Mental Health Issues in Long-Term Solitary and "Supermax" Confinement

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This article discusses the recent increase in the use of solitary-like confinement, especially the rise of so-called supermax prisons and the special mental health issues and challenges they pose. After briefly discussing the nature of these specialized and increasingly widespread units and the forces that have given rise to them, the article reviews some of the unique mental-health-related issues they present, including the large literature that exists on the negative psychological effects of isolation and the unusually high percentage of mentally ill prisoners who are confined there. It ends with a brief discussion of recent caselaw that addresses some of these mental health issues and suggests that the courts, though in some ways appropriately solicitous of the plight of mentally ill supermax prisoners, have overlooked some of the broader psychological problems these units create.

Keywords: *supermax; solitary confinement; effects of imprisonment*

The field of corrections is arguably impervious to much truly significant change. Of all of the institutions in our society, prisons retain the greatest similarity to their early 19th century form. Indeed, until relatively recently, more than a few prisoners were housed in facilities that had been constructed a half century or more ago. Although there have been advances in the methods by which correctional regimes approach the task of changing or rehabilitating prisoners, and a number of improvements made in overall conditions of confinement compared to the 19th century (often brought about by litigation compelling prison systems to modernize and improve), many of the basic facts of prison life have remained relatively constant. Notwithstanding increased sophistication in the technology of incarcerative social control, and the waxing and waning in popularity of one or another kind of prison treatment program, the argument that there has been nothing fundamentally new on the correctional landscape for many years would be difficult to refute.

However, in this article, I suggest that the last decade of the 20th century did see the rise of a new penal form—the so-called supermax prison. Increasing numbers of prisoners now are being housed in a new form of

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solitary or isolated confinement that, although it resembles the kind of punitive segregation that has been in use since the inception of the prison, has a number of unique features.[1] At the start of the 1990s, Human Rights Watch (1991) identified the rise of supermax prisons as "perhaps the most troubling" human rights trend in U.S. corrections and estimated that some 36 states either had completed or were in the process of creating some kind of "super maximum" prison facility. By the end of the decade, the same organization estimated that there were approximately 20,000 prisoners confined to supermax-type units in the United States (Human Rights Watch, 2000) and expressed even more pointed concerns about their human rights implications. Because most experts agree that the use of such units has increased significantly since then, it is likely that the number of persons currently housed in supermax prisons is considerably higher.

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. Thus, the mental health implications of these units are potentially very significant. Despite the slight (and sometimes not so slight) variations in the ways different state prison systems approach this most restrictive form of confinement, supermax prisons have enough in common to permit some generalizations about what they are, why they have come about, what special mental health issues they raise, and how they might be regulated and reformed to minimize some of the special risks they pose. I will try to address each of these issues in turn in the pages that follow.

SUPERMAX CONDITIONS OF CONFINEMENT

Supermax confinement represents a significant variation in the long-standing practice of placing prisoners in what is known as solitary confinement or punitive segregation. For practical as well as humanitarian reasons, prisoners have rarely been confined in literal or complete solitary confinement.[2] But prisoners in solitary or isolation have always been physically segregated from the rest of the prison population and typically excluded from much of the normal programming, routines, opportunities, and collective activities available in the mainline institution. By the late 19th century, most jurisdictions in the United States had, for the most part, restricted solitary confinement to relatively brief periods of punishment that were imposed in response to specified infractions of prison rules.[3]

In contrast to this traditional form of isolation, supermax differs in several important ways—primarily the totality of the isolation, the intended duration of the confinement, the reasons for which it is imposed, and the technological

sophistication with which it is achieved. In particular, supermax prisons house prisoners in virtual isolation and subject them to almost complete idleness for extremely long periods of time. Supermax prisoners rarely leave their cells. In most such units, an hour a day of out-of-cell time is the norm. They eat all of their meals alone in the cells, and typically no group or social activity of any kind is permitted.[4]

When prisoners in these units are escorted outside their cells or beyond their housing units, they typically are first placed in restraints—chained while still inside their cells (through a food port or tray slot on the cell door)—and sometimes tethered to a leash that is held by an escort officer. They are rarely if ever in the presence of another person (including physicians and psychotherapists) without being in multiple forms of physical restraints (e.g., ankle chains, belly or waist chains, handcuffs). Supermax prisoners often incur severe restrictions on the nature and amounts of personal property they may possess and on their access to the prison library, legal materials, and canteen. Their brief periods of outdoor exercise or so-called yard time typically take place in caged-in or cement-walled areas that are so constraining they are often referred to as "dog runs." In some units, prisoners get no more than a glimpse of overhead sky or whatever terrain can be seen through the tight security screens that surround their exercise pens.

Supermax prisoners are often monitored by camera and converse through intercoms rather than through direct contact with correctional officers. In newer facilities, computerized locking and tracking systems allow their movement to be regulated with a minimum of human interaction (or none at all). Some supermax units conduct visits through videoconferencing equipment rather than in person; there is no immediate face-to-face interaction (let alone physical contact), even with loved ones who may have traveled great distances to see them. In addition to "video visits," some facilities employ "tele-medicine" and "tele-psychiatry" procedures in which prisoners' medical and psychological needs are addressed by staff members who "examine" them and "interact" with them over television screens from locations many miles away.

Supermax prisons routinely keep prisoners in this near-total isolation and restraint for periods of time that, until recently, were unprecedented in modern corrections. Unlike more traditional forms of solitary confinement in which prisoners typically are isolated for relatively brief periods of time as punishment for specific disciplinary infractions, supermax prisoners may be kept under these conditions for years on end. Indeed, many correctional systems impose supermax confinement as part of a long-term strategy of correctional management and control rather than as an immediate sanction for discrete rule violations.

In fact, many prisoners are placed in supermax not specifically for what they have done but rather on the basis of who someone in authority has judged them to be (e.g., "dangerous," "a threat," or a member of a "disruptive" group). In many states, the majority of supermax prisoners have been given so-called indeterminate terms, usually on the basis of having been officially labeled by prison officials as gang members. An indeterminate supermax term often means that these prisoners will serve their entire prison term in isolation (unless they debrief by providing incriminating information about other alleged gang members).[5] Prisoners in these units may complete their prison sentence while still confined in supermax and be released directly back into the community. If and when they are returned to prison on a parole violation or subsequent conviction, they are likely to be sent immediately back to supermax because of their previous status as a supermax prisoner.

To summarize: prisoners in these units live almost entirely within the confines of a 60- to 80-square-foot cell, can exist for many years separated from the natural world around them and removed from the natural rhythms of social life, are denied access to vocational or educational training programs or other meaningful activities in which to engage, get out of their cells no more than a few hours a week, are under virtually constant surveillance and monitoring, are rarely if ever in the presence of another person without being heavily chained and restrained, have no opportunities for normal conversation or social interaction, and are denied the opportunity to ever touch another human being with affection or caring or to receive such affection or caring themselves. Because supermax units typically meld sophisticated modern technology with the age-old practice of solitary confinement, prisoners experience levels of isolation and behavioral control that are more total and complete and literally dehumanized than has been possible in the past. The combination of these factors is what makes this extraordinary and extreme form of imprisonment unique in the modern history of corrections. Its emergence in a society that prides itself on abiding "evolving standards of decency" (*Trop v. Dulles*, 1958) to regulate its systems of punishment requires some explanation.

THE ORIGINS OF THE MODERN SUPERMAX

Two important trends in modern American corrections help to account for the creation of this new penal form. The first is the unprecedented growth in the prison population that started in the mid-1970s and continued into the early years of the 21st century. The rate of incarceration in the United States (adjusting for any increases in overall population) remained stable over the

50-year period from 1925 to 1975. Remarkably, it then quintupled over the next 25-year period. Most state prison systems doubled in size and then doubled again during this period, with no commensurate increase in the resources devoted to corrections in general or to programming and mental health services in particular (Haney & Zimbardo, 1998).

This dramatic influx of prisoners—and the overcrowding crisis it produced—occurred at approximately the same time that another important change was underway. In the mid-1970s, the United States formally abandoned its commitment to the rehabilitative ideals that had guided its prison policy for decades. Often at the insistence of the politicians who funded their prison systems, correctional administrators embraced a new philosophy built on the notion that incarceration was intended to inflict punishment and little else. The mandate to provide educational, vocational, and therapeutic programming in the name of rehabilitation ended at an especially inopportune time (Haney, 1997). Prisons throughout the country were filled to capacity and beyond, and the prisoners who were crowded inside had few opportunities to engage in productive activities or to receive help for preexisting psychological or other problems.

Under these conditions of unprecedented overcrowding and unheard of levels of idleness, prison administrators lacked positive incentives to manage the inevitable tensions and conflicts that festered behind the walls. In systems whose raison d'être was punishment, it was not surprising that correctional officials turned to punitive mechanisms in the hope of buttressing increasingly tenuous institutional controls. Of course, disciplinary infractions often were met with increasing levels of punishment in the modern American prison, even before these trends were set in motion. But the magnitude of the problem faced by correctional administrators in the 1980s pushed their response to an unprecedented level. Supermax prisons emerged in this context—seized on as a technologically enhanced tightening screw on the pressure cooker-like atmosphere that had been created inside many prison systems in the United States. As the pressure from overcrowding and idleness increased, the screw was turned ever tighter.

Historically, correctional polices often harden in times of prison crisis. But once the problem causing the increased tension or turmoil has been identified and resolved, the punitive response typically de-escalates, sometimes leading to even more hospitable conditions and treatment. Unfortunately, the prison overcrowding problem did not subside during the 1980s and 1990s, and the continued punitive atmosphere that marked this period meant that corrections officials were in no position look "soft" in the face of the crisis.

The politics of the era deprived prison administrators of alternative approaches and guaranteed a one-way ratcheting up of punishment in the face of these tensions. They became increasingly committed to more forcibly subduing prisoners whose behavior was problematic ("a threat to the safety and security of the institution"), taking fewer chances with others whom they suspected might be a problem, and set about intimidating everyone else who might be thinking about causing disruption. Supermax simultaneously provided politicians with another stark symbol to confirm their commitment to tough-on-crime policies (Riveland, 1999) and gave prison officials a way of making essentially the same statement behind the walls.

I belabor this recent correctional history to debunk several myths that surround the rise of the supermax prison form. This new kind of prison did not originate as a necessary or inevitable response or backlash to some sort of "permissive" correctional atmosphere that allegedly prevailed in the 1960s, as some who defend the recent punitive trends in imprisonment have suggested (cf. O'Brien & Jones, 1999). It was not a badly needed corrective to liberal prison policies or to previous capitulations to the prisoners' rights movement. Quite the opposite. Supermaxes began in response to the overcrowded and punitive 1980s and came into fruition in the even more overcrowded and more punitive 1990s. They are in many ways the logical extension of a system founded on the narrow premise that the only appropriate response to misbehavior is increased punishment.

In addition, there is no evidence that the rise of supermax prisons was driven by the threat of some new breed of criminal or prisoner. The natural human tendency to individualize, dispositionalize, and sometimes even to demonize problematic behavior, and to ignore the contextual forces that help create it, is intensified in prison systems as perhaps nowhere else. Thus, when correctional officials faced unprecedented pressures from dramatically increased levels of overcrowding and idleness, they naturally ignored the contextual origins of the problem (over which they had little or no control) and blamed the prisoners (over which they did).

But, even if supermax prisons now contain only "the worst of the worst"[6]—a phrase that is often used to justify the use of these newly designed units but whose accuracy is hotly disputed by their critics—there is no evidence that these allegedly "worst" prisoners are any worse than those who had been adequately managed by less drastic measures in the past. In assessing the benefits and burdens of supermax confinement, it is important to keep in mind that correctional officials have not been given a mandate to engage in such extraordinarily punitive and unprecedented measures because they now

confront not only an extraordinarily dangerous but new strain of prisoner that has never before existed. There is no such new breed and no such mandate.

THE PSYCHOLOGICAL PAINS OF SUPERMAX CONFINEMENT

In assessing the mental health concerns raised by supermax prisons, it is important to acknowledge an extensive empirical literature that clearly establishes their potential to inflict psychological pain and emotional damage. Empirical research on solitary and supermax-like confinement has consistently and unequivocally documented the harmful consequences of living in these kinds of environments. Despite some methodological limitations that apply to some of the individual studies, the findings are robust. Evidence of these negative psychological effects comes from personal accounts, descriptive studies, and systematic research on solitary and supermax-type confinement, conducted over a period of four decades, by researchers from several different continents who had diverse backgrounds and a wide range of professional expertise. Even if one sets aside the corroborating data that come from studies of psychologically analogous settings—research on the harmful effects of acute sensory deprivation (e.g., Hocking, 1970; Leiderman, 1962), the psychological distress and other problems that are created by the loss of social contact such as studies of the pains of isolated, restricted living in the free world (e.g., Chappell & Badger, 1989; Cooke & Goldstein, 1989; Harrison, Clearwater, & McKay, 1989; Rathbone-McCuan & Hashimi, 1982), or the well-documented psychiatric risks of seclusion for mental patients (e.g., Fisher, 1994; Mason, 1993)—the harmful psychological consequences of solitary and supermax-type confinement are extremely well documented.

Specifically, in case studies and personal accounts provided by mental health and correctional staff who worked in supermax units, a range of similar adverse symptoms have been observed to occur in prisoners, including appetite and sleep disturbances, anxiety, panic, rage, loss of control, paranoia, hallucinations, and self-mutilations (e.g., Jackson, 1983; Porporino, 1986; Rundle, 1973; Scott, 1969; Slater, 1986). 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 attitudes and affect (e.g., Bauer, Priebe, Haring, & Adamczak, 1993; Hilliard, 1976; Koch, 1986; Korn, 1988a, 1988b; Miller & Young, 1997; Suedfeld, Ramirez, Deaton, & Baker-Brown, 1982), insomnia (e.g., Bauer et al., 1993; Brodsky &

Scogin, 1988; Haney, 1993; Koch, 1986; Korn, 1988a, 1988b), anxiety (e.g., Andersen et al., 2000; Brodsky & Scogin, 1988; Grassian, 1983; Haney, 1993; Hilliard, 1976; Koch, 1986; Korn, 1988a, 1988b; Toch, 1975; Volkart, Dittrich, Rothenfluh, & Werner, 1983; Walters, Callagan, & Newman, 1963), panic (e.g., Toch, 1975), withdrawal (e.g., Cormier & Williams, 1966; Haney, 1993; Miller & Young, 1997; Scott & Gendreau, 1969; Toch, 1975; Waligora, 1974), hypersensitivity (e.g., Grassian, 1983; Haney, 1993; Volkart, Dittrich, et al., 1983), ruminations (e.g., Brodsky & Scogin, 1988; Haney, 1993; Korn, 1988a, 1988b; Miller & Young, 1997), cognitive dysfunction (e.g., Brodsky & Scogin, 1988; Grassian, 1983; Haney, 1993; Koch, 1986; Korn, 1988a, 1988b; Miller & Young, 1997; Suedfeld & Roy, 1975; Volkart, Dittrich, et al., 1983), hallucinations (e.g., Brodsky & Scogin, 1988; Grassian, 1983; Haney, 1993; Koch, 1986; Korn, 1988a, 1988b; Suedfeld & Roy, 1975), loss of control (e.g., Grassian, 1983; Haney, 1993; Suedfeld & Roy, 1975; Toch, 1975), irritability, aggression, and rage (e.g., Bauer et al., 1993; Brodsky & Scogin, 1988; Cormier & Williams, 1966; Grassian, 1983; Haney, 1993; Hilliard, 1976; Koch, 1986; Miller & Young, 1997; Suedfeld et al., 1982; Toch, 1975), paranoia (e.g., Cormier & Williams, 1969; Grassian, 1983; Volkart, Dittrich, et al., 1983), hopelessness (e.g., Haney, 1993; Hilliard, 1976), lethargy (e.g., Brodsky & Scogin, 1988; Haney, 1993; Koch, 1986; Scott & Gendreau, 1969; Suedfeld and Roy, 1975), depression (e.g., Andersen et al., 2000; Brodsky & Scogin, 1988; Haney, 1993; Hilliard, 1976; Korn, 1988a, 1988b), a sense of impending emotional breakdown (e.g., Brodsky & Scogin, 1988; Grassian, 1983; Haney, 1993; Koch, 1986; Korn, 1988a, 1988b; Toch, 1975), self-mutilation (e.g., Benjamin & Lux, 1975; Grassian, 1983; Toch, 1975), and suicidal ideation and behavior (e.g., Benjamin & Lux, 1975; Cormier & Williams, 1966; Grassian, 1983; Haney, 1993).

In addition, among the correlational studies of the relationship between housing type and various incident reports, again, self-mutilation and suicide are more prevalent in isolated housing (e.g., Hayes, 1989; Johnson, 1973; A. Jones, 1986; Porporino, 1986), as are deteriorating mental and physical health (beyond self-injury), other-directed violence, such as stabbings, attacks on staff, and property destruction, and collective violence (e.g., Bidna, 1975; Edwards, 1988; Kratcoski, 1988; Porporino, 1986; Sestoft, Andersen, Lilleback, & Gabrielsen, 1998; Steinke, 1991; Volkart, Rothenfluh, Kobelt, Dittrich, & Ernst, 1983). The use of extreme forms of solitary confinement in so-called brainwashing and torture also underscores its painful, damaging potential (e.g., Deaton, Burge, Richlin, & Latrownik, 1977; Foster, 1987; Hinkle & Wolff, 1956; Riekert, 1985; Shallice, 1974; Vrca, Bozikov, Brzovic, Fuchs, & Malinar, 1996; West, 1985). In fact, many

of the negative effects of solitary confinement are analogous to the acute reactions suffered by torture and trauma victims, including post-traumatic stress disorder or PTSD (e.g., Herman, 1992, 1995; Horowitz, 1990; Hougen, 1988; Siegel, 1984) and the kind of psychiatric sequelae that plague victims of what are called "deprivation and constraint" torture techniques (e.g., Somnier & Genefke, 1986).

To summarize, 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. The damaging effects ranged in severity and included such clinically significant symptoms as hypertension, uncontrollable anger, hallucinations, emotional breakdowns, chronic depression, and suicidal thoughts and behavior. Of course, it is important to emphasize that not all supermax prisons are created equal, and not all of them have the same capacity to produce the same number and degree of negative psychological effects. Research on the effects of social contexts and situations in general and institutional settings in particular underscores the way in which specific conditions of confinement do matter. Thus, there is every reason to expect that better-run and relatively more benign supermax prisons will produce comparatively fewer of the preceding negative psychological effects, and the worse run facilities will produce comparatively more.

THE PREVALENCE OF PAIN AND SUFFERING IN SUPERMAX

In addition to the serious nature and wide range of adverse symptoms that have been repeatedly reported in a large number of empirical studies, it is important to estimate their prevalence rates—that is, the extent to which prisoners who are confined in supermax-type conditions suffer its adverse effects. My own research at California's Pelican Bay "security housing unit" (or SHU)—a prototypical supermax prison at the time these data were collected—provides one such estimate. In this section, I describe this research in some detail and situate its findings by comparing them to prevalence rates among several other relevant groups.

In the Pelican Bay study, each prisoner was individually assessed in face-to-face interviews. Because the sample of 100 SHU prisoners was randomly selected, the data are representative of and, within appropriate margins of error, generalizable to the entire group of prisoners at this supermax facility.[7] The following two important areas were explored in each interview. In the

TABLE 1: Symptoms of Psychological and Emotional Trauma

Symptom	*% Presence Among Pelican Bay SHU Prisoners*
Anxiety, nervousness	91
Headaches	88
Lethargy, chronic tiredness	84
Trouble sleeping	84
Impending nervous breakdown	70
Perspiring hands	68
Heart palpitations	68
Loss of appetite	63
Dizziness	56
Nightmares	55
Hands trembling	51
Tingling sensation[a]	19
Fainting	17

NOTE: SHU = security housing unit.
a. Not necessarily a symptom of psychological trauma. It is included as a control question to provide a baseline against which to measure the significance of the trauma-related responses.

first, one series of questions focused on whether the prisoner experienced any of 12 specific indices of psychological trauma or distress. A list of those symptoms regarded as reliable indicators of general psychological distress was employed. They were essentially the same indices of distress that Jones (1976) and others have used to assess mainline prison populations. In the second, a different series of questions was designed to determine whether the prisoner suffered any of 13 specific psychopathological effects of isolation. Based on previous research conducted by Grassian (1983) and others (e.g., Brodsky & Scogin, 1988; Korn, 1988a, 1988b), a list of isolation-related symptoms was developed and used to assess each prisoner in this regard.

The results of this prevalence study are depicted in Tables 1 and 2. As Table 1 indicates, every symptom of psychological distress but one (fainting spells) was suffered by more than half of the representative sample of supermax prisoners. Two thirds or more of the prisoners reported being bothered by many of these symptoms in the SHU, and some were suffered by nearly everyone. For example, virtually all of the isolated prisoners were plagued by nervousness and anxiety, by chronic lethargy, and a very high percentage (70%) felt themselves on the verge of an emotional breakdown. In addition, a very high number suffered from headaches and troubled sleep, and more than half were bothered by nightmares. Well over half of the supermax prisoners reported a constellation of symptoms—headaches, trembling, sweaty palms, and heart palpitations—that is commonly associated with hypertension.

TABLE 2: Psychopathological Effects of Prolonged Isolation

Symptom	*% Presence Among Pelican Bay SHU Prisoners*
Ruminations	88
Irrational anger	88
Oversensitivity to stimuli	86
Confused thought process	84
Social withdrawal	83
Chronic depression	77
Emotional flatness	73
Mood, emotional swings	71
Overall deterioration	67
Talking to self	63
Violent fantasies	61
Perceptual distortions	44
Hallucinations	41
Suicidal thoughts	27

NOTE: SHU = security housing unit.

As Table 2 shows, the psychopathological symptoms of isolation were even more prevalent among these prisoners. Almost all of the supermax prisoners reported suffering from ruminations or intrusive thoughts, an oversensitivity to external stimuli, irrational anger and irritability, confused thought processes, difficulties with attention and often with memory, and a tendency to withdraw socially to become introspective and avoid social contact. An only slightly lower percentage of prisoners reported a constellation of symptoms that appeared to be related to developing mood or emotional disorders—concerns over emotional flatness or losing the ability to feel, swings in emotional responding, and feelings of depression or sadness that did not go away. Finally, sizable minorities of supermax prisoners reported symptoms that are typically only associated with more extreme forms of psychopathology—hallucinations, perceptual distortions, and thoughts of suicide.

To put both sets of figures in perspective, it is possible to compare these prevalence rates with those derived from other populations in which similar assessments have been made. For example, Dupuy, Engel, Devine, Scanlon, and Querec (1970) assessed some similar indices of psychological distress with a representative national probability sample of more than 7,000 persons. More recent data focusing on similar indices of psychopathology were collected in Epidemiologic Catchment Area Study (ECAS), a multisite study in which the diagnostic interview schedule (DIS) was used to assess the prevalence of psychiatric symptoms in the population at large (Robins & Regier,

1991). Finally, even more extensive comparisons are possible with another systematic study of the effects of living under isolated prison conditions—Brodsky and Scogin's (1988) research on prisoners confined in two maximum security protective custody units.

Table 3 contains a summary of the comparisons between the prevalence rates found in the two studies of nonincarcerated normal populations, Brodsky and Scogin's protective custody prisoners, and the supermax sample from Pelican Bay SHU (of course, along only those dimensions measured in each of the respective studies). The contrasts with the nonincarcerated normal samples are striking. As would be expected, in almost every instance, the prevalence rates for indices of psychological distress and psychopathology in the samples from the general population are quite low. The only exceptions were for anxiety and nervousness, which Dupuy et al. (1970) found in 45% of their normal sample, and depression, which Robins and Regier (1991) found in almost a quarter of the persons they assessed. Otherwise, the indices of distress and symptoms of psychopathology occurred in less than 20% of the nonincarcerated samples. On the other hand, in both of the isolated prisoner populations, the prevalence rates were well above 50% on virtually all of the measured dimensions. For certain symptoms, rates for the prisoner samples were five to ten or more times as high.

In fact, in both comparative and absolute terms, the prevalence rates were extremely high for the supermax prisoner sample and exceeded even those reported for the protective custody prisoners. Conditions of confinement for protective custody prisoners are in many ways similar to those in supermax confinement. That is, they are typically segregated from the rest of the prison population, restricted or prohibited from participating in prison programs and activities, and often housed indefinitely under what amount to oppressive and isolated conditions. Unlike supermax prisoners per se, however, many have some control over their status as protective custody (PC) prisoners (e.g., many have "volunteered" for this status) and, although they live under the stigma of being PC prisoners, they are technically housed in these units for protection rather than for punishment.

Accordingly, Brodsky and Scogin (1988) found high rates of psychological trauma among their sample of protective custody prisoners, so much so that they worried about the "strong potential for harmful effects" that such confinement represented (p. 279).[8] They also observed, in terms that apply equally well to supermax prisoners, that "when inmates are subjected to extensive cell confinement and deprivation of activities and stimulation, a majority can be expected to report moderate to serious psychological symptoms" (p. 279). Yet, note that on 16 of 18 possible comparisons, the symptom prevalence rate for Pelican Bay SHU prisoners are greater than those reported

TABLE 3: Comparison of Prevalence Rates Between In Normal, Protective Custody, and Supermax Populations

Description	*% Normal Dupuy, Engel, Devine, Scanlon, and Querec's (1970) National Probability Sample of 7,000 Adults*	*% Normal Robins and Regier's (1991) Multisite Assessment of 20,000 Adults*	*% Protective Housing Brodsky and Scoggin's (1988) Sample of 31 Prisoners in Protective Housing*	*% Supermax Haney's (1993) Random Sample of 100 Prisoners in Security Housing Unit*
Symptoms of psychological trauma				
Anxiety, nervousness	45		84	91
Headaches	13.7		61	88
Lethargy, chronic tiredness	16.8		65	84
Trouble sleeping	16.8		61	84
Impending breakdown	7.7		48	70
Perspiring hands	17		45	68
Heart palpitations	3.7		39	68
Dizziness	7.1		45	56
Nightmares	7.6		42	55
Hands trembling	7		39	51
Fainting			0	17
Psychopathological effects of isolation				
Ruminations			74	88
Irrational anger		2.9	71	88
Confused thought process		10.8	65	84
Chronic depression		23.5	77	77
Overall deterioration			52	67
Talking to self			68	63
Hallucinations		1.7	42	41

in the protective custody study. Note also that many of the percentage differences are comparatively large. In fact, the Pelican Bay prevalence rates are, on average, 14.5% greater than those reported for the prisoners in Brodsky and Scogin's study.

The prevalence data collected in the Pelican Bay study partially address another important supermax-related issue. Several mental health experts have written about a distinct set of reactions or a syndrome-like condition that occurs in prisoners who have been subjected to long-term isolation. Canadian psychiatrist George Scott (1969) described what he termed "isolation sickness" as coming from "prolonged solitary confinement" (p. 3). In more recent research, it has been labled "RES" (reduced environmental stimulation) or "SHU" (security housing unit) syndrome. Perhaps the most detailed clinical description of the disorder came from psychiatrist Stuart Grassian (1983), who observed that it included massive free-floating anxiety, hypersensitivity to external stimulation, perceptual distortions or hallucinations, derealization experiences, difficulties with concentration or memory, acute confusional states, aggressive fantasies, paranoia, and motor excitement (that may include violent or self-destructive outbursts).

Because the Pelican Bay prevalence study was not designed to directly diagnose SHU syndrome, prisoners were not questioned about literally each one of its indices. However, the study found that a very high percentage of Pelican Bay prisoners suffered many symptoms similar to the ones Grassian had identified. Specifically, a high percentage of prisoners in the present study reported suffering from heightened anxiety (91%), hyper-responsivity to external stimuli (86%), difficulty with concentration and memory (84%), confused thought processes (84%), wide mood and emotional swings (71%), aggressive fantasies (61%), perceptual distortions (44%), and hallucinations (41%). Moreover, fully 34% of the sample experienced all eight of these symptoms, and more than half (56%) experienced at least five of them.

THE SOCIAL PATHOLOGIES OF SUPERMAX

The Pelican Bay prevalence study and the other direct studies of the psychological effects of supermax confinement I cited earlier focused on discrete and measurable consequences of this form of imprisonment. The tools used to provide these measurements are extremely useful and scientifically appropriate methods for documenting specific reactions and symptoms. However, they have some inherent limitations that may mask some of the subtle yet important transformations that are brought about by supermax confinement.

For one, indices of measurable harm generally rely on things that persons must be aware of in order to report. Obviously, prisoners must be consciously pained or in distress over a symptom in order to complain about it; the greater their conscious awareness, the higher the frequency and extent of negative effects. However, in the course of adjusting and adapting to the painful and distressing conditions of confinement, many prisoners will strive to essentially "get used to it," adapting and accommodating to make their day-to-day misery seem more manageable. In addition, some supermax prisoners will undergo forms of psychological deterioration of which they are unaware and, therefore, incapable of reporting. As long as the deterioration is not obvious or disabling, it is likely to escape the attention of mental health staff who, in most units, rarely perform careful psychiatric assessments on a routine basis for prisoners who appear to be otherwise minimally functioning.

Indeed, it is not uncommon to encounter a number of supermax prisoners who, although they voice few specific complaints and are not identified by staff as having any noticeable psychological problems or needs, nonetheless have accommodated so profoundly to the supermax environment that they may be unable to live anywhere else. In some instances, these changes are difficult to measure because prisoners are unaware that they are occurring or because they have blunted their perception that such transformations are underway. In other instances, the changes are too broad, complicated, and subtle to be precisely measured. Yet they appear to have lasting mental health implications.

Thus, a number of significant transformations occur in many long-term supermax prisoners that, although they are more difficult to measure, may be equally if not more problematic for their future health and well-being and the health and well-being of those around them. These come about because in order to survive the rigors of supermax, many prisoners gradually change their patterns of thinking, acting, and feeling. Some of these transformations have the potential to rigidify, to become deeply set ways of being, that are, in varying degrees for different people, more or less permanent changes in who these prisoners are and, once they are released from supermax, what they can become. Because they do not represent clinical syndromes per se, and because they constitute patterns of social behavior that are largely "functional" under conditions of isolation—for the most part becoming increasingly dysfunctional only if they persist on return to more normal social settings—I have termed them "social pathologies."

Several of the social pathologies that can and do develop in prisoners who struggle to adapt to the rigors of supermax confinement are discussed below.

First, the unprecedented totality of control in supermax units forces prisoners to become entirely dependent on the institution to organize their exis-

tence. Although this is a potential consequence of institutionalization or "prisonization" in general (e.g., Haney, in press), it occurs to an exaggerated degree in many supermax prisons. Thus, many prisoners gradually lose the ability to initiate or to control their own behavior, or to organize their own lives. The two separate components of this reaction—problems with the self-control and self-initiation of behavior—both stem from the extreme over-control of supermax. That is, all prisoners in these units are forced to adapt to an institutional regime that limits virtually all aspects of their behavior. Indeed, one of the defining characteristics of supermax confinement is the extent to which it accomplishes precisely that. But because almost every aspect of the prisoners' day-to-day existence is so carefully and completely circumscribed in these units, some of them lose the ability to set limits for themselves or to control their own behavior through internal mechanisms. They may become uncomfortable with even small amounts of freedom because they have lost the sense of how to behave in the absence of constantly enforced restrictions, tight external structure, and the ubiquitous physical restraints.

Second, prisoners may also suffer a seemingly opposite reaction that is caused by the same set of circumstances. That is, they may begin to lose the ability to initiate behavior of any kind—to organize their own lives around activity and purpose—because they have been stripped of any opportunity to do so for such prolonged periods of time. Chronic apathy, lethargy, depression, and despair often result. Thus, as their personal initiative erodes, prisoners find themselves unable to begin even mundane tasks or to follow through once they have begun them. Others find it difficult to focus their attention, to concentrate, or to organize activity. In extreme cases, prisoners may literally stop behaving. In either event, it is hard to imagine a set of adaptations more dysfunctional and problematic for persons who will one day be expected to exercise increased self-control and self-initiative in mainline prison settings or in the free world, if and when they are released there.

Third, the absence of regular, normal interpersonal contact and any semblance of a meaningful social context creates a feeling of unreality that pervades one's existence in these places. 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.

Fourth, the experience of total social isolation can lead, paradoxically, to social withdrawal for some supermax prisoners. That is, they recede even more deeply into themselves than the sheer physical isolation of supermax has imposed on them. Some move from, at first, 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.

Fifth, and 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. Others channel their supermax-created anger in more premeditated ways. Many supermax prisoners ruminate in the course of the countless empty hours of uninterrupted time during which they are allowed to do little else. Some occupy this idle time by committing themselves to fighting against the system and the people that surround, provoke, deny, thwart, and oppress them. There are supermax prisoners who become consumed by the fantasy of revenge, and others lash out against those who have treated them in ways they regard as inhumane. Sadly, there are some supermax prisoners who are driven by these deprived and oppressive conditions to pursue courses of action that further ensure their continued deprivation and oppression.

Although I have described these social pathologies as separate and distinct adaptations, they are not mutually exclusive. Thus, prisoners may move through one or another adaptation to their extraordinarily stressful life in supermax, or engage in several at once in an attempt to reduce the pains of their confinement and to achieve a tolerable equilibrium in this otherwise psychologically hostile environment. In fact, in extreme cases and over a long period of time, a combination of seemingly adaptive responses may coalesce into a more or less permanent lifestyle, one lived so exclusively and with such commitment that the prisoner's very being seems to be transformed. For example, some supermax prisoners whose opportunities for self-definition and self-expression have been effectively suppressed for extended periods of time—who have been denied conventional outlets through which to use their intellect or to express their heightened sense of injustice—come increasingly to define themselves in opposition to the prison administration. They begin to gradually fashion an identity that is anchored primarily by the goal of thwart-

ing and resisting the control mechanisms that are increasingly directed at them. The material out of which their social reality is constructed increasingly consists of the only events to which they are exposed and the only experiences they are allowed to have—the minutiae of the supermax itself and all of the nuance with which it can be infused.

Just as the social pathologies of supermax are the creations of a socially pathological environment, taking prisoners out of these places often goes a long way in reducing or eliminating the negative effects. But there is good reason to believe that some prisoners—we do not yet know how many or, in advance, precisely who—cannot and will not overcome these social pathologies; their extreme adaptations to supermax confinement become too ingrained to relinquish. Those who are not blessed with special personal resiliency and significant social and professional support needed to recover from such atypical and traumatic experiences may never return to the free world and resume normal, healthy, productive social lives. These are extraordinary—I believe often needless and indefensible—risks to take with the human psyche and spirit. Such extreme, ultimately dysfunctional, but often psychologically necessary adaptations to supermax confinement underscore the importance of continuing to critically analyze, modify, and reform the extremely harsh conditions that produce them. Understanding how and why they occur also brings some real urgency to the development of effective programs by which prisoners can be assisted in unlearning problematic habits of thinking, feeling, and acting on which their psychological survival in supermax often depends.

But they also highlight another issue. In what is one of the core irrationalities in the logic on which supermax regimes are premised, these units make the ability to withstand the psychological assault of extreme isolation a prerequisite for allowing prisoners to return to the intensely social world of mainline prison or free society. In this way, prisoners who cannot "handle" the profound isolation of supermax confinement are almost always doomed to be retained in it. And those who have adapted all too well to the deprivation, restriction, and pervasive control are prime candidates for release to a social world to which they may be incapable of ever fully readjusting.

ADDITIONAL MENTAL HEALTH ISSUES IN SUPERMAX

In addition to the negative psychological effects of solitary and supermax-like confinement reviewed above, there are several other important mental health issues raised by the nature of these conditions and the policies by

which prisoners are placed in them. One such issue involves the number of mentally ill prisoners who are housed in supermax. Prisoners often describe their experience in supermax environments as a form of psychological torture; most of them are in varying degrees of psychic pain, and many of them struggle to cope with the daily stress of their confinement. Although in my experience, virtually everyone in these units suffers, prisoners with preexisting mental illnesses are at greater risk of having this suffering deepen into something more permanent and disabling. Those at greatest risk include, certainly, persons who are emotionally unstable, who suffer from clinical depression or other mood disorders, who are developmentally disabled, and those whose contact with reality is already tenuous. There is good reason to believe that many of these prisoners in particular will be unable to withstand the psychic assault of dehumanized isolation, the lack of caring human contact, the profound idleness and inactivity, and the otherwise extraordinarily stressful nature of supermax confinement without significant deterioration and decompensation.

How many such persons are there? Research conducted over the past several decades suggests that somewhere between 10% to 20% of mainline prisoners in general in the United States suffer from some form of major mental illness (e.g., Jamelka, Trupin, & Chiles, 1989; Veneziano & Veneziano, 1996). The percentages in supermax appear to be much higher. Although too few studies have been done to settle on precise estimates of mentally ill supermax prisoners, and the numbers undoubtedly vary some from prison system to prison system, the percentages may be as much as twice as high as in the general prisoner population.

For example, a Canadian study estimated that approximately 29% of prisoners in special handling and long-term segregation units suffered from "severe mental disorders" (Hodgins & Cote, 1991). A more recent study conducted by a group of Washington state researchers (Lovell, Cloyes, Allen, & Rhodes, 2000) found exactly the same thing: 29% of intensive management prisoners in the state's correctional system manifested at least one predefined indication of serious mental disorder (such as multiple admissions to an acute care mental care facility, or having been in one of the prison system's residential mental health units).

Why this overrepresentation? Unproblematic adjustment to prison requires conformity to rigidly enforced rules and highly regimented procedures. Many mentally ill prisoners lack the capacity to comply with these demands and they may end up in trouble as a result. If they are not treated for their problems, the pattern is likely to be repeated and eventually can lead to confinement in a supermax unit. As Toch and Adams (2002) have succinctly put it, "an unknown proportion of people who are problems (prove trouble-

some to settings in which they function) also have problems (demonstrate psychological and social deficits when they are subjected to closer scrutiny)" (p. 13). Prison systems that fail to realize this basic fact will end up blaming—and punishing—prisoners for manifesting psychological conditions for which they should have been treated. Especially for prison systems that lack sufficient resources to adequately address the needs of their mentally ill mainline prisoners, disciplinary isolation and supermax confinement seems to offer a neat solution to an otherwise difficult dilemma. In such systems, supermax becomes the default placement for disruptive, troublesome, or inconvenient mentally ill prisoners. Thus the presence of a disproportionately high number of mentally ill prisoners in supermax often reflects a failure of system-wide proportions.

A number of supermax prisons fail to adequately screen out prisoners with preexisting mental illness, and fail to remove those whose mental health problems worsen under the stress of the extreme isolation, deprivation, and forceful control they confront inside. In addition, many of the units fail to appreciate the potential for these kinds of conditions of confinement to produce psychopathology in previously healthy prisoners. These problems are exacerbated by the fact that even if mental health staff members manage to identify those prisoners with serious psychological and psychiatric needs, many supermaxes are uniquely ill-suited to address them. Not only are they likely to be staffed with too few treatment personnel and plagued by high turnover, but the extraordinary and unyielding security procedures that characterize these kinds of prisons often preclude meaningful and appropriate therapeutic contact.

Thus, supermax prisoners who are in acute distress typically have the option of receiving what is euphemistically called "cell front therapy" in which they can discuss intimate, personal problems with mental health staff who cannot easily see or hear them through the cell doors (unless they speak so loudly that other prisoners in the housing unit also can listen in). Or they can choose to undergo strip searches, be placed in multiple restraints (which are typically left on throughout the therapy session), and taken either to a counselor's office (where correctional officer escorts are often stationed close enough to overhear what is being said) or special rooms fitted with security cages in which the prisoner is placed to be counseled by a therapist who speaks to them through wire screening of the cage. Or, in some places they can submit to "tele-psychiatry" sessions in which disembodied images attempt to assess and address their problems from distant locations. Not surprisingly, under these circumstances many prisoners fail to ask for help or reject it when it is offered.

A separate but related problem pertains to the group of prisoners who, although they do not suffer from preexisting mental illness, nonetheless are

psychologically damaged by the extreme situational stress to which they are subjected in supermax. There is much reason to believe that supermax confinement may produce psychopathology in certain persons who otherwise would not have suffered it. For example, a study of Danish prisoners found that for prisoners who remained in solitary confinement for longer than 4 weeks "the probability of being admitted to the prison hospital for a psychiatric reason was about 20 times as high as for a person [in a mainline prison]" (Sestoft et al., 1998, p. 103), leading the researchers to conclude that "individuals detained [in solitary confinement] are forced into an environment that increases their risk of hospitalization...for psychiatric reasons" (p. 105).

Finally, as I earlier alluded, many of the psychological and psychiatric reactions created or exacerbated by supermax confinement may persist long after a prisoner has been released into the mainline population or freed from incarceration altogether. In addition, even among prisoners who suffer no readily identifiable set of psychological symptoms, the social pathologies of supermax confinement may significantly interfere with long-term adjustment. To date, most supermax prisons appear oblivious to these persistent problems and many offer no meaningful counseling or transitional programs at all to prisoners who are attempting to make the daunting adjustment from near total isolation to an intensely social existence.

These interrelated problems—that prisoners suffering from preexisting mental illnesses are overrepresented in supermax, that the pains of supermax confinement are too severe for many prisoners to withstand, and that many of the psycho- and social pathologies of supermax confinement have disabling long-term consequences—have several important correctional policy implications. In particular, procedures must be implemented for screening prisoners in advance of their transfer to supermax (so that mentally ill and otherwise vulnerable persons are never placed there in the first place). In addition, because the mental health needs of any supermax prisoner can become acute and substantial at any time, prison systems need to be fully prepared to adequately address them (setting aside the obvious question of whether anyone can and should, in a humane system, be housed in such environments in the first place).

This also means that supermax prisons must implement careful psychiatric monitoring of all prisoners during their confinement and have readily accessible procedures in place for the removal of any prisoner at the first sign of deterioration. Given the fact that supermax prisoners behave so little—they are not permitted to actually do much of anything—the opportunities for disturbed behavior to be observed by staff are extremely limited. If monitoring is done passively, as it often is, only the most flagrant cases are likely to come to anyone's attention. Mental health staff who walk through supermax

housing units, pausing briefly at each cell to ask prisoners how they are doing or to pose some other equally superficial, pro forma inquiry are not engaging in careful psychiatric screening. In light of the psychological risks posed by this environment and the widely shared reluctance of these prisoners to admit vulnerability, the regular and in-depth evaluation of supermax prisoners should be regarded as the only acceptable and truly effective form of monitoring.

Finally, supermax units should be required to provide extensive mental health resources that are specifically targeted to ease the psychological pains of this kind of confinement and the extremely difficult transitions that typically follow it. Supermax prisoners must enter so-called de-escalation or step-down programs well in advance of their release, and the programs themselves must grapple seriously and forthrightly with the negative psychological changes that supermax confinement often brings about. This will require prison systems that are in denial about the issues reviewed in the preceding pages to overcome it, and to acknowledge and confront the psychological consequences of housing prisoners under conditions that pose such significant mental health risks. Attempts to provide these kinds of transitional services through programs that are delivered without genuine interpersonal interaction and social contact—some systems actually use videotapes that supermax prisoners watch alone in their cells, supposedly to reacquaint them with the social world they are about to reenter—will prove to be painfully inadequate. Moreover, like all meaningful mental health and counseling services, these transitional programs must be made available to prisoners under genuinely therapeutic conditions that foster some degree of privacy, trust, and supportive social interaction.

THE LEGAL REGULATION OF SUPERMAX

Because supermax prisons are of relatively recent origin, their constitutionality—the question of whether the conditions of confinement in this new prison form represent cruel and unusual punishment—has been tested in only a few important cases. In this section, I review the three most important legal challenges to supermax confinement and examine the implications of the way in which the courts have responded in each. Judges in all three cases recognized the need for some form of segregated housing in correctional settings, emphatically acknowledged—with varying degrees of clarity and scope—the potential psychological harms of supermax-type confinement, and explicitly prohibited certain categories of prisoners from being housed under such conditions.

The first such case, *Madrid v. Gomez* (1995), addressed conditions of confinement in California's Pelican Bay Security Housing Unit, the site at which my earlier reported research was conducted. The judge was candid and critical in his assessment of the conditions of confinement in the California supermax. He pointed to the "stark sterility and unremitting monotony" of the interior of the prison itself, was concerned about the fact that prisoners "can go weeks, months or potentially years with little or no opportunity for normal social contact with other people," and commented that the sight of prisoners in the barren exercise pens to which they were restricted creating an image "hauntingly similar to that of caged felines pacing in a zoo" (p. 1229).

He found further that "many, if not most, inmates in the SHU experience some degree of psychological trauma in reaction to their extreme social isolation and the severely restricted environmental stimulation in the SHU" (p. 1235). Indeed, the court's opinion acknowledged that "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" (p. 1230). He concluded that Pelican Bay inflicted treatment on prisoners that, in his words, "may well hover on the edge of what is humanly tolerable for those with normal resilience, particularly when endured for extended periods of time" (p. 1280).

However, although the judge in *Madrid* also found that overall conditions in the supermax units were "harsher than necessary to accommodate the needs of the institution" (p. 1263), he concluded that he lacked any constitutional basis to close the prison or even to require significant modifications in many of its general conditions. Instead, he barred certain categories of prisoners from being sent there because of the tendency of the facility to literally make them mentally ill or significantly exacerbate preexisting mental illness. In particular, he limited the class of prisoners to be protected from these harms to the mentally ill and those prisoners who were at an unreasonably high risk of suffering a serious mental illness as a result of the conditions (including prisoners diagnosed as chronically depressed, brain damaged, and developmentally disabled).[8] Finally, the judge emphasized that the record before him pertained to prisoners who had been in supermax for no more than a few years and that longer term exposure might require a different result.[9]

In the second significant case to examine conditions of confinement in supermax-like settings, *Ruiz v. Johnson* (1999), a federal district court reached even more sweeping legal conclusions than the judge had in *Madrid*. For nearly 30 years, the *Ruiz* court had overseen the sweeping reform of the Texas prison system. Starting with a landmark opinion in 1980 in which the entire Texas prison system was declared unconstitutional (*Ruiz v. Estelle*,

1980), an extensive number of court-ordered changes had been implemented. Hoping to end this judicial oversight, the state petitioned to terminate the court's jurisdiction, arguing that a sufficient number of reforms had been made in the Texas prison system and that no unconstitutional conditions of confinement remained. The federal court agreed on some counts but disagreed emphatically on others.

Conditions of confinement in Texas's "administrative segregation" or "high security" units were a major part of this round of the *Ruiz* litigation. Despite acknowledging significant improvements in many other areas of the state's prison system, the court ruled that its disciplinary lockup units still operated below constitutionally minimum standards. In particular, the judge ruled that the "extreme deprivations and repressive conditions of confinement" of the administrative segregation units constituted cruel and unusual punishment "both as to the plaintiff class generally and to the subclass of mentally ill inmates housed in such confinement" (p. 861). Indeed, the judge concluded that "more than mere deprivation," the prisoners in these units "suffer actual psychological harm from the almost total deprivation of human contact, mental [stimulation], personal property and human dignity" (p. 913).

The judge also understood that the psychological harm inflicted by long-term supermax confinement could result in mental illness, even among those prisoners not previously afflicted. Thus, the court concluded that "Texas's administrative segregation units are virtual incubators of psychoses—seeding illness in otherwise healthy inmates and exacerbating illness in those already suffering from mental infirmities" (p. 907). The judge was clear and decisive in his ruling, writing that "it is found that administrative segregation is being utilized unconstitutionally to house mentally ill inmates—inmates whose illness can only be exacerbated by the depravity of their confinement" (p. 915).

He further speculated about why prison officials, who were clearly aware of these conditions and cognizant of the "inmates' ensuing pain and suffering" might maintain such a system. Whatever the cause—including the possibility that the officials labored under what he termed "a misconception of the reality of psychological pain"—the judge condemned the fact that the prison system had "knowingly turned its back on this most needy segment of its population" (p. 914).[10]

The final and most recent case, *Jones 'El v. Berge* (2001), presented a somewhat narrower issue but resulted in a similarly strong ruling. In this case, a federal district court in Wisconsin granted prisoners' motion for injunctive relief on the grounds that seriously mentally ill prisoners were at risk of irreparable emotional damage if the state continued to confine them in its supermax facility. The court concluded that the

> extremely isolating conditions in supermaximum confinement cause SHU Syndrome in relatively healthy prisoners who have histories of serious mental illness, as well as prisoners who have never suffered a breakdown in the past but are prone to break down when the stress and trauma become exceptionally severe. (pp. 1101-1102)

The court found further that

> credible evidence indicates that Supermax is not appropriate for seriously mentally ill inmates because of the isolation resulting from the physical layout, the inadequate level of staffing and the customs and policies. Supermax was designed to house especially disruptive and recalcitrant prisoners but not mentally ill ones. (p. 1118)

The judge ordered several prisoners to be removed from the supermax facility. In addition, she required mental health professionals to evaluate several categories of prisoners among those who remained, and if any of them were determined to be seriously mentally ill, she ordered that they be transferred out of supermax.

In each of these three cases in which federal district courts were presented with evidence of the psychological effects of supermax confinement, they acknowledged the significant psychological risks it posed, expressed strongly worded concerns about the constitutionality of exposing prisoners to these conditions for long periods of time, and expressly prohibited the use of supermax for certain categories of prisoners (in particular, those with preexisting histories of mental illness, and those likely to become mentally ill in the course of their solitary confinement).

CONCLUSION

Supermax prisons inflict varying amounts of psychological pain and emotional trauma on prisoners confined in them. The range of psychopathological reactions to this form of confinement is broad, many of the reactions are serious, and the existing evidence on the prevalence of trauma and symptomatology indicates that they are widespread. The mental health risks posed by this new form of imprisonment are clear and direct, exacerbated by the tendency of correctional systems to place a disproportionate number of previously mentally ill prisoners in supermax confinement, to ignore emerging signs of mental illness among the supermax prison population, and to fail to provide fully adequate therapeutic assistance to those prisoners who are in psychic pain and emotional distress.

It is important to reflect on whether the psychologically destructive conditions to which prisoners in supermax prisons are exposed would be countenanced for any other group in our society. Indeed, revelations that mental patients or elderly nursing home residents have been subjected to punitive isolation are understandably followed by widespread public outcry. Similarly, when typically more psychologically resilient populations have been taken as prisoners of war or as hostages subsequently held in isolation, recognition of the adverse psychological consequences is immediate and generates broad concern. Support for providing psychiatric counseling to the victims of these kinds of traumatic experiences is unquestioned.

The fact that no such recognition and concern is typically extended to prisoners in supermax confinement whose experiences in captivity may be comparable or worse, and of longer duration, raises disturbing questions: Do we allow what we believe to be their blameworthiness for this kind of mistreatment—that they earned it, they deserve it, they asked for it—to blur our understanding of the consequences of the mistreatment itself? That is, has devaluing the prisoners' claim to be free from such harm led to the erroneous perception that the harm is not real? If so, the empirical evidence suggests that we have made a grievous mistake.

I believe that the overwhelming evidence of the negative psychological effects of many forms of long-term supermax confinement provides a strong argument for placing enhanced correctional and legal limits on the use of this new prison form and carefully scrutinizing all aspects of its operation and effect (e.g., Haney & Lynch, 1997, pp. 558-566). As I noted earlier, there are better and worse supermax prisons, and we should take steps to ensure that all such facilities implement the best and most humane of the available practices. In general, far more careful screening, monitoring, and removal policies should be implemented to ensure that psychologically vulnerable—not just mentally ill—prisoners do not end up in supermax in the first place, and that those who deteriorate once there are immediately identified and transferred to less psychologically stressful environments. In addition, prison disciplinary committees should ensure that no prisoner is sent to supermax for infractions that were the result of preexisting psychiatric disorders or mental illness.[11]

Moreover, harsh supermax conditions of confinement themselves must be modified to lessen their harmful effects. That is, it is important to recognize that placing people in conditions of confinement that we know in advance are likely to psychologically harm and endanger them cannot be morally justified merely through assurances that, if and when they do deteriorate, the prison system will make a good faith effort to identify the damage and work reasonably diligently to repair it. Thus, meaningful activities and program-

ming—including access to therapy, work, education, and recreation—should be afforded all supermax prisoners to prevent deterioration, and out-of-cell time should be maximized within the limits of correctional resources. To prevent the total atrophy of social skills and the deterioration of social identities, supermax prisoners should be afforded some form of meaningful collective activity and opportunities for normal social interaction (that includes contact visiting).

Finally, strict time limits should be placed on the length of time that prisoners are housed in supermax. No prisoner should be subjected continuously to even these modified conditions of supermax-like confinement for longer than a period of 2 years, no prisoner should ever be subjected to indeterminate supermax terms for any reason, and no prisoner should be sent to supermax solely on the basis of alleged gang membership in the complete absence of other overt behavioral infractions. Indeed, the units themselves should be organized around the goal of rapid return and reintegration and judged on the basis of their ability to release rather than retain prisoners. Once prisoners are about to be released from supermax confinement, they should be afforded transitional or step-down programming to accustom them to the kind of environment to which they will be sent (mainline prison housing or the free world). Moreover, given the likely long-term effects of such confinement, these transitional programs and services should be continued after the prisoner has been transferred from supermax.

Correctional administrators, politicians, legal decision makers, and members of the public eventually may decide that the harm that supermax prisons inflict is worth the benefit that they arguably beget and that the pains of such confinement are the regrettable but unavoidable price of an otherwise justified policy. However, there are very serious psychological, correctional, legal, and even moral issues at the core of this calculation that are worthy of serious, continued debate. This debate has hardly begun and, in most instances, it has hardly been informed by the empirical record that I have cited in the preceding pages.

Many scholars who have studied supermax prisons—myself included—doubt the validity of the claims that are made on their behalf,[12] and believe that in any event many of the publicly asserted goals of this new form of imprisonment can be achieved through less psychologically onerous and invasive alternatives. Yet, whatever one concludes about the value of supermax prisons in achieving these goals, it represents only one term in a more complex equation. The important determination of what, if any, legitimate role this kind of imprisonment should have in an effective and humane prison system can only be made with its psychological effects clearly in mind. The best available evidence indicates very clearly that many

supermax-like conditions of confinement inflict extraordinary levels of psychological pain and create substantial mental health risks. We should not continue to ignore, overlook, or minimize these data in this continuing and important debate.

NOTES

1. I have chosen to use the more encompassing term *supermax prison* even though it is rarely used as the official designation for such places. Different prison systems use different terminology to refer to these kinds of units. For example, the program at Marion Penitentiary generally regarded as having given rise to the supermax design was referred to as the "control unit." Arizona's supermax units are called "special management units" or "SMUs"; in California, they are known as "security housing units," or "SHUs"; in Texas, they are "high security units"; Washington State employs the term "intensive management unit" or "IMU," whereas New Mexico prefers "special controls unit" or "SCU." Although penologist Chase Riveland (1999) was correct to conclude that "there is no universal definition of what supermax facilities are and who should be in them" (p. 4), most of these units, whatever they are called, have enough distinctive features in common to be analyzed together.

2. Few "isolation" units, including supermax prisons, have been able to successfully prevent literally all forms of interpersonal communication. Of necessity, prisoners in solitary confinement must have some form of regular and routine contact with staff. In addition, the physical layouts of most such units—adjoining cells connected by plumbing, heating vents, and ventilation ducts—typically allow for some minimal form communication between prisoners (however strained and denatured the "interaction" may be and however inventive prisoners must be to bring it about).

3. Long-term solitary confinement was once a standard feature of imprisonment. But by the last decade of the 19th century, it essentially had been abandoned (see Haney & Lynch, 1997, pp. 481-496). In 1890, U.S. Supreme Court Justice Miller (*Re Medley*, 1890), summarized the preceding hundred years of experience with this kind of punishment by noting, "There were serious objections to it . . . and solitary confinement was found to be too severe." To illustrate, he also provided this account of its psychological effects:

> 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; although 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. (p. 168)

4. In some jurisdictions, overcrowding in these units has forced prison officials to double-cell supermax prisoners. In a sense, this kind of confinement leaves prisoners simultaneously and paradoxically isolated and overcrowded.

5. Most states conduct periodic reviews of such indeterminate sentences. But the reviews are typically pro forma and continued supermax placement is virtually always authorized. Since the initial decision about a prisoner's status as a gang member is based entirely on the judgement of staff members, and since these judgements rarely if ever change, continued and indefinite supermax placement is essentially assured. See Tachiki (1995) for a more detailed discussion of this issue.

6. What, exactly, qualifies a prisoner to be considered one of the so-called "worst of the worst" has never really been clarified in correctional policy or constitutional decision making. Nonetheless, correctional administrators (e.g., Hershberger, 1998) and even some federal judges talk about the category as though it was unproblematic to define and apply. For example, "Common sense, moreover, tells us that the prisoners in the disciplinary unit of a maximum security prison are apt to be the worst of the worst and that guards must therefore use more repressive methods in dealing with them" (*Cooper v. Casey*, 1996, p. 918). See, also, *Jones 'El v. Berge* (2001): "Supermax Correctional Institution is a 500 bed supermaximum security facility in Boscobel, Wisconsin, designed to incarcerate the worst of the worst offenders" (p. 1099). However, as another federal judge correctly observed, "this concept has proven difficult to operationalize" (*Austin v. Wilkinson*, 2002, p. 723). Critics have questioned the use of this terminology and worry that its vagueness leads repeatedly to overclassification and the blanket justification for harsh treatment. When it is applied to prisoners solely on the basis of alleged gang affiliation or in response to disciplinary infractions that, in at least some instances, appear to stem more from mental illness than willful propensities on the part of the prisoner, it seems particularly questionable and subject to abuse. See, for example, DeMaio (2001) and Tachiki (1995).

7. Random sampling of prisoners permits the sample statistics to be generalized to the characteristics of the entire SHU population, within a margin of error associated with the particular estimate. This margin of error is a function of both the size of the sample (in this case, 102) and the specific sample percentage being generalized. For example, at the 95% confidence level (the level ordinarily used in academic and scientific writing), the margin of error for this sample is somewhere between ±6% to 10%, depending on the specific sample percentage. The more even the percentage split (i.e., 50%), the closer to the higher limit (in this case ±10%) the margin of error will be.

8. In a key passage in the opinion, the judge (*Madrid v. Gomez*, 1995) limited his ruling in this way:

> While a risk of a more serious [mental] injury is not non-existent, we are not persuaded, on the present record and given all the circumstances, that the risk of developing an injury to mental health of *sufficiently serious magnitude* due to current conditions in the SHU is high enough for the SHU population as a whole, to find that current conditions in the SHU are *per se* violative of the Eighth Amendment with respect to all potential inmates. (p. 1265)

9. He wrote, "We emphasize, of course, that this determination is based on the current record and data before us. We can not begin to speculate on the impact that Pelican Bay SHU conditions may have on inmates confined in the SHU for periods of 10 or 20 years or more; the inmates studied in connection with this action had generally been confined to the SHU for three years or less" (*Madrid v. Gomez*, 1995, p. 1267).

10. A short time later in the opinion, the judge was equally pointed in his analysis:

> As the pain and suffering caused by a cat-o'-nine-tails lashing an inmate's back are cruel and unusual punishment by today's standards of humanity and decency, the pain and suffering caused by extreme levels of psychological deprivation are equally, if not more, cruel and unusual. The wounds and resulting scars, while less tangible, are no less painful and permanent when they are inflicted on the human psyche. (p. 914)

11. It is important not to be naïve about vague recommendations like "screening, monitoring, and removal." The utility of these reforms turns entirely on the way in which they are actually implemented. For example, if mental health personnel must always defer to the judgements of custodial staff, are under pressure to admit or retain prisoners in supermax whom they believe should not be there, are inadequately trained to recognize vulnerabilities to isolation-related

stressors, or predisposed to attribute psychiatric complaints to preexisting character disorders (and thereby dismiss them), then the reforms will help to ameliorate the harms of supermax very little or not at all.

12. For example, "Not one of the state supermax prisons, however, is necessary, and all are a grave error in the sad tale of man's brutality to man" (Kurki & Morris, 2001, p. 421); "Where prison regimes are so depriving as those offered in most supermax facilities, the onus is upon those imposing the regimes to demonstrate that this is justified. . . . To the best of my knowledge, no convincing demonstration has yet been provided" (King, 2000, p. 182); "Supermaxes have to justify or modify the draconian strictures that typically prevail at entry into the setting. The argument that such strictures are required as an incentive for promotion to a less sensorily-deprived environment is specious because less onerous gradations of conditions would serve the same ends" (Toch, in press).

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Solitary Confinement: Can the Courts Get Inmates out of the Hole?

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Mariam Hinds and John Butler

Solitary Confinement: Can the courts Get Inmates out of the Hole?

Mariam Hinds & John Butler*

In the last several years, solitary confinement has leapt to the attention of lawmakers, prisoner rights advocates, and the media. Disturbing accounts of prisoners who have been in solitary confinement for ten, twenty, even thirty years in California prisons have begun to emerge and demand the public's attention. With the judicial, legislature, and executive branches all beleaguered by cases, bills, reforms, and proposals for amending the State's solitary confinement practices, California stands on the precipice of a major reform movement. But the type of reform that California should aspire to achieve is not that often produced by the courts. Historically, in cases challenging solitary confinement, the courts have tailored their remedies to address the specific injury that violates the plaintiffs' constitutional rights. Rather than slowly chipping away at solitary confinement through endless litigation in the courts, structural reform should be pursued through the legislative and executive branches of government. By learning lessons from other states such as Maine, New York, and Colorado who have successfully reformed their solitary confinement practices, California can become a leader in the humane and fair treatment of its prison population.

Introduction

Historically believed to be a method for encouraging offenders to repent for their sins and rehabilitate, solitary confinement is now used as a tool for controlling, managing, and punishing inmates in prisons. As awareness of the conditions in solitary confinement emerge—extreme sensory deprivation, exceptionally restricted movement, limited access to showers and other basic materials—a movement has grown in California calling for a reexamination of both the routine use of solitary confinement as a management tool as well as the policies and practices that govern how inmates are assigned to, live in, and exit solitary confinement. This movement has been bolstered by emerging studies and research verifying the deleterious effects that solitary confinement has on the mental and physical health of inmates as well as by personal accounts of prisoners who have gone decades without so much as touching another human being's hand because of their assignment to solitary confinement.

As in cases where the constitutional rights of a population are threatened, the courts have become the primary vehicle for attacking the use of solitary confinement in California. Inmates have filed lawsuits against the California Department of Corrections and Rehabilitation ("CDCR") and have won some victories but also suffered some defeats. Dissatisfied with the lack of progress, hunger strikes have broken out, including the most recent which involved over 30,000 inmates refusing food across California's prisons. Faced with lawsuits, growing discontent amongst prisoners, and an increasingly engaged public, California stands on the precipice of a fundamental reexamination of solitary confinement as a penological tool.

But what type of change will suffice? This Note argues that piecemeal reform of solitary confinement is insufficient for addressing the constitutional violations that pervade it. Because the courts have typically crafted remedies that are narrowly tailored to address only the very specific injury alleged by inmates in solitary confinement cases, we argue that the courts are insufficient for creating structural reform to California's solitary confinement practices. Reformers seeking structural change to solitary confinement practices should instead focus their efforts on the executive and legislative branches as the primary units of change. In the states where large-scale reform of solitary confinement has been successful, it has been driven by an executive administration responding to a crisis, or a legislative push, motivated by political pressure. Litigation has been useful for increasing visibility of the cause, and thus increasing the potential for political pressure, but court-ordered remedies have not been sufficient to address the structural inadequacies of solitary confinement practices.

This Note proceeds in six parts. Part I provides a brief history of the emergence of solitary confinement as a penological tool, tracing its evolution from a religion-based form of repentance to a tool of management and control. Part II discusses how solitary confinement is utilized in practice, addressing the conditions in solitary confinement, who ends up in solitary confinement, and how they emerge from it. Part III explores the impact that solitary confinement has on inmates by considering studies and research that investigate its efficacy and effect on inmates. Part IV surveys the legal

cases that have been brought challenging solitary confinement, specifically noting the narrowness of the remedy. In Part V, we consider efforts in other states that have resulted in structural reform of their solitary confinement practices. Finally, in Part VI, we provide recommendations for effectuating structural reform to California's solitary confinement practices.

I. Historical Background

The modern notion of solitary confinement emerged in the United States as a result of a penological revolution led by American Quakers in the 19th century that resulted in the development of penitentiaries.[1] Believing that society (and its accompanying vices) was responsible for corrupting the individual, isolation from the community through imprisonment was determined to be the most effective means of rehabilitating the offender.[2] "In forced isolation, prisoners would have nothing to do but consider the evil of their prior bad acts, repent, and reform themselves."[3] Therefore, isolation in penitentiaries replaced the infliction of pain (whipping, for example) and shaming as the primary modes of punishment.[4]

The first solitary confinement cells were constructed in 1790 at the Walnut Street prison in Philadelphia and featured sixteen eight by six by ten foot cells designed to house the most serious and wicked offenders in complete isolation.[5] Prisoners were isolated for the entire duration of their sentences and "permitted to speak with only a limited number of prison guards and a few preselected visitors."[6] Prisoners did not know their fellow inmates' identities and "extreme measures," such as covering prisoners' heads with hoods, were used to maintain this system of isolation.[7] "This lonely asceticism, presumably, would give the prisoners of Walnut Street time to rethink their lives, and meditate on self-improvement."[8] In other words, it would give them time to repent.

However, despite its promising philosophy, the deleterious effects of solitary confinement soon emerged. Reports of prisoners going insane, committing suicide, lapsing into catatonic states, and displaying an inability to function began to appear, and by the early- to mid-nineteenth century, the routine use of solitary confinement was abandoned because of these adverse consequences.[9] But while sentences served exclusively in solitar confinement were not routinely imposed, serving time in isolation for a limited duration still occurred.[10] For example, a prisoner facing the death sentence may serve the final months before his execution in solitary confinement or an additional punishment of time in solitary confinement may be imposed on a repeat offender.[11] By the beginning of the twentieth century, "[l]ong-term solitary confinement was no longer commonplace," and it was primarily "reserved as punishment for prison infractions."[12]

This trend reversed dramatically when the federal government opened two prisons designed exclusively to house the nation's worst offenders—Alcatraz Prison in 1934 and the United States Penitentiary in 1963.[13] Both facilities relied heavily on segregation to manage and control these offenders.[14] States soon began replicating the federal government, especially beginning in the late twentieth century when the nation experienced a rapid explosion in its prison population.[15] In California, during the 1980s and 1990s, the prison population increased at a significantly faster rate than the state's population as a whole.[16] The prison population grew so rapidly that it quickly outstripped the number of available prison beds, and prison construction projects failed to keep up with the growth.[17] This led to "extreme overcrowding" and "serious management and control problems" resulting from the reintroduction of solitary confinement.[18] Yet prison administrators believed that order could be maintained despite overcrowding if troublesome prisoners could be segregated from the general population.[19] This philosophy was especially popular amongst officials managing gang membership and violence within the prison. During this period, "the rise in power of prison gangs . . . made supermax facilities increasingly popular."[20]

In addition to using solitary confinement as a means for controlling gangs within the prisons, California prison officials argued that solitary confinement was necessary to manage a new, more violent type of offender.[21] Prisoners were depicted as "rapacious monsters" who were more dangerous and more aggressive than their predecessors.[22] "In response, a penal philosophy . . . has emerged in which prison systems are now using *long-term* solitary confinement as a proactive policy of management and control."[23]

II. Practice

A. What Is Solitary Confinement?

The California Department of Corrections and Rehabilitation ("CDCR") does not recognize "solitary confinement" as a term or concept.[24] Rather, CDCR classifies and reports the number of inmates in "single-cell" housing.[25] The classification "single-cell" housing covers a wide array of inmates including people in segregation housing units (SHUs), Administrative Housing Units (ASUs), or the general population.[26] It includes people who are housed in single-cell units voluntarily and involuntarily.[27] Additionally, some inmates in SHUs are housed with another person but still subject to the harsh conditions and regulations typically associated with solitary confinement.

CDCR's classification system makes it difficult to draw broad generalizations about the conditions of solitary confinement in California. However, in examining the conditions at Pelican Bay State Prison—the facility that accounts for the largest number of single-cell housing cells in the state—a general picture of solitary confinement begins to emerge.

Opened on October 1, 1989, Pelican Bay State Prison was, as Governor George Deukmejian boasted, "a state-of-the-art prison that will serve as a model for the rest of the nation."[28] It was "[t]he first supermax prison, built solely to house prisoners in segregation."[29] Sprawling across 270 acres in Crescent City, California, Pelican Bay is considered "a modern prison [that] employes cutting-edge technology and security devices."[30] The prison consists of eight-cell "pods" with four 500-foot corridors.[31] Armed control booth officers monitor each set of corridors from a central control room.[32] They monitor inmates via video cameras, and there are in-cell speakers and microphones for communication with control booth officers.[33] Three locked doors separate a prisoner from an armed control booth officer, and all the cell doors are controlled electronically.[34]

Figure 1: Administrative Segregation Unit at Mule Creek State Prison

SHU cells remain locked for twenty-two and one-half hours per day.[35] SHU inmates exercise for at most one and one-half hours per day in a space measuring twenty-eight by twelve feet.[36] When leaving their cells, they are escorted by two armed guards and wear waist restraints and handcuffs.[37]

SHU is designed to reduce visual stimulation and reinforce a sense of isolation from the outside world.[38] "[N]o direct sunlight ever reaches the[] cells."[39] Each cell has "a concrete stool, concrete bed, concrete writing table, and a toilet and sink made of heavy stainless steel."[40] Prisoners eat twice per day off of trays pushed through slots in cell doors.[41] They may shower three times per week but may not participate in classes or work.[42]

3. Who Is in Solitary Confinement?

Craig Haney, a professor at the University of California, Santa Cruz testified before the California legislature in 2014 that "there is simply no other prison system in the country that I know of that places so many prisoners in isolation, and no other state that places them remotely for as long as we do."[43] CDCR's Code of Regulations (the "Regulations")[44] permit inmates to be placed in SHU for both indeterminate terms—known as an "administrative" term in the Regulations—and determinate periods of time.[45] Recently, accounts of prisoners spending up to forty years in SHU have begun to emerge.[46]

Who ends up serving their prison sentences in these conditions? The Regulations outline several "Serious Rule Violations" that permit placement in segregation for a determinate period of time.[47] These include "[t]attooing or possession of tattoo paraphernalia," "[p]ossession of five dollars or more without authorization," "[p]articipation in gambling," and "[p]articipation in a strike or work stoppage."[48] In addition to inmates who commit disciplinary infractions, two populations draw special attention—from researchers, activists, and prison officials—for their presence in solitary confinement: inmates with mental illnesses and gang members.

1. Inmates With Mental Illnesses

In the 1990s, mentally ill inmates in California prisons filed a class action against the State, alleging that CDCR's failure to provide constitutionally compliant mental health care violated their Eighth Amendment rights.[49] The use of solitary confinement on mentally ill inmates has been a particular area of concern for the *Coleman* plaintiffs. Despite gaining a favorable decision in the Supreme Court that they hoped would remedy the constitutional violations,[50] the plaintiffs continue to identify deficiencies with mentally ill inmates in solitary confinement.

Figure 2: Administrative Segregation Unit Housing Board with Pink or Purple Cards Indicating Lack of Bed[51]

In a recent declaration, *Coleman* plaintiffs' counsel Michael Bien alleges that mentally ill prisoners are often placed into segregated housing units for non-disciplinary reasons including "'safety' reasons, pending transfer to other yards, and recent discharge from [SHU]."[52] This phenomenon of holding prisoners in segregation even when they have not committed a rule infraction is called "LOB" for "lack of bed."[53] Figure 2 demonstrates how pervasive this practice of housing inmates in segregation for no fault of their own is.

Moreover, "prisoners held in segregation units for no fault of their own are subjected to the same harsh custodial measures imposed throughout segregation units, including blanket strip searches, indiscriminate use of cages for mental health treatment, and escorting in cuffs."[54] Figure 3 illustrates the severity of these practices by showing a group of inmates participating in group therapy at Mule Creek State Prison.[55] Placing mentally ill inmates in these conditions is dangerous, especially given the suicide rate difference in segregated housing and non-segregated housing.[56]

Figure 3: Group Therapy in ASU at Mule Creek State Prison

The *Coleman* plaintiffs identified part of the reason for the presence of mentally ill inmates without disciplinary infractions in segregated housing: "systematic shortages of Special Needs Yards beds."[57] Because the plaintiffs have identified unceasing constitutional violations, they will continue to advocate for changes to the policies governing the placement of mentally ill inmates in solitary confinement.

2. Gangs or Security Threat Groups

Recent revisions to the Regulations, which became effective on October 17, 2014, have significantly changed how CDCR classifies and handles gang members and associates. For example, the Regulations have changed the relevant terminology: a gang now refers to an organization that commits acts "outside of the California Department of Corrections and Rehabilitation jurisdiction," whereas a Security Threat Group ("STG") operates within CDCR's jurisdiction.[58] However, because this revision is relatively new and many of the sources relied upon in this Article use data collected prior to the change in terminology, the terms "gang" and "security threat group" will both refer to organizations operating within CDCR's jurisdiction.

a. The Regulations Before October 17, 2014

Prior to the Regulation's recent revisions, it was estimated that about 50% of SHU was comprised of inmates who had not necessarily committed any rule violation at all.[59] Instead, inmates participated in a gang validation process that could result in an indefinite placement in SHU.[60] Gang validation was the process by which prison authorities verified that an inmate was a member or associate of a gang. The Regulations defined those terms as follows:

> A member is an inmate/parolee or any person who has been accepted into membership by a gang. This identification requires at least three (3) independent source items of documentation indicative of actual membership. Validation of an inmate/parolee or any person as a member of a prison gang shall require at least one (1) source item be a direct link to a current or former validated member or associate of the gang, or to an inmate/parolee or any person who is validated by the department within six (6) months of the established or estimated date of activity identified in the evidence considered.[61]

An associate is an inmate/parolee or any person who is involved periodically or regularly with members or associates of a gang. This identification requires at least three (3) independent source items of documentation indicative of association with validated gang members or associates. Validation of an inmate/parolee or any person as an associate of a prison gang shall require at least one (1) source item be a direct link to a current or former validated member or associate of the gang, or to an inmate/parolee or any person who is validated by the department within six (6) months of the established or estimated date of activity identified in the evidence considered.[62]

This gang validation policy was reviled amongst inmates and drew considerable negative attention from advocates and the public. Prisoners alleged that the independent source items were often innocuous materials found in their cells unrelated to gang membership and affiliation.[63] Furthermore, a source could have been a confidential allegation made by fellow prisoners that the accused had no way of challenging.[64] Countless stories emerged from inmates demonstrating the flimsiness of the validation process. For example, Richard Johnson alleged that "he was denied inactive gang status after prison officials discovered a book about [former Black Panther] George Jackson . . . in his cell."[65] Another inmate claimed that he was accused of promoting gang activity and written up for saying "Hey, Abdul" and "All right, Vitani" to fellow inmates on his way in and out of the clinic.[66]

Perhaps responding to the negative attention and publicity that the gang validation process had garnered, CDCR significantly revised its practices and implemented a revised set of Regulations that became effective on October 17, 2014.

b. The Regulations After October 17, 2014

The revised Regulations create two categories of prison gangs known as STG-I, which include STGs that post the greatest threat, and STG-II, which may include "traditional disruptive groups/street gangs."[67] The Regulations retain the distinction between STG members and associates, defining those terms as follows:

Member: Any offender or any person who, based on documented evidence, has been accepted into membership by a STG. . . . Initial [v]alidation of an offender as a member requires at least three (3) independent source criteria items with a combined value of 10 points or greater coupled with information/activity indicative of a member.

. . .

Associate: Any offender or any person who, based on documented evidence, is involved periodically or regularly with the members or associates of a STG. . . . Initial validation of an offender as an associate requires at least three independent source criteria items with a combined value of 10 points or greater coupled with information/activity indicative of an associate.[68]

Validation as a member or associate of a STG-I requires that one of the source items be a direct link to a current, former, or soon to be (within 6 months of the date of activity) validated member or associate of an STG-I.[69] The source items referenced above include symbols, informants, debrief reports, written materials, photographs, tattoos, communications, legal documents, and visitors.[70] Each type of source item is assigned a corresponding point value that is used in the determination of whether an individual is a STG member or associate.[71]

"[A] validated STG affiliate is deemed to be a severe threat to the safety of others or the security of the institution and will be placed in a SHU for an administrative term when [certain] criteria are met."[72] STG-I members will be placed in SHU after being validated and confirmed by the Institutional Classification Committee ("ICC").[73] STG-I associates will be placed in SHU if the source items used in the validation process document certain serious STG behavior.[74] STG-II members and associates will be placed in SHU if, "as part of initial validation, source items include two occurrences, both of which have occurred within four years of the validation date, of [certain] serious documented STG behavior or activity."[75]

C. How Do You Leave Solitary Confinement?

According to the Regulations, there are a few ways of leaving SHU.[76] The first is at the end of a determinate sentence or after 11 months in SHU unless (1) the inmate has an unexpired minimum eligible release date from SHU,[77] (2) releasing the inmate would pose a severe danger to the institution, its occupants, or an open investigation into criminal activity or serious misconduct, or (3) the inmate has requested a continued stay.[78]

The second method is for an inmate to get paroled while in SHU.[79] If that inmate returns to prison, either because of a parole violation or commission of a new offense, that SHU term can be reimposed.[80]

For gang members in SHU, a period of inactivity—abstention from gang activity—or dropping out of a gang can eventually result in departure from SHU. This can occur through participation in a debriefing process or through participation in the Step Down Program ("SDP"). With respect to the debriefing process, the Regulations provide that "[a] validated STG affiliate shall be considered for release from a SHU . . . after the inmate is verified as a STG dropout through a debriefing process."[81] "Debriefing is the process by which a STG coordinator/investigator determines whether an offender (subject) has dropped out of a STG."[82] The debriefing process may involve up to two steps: an interview and an observation phase.[83] During the interview, inmates "provide staff with information about the STG's structure, activities, and affiliates."[84] The Regulations state that this information is gathered so that the staff can "reasonably conclude" that the inmate has left the gang and so that the subject can be reclassified.[85] "A requirement of the interview phase is that the offender provides staff a written autobiography of their STG involvement, which is then verified by staff for completeness and accuracy."[86] Following the interview phase, the inmate may be observed for no longer than 6 months while living in housing with other debriefing inmates.[87]

Participation in the Step Down Program—a new program that became effective with the revised Regulations—is also an avenue for leaving SHU.[88] The Step Down Program (SDP) is a five-step, incentive-based program intended to manage, monitor, and transition STG affiliates in SHU to the general population.[89] Steps 1 and 2 are designated to house the most serious STG affiliates that are determined to pose the greatest threat and are "primarily intended as periods of observation."[90] Inmates who are in Steps 1 or 2 are reviewed by the Institution Classification Committee ("ICC") every 180 days and, although these steps are designed to last 12 months each, the ICC can accelerate an inmate's progression.[91] Step 3 begins

inmates' reintegration and offers programming, privileges, and continued monitoring.[92] Step 3 lasts for a minimum of 12 months, and the ICC reviews inmates at least every 180 days.[93] Step 4 continues the reintegration process, lasts at least 12 months, and presents inmates to the ICC every 90 days.[94] Step 5 permits inmates to be placed in the general population for a 12-month observation period.[95]

While it is still unclear how the recent revisions to the Regulations will affect the ease or difficulty of leaving SHU, the pervading sentiment prior to the revisions was that "the only way you'll leave is to 'parole, die, or debrief.'"[96] These are the words of a prison guard to an inmate in SHU. This phrase, often referred to as "Parole, Snitch, or Die,"[97] characterized the futility of attempting to leave SHU for many inmates. Even if they are successfully released from SHU, perhaps by going through the debrief process, some inmates still feared retaliation in the general population for "snitching" on other inmates.[98]

II. The Impact of Solitary Confinement on Inmates

No one argues that solitary confinement does not have an impact on inmates. Even advocates of the practice justify the added stress as righteous punishment for prison indiscretions. The policy debate instead focuses on the extent of the impact on prisoners and whether that impact rises to the level of "torture."[99] The psychological debate over impact, however, is more nuanced. There is no real disagreement in psychological literature about whether or not solitary confinement has a negative effect on the prisoner's psyche.[100] Instead, the psychological literature focuses on isolating aspects of the solitary experience to see what causes the most damage, and figuring out what symptoms are common across prisoners experiencing solitary confinement.

Solitary confinement can have a negative impact on inmates in a number of ways. Inmates miss out on programs and opportunities that are offered by the prison. They often aren't able to see their loved ones, are stripped of the very limited amount of control they have in prison, are left without human contact and sensory stimulation, and are often left in a state of limbo unsure when they will be removed from solitary. After reviewing the bulk of studies—historical and contemporary—on the effects of solitary confinement on the individual, psychologist Craig Haney summed up the thrust of the literature: solitary confinement is "psychologically painful, can be traumatic and harmful, and puts many of those who have been subjected to it at risk of long-term emotional and even physical damage."[101]

This Part will examine and highlight some of the leading literature on the psychological effects of solitary confinement on prisoners. It begins with studies outside of prisons that shed light on the solitary experience, moves to studies of the psychological effects of solitary on actual prisoners, and concludes with a discussion of some of the qualitative work done on the issue in the form of sociological research and prisoner narratives. While an exhaustive study is beyond the scope of this Note and better left to those with more expertise, lawyers and policymakers examining solitary confinement will do well to keep the physical and psychological effects of the practice in mind.

A. Non-Prison Research

Much of the scholarship that informs our understanding of the psychological effects of solitary confinement in prisons comes from studies in analogous settings that test the effects of social isolation and sensory deprivation in other contexts. Early scientific studies shedding light on the effect of solitary confinement occurred during the Korean War, when researchers attempted to study the role of isolation and sensory deprivation in possible "brainwashing" of American prisoners of war by the Korean military.[102] Best exemplified by the movie *The Manchurian Candidate*, the studies were aimed at a very specific type of sensory deprivation—relatively short-lived and occurring in an environment not perfectly analogous to American prison. Nevertheless, the early experiments shed light on the effect that "conditions aimed at reducing, altering or by some means or other, interfering with a person's normal stimulation" might have on a prisoner in isolation.[103] Researchers consistently found that human subjects had difficulty dealing with even short-term sensory deprivation. In one study, participants were placed in a soundproof room with goggles and earphones so that they could neither see nor hear other people in the room.[104] In a similar study conducted in a sound proof room, participants were allowed to leave whenever they wanted.[105] Most participants left after just one or two days in that situation, citing "anxiety" and "panic" as the reasons for quitting.[106] As one study summarized, "'the absence of stimulation leads to the debilitation of behavior, making the individual less efficient and inducing strong affective states which are associated with marked changes in motivation.'"[107] In other words, sensory deprivation can seriously affect an individual's mental state.

A different, but related strand of research studied the positive effect of social contact on people. These studies stressed the importance of "social support" and supportive interactions to one's physical and mental health.[108] As a corollary to these studies, researchers have found that where social connectedness is lacking, for example in isolated elderly populations,[109] or unmarried or unemployed people,[110] patients are more likely to need psychiatric services. Although the social isolation of mental patients has been advocated by some as a treatment, studies have shown that when confined mental patients are segregated from the hospital population and left in isolation, they similarly suffer "substantial deleterious physical and (more often) psychological effects."[111] This means that when a person has a pre-existing mental health condition, time in solitary can exacerbate the effects of that condition.

None of these early studies perfectly mirrored the conditions of solitary confinement, but they shed light on the contours of the human mind's ability to deal with isolation in a way directly relevant to prisoners in isolation. The conditions of these studies were often *more* severe than contemporary solitary confinement, but they also all lasted for much shorter periods of time than the often-indefinite period of detention for inmates. While they had their limitations, these analogous studies were effective at isolating the impact of isolation or connectedness on the psychology of people exposed to extremes. Studies of prisoners built on this research and applied the findings to the specific context of prison.

B. Studies of the Psychological Effects of Solitary Confinement

Part of the reason non-prison studies have been so useful is that it has been difficult for researchers to accurately study the effects of solitary confinement on actual prison inmates in any sort of controlled study. The most common research design involves asking for inmate volunteers to undergo solitary confinement for a certain amount of time to study the reactions.[112] This has a few obvious flaws. First, the subjects volunteered for

solitary, and thus were likely more mentally capable of handling the stress than a randomized sample.[113] Second, the limits of the experiment were known—or at least could be presumed—by the subjects. Previous studies have shown that where a subject knows the duration of their time in isolation, it is easier to bear.[114] Finally, the subjects in most controlled solitary experiments generally have a much greater degree of control than actual solitary prisoners. They decide whether or not to participate and when to stop participating in the study. This makes it difficult to study the lack of control felt by actual inmates in solitary.

Despite these flaws, much has still been learned about the psychological effect of solitary confinement through the study of prisoners. In one study in Maine of prisoners held indefinitely in solitary confinement without a given reason, the authors found that almost every prisoner in the isolation unit had attempted suicide.[115] Suicide, or self-harm, is used as an indicator of extreme mental distress, and it is remarkably common among prisoners in solitary confinement.[116] This is further supported by a statistic quoted in the Associated Press that of the forty-four prisoners in the California prison system who committed suicide in 2005, 70% were in solitary confinement.[117] Suicide is a common theme throughout the studies.

Several large-scale studies of prisoners in general, and prisoners in solitary confinement illuminate the effect of the practice on the psyche. One of the largest and most comprehensive studies of prison mental health was Hans Toch's *Mosaic of Despair*, a 1992 study of prisoners in the New York prison system.[118] Though not limited to solitary confinement, Toch's study concluded that "isolation panic" was "sharply prevalent" in solitary confinement.[119] Toch specifically distinguished between normal imprisonment, which was tolerable for many inmates, and isolation, which was not tolerable.[120] "Isolation panic" was characterized by rage, breakdowns, psychological regression, and self-mutilation.[121] Another researcher, Stuart Grassian, observed isolated prisoners in Massachusetts.[122] He too remarked on the great anxiety felt by prisoners in isolation. Prisoners were confused, and suffered hallucinations.[123] Several of the prisoners studied attempted suicide, and almost all of the prisoners also reported having never felt that way before being placed in isolation.[124]

Finally, in California Craig Haney has done extensive research on the psychological effect of incarceration in the SHU at Pelican Bay.[125] More than four-fifths of the prisoners studied suffered from anxiety, headaches, troubled sleep, and lethargy.[126] More than half also suffered from nightmares, heart palpitations, and "impending nervous breakdown[s]."[127] Nearly half suffered from hallucinations, and a quarter had suicidal tendencies.[128]

Each of these studies highlights the severe mental anguish of inmates in solitary confinement. Taken together, they represent a stunning body of work on the effect of isolation on the human psyche. At base, every study shows a sharp increase in anxiety for nearly every prisoner involved. This result may be expected and even encouraged by prison officials, since solitary is used as a punishment for prisoners who have broken prison rules. In other words, supporters of the practice argue it *should* be more uncomfortable than prison; otherwise it would not be an effective punishment. This may be true for well-adjusted prisoners who are only kept in solitary for a short time, but as psychologist Terry Kupers testified in a Wisconsin case, confinement of "prisoners suffering from serious mental illness . . . is an extreme hazard to their mental health and well-being."[129] When prisoners with existing conditions are placed in solitary, it "causes irreparable emotional damage and psychiatric disability."[130]

C. Descriptive Accounts

In addition to clinical and scientific studies, much can be gleaned about the psychological effect of solitary confinement from descriptive accounts by those who have experienced it or those who witnessed solitary confinement and wrote about what they saw. These are, in many ways, the most useful and the most difficult to read. As one solitary inmate in Pelican Bay explained: "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."[131] Thus, the words of inmates themselves are often the best descriptor of the effects of solitary. Despite the difficulties of communicating from solitary, there are many prisoner accounts about the treatment they receive in solitary confinement. Many of the stories are nearly philosophical in their analysis of their condition, shedding light on not just the psychology of solitary, but also offering a sort of existential commentary on the impact of the practice. One of the most meditative of this genre of prisoner narratives is the book-length memoir by Christopher Burney, who was arrested for supporting the French resistance during WWII and placed in solitary confinement for 15 months.[132] Burney talks about the slow deterioration of his mental state:

I soon learned that variety is not the spice, but the very stuff of life. We need the constant ebb and flow of wavelets of sensation, thought, perception, action, and emotion, lapping on the shore of our consciousness, now here, now there, keeping even our isolation in the ocean of reality, so that we neither encroach nor are encroached upon.[133]

Burney's moving account of his time in solitary is a model followed by many prisoners and observers since.

More contemporary accounts have similarly meditated on the relationship between isolation, psychosis, and punishment. Robert Slater described the environment at San Quentin prison in the 1980s, when many of the prison's inmates were in solitary confinement.[134] Slater described the symptoms suffered by prisoners in solitary:

[T]ension, irritability, sleeplessness, nightmares, inability to think clearly or to concentrate, and fear of impending loss of impulse control. Sometimes the anxiety is severe enough to be crippling. It interferes with sleep, concentration, work, and study and predisposes to brief psychotic reactions, suicidal behavior and psychophysiological reactions. It causes misperceptions and over-reactions. It fuels the cycle of violence . . . leading to more violence and terror.[135]

This description could have been taken from a psychological study, but is more evocative for coming from Slater's actual experience with prisoners in solitary confinement. Prisoners themselves also express the psychological anguish of life in solitary. In the words of one prisoner: "I started hearing voices and losing control of my own thoughts . . . . I really started noticing more when I started being in the hole . . . . It just started getting worse for me."[136] Gabriel Reyes, imprisoned for sixteen years in solitary confinement at Pelican Bay, described his cell as a "living tomb."[137] He was not allowed physical contact for all of that time. He gives voice to his maladies in his own words: "I have developed severe insomnia, I suffer frequent headaches, and I feel helpless and hopeless. In short, I am being psychologically tortured."[138] Other prisoners at Pelican Bay also complain of "chronic insomnia," "hopelessness," "anxiety and humiliation," and "depression."[139]

Like the scientific studies mentioned above, prisoner narratives from isolation are also far too limited. Though prison narratives in general have had a long history, prisoners in solitary are segregated from the outside world by design. Thus, the narratives we do have, while helpful, form a very small sample of prisoners and are most useful to elucidate and dramatize the scientific studies.

V. Legal Standards

The conditions of solitary confinement have been litigated almost from its inception as a common American penal practice in the 18th century.[140] In the earliest successful challenge to solitary confinement in the United States, *In re Medley*, the Supreme Court decided that holding prisoners in solitary confinement in state prison after being sentenced to death "was an additional punishment of the most important and painful character" and was therefore forbidden under the ex post facto provision of the U.S. Constitution.[141] That same year, the Supreme Court first held that the Fourteenth Amendment incorporates the Eighth Amendment against the states.[142] Despite this, over the next fifty years the Supreme Court continuously acknowledged the use of solitary confinement as an extreme, but constitutional, form of punishment.[143] Only one case, decided in 1999 in a district court in Texas, has found solitary confinement unconstitutional if "conditions are so extreme as to violate basic concepts of humanity and deprive inmates of a minimal level of life's basic necessities."[144]

There are two constitutional hooks for bringing claims against solitary confinement—the Eighth Amendment and the Fourteenth Amendment. Each present their own challenges and opportunities and each has been used nationally and in California. In this section we will examine each constitutional rationale and look at how solitary confinement has been litigated in California. Scholars, such as Keramet Ann Reiter, have articulated the importance of litigation in shaping contemporary conditions of solitary confinement.[145] The history of solitary confinement litigation in California reveals the deep impact the cases have had on the practice of solitary confinement, but no case has cut to the core of the issues present. While litigation has been a worthwhile vehicle for relatively minor changes to a prisoner's condition of confinement, reform has been piecemeal, solely in response to the specific circumstances raised in a particular suit. Despite recent ongoing challenges to the use of solitary confinement in California, an examination of past cases reveals that the most effective avenue for reform is most likely political, not judicial.

A. Eighth Amendment Challenges

The Eighth Amendment is both the most common and the most impactful avenue for solitary confinement litigation. When the Eighth Amendment was written, prisons barely existed in America.[146] The Eighth Amendment, then, was primarily concerned with the public displays of punishment that were common in that day.[147] It was, essentially, a prohibition against torture, but not excessive punishment.[148] By the early twentieth century, the Eighth Amendment was read to include prohibitions against punishment disproportionate to the crime committed.[149] This doctrine gets to the core of the concerns prisoners and advocates have with solitary confinement. While Fourteenth Amendment complaints address the process by which inmates are assigned to, or removed from, solitary confinement, Eighth Amendment complaints deal specifically with the conditions in which inmates are kept.

Despite doctrine allowing prisoners to challenge their conditions of confinement, litigation challenging solitary confinement under the Eighth Amendment has only had limited success. First, the bar for successful claims is high. Prisoners making an Eighth Amendment claim must show first that the prison conditions are "sufficiently grave" to result in denying "the minimal civilized measure of life's necessities."[150] The denial of those necessities must also pose a "substantial risk of serious harm."[151] The second, and much harder, step is to show that prison officials were "deliberate[ly] indifferen[t]" to the inmate's poor condition.[152] To show this, prisoners must prove that officials knew of the risk of harm to the inmate and deliberately ignored it.[153] Second, even if successful, most Eighth Amendment remedies address only the narrow circumstances of the violation. For example, litigation claiming an Eighth Amendment violation for inmates kept in solitary confinement without any exercise proscribed a minimum amount of exercise required for prisons to remain constitutionally compliant.[154]

Most solitary confinement litigation raises Eighth Amendment claims. Though the bar is high, courts have been amenable to claims that a particular aspect of solitary confinement in a specific case violates the Eighth Amendment.[155] Only one case has found that solitary confinement, as a whole, violates the Eighth Amendment.[156]

B. Fourteenth Amendment Challenges

The second primary area of prison condition litigation is the Due Process Clause of the Fourteenth Amendment. Fourteenth Amendment challenges generally require that the petitioner show that his or her right to life, liberty, or property is threatened "without due process of law."[157] This avenue has had some limited success in ensuring that prisoners are not confined to solitary without some minimal process. Courts are very deferential to the administrative decisions of prisons,[158] but have found a protected liberty interest in avoiding placement into solitary confinement.[159]

The most notable case on this issue is *Wilkinson v. Austin*, which dealt almost exclusively with the question of what procedures were necessary to place a prisoner in solitary confinement.[160] *Wilkinson* arose out of a challenge to Ohio's supermax prison: Ohio State Penitentiary. *Wilkinson* first acknowledged that there is a liberty interest in avoiding assignment to a restrictive housing unit.[161] The liberty interest is compared against the liberty of a prisoner in general prison population, so a short confinement in solitary would not likely raise a liberty interest because other prisoners could be expected to be "locked down" for short periods of time as well. The liberty interest protected in *Wilkinson* is really limited to long-term solitary confinement. Despite finding that a liberty interest existed for the prisoners in *Wilkinson*, the Supreme Court found that the program for assigning inmates to solitary in Ohio was constitutionally sufficient.[162] The Court applied a *Mathews v. Eldridge*[163] balancing test, weighing the process afforded to inmates against the needs and burdens of the state, to find that the Ohio system was constitutionally valid.[164] The Court found that Ohio's interest in "prison management" was a "dominant consideration" and that "the safety of guards and prison personnel, the public, and the prisoners themselves" is the "State's first obligation."[165]

Fourteenth Amendment complaints are generally limited to process violations. While vital for inmates entering or exiting solitary, the procedure used to send inmates to solitary is not the central concern. Though wanton removal from general population to solitary without notice and/or without a known termination point might exacerbate the solitary experience, the isolation itself is the root cause of the psychological stress.[166] Thus, though flawed, the Eighth Amendment has consistently provided a better avenue for litigating solitary confinement for reformers.

C. Litigation in California

In California, inmates have challenged their solitary confinement on both Eighth and Fourteenth Amendment grounds. Early California litigation of conditions carved out various rights for prisoners, specifically remedying the problem presented in each case. The ongoing litigation of these rights led to the creation of supermax prisons, epitomized by the Pelican Bay prison on the northern border of California. Supermax prisons were built to be constitutionally compliant. Despite this, they became the target of frequent lawsuits claiming Eighth and Fourteenth Amendment violations. In California, litigation has been minimally successful at ensuring adequate procedures for placing inmates into and removing inmates from solitary, and in ensuring a minimum standard of treatment in solitary. Still, California litigation has not been successful in creating structural change to the solitary confinement program in California.

1. Early Conditions Cases

In the late 1970s, federal courts in California began to evaluate the constitutionality of prison conditions in the State's solitary confinement units, use generally to punish inmates who had broken prison rules or for protective custody housing. In *Wright v. Enomoto,* the Northern District of California heard a class action suit challenging both the conditions in which prisoners were confined in solitary and the process used to send prisoners to solitary confinement.[167] The *Wright* court summarized the findings of fact regarding conditions in solitary as follows, in part:

Prisoners in the maximum security units are confined in cells approximately five feet wide by eight feet long. The cells are without fresh air or daylight, both ventilation and lighting being poor. The lights in some cells are controlled by guards. It is difficult for prisoners to get needed medical attention. . . . They are allowed very limited exercise and virtually no contact with other prisoners.[168]

After reviewing these conditions, the court concluded that "a prisoner confined in a maximum security unit suffers a loss of liberty much more severe than that experienced by a prisoner in the general prison population."[169] The court also found that the administrative process for assigning prisoners to solitary confinement was insufficient.[170] The court remedied the procedural flaws by requiring that prisoners have notice before being transferred as well as a hearing and representation at that hearing.[171]

Over the next decade, cases bounced between the district court and the Ninth Circuit, steadily expanding the suite of rights afforded inmates in solitary confinement. In 1983, for instance, the court ordered the California Department of Corrections to provide generally clean cells, bedding, clothing, and cleaning supplies to all prisoners.[172] The court also ordered that prisoners be allowed three showers and eight to ten hours of exercise per week and be permitted to visit with family members and friends.[173] These later cases also granted prisoners the right to be held "in an environment . . . reasonably free of excess noise,"[174] the right to access to personal hygiene supplies[AA: Citation needed], and the right to be housed in an environment with adequate lighting.[175] Though these cases granted protections to prisoners, no federal court found the act of solitary confinement itself unconstitutional. In fact, in whittling away at abject conditions, the California federal courts continuously upheld the use of solitary confinement in general, while tweaking reprehensible elements of the practice.

2. Pelican Bay Litigation

After years of minor, court-ordered tweaks to the practice of solitary confinement, policymakers around the country saw an opportunity to save costs by constructing whole new facilities that met the constitutional minimum requirements and avoided the costly ongoing litigation over the conditions of solitary confinement in existing prisons.[176] In California, during this time, the result was the construction of Pelican Bay State Prison.[177] As discussed in Part II.A, Pelican Bay houses the largest and most notorious Secure Housing Unit in the California prison system. The principle focus of solitary confinement litigation in California has been against Pelican Bay State Prison.

Madrid v. Gomez[178] is the most comprehensive attempt to eliminate solitary confinement in California through litigation to date. *Madrid* stemmed from a lengthy complaint filed by a class of prisoners in Pelican Bay prison. The class claimed violations of their First, Eighth, and Fourteenth Amendment rights through the regular use by prison officials of excessive force, isolation, insufficient medical care, lack of access to the courts, and lack of due process in the decision to be segregated.[179] When ruling on *Madrid,* the Northern District of California acknowledged many of the prisoners' complaints and ordered serious reforms of the SHU at Pelican Bay.[180] Perhaps most importantly, Judge Thelton Henderson's opinion is the first in California to grapple with the complicated relationship between mental health and solitary confinement. Judge Henderson wrote that the conditions in Pelican Bay violated the Eighth Amendment when imposed upon prisoners who were "already mentally ill, as well as persons with borderline personality disorders, brain damage or mental retardation, impulse-ridden personalities, or a history of prior psychiatric problems or chronic depression."[181] Henderson continued, saying that solitary confinement, "as it is currently constituted, deprives inmates of a minimal civilized level of one of life's necessities."[182] This is extraordinary language found in a 128-page opinion that seems to be the first to really understand and care about the effect of solitary confinement on the mental health of inmates. Judge Henderson criticized the "deliberate, and often shocking, disregard for the serious mental health needs of inmates at Pelican Bay."[183]

Though the court employed sweeping and condemning language to discuss the use of solitary confinement for the mentally ill, the opinion in *Madrid* was fairly limited. As Craig Haney and Mona Lynch explain, the *Madrid* court was "unable to extend its otherwise complex and nuanced understanding of the psychological forces at work in a punitive segregation unit to the critical task of directly modifying the totality of conditions that adversely affected the great majority of prisoners who experienced them on a long-term basis."[184] In other words, the court balked at eliminating solitary confinement for *all* prisoners, accepting that "for many inmates, it does not appear that the degree of mental injury suffered significantly exceeds the kind . . . that courts have found compatible with Eighth Amendment standards."[185]

As discussed above, solitary confinement has a lasting impact on the mental health of nearly all who are exposed to it. The court's distinction between pre-existing mental conditions and mentally sound prisoners is a fallacy. Solitary confinement itself creates the conditions for complete mental breakdown, even in prisoners who were healthy when committed to the SHU. It is isolation and sensory deprivation itself that causes the psychological stress, though the abuse or neglect of prison officials certainly exacerbates it.[186] The *Madrid* opinion comes as close to acknowledging this as any other. If solitary confinement survived a direct Eighth Amendment attack under the circumstances of *Madrid*, it is unlikely there is any fact pattern that would convince a court to rule solitary confinement per se unconstitutional.

. Current Litigation

There is currently a renewed complaint against Pelican Bay in the Northern District of California. *Ashker v. Brown* was initiated in 2012 on behalf of ten named plaintiffs and a larger class that includes other prisoners who have been kept in the SHU at Pelican Bay for "an unconscionably long period of time without meaningful review of their placement."[187] The plaintiffs class size could be over 1000 people.[188] The complaint alleges both Eighth and Fourteenth Amendment violations to prisoners held in long-term confinement in the SHU. The complaint alleges five separate Eighth Amendment cruel and unusual punishment violations and claims they occur with "[d]efendants' [d]eliberate [i]ndifference," to the conditions.[189] The complaint also alleges serious Fourteenth Amendment due process problems.[190] If successful, the petitioners ask the court to issue an injunction requiring "the release from SHU of" class members who have been in solitary for more than ten years, improved conditions for those who remain, and "meaningful review" of all prisoners currently confined in the SHU and all future prisoners who will be confined in the SHU.[191]

In another California case, U.S. District Court Judge Lawrence Karlton recently issued a ruling in the *Coleman v. Brown* litigation addressing the use of solitary confinement on mentally ill inmates:

[T]he court finds that placement of seriously mentally ill inmates in the harsh, restrictive and non-therapeutic conditions of California's administrative segregation units for non-disciplinary reasons for more than a minimal period necessary to effect transfer to protective housing or a housing assignment violates the Eighth Amendment. . . . Defendants shall commence forthwith to reduce the number of *Coleman* class members housed for non-disciplinary reasons in any administrative segregation unit that houses disciplinary segregation inmates. Commencing sixty days from the date of this order, defendants will be prohibited from placing any *Coleman* class member in any administrative segregation unit that houses disciplinary segregation inmates for a period of more than seventy-two hours if the placement is for non-disciplinary reasons including but not limited to safety concerns or lack of appropriate bed space.[192]

The court provided recommendations for how the state could remedy these constitutional violations, including creating "separate units for disciplinary and nondisciplinary segregation" and developing a policy based on a remedial plan adopted in other litigation.[193]

Again, while this ruling is a major victory for the *Coleman* plaintiffs, notice how tailored the remedy is to the specific injury. While inmates with mental health disabilities may not be placed into disciplinary segregation when they haven't committed a disciplinary infraction, they can be placed into non-disciplinary segregation. This is indicative of a pervasive philosophy in California that segregation can and should be routinely used as a form of management and control.

Though one shouldn't undervalue the current litigation, if successful, it is likely only to result in the sort of piecemeal change we have seen in previous court opinions. Of the four court remedies requested by the *Ashker* plaintiffs, one is fairly general: eliminating conditions of "isolation, sensory deprivation, lack of social and physical human contact, and environmental deprivation."[194] Given the federal court system's past experience with Eighth Amendment solitary confinement claims, it is unlikely the Northern District of California will draw the remedy that broadly if the plaintiffs are successful.[195] Either way, the sheer deprivation of inmates in solitary confinement, combined with the national and international condemnation of the practice from advocacy and human rights groups will ensure that many more challenges to the practices of Pelican Bay and other supermax prisons continue.

V. Reform Movements

Stories about solitary confinement have erupted in the media recently as hunger strikes, protests, and demonstrations have swept across the nation's prisons.[196] International human rights groups, humanitarian organizations, political figures, and many others have condemned the use and conditions of solitary confinement, denouncing it as torture and a human rights violation.[197] While litigation is certainly being utilized as a vehicle for instigating change, all three branches of state government—legislators, judges, and prison officials—are jumping into the fray and reexamining their state's practices and implementing reforms to solitary confinement. Based on trends witnessed in states that are leading the solitary confinement reform movement (i.e. New York, Colorado, and Maine), it is clear that reform originating from the political process—the legislature and executive—are most effective at inspiring structural change to solitary confinement policies and practices.

A. Other States' Reform Efforts

1. New York: A Quasi-Judicial Approach

In *Peoples v. Fischer*, the New York Civil Liberties Union sued the New York State Department of Corrections and Community Supervision (DOCCS) "alleging that the use and length of confinement sanctions and conditions in DOCCS Special Housing Units ('SHU') create[d] an unconstitutional risk of harm."[198] On February 19, 2014, the parties reached an unprecedented agreement to suspend the litigation pending the implementation of certain stipulated reforms in New York prisons.[199]

Peoples v. Fischer was motivated by solitary confinement practices employed by DOCCS that are strikingly similar to those used in California. DOCCS has approximately 3800 inmates in lockdown daily as punishment for violating prison rules.[200] They are locked down for twenty-two to twenty-four hours per day and "the average time spent in isolation was 150 days," which is "five to 10 times longer than experts say is the maximum tolerable span."[201] Despite these averages, some prisoners spend "years or even decades" in solitary confinement.[202] For example, lead plaintiff Leroy Peoples spent "780 consecutive days in [solitary confinement] for nonviolent behavior after prison officials determined he filed false legal documents."[203] Of the prisoners held in isolation, over 2000 are released directly from solitary confinement into the community without any re-acclimation period.[204]

The parties in *Peoples v. Fischer* recently agreed to a stay of the litigation to provide time for the implementation of reforms to DOCCS's disciplinary system and solitary confinement conditions, and for expert evaluation and consultation on DOCCS's practices and policies.[205] During this time, the defendants will pursue the following goals:

(i) removing certain vulnerable populations from SHU confinement to alternative programs, (ii) increasing system-wide oversight to promote consistent prison disciplinary practices and confinement sanctions that are appropriate and necessary to protect the safety of both staff and inmates, (iii) implementing guidelines for all confinement sanctions to promote transparency and consistency of disciplinary confinement sanctions, (iv) improving SHU conditions as provided in [the stipulated agreement], and (v) reaching a final comprehensive settlement agreement . . . .[206]

The conditions of the stay call for several specific, immediate changes. First, DOCCS will prohibit the use of solitary confinement against inmates who are below the age of eighteen.[207] Second, DOCCS will implement a policy establishing a presumption against placing pregnant inmates in SHU for disciplinary reasons.[208] Similarly, DOCSS will implement a program that provides an alternative to SHU for special needs inmates.[209] Additionally, DOCCS will create a new Assistant Commissioner and research staff positions to collect data and track the state's performance.[210] Moreover, DOCCS will implement new guidelines for disciplinary confinement sanctions, "develop new training materials for" its correctional officers, host regional training sessions, and "give full consideration to" the experts' recommendations.[211] Finally, DOCCS will improve isolation conditions including increasing recreation time and access to headphones and educational materials.[212]

The experts will provide additional recommendations that will be memorialized in a final settlement agreement within two years of the stay.[213] If the reform process fails, the plaintiffs "will resume litigation."[214] While compliance with the conditions of the stay is voluntary, both parties appear optimistic that this will be a groundbreaking and successful collaboration that other states can aspire to replicate.

2. Colorado: An Executive Approach

Colorado's most recent solitary confinement reforms are in part motivated by a far more traumatic and personal event. Tom Clements, the former state corrections chief, was assassinated in March 2013 by Evan Ebel, a gang member who had recently been released into the community directly from solitary confinement.[215] Ebel killed a pizza delivery person and impersonated him by wearing his uniform in order to get Mr. Clements to open the front door.[216] "A few days later, [Ebel] was killed in a shootout with the Texas police after he had shot an officer during a traffic stop."[217]

Governor John Hickenlooper appointed Rick Raemisch to the vacant position and "charged [him] with three goals: limiting or eliminating the use of solitary confinement for mentally ill inmates; addressing the needs of those who have been in solitary for long periods; and reducing the number of offenders released directly from solitary back into their communities."[218]

On January 23, 2014, Raemisch voluntarily spent twenty hours in solitary confinement in a seven by thirteen foot cell.[219] He wrote the following description of his experience:

> First thing you notice is that it's anything but quiet. You're immersed in a drone of garbled noise—other inmates' blaring TVs, distant conversations, shouted arguments. I couldn't make sense of any of it, and was left feeling twitchy and paranoid. I kept waiting for the lights to turn off, to signal the end of the day. But the lights did not shut off. I began to count the small holes carved in the walls. Tiny grooves made by inmates who'd chipped away at the cell as the cell chipped away at them.[220]

When he emerged from his time in solitary confinement, Raemisch "felt even more urgency for reform."[221]

Raemisch has already begun to implement the reforms that he has promised. The Colorado Department of Corrections has "brought down the total number of inmates placed in solitary confinement to 662 in September [2013]—down from 1,505 in September of 2011."[222] A memo was released in December 2013 to the state wardens informing them that "offenders with MMI [major mental illness] Qualifiers cannot be referred for Administrative Segregation placement."[223] Thus, while in Spring 2013, "50 severely mentally ill prisoners were serving in solitary," in February 2014 "that number [was] four."[224] He testified before a Senate panel and questioned why inmates had to spend twenty-three hours a day in solitary confinement (a number that he considers subjective), suggesting that an incentive system could be used instead to change inmates' behavior.[225] Additionally, he has consistently emphasized "that 97 percent of inmates are ultimately returned to their communities," and recognized the pitfalls and dangers of regularly allowing inmates to be released from solitary confinement directly back into the community.[226] Raemisch states that "[i]n Colorado, in 2012, 140 people were released into the public from" solitary confinement; in 2013, "70; so far in 2014, two."[227]

Raemisch does not plan to stop at these victories. He hopes "to allow[] death row prisoners out of their cells for four hours a day[,] . . . send[] inmates to solitary confinement for specific lengths of time instead of indefinite periods[, and] . . . . mak[e] changes in the training of corrections officers, the preparation inmates receive before they are released and the way that corrections officers interact with inmates."[228] With Raemisch at its helm, the Colorado Department of Corrections will continue to lead the nation in solitary confinement reform.

3. Maine: A Legislative Approach

Maine's structural reform of solitary confinement primarily took place in the state legislature, and is outlined in detail by Zachary Heiden's ACLU report.[229] Supported by local activists like the Maine Civil Liberties Union, Representative James Schatz drafted a bill entitled "An Act to Ensure Human Treatment for Special Management Prisons."[230] The reforms were motivated by conditions in Maine State Prison's Special Management Unit (SMU) that are typical of solitary confinement. Inmates in SMU were "isolate[ed] alone in an 86 square foot cell . . . for 23 hours per day during the week, and 24 hours per day on the weekends."[231] They "had no human contact" and inmates could be isolated in the SMU for "days, weeks, months, or even years."[232] Inmates "could be sent to the SMU 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)."[233] Inmates in the SMU could also be there for "administrative segregation"—to isolate the victim and aggressor in a fight even when the victim was blameless.[234] Furthermore, like Raemisch's concern in Colorado, there was "no policy of providing support or assistance to prisoners transitioning back into general population or out into the free world."[235]

The bill proposed in the Maine legislature was designed to remedy these conditions and sought to implement a modest set of changes: (1) "[a] 45-day cap on the number of days that a prisoner could spend in solitary confinement (with [limited] exceptions for . . . serious acts of violence . . .);" (2) "a prohibition on the placement of prisoners with serious mental illness in solitary confinement, and a process for removing [inmates] . . . [with]

ymptoms of mental illness from solitary;" (3) "a set of basic due process requirements for prisoner disciplinary proceedings;" (4) "a prohibition on the se of chemical agents or forcible extractions for the purpose of punishement;" and (5) "a prohibition on the transfer of prisoners to out-of-state facilities lacking analogous protections."[236]

his bill was met with vehement opposition from the Maine Department of Corrections, which asserted that it would compromise both inmates' and orrections officers' safety.[237] While the bill was ultimately defeated in the Maine Legislature's Joint Committee on Criminal Justice and Public Safety, it was converted into a Resolve entitled "Resolve, Directing the Department of Corrections to Coordinate Review of Due Process Procedures nd To Ensure Transparency in Policies Regarding Placement of Special Management Prisoners."[238] The Resolve required the creation of the Mental Health and Substance Abuse Focus Group (the Group), which was tasked with "review[ing] due process procedures and other policies related to" placing prisoners in SMU at the Maine State Prison.[239] The resolve was approved on April 15, 2010 and "[t]he Group's conclusions were shocking in their thoroughness and honesty."[240] Expressing concern with "the amount of discretion exercised by corrections officers in sending risoners to the SMU," the Group issued a series of recommendations that addressed, amongst other things: hiring more professional clinicians "with ackgrounds in behavior modification"; improving data collection regarding SMU; reviewing the practice of using SMU to house inmates with pending investigations; keeping the beds of SMU inmates open so that they can transfer back to the general population easily; expanding the range of isciplinary "tools and sanctions" in order to ensure "that the SMU is only a last-resort punishment"; improving the physical conditions in SMU; and roviding for additional mental health training to staff in the SMU.[241]

Joseph Ponte, the Commissioner of Corrections, took these recommendations and hit the ground running. The reforms that have been implemented epresent a restructuring of not only the technical criteria for entering or being held in SMU, but also a rethinking of the role that solitary confinement hould (or should not) play in corrections. The main reforms that Maine has enacted fall into three categories: changes to how an inmate enters SMU, changes to conditions in SMU, and changes to how inmates leave SMU.

. Entering SMU

The admissions criteria for entering solitary confinement are stricter, especially those for a disciplinary infraction.[242] For example, in order to be laced into disciplinary segregation, an offender must meet one of four requirements:

) the prisoner constitutes an escape risk in less restrictive status; 2) the prisoner poses a threat to the safety of others in less restrictive status; 3) the prisoner poses a threat to his/her own safety in less restrictive status; or 4) there may be a threat to the prisoner's safety in a less restrictive tatus.[243]

MDOC has also addressed the Group's concern regarding holding an inmate in SMU pending the conclusion of an investigation. MDOC policy 20.1 now provides that "no prisoner shall be detained pending investigation, hearing, or review or appeal of recommended disciplinary dispositions except s provided in Policy 15.1, Administrative Segregation, using the procedures and criteria for the placement of a prisoner on administrative segregation tatus."[244]

Additionally, MDOC has expanded the options for "alternative forms of punishment."[245] These include "confining the prisoner to his own cell; limiting ontact visits; restricting the visitors allowed to immediate family; loss of work opportunities; et cetera."[246] Corrections officers and staff have been iven additional training and resources for how to deal use these alternatives as well as how to cope with challenging inmates.[247]

. Conditions in SMU

For those inmates who are placed in solitary confinement, MDOC has worked to improve the conditions of their stay. In order to "reduce[] the likelihood of decompensation," inmates are now given "access to radios, televisions, and reading material."[248] Additionally, they are "given more pportunity to interact with other prisoners through group recreation and counseling sessions."[249] Finally, MDOC utilizes an incentive system hereby prisoners can gain privileges "like additional hours of recreation through positive behavior."[250]

c. Leaving SMU

When placed in SMU, inmates work with prison staff and mental health professionals "to develop a road map of behavior that will lead back to the general population."[251] These maps include specific goals such as meeting with a mental health practitioner, exercising impulse control, engaging in "socially appropriate interactions," and not engaging in self-harm.[252] This approach demonstrates to inmates that there is an end in sight, and laces control over their housing in their own hands.

In order to prevent inmates from being stuck in solitary confinement indefinitely because of a lack of bed space and incentivize corrections staff to earn to cope with difficult inmates, MDOC policy 15.01 states: "If a prisoner is moved out of his/her bed, the prisoner's bed shall be retained pending he review of emergency observation status."[253]

Maine illustrates that structural reform in solitary confinement is possible provided that key players such as Commissioner Ponte envision a corrections system that doesn't use solitary confinement as a routine method for maintaining institutional control. The numbers suggest that these structural reforms have been successful; as of "August 23, 2012, there were 46 prisoners being held in the SMU—approximately half the number of 18 months prior."[254]

3. California's Reform Efforts

In California, the impetus for reforming solitary confinement has come from both an unlikely and likely source: state prisoners. In July 2011, prisoners across California refused food in an organized hunger strike to protest the California Department of Corrections and Rehabilitation's (CDCR) practices and policies towards inmates held in solitary confinement.[255] The hunger strikers issued five "core demands":

1. End Group Punishment and Administrative Abuse . . .

2. Abolish the Debriefing Policy, and Modify Active/Inactive Gang Status Criteria . . .

3. Comply with the U.S. Commission on Safety and Abuse in America's Prisons 2006 Recommendations Regarding an End to Long-Term Solitary Confinement . . .

4. Provide Adequate and Nutritious Food . . .

5. Expand and Provide Constructive Programming and Privileges for Indefinite SHU Status Inmates . . . [256]

The hunger strike continued until July 20, 2011 when the hunger strikers and CDCR entered into an agreement where CDCR would conduct a major policy review of SHU housing conditions, the gang validation process, and the debriefing process.[257] Dissatisfied with the proposed policies from CDCR, prisoners undertook two additional hunger strikes over the next two years.[258] One ran from September 26, 2011 to October 16, 2011 and the other, involving over 30,000 inmates, from July 8, 2013 to September 5, 2013.[259]

In response to these hunger strikes and mounting pressure from the public and advocates, CDCR issued a memorandum announcing the implementation of a new pilot policy regarding Security Threat Group (STG) "prevention, identification, interdiction, and management."[260] The pilot policy tested many of the revisions that were recently made to the Regulations. For example, like the revisions to the Regulations, the pilot policy had two main components: changes to the gang validation process and initiating a new step down program for inmates to get out of SHU.[261] Even before the Regulations were revised and these changes were implemented, advocates expressed dissatisfaction with the pilot policy. Some remained concerned because being validated as a member of certain STGs could result in placement in SHU for a significant duration of time.[262] Furthermore, advocates assert that the gang validation process is still problematic because innocuous behaviors, like possessing a particular book, could still be used as evidence of gang membership.[263] State Assembly Member Tom Ammiano, who chairs the Assembly's Public Safety Committee, said, "According to CDCR's policy . . . many of us sitting on this committee would be gang associates, I don't know how it's possible to avoid association under this system."[264]

In addition to revising the Regulations, CDCR has also been conducting a review of their gang-related SHU population.[265] "According to data obtained from CDCR, 725 SHU case reviews have been conducted, with about 69% [sic] those cases leading to release to the final step in the Step Down Program and/or a General Population setting."[266] While some are applauding CDCR for this review effort, others believe that this proves that the "gang validation policy was not working" and that those individuals who will soon be released should never have been in SHU.[267]

Reform in California has also come from other quarters such as politicians who heard the cries from inmates and the public, and responded by holding two joint hearings of the California Assembly and Senate Public Safety Committees. National experts, family members, and advocates testified, arguing forcefully for legislative reform to solitary confinement at these hearings on October 9, 2013 and February 11, 2014.[268] Moreover, following these hearings, Assembly Member Ammiano introduced Assembly Bill 1652 which limits the violations and situations for which a prisoner can be placed in SHU, and Senator Hancock introduced Senate Bill 892 which achieves more comprehensive reform of solitary confinement practices by adding due process requirements before an inmate is placed in SHU, creating a reentry plan for inmates paroled directly from SHU, and providing additional social and sensory stimulation for inmates in SHU.[269] Although Assembly Bill 1652 did not pass and Senate Bill 892 died in the Assembly,[270] they demonstrate the growing momentum behind the solitary confinement reform cause. In the next Part, we consider the State's next steps and provide recommendations based on the successes and failures experienced in other states.

VI. The Future of Solitary Confinement in California

A. How Should California Seek Reform?

California is fortunate to have the successes and failures of other states to guide its efforts in confronting its practices and policies governing solitary confinement. Both the lessons learned from other states and California's litigation history suggest that structural reform will likely emerge from legislative or executive efforts, not the courts.

When a solitary confinement case reaches the courts, the litigation tends to be protracted and, even when the plaintiffs prevail, mildly disappointing. The relief is often so narrowly tailored to the alleged injury that only piecemeal change is achieved through each suit. Even in New York, where litigation led to structural reform, it was through a cooperative agreement reached between the parties and not relief ordered by the court. Colorado exemplifies reform achieved through efforts in the executive branch. Once the governor identified solitary confinement as a practice deserving of reform, he appointed a chief corrections officer who was driven to execute his vision. In Maine, even when legislative efforts initially failed, a resolve that led to the illumination of pervasive issues was successfully passed. The executive then used the information and recommendations provided by experts to institute radical changes to its policies.

So how does California achieve the same results? First, while *Ashkar* is unlikely to result in structural reform of solitary confinement, it is an effective method for bringing CDCR to the table and drawing attention to the situation. Second, the hunger strikes in the prisons have placed California prisons at the forefront of national news and placed a reluctant CDCR in a position where not only the prisoners but also the nation are demanding change. Third, politicians like Tom Ammiano should continue to lobby for bills in the legislature that reform the state's practices. Finally, what united New York, Maine, Colorado, and other states that have restructured their use of solitary confinement are heads of corrections who are willing—whether grudgingly or eagerly—to change. Until the executive branch feels compelled to reevaluate its policies and practices with respect to solitary confinement, prison administrators and heads of corrections will only agree to small concessions that permit solitary confinement to persist as a default tool for management and control.

B. Recommendations

Whether California takes a piece-by-piece approach to reform or reinvents its solitary confinement practices entirely, certain aspects of its policies need to be addressed immediately. The following recommendations highlight several of the policies that deserve immediate attention from lawmakers, CDCR, advocates, and the public.

Make Solitary Confinement a Last Resort

A successful structural reform of solitary confinement would require reimagining segregation as a tool of last resort. Under this restructuring of solitary confinement, it would be used, not as a first response or first line of defense against a noncompliant inmate, but as a final measure against an inmate who has failed at every other opportunity. This would require creating a disciplinary system that is based on incentives and disincentives, and that utilizes alternative sanctions for minor transgressions. Like Maine's reformed approach, incremental disciplinary measures such as loss of work privileges, limited visitation, or even confinement to a cell in the general population are all potential punitive options. Corrections officers and staff would need to be trained on these new policies and given additional support and resources for dealing with difficult inmates. Only after an inmate has failed to correct his behavior after every other option has been exhausted should segregation be considered.

Reserve Solitary Confinement for the Most Dangerous Inmates

If CDCR insists that eliminating solitary confinement entirely will place inmates and prison staff at risk, then segregation should be used only for the most serious and unruly offenders. As discussed above, Maine limits its use of solitary confinement to prisoners who constitute an escape risk, pose a threat to their own safety or the safety of others, or whose safety is threatened by others. However, because CDCR has identified gangs as a main contributor to violence in California's prisons, the following should be additional, permissible reasons for placing an inmate in solitary confinement: committing a serious, violent infraction or being a high-level gang leader.

Such a policy would go one step further than the current proposed change, which does not permit gang *associates* to automatically be placed in solitary confinement and instead requires that an inmate commit an offense in service of the gang before being segregated. Although this proposed change is a step in the right direction, it still permits an inmate to be placed in solitary confinement indefinitely if he is a gang *member* even if he has not committed a single disciplinary infraction or crime. Unless an inmate is a high-level gang member in a position of command and control, indefinite segregation is unwarranted. A policy that permits segregation for the commission of a serious, violent offense would permit CDCR to punish gang associates, members, and leaders who compromise the safety of the institution without casting an unnecessarily wide net.

Prohibit the Use of Extreme Isolation

Extreme isolation is characterized by severe sensory and social deprivation and many of the practices in California's segregation units utilize this form of confinement. These practices include confinement in cells for more than twenty-two hours per day, limited access to natural light, rare phone calls or visitation, infrequent opportunities to communicate with other inmates, and a lack of reading or other stimulating materials. In an article commenting on the American Bar Association's Criminal Justice Standards on the Treatment of Prisoners, Margo Schlanger and colleagues state the following about extreme isolation:

Some dangerous prisoners pose a threat to others unless they are physically separated. But such separation does not necessitate the social and sensory isolation that has become routine. Extreme isolation is not about physical protection of prisoners form each other. It is a method of deterrence and control—and as currently practiced it is a failure.[271]

Rather than placing inmates in extreme isolation, solitary confinement should segregate prisoners to the extent necessary to maintain the safety of the other inmates and prison staff without unduly restricting the prisoner's access to basic forms of social and sensory stimulation.

Make Solitary Confinement More Humane By Increasing Access to Social and Sensory Stimuli

Inmates in solitary confinement should be given the opportunity for meaningful interaction with others as well as the chance to escape enforced idleness. They should be given access to reading materials, televisions or radios, writing utensils, and notebooks. They should be permitted to make telephone calls and accept visitors, even if these are no-contact visits. They should also be permitted to spend more time outside of their cells in recreation yards or common eating areas. Each of these changes can occur without compromising the safety of the prison staff or inmates.

Require Frequent Individualized Determinations That an Inmate Belongs in and Should Be Retained in Solitary Confinement

An inmate should not be kept in solitary confinement unless a committee frequently and periodically reviews his case and makes a determination that *continued* isolation is necessary. Such individual determinations should permit inmates to have a meaningful opportunity to challenge the alleged conduct or accusation that leads to their placement in isolation. Furthermore, these determinations should occur every thirty to sixty days.

Tighten the Criteria for Gang Validation

Under these proposed recommendations, only gang members or affiliates who have committed serious offenses should be assigned to solitary confinement. The evidence needed to prove that an inmate is a gang member or leader should be far more stringent such that drawings, possession of a particular book, or innocuous conversations amongst inmates is not satisfactory evidence to support gang validation. Instead, actual conduct or discovery of a conspiracy to commit a serious infraction in furtherance of the gang that can be independently verified should be the only appropriate sources for gang validation.

Make All Segregation Sentences Determinate with Earlier Release Opportunities Pending Completion of an Individualized Plan

Once an inmate is assigned to solitary confinement, prison officials and mental health providers should formulate a plan to transition the inmate out of segregation. This individualized plan should include behavioral goals such as those utilized by the Maine Department of Corrections. Such an incentive system should permit inmates to earn additional privileges for good behavior with the ultimate goal being reintroduction into the general

population. It should incorporate opportunities and interactions that gradually resocialize the inmate into the general population. Inmates should periodically meet with their team to assess their performance and adjust the plan as necessary. This should be an alternative to debriefing but, unlike the current pilot Step Down Program, should not last four years.

Require a Mental Health Screening Within 24 hours of Being Placed in Segregation and Ongoing Mental Health Monitoring, Resources, and Evaluations

Given the prevalence of mental illness in SHU units, ensuring that inmates receive mental health treatment to address preexisting mental illnesses, as well as ongoing treatment to combat the development of mental illnesses while in solitary confinement, is essential. Within twenty-four hours of being placed in segregation, each inmate should receive a mental health screening to ensure that placement in solitary confinement is appropriate. Furthermore, inmates in solitary confinement should receive ongoing mental health monitoring to (1) ensure that they do not start to exhibit behaviors that are cause for concern, and (2) verify that they are progressing through their individualized plans appropriately.

Reserve Inmates' Beds in the General Population While They Are In Solitary Confinement

If inmates spend a determinate period of time in solitary confinement, then CDCR should be able to ensure that a bed in the general population will be available once the inmate is released from segregation. Maine implemented a policy that requires an inmate's bed to be retained pending a review of emergency observation status. Adopting a similar policy here will minimize the number of inmates who are isolated, through no fault of their own, simply because of lack of bed.

Inmates Should Not Be Released Directly From Solitary Confinement Into the Community

The untimely death of Colorado's former state correction chief at the hands of an inmate released directly from solitary confinement illustrates the dangerous and potentially tragic consequences of permitting inmates to "max out" of segregation. Inmates in solitary confinement who are nearing the expiration of their sentences should preemptively be placed into a prerelease resocialization program. Such a program should gradually reintroduce the inmate into the general population before his release and prepare him for life outside of prison. This should include both a behavioral and a resource-based component. In other words, inmates should be prepared for the freedom and choices that accompany life outside of prison, but also be provided with resources regarding potential job opportunities, housing, and community support organizations.

Conclusion

Poised on the precipice of change, California should seize this opportunity to challenge its use of solitary confinement as a routine, default mechanism of control and management in its prisons. While the courts have been successful in attracting attention to the cause and bringing resistant corrections departments to the table, they are primarily vehicles for incremental or piecemeal reform. But armed with scientific research on the detrimental effects of solitary confinement on inmates' mental health, condemnation of the practice from human rights and other organizations, and harrowing personal accounts from inmates living under these conditions, advocates should aspire for more and focus their efforts on the legislative and executive branches of government to achieve structural reform of California's solitary confinement policies and practices.

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[1]. *See* Craig Haney & Mona Lynch, *Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement*, 23 N.Y.U. Rev. L. & Soc. Change 477, 483 (1997).

[2]. Lawrence M. Friedman, A History of American Law 219 (3d ed. 2005).

[3]. Sally Mann Romano, Note, *If the SHU Fits: Cruel and Unusual Punishment at California's Pelican Bay State Prison*, 45 Emory L.J. 1089, 1093 (1996).

[4]. Friedman, *supra* note 2, at 219.

[5]. *See id.*; Haney & Lynch, *supra* note 1, at 483 (citing Harry Elmer Barnes, The Evolution of Penology in Pennsylvania 120 (1927)).

[6]. Romano, *supra* note 3, at 1094 (citing David J. Rothman, The Discovery of the Asylum: Social Order and Disorder in the New Republic 82 (1971)).

[7]. *Id.* (citing Rothman, *supra* note 6, at 85).

[8]. Friedman, *supra* note 2, at 220.

[9]. Haney & Lynch, *supra* note 1, at 484 (citing *In re* Medley, 134 U.S. 160, 168 (1890)).

[10]. *See id.*

[11]. *See id.* at 484-85.

[12]. *Id.* at 487.

[13]. *See* Angela Browne et. al., *Prisons Within Prisons: The Use of Segregation in the United States*, 24 Fed. Sent'g Rep. 46, 46 (2011).

[14]. *Id.*

[15]. *Id.* at 46-47; *see also* Michelle Alexander, *The New Jim Crow*, 9 Ohio St. J. Crim. L. 7, 11 (2011).

[16]. *See, e.g.*, Tim Stelloh, *California's Great Prison Experiment,* Nation (June 5, 2013), http://www.thenation.com/article/174680/californias-great-prison-experiment ("Between 1984 and 2006, California built twenty-one new prisons and, in roughly the same period, increased its prison population from 34,000 to 173,000 prisoners.").

[17]. Haney & Lynch, *supra* note 1, at 491.

[18]. *Id.*

[19]. *Id.*

[20]. Scott N. Tachiki, *Indeterminate Sentences in Supermax Prisons Based upon Alleged Gang Affiliations: A Reexamination of Procedural Protection and a Proposal for Greater Procedural Requirements*, 83 Calif. L. Rev. 1115, 1131 (1995). The term "supermax facilities" in this Article refers to prisons designed "*entirely* to long-term punitive segregation and solitary confinement-like conditions and routines." Haney & Lynch, *supra* note 1, at 495. This differs from other prison facilities that house inmates in the general population with a limited subset of units utilized for solitary confinement.

[21]. *See* Haney & Lynch, *supra* note 1, at 494 ("[T]he Pelican Bay Security Housing Unit was described by the correctional official who authorized its construction as 'an important tool in managing a growing and more violent inmate population.'" (citation omitted)).

[22]. *Id.*

[23]. *Id.*

[24]. Sal Rodriguez, *How Many People Are in Solitary Confinement in California's Prisons?*, Solitary Watch (Dec. 4, 2013), http://solitarywatch.com/2013/12/04/many-california-prisoners-solitary-confinement/.

[25]. *Id.*

[26]. *Id.*

[27]. *Id.*

[28]. Haney & Lynch, *supra* note 1, at 478 (citation omitted) (internal quotation marks omitted).

[29]. Browne et. al., *supra* note 13, at 47.

[30]. Romano, *supra* note 3, at 1098 (citing Kevin Leary, *Pelican Bay as the Prison of the Future*, S.F. Chron., Apr. 18, 1994, at A7).

[31]. *Id.* at 1102.

[32]. *Id.*

[33]. *Id.*

[34]. *Id.* at 1101.

[35]. *Id.*

[36]. *Id.* at 1102-03.

[37]. *Id.* at 1103.

[38]. *See id.* at 1101 ("The inmates can see no other prisoners, nor can they see outdoors.").

[39]. *Id.*

[40]. *Id.* (citing Jan Elvin, *Isolation, Excessive Force Under Attack at California's Supermax*, Nat'l Prison Project J., Fall 1992, at 21).

[41]. *Id.* at 1102.

[42]. *Id.*

[43]. Jeremy B. White, *California Solitary Confinement Changes Questioned at Hearing,* Sacramento Bee (Feb. 11, 2014), http://blogs.sacbee.com/capitolalertlatest/2014/02/solitary-confinement-hearing-hold.html.

[44].The California Code of Regulations was recently updated and involved substantial revisions to CDCR's policies and practices with respect to prison gangs and solitary confinement. These revisions became effective on October 17, 2014. This Article has been updated to reflect the new regulations that are currently in effect.

[45].Cal. Code Regs. tit. 15, § 3341.5(c)(2)(A)-(B) (2015).

[46].*See Learn More*, Prisoner Hunger Strike Solidarity, https://prisonerhungerstrikesolidarity.wordpress.com/education/ (last visited Mar. 2, 2015).

[47].Cal. Code Regs. tit. 15, §§ 3315(b), 3341.5(c)(2)(B)(1) (2015).

[48].*Id.* § 3315(a)(3).

[49].Coleman v. Wilson, 912 F. Supp. 1282, 1293 (E.D. Cal. 1995).

[50].After over twenty years of litigation, the Supreme Court upheld a three-judge district court's remedial order requiring the state to reduce its prison population to 137.5% of design capacity and provide constitutionally compliant medical and mental health care. Brown v. Plata, 131 S. Ct. 1910, 1922-23 (2011).

[51].Declaration of Michael W. Bien in Support of Plaintiffs' Response to Defendants' Amended Application and [Proposed] Order Ex. 25, Coleman v. Brown, (E.D. Cal. Jan. 28, 2014) (No. 2:90-cv-00520).[EE2: Will we be using the photographs?]

[52].*Id.* ¶ 37 (citation omitted).

[53].*Id.* ¶ 40.

[54].*Id.* ¶ 39 (citation omitted).

[55].[SE] Need citation to this figure/picture. Could not find in Declaration of Michael W. Bien in Support of Plaintiffs' Response to Defendants' Amended Application and [Proposed] Order [EE2: No idea what's going on with this footnote. Depends, I suppose, on what we decide re: including photos.]

[56].Declaration of Michael W. Bien, *supra* note 51, ¶ 43.

[57].*Id.* ¶ 38.

[58].Cal. Code Regs. tit. 15, § 3000 (2015). *Compare* Cal. Code Regs. tit. 15, § 3000 (2015), *with* Cal. Code Regs. tit. 15, § 3000 (2013).

[59].Sal Rodriguez, *FAQ*, Solitary Watch (2012), http://solitarywatch.com/facts/faq/.

[60].*See* Cal. Code Regs. tit. 15, § 3341.5(c)(2)(A)(2) (2013). "Except as provided at section 3335(a), section 3378(d) and subsection (c)(5), a validated prison gang member or associate is deemed to be a severe threat to the safety of others or the security of the institution and will be placed in a SHU for an indeterminate term." *Id.*

[61].*Id.* § 3378(c)(3).

[62].*Id.* § 3378(c)(4).

[63].*See, e.g.*, Ryan Devereaux, *Prisoners Challenge Legality of Solitary Confinement Lasting More than a Decade,* Guardian (May 31, 2012, 1:54 PM), http://www.theguardian.com/law/2012/may/31/california-prison-lawsuit-solitary-confinement.

[64].*See id.*

[65].*Id.*

[66].Sadhbh Walshe, *The Solitary Struggle in California Prisons,* Guardian (May 10, 2012, 1:48 PM), http://www.theguardian.com/commentisfree/cifamerica/2012/may/10/solitary-struggle-california-prisons.

[67].Cal. Code Regs. tit. 15, § 3000 (2015).

[68].*Id.* § 3378.2(b).

[69].*Id.*

[70].*Id.* § 3378.2(b)(1), (3)-(6), (9)-(10), (13)-(14).

[71].*Id.*

[72].*Id.* § 3341.5(c)(2)(A)(2).

[73].*Id.* § 3341.5(c)(2)(A)(2)(a).

[74].*Id.* § 3341.5(c)(2)(A)(2)(b).

[75].*Id.* § 3341.5(c)(2)(A)(2)(c).

[76].Although the Code of Regulations designates a separate unit—the Psychiatric Services Unit—for housing inmates with mental illnesses "who require placement in housing equivalent to" SHU, it is unclear if the criteria for leaving the Psychiatric Services Unit differ from the criteria for leaving SHU. *Id.* § 3341.5(b).

[77].This refers to a situation where an inmate was sentenced to SHU for a determinate period of confinement that has not been completed. *See id.* § 3341.5(c)(3)(A).

[78].*Id.* § 3341.5(c)(3).

[79].*Id.* § 3341.5(c)(8).

[80].*Id.*

[81].*Id.* § 3341.5(c)(4).

[82].*Id.* § 3378.5(a).

[83].*Id.*

[84].*Id.* § 3378.5(b).

[85].*Id.*

[86].*Id.*

[87].*Id.* § 3378.5(c).

[88].*Id.* § 3341.5(c)(5).

[89].*Id.* §§ 3000, 3378.3(a).

[90].*Id.* §§ 3000, 3378.3(b)(1).

[91].*Id.*

[92].*Id.* §§ 3000, 3378.3(b)(2).

[93].*Id.*

[94].*Id.* §§ 3000, 3378.3(b)(3).

[95].*Id.* §§ 3000, 3378.3(b)(5)-(6).

[96].Complaint at 18, Ashker v. Brown, No. 4:09-cv-05796 (N.D. Cal. Dec. 9, 2009).

[97].Rodriguez, *supra* note 24.

[98].*See Prisoners' Demands*, Prisoner Hunger Strike Solidarity, https://prisonerhungerstrikesolidarity.wordpress.com/the-prisoners-demands-2/ (last visited Mar. 7, 2015).

[99].*See, e.g.*, Amnesty Int'l, USA: The Edge of Endurance: Prison Conditions in California's Security Housing Units 2-3, 52 (Sept. 26, 2012), *available at* http://www.amnestyusa.org/sites/default/files/edgeofendurancecaliforniareport.pdf.

[100].There are two exceptions. *See* Ivan Zinger, Cherami Wichmann & D.A. Andrews, *Segregation: The Psychological Effects of 60 Days in Administrative Segregation*, 43 Can. J. Criminology 47, 49-50 (2001); Peter Suedfeld, Carmenza Ramirez, John Deaton & Gloria Baker-Brown, *Reactions and Attributes of Prisoners in Solitary Confinement*, 9 Crim. Just. & Behav. 303, 308 (1982). However, each of these studies has been criticized for their methodological flaws. The former involved a sample size much too small to draw any meaningful conclusions, and the latter found numerous negative psychological effects on inmates in solitary but "refused to treat these symptoms reported by prisoners as objective negative health effects of solitary confinement." *See* Peter Scharff Smith, *The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature*, 34 Crime & Just. 441, 472-73 (2006).

[101].Haney & Lynch, *supra* note 1, at 500.

[102].*See* Scharff Smith, *supra* note 100, at 470.

[103].Leo Goldberger, *Experimental Isolation: An Overview*, 122 Am. J. Psychiatry 774, 774-775 (1966) (emphasis omitted).[EE2: Volume number verified via the Google.]

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[105].S. Smith & W. Lewty, *Perceptual Isolation Using a Silent Room*, 2 Lancet 342, 343 (1959).

[106].*See id.* tbl.1.

[107].*See* Haney & Lynch, *supra* note 1, at 500 (quoting Philip E. Kubzansky & P. Herbert Leiderman, *Sensory Deprivation: An Overview, in* Sensory Deprivation: A Symposium Held at Harvard Medical School 220, 237 (Philip Solomon et al. eds., 1961)).

[108].*See* Sidney Cobb, *Social Support as a Moderator of Life Stress*, 38 Psychosomatic Med. 300, 300 (1976).

[109].*See* Neena L. Chappell & Mark Badger, *Social Isolation and Well-Being*, 44 J. Gerontology S169, S169, S175 (1989).

[110].Haney & Lynch, *supra* note 1, at 505.

[111].*See* William A. Fisher, *Restraint and Seclusion: A Review of the Literature*, 151 Am. J. Psychiatry 1584, 1590 (1994).

[112].*See, e.g.*, Paul Gendreau, N.L. Freedman, G.J.S. Wilde & G.D. Scott, *Changes in EEG Alpha Frequency and Evoked Response Latency During Solitary Confinement*, 79 J. Abnormal Psych. 54, 55 (1972).

[113].Haney & Lynch, *supra* note 1, at 516-17.

[114].*See id.* at 516.

[115].Thomas B. Benjamin & Kenneth Lux, *Constitutional and Psychological Implications of the Use of Solitary Confinement: Experience at the Maine State Prison*, 9 Clearinghouse Rev. 83, 84 (1975).

[116].This point is made most vividly in *Solitary Nation*, a PBS Documentary that interviews prisoners and prison officials about solitary confinement. The documentary also illustrates the belief among many corrections officers that self-harm is a way to elicit a response from guards and to be transferred to the hospital and does not represent a psychological response to the extreme conditions of solitary confinement. *Frontline: Solitary Nation* (PBS television broadcast Apr. 22, 2014), *available at* http://video.pbs.org/video/2365229709/.

[117].Sal Rodriguez, *Fact Sheet*, Solitary Watch (2011), *available at* http://solitarywatch.com/wp-content/uploads/2011/06/fact-sheet-psychological-effects-final.pdf (citing Don Thompson, *Convict Suicides in State Prison Hit Record High*, Associated Press (Jan. 3, 2006)).

[118].*See generally* Hans Toch, Mosaic of Despair: Human Breakdowns in Prisons (rev. ed. 1992).

[119].*Id.* at 54.

[120].*Id.*

[121].*See* Haney & Lynch, *supra* note 1, at 518.

[122].*See* Stuart Grassian, *Psychopathological Effects of Solitary Confinement*, 140 Am. J. Psychiatry 1450, 1451 (1983).

[123].*Id.* at 1452.

[124].*See id.* at 1452-53.

[125].Craig Haney, *"Infamous Punishment": The Psychological Effects of Isolation*, 8 Nat'l Prison Project J. 3 (1993).

[126].Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax" Confinement*, 49 Crime & Delinq. 124, 133 tbl.1 (2003).

[127].*Id.*

[128].*Id.* at 134 tbl.2.

[129].Declaration of Dr. Terry A. Kupers ¶ 8, Jones 'El v. Berge, No. 00-C-421-C (W.D. Wis. Aug. 9, 2001).

[130].*Id.*

[131].Gabriel Reyes, *The Crime of Punishment at Pelican Bay State Prison*, S.F. Gate (Nov. 27, 2012), http://www.sfgate.com/opinion/openforum/article/The-crime-of-punishment-at-Pelican-Bay-State-3597332.php.

[132].*See generally* Christopher Burney, Solitary Confinement (1952).

[133].*Id.* at 16.

[134].*See* Robert G. Slater, *Psychiatric Intervention in an Atmosphere of Terror*, 7 Am. J. Forensic Psychiatry 5, 6 (1986).

[135].*Id.* at 10.

[136].Ildiko Suto, Inmates Who Attempted Suicide in Prison: A Qualitative Study 92 (July 27, 2007) (unpublished Ph.D. dissertation, Pacific University), *available at* http://commons.pacificu.edu/cgi/viewcontent.cgi?article=1061&context=spp.

[137].Reyes, *supra* note 131.

[138].*Id.*

[139].*See, e.g.*, *Pelican Bay Prison Hunger-Strikers*, Ctr. for Constitutional Rights, http://ccrjustice.org/pelican-bay-prison-hunger-strikers (last visited May 7, 2015).

[140].*See In re* Medley, 134 U.S. 160, 167 (1890).

[141].*Id.* at 171.

[142].*See In re* Kemmler, 136 U.S. 436, 446 (1890). This was soon overturned in 1898 in *O'Neil v. Vermont*, 144 U.S. 323, 332 (1892), and then later held to be true in *Robinson v. California*, 370 U.S. 660, 667 (1962).

[143].*See* United States v. Moreland, 258 U.S. 433, 449 (1922) (acknowledging solitary confinement as a recognized punishment for prisoners).

[144].Ruiz v. Johnson, 37 F. Supp. 2d 855, 914-15 (S.D. Tex. 1999), *rev'd in part on other grounds sub nom.* Ruiz v. United States 243 F.3d 941 (5th Cir. 2001).

[145].*See generally* Keramet Ann Reiter, *The Most Restrictive Alternative: A Litigation History of Solitary Confinement in U.S. Prisons, 1960-2006*, 57 Stud. Law, Pol. & Soc'y 71 (2012).

[146].*See* David J. Rothman, *Perfecting the Prison: United States, 1789-1865, in* The Oxford History of the Prison: The Practice of Punishment in Western Society 100, 114 (Norval Morris & David J. Rothman eds., 1998).

[147].*See* Anthony F. Granucci, *"Nor Cruel and Unusual Punishments Inflicted:" The Original Meaning*, 57 Calif. L. Rev. 839, 865 (1969).

[148].*Id.*

[149].Weems v. United States, 217 U.S. 349, 367 (1910).

[150].Wilson v. Seiter, 501 U.S. 294, 298 (1991) (internal quotation marks omitted) (quoting Rhodes v. Chapman, 452 U.S. 337, 347 (1981)).

[151].Farmer v. Brennan, 511 U.S. 825, 834 (1994) (citation omitted) (internal quotation marks omitted).

[152].*Id.* (citation omitted).

[153].*Id.* at 837.

[154].Anderson v. State, 887 F. Supp. 2d 1133, 1138-42, 1157-58 (D. Colo. 2012) (granting petitioner's request for outdoor exercise, denying broader due process claim for mental health care).

[155].*See e.g.*, Hutto v. Finney, 437 U.S. 678, 685-88 (1978); Madrid v. Gomez, 889 F. Supp. 1146, 1261-66 (N.D. Cal. 1995).

[156].Ruiz v. Johnson, 37 F. Supp. 2d 855, 928-29 (S.D. Tex. 1999), *rev'd on other grounds sub nom.* Ruiz v. United States, 243 F.3d 941 (5th Cir. 2001).

[157].U.S. Const. amend. XIV, § 1.

[158].*See e.g.*, Hewitt v. Helms, 459 U.S. 460, 467 (1983).

[159].*See* Wilkinson v. Austin, 545 U.S. 209, 220 (2005).

[160].*Id.* at 209-12.

[161].*Id.* at 224.

[162].*Id.* at 220.

[163].424 U.S. 319 (1976).

[164].*Wilkinson*, 545 U.S. at 230.

[165].*Id.* at 227 (citation omitted).

[166].*See, e.g.*, Haney & Lynch, *supra* note 1, at 515-25.

[167].426 F. Supp. 397, 398-99 (N.D. Cal. 1976).

[168].*Id.* at 399.

[169].*Id.*

[170].*Id.* at 403-04.

[171].*Id.* at 404-05.

[172].Toussaint v. Rushen, 553 F. Supp. 1365, 1385 (N.D. Cal. 1983).

[173].*Id.*

[174].Toussaint v. McCarthy, 597 F. Supp. 1388, 1410 (N.D. Cal. 1984), *rev'd on other grounds*, 926 F.2d 800 (9th Cir. 1990).

[175].Hoptowit v. Spellman, 753 F.2d 779, 783 (9th Cir. 1985).

[176].Reiter, *supra* note 145, at 118.

[177].Miles Corwin, *High-Tech Facility Ushers in New Era of State Prisons*, L.A. Times (May 1, 1990), http://articles.latimes.com/1990-05-01/news/mn-141_1_state-prison.

[178].889 F. Supp. 1146 (N.D. Cal. 1995).

[179].*Id.* at 1155-56.

[180].*Id.* at 1280-82.

[181].*Id.* at 1265.

[182].*Id.* at 1266.

[183].*Id.*

[184].Haney & Lynch, *supra* note 1, at 555.

[185].*Madrid*, 889 F. Supp. at 1265.

[186].*See* Haney, supra note 125, at 5-6 (1993).

[187].Plaintiffs' Second Amended Complaint at 1, Ashker v. Brown, No. 4:09-cv-05796-CW (N.D. Cal. May 31, 2012) [hereinafter *Ashker* Complaint].

[188].*Ashker v. Brown*, Center for Const. Rts., http://ccrjustice.org/pelican-bay (last visited May 26, 2014).

[189].*Ashker* Complaint, *supra* note 187, at 39-42.

[190].*Id.* at 43.

[191].*Id.* at 46.

[192].Order at 55, Coleman v. Brown, No. CIV. S-90-520 LKK/DAD (PC) (E.D. Cal. Apr. 10, 2014).

[193].*Id.*

[194].*Ashker* Complaint, *supra* note 187, at 46.

[195].*See* Madrid v. Gomez, 889 F. Supp. 1146, 1282 (N.D. Cal. 1995). But the Northern District of California, and specifically Judge Thelton Henderson, has been amenable to large-scale systemic overhaul and general remedies in other areas of prison litigation more recently. *See, e.g.*, Plata v. Schwarzenegger, C01-1351 TEH, 2005 WL 2932253, at *33 (N.D. Cal. 2005) (imposing court intervention via a receivership on a case decided after more than twenty years of litigation addressing the mental and physical health of prison inmates).

[196].*See, e.g.*, Kirsten Weir, *Alone, in 'the Hole'*, 43 Amer. Psych. Ass'n 54 (May 2012), *available at* https://www.apa.org/monitor/2012/05/solitary.aspx; Jean Casella, *Way Down in the Hole: Senate Hearing Challenges Solitary Confinement for Some, But Not All,* Solitary Watch (Mar. 5, 2014), http://solitarywatch.com/2014/03/05/way-hole-senate-hearing-confirms-growing-opposition-solitary-confinement-prisoners; Elizabeth Landau, *Solitary Confinement: 29 Years in a Box,* CNN (Feb. 23, 2014, 3:44 AM), http://www.cnn.com/2014/02/23/health/solitary-confinement-psychology; Victoria Law, *New ACLU Report Examines Devastating Impact of Solitary Confinement on Women,* Solitary Watch (Apr. 24, 2014), http://solitarywatch.com/2014/04/24/new-aclu-report-examines-devastating-impact-solitary-confinement-women.

[197].*See, e.g.*, *Colorado Prison Director to Reform Solitary Confinement After Enduring It Himself,* RT USA (Mar. 1, 2014, 1:42 AM), http://rt.com/usa/colorado-prison-director-reform-solitary-293; Ryan J. Reilly, *Eric Holder Calls for Rollback of 'Excessive' Use of Juvenile Solitary Confinement*, HuffPost Politics (May 14, 2014, 2:59 PM EDT), http://www.huffingtonpost.com/2014/05/14/holder-solitary-confinement_n_5324768.html; Joel N. Shurkin, *Is Solitary Confinement a Form of Torture?*, Inside Sci. (Feb. 21, 2014, 2:30 PM), http://www.insidescience.org/content/solitary-confinement-form-torture/1569; Paige St. John, *Judge Calls Use of Pepper Spray on Mentally Ill Inmates 'Horrific,'* L.A. Times (Apr. 10, 2014), http://articles.latimes.com/2014/apr/10/local/la-me-ff-judge-pepper-spray-mentally-ill-inmates-20140410; Helen Vera, *The Definitive Case for Ending Solitary Confinement*, Slate (Feb. 26, 2014, 10:59 AM), http://www.slate.com/articles/news_and_politics/jurisprudence/2014/02/against_solitary_confinement_states_are_finding_it_s_impractical_as_well.html/jurisprudence/2014/02/against_solitary_confinement_states_are_finding_it_s_impractical_as_well.html.

[198].Stipulation for a Stay with Conditions at 1, Peoples v. Fischer, No. 11-CV-2694 (SAS) (S.D.N.Y. Feb. 19, 2014) [hereinafter Stipulation].

[199].*Id.* at 2.

[200].*NYCLU Lawsuit Secures Historic Reforms to Solitary Confinement,* N.Y.C.L. Union (Feb. 19, 2014), http://www.nyclu.org/news/nyclu-lawsuit-secures-historic-reforms-solitary-confinement [hereinafterhereafter, *NYCLU Lawsuit*].

[201].*Id.*

[202].*Id.*

[203].*Id.*

[204].*Id.*

[205].Stipulation, *supra* note 198, at 2.

[206].*Id.*

[207].*Id.* at 3.

[208].*Id.*

[209].*Id.* at 3-4.

[210].*Id.* at 4.

[211].*Id.* at 4-6.

[212].*Id.* at 6.

[213].*NYCLU Lawsuit*, *supra* note 200.

[214].*Id.*

[215].Susan Greene, *Tom Clements Death: Prison Officials Acknowledge Chief's Death Tied to Solitary Confinement Policies*, Colo. Indep. (Jul. 8, 2013, 8:53 PM EDT), *available at* http://www.huffingtonpost.com/2013/07/08/tom-clements-solitary-con_n_3564019.html.

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[217].*Id.*

[218].*Id.*

[219].*Id.*

[220].*Id.*

[221].*Id.*

[222].Andrea Rael, *Prisoners With 'Major Mental Illness' Moved Out of Solitary Confinement In Colorado,* Huffington Post (Dec. 16, 2013), http://www.huffingtonpost.com/2013/12/16/colorado-solitary-confinement-mental-illness_n_4453656.html?view=screen.

[223].Memorandum from Lou Archuleta, Interim Dir. of Prisons, State of Colo., to Wardens, Offender Servs., State of Colo. (Dec. 10, 2013).

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[226].Raemisch, *supra* note 216.

[227].*Id.*

[228].Erica Goode, *After 20 Hours in Solitary, Colorado's Prisons Chief Wins Praise,* N.Y. Times (Mar. 15, 2014), http://www.nytimes.com/2014/03/16/us/after-20-hours-in-solitary-colorados-prisons-chief-wins-praise.html.

[229].Zachary Heiden, Change Is Possible: A Case Study of Solitary Confinement Reform in Maine (2013), *available at* http://www.aclumaine.org/sites/default/files/uploads/users/admin/ACLU_Solitary_Report_webversion.pdf.

[230].*Id.* at 20.

[231].*Id.* at 10.

[232].*Id.*

[233].*Id.*

[234]. *Id.* (internal quotation marks omitted).

[235]. *Id.* at 11.

[236]. *Id.* at 20.

[237]. *Id.* at 21, 23.

[238]. *Id.* at 24.

[239]. *Id.*

[240]. *Id.*

[241]. *Id.* at 24-26.

[242]. *Id.* at 14-15.

[243]. *Id.* at 15.

[244]. *Id.* at 17.

[245]. *Id.* at 13.

[246]. *Id.* at 15.

[247]. *Id.* at 14.

[248]. *Id.* at 13.

[249]. *Id.*

[250]. *Id.*

[251]. *Id.* at 14.

[252] *Id.* at 17.

[253]. *Id.* at 16 (internal quotation marks omitted).

[254]. *Id.* at 13.

[255]. *See* Cal. Dep't of Corr. & Rehab., Background: Hunger Strikes in California Prisons 1 (Oct. 2013), *available at* http://www.cdcr.ca.gov/stg/docs/Fact%20Sheet-hunger%20strikes%20in%20CA%20prisons.pdf.

[256]. *Prisoners' Demands*, Prisoner Hunger Strike Solidarity (Apr. 3, 2011), http://prisonerhungerstrikesolidarity.wordpress.com/the-prisoners-demands-2/

[257]. *See* Cal. Dep't of Corr. & Rehab., *supra* note 255, at 1; Todd Ashker et. al., *Peaceful Protest to Resume July 08, 2013, If Demands Are Not Met*, Prisoner Hunger Strike Solidarity (Feb. 14, 2013), http://prisonerhungerstrikesolidarity.wordpress.com/2013/02/14/peaceful-protest-to-resume-july 8th-2013-if-demands-are-not-met/ ("Governor Brown's, and CDCR Secretary Cate's, failure to make the changes agreed upon during the July/October 2011 negotiation process, has forced us to resume our nonviolent hunger strike/work stoppage protest. During these negotiations, CDCR's Undersecretary Keman, et al, acknowledged the reasonableness of our Five (5) Core Demands and asked us to suspend our hunger strike in order to give the CDCR time to implement timely and meaningful changes of real sub- stance[sic], in response to our demands. We agreed—while CDCR has failed to do their part.").

[258]. *See* Cal. Dep't of Corr. & Rehab., *supra* note 255, at 1-2; Ashker et al., *supra* note 257.

[259]. *See* Cal. Dep't of Corr. & Rehab., *supra* note 255, at 1-2.

[260]. Cal. Dep't of Corr. & Rehab., Security Threat Group Prevention, Identification, and Management Instructional Memorandum 1 (Oct. 12, 2012), *available at* http://www.cdcr.ca.gov/stg/docs/Security-Threat-Group-Prevention-ID-Mgmt-Inst-Memo-1.pdf [hereinafter Security Threat]. As stated above, CDCR has recently adopted revised Regulations that implement many of the changes pioneered in the pilot policy. *See supra* note 45[EE2: Need to double check this once Kip finishes the first half].

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[263]. *Id.*

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[265].Sal Rodriguez, *In California Prisons, Hundreds Have Been Removed from Solitary Confinement-and Thousands Remain,* Solitary Watch (Jan. 27, 2015), http://solitarywatch.com/2015/01/27/in-california-hundreds-have-been-removed-from-solitary-confinement-and-thousands-remain/.

[266].*Id.*

[267].Shourd, *supra* note 262 (internal quotation marks omitted).

[268].Victoria Law, *One Month After Historic Hunger Strike, California Lawmakers Holding Hearings on Solitary Confinement,* Solitary Watch (Oct. 22, 2013), http://solitarywatch.com/2013/10/22/one-month-historical-hunger-stirke-california-lawmakers-hold-hearings-solitary-confinement/; *Video of Legislative Hearing February 11, 2014*, Prison Hunger Strike Solidarity (March 10, 2014), https://prisonerhungerstrikesolidarity.wordpress.com/2014/03/10/video-of-legislative-hearing-february-11-2014/.

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[270].Cal. S.B. 892; Assemb. B. 1652. 2013-2014 Leg., Reg. Sess. (Cal. 2014).

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BEYOND SUPERMAX ADMINISTRATIVE SEGREGATION

Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs

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Litigation in Mississippi required the Department of Corrections to ameliorate substandard conditions at the supermaximum Unit 32 of Mississippi State Penitentiary at Parchman, remove prisoners with serious mental illness from administrative segregation and provide them with adequate treatment, and reexamine the entire classification system. Pursuant to two federal consent decrees, the Department of Corrections greatly reduced the population in administrative segregation and established a step-down mental health treatment unit for the prisoners excluded from administrative segregation. This article describes and discusses not only the process of enacting the changes but also the outcomes, including the large reductions in rates of misconduct, violence, and use of force.

Keywords: supermaximum security; administrative segregation; classification; use of force; mental health step-down unit

Between the 1970s and the 1990s, the prison population in the United States multiplied several times over, and prisoners who were suffering from serious mental illness (SMI) grew to a greater proportion of the prison population (U.S. Bureau of Justice Statistics, 2006). Meanwhile, and predictably (based on the crowding), correctional facilities experienced a sharp rise in rates of misbehavior and violence. In response to what many perceived as unmanageable prisons, departments of correction increasingly turned to lockdown and administrative segregation as the way to manage the rising rates of violence and misbehavior. Sections of prisons and even entire newly constructed facilities were dedicated to administrative segregation. The supermaximum security prison thus emerged (Riveland, 1999; Scharff-Smith, 2006).

In administrative segregation units and supermaximum security facilities, prisoners are confined to their cells, by themselves or with cellmates, nearly 24 hours per day. They eat meals in their cells, and their out-of-cell activities are limited to solitary trips to a small yard for recreation (several hours per week) and to relatively rare, noncontact visits with family and friends.

Immediately following the advent of the supermaximum security prison in the early 1990s, litigation challenged the constitutionality of the conditions (*Jones 'El v. Berge*, 2001; *Madrid v. Gomez*, 1995). The argument of plaintiffs was that the extreme isolation and idleness caused unnecessary pain, suffering, and serious psychiatric harm. The courts concurred and so ordered amelioration of some of the harshest conditions, as well as the removal of prisoners with SMI from long-term administrative segregation. Cohen (2008) provides a comprehensive history of this litigation. By the late 1990s, some states began to realize that supermaximum security and other forms of long-term administrative segregation were expensive. It also became apparent that a disproportionate number of prison suicides were occurring among prisoners in administrative segregation and that recidivism rates were rising. Furthermore, it had never actually been proved that the advent of supermaximum security units diminished the prison and postrelease rates of misconduct and violence (Briggs, Sundt, & Castellano, 2003).

Clinical research supported the notion that many prisoners suffering from SMI were being consigned to long-term administrative segregation (Rhodes, 2004), that the idleness and isolation tended to make psychiatric conditions and prognoses worse (Grassian & Friedman, 1986; Hodgins & Cote, 1991), and that providing treatment to prisoners with SMI resulted in their involvement in far fewer disciplinary infractions (Condelli, Dvoskin, & Holanchock, 1994). Several states—including Virginia, Maryland, Ohio, and Michigan—converted facilities that had been dedicated to administrative segregation, utilizing the buildings for other purposes.

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Beginning in 2002, advocates of prisoners' rights brought litigation aimed at improving the plight of prisoners in Unit 32 at Mississippi State Penitentiary, Parchman (*Presley v. Epps*, 2007; *Russell v. Johnson*, 2003). A 1,000-cell supermaximum security facility, Unit 32 contained the state's death row, plus a large number of cells for administrative segregation. In other states, this type of litigation leads to endless court battles and little change; in Mississippi, however, the adversarial relationship, at some point, shifted to a mostly collaborative one. As a result, the litigation was amicably settled, and the monitoring of the required changes commenced. The Mississippi Department of Corrections (MDOC) changed course after a few court hearings, instituting the changes in classification and the mental health programming that the plaintiff class had been demanding. There are legal, organizational, and programmatic aspects to the changes that ensued. The subsequent decreases in rates of violence, disciplinary infractions, and use of force were substantial.

CONDITIONS AT UNIT 32 BEFORE LITIGATION

Beginning in the early 1990s, prisoners at Unit 32 described a harsh environment: severe isolation, unrelieved idleness and monotony, little access to exercise, stench, and filth. The toilet in every cell had a "ping-pong" mechanism: Whenever it was flushed, it pushed the waste in the bowl into the bowl in the adjoining cell. Infestations of mosquitoes and other stinging insects forced prisoners to keep their windows closed and their bodies completely covered, even in the hottest weather—and the temperatures in the cells during the long Delta summers were extreme. The light was too dim for reading and writing. Medical, dental, and mental health care was inadequate. Psychotic prisoners started fires, flooded the tiers, smeared feces, and screamed, often all night. Prisoners were moved into cells that had been smeared from floor to ceiling with excrement from previous, psychotic tenants. Takedown teams extracted prisoners from their cells and subdued them with pepper spray, adding to the toxic environment caused by fire and flooding. Many prisoners stayed in Unit 32 for the duration of their sentences, some for life. In January 2002, the prisoners on Mississippi's death row went on a hunger strike to protest the conditions of their confinement.

THE LITIGATION

In July 2002, the National Prison Project of the ACLU (American Civil Liberties Union), the ACLU of Mississippi, and the law firm of Holland & Knight filed suit on behalf of the death row prisoners. In May 2003, U.S. magistrate judge Jerry Davis entered an opinion and injunction granting the relief that plaintiffs had requested (*Russell v. Johnson*, 2003). The Fifth Circuit issued a decision, for the most part, upholding Judge Davis's injunction (*Gates v. Cook*, 2004).

Meanwhile conditions in the rest of Unit 32 continued to deteriorate. In 2005, the prisoners filed a new suit to extend the remedies ordered in the death row case to all of Unit 32 (*Presley v. Epps*, 2005). The new case, however, addressed additional, more complex correctional issues. The most severe problems stemmed from the classification system, which effectively assigned most of the 1,000-man population in Unit 32 to permanent

administrative segregation. A negotiated consent decree in *Presley v. Epps* incorporated all the relief upheld by the Fifth Circuit in the death row case, including the exclusion of administrative segregation for prisoners suffering from SMI. The parties added provisions on excessive force, procedural due process, and classification.

Plaintiffs retained a classification expert, Dr. James Austin, to carry out an objective analysis of the Unit 32 population, which concluded that nearly 80% of the unit's population did not belong in administrative segregation and should thus be transferred to general population. In December 2006, the parties met and agreed to collaborate to reform the classification system within a 12-month period. MDOC Commissioner Christopher Epps promptly established a classification task force under the direction of Deputy Commissioner Emmitt Sparkman to work closely with Dr. Austin and key Department of Corrections officials.

Meanwhile, progress on the mental health issues was slow. Addressing the mental health issues was essential to fully addressing the classification issues. Prisoners with untreated mental illness became more disturbed in administrative segregation; their illness led them to misbehave; security staff sprayed them with chemicals; and their mental health further deteriorated. This cycle of psychosis, disturbed behavior, use of force, further clinical deterioration, and increasingly psychotic behaviors put severe pressure on, not just prisoners with SMI, but everyone who lived and worked in Unit 32.

In April 2007, Judge Davis held an evidentiary hearing on the mental health issues. At the end of 6 hours of testimony, the judge called the lawyers into chambers. He advised them, in the most urgent terms, to make every effort to come up with a joint plan to remedy the situation. He said that he feared Unit 32 was a tinderbox about to explode.

A few weeks later, Unit 32 did explode. At the end of May 2007 and continuing into August, there was an outburst of gang warfare in which many inmates were stabbed and some died. One may wonder how prisoners in a segregation unit can attack one another. Athough prisoners were mostly confined to their cells, some worked as tier tenders and had unsupervised access to the front of other cells; as such, there were occasions when cell doors were accidentally left ajar, and prisoners had sufficient access to one another to permit violence.

Then came an extraordinary development: Commissioner Epps and Deputy Commissioner Sparkman decided, even in the face of this deep crisis in security, to go forward and implement the recommendations of the classification task force. Deputy Commissioner Sparkman left his home in Jackson to live at Parchman for months, overseeing the release of several hundred carefully selected men into general population, walking among them, speaking and interacting with them, getting to know their histories, showing his staff at the prison that these men were not so dangerous that they needed to be in administrative segregation.

These were remarkable acts of courage—and they worked. Within a few months, a striking transformation of Unit 32 had taken place. In accordance with Dr. Austin's recommendations—and following a procedure to be described below—more than three fourths of the unit's population had been reclassified from administrative segregation to general population. Program and recreation areas were constructed. General population housing areas were created in housing areas that had previously been used to lock down prisoners. The prisoners in these housing areas could spend several hours per day out of their cells. Education and general mental health services were expanded. A dining hall was constructed, and for the first time, prisoners could eat meals together. In November 2007,

the parties entered into a far-reaching supplemental consent decree with the MDOC on classification, mental health, and use of force (*Presley v. Epps*, 2007).

REVISION OF CLASSIFICATION AND SECURITY PROCEDURES

Before 2002, the MDOC used a subjective prisoner classification system, placing inmates in facilities and custody levels based solely on the subjective judgment of staff, as guided by agency policies. The MDOC decided to implement an objective prisoner classification system in 2002, consisting of an initial classification process and a reclassification process that, in theory, would allow prisoners to lower their custody levels if their conduct was good. The system was fully automated, which allowed for a comprehensive analysis of how prisoners were being classified and what factors were used to determine custody levels.

But the system had some serious design flaws that fostered overclassification and, in particular, increased the number of prisoners assigned to Unit 32. Dr. Austin found that prisoners were transferred directly from reception to Unit 32 even if they had not engaged in serious misconduct in prison; that redundancies in scoring resulted in overclassification; that some of the scoring items had never been validated among the MDOC population; that classification staff were making scoring errors; that some prisoners who simply required protection were being transferred to Unit 32; that a large number of prisoners were being retained in Unit 32 even though they had no serious misconduct reports for years; that required reassessments were not being done; and that the caseload for case managers was so large that they could not have adequate contact with prisoners.

Given these findings, Dr. Austin recommended a number of reforms. The first step was to develop more objective criteria for placement at Unit 32. Deputy Commissioner Sparkman worked with Dr. Austin to establish the criteria and implement the new system. The criteria that were finally adopted mandate that prisoners in Mississippi may be held in administrative segregation only if they have committed serious infractions, are active high-level members of a gang, or have prior escapes or escape attempts from a secure facility. The only permissible subjective basis for overriding these criteria is a finding by the commissioner (or the commissioner's designee) that housing the inmate in the general population would pose an unacceptable risk to the safety of staff and other prisoners.

When the classification staff employed the new criteria and reviewed all the prisoners in Unit 32, they discovered that nearly 80% of the population in administrative segregation did not meet the new criteria. Over the following 6 months, the number of prisoners assigned to administrative segregation at Unit 32 dropped from 1,000 to fewer than 150. Death-sentenced prisoners remained in segregation.

Criteria were also established, as modeled on a process in the Ohio Department of Corrections, that would allow the majority of prisoners to be released from administrative segregation within 12 months. The MDOC created a process that mandated a 90-day review for all prisoners in administrative segregation and a written case plan for each prisoner specifying what he must do to gain release from administrative segregation.

The changes that the MDOC adopted were not limited to Unit 32. The new classification system is expected to dramatically decrease the number of women in maximum custody and to increase the proportion of the statewide male population in minimum custody.

A STEP-DOWN UNIT FOR PRISONERS WITH SMI

As required by the *Presley v. Epps* consent decree, mental health staff worked in close collaboration with custody staff to develop an intermediate-level treatment program, or step-down unit, for prisoners with SMI (Lovell, Allen, Johnson, & Jemelka, 2001; O'Connor, Lovell, & Brown, 2002). Prisoners who require an intermediate level of mental health treatment—equivalent to halfway house or day treatment in the community—are candidates for the step-down unit, which is jointly administered by Wexford Health Sources, the health and mental health contractor, and the MDOC.

Wexford and MDOC opted to keep the step-down mental health treatment unit inside Unit 32 but to move prisoners with SMI from administrative segregation status into congregate activities in program phases, at a pace that would not jeopardize safety in the facility (Adams & Ferrandino, 2008). Prisoners who require inpatient psychiatric services are transferred to an inpatient psychiatric unit at another facility—namely, the East Mississippi Correctional Facility.

The step-down unit was developed to treat prisoners who have to remain segregated for the time being and open-population prisoners (i.e., general-population prisoners) with SMI. The unit occupies two tiers, each containing 16 cells: an upper tier, housing segregated prisoners, and a lower tier, which is reserved for prisoners who have proved, by exhibiting appropriate behavior, that they can get along in an open unit. In fact, the step-down unit provides, for many prisoners, the portal for leaving administrative segregation. The program fosters movement from the closed tier to the open tier.

The target population is patients who have the most serious and intractable symptoms of mental illness and who experience the greatest impairment in functioning. The main criterion for admission to the step-down unit is a diagnosis that qualifies as a SMI. In addition, prisoners with other diagnoses, such as severe generalized anxiety disorder and posttraumatic stress disorder, qualify if there is significant disability. Any psychiatric disorder characterized by repetitive self-harm also qualifies a prisoner for admission. Preference for admission is given to motivated prisoners.

Prisoners begin in the closed or segregated tier, progress through the open tier, and then graduate and transfer from the step-down unit to general population. Treatment in the step-down unit is modeled on the assertive community treatment approach (Drake et al., 1998; Marx, Stein, & Test, 2003; Scott & Dixon, 1995). The idea is to deliver intensive mental health services to the place where the patients live and work and for staff working as a team to be assertive in gaining the patients' cooperation in the treatment. A positive psychology approach is employed, removing the focus from mental illness and, instead, focusing on "persons' intact faculties, ambitions, positive life experiences, and strengths of character, and how those buffer against disorder" (Duckworth, Steen, & Seligman, 2005, p. 631).

Prisoners earn passage to each successive phase. In the first phase, they learn about their illnesses and are educated about how to appropriately cope with anger, impulses, and anxiety. An incentive plan rewards appropriate behaviors, with incrementally more time alone in an activity room where they can access media equipment, use a library of educational materials and fiction, and use drawing and writing materials.

Group treatment and psychoeducation permit interconnectedness among prisoners who must remain separated for the time being. A group of four prisoners meet weekly for group treatment. The original plan for this group treatment was to construct therapeutic cubicles

in which the prisoners would sit during the sessions while remaining in the same room. However, the staff decided that it would be more practical, humane, and therapeutic to not use cubicles but rather keep group participants in ankle restraints attached to secure bolts in the floor. This was the minimum restraint that custody staff would allow. If animosities escalate, participants in the group cannot reach one another. In fact, the prisoners in the program have never lunged at anyone, but at their level of security, the ankle-to-floor restraints are required.

The next phase of treatment involves congregate, peer-facilitated programming. This phase takes place on the open-custody tier and lasts several months. Prisoners move about and enjoy congregate activities free of cuffs and ankle restraints. Topics addressed include domestic violence, mentorship, accountability, and moral reasoning.

The step-down unit employs a collaborative treatment team approach. The Risk Assessment Team includes mental health staff and key security personnel who come together on a weekly basis to work on quality care as well as security. Of course, confidentiality is an issue, and custody staff who work on the unit must agree to respect the prisoners' confidentiality to a reasonable extent while attending to security needs. In general, custody staff and mental health staff attend to the delicate balance between confidentiality and security concerns.

Staff selection and training are critical elements of an effective program. In April 2008, before the step-down unit could be officially implemented, a comprehensive mental health training curriculum was expressly designed for correctional officers. The administration approved a plan to require that any officer working on the step-down unit undergo training on mental health issues. The intensive training is conducted by trained and experienced mental health staff and veteran MDOC correctional officers. Completion of the mental health training is considered an honor and is thus celebrated in a ceremony where officer graduates are given a special uniform patch and awarded the title *correctional mental health manager*.

Prisoners remain in the step-down unit an average of 3 to 6 months. They are considered ready for discharge from the program when their treatment plans have been accomplished and their conditions have become stable. After being discharged, a prisoner may be readmitted if he experiences a relapse. If he is discharged for lack of compliance or behavioral issues, he may be considered for readmission following intensive individual treatment with mental health staff.

CHANGES IN THE FACILITY AND IN THE BEHAVIOR OF PARTICIPANTS

SERIOUS MISCONDUCT AND USE OF FORCE

After a large proportion of prisoners were transferred to general population within Unit 32 (necessitating the physical conversion of pods and buildings), the number of incidents requiring use of force plummeted (e.g., spraying a prisoner with immobilizing gas or taking down a recalcitrant prisoner). Monthly statistics showed an almost 70% drop in serious incidents, both prisoner-on-staff and prisoner-on-prisoner. Figure 1 reflects this development. Toward the end of 2006, the number of serious incidents began to decline, and they reached a nadir by January 2008. In the same period, incidents requiring the staff's use of force also significantly declined (see Figure 2).

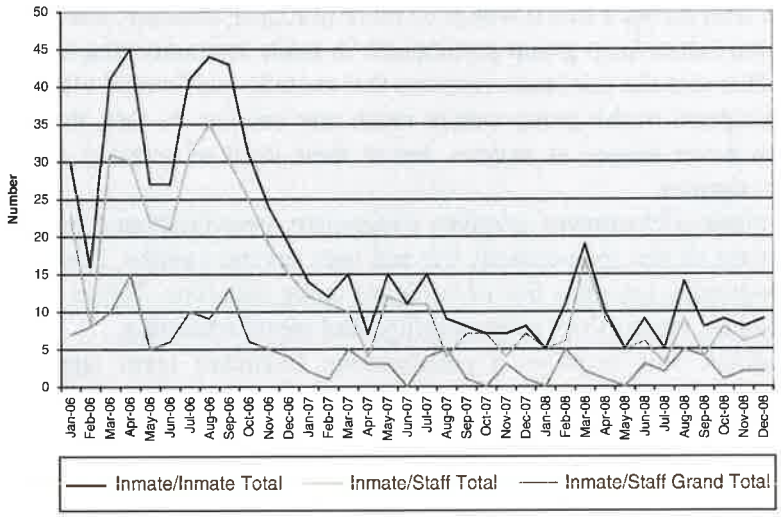

Figure 1: Serious Incidents at Unit 32, 2006–2008

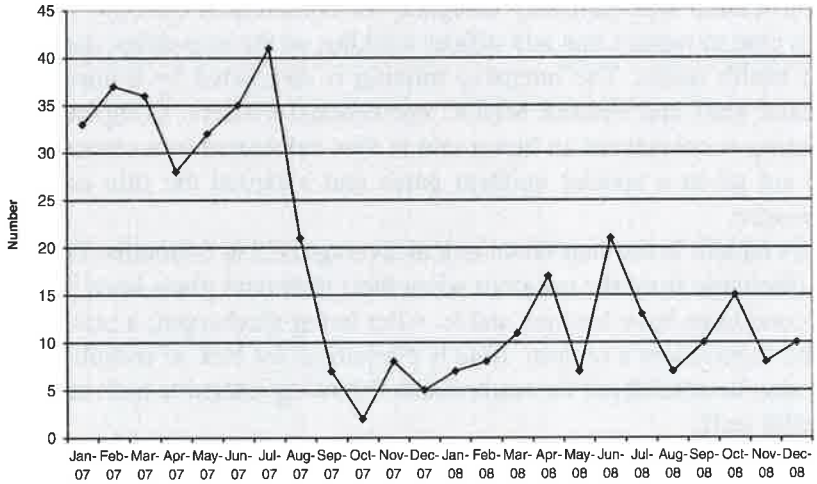

Figure 2: Use of Force at Unit 32, 2007–2008

From 2006 through 2008, the population of Unit 32 also varied, from a high of approximately 990 in August 2006 to a low of fewer than 600 by October 2008. (By this time, the census included administrative segregation and general population.) For various reasons, the MDOC transferred some of the prisoners who had been reclassified to general population out of Unit 32. January 2008 became the first time that the population dipped lower than 800. Thus, the sharp reduction in rates of serious incidents and use of force that occurred between late 2006 and January 2008 took place while the total population in Unit 32 remained relatively constant.

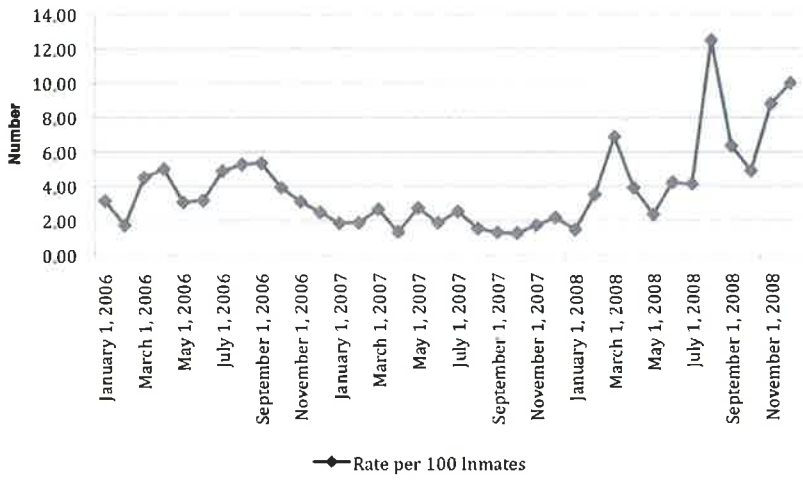

Figure 3: Rates of Serious Incidents and Use of Force per 100 Inmates

In early 2008, when the population dipped beneath 800, a calculation of the rate of serious incidents and use of force (i.e., the ratio of events to 100 prisoners) reflected occasional spikes (see Figure 3). The prisoners remaining in administrative segregation subsequent to the transfer of a majority of prisoners to general population were a relatively more disruptive subpopulation; as such, with the reduced population, repeated disciplinary infractions by a few individuals register as a larger spike on the graph. Even so, the raw number of serious incidents remained relatively low throughout.

Developments reported in this article did not occur under entirely controlled conditions in a laboratory. The results would have been more impressive had the total population in Unit 32 been kept constant subsequent to the revision of the classification system and the establishment of the step-down unit. But the MDOC had to maintain operations and could not permit outcome research to determine practices regarding institutional housing.

In reviewing changes at one unit, one must take into account changes that occur at other units and at other state facilities that may be counterproductive. In some states, compliance with a court's consent decree to downsize a supermaximum security unit or to exclude prisoners with SMI from isolated confinement has resulted in the transfer of this population to some form of segregation at a different facility not under the court's jurisdiction (e.g., *Jones 'El v. Berge*, 2001). In the MDOC, recent statewide figures reflect that this kind of nutshell game has not occurred. As noted above, by February 2009, the number of prisoners in administrative segregation at Unit 32 had decreased from just over 900 to below 100 (an additional 70 to 80 prisoners remain on segregation status on death row). Meanwhile, as of March 2009, the statewide number in administrative segregation (outside of death row) is 181. The population of MDOC is approximately 21,000, which means that about 1% of the entire prison system is housed in long-term administrative segregation. Most states have at least 3% of their prisoner population in administrative segregation at any given time (Austin & McGinnis, 2004). Thus, the percentage of MDOC prisoners in administrative segregation is relatively low, and it did not rise in other units or institutions when the percentage of prisoners on administrative segregation status at Unit 32 was vastly reduced.

TABLE 1: Rule Violation Reports Before, During, and After Participation in the Step-Down Unit

	Rule Violation Reports	
Period	n	M
Six months before step-down unit	203	4.7
While in step-down unit	50	1.2
Six months after step-down unit	27	0.6

OUTCOMES IN PRISONERS WITH SMI

Prisoners, custody staff, and mental health staff provide positive assessments of the step-down unit. Of course, prisoners with SMI had been heavily overrepresented in the earlier serious disciplinary incidents, and it is obvious to mental health and custody staff that participation in the step-down unit has helped to keep this group out of trouble.

One reflection of this outcome lies in the number of rule violation reports (RVRs), or tickets, that participants in the step-down program acquired as they went through the process—that is, before participating in the program, while participating in the program, and after being discharged from the program. A recent compilation (February 12, 2009) reflected that 43 prisoners with SMI had completed the step-down unit program and had been discharged. A search of their disciplinary records revealed that in the 6 months before their admission to the program, this group received 253 RVRs, an average of 4.7 RVRs per prisoner; while in the program (for an average stay of 6 months), they received 50 RVRs, an average of 1.2 per prisoner; and in the 6 months after they completed the program, they accounted for 30 RVRs, for an average 0.6 per prisoner (for overview, see Table 1).

Prisoners have been writing to request transfer into the program, and the program has proved to be an effective point of entry into mental health treatment for previously non-compliant prisoners with SMI. Prisoners in the program report that they expect to be treated with respect and not be inappropriately punished or otherwise abused.

Recently, the step-down unit successfully graduated most of the Security Threat Group leadership who were participants. One former leader has been granted Open C custody (essentially, general population privileges); two other leaders graduated with honors. One of these prisoners will be released from prison in the near future and plans on lecturing youth on "going straight in life."

DISCUSSION

The results of this series of events at Unit 32 contradict some widespread assumptions about supermax administrative segregation. The popularity of supermaximum security units is premised on the assumption that the dangerous prisoners confined therein cannot program safely at any lower level of security and that violence and misconduct in the prisons cannot be controlled without keeping a growing number of dangerous prisoners in long-term administrative segregation. An extrapolation of this assumption suggests that releasing the majority of prisoners from supermax to general population will result in increases in the rates of violence, serious disciplinary incidents, and use of force. The fall

in these rates, following the transfer of a majority of prisoners out of administrative segregation at Unit 32, contradicts that assumption.

Of course, the MDOC classification system was flawed before the developments described here were initiated. Could that mean that the men consigned to administrative segregation at Unit 32 were simply not the most dangerous in the MDOC and that, because of a uniquely flawed classification system in the MDOC, the results of changes at Unit 32 cannot be generalized to other correctional settings? The number of prisoners in administrative segregation throughout the MDOC remains relatively low today. Most of the prisoners who were released from administrative segregation remain in general population, thus making it unlikely that the placement of the wrong group of prisoners in supermax security explains the reported findings. Also, attorneys and experts in the Mississippi lawsuits who have taken part in investigations and litigation in other states report that it is not unusual for supermaximum security units to contain a significant proportion of prisoners who are not especially prone to violence. Classification systems in many other departments of correction contain flaws equivalent to those in the earlier MDOC system. Furthermore, among the approximately 800 prisoners transferred from administrative segregation to general population, many had been convicted of violent crimes and had been assaultive earlier in their prison careers; however, when they were transferred out of administrative segregation, most of them did not proceed to get into trouble.

Prisoners who remain in administrative segregation at Unit 32 have relatively serious misconduct records; as such, the residual administrative segregation population at Unit 32 is a difficult population to manage and treat (Cohen, 2006). Even so, Unit 32 today has relatively low rates of serious incidents and use of force. Many factors must be considered if we are to understand this phenomenon. Because the classification system was revised and the review process permitted prisoners in administrative segregation to earn their way to general population, they must have felt as though they were being treated with fairness and that they had greater hope for gaining freedom—all of which must have helped them control their tempers and their behavior. In addition, in the course of the litigation, the MDOC administration focused greater attention on the professionalism of custody staff, and a subgroup of custody staff received training in mental health. These changes, plus the reduction in crowding as the population of Unit 32 declined, all played into a greater sense of fairness and calm within the facility (Haney, 2008). The overall result is far fewer prisoners in need of administrative segregation.

There was a sharp decrease in the number of RVRs accumulated by prisoners with SMI after they were transferred to the step-down unit, which strongly supports a conclusion that prisoners with SMI tend to suffer psychiatric deterioration and get into disciplinary trouble in supermax administrative segregation; as such, they fare much better in treatment programs (Condelli et al., 1994; Lovell, Johnson, & Cain, 2007; Metzner & Dvoskin, 2006). Clearly, the changed management of prisoners with SMI played a part in reducing the number of serious incidents and use of force at Unit 32.

Of course, this is a preliminary report of the outcome of changes in classification and mental health treatment at Unit 32. Problems remain and monitoring is ongoing, but the problems encountered are less generalized, and a collaborative approach to their resolution is much more the standard operating procedure. For example, on a recent monitoring tour, plaintiffs' attorneys and experts heard allegations from prisoners regarding excessive force—specifically, the inappropriate use of immobilizing gas. These allegations were reported to the

superintendent and deputy commissioner, and a procedure was put into place to investigate allegations as well as make absolutely clear to staff and prisoners that inappropriate use of force by officers will not be tolerated. Another problem being addressed involves delays in accomplishing warranted transfers and other rewards for successful completion of phases in the step-down unit.

Tough issues remain. The monitor and plaintiffs' attorneys would like to see more amenities and freedoms for prisoners in the step-down unit. An even more thorny issue is the management of prisoners in the step-down unit who break rules or commit assaults. Should they be ejected from the treatment program? And, if so, where can they go and receive the treatment they need? As we write, the parties are discussing the housing and mental health treatment of prisoners whose misconduct results in their ejection from the step-down unit. Meanwhile, much has been accomplished at Unit 32.

DEBATING ADMINISTRATIVE SEGREGATION

There is an ongoing national debate about the need for evermore severe restrictions and harsher punishments in corrections (Cohen, 2006; Scharff-Smith, 2006). Mounting prison violence was a major part of the rationale for transferring so many prisoners into some form of segregation. But does long-term administrative segregation actually improve the situation? The big problem with locking prisoners down is that the majority of them must be eventually released (Kupers, 2008). The results of changes at Unit 32 support the notion that, on average, long-term administrative segregation—especially if prisoners perceive it as being unfair and indefinite—will in many cases exacerbate misconduct and psychiatric dysfunction.

The developments described here also illustrate something about the effect of litigation on corrections. When litigation is brought, the state too often believes that it has to defend its policies and practices, and it is slow or resistant in responding to consent decrees and court orders. But when the parties to the litigation reach an amicable negotiated settlement, as memorialized by the court in a consent decree, then a more collaborative approach to effecting change becomes possible (Cohen & Aungst, 1997). In Mississippi, the administration of the Department of Corrections eventually welcomed the changes demanded by the plaintiffs in a series of class-action lawsuits, which cleared the way for the changes to be put into effect in an atmosphere of strong collaboration. As such, there are at least two levels of collaboration: The expert witnesses in the litigation essentially became consultants to the MDOC, and within the MDOC, there was greatly improved collaboration between custody and mental health staff in effecting the agreed-on changes. The writing of this article is just one of many products of that collaboration.

In this kind of collaborative process, it becomes possible to devise management and treatment strategies for prisoners who might otherwise be considered incorrigible. Hans Toch points out that the older notion that a prisoner's misbehavior is due to either badness or madness misses the fact that for many prisoners, there is both madness and badness—that is, the disturbed/disruptive prisoner (in Toch & Adams, 2002). In fact, effective strategies have been devised to intervene with disturbed/disruptive prisoners (Jones, 2004; Toch & Adams, 2002; Toch & Kupers, 2007). Outcome studies reflect that such methods work (Jones, 2004; Lovell et al. 2001).

The assumption that a large number of prisoners are beyond help and will never change their unacceptable behaviors, when coupled with the practice of locking them in segregation and punishing them harshly, predictably leads to worse behavior problems on the part of those locked away. Alternatively, when custody and mental health experts put their heads together, devise creative approaches to the management and treatment of some of the most difficult cases, and give prisoners clear and incremental requirements to win greater freedom, great strides are made.

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Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics

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Abstract

In recent years, prison officials have increasingly turned to solitary confinement as a way to manage difficult or dangerous prisoners. Many of the prisoners subjected to isolation, which can extend for years, have serious mental illness, and the conditions of solitary confinement can exacerbate their symptoms or provoke recurrence. Prison rules for isolated prisoners, however, greatly restrict the nature and quantity of mental health services that they can receive. In this article, we describe the use of isolation (called segregation by prison officials) to confine prisoners with serious mental illness, the psychological consequences of such confinement, and the response of U.S. courts and human rights experts. We then address the challenges and human rights responsibilities of physicians confronting this prison practice. We conclude by urging professional organizations to adopt formal positions against the prolonged isolation of prisoners with serious mental illness.

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Jeffrey L. Metzner, MD, and Jamie Fellner, Esq.

In recent years, prison officials have increasingly turned to solitary confinement as a way to manage difficult or dangerous prisoners. Many of the prisoners subjected to isolation, which can extend for years, have serious mental illness, and the conditions of solitary confinement can exacerbate their symptoms or provoke recurrence. Prison rules for isolated prisoners, however, greatly restrict the nature and quantity of mental health services that they can receive. In this article, we describe the use of isolation (called segregation by prison officials) to confine prisoners with serious mental illness, the psychological consequences of such confinement, and the response of U.S. courts and human rights experts. We then address the challenges and human rights responsibilities of physicians confronting this prison practice. We conclude by urging professional organizations to adopt formal positions against the prolonged isolation of prisoners with serious mental illness.

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Physicians who work in U.S. prison facilities face ethically difficult challenges arising from substandard working conditions, dual loyalties to patients and employers, and the tension between reasonable medical practices and the prison rules and culture. In recent years, physicians have increasingly confronted a new challenge: the prolonged solitary confinement of prisoners with serious mental illness, a corrections practice that has become prevalent despite the psychological harm it can cause. There has been scant professional or academic attention to the unique ethics-related quandary of physicians and other healthcare professionals when prisons isolate inmates with mental illness. We hope to begin to fill this gap.

Solitary confinement is recognized as difficult to withstand; indeed, psychological stressors such as isolation can be as clinically distressing as physical torture.[1,2] Nevertheless, U.S. prison officials have increasingly embraced a variant of solitary confinement to punish and control difficult or dangerous prisoners. Whether in the so-called supermax prisons that have proliferated over the past two decades or in segregation (i.e., locked-down housing) units within regular prisons, tens of thousands of prisoners spend years locked up 23 to 24 hours a day in small cells that frequently have solid steel doors. They live with extensive surveillance and security controls, the absence of ordinary social interaction, abnormal environmental stimuli, often only three to five hours a week of recreation alone in caged enclosures, and little, if any, educational, vocational, or other purposeful activities (i.e., programs). They are handcuffed and frequently shackled every time they leave their cells.[3–5] The terms segregation, solitary confinement, and isolation will be used interchangeably to describe these conditions of confinement.

Isolation can be psychologically harmful to any prisoner, with the nature and severity of the impact depending on the individual, the duration, and particular conditions (e.g., access to natural light, books, or radio). Psychological effects can include anxiety, depression, anger, cognitive disturbances, perceptual distortions, obsessive thoughts, paranoia, and psychosis.[6]

The adverse effects of solitary confinement are especially significant for persons with serious mental illness, commonly defined as a major mental disorder (e.g., schizophrenia, bipolar disorder, major depressive disorder) that is usually characterized by psy-

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chotic symptoms and/or significant functional impairments. The stress, lack of meaningful social contact, and unstructured days can exacerbate symptoms of illness or provoke recurrence.[7] Suicides occur disproportionately more often in segregation units than elsewhere in prison.[8–10] All too frequently, mentally ill prisoners decompensate in isolation, requiring crisis care or psychiatric hospitalization. Many simply will not get better as long as they are isolated.

Mental health professionals are often unable to mitigate fully the harm associated with isolation. Mental health services in segregation units are typically limited to psychotropic medication, a health care clinician stopping at the cell front to ask how the prisoner is doing (i.e., mental health rounds), and occasional meetings in private with a clinician.[7] Individual therapy; group therapy; structured educational, recreational, or life-skill-enhancing activities; and other therapeutic interventions are usually not available because of insufficient resources and rules requiring prisoners to remain in their cells.[11]

The use of segregation to confine the mentally ill has grown as the number and proportion of prisoners with mental illness have grown. Although designed and operated as places of punishment, prisons have nonetheless become *de facto* psychiatric facilities despite often lacking the needed mental health services.[7] 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.[12] 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.[13]

Despite significant improvements in correctional mental health services, often related to litigation and development of standards and guidelines by the National Commission on Correctional Health Care (NCCHC), the American Psychiatric Association (APA), and other professional organizations, in many prisons the services remain woefully inadequate. Relative to the number of prisoners needing help, there is an insufficient number of qualified staff, too few specialized facilities, and few programs.[7] Mindful of budget constraints and scant public support for investments in the treatment (as opposed to punishment) of prisoners, elected officials have been reluctant to provide the funds and leadership needed to ensure that prisons have sufficient mental health resources. Twenty-two of 40 state correctional systems reported in a survey that they did not have an adequate mental health staff.[13]

Persons with mental illness are often impaired in their ability 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. Prison officials generally respond to them as they do to other prisoners who break the rules. When lesser sanctions do not curb the behavior, they isolate the prisoners in the 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.[7,14]

In class action cases challenging the segregation of inmates with serious mental illness as unconstitutionally cruel because of the psychological harm it can inflict, U.S. federal courts have either issued rulings or accepted settlements that prohibit or sharply curtail the practice. According to one federal judge, putting mentally ill prisoners in isolated confinement "is the mental equivalent of putting an asthmatic in a place with little air. . . ."[15] Unfortunately, except in the small number of prisons governed by the outcome of such litigation, mentally ill prisoners continue to be sent to segregation; indeed, they are often disproportionately represented in segregation units.[16,17]

International treaty bodies and human rights experts, including the Human Rights Committee,[18] the Committee against Torture,[19,20] and the U.N. Special Rapporteur on Torture,[21] have concluded that solitary confinement may amount to cruel, inhuman, or degrading treatment in violation of the International Covenant on Civil and Political Rights[22] and the Convention against Torture and other Cruel, Inhuman, and Degrading Treatment or Punishment.[23] They have specifically criticized supermax confinement in the United States because of the mental suffering it inflicts.[19,20] Whatever one's views on supermax confinement in general, human rights experts agree that its use for inmates with serious mental illness violates their human rights.

Principles of ethics regarding beneficence, nonmaleficence, and respect for the rights and dignity of all patients have led international and national profes-

sional organizations to affirm that physicians are ethically obligated to refrain from countenancing, condoning, participating in, or facilitating torture or other forms of cruel, inhuman, or degrading treatment.[24–27] Involvement of healthcare practitioners in abusive interrogations recently prompted the American Medical Association[28] and the APA[29] to oppose the participation of physicians in interrogations. Two years ago, the NCCHC issued a position statement that correctional health care professionals "should not condone or participate in cruel, inhumane or degrading treatment of inmates."[30] To date, however, the medical organizations have not formally acknowledged that prolonged isolation of the mentally ill constitutes cruel or inhuman treatment in violation of human rights, nor have they addressed health professionals' ethics-related responsibilities when faced with such cases.

Correctional health care professionals struggle with constrained resources and large caseloads that limit the services they can provide their patients. It is ethical for them to do the best they can under the circumstances rather than resigning, which would result in even fewer services for their patients. But what are practitioners' ethics-related responsibilities when prison officials impose conditions of confinement that exacerbate the symptoms of a prisoner's mental illness?

The ethic-based calculus physicians face when prisoners are isolated for disciplinary or security reasons is different than that created by the struggle with limited resources. Segregation of mentally ill prisoners (or any other prisoner) is not an unintended consequence of tight budgets, for example. It reflects a penal philosophy and the conscious decision by prison officials about whom to isolate, for how long, and under what conditions. If health professionals simply do their rounds but say nothing, are they implicitly legitimizing the segregation of mentally ill prisoners and thereby contributing to the continuation of the harm? What must they do to avoid being complicit in conditions of confinement that may well constitute a human rights violation?

We believe it is ethical for physicians to treat prisoners who have been abused, but they must also take measures to end the abuse. In addition to providing whatever services they can to segregated patients, they should advocate within the prison system for changed segregation policies and, if that fails, they should undertake public advocacy.[31–33]

Publically exposing and urging change in harmful prison practices is difficult and, needless to say, can threaten job security, but individual practitioners should not have to wrestle alone with a prison practice that violates human rights norms. Their professional organizations should help them. Through the organizations, health professionals collectively can support colleagues who work in prisons in the quest to ensure ethically defensible correctional policies. The APA[34] and the NCCHC[35] have provided basic frameworks for increased mental health monitoring and treatment of segregated inmates. They must do more, however.

Professional healthcare organizations should acknowledge that prolonged segregation of inmates with serious mental illness violates basic tenets of mental health treatment. The mental health standards of the NCCHC include the "optional recommendation" that mentally ill prisoners be excluded from extreme isolation,[35] noting in an appendix that clinicians "generally agree that placement of inmates with serious mental illnesses in settings with 'extreme isolation' is contraindicated because many of these inmates' psychiatric conditions will clinically deteriorate or not improve (Working Group on Schizophrenia, 1997)."[36,37] In light of that general consensus, shouldn't the NCCHC make the exclusion mandatory, instead of optional? The APA and AMA should also formally adopt a similar position.

However, adopting a similar position is easier said than done. Very few physicians in the APA and AMA have experience or knowledge regarding correctional mental health care, let alone correctional environments in general. They are not familiar with the differences between a general population housing unit and a disciplinary segregation housing unit. Administrative segregation, supermax, rules infractions, mental health rounds, and "kites" are terms most noncorrectional physicians do not understand. In short, we recognize that a serious educational effort must be mounted so that noncorrectional mental health practitioners have a better understanding of the world in which their correctional colleagues work and the unique challenges they face, including the isolation of seriously ill patients for months, even years, that would never be condoned in a noncorrectional mental health setting.

No doubt some correctional mental health clinicians will not agree with us. They may believe the isolation of volatile mentally ill prisoners is necessary

for security reasons. They may believe they are guests in the house of corrections who have no business addressing custody policies, or they may have become so accustomed to the extended use of isolation that they have lost sight of its potential to cause psychological harm.

Experience demonstrates that prisons can operate safely and securely without putting inmates with mental illness in typical conditions of segregation. Because of litigation, in some prisons, mentally ill prisoners who would otherwise be locked in their cell for 23 to 24 hours a day are given more time outside their cells, including time in group therapy and other therapeutic interventions.[11] The improved clinical responses of prisoners with mental illness have been achieved without sacrificing needed controls or relinquishing the goal of holding those accountable, whether mentally ill or not, who willfully violate prison rules.

The professional organizations should acknowledge that it is not ethically defensible for health care professionals to acquiesce silently to conditions of confinement that inflict mental harm and violate human rights. They should affirm that practitioners are ethically obligated, not only to treat segregated inmates with mental illness, but also to strive to change harmful segregation policies and practices.[31–33] Finally, the organizations should not be content with clarifying the ethics-related responsibilities of individual practitioners in these circumstances. They should actively support practitioners who work for changed segregation policies, and they should use their institutional authority to press for a nationwide rethinking of the use of isolation. The medical professions' commitment to ethics and human rights would be well served by such steps.

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