Red Onion and see conditions first hand. Del. Hope concluded, "Many of these prisoners have a very serious mental illness or become seriously mentally ill primarily to their segregation. With a trend in other States moving away from this kind of confinement, maybe it's time we took a hard look at what Virginia is doing and see if we can do it better in a safe and more humane way." We are encouraged that Governor Bob McDonnell, and Director Clarke with the Department of Corrections have both indicated they plan on making reforms in Virginia, and we look forward to working with them.

We are grateful that today, through this hearing, you are beginning to take a look at how the federal system is using solitary confinement and we hope that this process will lead you toward more effective and humane alternatives. We believe such progress at the federal level

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would also send a strong message to states, like mine, where a reduction in solitary confinement is still urgently needed.

Our Scriptures admonish us "Remember those in prison, as though you were in prison with them; those who are being tortured, as though you yourselves were being tortured." (Hebrews 13:3.) However, solitary confinement is not just a concern for people of faith, the law enforcement community or the friends and family of inmates, but rather, all Americans have a stake in limiting the use of solitary confinement.

The drastic rise in solitary confinement has cost us financially. Super-max prisons are far more expensive than standard facilities to build. Additionally, the daily cost per inmate in a solitary confinement unit significantly surpasses the costs of housing an inmate in lower security facility since solitary confinement units require individual cells and appreciably more staff.

Default reliance on prolonged solitary confinement is ineffective and destructive. The success of several states demonstrates that solitary is not the only, or best, option. Several states including Mississippi, Maine, and Colorado have reduced their use of isolation and have proven there are safe alternatives. In an interview with the National Religious Campaign Against Torture, Maine Department of Corrections Commissioner, Joseph Ponte, explained, "Over time, the more data we're pulling is showing that what we're doing now [through greatly reducing the use of solitary confinement] is safer than what we were doing before." Further, we must not neglect the larger public safety impact. The negative effects of prolonged solitary confinement harm our communities. Prisoners who are freed directly from solitary confinement cells are significantly more likely to commit crimes again. Successful reentry of these citizens to our local communities requires preparation for release while they are still incarcerated.

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Mr. Chairman, Members of the Subcommittee, the Virginia Council of Churches believes strongly that the United States should do everything it can to reverse our nation's harmful and expensive reliance on solitary confinement. We have a moral obligation to uphold the dignity and the mental health of those currently incarcerated. To that end, we would strongly support your leadership in sponsoring legislation that would limit the use and length of solitary confinement. We implore you to immediately take steps to end the use of prolonged solitary confinement. Your hearing today is a very important effort in doing that, and we thank you for the opportunity to contribute to it.

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Women's Refugee Commission Statement on
Solitary Confinement in Immigration Detention

Hearing Before the Senate Judiciary Committee
Subcommittee on the Constitution, Civil Rights and Human Rights

"Reassessing Solitary Confinement: the Human Rights, Fiscal and Public Safety Consequences"

June 19, 2012

The Women's Refugee Commission works to protect the basic rights of women, children, families and other vulnerable migrants seeking protection in the United States and to ensure that they are not detained unless absolutely necessary. To this end, the Women's Refugee Commission conducts research and advocates for legislation and policy that protects the safety, well being, and dignity of migrant women, families, and children.

Introduction

Solitary confinement is by nature a punitive measure. A growing number of mental health studies over the years have shown that exposing an individual to extreme sensory deprivation and isolation from human contact, even for short periods of time, can lead to significant psychological and even physical damage.[1] The punitive nature of solitary confinement should automatically bar its use in the civil detention of asylum seekers and other unauthorized migrants. Under U.S. immigration law, immigration detention is intended to serve purely administrative purposes. Nonetheless, the vast majority of the immigration detention centers used by U.S. Immigration and Customs Enforcement ("ICE") are designed to be secure, jail-like facilities for criminal offenders. Officials in these detention centers routinely place immigration detainees in solitary confinement, calling it "isolation," "administrative segregation," or "protective custody." Whatever its official title, the use of this harsh practice in immigration detention facilities is inappropriate and unjustified. The Women's Refugee Commission therefore welcomes this hearing as a crucial step on the path to reducing and regulating the use of solitary confinement for immigration detainees.

Lack of Legal Protections for Immigration Detainees

Immigrants held in civil detention for violations of immigration law are a particularly vulnerable population because they are denied many of the basic due process rights granted to U.S. citizens in the criminal justice system. Immigration detainees have no right to counsel and they are not guaranteed prompt bond hearings to determine whether their detention is justified. Furthermore, immigrants who have been convicted of a broad range of criminal offenses (including those that would not be considered "aggravated" in the criminal justice system) are subject to mandatory detention laws and are generally not

[1] Haney, Craig (2003). Mental Health Issues in Long-Term Solitary and Supermax Confinement, 49 *Crime & Delinquency* 124.

eligible for bond. All immigration detainees lack sufficient access to pro bono legal and social service providers, regular visitation with family, and access to meaningful institutional grievance systems. Immigration detainees who have been placed in solitary confinement face even greater limitations, including less access to resources and opportunities that might help to protect their rights and make their detention more bearable.

Conditions of Detention and Solitary Confinement for Immigration Detainees

In 2009, the Obama administration announced its intent to make immigration detention facilities more civil as a way of moving away from the correctional model of criminal incarceration. However, ICE is only now beginning to implement updated detention standards. These standards remain unenforceable and even when implemented will require only the bare minimum level of appropriate conditions for civil detention. In addition, ICE continues to house detainees in facilities that are inherently penal, limiting the degree to which the new standards can sufficiently change the conditions of confinement for the individuals in custody.

At the facilities the Women's Refugee Commission has visited—whether local jails or dedicated ICE facilities—we have found conditions of solitary confinement to have several troubling characteristics in common, including small cell size, inadequate ventilation and sunlight and limited access to recreation. In addition, there are no clear limits on the amount of time an individual can be held in these cells. These conditions are inappropriate for anyone in immigration detention, and have particularly concerning implications for some of the most vulnerable individuals.

Vulnerable Groups

Certain groups within the larger immigration detainee population are uniquely vulnerable to the stresses of solitary confinement as they affect mental health. Asylum-seekers comprise a particularly vulnerable group. Each year, thousands of asylum-seekers ask for protection in the U.S. and are placed into immigration detention pending eligibility for parole or resolution of their case. These asylum seekers are often subjected to the same disciplinary regime as criminally charged inmates housed in the same facilities. Guards in these facilities rely on the use of solitary confinement as a tool for both punishing infractions and "protecting" inmates from the broader detainee population.

Detainees placed in solitary confinement are more likely to be deprived of adequate medical and mental health services. For asylum-seekers, who often suffer from emotional trauma, physical injuries, or post-traumatic stress disorder as a result of abuse in their home countries, the experience of solitary confinement can be particularly horrific. Studies have shown that individuals with histories of psychological trauma and mental illness who are subjected to solitary confinement are at a particularly high risk for depression, self-harming behavior, and suicide.[2]

[2] Stuart Grassian, *Psychopathological Effects of Solitary Confinement*, 140 AM J. OF PSYCHIATRY 1450 (1983).

Unaccompanied minors in immigration custody comprise another particularly vulnerable group. While unaccompanied children are generally not kept in isolation for longer than 72 hours, research has shown that young people are far more likely than adults to develop symptoms of acute anxiety and depression even after brief periods of solitary confinement.[3] On October 18, 2011, Juan Mendez, the U.N. Human Rights Council's Special Rapporteur on Torture, presented a report that highlighted the harmful mental and physical effects of solitary confinement, particularly on children. The report calls on all countries signatory to the Convention Against Torture to ban the practice of subjecting juveniles to solitary confinement, citing the fact that their "physical and mental immaturity" makes juveniles particularly vulnerable to the negative effects of isolation.[4] The Rapporteur's report focused specifically on the potentially irrevocable, long-term effects of solitary confinement on children, including impaired memory and concentration, decline in brain activity, lasting changes in personality, and the inability to reintegrate into society upon release.

Solitary confinement is also regularly used as a protective measure for immigration detainees who have suffered from sexual abuse during detention, abuse to which lesbian, gay, bisexual and transgender individuals—and women—are particularly vulnerable. Guards will often place survivors of sexual assault in "protective custody" shortly after an assault to segregate them from their alleged abuser and protect them from future attacks. Despite its intended purpose, this harsh confinement only creates more suffering for victims, leading to heightened trauma and diminished access to crisis services, mental health counseling, and medical care. These victims, like all immigration detainees who are held in solitary confinement, have even less access than the general immigrant population to the historically insufficient and inconsistent grievance procedures that can play a role in protecting victims, punishing perpetrators and creating protective practices.

Conclusion

Solitary confinement is a harsh and punitive practice that is inconsistent with the administrative nature of immigration detention. The U.S. Department of Homeland Security and U.S. Department of Health and Human Services should act quickly to institute a presumption against its use in all facilities housing migrants for any length of time, except as a measure of last resort subject to strict oversight. In addition, the federal government should institute rules that explicitly ban the solitary confinement of children, the mentally ill, and victims of sexual and/or physical abuse and crime. This hearing represents a step in the right direction, but there is still a great deal of progress that must be made to ensure the fair and humane treatment of asylum-seekers and other immigration detainees.

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[3] C.J. MUMOLA, U.S. DEPT. OF JUST., BUREAU OF JUSTICE STATISTICS, SUICIDE AND HOMICIDE IN STATE PRISONS AND LOCAL Jails (2005); Linda Finke, *The Use of Seclusion is not Evidence-Based Practice*, J. OF CHILD & ADOLESCENT PSYCHIATRIC NURSING (2001).

[4] Press Release, Office of the High Commissioner for Human Rights, U.N. Special Rapporteur on Torture Call for the Prohibition of Solitary Confinement, U.N. Press Release HR11/226E (October 18, 2011).

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The Honorable Richard Durbin, Chairman
Senate Judiciary Subcommittee on the Constitution,
Civil Rights and Human Rights
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Re: Statement of the Youth Law Center
Reassessing Solitary Confinement: The Human Rights, Fiscal and Public Safety Consequences; Hearing Before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights (June 19, 2012)

Dear Chairman Durbin and Members of the Subcommittee:

The Youth Law Center is grateful for the opportunity to offer our experience and insight on the solitary confinement of juveniles in detention centers, training schools, jails and other institutions around the country.[1] The Youth Law Center is a national public interest law firm working on behalf of children and youth in the juvenile justice and child welfare systems since 1978. Our attorneys are widely recognized as experts on juvenile confinement law, and have been involved in conditions work in approximately 40 states. Many of our conditions lawsuits have involved solitary confinement issues. We have inspected or visited dozens of juvenile facilities where solitary confinement is used, and have received numerous complaints from youth and families of youth held in solitary confinement. For many years, we have worked for stronger laws and institutional policies governing solitary confinement, and better professional education about what it does to children. This statement will provide examples of solitary confinement and its impact on juveniles; rebut commonly used rationales for using solitary confinement; and suggest ways that Congress may act to eliminate this dehumanizing, damaging, and counter-productive practice.

[1] In juvenile facilities, solitary confinement is used for multiple purposes and goes by many names, including room time, room lock, 23 and 1, "the box", isolation, suicide watch, administrative segregation, and special program. It all comes down to the same thing: a young person locked, alone, in a tiny room.

Solitary Confinement is Especially Harmful to Juveniles

While solitary confinement is harmful to all human beings, it is especially so for children. For youth locked in a tiny room, a moment is an eternity, and it seems that the confinement will never end. And because youth in such confinement lack the maturity to put their current circumstances into a long term perspective, many feel hopeless and depressed. Alternatively, they may feel that the system isn't fair and that those in authority cannot be trusted. The message conveyed to them is that they are worthless and beyond all help.

Many of the very youth who wind up in solitary confinement have already experienced trauma or abuse and/or suffer from mental illness. Placing them in solitary confinement exacerbates already fragile psychological conditions, sometimes with devastating results. A national study of juvenile institutional suicides found that 75% involved youth confined to single occupant rooms, and 50% of those were youth being subjected to disciplinary confinement.[2]

Even brief periods of solitary confinement may have a lasting impact on a young person.[3] This is especially so for the many youth who have already experienced abuse, neglect, or previous institutionalization. Locking them away subjects them to re-traumatization. This is a cruel outcome for those who depend on the system to recognize and help them work through the horrifying events they have already experienced in their young lives.

Youth subjected to solitary confinement are unable to do the very things that may reduce the length of confinement and ensure success in the community. Most are deprived of access to educational services, or are given worksheets or packets that do not help to advance them academically. They are unable to participate in group activities that would help them to present themselves in a positive light and move away from delinquency. They leave custody in worse condition than when they entered. Because of solitary confinement, the youth who need the most attention, receive the least.[4]

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[2] Lindsay M. Hayes, "Characteristics of Juvenile Suicides in Confinement," OJJDP Juvenile Justice Bulletin (Feb. 2009).

[3] Sandra Simkins, Marty Beyer, Lisa M. Geis, "The Harmful Use of Isolation in Juvenile Detention Facilities: The need for Post-Disposition representation," 38 *Washington University Journal of Law & Policy* 241 (2012).

[4] *See* Michelle Deitch, Anna Lipton Galbraith, and Jordan Pollock, *Conditions for Certified Juveniles in Texas County Jails*, University of Texas at Austin, LBJ School of Public Affairs (2012).

The Systemic Impact of Solitary Confinement

The harm caused by solitary confinement has broader ramifications. Deteriorating mental and physical health translate into added costs to the justice system because youth are harder to place, and this results in additional costs of confinement. There are also costs for staff. Use of solitary confinement contributes to stress and work dissatisfaction, which in turn results in costly absenteeism, workers compensation claims and job turnover.

When something bad happens to a youth in solitary confinement – a suicide or a serious attempt - there are enormous additional costs from the inevitable litigation. In California, the family of a girl who suffered permanent brain damage after hanging herself in solitary confinement recently settled the case for more than two million dollars.

To the extent that use of solitary confinement interferes with the ability of the system to provide education, recreation, social interaction and emotional support to the child, there are even greater costs. For every minute a youth spends locked in a cell, opportunities are missed to provide much needed interventions that could change the course of the young person's life. For every youth the system fails to rehabilitate, there may be additional costs to the community in future criminality, victimization, court costs and dependence on public benefits.

Routine Use of Solitary is Pervasive in Juvenile facilities

While the United State Supreme Court has repeatedly recognized that juveniles are different from adults, and that their immaturity requires different interventions and sanctions,[5] our correctional system has yet to catch up.[6] Despite the serious short and long term consequences of solitary confinement, it is routinely used for

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[5] *Roper v. Simmons,* 543 U.S. 551 (2005); *Safford Unified School District v. Redding* (2009) 557 U.S. 364; *Graham v. Florida* (2010) 560 U.S. ___, 130 S.Ct 2011; *J.D.B. v. North Carolina* (2012) ___ U.S. ___, 131 S.Ct. 2394.

[6] International law also prohibits the use of solitary confinement for juveniles. The United Nations Rules for the Protection of Juveniles Deprived of their Liberty, adopted by the General Assembly in Resolution 45/113, Article 67 (December 1990), prohibits "closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned." The Convention on the Rights of the Child (CRC), Article 37, also prohibits cruel, inhuman or degrading treatment or punishment, and comments to that section reference "closed or solitary confinement."

punishment, administrative convenience, or the misguided belief that it is needed to protect youth. The use of solitary confinement is found, for example, in facilities that:

- Impose disciplinary sanctions calling for multiple days in room confinement for violation of facility rules (for example, possession of a pencil);
- Place youth perceived to be vulnerable (for example youth with developmental disabilities) in solitary confinement for their own protection;
- Feature "special programs" that consist of 20 or more hours of lockdown a day and no programs;
- Isolate suicidal youth for their own protection;
- Lock youth in their rooms for extended periods because staff called in sick and there are insufficient on-call staff;
- Keep youth considered to be high security locked in their rooms, even though they are in a discrete living unit;
- "Treat" youth with mental illness or behavioral issues primarily with locked room time;
- Require youth who do not receive visits to remain locked in their room during visiting hours;
- Lock youth in their room while staff do paperwork;
- Impose institutional lockdowns that extend long after security dangers have subsided; or
- Allow juveniles to be held in adult institutions, and then place them in solitary confinement for their own protection.

While it surely may be necessary to isolate youth for brief periods to address safety issues or quell disturbances, the foregoing list reflects a system that does not treat solitary confinement as the rarely used crisis intervention it should be.

Solitary Confinement is Unnecessary and Alternative Models Already Exist

The pervasive use of solitary confinement on juveniles is often related to understaffing, inadequate staff training, and lack of professional mental health support. For example, facilities with large youth to staff ratios resort more quickly to solitary confinement because staff do not know the youth as well; are less able to head off escalating situations; do not have the time to work through alternative approaches that could prevent the need for solitary confinement; and are less able to supervise youth who cannot program with the rest of the youth. Similarly, in facilities that do not provide good training in behavioral interventions, staff are less likely to see alternative ways to handle situations that currently result in solitary confinement. Further, in facilities with meaningful mental health staffing, youth at risk of suicide and youth with behavioral issues are more likely to be dealt with in more normalized settings.

Solitary confinement also persists because "this is how we have always done it." Many facilities have historically relied on solitary confinement as their sole response to disciplinary issues, and have never explored other ways to handle misbehavior. In fact, a number of jurisdictions have moved in a different direction. Missouri had only one isolation cell for its entire state facility system when we visited. It avoids the need for solitary by having good staffing ratios (2 to 11), lots of programs, and positive support systems for youth. A number of other jurisdictions have drastically reduced their use of solitary confinement by replacing punitive discipline systems with positive behavior support systems.

Finally, and perhaps, most disturbingly, a number of forms of solitary confinement are justified as "for the protection of the child." Thus, in many facilities around the country, youth spend days and weeks in solitary confinement because they are at risk of suicide or other self harm. This practice persists despite the fact that experts urge facilities not to isolate youth on suicide watch.[7] Similarly, in the mental health community, the harm to juveniles caused by "seclusion" is well-recognized. The Substance Abuse and Mental Health Services Administration (SAMSHA) has noted the particular dangers of seclusion for children, and has a national project aimed at eliminating seclusion and restraint.[8] Federal regulations now strictly limit the practice in treatment facilities, and require intensive involvement by mental health professionals in its use for even those brief periods.[9]

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[7] *See* Lindsay Hayes, *supra*, note 2.

[8] *See* http://www.samhsa.gov/matrix2/seclusion_matrix.aspx; and "Promoting Alternatives to the Use of Seclusion and Restraint," SAMSHA Issue Brief #1 (March 2010), http://www.samhsa.gov/matrix2/IssueBrief1_B.pdf.

[9] 42 C.F.R. § 482.13, *et seq.*

What Congress Should Do

The recent promulgation of the Prison Rape Elimination Act stands as a testament to the fact that Congress can effectively intervene to address institutional abuses. The SAMSHA work on seclusion and restraint also provides a strong model that includes standards, professional education, and technical assistance in developing alternative interventions. Eliminating juvenile solitary confinement calls for the same kind of multi-faceted approach, including standards, fiscal incentives, and technical assistance. Here are some of the specific things Congress should do to help:

- Reauthorize the Juvenile Justice and Delinquency Prevention Act (JJDPA) and condition funding to the States on elimination of solitary confinement; provide incentive grants and technical assistance to jurisdictions to assist in this process. Also, eliminate the loopholes that currently permit juveniles to be held in adult jails and status offenders to be held in secure detention for violation of court orders – both of which frequently result in solitary confinement of youth;

- Enact legislation requiring the promulgation of national standards that eliminate solitary confinement for discipline, mental health/behavioral purposes, and administrative convenience. Because eliminating solitary confinement requires attention to many other areas of institutional operation (staffing, training, mental health resources, oversight), consider dusting off and updating the outstanding National Advisory Commission for Juvenile Justice and Delinquency Prevention *Standards for the Administration of Juvenile Justice* (July 1980), and formally adopting them;

- Require juvenile facilities to adhere to the strict requirements for "seclusion" now imposed by federal statute for treatment facilities;[10]

- Support diversion programs and wraparound services for youth who are incompetent to stand trial or have mental health issues that frequently result in solitary confinement in juvenile facilities;

- Provide support to advocates to monitor and respond to complaints about solitary confinement; and

- Provide additional support for Department of Justice investigations into solitary confinement.

[10] *Id.*

Conclusion

The rampant use of solitary confinement on juveniles is antithetical to our values about the treatment of young people. It hurts rather than helps youth in their journey toward rehabilitation. In today's world of evidence-based practices, there is no place for this medieval holdover. There are effective, more humane ways to address the issues that result in solitary confinement. We urge the Subcommittee to take action to respond to these issues. Thank you for your consideration, and please count on us to assist in any we can as your efforts move forward.

Sincerely,

Sue Burrell

Sue Burrell, Staff Attorney
YOUTH LAW CENTER

youth law center