Multiple Reports regarding Solitary Confinement

Included in the Department of Corrections' (SCDC) April 29, 2019 letter to the House Legislative Oversight Committee (LOC). This information was provided in response to the following question in LOC's March 27, 2019 letter to the Department of Corrections: "34. Are there any studies or evaluations, performed internally or externally, which include information on the impacts of a lock-down on inmates and/or operations? If so, please provide copies."

Aiming to Reduce Time-In-Cell:

Reports from Correctional Systems on the Numbers of Prisoners in Restricted Housing and on the Potential of Policy Changes to Bring About Reforms

Aiming to Reduce Time-In-Cell

Association of State Correctional Administrators
The Arthur Liman Public Interest Program
Yale Law School

November 2016

November 2016

Included in SCDC' 4.29.19 letter to LOC

ASSOCIATION OF STATE CORRECTIONAL ADMINISTRATORS

Executive Officers

President Leann Bertsch
Vice President John Wetzel
Treasurer Colette S. Peters
Past President Ashbel T. Wall, II

Regional Representatives

Midwest Heidi Washington
Northeast Scott Semple
Southern Wendy Kelley
Western Rick Raemisch

Embargoed until 3pm on November 30, 2016
Contacts: George or Camille Camp 301-791-2722; gcamp@asca.net
Judith Resnik, 203-432-1447; judith.resnik@yale.edu

Aiming to Reduce Time-In-Cell: Correctional Administrators and Yale Law School's Liman Program Release New Report on Efforts to Reduce the Use of Isolation in State and Federal Prisons

New Information from Prison Officials Reflects the National Consensus on the Need to Reduce Reliance on Restricted Housing

A new report, jointly authored by the Association of State Correctional Administrators (ASCA) and the Arthur Liman Program at Yale Law School, reflects a profound change in the national discussion about the use of what correctional officials call "restrictive housing" and what is popularly known as "solitary confinement." Just published, *Aiming to Reduce Time-In-Cell* provides the only current, comprehensive data on the use of restricted housing, in which individuals are held in their cells for 22 hours or more each day, and for 15 continuous days or more at a time. The Report also documents efforts across the country to reduce the number of people in restricted housing and to reform the conditions in which isolated prisoners are held in order to improve safety for prisoners, staff, and communities at large.

The 2016 publication follows the 2015 ASCA-Liman Report, *Time-In-Cell*, which documented the use of restricted housing as of the fall of 2014. As ASCA explained then, "prolonged isolation of individuals in jails and prisons is a grave problem in the United States." Today, a national consensus has emerged focused on limiting the use of restricted housing, and many new initiatives, as detailed in the report, reflect efforts to make changes at both the state and federal levels.

The 2016 Report is based on survey responses from 48 jurisdictions (the Federal Bureau of Prisons, 45 states, the District of Columbia, and the Virgin Islands)—that held about 96% of the nation's prisoners convicted of a felony. That number excludes people held in most of the country's jails (housing hundreds of thousands of people), in most of the country's juvenile facilities, and in military and immigration facilities.

Tallying the responses, the new 2016 Report found that 67,442 prisoners were held, in the fall of 2015, in prison cells for 22 hours or more for 15 continuous days or more. The percentages of prisoners in restricted housing in federal and state prisons ranged from under 1%

Included in SCDC' 4.29.19 letter to LOC

to more than 28%. Across all the jurisdictions, the median percentage of the prison population held in restricted housing was 5.1%.

How long do prisoners remain in isolation? Forty-one jurisdictions provided information about the length of stay for a total of more than 54,000 people in restricted housing. Approximately 15,725 (29%) were in restricted housing for one to three months; at the other end of the spectrum, almost 6,000 people (11%) across 31 jurisdictions had been in restricted housing for three years or more.

The Report also chronicles efforts throughout the country and the world to reduce the use of restricted housing. In August of 2016, the American Correctional Association (ACA) approved new standards, calling for a variety of limits on the use of isolation, including a prohibition against placing prisoners in restricted housing on the basis of their gender identity alone. The standards also included provisions that pregnant women, prisoners under the age of 18, and prisoners with serious mental illness ought not be placed for extended periods of time in restricted housing. Further, in some jurisdictions, prison systems (sometimes prompted by legislation and litigation) have instituted rules to prevent vulnerable populations from being housed in restricted housing except under exceptional circumstances and for as short an amount of time as possible.

As the Report also details, several jurisdictions described making significant revisions to the criteria for entry, so as to limit the use of restricted housing, as well as undertaking more frequent reviews to identify individuals to return to general population, thereby reducing the number of people in restricted housing by significant percentages.

In short, while restricted housing once was seen as central to prisoner management, by 2016 many prison directors and organizations such as ASCA and the ACA have defined restricted housing as a practice to use only when absolutely necessary and for only as long as absolutely required. The goals of ASCA and the ACA are to formulate and to apply policies to improve the safety of institutions and communities by ensuring that the *separation* of individuals to promote safety and well-being need not be accompanied by *deprivation* of all opportunities for social contact, education, programming, and other activities.

As Leann K. Bertsch, President of ASCA, explained:

> "What we are seeing is that prison systems are motivated to reduce the use of isolation in prisons and are actively putting into place policies designed to reduce the use of restrictive housing. Restricted housing places substantial stress on both the staff working in those settings as well as the prisoners housed in those units. Our highest priority is to operate institutions that are safe for staff and inmates and to keep communities to which prisoners will return safe."

For more information, please contact George and Camille Camp, Co-Executive Directors of ASCA, at 301-791-2722, and Judith Resnik, Arthur Liman Professor of Law at Yale Law School, at 203-432-1447. The full report may be downloaded, free of charge, at www.asca.net or https://www.law.yale.edu/centers-workshops/arthur-liman-public-interest-program/liman-publications.

Included in SCDC' 4.29.19 letter to LOC

Aiming to Reduce Time-In-Cell: Reports from Correctional Systems on the Numbers of Prisoners in Restricted Housing and on the Potential of Policy Changes to Bring About Reforms

Association of State Correctional Administrators
The Arthur Liman Public Interest Program, Yale Law School

November 2016

Included in SCDC' 4.29.19 letter to LOC

Association of State Correctional Administrators (ASCA)

ASCA is the association of persons directly responsible for the administration of correctional systems. ASCA includes the heads of state corrections agencies, the Federal Bureau of Prisons, the District of Columbia Department of Corrections, and some large county jail systems. Founded in the 1950s, ASCA gained its current organizational structure in the 1980s. ASCA is premised on the belief that each represented correctional jurisdiction is unique in its own obligations, structures, and resources and that similarities of purpose, responsibilities, and challenges among member jurisdictions unite them in a quest for public safety, secure and orderly facilities, and professionalism.

The Arthur Liman Public Interest Program, Yale Law School

The Arthur Liman Public Interest Program was endowed to honor one of Yale Law School's most accomplished graduates, Arthur Liman, who graduated in 1957 and who personified the ideal of commitment to the public interest. Throughout his distinguished career, he demonstrated how dedicated lawyers, in both private practice and public life, can serve the needs of people and causes that might otherwise go unrepresented. The Liman Program was created in 1997 to continue the commitments of Arthur Liman by supporting lawyers, in and outside the academy, who are dedicated to public service in the furtherance of justice.

Acknowledgements

This report is based on a survey co-authored by ASCA and by the Liman Program at Yale Law School. The research and report teams were led by George and Camille Camp of ASCA and by Professor Judith Resnik, former Director Johanna Kalb and current Director Anna VanCleave of the Liman Program, former Senior Liman Fellow in Residence Sarah Baumgartel and current Senior Fellow Kristen Bell, all of Yale Law School. Olevia Boykin, Corey Guilmette, Tashiana Hudson, Diana Li, Joseph Meyers, Hava Mirell, and Jessi Purcell, current and former students at Yale Law School, conducted the research and drafted this report.

Thanks are due to all the jurisdictions that responded to the survey, and for their thoughtful comments and reviews received after drafts of the report were circulated in the winter of 2016 and in the summer of 2016. Yale Law School, the Liman Program, the Vital Projects Fund, and the Oscar M. Ruebhausen Fund at Yale Law School have generously supported this project. Special thanks are due to Skylar Albertson, Alison Gifford, and Bonnie Posick for expert editorial advice.

To download copies of this Report, please visit the website of the Liman Program at https://www.law.yale.edu/centers-workshops/arthur-liman-public-interest-program/liman-publications. This Report may be reproduced free of charge and without the need for additional permission. All rights reserved, 2016.

Inquiries:

George and Camille Camp
Co-Executive Directors of ASCA
gcamp@asca.net; ccamp@asca.net

Judith Resnik
Arthur Liman Professor of Law
Yale Law School
judith.resnik@yale.edu

Included in SCDC' 4.29.19 letter to LOC

Table of Contents

I. LEARNING ABOUT ISOLATION IN PRISON 4
- **A. Collecting Data to Establish Baselines and Parameters: 2012-2015** 4
- **B. Looking for Changes: 2015-2016** 6
- **C. The Context: Demands for Change** 8

II. THE 2015 SURVEY'S DESIGN AND PURPOSES 15
- **A. Goals and Methods** 15
- **B. Research Challenges: Various Definitions of Restricted Housing and the Overlaps and Differences between the 2015 and 2016 ASCA-Liman Reports** 16

III. TYPES OF FACILITIES AND OF CELLS IN THE 2015 SURVEY 17
- **A. Types of Facilities for which State-Wide Data Were Available** 17
- **B. The Use of Single and of Double Cells** 19

IV. THE NUMBERS AND PERCENTAGES OF PRISONERS IN RESTRICTED HOUSING: THE DATA FROM THE 2015 SURVEY 20
- **A. Counting and Comparing General and Restricted Populations** 20
- **B. The Numbers and Percentages of Prisoners In-Cell for 16 to 21 Hours** 24

V. THE DURATION OF TIME INDIVIDUALS SPENT IN RESTRICTED HOUSING 26
- **A. Length of Time** 26
- **B. Length of Time by Classification of the Type of Restricted Custody** 29

VI. THE DEMOGRAPHICS OF RESTRICTED HOUSING 30
- **A. Gender** 30
- **B. Race and Ethnicity** 35
- **C. Age Cohorts** 42
- **D. Vulnerable Populations: Mentally Ill, Pregnant, and Transgender Prisoners** 48
  1. **Prisoners with Serious Mental Health Issues (according to each jurisdiction's own definition)** 48
  2. **Pregnant Prisoners** 54
  3. **Transgender Prisoners** 55

VII. PLANNED OR PROPOSED POLICY CHANGES IN RESTRICTED HOUSING: 2013-2016 55
- **A. Reducing Placement in Restricted Housing: Narrowing Criteria for Entry and Creating Alternatives** 56
- **B. Focusing on Release: Time Caps, Step-Down Programs, and Increased Oversight of Retention Decisions** 57
- **C. Mandated Time Out-of-Cell** 58
- **D. Conditions: The Physical Environment and Programming** 59
- **E. Staffing: Policies and Training** 59

Included in SCDC' 4.29.19 letter to LOC

F. Jurisdictions Seeking Substantial Reductions in Restricted Housing Use 60
1. The Federal Prison System: Changes Recommended in the 2016 Department of Justice Restricted Housing Report 60
2. Colorado 62
3. North Dakota 64
4. Ohio 65
5. South Carolina 66
6. Utah 69

VIII. REFLECTING ON EFFORTS TO REDUCE TIME-IN-CELL 71

ENDNOTES

APPENDICES
Appendix A: ASCA-Liman Restricted Housing Survey – Fall 2015
Appendix B: List of the Report's Charts and Tables
Appendix C: Jurisdictions' Definitions of Serious Mental Illness

Included in SCDC' 4.29.19 letter to LOC

I. Learning about Isolation in Prison

This Report is the third in a series that examines what correctional officials in the United States call "restrictive housing" and what is known more generally as "solitary confinement." Working together, the Association of State Correctional Administrators (ASCA) and the Arthur Liman Program at Yale Law School have sought to understand the formal rules governing aspects of the segregation of prisoners in the United States; the numbers of individuals confined; the conditions under which they live; and the limits on the use of isolation.

Below, we provide a brief overview of prior ASCA-Liman work in this area, a description of this study, and a review of initiatives during the last few years aimed at producing significant reforms to reduce the numbers of people in restricted housing and the degrees of their isolation.

A. Collecting Data to Establish Baselines and Parameters: 2012-2015

Prison systems across the United States separate some prisoners from general population and put them into special housing units, typically with more isolating conditions. The reasons for doing so include the imposition of punishment ("disciplinary segregation"), protection ("protective custody"), and incapacitation (often termed "administrative segregation").

In *Administrative Segregation, Degrees of Isolation, and Incarceration: A National Overview of State and Federal Correctional Policies*, published in 2013, we asked directors of state and federal corrections systems to provide their policies on administrative segregation, defined as removing a prisoner from general population to spend 22 to 23 hours a day in a cell for 30 days or more.[1] Administrative segregation was the form of confinement that we believed was the most common basis for segregation.

What we learned, based on responses from 47 jurisdictions, was that correctional policies made getting *into* segregation relatively easy, and few systems focused on getting people *out*. The criteria for entry were broad. Many jurisdictions permitted moving a prisoner into segregation if that prisoner posed a threat to institutional safety or a danger to self, staff, or other inmates. Constraints on decision-making were minimal; the kind of notice provided and what constituted a "hearing" varied substantially.

In 2014, the Liman Program and ASCA took the next step by asking correctional administrators more than 130 questions—this time about the numbers of people in restricted housing and the conditions under which they lived.[2] The overall focus was on a subset of restricted housing—"administrative segregation," while a few questions focused on all forms of restricted housing. Responses came from 46 jurisdictions (albeit not all jurisdictions answered all the questions). Published in 2015, the *Time-In-Cell* Report provided a unique multi-jurisdictional window into segregation.

A central question is about the numbers of individuals in segregation, regardless of the different names under which the practice goes. Before that Report, information on the number of prisoners held in restricted housing was a decade old or more; the figure often cited was 25,000.[3] The 2015 ASCA-Liman Report provided new information. What we learned from the 34

Included in SCDC' 4.29.19 letter to LOC

jurisdictions answering this question and housing about 73% of the more than 1.5 million people incarcerated in U.S. prisons, was that they reported a total of more than 66,000 people held in restricted housing as of the fall of 2014. Given that number, ASCA and Liman estimated that some 80,000 to 100,000 people were, in 2014, in restricted housing (however termed) in U.S. prisons—or about one in every six or seven prisoners.[4] Those figures, in turn, did not include jails, juvenile facilities, or immigration and military detention.

We also learned that prisoners in many jurisdictions across the country were required to spend 23 hours in their cells on weekdays and in many, 24 hours in their cells on weekends.[5] Jurisdictions reported that cells, sometimes holding two people, ranged in size from 45 to 128 square feet.[6]

Opportunities for social contact, such as out-of-cell time for exercise, visits, and programs, were limited, ranging from three to seven hours a week in many jurisdictions.[7] Phone calls and social visits could be as infrequent as once per month. A few jurisdictions provided more opportunities.[8] In most jurisdictions, prisoners' access to social contact, programs, exercise, and items kept in their cells, could be cut back as sanctions for misbehavior.[9]

Moreover, administrative segregation generally had no fixed endpoint, and several systems did not keep track of the numbers of continuous days that people remained in isolation. In the 24 jurisdictions reporting on this question, a substantial number indicated that prisoners remained in segregation for more than three years. As to release and reentry, in 30 jurisdictions tracking the numbers in 2013, a total of 4,400 prisoners were released directly from the isolation of administrative segregation to the outside community.[10]

Running administrative segregation units posed many challenges for prison systems. These problems—coupled with a surge of concerns about the negative impact of isolation on individuals—have created incentives for change. Prison directors cited prisoner and staff well-being, pending lawsuits, and costs as reasons to revise their practices. Some also commented that change was important because it was "the right thing to do."[11]

When releasing *Time-In-Cell*, ASCA stated that "prolonged isolation of individuals in jails and prisons is a grave problem in the United States."[12] As that press release also explained, "insistence on change comes not only from legislators across the political spectrum, judges, and a host of private sector voices, but also from the directors of correctional systems at both state and federal levels."[13]

Time-In-Cell provided a window into the prevailing practices and a baseline from which to assess whether the many efforts to limit isolation would have an impact. That Report made plain that segregation practices had become entrenched during the past 40 years, that many correctional systems sought to make changes, and that unraveling the structures producing so much isolation would require intensive work.

When released in September 2015, the *Time-In-Cell* Report became front-page news, reflecting the broad concern about these problems and the need for reform.[14] Much commentary followed, including several essays published by the Yale Law Journal Forum in January of 2016.

Included in SCDC' 4.29.19 letter to LOC

These comments analyzed the data in the Report, the need for reform, and the challenges entailed in making major changes.[15]

B. Looking for Changes: 2015-2016

In early October 2015, ASCA and Liman launched this follow-up study to gather national information on all forms of restricted housing, to learn what numbers of people were in that form of detention in the fall of 2015, and to see what changes were underway. The hope was twofold: that the numbers of people held in such settings were diminishing and that the conditions in restricted housing were improving by becoming less isolating.

This study relied again on asking the directors of prison systems to respond to questions. This time, a set of 15 questions focused on the people in any and all forms of what we termed restricted housing (or what is also termed "restrictive" housing). We queried 53 jurisdictions (all the states, the federal system, the District of Columbia, and the Virgin Islands), and 52 responded; the one jurisdiction not providing any information was the State of Maine. As detailed below, a few jurisdictions that did respond did not have answers to all the topics surveyed. For many questions, 48 jurisdictions had sufficiently detailed and consistent information on which to report,[16] and for each topic, we specify the number of responding jurisdictions.

We sought to learn about numbers and demographics—including race, gender identity, age, and mental health status. As the data set forth below reflect, those ambitions were made complex by the variety of different facilities under the control of state-wide correctional departments, the many terms used to denote segregating prisoners, the range of data kept, and the limited amount of data available. The jurisdictions surveyed did not all keep comparable data about how many hours, over how many days, prisoners were in their cells.

To enable cross-jurisdictional comparisons, we imposed a definition by describing restricted housing as the separation of prisoners from general population and in detention for 22 hours per day or more, for 15 or more continuous days, in single-cells or in double-cells. This survey did not inquire into whether jurisdictions regularly audited their facilities to learn if the parameters were consistently met. For example, we did not ask about what methods were used to ensure that individual prisoners were out of their cells for the time stipulated in rules, nor did we learn how often or for how long lockdowns occurred during which no prisoners were permitted to leave cells.

Further, if a jurisdiction provided for prisoners to spend 14.5 hours a week out-of-cell, or had no count of whether prisoners were held 15 days or more, that jurisdiction could have described itself as having no one in restricted housing, even as the jurisdiction understood itself *to have* a restricted-housing population. Therefore, and as noted below, in a few instances we included information provided by jurisdictions that required minor modifications of our 22-hour/15-days-or-more definition.

Included in SCDC' 4.29.19 letter to LOC

A preview of some of this Report's findings is in order. As of the fall of 2015, 67,442 people were held in restricted housing across the 48 jurisdictions that reported their numbers.[17] Relying on data on the United States and its territories from the Bureau of Justice Statistics, we looked at the total number of individuals confined in the 48 jurisdictions, and learned that these jurisdictions accounted for 96.4% of the total prison population in the United States.[18]

We then calculated the percentage of prisoners who were held in restricted housing across all of the jurisdictions which regularly kept data on the number of prisoners in restricted housing (22 hours a day/15 days or more). The focus was on state prisoners housed under state (not local) control. The percentages of prisoners held in different jurisdictions in restricted housing ranged from 0.5% (Hawaii, in-state only) to 28.3% (the Virgin Islands). The median was 5.1%.[19]

We also asked about the numbers of people held in segregation between 16 and 21 hours per day in their cells. Thirty-four jurisdictions responded about those populations. In 23 of those jurisdictions, we tallied a total of 16,455 additional prisoners in cells for 16 to 21 hours per day for 15 consecutive days or more.[20] In these 23 jurisdictions, the median so confined was 1.6% of their total populations.[21] (Eleven of the responding 34 jurisdictions reported that they did not hold prisoners in-cell for 16-21 hours per day for 15 consecutive days or more.)

Some of the reporting jurisdictions did not include information on all of the facilities directly under their control, and very few included information from county and municipal level facilities at which prisoners or pretrial detainees were held.[22] The dearth of information on county jails is important to underscore because counties were responsible, as of 2016, for 91% of the jails in the United States, and "11.4 million individuals pass through jail each year."[23] In short, through this survey, we have accounted for *at least* 67,442 individuals in restricted housing (22 hours a day/15 days or more) in the fall of 2015. When adding the 16,455 people confined 16 to 21 hours, a total of at least 83,897 prisoners were held in their cells for more than 16 hours a day for 15 days or more. Yet, given the data limitations, neither of these numbers includes all the people held in cell for either 16-hours or more or for 22-hours or more in all of the types of U.S. prison and jail facilities.

How long, in months and years, did prisoners spend in restricted housing? Forty-one jurisdictions—holding 54,382 prisoners—provided length-of-stay data. Of those prisoners, 15,725 people—or 29%—were in restricted housing from one month up to three months. Some 15,978 people—or 29%—were in restricted housing for three months up to one year. Another 13,041 prisoners—or 24%—were in restricted housing for a year or more. Of these, 2,976 people—5.5% of 54,382—had spent from three years to six years in restricted housing. Twenty-six jurisdictions reported holding some prisoners—a total of 2,933 people, or 5.4% of the 54,382—in restricted housing for six years or more.[24]

The survey also asked whether correctional systems were making policy-level changes to reduce the use of restricted housing. Forty-five jurisdictions reported on their policies, and many described proposed or recently implemented revisions. Jurisdictions reported policies revising the criteria for being placed in isolation to limit its use, increasing the oversight of restricted housing, expanded efforts at programming and rehabilitative services in restricted housing,

Included in SCDC' 4.29.19 letter to LOC

developing exit paths (sometimes called "step-down" programs), and imposing caps on the length of time spent in restricted confinement.

In addition to summarizing changes in policies, we provide descriptions of efforts reported by a few jurisdictions seeking to make substantial reductions in the use of restricted housing. We did not inquire into either the details or metrics of implementation, nor did we conduct case studies to learn about the effects, in practice, of the new policies described.

C. The Context: Demands for Change

As this study was underway, concerns about restricted housing intensified. In July 2015, President Barack Obama announced that he had directed the Attorney General of the United States to conduct a review of the use of solitary confinement in the federal prison system.[25] The review resulted in a report, *U.S. Department of Justice Report and Recommendations Concerning the Use of Restrictive Housing*, published in January of 2016. That monograph provided an overview of what the Justice Department termed "restrictive housing" practices in the federal system and proposals for reform.[26] In the same month, in a *Washington Post* op-ed entitled *Why we must rethink solitary confinement* and which cited the ASCA-Liman *Time-In-Cell* Report, the President stated:

> The Justice Department has completed its review, and I am adopting its recommendations to reform the federal prison system. These include banning solitary confinement for juveniles and as a response to low-level infractions, expanding treatment for the mentally ill and increasing the amount of time inmates in solitary can spend outside of their cells. These steps will affect some 10,000 federal prisoners held in solitary confinement—and hopefully serve as a model for state and local corrections systems. . . .[27]

The Justice Department's Report laid out several "Guiding Principles" and "Policy Recommendations." The recommendations included ending "the practice of placing juveniles in restrictive housing."[28] In addition, the Justice Department recommended against placing pregnant women in restricted housing, and proposed banning the practice of using the status of LGBTI and gender non-conforming individuals as the sole basis for placement in restricted housing. Further, the Justice Department recommended that, absent special circumstances, seriously mentally ill prisoners ought not to be placed in restricted housing.[29] The Justice Department also urged the Federal Bureau of Prisons (BOP) to eliminate the use of disciplinary segregation as a sanction for "low level" offenses and to reduce the time that prisoners spend in restricted housing for other offenses.[30]

Further, the Justice Department recommended that prisoners be housed "in the least restrictive setting necessary" to ensure the safety of all; that placement be based on specific, "clearly articulate[d]" reasons; and that the placement of prisoners in restricted housing serve "a specific penological purpose."[31] The Justice Department further recommended that there be "a clear plan for returning the inmate to less restrictive conditions as promptly as possible;"[32] that each individual's placement in restricted housing be reviewed on a regular basis by a committee that includes medical and mental health professionals;[33] and that restricted housing policies

Included in SCDC' 4.29.19 letter to LOC

generally be regularly reviewed by a standing committee that consisted of "high-level correctional officials."[34] The Justice Department called for the BOP to implement these policies, to add "opportunities for out-of-cell time" and programming,[35] and to increase transparency in the use of restricted housing.[36]

In March of 2016, the President issued a Presidential Memorandum, "Limiting the Use of Restrictive Housing by the Federal Government;" he directed executive departments and agencies to implement the Justice Department's recommendations.[37] President Obama wrote that in light of "the urgency and importance of this issue, it is critical that DOJ accelerate efforts to reduce the number of Federal inmates and detainees held in restrictive housing and that Federal correctional and detention systems be models for facilities across the United States."[38]

These national efforts came in the context of work in many other venues, ranging from professional associations of correctional and health professionals to state and federal legislatures and courts, both in the United States and abroad. In 2014, the American Correctional Association (ACA), an umbrella organization comprised of correctional facilities' leaders from across the country, created a Restrictive Housing Ad Hoc Standards Committee to revise its model standards.[39] The co-chairs, Gary Mohr (the Director of the Ohio Department of Rehabilitation and Correction) and Rick Raemisch (Executive Director of the Colorado Department of Corrections) wrote in 2015 of the need for an overall reduction in the use of restricted housing; as they explained, "lengthy periods of 23 hours per day in confinement multiplies a problem"—rather than solving it.[40]

The ACA's Ad Hoc Committee released a draft report in the winter of 2016 and proposed precluding the use of restricted housing on the basis of gender identity alone,[41] for pregnant women,[42] and for juveniles under 18.[43] Further, the ACA Committee proposed heightened oversight and review of decisions to place and to keep individuals in restricted housing,[44] ending the placement of individuals with serious mental illnesses in restricted housing unless they presented a "clear and present danger" to staff or other prisoners that was not associated with their mental illness,[45] and avoiding direct release of prisoners into the community.[46] In January of 2016, the ACA held a hearing to discuss its proposed guidelines for the use of restricted housing.[47]

In August of 2016, the ACA approved recommendations from a revised report of its Ad Hoc Committee.[48] The ACA's new standards called for an end to the practice of placing prisoners in restricted housing on the basis of their gender identity alone.[49] The standards also included provisions that pregnant women,[50] prisoners under the age of 18,[51] and prisoners with serious mental illness not be placed in "extended restricted housing."[52]

In addition, the ACA's revised standards set forth provisions for increased oversight of decisions to place prisoners in restricted housing[53] and more frequent opportunities for review.[54] The new standards also called for more frequent mental and physical health evaluations and treatment for all prisoners in restricted housing,[55] and specialized training for staff working with prisoners in restricted housing.[56]

Included in SCDC' 4.29.19 letter to LOC

In terms of the physical conditions, the ACA 2016 standards stated that restricted housing should include "living conditions that approximate those of the general inmate population" with "all exceptions . . . clearly documented."[57] The 2016 Restrictive Housing Standards stated that facilities should make efforts to move prisoners out of restricted housing through step-down programs and measures to ensure that restricted housing prisoners not be released directly to the community.[58]

The ACA initiative built on ASCA-based reform proposals to make changes in restricted housing. In 2013, ASCA adopted guidelines on Restrictive Status Housing Policy that aimed to constrain the use of isolating settings.[59] In 2014, ASCA identified administrative segregation as one of the "top five critical issues" reported by correctional agencies,[60] and, as discussed above, ASCA and the Liman Program have been working for several years on a series of collaborative research projects on this issue. In addition, as of the fall of 2016, ASCA was revising its guidelines on restricted housing.

Other voices within corrections and beyond have also insisted on the need for change. Some of the focus has been on limiting the placement of any person in restricted housing, while other activities have centered on subpopulations with special needs.

In terms of the use of restricted housing in general, in the summer of 2015, a group of "correctional directors and administrators with first-hand experience supervising solitary confinement units in prisons across the United States" joined together to file an *amicus* brief in the United States Supreme Court.[61] They described the "debilitating" effects of solitary confinement and argued that the Constitution requires individualized classification before a person could be placed in such confinement.[62] Their views about the effects of isolation were echoed by a group of psychiatrists and psychologists, also calling for the Supreme Court to step in; these medical professionals highlighted the "scientific research" establishing the many harms imposed by prolonged solitary confinement.[63]

Health professionals, social scientists, and organizations concerned with prisoner well-being have likewise detailed the harms of isolating confinement and have argued that the practice lacks utility.[64] In addition, empirical work has found that solitary confinement has not been effective in reducing violence and promoting safety.[65] Reports on specific prison systems also documented how disabling isolation was for prisoners and for staff, and how it has not ensured the safety of the communities to which individuals return.[66] Certain forms of restrictive housing have drawn particular attention; for example, in the fall of 2016, The Marshall Project and National Public Radio published a joint investigative report documenting incidents of violence and murder between "double-celled" prisoners in restrictive housing.[67]

This growing body of literature and case law has shifted the understanding of restricted housing and produced many calls for it to end. One example comes from a report based on a colloquium that was convened by the John Jay College of Criminal Justice in October of 2015 to discuss ending the over-use of isolation.[68] The colloquium's purpose was to gather corrections agency heads and advocates together "to determine if consensus might be achievable about ways to reform the use of social isolation by coming to common agreement rather than resorting to litigation."[69] The result, *Solitary Confinement: Ending the Over-Use of Extreme Isolation in*

Included in SCDC' 4.29.19 letter to LOC

Prison and Jail, included a series of recommendations calling for alternatives to segregation such that segregation should be used only as a last resort; humane conditions in segregation, such as permission for family contact and programming; due process for admission into segregation and periodic review for those already in segregation; and limited use of segregation of vulnerable populations, such as juveniles, the elderly, and people with mental illnesses.[70]

State legislatures, municipal authorities, and courts have continued to consider, and sometimes to impose, curbs on restricted housing. In October of 2016, New Jersey enacted a statute (awaiting the governor's signature as of this writing) limiting the use of "isolated confinement" to no more than 15 consecutive days, and no more than 20 days during any 60-day period.[71] The law defined "isolated confinement" as "confinement of an inmate . . . in a cell or similarly confined holding or living space, alone or with other inmates, for approximately 20 hours or more per day, with severely restricted activity, movement, and social interaction."[72] The law also prohibited, with a few exceptions, isolated confinement for prisoners who are members of a vulnerable population, including pregnant women, those 21 or younger, those 65 or older, those perceived to be lesbian, gay, bisexual, transgender or intersex, and those with a mental illness, a developmental disability, a serious medical condition, or an auditory or visual impairment.[73]

As of the fall of 2016, other bills pending in Illinois,[74] Massachusetts,[75] and Rhode Island[76] aimed to limit the use of restricted housing for all prisoners. Settlements approved in 2015-2016 in class actions in California,[77] Indiana,[78] and New York[79] imposed substantial limits on the use of restricted housing in each of these states.

Other reform efforts have focused specifically on populations with special needs. A decade ago, the Bureau of Justice Statistics estimated that 56% of people in state prisons had some form of mental illness.[80] Given the research documenting how placing people with preexisting mental illness in isolating housing can increase the risk of psychiatric deterioration, violence, self-injury, and suicide,[81] the American Psychiatric Association has advised against segregating individuals with mental illness,[82] as has the American Public Health Association,[83] and the National Commission on Correctional Health Care.[84] Legislation has also called for screening individuals and imposing limits on isolation for individuals with mental illness.[85]

Reflecting these concerns, the resolutions of some lawsuits have provided that individuals with cognitive or mental impairment should not be placed in restricted housing, or only briefly if exigent circumstances exist.[86] Correctional officials have also altered their rules and programs. For example, in 2015, after a report released by Disability Rights Oregon (DRO) detailed harmful conditions at its "Behavioral Health Unit," the Oregon Department of Corrections announced an agreement with DRO restricting the use of solitary for the mentally ill.[87] In Pennsylvania, after the settlement in another lawsuit also brought by a disability rights group,[88] the Secretary of the Department of Corrections created new education programs for staff as part of a system-wide initiative on mental illness.[89]

Another area of particular attention is the use of isolation for juveniles. Limits have been put in place by legislation, court orders, local ordinances, and correctional policies.[90] For example, legislation restricting the placement of juveniles in isolation was enacted in 2016 in

Included in SCDC' 4.29.19 letter to LOC

Colorado,[91] and a bill has likewise been enacted in California.[92] In the spring of 2016, the Board of Supervisors of Los Angeles directed that county officials end placement of youth in isolated housing, except in very rare circumstances.[93]

In 2015, proposed legislation was before the Congress to curtail isolation for the few juveniles in the federal system.[94] Further, in response to an investigation by the Department of Justice, Ohio adopted a policy to end the placement of youth in solitary confinement.[95] The U.S. Attorney for the Southern District of New York intervened in a lawsuit, begun by detainees in 2012, against New York City; the case challenged the City's treatment of youth at Rikers Island. In 2015, New York City's mayor announced a plan that would end the use of solitary confinement for people 21 and younger.[96]

In addition to the focus on subpopulations, proposals at the federal level sought to improve information about the use of restrictive housing and to impose oversight across the various populations in restricted housing. In the fall of 2016, the National Institute of Justice (NIJ) published a volume on solitary confinement and awarded $1.4 million to the Vera Institute of Justice to study the use of restricted housing and step-down programs in prisons and jails and to "assess the impact" of working in restricted housing facilities on "mental, emotional, and physical well-being."[97] The grant provided for a study to conduct a national survey of state prison systems, akin to the ASCA-Liman Reports, that would also include a sampling of jails. Further, NIJ provided Vera with funds to review state administrative data on restricted housing placement and to do interviews with and surveys of prison administrators and corrections officers.[98] The Bureau of Justice Assistance also announced a grant of $2.2 million to fund the Vera Institute's Safe Alternatives to Segregation Initiative, which as of the fall of 2016, assisted several jurisdictions seeking to reduce their use of restricted housing and to create alternatives to solitary confinement.[99]

In the fall of 2016, major legislation was put forth in Congress to limit solitary confinement. Senator Dick Durbin, joined by Senators Chris Coons, Cory Booker, Patrick Leahy, and Al Franken, introduced the "Solitary Confinement Reform Act," a bill that would "reform the use of solitary confinement and other forms of restrictive housing" in Bureau of Prisons facilities.[100] The legislation seeks to mandate that placement in solitary confinement be limited to "the briefest term and the least restrictive conditions practicable," including at least four hours out-of-cell every day unless a prisoner "poses a substantial and immediate threat."[101] The bill would also prohibit the placement in solitary confinement of juveniles,[102] pregnant women,[103] prisoners with serious mental illness,[104] and prisoners with intellectual or physical disabilities,[105] unless the prisoner "poses a substantial and immediate threat" and "all other options to de-escalate" have been exhausted."[106] The proposed legislation would also prohibit the placement of "lesbian, gay, bisexual, transgender, intersex, or gender nonconforming" prisoners in solitary confinement based solely on their sexual or gender identity.[107]

Further, the bill would limit placement in administrative segregation to a maximum of 15 consecutive days, and 20 total days in a 60-day period, unless necessary to contain a "substantial and immediate threat."[108] The legislation would also mandate that correctional facilities allow prisoners in restricted housing to participate in programming "as consistent with those available in general population as practicable."[109] In addition, the 2016 Solitary Confinement Reform Act

Included in SCDC' 4.29.19 letter to LOC

proposed to ensure that "time served" during the investigation of an alleged offense be "credited" for disciplinary segregation and that "concurrent sentences" be imposed where more than one disciplinary violation arises from a single episode.[110] The bill also proposed "timely, thorough, and continuous" reviews of confinement, which would include "private, face-to-face interviews with a multidisciplinary staff committee," to determine if the conditions comply with the provisions and if continued confinement is necessary.[111]

The proposed Solitary Confinement Reform Act also would create a "Civil Rights Ombudsman" within the Bureau of Prisons.[112] The Ombudsman position, to be filled by the Attorney General of the United States, would have unrestricted access to the federal prison facilities and contract facilities.[113] The Ombudsman would meet regularly with the Director of the Bureau of Prisons to address civil rights concerns and to raise issues regarding solitary confinement policies and practices.[114] The bill would also require that prisons offer multiple internal mechanisms for prisoners to report violations of this legislation and any other civil rights violations.[115] Specifically, prisons would be required to offer at least two procedures for reporting violations to an entity outside of the facility and at least two procedures for confidentially reporting violations to the Ombudsman.[116] Each year, under the bill, the Ombudsman would be required to submit reports to both houses of Congress on its findings, the problems relating to civil rights violations, violations of the bill's provisions, and recommendations for change.[117] The Federal Bureau of Prisons, in turn, would be required to keep extensive data on solitary confinement, including its costs and the number of assaults in the general population and in the isolated population.[118] The legislation also proposed the creation of a national resource center that would coordinate activities among state, local, and federal prison systems to centralize research and data related to reducing the population of prisoners in solitary confinement.[119]

In short, what commentators have termed a "national consensus" in the United States to end the "over-use of extreme isolation in prisons"[120] has emerged. That consensus comports with recent developments in legal systems other than the United States and in international law that also aim to limit the use of isolation. In December 2015, the United Nations General Assembly unanimously adopted the United Nations Standard Minimum Rules for the Treatment of Prisoners, commonly known as the "Nelson Mandela Rules."[121] The Rules defined solitary confinement as being held for 22 hours or more a day for longer than 15 days without "meaningful human contact,"[122] and stated that "[s]olitary confinement shall be used only in exceptional cases as a last resort, for as short a time as possible and subject to independent review, and only pursuant to the authorization by a competent authority," and "shall not be imposed by virtue of a prisoner's sentence."[123] In addition, the rules provided that "solitary confinement should be prohibited in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures."[124] Further, the rules stipulated that "indefinite" and "prolonged solitary confinement"[125] should not be used, and that women and children should not be held in solitary confinement.[126]

Solitary confinement has also been the subject of several decisions by the European Court of Human Rights (ECtHR), which has analysed degrees of isolation and the duration in specific instances.[127] The ECtHR has considered whether such treatment violates Article 3 of the Convention for the Protection of Human Rights and Fundamental Freedoms, which prohibits

Included in SCDC' 4.29.19 letter to LOC

subjecting any person to "torture or to inhuman or degrading treatment or punishment," or violates Article 8's protection of family and private life.[128] In 2014, the Court found that although "a prisoner's segregation from the prison community does not in itself amount to inhuman treatment . . . substantive reasons must be given when a protracted period of solitary confinement is further extended."[129] In Norway in 2016, a lower court judge held that, under European and Norwegian law, a person convicted of killing dozens of people could not be placed in "social isolation" that cut off his contact with all others, aside from staff.[130]

During the past few years, several research initiatives have documented the use of restricted housing around the world. In 2008, for example, Sharon Shalev published *A Sourcebook on Solitary Confinement*, which examined the health effects of solitary confinement. She also discussed professional, ethical and human rights guidelines and codes of practice relating to the use of solitary confinement.[131] In 2011, Juan E. Méndez, the United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, issued a report and called for general principles to minimize the use of solitary confinement and to abolish the practice under certain circumstances.[132] The Special Rapporteur emphasized that "[t]he practice should be used only in very exceptional circumstances, as a last resort, for as short a time as possible." In 2015, the Prison Reform Trust, based in the U.K., published *Deep Custody: Segregation Units and Close Supervision Centres in England and Wales,*[133] which detailed the use of isolation there.

In 2016, U.N. Special Rapporteur Méndez, working with other institutions, published a report, *Seeing into Solitary: Review of the Laws and Policies of Certain Nations around the World with Regard to Solitary Confinement of Detainees*, written in collaboration with other organizations.[134] The report included results from surveys and a comparative analysis of solitary confinement practices in 34 jurisdictions; information came from Argentina, Austria, Brazil, China, the Czech Republic, England and Wales ("England"), Ethiopia, Finland, France, Germany, Guatemala, Hungary, Japan, Kenya, Kyrgyzstan, Mexico, New Zealand, Norway, Poland, Russia, South Africa, Turkey, Uganda, the United States of America, Uruguay, and Venezuela, as well as eight states within the United States: California, Colorado, Florida, Illinois, Maine, New York, Pennsylvania, and Texas.

Seeing into Solitary found that "the practice of solitary confinement appears to be an established fixture of the prison systems in all the countries examined, with few signs that it will disappear from those systems any time soon."[135] The report identified a significant gap in many jurisdictions between "the law and the practice of solitary confinement," in that solitary confinement was imposed more often than the law authorized.[136] The reasons for placement in solitary confinement were found to be varied, and included both disciplinary and non-disciplinary reasons. The report noted that safeguards, access to legal counsel, and mandatory medical examinations that were available in many disciplinary segregation units were often lacking in non-disciplinary segregation units.[137] The report also noted that "some countries which have made the most consequential improvements on solitary confinement regimes, such as England and the United States, also tend to authorize some of the longest periods of solitary confinement for inmates."[138]

Included in SCDC' 4.29.19 letter to LOC

Seeing into Solitary also detailed efforts of some jurisdictions to improve conditions in solitary confinement, of other jurisdictions to establish appeals processes to challenge decisions to impose solitary confinement, and of many jurisdictions to prohibit or limit the use of solitary confinement for juveniles, women (mostly pregnant women), and mentally ill or disabled people.[139] The most common limitation that the report identified was on the length of time that a person may be placed in solitary confinement. Many jurisdictions permitted 30 days or less, although the limit was at times extended or ignored.[140] Further, "some countries, including highly developed nations with what may be viewed as enlightened approaches to certain aspects of solitary confinement, allow such confinement, whether for disciplinary or non-disciplinary purposes, and in theory or practice, to be extended either for extremely long periods, including years in some cases, or indefinitely."[141]

In sum, demands for change can be found around the world. Commitments to reform and efforts to limit or abolish the use of isolating confinement come from stakeholders and actors in and out of government. Documentation of the harms of isolation, coupled with its costs and the dearth of evidence suggesting that it enhances security, has prompted prison directors, legislatures, executive branch officials, and advocacy groups to try to limit reliance on restricted housing. Instead of being cast as the solution to a problem, restricted housing has come to be understood by many as a problem in need of a solution.[142]

II. The 2015 Survey's Design and Purposes

Three additional introductory comments are in order. First, we sketch the research methodology used in the questionnaire, which is reproduced in Appendix A. Second, we discuss the challenges of defining and of gathering data on restricted housing. Third, we explain the relationship of this study to the report, *Time-In-Cell*, published by ASCA and Liman in 2015.

A. Goals and Methods

ASCA and the Liman Program jointly developed a survey that was sent to the directors of state and federal correctional systems in the United States to learn about the use of restricted housing as of the fall of 2015. The goal was to understand as much as possible about the numbers of people separated from general prison populations and held for 22 hours or more, for 15 continuous days or more, in single or double cells.

To do so, the survey's 15 questions requested information on all forms of restricted housing within each of the jurisdictions. To understand the information provided, we sought to learn about the types of facilities—prisons, jails, juvenile or other specially organized institutions—a jurisdiction had, as well as for which facilities the jurisdiction could provide information on restricted housing. We also asked about the number of people in restricted housing; demographic information, including gender, race, and age; whether prisoners with serious mental illness were held in restricted housing; how long individuals were confined in restricted housing; and whether reforms were underway.

Included in SCDC' 4.29.19 letter to LOC

As in prior reports by ASCA and the Liman Program, the survey was distributed through ASCA to the 50 states, the Federal Bureau of Prisons, the District of Columbia and, in the summer of 2016, the Virgin Islands which requested that it also be included and then promptly provided information that was integrated thereafter.[143] We received responses from 52 jurisdictions (as noted, Maine did not respond). For a few questions, we compiled information from all the responses; more of the data come from the 48 jurisdictions providing detailed responses. Of these, not every jurisdiction responded to all questions.

Previews of this report were provided twice at ASCA meetings. After receiving initial responses in the fall of 2015, we presented an overview in January of 2016 at the ASCA mid-year meeting. We then followed up in the spring of 2016 to clarify responses as needed. At the summer 2016 ASCA meeting, a draft report was circulated and discussed. Thereafter, many jurisdictions offered comments, prompting additional revisions. Unless otherwise noted, all data provided come from the answers given by each jurisdiction, reporting about itself.

B. Research Challenges: Various Definitions of Restricted Housing and the Overlaps and Differences between the 2015 and 2016 ASCA-Liman Reports

As the introduction explained, several caveats are in order about the goals, the data gathered, and the limits of this Report. The first concerns the focus of this work on "restricted housing" or "restrictive housing." As noted, the primary rationales relied upon by correction systems for using restricted housing are the perceived needs to protect, to discipline, or to prevent future harm. In addition to terms such as protective custody, disciplinary segregation, and administrative segregation, different systems use an array of other terms, such as "special housing units (SHU)," "security housing units (SHU)," and "special management units (SMU)."

In an effort to develop nationwide data that focused on all forms of restricted housing, the 2015 survey defined "restricted housing" as:

> separating prisoners from the general population and holding them in their cells for 22 hours per day or more, for 15 or more continuous days. The definition includes prisoners held in both single or double cells, if held for 22 hours per day or more in a cell, for 15 or more continuous days.[144]

Yet some jurisdictions indicated that the information they routinely collected did not easily fall within the parameters that we provided. Seven jurisdictions reported being unable to identify whether prisoners were in restricted conditions for more or less than the 15-day benchmark.[145] Other jurisdictions did not have clear information about the 22-hour measure; they described some forms of restricted housing that reduced the number of hours within cells to below 22 for at least one day of a week, or they had other questions about the definition.[146] We did as much follow-up as time would permit to enable this Report to be completed, we included as much of the information provided to us as we could, and we noted when information could include variations related to the specific questions asked.

Included in SCDC' 4.29.19 letter to LOC

Second, when gathering data on restricted housing and administrative segregation in 2014-2015 for the *Time-In-Cell* Report, we asked jurisdictions to tell us about the number of individuals in all forms of restricted housing, but did not provide a specific and separate definition in that question, except to indicate that it included disciplinary segregation, protective custody, and administrative segregation.[147] Further, the *Time-In-Cell* Report focused most of the 130 questions on the practices governing administrative segregation, and we instructed:

> For the purposes of this questionnaire, the term "administrative segregation" refers to separating prisoners from the general population, typically in cells (either alone or with cellmates), and holding them in their cells for most of the hours of the day for 30 days or more. Common terms for this type of confinement include administrative detention, intensive management, and restrictive housing. Please note that administrative segregation does not include punitive/disciplinary segregation or protective custody.[148]

In contrast, the 2015 survey focused specifically on restricted housing of all kinds. We asked about the numbers of prisoners held for at least 22 hours a day in their cells, and used those responses for our overall tallies.

When responding to the general question on restricted housing in the 2015 *Time-In-Cell* Report, 34 jurisdictions reported that, as of the fall of 2014, 66,000 people were held in restricted housing. Because those jurisdictions housed 73% of the country's prison population, ASCA and Liman estimated that 80,000 to 100,000 people were housed in isolation in the fall of 2014.

In short, the 2014 and 2015 surveys differed on a few dimensions. While in 2014, we did not specify the number of hours held in-cell beyond saying "most hours of the day," we did learn that in many jurisdictions individuals in restricted housing were held for 22-24 hours per day in-cell. In contrast, this 2015 survey gave the 22-hour benchmark. Further, in 2014, we asked about prisoners held in-cell for 30 days or more; in this 2015 survey, we asked about people held in-cell for 15 days or more. This 15-day marker was selected because it is used in many jurisdictions[149] as well as internationally as identifying what is considered to be prolonged or extended solitary confinement.[150] Moreover, because we learned in the *Time-In-Cell* Report that all of the jurisdictions reporting on administrative segregation held prisoners in cells for 19 hours or more and that 89% of the prisoners were in-cell 22 hours or more on weekdays and on weekends,[151] we used 22 hours as the marker for restricted housing and additionally sought more information on individuals placed in restricted housing for time intervals short of 22 hours.

III. Types of Facilities and of Cells in the 2015 Survey

A. Types of Facilities for which State-Wide Data Were Available

As discussed above, based on information provided in prior surveys, we knew that not all state-level correctional systems had information regarding the number of people held in restricted housing in every type of confinement facility within their state. Further, most state level agencies did not have authority over all of the detention facilities within their jurisdiction.

Included in SCDC' 4.29.19 letter to LOC

For example, while state governments most commonly operate prisons, separate local government agencies typically operate jails.[152]

Therefore, we asked jurisdictions to explain what they *did* know: we asked which types of facilities were included within their state-level correctional systems and if they had data regarding individuals held in restricted housing in each of the types of facilities under their control.[153] Some states had significant numbers of prisoners in county jails. Data about such prisoners has generally only been included if that jurisdiction had information about those held in the fall of 2015 in restricted housing and if that state's policies on restricted housing governed the local facilities.

In the survey, we asked if each jurisdiction's correctional system included prisons, jails, juvenile facilities, mental health facilities, privately-contracted facilities, special facilities for death sentenced prisoners, or any other types of facilities. Of the 52 jurisdictions responding, all ran prison systems except the District of Columbia, which administers its own jail system and relies on federal and privately-contracted facilities to house its prison population.[154] In total, 12 of the 52 responding jurisdictions reported that their correctional systems included jails, while 40 jurisdictions' correctional systems did not include jails.[155] As we learned from the responses, the relationship of jails to state prison systems is varied; some systems used jails in the sense of contracting to house prisoners in jails but did not have direct authority over them. Our focus was on rules imposed at the state-wide level.

In Table 1, we summarize the information from the 52 jurisdictions responding by type of facility.

Table 1 – Types of Facilities Within State and Federal Corrections Systems (*n* = 52)

Facilities	Jurisdictions	Jurisdictions Collecting Restricted Housing Data
Prisons	51	49
Jails	12	7[156]
Juvenile Facilities	4	3
Mental Health Facilities	7	4
Privately-Contracted Facilities	21	15
Special Housing for Death-Sentenced Prisoners	2	2

As Table 1 indicates, we also asked jurisdictions if they had information on restricted housing for each category of facility that they identified as within their control in their systems.[157] Of the 51 jurisdictions with prisons in their correctional system, 49 reported on individuals in restricted housing in the prisons that they run directly, as distinguished from those run by private providers. Of the 12 jurisdictions whose systems included jails (nine states, the Virgin Islands, the Federal Bureau of Prisons, and the District of Columbia), seven had data on the use of restricted housing in their jails.[158]

The information provided on privately-contracted facilities was also limited. Nonetheless, we did identify 2,425 prisoners held in 15 jurisdictions in restricted housing in private facilities. Specifically, 21 reported that they have privately-contracted facilities in their correctional

Included in SCDC' 4.29.19 letter to LOC

system, and 15 provided information on restricted housing within those facilities. As of the fall of 2015, those 21 jurisdictions housed 942,248 prisoners in their total custodial population across all types of facilities, and 96,487—or about 10%—were housed in privately-contracted facilities. The 15 jurisdictions reporting on the use of restricted housing in privately-contracted facilities housed 85,701 prisoners, and 2.8% of that number—2,425 individuals—were reported to be in restricted housing.

The information provided on juveniles held in custody was minimal. Four responding jurisdictions indicated that their correctional systems included juvenile facilities.[159] Of these four jurisdictions, three provided data on the use of restricted housing in these juvenile facilities.

We also asked about other specialized facilities for subsets of prisoners. Some jurisdictions indicated that they had distinct facilities, while others referenced special units within facilities. Seven jurisdictions responded that they had separate institutions for the mentally ill.[160] Six jurisdictions reported that their data included facilities that they denoted as "Other" because they did not fall into the named categories we provided.[161]

In short, most of the information on restricted housing provided in this Report is about its use *in prisons*. Further, the "total" numbers provided in this Report do not include *all* the people who were, in the fall of 2015, held in restricted housing. For example, the numbers discussed in the demographic section on age cohorts in restricted housing were based almost entirely on information about adult prisons. As discussed, we have almost no information on juvenile facilities around the country.[162] Also, we know that millions of people are incarcerated in jails, that some jails have restricted housing, and that more than 90% of the jails are run at the county level. Yet, this Report has very little information on the number of individuals held in restricted housing within jails.

B. The Use of Single and of Double Cells

As noted, the survey's definition of restricted housing included individuals held for 22 hours or more, for 15 days or more, in single and double cells. The inclusion of double-celling mirrors the views of the Department of Justice, which noted in its 2016 Report that "[n]ot all segregation is truly 'solitary,' . . . . Many prison systems, including the [Federal Bureau of Prisons], often house two segregated inmates together in the same cell, a practice known as 'double-celling.'"[163]

For this survey, we asked jurisdictions, "How many prisoners, if any, (including both male and female, of every age)" in restricted housing "are housed in double cells?"[164] Among the 47 jurisdictions that responded to this question, 26 housed prisoners in double cells. Twenty-one of the 26 jurisdictions provided the number of prisoners confined in double cells, which totaled 17,460 prisoners. Five jurisdictions reported that they housed prisoners in double cells but were not able to provide a number.

Included in SCDC' 4.29.19 letter to LOC

IV. The Numbers and Percentages of Prisoners in Restricted Housing: The Data from the 2015 Survey

A. Counting and Comparing General and Restricted Populations

The survey asked jurisdictions to report on the number of men and women held in any form of restricted housing as of October 1, 2015. As noted, 48 jurisdictions described a total of 67,442 prisoners in restricted housing.[165] These 48 jurisdictions housed 96.4% of the total prison population in the United States and its territories,[166] as calculated by using data provided in a 2014 report by the Bureau of Statistics (BJS), which regularly provides the numbers of prisoners by jurisdiction.[167]

We also sought to gather baseline general population data directly from each jurisdiction, so as to understand what percent of prisoners *within* a jurisdiction were held in restricted housing. The 2015 survey asked each jurisdiction for its total custodial population, including prisoners in restricted housing and in the general population. In addition, we asked about the numbers of prisoners housed in different types of facilities, as detailed above.

First, we asked for the total number of prisoners housed in each jurisdiction. On this question, 52 jurisdictions provided information; the total custodial population reported by was 1,452,691 prisoners.[168] Forty-eight jurisdictions provided information on restricted housing populations; the total custodial population for the 48 jurisdictions for which we have restricted housing data was 1,437,276. This total accounts for prisoners held in-state (as compared to being sent to another jurisdiction); our operative assumption was that most states house almost all of their prisoners in-state. We know of exceptions, of which Hawaii is a prominent example.[169] For Hawaii, we used the in-state population when calculating the percentage of people held in restricted housing.

Second, we asked for the total number of prisoners housed in facilities for which the jurisdiction also had information on restricted housing. When we totaled the numbers from those answers, the custodial population *in facilities for which restricted housing data was reported*—at 1,387,161 prisoners—was slightly lower than the answers by these jurisdictions to the question of total custodial population—specifically, by 65,530 fewer individuals. That lower number reflects that some jurisdictions reported that they did not track data on individuals in restricted housing in *all* of their facilities.[170]

More details are in order to explain both the Table and Chart with asterisks and two double entries. In the 41 jurisdictions in which the total population numbers were the same for both inquiries, we used that number as the baseline to calculate the percentage of prisoners in restricted housing. In the seven jurisdictions that had some facilities for which they could not provide restricted housing information (i.e. jurisdictions for which the total population in facilities with restricted housing data was less than the total custodial population), we used the total population in facilities with restricted housing data to calculate the percentage of prisoners in restricted housing. In Table 2, below, we use an asterisk to note those jurisdictions.

Directors at the two jurisdictions that were (before the Virgin Islands reported its data) at the highest end—Louisiana and Utah—reached out to us after we had circulated a draft report in

Included in SCDC' 4.29.19 letter to LOC

the summer of 2016 to describe how calculations about their states could be different. Louisiana staff suggested that we should include state prisoners held in local jails—some 18,000—in the denominator and that we could extrapolate the number held in parish jails in restricted housing from a special audit conducted in August of 2016 that identified 314 people held in such confinement. Using those numbers, Louisiana would have had 8.2% of its prison population in restricted housing. Further, as discussed in more detail in Part VII, Utah reported making significant changes in how it authorized the use of restricted housing. As of August of 2016, the number of people in restricted housing in Utah was reported to have dropped from 912 (14% of the state prison population) to 380 (6% of the state prison population). The focus of our data was on the fall of 2015, but because these jurisdictions reached out specially to provide extra information, we included an added layer of data for Louisiana and Utah in Table 2 and Chart 1.

We provide a summary of the findings in Table 2 and Chart 1 below. The percentage of prisoners in restricted housing ranged from 0.5% (Hawaii, in-state only) to 28.3% (Virgin Islands). The Virgin Islands was also the jurisdiction reporting the smallest absolute number of prisoners in the total custodial population (491 prisoners). Across all the jurisdictions, the median percentage of the population held in restricted housing was 5.1%.

Included in SCDC' 4.29.19 letter to LOC

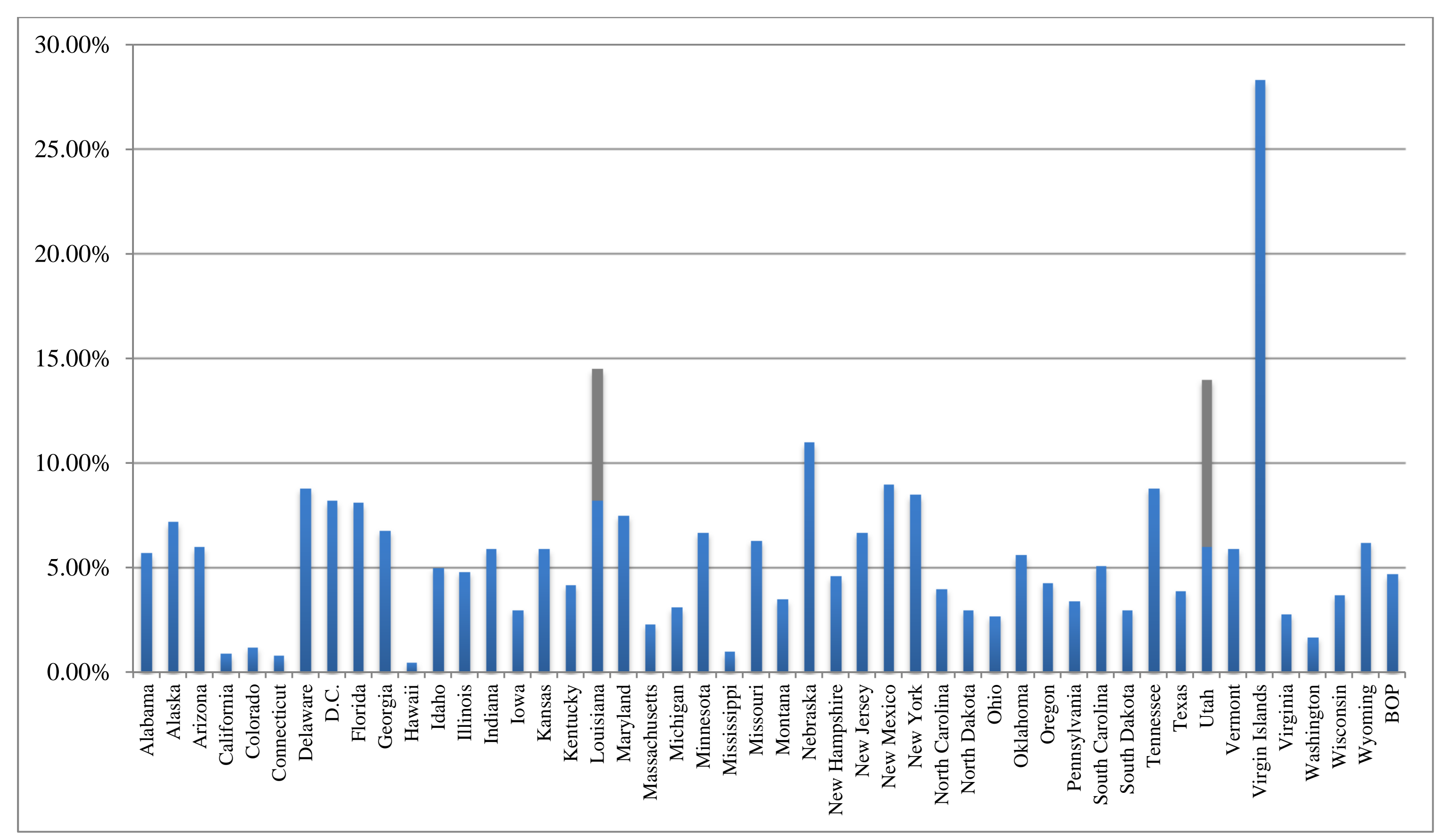
Table 2 – Numbers and Percentages of Men and Women in Custodial Population in Restricted Housing by Jurisdiction (15 Consecutive Days or Longer, 22 Hours or More per Day) (*n* = 48)[171]

	Total Custodial Population	Total Custodial Population for Facilities Reporting RH Data	Population in Restricted Housing	Percentage in Restricted Housing
Alabama	25,284	24,549*	1,402	5.7%
Alaska	4,919	4,919	352	7.2%
Arizona	42,736	42,736	2,544	6.0%
California	128,164	117,171*	1,104[172]	0.9%
Colorado	18,231	18,231	217[173]	1.2%
Connecticut	16,056	16,056	128	0.8%
Delaware	5,824	4,342*	381	8.8%
D.C.	1,153	1,153	95	8.2%
Florida	99,588	99,588	8,103	8.1%
Georgia	56,656	56,656	3,880	6.8%
Hawaii	4,200	4,200	23	0.5%
Idaho	8,013	8,013	404	5.0%
Illinois	46,609	46,609	2,255	4.8%
Indiana	27,508	27,508	1,621	5.9%
Iowa	8,302	8,302	247	3.0%
Kansas	9,952	9,952	589	5.9%
Kentucky	11,669	11,669	487	4.2%
Louisiana	36,511	18,515* (36,511)	2,689 (3,003)	14.5% (8.2%)
Maryland	19,687	19,687	1,485	7.5%
Massachusetts	10,004	10,004	235	2.3%
Michigan	42,826	42,826	1,339	3.1%
Minnesota	9,321	9,321	622	6.7%
Mississippi	18,866	18,866	185	1.0%
Missouri	32,266	32,266	2,028	6.3%
Montana	2,554	2,554	90	3.5%
Nebraska	5,456	5,456	598	11.0%
New Hampshire	2,699	2,699	125	4.6%
New Jersey	20,346	20,346	1,370	6.7%
New Mexico	7,389	7,389	663	9.0%
New York	52,621	52,621	4,498	8.5%
North Carolina	38,039	38,039	1,517	4.0%
North Dakota	1,800	1,800	54	3.0%
Ohio	50,248	50,248	1,374	2.7%

Included in SCDC' 4.29.19 letter to LOC

Oklahoma	27,650	27,650	1,552	5.6%
Oregon	14,724	14,724	630	4.3%
Pennsylvania	50,349	50,349	1,716	3.4%
South Carolina	20,978	20,978	1,068	5.1%
South Dakota	3,526	3,526	106	3.0%
Tennessee	20,095	20,095	1,768	8.8%
Texas	148,365	148,365	5,832	3.9%
Utah	6,497	6,497 (6,112)[174]	912 (380)	14.0% (6%)
Vermont	1,783	1,783	106	5.9%
Virgin Islands	491	339*	96	28.3%
Virginia	30,412	30,412	854	2.8%
Washington	16,308	16,308	274	1.7%
Wisconsin	22,965	20,535*	751	3.7%
Wyoming	2,128	2,128	131	6.2%
BOP	205,508	189,181*	8,942	4.7%
Across Jurisdictions	1,437,276	1,387,161	67,442	4.9%

Chart 1 – Percentages of Men and Women in Custodial Population in Restricted Housing by Jurisdiction (15 Consecutive Days or Longer, 22 Hours or More per Day) (n = 48)[175]



Included in SCDC' 4.29.19 letter to LOC

B. The Numbers and Percentages of Prisoners In-Cell for 16 to 21 Hours

As noted, our general definition of restricted housing was focused on people held in-cell for 22 hours or more per day for 15 continuous days or more. Given ongoing efforts to lower the number of hours in cells, we asked jurisdictions to provide information on prisoners who were held in their cells for less than 22 hours a day but nonetheless for most of each day. For example, California reported that it used forms of segregation that permit prisoners 10 hours per week out-of-cell, and distributed those 10 hours throughout the week such that on some days in a week, prisoners were allowed more than three hours out-of-cell. As a consequence, prisoners in these forms of segregation would not be included in California's restricted housing numbers.

Therefore, in addition to the 22 hours or more question, we inquired about two subsets: individuals in-cell for 20 to 21 hours per day and those in-cell for 16 to 19 hours per day. Thirty-four jurisdictions with a total custodial population (in facilities for which they tracked restricted housing data) of 788,871 prisoners responded to the questions about prisoners in cells in these different time periods. Eleven of the 34 jurisdictions answered that, in addition to the prisoners held in restricted housing for 22 or more hours, they held no prisoners in cell for 16-21 hours.

Of those responding, 23 jurisdictions reported an additional 11,827 prisoners held in-cell for 20 to 21 hours per day and 4,628 prisoners were held in-cell for 16 to 19 hours per day. In this subset of 23 jurisdictions, a total of 16,455 prisoners were held in-cell for 16 to 21 hours per day. Within these 23 jurisdictions, the percentage of prisoners held in-cell for 16 to 21 hours ranged from 0.03% (New Jersey) to 6.2% (California). In these 23 jurisdictions holding prisoners for 16 to 21 hours, a median of 1.6% of the total custodial population was held in-cell for 16 to 21 hours, as well as prisoners held in-cell for 22 hours or more.

In short, in addition to the 67,442 prisoners held in-cell 22 hours or more across the 48 responding jurisdictions represented in Table 2 and Chart 1, another 16,455 prisoners in 23 of those 48 jurisdictions were held in conditions that were also restricted, but not as limiting as the 22 hours reflected in Table 2 and Chart 1. When these two numbers are combined, a total of at least 83,897 prisoners were held in-cell for more than 16 hours per day, for 15 days or more.

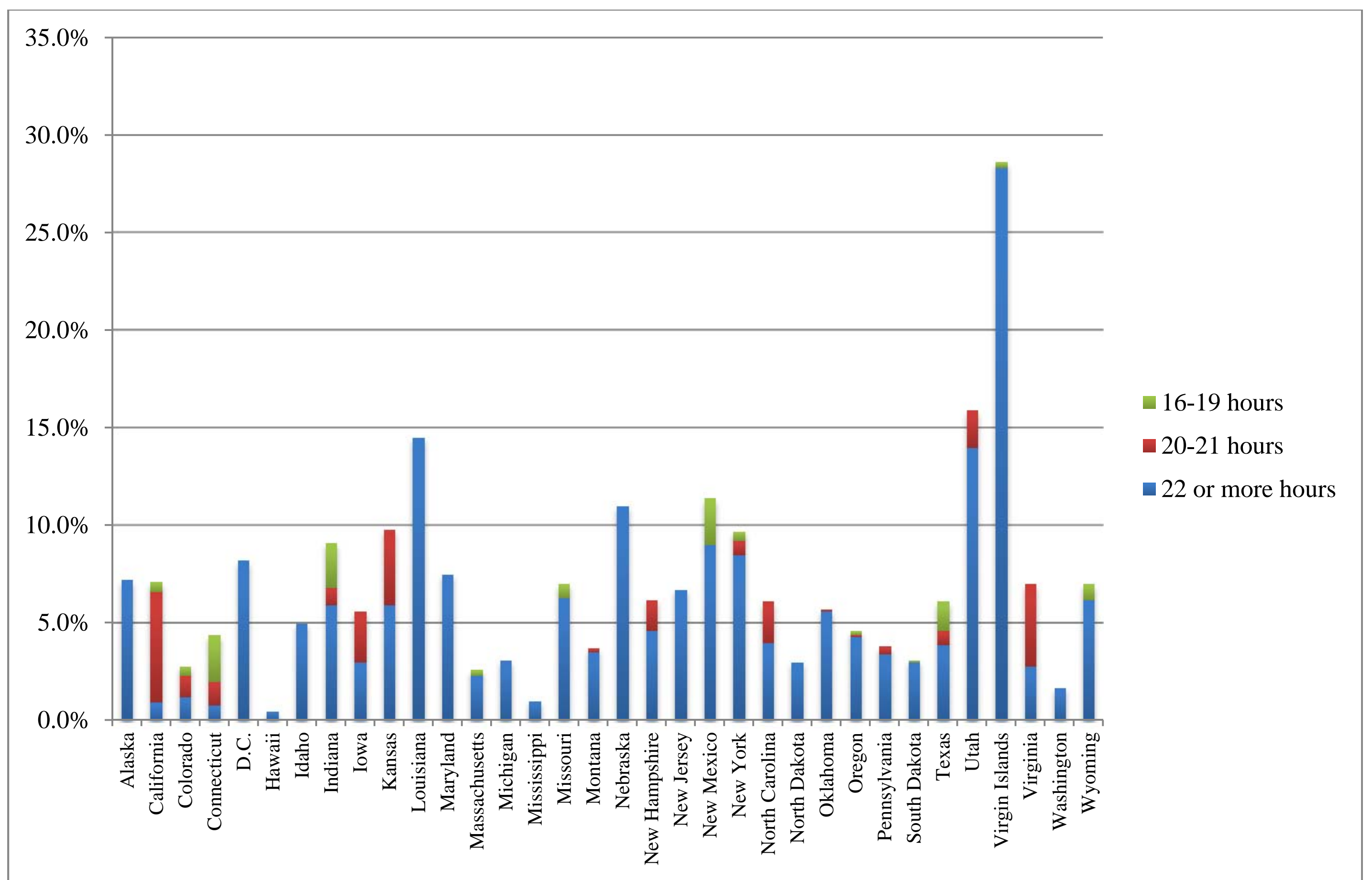
Included in SCDC' 4.29.19 letter to LOC

Table 3 – Numbers and Percentages of Men and Women in Custodial Population In-Cell for 16 or More Hours per Day and for 15 Consecutive Days or Longer by Jurisdiction (*n* = 34)[176]

	Total Custodial Population	22 Hours or More		20-21 Hours		16-19 Hours		Total 16-24 Hours	
Alaska	4,919	352	7.2%	0	0.0%	0	0.0%	352	7.2%
California[177]	117,171	1,104	0.9%	6,628	5.7%	597	0.5%	8,329	7.1%
Colorado	18,231	217	1.2%	202	1.1%	99	0.5%	518	2.8%
Connecticut	16,056	128	0.8%	186	1.2%	381	2.4%	695	4.3%
D.C.	1,153	95	8.2%	0	0.0%	0	0.0%	95	8.2%
Hawaii	4,200	23	0.5%	0	0.0%	0	0.0%	23	0.5%
Idaho	8,013	404	5.0%	0	0.0%	0	0.0%	404	5.0%
Indiana	27,508	1,621	5.9%	246	0.9%	640	2.3%	2,507	9.1%
Iowa	8,302	247	3.0%	213	2.6%	0	0.0%	460	5.5%
Kansas	9,952	589	5.9%	392	3.9%	0	0.0%	981	9.9%
Louisiana	18,515	2,689	14.5%	0	0.0%	0	0.0%	2,689	14.5%
Maryland	19,687	1,485	7.5%	0	0.0%	0	0.0%	1,485	7.5%
Massachusetts	10,004	235	2.3%	0	0.0%	29	0.3%	264	2.6%
Michigan	42,826	1,339	3.1%	0	0.0%	0	0.0%	1,339	3.1%
Mississippi	18,866	185	1.0%	0	0.0%	0	0.0%	185	1.0%
Missouri	32,266	2,028	6.3%	0	0.0%	222	0.7%	2,250	7.0%
Montana	2,554	90	3.5%	6	0.2%	0	0.0%	96	3.8%
Nebraska	5,456	598	11.0%	0	0.0%	0	0.0%	598	11.0%
New Hampshire	2,699	125	4.6%	44	1.6%	0	0.0%	169	6.3%
New Jersey	20,346	1,370	6.7%	6	0.0%	0	0.0%	1,376	6.8%
New Mexico	7,389	663	9.0%	0	0.0%	175	2.4%	838	11.3%
New York	52,621	4,498	8.5%	347	0.7%	245	0.5%	5,090	9.7%
North Carolina	38,039	1,517	4.0%	815	2.1%	0	0.0%	2,332	6.1%
North Dakota	1,800	54	3.0%	0	0.0%	0	0.0%	54	3.0%
Oklahoma	27,650	1,552	5.6%	20	0.1%	0	0.0%	1,572	5.7%
Oregon	14,724	630	4.3%	22	0.1%	34	0.2%	686	4.7%
Pennsylvania	50,349	1,716	3.4%	226	0.4%	0	0.0%	1,942	3.9%
South Dakota	3,526	106	3.0%	0	0.0%	5	0.1%	111	3.1%
Texas	148,365	5,832	3.9%	1,063	0.7%	2,183	1.5%	9,078	6.1%
Utah[178]	6,497	912	14.0%	122	1.9%	0	0.0%	1,034	15.9%
Virgin Islands	339	96	28.3%	0	0.0%	1	0.3%	97	28.6%
Virginia	30,412	854	2.8%	1,289	4.2%	0	0.0%	2,143	7.0%
Washington	16,308	274	1.7%	0	0.0%	0	0.0%	274	1.7%
Wyoming	2,128	131	6.2%	0	0.0%	17	0.8%	148	7.0%

Included in SCDC' 4.29.19 letter to LOC

Chart 2 – Percentage of Men and Women in Custodial Population In-Cell for 16 or More Hours per Day and for 15 Consecutive Days or Longer by Jurisdiction (n = 34)



V. The Duration of Time Individuals Spent in Restricted Housing

We asked whether jurisdictions regularly gather, collect, or report information on each prisoner's length of stay in restricted housing. Fifty of the 53 jurisdictions we queried responded to this question.[179] Thirty-three jurisdictions stated that they did regularly gather information on length of stay.[180] The following 17 jurisdictions stated that they do not regularly track information on length of stay: Alabama, Alaska, Arkansas, Delaware, Florida, Illinois, Louisiana, Michigan, Missouri, Nebraska, Nevada, Oklahoma, Oregon, Pennsylvania, Rhode Island, West Virginia, and Wisconsin.[181]

A. Length of Stay

We also asked jurisdictions how many prisoners, as of October 1, 2015, had been in restricted housing for the following intervals: 15 days to one month; one month to three months; three months to six months; six months to one year; one year to three years; three years to six years; and over six years. Forty-one of the 53 jurisdictions we queried provided sufficiently detailed data on which to report.[182] The data are summarized in Table 4,[183] and endnotes indicate jurisdictions that reported length-of-stay data for some, but not all prisoners in restricted housing.

Included in SCDC' 4.29.19 letter to LOC

Table 4 – Numbers of Prisoners in Restricted Housing by Length of Time and by Jurisdiction (*n* = 41)

	15 days- 1 mo.	1-3 mo.	3-6 mo.	6 mo.- 1 year	1-3 years	3-6 years	6+ years
Alaska[184]	124	74	49	60	43	5	0
Arizona	140	472	530	809	488	34	71
California[185]	23	106	177	181	270	168	154
Colorado	64	65	64	23	1	0	0
Connecticut[186]	19	20	23	17	22	7	13
Delaware	25	99	84	76	67	12	18
District of Columbia	33	51	6	5	0	0	0
Florida	2,026	3,254	1,327	741	401	195	159
Hawaii	21	2	0	0	0	0	0
Idaho[187]	55	91	49	55	21	3	1
Indiana	212	224	388	496	175	80	46
Iowa	97	80	30	24	16	0	0
Kansas	125	146	87	105	94	22	10
Kentucky	139	222	52	41	28	4	1
Louisiana[188]	327	551	334	302	450	221	0
Maryland	201	725	357	136	56	8	2
Massachusetts[189]	2	3	12	65	71	24	43
Minnesota[190]	102	308	103	47	7	0	0
Mississippi	3	21	29	41	69	17	5
Montana[191]	58	0	67	2	4	0	3
Nebraska	48	121	158	87	106	48	30
New Jersey	54	247	295	354	184	128	108
New York[192]	1,615	1,454	671	257	101	32	0
North Carolina	461	579	460	12	4	1	0
North Dakota	8	13	12	17	4	0	0
Ohio[193]	119	360	181	253	162	43	22
Oklahoma	169	270	206	270	490	77	70
Oregon	90	152	277	81	26	4	0
Pennsylvania	349	524	288	156	157	52	190
South Carolina	238	370	128	114	151	67	0
South Dakota	18	16	10	15	27	12	8
Tennessee[194]	89	239	222	353	500	166	205
Texas	109	204	277	537	1,840	1,278	1,587
Utah	233	169	173	125	166	35	11
Vermont[195]	17	3	2	0	0	0	0
Virgin Islands	14	12	15	23	17	10	5
Virginia	219	306	119	89	101	20	0
Washington	16	55	68	70	37	16	12
Wisconsin	278	285	88	60	36	4	0
Wyoming	8	30	24	59	9	0	1
BOP	1,690	3,802	1,449	929	731	183	158
Across Jurisdictions	9,638	15,725	8,891	7,087	7,132	2,976	2,933

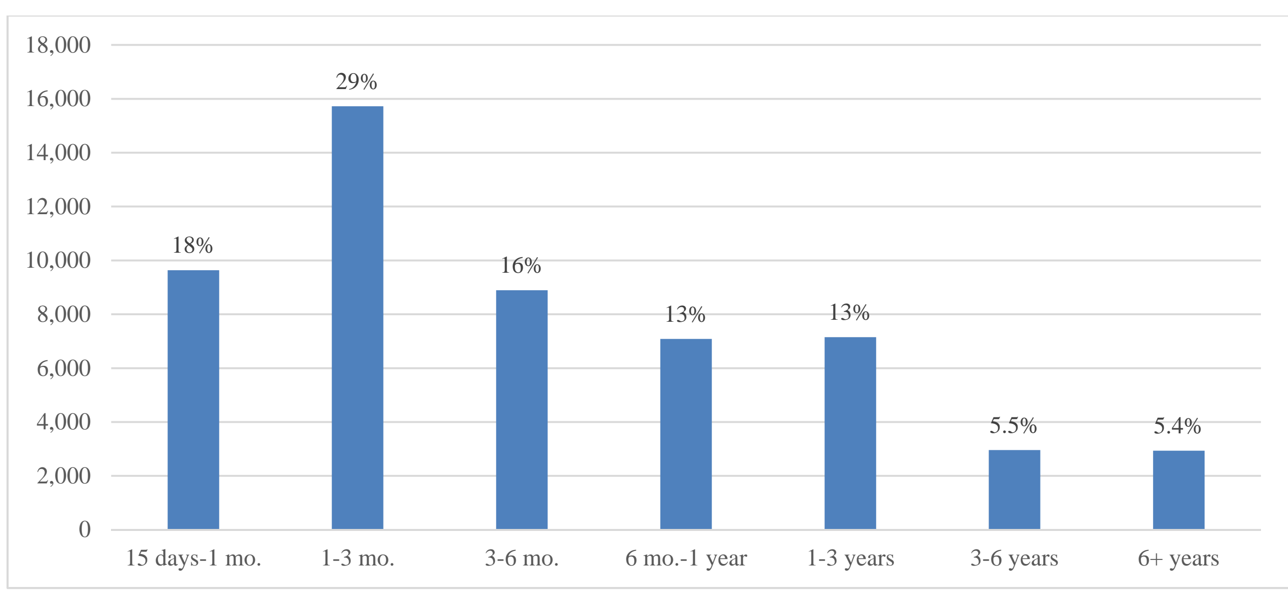
Included in SCDC' 4.29.19 letter to LOC

The 41 responding jurisdictions provided length-of-stay data for 54,382 prisoners in restricted housing. We therefore identified length-of-time spent in restricted housing for 81% of the total restricted housing population described in this report.

According to the 41 responding jurisdictions, 18% of prisoners were in restricted housing for 15 days up to 30 days. Twenty-nine percent of the 54,382 prisoners—15,725 people—were in restricted housing for one month up to three months. Another 29% of the 54,382 prisoners—15,978 people—were in restricted housing for three months up to one year. Twenty-four percent of the 54,382 prisoners—13,041 people—were in restricted housing for one year or more.

Almost 6,000 people, comprising 11% of the population on which we have duration data for the length of time spent in restricted housing, were held in restricted housing three years or more, and about half of these were held in restricted housing for six years or more. Specifically, 32 jurisdictions reported housing 2,976 people for three years up to six years; this population constitutes 5.5% of the restricted housing population on which we have length-of-time data. Twenty-six jurisdictions reported holding 2,933 prisoners for six years or more, which is 5.4% of the population for which we had this kind of data. Chart 3 details this distribution.

Chart 3 – Prisoners in Restricted Housing by Length of Time and by Percent of the 54,382 Prisoners for Which Length-of-Stay Data Were Provided (*n* = 41)



Included in SCDC' 4.29.19 letter to LOC

B. Length of Time by Classification of the Type of Restricted Custody

For each time period, we asked jurisdictions about prisoners held in protective custody, disciplinary custody, administrative segregation or any other classification that met our definition of restricted housing—prisoners separated from the general population and held in-cell for 22 hours per day or more, for 15 or more continuous days. If jurisdictions included prisoners under some "other" restricted housing classification, we asked for information about this classification; jurisdictions reported classifications such as death row, medical classifications, and intensive management units.[196]

Thirty-seven jurisdictions were able to provide data on prisoners' length of stay by classification.[197] These jurisdictions reported type-of-custody data for 50,036 prisoners in restricted housing and thus comprised roughly 74% of the 67,442 population that were reported to be in restricted housing as of the fall of 2015.

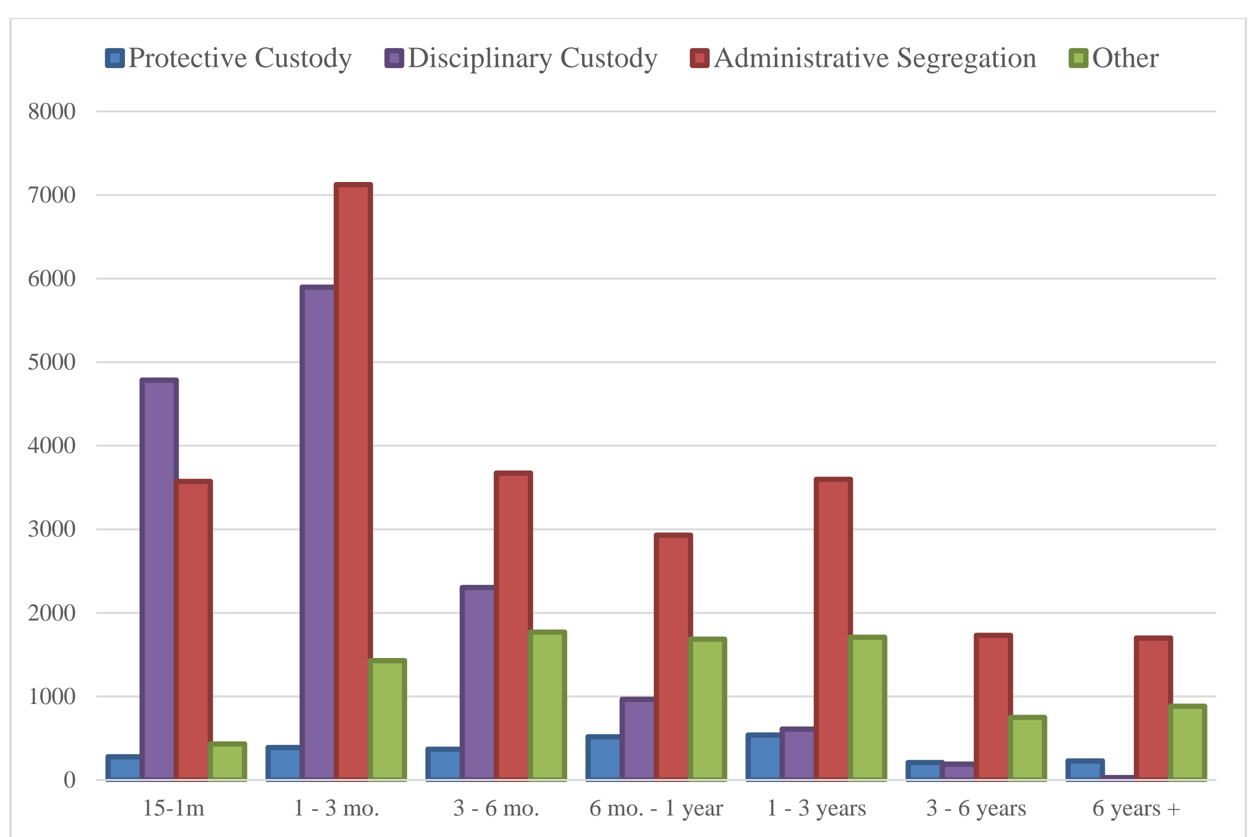
The majority of this subset of 50,036 prisoners were held in disciplinary or administrative segregation. Of the 50,036 prisoners reported by type of classification that put them into restricted housing 2,527 (5%) were classified as being held in protective custody; 14,809 (30%) were classified as being held in disciplinary custody; 23,997 (48%) were classified as being held in administrative segregation; and 8,681 (17%) were segregated for some other reason.

Prisoners who were held in disciplinary custody stayed there for shorter intervals than did prisoners held under other classifications. Of the prisoners in restricted housing for 15 days up to one month, 53% were in disciplinary custody. Of prisoners held for one month up to three months, 40% were classified as placed into restrictive housing for discipline.

Prisoners who were held for longer periods of time in restricted housing, particularly longer than six months, were more likely to be held in administrative segregation or "other" forms of restricted housing. Of prisoners who were in restricted housing for six months or longer in the jurisdictions providing data, 82%, or 14,847 prisoners, were housed in administrative segregation or some "other" form of restricted housing. Prisoners in disciplinary and protective custody accounted for 18% of those who spent longer than six months in restricted housing, whereas prisoners in administrative segregation accounted for 54% of those who spent longer than six months, and prisoners in "other" forms of restricted housing accounted for 28%. Chart 4 provides the details.

Included in SCDC' 4.29.19 letter to LOC

Chart 4 – Prisoners in Restricted Housing by Length of Time and by Classification of the Type of Restrictive Custody (*n* = 37)



VI. The Demographics of Restricted Housing

The survey asked jurisdictions to provide demographic data for their total custodial and restricted housing populations. Forty-three responding jurisdictions provided some information about gender, race, ethnicity, and age. A smaller number of jurisdictions provided information on people identified as transgender, as pregnant women, and as individuals labeled with mental health issues.

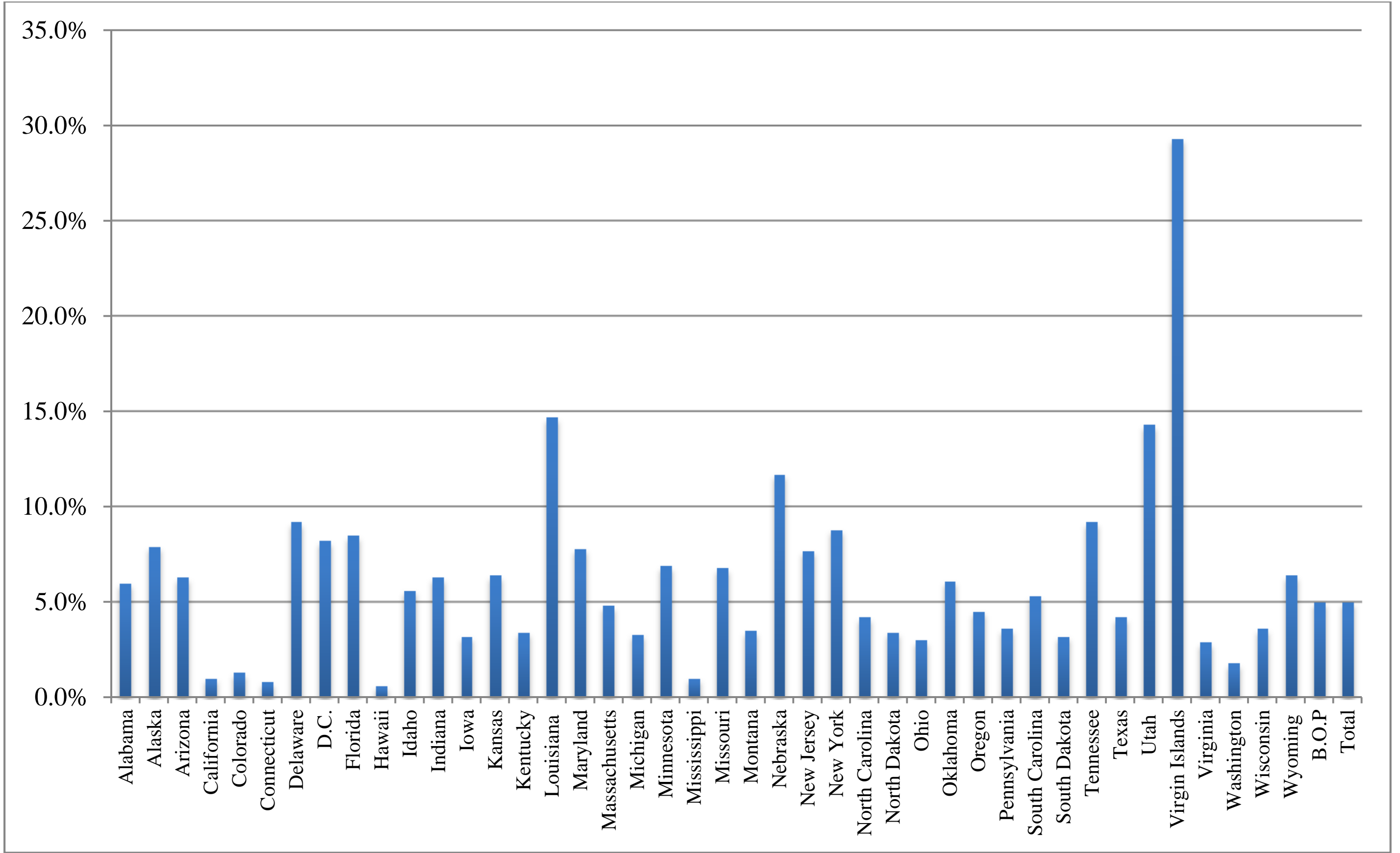
A. Gender

Forty-three jurisdictions provided sufficiently detailed data on men and 40 did so about women. Across the 40 jurisdictions that provided data on both genders, a higher number of men than women prisoners were confined in restricted housing.

The percentage held in restricted housing ranged from 29.3% of the male custodial population (95 out of 324 male prisoners) in the Virgin Islands and 14.7% of the male custodial population (2,583 out of 17,577 prisoners) in Louisiana[198] to approximately 0.6% of the male custodial population (22 out of 3,989) held in-state in Hawaii.[199] Across the 43 jurisdictions providing data, the median percentage of male prisoners in restricted housing was 5.3%. Jurisdiction-by-jurisdiction information is provided in Chart 5 and Table 5, below.

Included in SCDC' 4.29.19 letter to LOC

Chart 5 – Percentage of Male Custodial Population in Restricted Housing (*n*=43)[200]



Included in SCDC' 4.29.19 letter to LOC

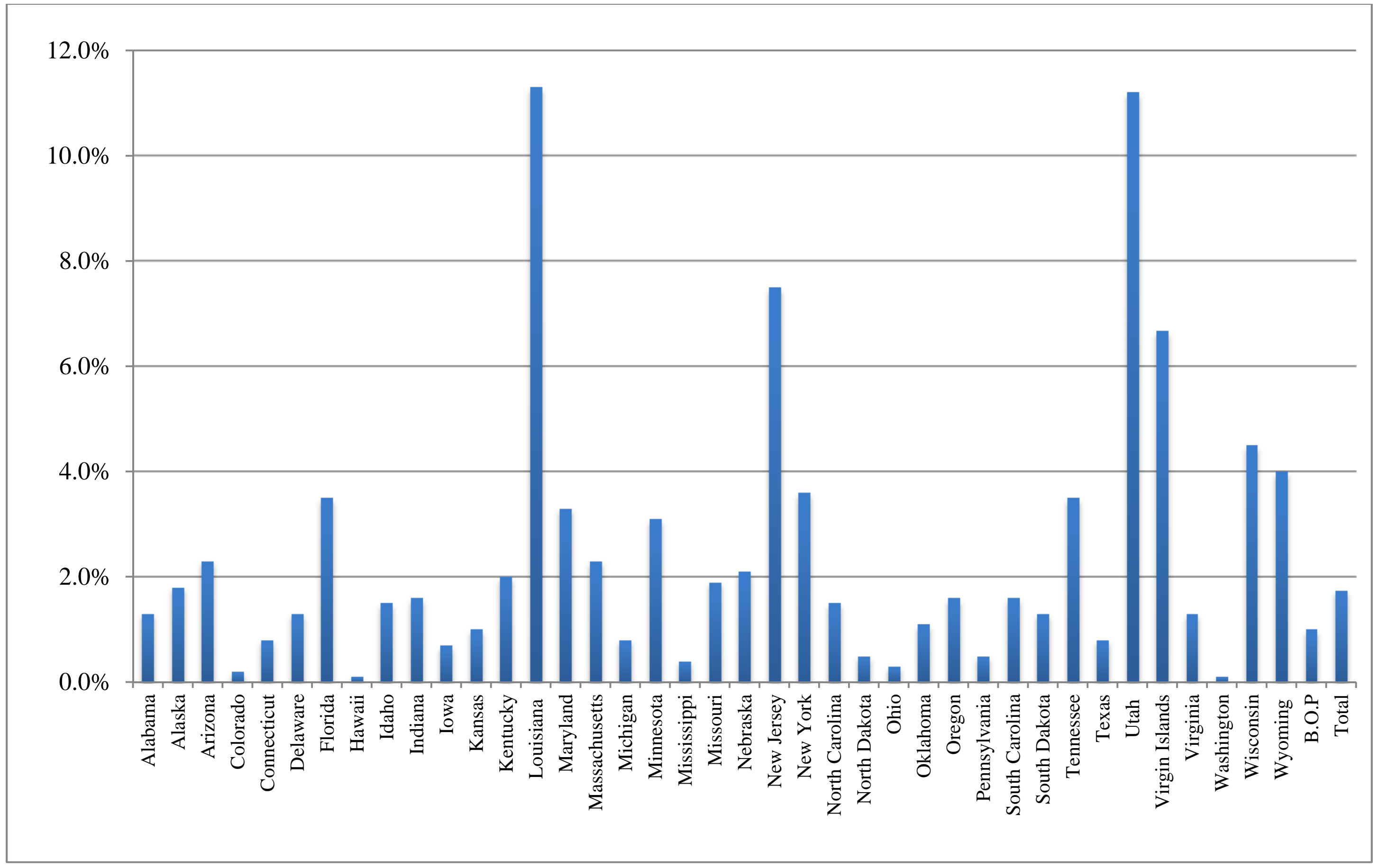
Table 5 – Number and Percentage of Male Custodial Population in Restricted Housing (*n*=43)[201]

	Total Custodial Population	Restricted Housing Population	Percentage in Restricted Housing
Alabama	23,062	1,382	6.0%
Alaska	4,360	345	7.9%
Arizona	38,764	2,452	6.3%
California	111,996	1,079	1.0%
Colorado	16,719	214	1.3%
Connecticut	14,993	120	0.8%
Delaware	4,119	378	9.2%
D.C.	1,153	95	8.2%
Florida	92,679	7,863	8.5%
Hawaii	3,989	22	0.6%
Idaho	7,001	389	5.6%
Indiana	24,937	1,579	6.3%
Iowa	7,575	242	3.2%
Kansas	9,132	581	6.4%
Kentucky	10,664	362	3.4%
Louisiana	17,577	2,583	14.7%
Maryland	18,736	1,454	7.8%
Massachusetts	9,313	447	4.8%
Michigan	40,625	1,321	3.3%
Minnesota	8,674	602	6.9%
Mississippi	17,516	180	1.0%
Missouri	29,028	1,968	6.8%
Montana	2,345	83	3.5%
Nebraska	5,018	589	11.7%
New Jersey	17,027	1,316	7.7%
New York	50,189	4,410	8.8%
North Carolina	35,228	1,476	4.2%
North Dakota	1,582	53	3.4%
Ohio	46,115	1,363	3.0%
Oklahoma	24,722	1,519	6.1%
Oregon	13,451	609	4.5%
Pennsylvania	47,551	1,701	3.6%
South Carolina	19,575	1,045	5.3%
South Dakota	3,132	101	3.2%
Tennessee	18,630	1,716	9.2%
Texas	135,580	5,726	4.2%
Utah	5,960	852	14.3%
Virgin Islands	324	95	29.3%
Virginia	28,059	824	2.9%
Washington	15,172	273	1.8%
Wisconsin	19,221	692	3.6%
Wyoming	1,877	121	6.4%
BOP	177,451	8,827	5.0%
Across Jurisdictions	1,180,821	59,049	5.0%

Included in SCDC' 4.29.19 letter to LOC

As the table and chart above reflect, a total of 59,048 men were reported confined in restrictive housing in the fall of 2015. As we detail below, smaller numbers and percentages of women prisoners were placed in restrictive housing. Specifically, across the 40 jurisdictions providing data for female prisoners that reported some numbers other than zero,[202] the jurisdiction reporting the highest percentage of female prisoners in restricted housing was Louisiana, where approximately 11.3% of its female custodial population (106 out of 938 prisoners) was in restricted housing.[203] The jurisdiction reporting the lowest percentage was Washington, where approximately 0.1% of the female custodial population (1 out of 1,136 prisoners) was in restricted housing. The total number of women reported in the data were 83,749, of whom 1,458 were in restrictive housing. The median percentage of female prisoners in restricted housing across these 40 jurisdictions was 1.6%. Jurisdiction-by-jurisdiction information is reported in Chart 6 and Table 6 below.

Chart 6 – Percentage of Female Custodial Population in Restricted Housing (*n*=40)[204]



Included in SCDC' 4.29.19 letter to LOC

Table 6 – Number and Percentage of Female Custodial Population in Restricted Housing (*n*=40)

	Total Custodial Population	Restricted Housing Population	Percentage in Restricted Housing
Alabama	1,487	20	1.3%
Alaska	559	10	1.8%
Arizona	3,972	92	2.3%
Colorado	1,512	3	0.2%
Connecticut	1,063	8	0.8%
Delaware	223	3	1.3%
Florida	6,909	240	3.5%
Hawaii	738	1	0.1%
Idaho	1,012	15	1.5%
Indiana	2,571	42	1.6%
Iowa	727	5	0.7%
Kansas	820	8	1.0%
Kentucky	1,005	20	2.0%
Louisiana	938	106	11.3%
Maryland	951	31	3.3%
Massachusetts	691	16	2.3%
Michigan	2,201	18	0.8%
Minnesota	647	20	3.1%
Mississippi	1,350	5	0.4%
Missouri	3,238	60	1.9%
Nebraska	438	9	2.1%
New Jersey	722	54	7.5%
New York	2,432	88	3.6%
North Carolina	2,811	41	1.5%
North Dakota	218	1	0.5%
Ohio	4,133	11	0.3%
Oklahoma	2,928	33	1.1%
Oregon	1,273	21	1.6%
Pennsylvania	2,798	15	0.5%
South Carolina	1,403	23	1.6%
South Dakota	394	5	1.3%
Tennessee	1,465	52	3.5%
Texas	12,785	106	0.8%
Utah	537	60	11.2%
Virgin Islands	15	1	6.7%
Virginia	2,353	30	1.3%
Washington	1,136	1	0.1%
Wisconsin	1,313	59	4.5%
Wyoming	251	10	4.0%
BOP	11,730	115	1.0%
Across Jurisdictions	83,749	1,458	1.7%

Included in SCDC' 4.29.19 letter to LOC

B. Race and Ethnicity

The survey asked for race and ethnicity data for both the total custodial and the restricted housing populations of men and women. Jurisdictions were asked to provide information in five categories: White, Black, Hispanic, Asian, and Other.[205]

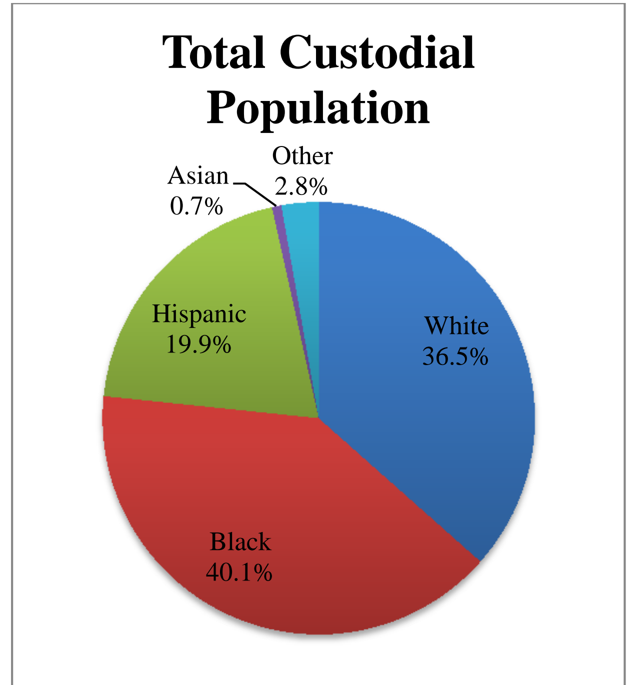
Among the 43 jurisdictions reporting on men, Black prisoners comprised 45% of the restricted housing population, as compared to comprising 40% of the total of all of the male custodial population in those jurisdictions. In 31 of the 43 reporting jurisdictions, the male restricted housing population contained a greater percentage of Black prisoners than did the total male custodial population in each of those jurisdictions.

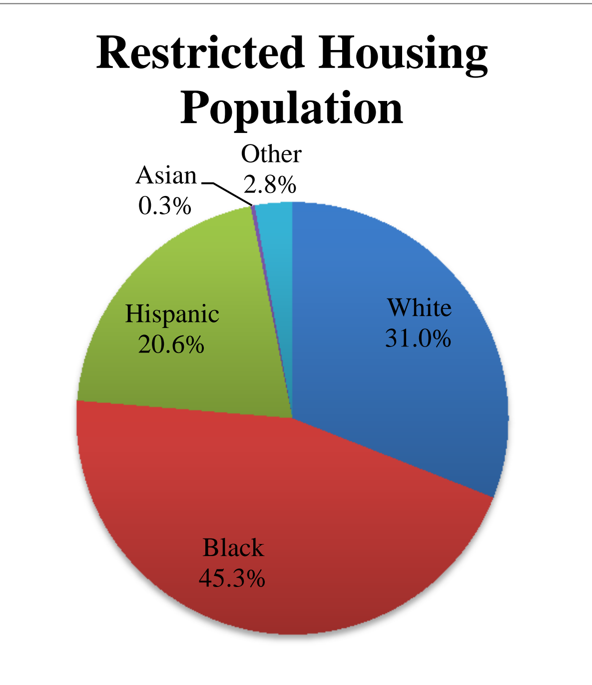
Hispanic prisoners comprised 21% of the restricted housing population, as compared to 20% of all of the total custodial population. In 22 of 43 reporting jurisdictions, the male restricted housing population contained a greater percentage of Hispanic prisoners than did the total male custodial population in each of those jurisdictions.[206] In 36 of the 43 jurisdictions, the male restricted housing population contained a smaller percentage of White prisoners than in the total male custodial population. As detailed below, jurisdictions reported a small percentage of Asian prisoners in their general prison population and a smaller percentage in their population in restricted housing. The “Other” category (which could include members of Indian Tribes, American Samoans, and other groups) was small and comparable in size in the general and in the restricted housing populations.

Chart 7 displays and compares these percentages; Table 7 lists by jurisdictions the number of male prisoners in the general population and in restrictive housing by race/ethnicity. Table 8 compares the percent of all male prisoners to those by race and ethnicity in restrictive housing.

Included in SCDC' 4.29.19 letter to LOC

Chart 7 – Demographic Percentage Composition of Total Male Custodial Population and Male Restricted Housing Population (*n* = 43)





Included in SCDC' 4.29.19 letter to LOC

Table 7 – Demographic Composition of Total Male Custodial Population and of Male Restricted Housing Population (n = 43)

	Total Male Custodial Population						Male Restricted Housing Population					
	White	Black	His-panic	Asian	Other	*Total*	White	Black	His-panic	Asian	Other	*Total*
Alabama	8,901	14,063	0	2	96	23,062	423	955	0	0	4	1,382
Alaska	2,011	464	128	38	1,719	4,360	165	28	9	5	138	345
Arizona	14,762	5,431	15,932	152	2,487	38,764	647	388	1,210	7	200	2,452
California	24,486	32,905	46,508	1,200	6,897	111,996	95	34	931	0	19	1,079
Colorado	7,551	3,137	5,357	176	498	16,719	81	31	92	0	10	214
Connecticut	4,735	6,322	3,826	73	37	14,993	27	68	23	2	0	120
Delaware	1,538	2,404	167	7	3	4,119	110	249	19	0	0	378
D.C.	24	1,041	64	3	21	1,153	2	89	3	0	1	95
Florida	35,474	45,122	11,770	13	300	92,679	2,181	4,639	1,021	0	22	7,863
Hawaii	934	175	99	755	2,026	3,989	5	0	0	2	15	22
Idaho	5,243	198	1,095	33	432	7,001	285	11	64	3	26	389
Indiana	14,750	8,800	1,160	49	178	24,937	831	645	96	0	7	1,579
Iowa	4,894	1,978	513	64	126	7,575	132	70	35	1	4	242
Kansas	5,073	2,802	1,005	82	170	9,132	253	220	86	2	20	581
Kentucky	7,446	2,890	187	24	117	10,664	253	100	6	0	3	362
Louisiana	4,679	12,826	39	22	11	17,577	586	1,991	4	2	0	2,583
Maryland	4,075	11,443	605	47	2,566	18,736	408	966	52	2	26	1,454
Massachusetts	4,002	2,655	2,417	127	112	9,313	167	157	110	7	6	447
Michigan	17,509	22,006	322	112	676	40,625	383	912	8	0	18	1,321
Minnesota	3,930	3,154	585	231	774	8,674	171	271	41	8	111	602
Mississippi	5,533	11,763	152	36	32	17,516	37	143	0	0	0	180
Missouri	17,512	10,810	539	55	112	29,028	1,011	916	32	2	7	1,968
Montana	1,758	60	0	6	521	2,345	51	4	0	0	28	83
Nebraska	2,757	1,362	634	41	224	5,018	306	135	108	6	34	589
New Jersey	3,805	10,160	2,689	95	278	17,027	244	827	227	5	13	1,316
New York	12,138	25,097	11,321	235	1,398	50,189	765	2,459	1,052	4	130	4,410
North Carolina	12,881	19,586	1,697	109	955	35,228	378	992	48	4	54	1,476
North Dakota	1,051	125	97	8	301	1,582	23	9	8	0	13	53
Ohio	23,364	21,276	1,189	60	226	46115	536	781	41	1	4	1363
Oklahoma	13180	6893	1889	75	2,685	24,722	647	529	148	3	192	1,519
Oregon	9,859	1,270	1,787	193	342	13,451	430	70	78	3	28	609
Pennsylvania	18,879	23,322	5,032	128	190	47,551	498	1,024	169	2	8	1,701
South Carolina	6,427	12,551	408	19	170	19,575	254	769	10	2	10	1,045
South Dakota	1,888	236	140	10	858	3,132	37	7	4	0	53	101
Tennessee	9,338	8,785	438	43	26	18,630	1,034	643	32	4	3	1,716
Texas	41,626	46,765	46,460	434	295	135,580	1,427	1,418	2,866	3	12	5,726
Utah	3,881	404	1,116	183	376	5,960	418	57	288	27	62	852
Virgin Islands	5	227	92	0	0	324	4	72	19	0	0	95
Virginia	9,884	17,314	730	107	24	28,059	274	530	16	2	2	824
Washington	9,083	2,815	1,960	539	775	15,172	135	41	82	7	8	273
Wisconsin	8,487	8,068	1,871	194	601	19,221	223	354	88	3	24	692
Wyoming	1,415	104	242	7	109	1,877	72	9	20	0	20	121
BOP	44,695	64,576	62,669	2,523	2,988	177,451	2,280	3,154	3,015	57	321	8,827
Across Jurisdictions	431,463	473,385	234,931	8,310	32,732	1,180,821	18,289	26,767	12,161	178	1,666	59,049

Included in SCDC' 4.29.19 letter to LOC

Table 8 – Demographic Percentage Composition of Total Male Custodial Population and of Male Restricted Housing Population (*n* = 43)

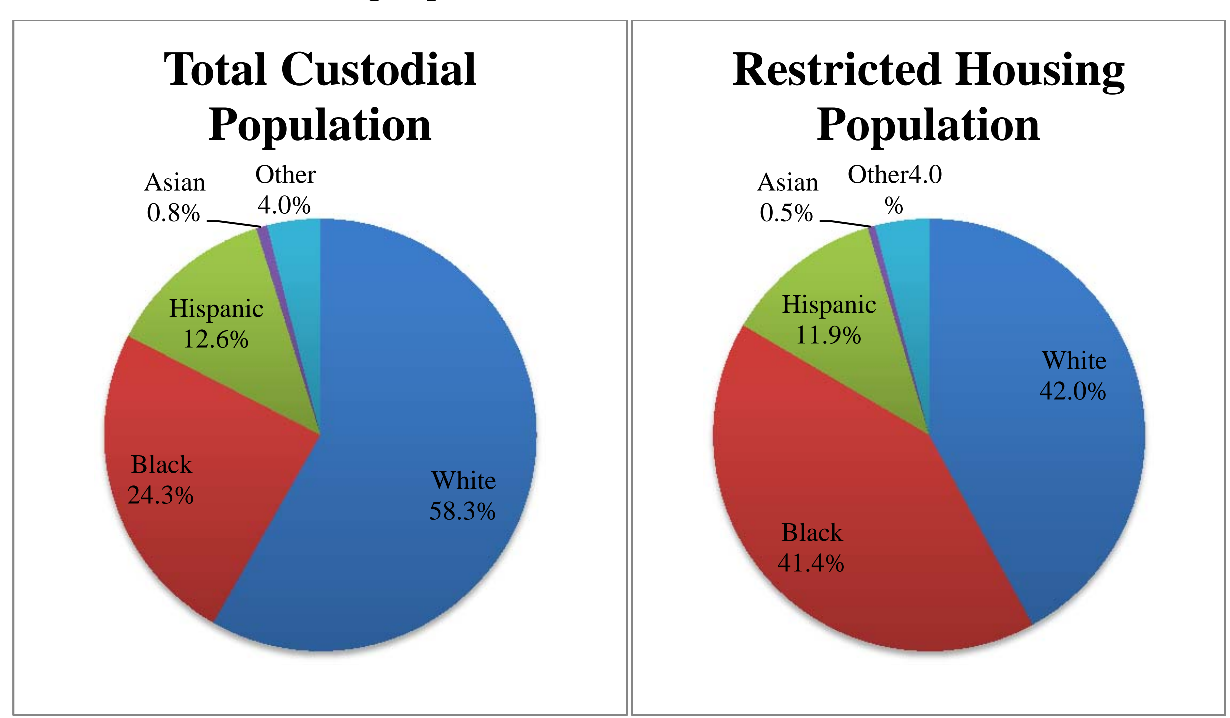
	Total Male Custodial Population					**Male Restricted Housing Population**				
	White	Black	Hispanic	Asian	Other	White	Black	Hispanic	Asian	Other
Alabama	39%	61%	0%	0%	0%	31%	69%	0%	0%	0%
Alaska	46%	11%	3%	1%	39%	48%	8%	3%	1%	40%
Arizona	38%	14%	41%	0%	6%	26%	16%	49%	0%	8%
California	22%	29%	42%	1%	6%	9%	3%	86%	0%	2%
Colorado	45%	19%	32%	1%	3%	38%	14%	43%	0%	5%
Connecticut	32%	42%	26%	0%	0%	23%	57%	19%	2%	0%
Delaware	37%	58%	4%	0%	0%	29%	66%	5%	0%	0%
D.C.	2%	90%	6%	0%	2%	2%	94%	3%	0%	1%
Florida	38%	49%	13%	0%	0%	28%	59%	13%	0%	0%
Hawaii	23%	4%	2%	19%	51%	23%	0%	0%	9%	68%
Idaho	75%	3%	16%	0%	6%	73%	3%	16%	1%	7%
Indiana	59%	35%	5%	0%	1%	53%	41%	6%	0%	0%
Iowa	65%	26%	7%	1%	2%	55%	29%	14%	0%	2%
Kansas	56%	31%	11%	1%	2%	44%	38%	15%	0%	3%
Kentucky	70%	27%	2%	0%	1%	70%	28%	2%	0%	1%
Louisiana	27%	73%	0%	0%	0%	23%	77%	0%	0%	0%
Maryland	22%	61%	3%	0%	14%	28%	66%	4%	0%	2%
Massachusetts	43%	29%	26%	1%	1%	37%	35%	25%	2%	1%
Michigan	43%	54%	1%	0%	2%	29%	69%	1%	0%	1%
Minnesota	45%	36%	7%	3%	9%	28%	45%	7%	1%	18%
Mississippi	32%	67%	1%	0%	0%	21%	79%	0%	0%	0%
Missouri	60%	37%	2%	0%	0%	51%	47%	2%	0%	0%
Montana	75%	3%	0%	0%	22%	61%	5%	0%	0%	34%
Nebraska	55%	27%	13%	1%	4%	52%	23%	18%	1%	6%
New Jersey	22%	60%	16%	1%	2%	19%	63%	17%	0%	1%
New York	24%	50%	23%	0%	3%	17%	56%	24%	0%	3%
North Carolina	37%	56%	5%	0%	3%	26%	67%	3%	0%	4%
North Dakota	66%	8%	6%	1%	19%	43%	17%	15%	0%	25%
Ohio	51%	46%	3%	0%	0%	39%	57%	3%	0%	0%
Oklahoma	53%	28%	8%	0%	11%	43%	35%	10%	0%	13%
Oregon	73%	9%	13%	1%	3%	71%	11%	13%	0%	5%
Pennsylvania	40%	49%	11%	0%	0%	29%	60%	10%	0%	0%
South Carolina	33%	64%	2%	0%	1%	24%	74%	1%	0%	1%
South Dakota	60%	8%	4%	0%	27%	37%	7%	4%	0%	52%
Tennessee	50%	47%	2%	0%	0%	60%	37%	2%	0%	0%
Texas	31%	34%	34%	0%	0%	25%	25%	50%	0%	0%
Utah	65%	7%	19%	3%	6%	49%	7%	34%	3%	7%
Virgin Islands	2%	70%	28%	0%	0%	4%	77%	20%	0%	0%
Virginia	35%	62%	3%	0%	0%	33%	64%	2%	0%	0%
Washington	60%	19%	13%	4%	5%	49%	15%	30%	3%	3%
Wisconsin	44%	42%	10%	1%	3%	32%	51%	13%	0%	3%
Wyoming	75%	6%	13%	0%	6%	60%	7%	17%	0%	17%
BOP	25%	36%	35%	1%	2%	26%	36%	34%	1%	4%
Across Jurisdictions	37%	40%	20%	1%	3%	31%	45%	21%	0%	3%

Included in SCDC' 4.29.19 letter to LOC

As noted, 40 jurisdictions responded on gender, and that group also provided information about race for their female custodial populations. Among these 40 responding jurisdictions, Black prisoners constituted 24% of the total female custodial population and 41% of the female restricted housing population. In 33 of the 40 reporting jurisdictions, the female restricted housing population contained a greater percentage of Black prisoners than were in each of the jurisdictions reporting on the total female custodial population.

In 16 of 40 reporting jurisdictions, the female restricted housing population contained a greater percentage of Hispanic prisoners than the total female custodial population.[207] In 34 of the 40 jurisdictions, the female restricted housing population contained a smaller percentage of White prisoners than the total female custodial population. Again, the percentages of Asian and of prisoners termed "Other" were small and roughly comparable in both general and restricted housing populations. Chart 8 and Tables 9 and 10 provide the details.

Chart 8 – Demographic Percentage Composition of Total Female Custodial Population and Female Restricted Housing Population (*n* = 40)



Included in SCDC' 4.29.19 letter to LOC

Table 9 – Demographic Composition of Total Female Custodial Population and Female Restricted Housing Population (*n* = 40)

	Total Female Custodial Population						Female Restricted Housing Population					
	White	Black	Hispanic	Asian	Other	*Total*	White	Black	Hispanic	Asian	Other	*Total*
Alabama	964	517	0	0	6	1,487	10	10	0	0	0	20
Alaska	286	30	10	1	232	559	7	1	0	0	2	10
Arizona	2,109	353	1,097	21	392	3,972	33	20	31	0	8	92
Colorado	810	217	407	14	64	1,512	2	1	0	0	0	3
Connecticut	579	291	179	5	9	1,063	3	5	0	0	0	8
Delaware	140	76	6	1	0	223	0	3	0	0	0	3
Florida	4,456	2,078	352	2	21	6,909	103	121	15	0	1	240
Hawaii	201	19	10	116	392	738	0	0	0	0	1	1
Idaho	807	14	106	1	84	1,012	12	1	0	0	2	15
Indiana	2,082	395	54	3	37	2,571	22	15	4	0	1	42
Iowa	549	126	29	6	17	727	3	2	0	0	0	5
Kansas	551	153	80	9	27	820	0	3	3	0	2	8
Kentucky	866	123	5	0	11	1,005	17	3	0	0	0	20
Louisiana	475	461	0	1	1	938	45	61	0	0	0	106
Maryland	389	355	10	0	197	951	15	13	0	0	3	31
Massachusetts	460	103	56	0	72	691	9	4	2	0	1	16
Michigan	1,272	877	5	5	42	2,201	10	8	0	0	0	18
Minnesota	380	107	30	10	120	647	10	6	0	1	3	20
Mississippi	768	566	9	4	3	1,350	1	4	0	0	0	5
Missouri	2,567	545	88	13	25	3,238	31	29	0	0	0	60
Nebraska	293	66	39	2	38	438	3	3	2	0	1	9
New Jersey	289	316	99	10	8	722	13	33	8	0	0	54
New York	1,160	886	291	13	82	2,432	25	45	18	0	0	88
North Carolina	1,820	852	51	6	82	2,811	17	22	0	0	2	41
North Dakota	137	5	10	0	66	218	0	0	0	0	1	1
Ohio	3,050	1,022	37	10	14	4,133	7	4	0	0	0	11
Oklahoma	1,856	470	133	7	462	2,928	7	10	5	0	11	33
Oregon	1,065	94	58	15	41	1,273	15	1	2	0	3	21
Pennsylvania	1,822	766	182	8	20	2,798	3	10	1	0	1	15
South Carolina	875	490	18	0	20	1,403	15	8	0	0	0	23
South Dakota	207	8	8	1	170	394	3	0	0	0	2	5
Tennessee	1,052	381	20	5	7	1,465	29	22	1	0	0	52
Texas	6,159	3,495	3,057	28	46	12,785	18	55	33	0	0	106
Utah	389	15	80	19	34	537	38	0	12	5	5	60
Virgin Islands	0	13	2	0	0	15	0	1	0	0	0	1
Virginia	1,438	883	19	10	3	2,353	12	18	0	0	0	30
Washington	726	127	146	46	91	1,136	0	1	0	0	0	1
Wisconsin	885	305	38	8	77	1,313	29	22	4	0	4	59
Wyoming	200	9	21	1	20	251	7	0	2	0	1	10
BOP	4,650	2,756	3,738	279	307	11,730	39	39	31	2	4	115
Across Jurisdictions	48,784	20,365	10,580	680	3,340	83,749	613	604	174	8	59	1,458

Included in SCDC' 4.29.19 letter to LOC

Table 10 – Demographic Percentage Composition of Total Female Custodial Population and Female Restricted Housing Population (*n* = 40)

	Total Female Custodial Population					Female Restricted Housing Population				
	White	Black	Hispanic	Asian	Other	White	Black	Hispanic	Asian	Other
Alabama	65%	35%	0%	0%	0%	50%	50%	0%	0%	0%
Alaska	51%	5%	2%	0%	42%	70%	10%	0%	0%	20%
Arizona	53%	9%	28%	1%	10%	36%	22%	34%	0%	9%
Colorado	54%	14%	27%	1%	4%	67%	33%	0%	0%	0%
Connecticut	54%	27%	17%	0%	1%	38%	63%	0%	0%	0%
Delaware	63%	34%	3%	0%	0%	0%	100%	0%	0%	0%
Florida	64%	30%	5%	0%	0%	43%	50%	6%	0%	0%
Hawaii	27%	3%	1%	16%	53%	0%	0%	0%	0%	100%
Idaho	80%	1%	10%	0%	8%	80%	7%	0%	0%	13%
Indiana	81%	15%	2%	0%	1%	52%	36%	10%	0%	2%
Iowa	76%	17%	4%	1%	2%	60%	40%	0%	0%	0%
Kansas	67%	19%	10%	1%	3%	0%	38%	38%	0%	25%
Kentucky	86%	12%	0%	0%	1%	85%	15%	0%	0%	0%
Louisiana	51%	49%	0%	0%	0%	42%	58%	0%	0%	0%
Maryland	41%	37%	1%	0%	21%	48%	42%	0%	0%	10%
Massachusetts	67%	15%	8%	0%	10%	56%	25%	13%	0%	6%
Michigan	58%	40%	0%	0%	2%	56%	44%	0%	0%	0%
Minnesota	59%	17%	5%	2%	19%	50%	30%	0%	5%	15%
Mississippi	57%	42%	1%	0%	0%	20%	80%	0%	0%	0%
Missouri	79%	17%	3%	0%	1%	52%	48%	0%	0%	0%
Nebraska	67%	15%	9%	0%	9%	33%	33%	22%	0%	11%
New Jersey	40%	44%	14%	1%	1%	24%	61%	15%	0%	0%
New York	48%	36%	12%	1%	3%	28%	51%	20%	0%	0%
North Carolina	65%	30%	2%	0%	3%	41%	54%	0%	0%	5%
North Dakota	63%	2%	5%	0%	30%	0%	0%	0%	0%	100%
Ohio	74%	25%	1%	0%	0%	64%	36%	0%	0%	0%
Oklahoma	63%	16%	5%	0%	16%	21%	30%	15%	0%	33%
Oregon	84%	7%	5%	1%	3%	71%	5%	10%	0%	14%
Pennsylvania	65%	27%	7%	0%	1%	20%	67%	7%	0%	7%
South Carolina	62%	35%	1%	0%	1%	65%	35%	0%	0%	0%
South Dakota	53%	2%	2%	0%	43%	60%	0%	0%	0%	40%
Tennessee	72%	26%	1%	0%	0%	56%	42%	2%	0%	0%
Texas	48%	27%	24%	0%	0%	17%	52%	31%	0%	0%
Utah	72%	3%	15%	4%	6%	63%	0%	20%	8%	8%
Virgin Islands	0%	87%	13%	0%	0%	0%	100%	0%	0%	0%
Virginia	61%	38%	1%	0%	0%	40%	60%	0%	0%	0%
Washington	64%	11%	13%	4%	8%	0%	100%	0%	0%	0%
Wisconsin	67%	23%	3%	1%	6%	49%	37%	7%	0%	7%
Wyoming	80%	4%	8%	0%	8%	70%	0%	20%	0%	10%
BOP	40%	23%	32%	2%	3%	34%	34%	27%	2%	3%
Across Jurisdictions	58%	24%	13%	1%	4%	42%	41%	12%	1%	4%

Included in SCDC' 4.29.19 letter to LOC

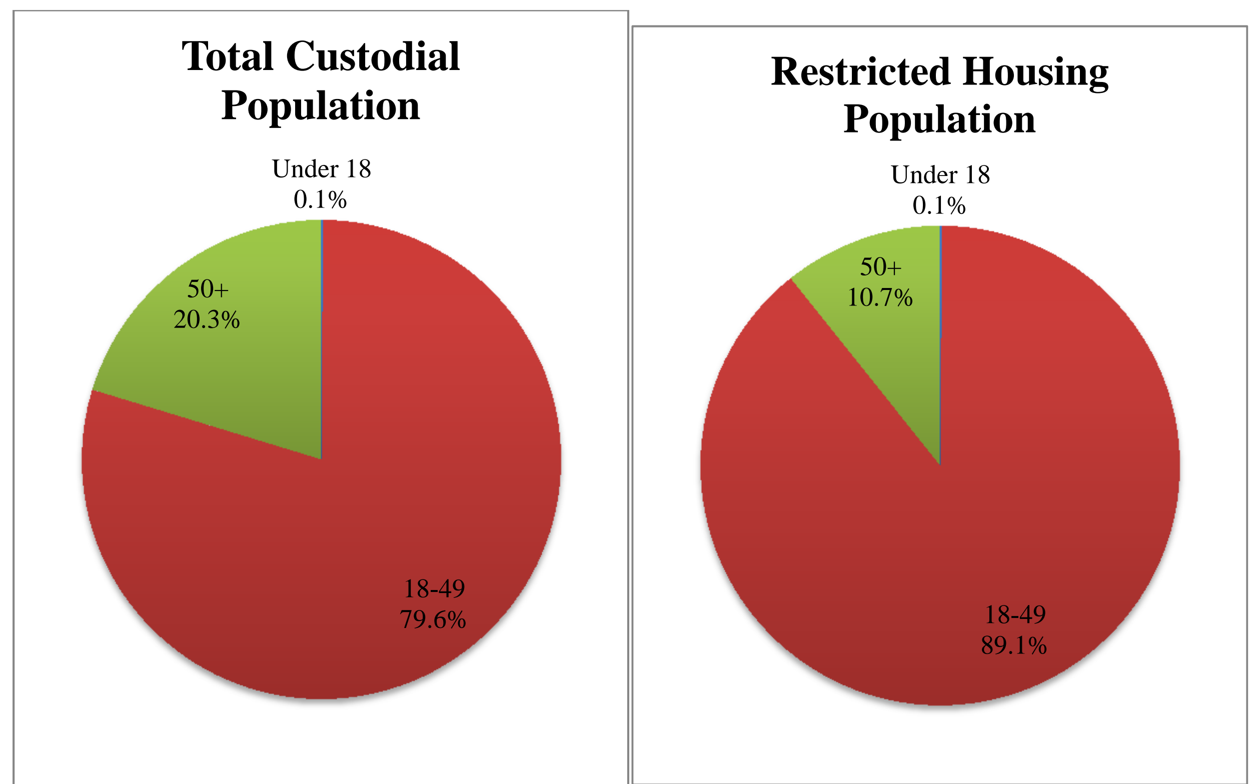
C. Age Cohorts

The survey asked jurisdictions to provide age data for their male and female total custodial and restricted housing populations. We asked about individuals in three cohorts: under 18 years old, between 18 and 49 years old, and 50 years and older. We sought to understand the distribution of age cohorts within restricted housing populations and to compare the age of individuals in restricted housing to the age of those in the general population.

Across the 43 responding jurisdictions, males under 18 years old made up approximately 0.1% of both the total custodial and the restricted housing populations. Among reporting jurisdictions, males between the ages of 18 and 49 comprised 79.6% of the total custodial population and 89.1% of the restricted housing population. Males 50 and older comprised 20.3% of the total custodial population and 10.7% of the restricted housing population.

In the 43 responding jurisdictions, approximately 5.9% (78 of 1,326) of male prisoners under 18 years old were in restricted housing. Approximately 5.6% (52,636 of 939,886) of male prisoners 18-49 were in restricted housing, while 2.6% (6,335 of 239,609) of male prisoners 50 and older were in restricted housing. We provide the jurisdiction-by-jurisdiction information in Chart 9 and Tables 11 and 12.

Chart 9 – Age Cohorts of Male Total Custodial Population and of Male Restricted Housing Population (*n* = 43)



Included in SCDC' 4.29.19 letter to LOC

Table 11 – Age Cohorts of Male Total Custodial Population and of Male Restricted Housing Population (*n* = 43)

	Total Male Custodial Population				Male Restricted Housing Population			
	Under 18	**18-49**	**50+**	**Total**	**Under**	**18-49**	**50+**	**Total**
Alabama	11	17,748	5,303	23,062	0	1,204	178	1,382
Alaska	67	3,418	875	4,360	15	262	68	345
Arizona	75	32,005	6,684	38,764	N/A	2,228	224	2,452
California	0	86,179	25,817	111,996	0	962	117	1,079
Colorado	1	13,302	3,416	16,719	0	199	15	214
Connecticut	91	12,768	2,134	14,993	0	102	18	120
Delaware	4	3,217	898	4,119	0	333	45	378
D.C.	22	968	163	1,153	0	84	11	95
Florida	138	71,814	20,727	92,679	34	6,931	898	7,863
Hawaii	0	3,212	777	3,989	0	22	0	22
Idaho	13	5,616	1,372	7,001	1	344	44	389
Indiana	6	20,601	4,330	24,937	0	1,440	139	1,579
Iowa	6	6,179	1,390	7,575	0	228	14	242
Kansas	111	7,263	1,758	9,132	0	533	48	581
Kentucky	0	8,433	2,231	10,664	0	341	21	362
Louisiana	13	12,584	4,980	17,577	2	2,172	409	2,583
Maryland	3	15,356	3,377	18,736	0	1,368	86	1,454
Massachusetts	0	6,875	2,438	9,313	0	401	46	447
Michigan	86	31,761	8,778	40,625	0	1,207	114	1,321
Minnesota	10	7,370	1,294	8,674	3	563	36	602
Mississippi	27	14,491	2,998	17,516	0	169	11	180
Missouri	7	23,310	5,711	29,028	2	1,769	197	1,968
Montana	0	1,704	641	2,345	0	71	12	83
Nebraska	12	4,118	888	5,018	1	529	59	589
New Jersey	5	14,215	2,807	17,027	0	1,186	130	1,316
New York	85	40,455	9,649	50,189	0	4,101	309	4,410
North Carolina	348	28,056	6,824	35,228	4	1,364	108	1,476
North Dakota	0	1,339	243	1,582	0	50	3	53
Ohio	31	37,771	8,313	46,115	0	1,297	66	1,363
Oklahoma	7	19,851	4,864	24,722	1	1,380	138	1,519
Oregon	0	10,483	2,968	13,451	0	571	38	609
Pennsylvania	19	37,878	9,654	47,551	0	1,464	237	1,701
South Carolina	30	16,004	3,541	19,575	1	976	68	1,045
South Dakota	0	2,559	573	3,132	0	94	7	101
Tennessee	9	15,037	3,584	18,630	7	1,472	237	1,716
Texas	44	107,071	28,465	135,580	3	4,854	869	5,726
Utah	1	4,732	1,227	5,960	1	767	84	852
Virgin Islands	0	236	88	324	0	76	19	95
Virginia	8	21,858	6,193	28,059	0	692	132	824
Washington	0	12,152	3,020	15,172	0	246	27	273
Wisconsin	35	15,613	3,573	19,221	3	622	67	692
Wyoming	1	1,422	454	1,877	0	115	6	121
BOP	0	142,862	34,589	177,451	0	7,847	980	8,827
Across Jurisdictions	1,326	939,886	239,609	1,180,821	78	52,636	6,335	59,049

Included in SCDC' 4.29.19 letter to LOC

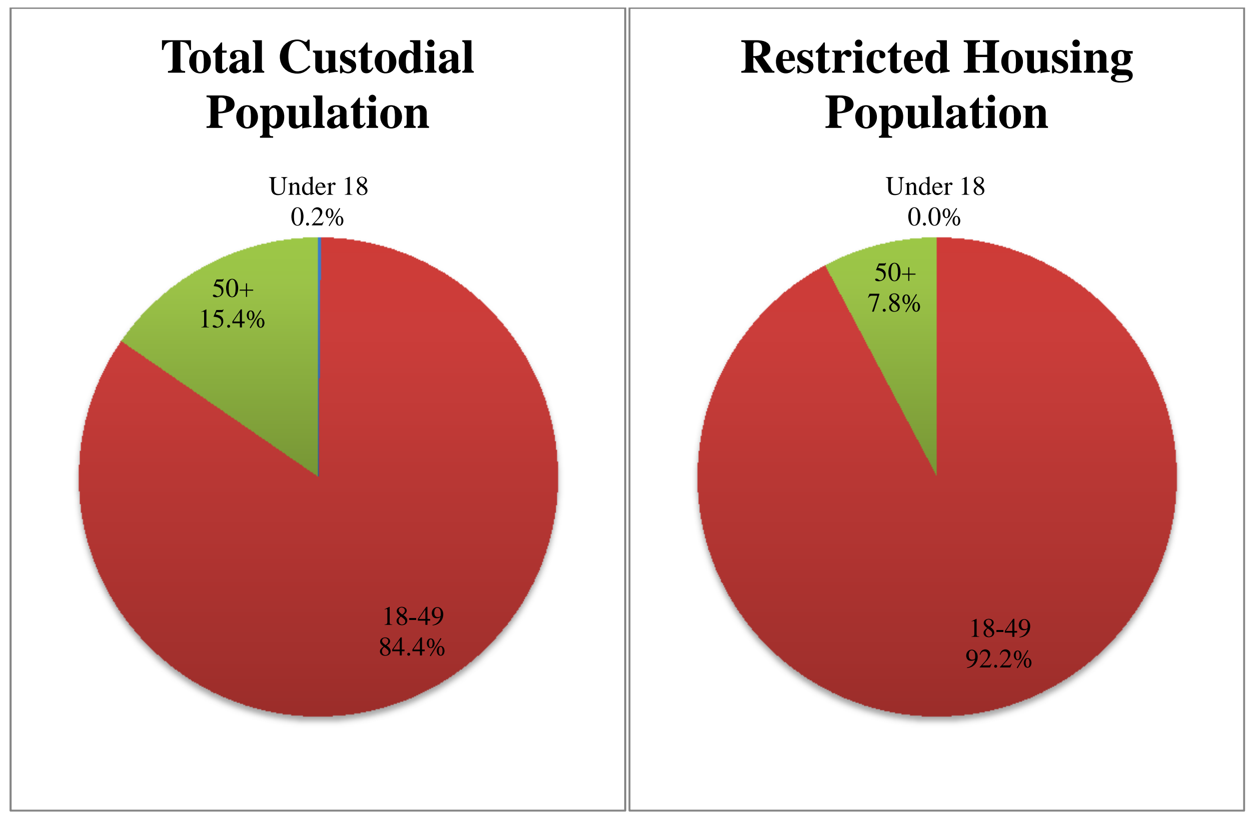
Table 12 – Age Cohorts by Percentage of Male Total Custodial Population and of Male Restricted Housing Population (*n* = 43)

	Total Male Custodial Population			Male Restricted Housing Population		
	Under 18	**18-49**	**50+**	**Under 18**	**18-49**	**50+**
Alabama	0%	77%	23%	0%	87%	13%
Alaska	2%	78%	20%	4%	76%	20%
Arizona	0%	83%	17%	0%	91%	9%
California	0%	77%	23%	0%	89%	11%
Colorado	0%	80%	20%	0%	93%	7%
Connecticut	1%	85%	14%	0%	85%	15%
Delaware	0%	78%	22%	0%	88%	12%
D.C.	2%	84%	14%	0%	88%	12%
Florida	0%	77%	22%	0%	88%	11%
Hawaii	0%	81%	19%	0%	100%	0%
Idaho	0%	80%	20%	0%	88%	11%
Indiana	0%	83%	17%	0%	91%	9%
Iowa	0%	82%	18%	0%	94%	6%
Kansas	1%	80%	19%	0%	92%	8%
Kentucky	0%	79%	21%	0%	94%	6%
Louisiana	0%	72%	28%	0%	84%	16%
Maryland	0%	82%	18%	0%	94%	6%
Massachusetts	0%	74%	26%	0%	90%	10%
Michigan	0%	78%	22%	0%	91%	9%
Minnesota	0%	85%	15%	0%	94%	6%
Mississippi	0%	83%	17%	0%	94%	6%
Missouri	0%	80%	20%	0%	90%	10%
Montana	0%	73%	27%	0%	86%	14%
Nebraska	0%	82%	18%	0%	90%	10%
New Jersey	0%	83%	16%	0%	90%	10%
New York	0%	81%	19%	0%	93%	7%
North Carolina	1%	80%	19%	0%	92%	7%
North Dakota	0%	85%	15%	0%	94%	6%
Ohio	0%	82%	18%	0%	95%	5%
Oklahoma	0%	80%	20%	0%	91%	9%
Oregon	0%	78%	22%	0%	94%	6%
Pennsylvania	0%	80%	20%	0%	86%	14%
South Carolina	0%	82%	18%	0%	93%	7%
South Dakota	0%	82%	18%	0%	93%	7%
Tennessee	0%	81%	19%	0%	86%	14%
Texas	0%	79%	21%	0%	85%	15%
Utah	0%	79%	21%	0%	90%	10%
Virgin Islands	0%	73%	27%	0%	80%	20%
Virginia	0%	78%	22%	0%	84%	16%
Washington	0%	80%	20%	0%	90%	10%
Wisconsin	0%	81%	19%	0%	90%	10%
Wyoming	0%	76%	24%	0%	95%	5%
BOP	0%	81%	19%	0%	89%	11%
Across Jurisdictions	0%	80%	20%	0%	89%	11%

Included in SCDC' 4.29.19 letter to LOC

As noted above, we sought to understand the percentage of each age cohort in the restricted housing population and to compare the numbers by age cohort in the general population and in the restricted population. Among the 40 jurisdictions providing data for female prisoners in restricted housing, none reported any female prisoners under the age of 18 in restricted housing. These jurisdictions reported that female prisoners between the ages of 18 and 49 comprised 84.4% of the total custodial population and 92.2% of the restricted housing population. Jurisdictions reported that women 50 years and older comprised 15.4% of their total custodial populations, and 7.8% of the restricted housing population. Across the 40 responding jurisdictions, 1.9% (1,345 of 70,710) of female prisoners 18-49 were held in restricted housing; 0.9% (113 of 12,895) of female prisoners 50 and older were held in restricted housing. Chart 10 and Tables 13 and 14 provide the details.

Chart 10 – Age Cohorts of Female Total Custodial Population and of Female Restricted Housing Population (*n* = 40)



Included in SCDC' 4.29.19 letter to LOC

Table 13 – Age Cohorts of Female Total Custodial Population and of Female Restricted Housing Population (*n* = 40)

	Total Female Custodial Population				Female Restricted Housing Population			
	Under	**18-49**	**50+**	**Total**	**Under**	**18-49**	**50+**	**Total**
Alabama	0	1,231	256	1,487	0	19	1	20
Alaska	49	468	42	559	0	10	0	10
Arizona	3	3,461	508	3,972	N/A	87	5	92
Colorado	0	1,327	185	1,512	0	3	0	3
Connecticut	2	917	144	1,063	0	8	0	8
Delaware	0	192	31	223	0	3	0	3
Florida	5	5,683	1,221	6,909	0	227	13	240
Hawaii	0	638	100	738	0	1	0	1
Idaho	2	893	117	1,012	0	11	4	15
Indiana	0	2,286	285	2,571	0	37	5	42
Iowa	1	631	95	727	0	4	1	5
Kansas	15	705	100	820	0	8	0	8
Kentucky	0	878	127	1,005	0	18	2	20
Louisiana	0	733	205	938	0	93	13	106
Maryland	0	797	154	951	0	31	0	31
Massachusetts	0	584	107	691	0	13	3	16
Michigan	2	1,809	390	2,201	0	15	3	18
Minnesota	0	567	80	647	0	17	3	20
Mississippi	0	1,157	193	1,350	0	5	0	5
Missouri	1	2,856	381	3,238	0	57	3	60
Nebraska	0	379	59	438	0	9	0	9
New Jersey	0	605	117	722	0	52	2	54
New York	3	2,028	401	2,432	0	84	4	88
North	44	2,355	412	2,811	0	39	2	41
North Dakota	0	202	16	218	0	1	0	1
Ohio	1	3,678	454	4,133	0	11	0	11
Oklahoma	2	2,512	414	2,928	0	32	1	33
Oregon	0	1,071	202	1,273	0	19	2	21
Pennsylvania	1	2,317	480	2,798	0	14	1	15
South	1	1,181	221	1,403	0	21	2	23
South Dakota	0	360	34	394	0	5	0	5
Tennessee	3	1,267	195	1,465	0	38	14	52
Texas	6	10,954	1,825	12,785	0	100	6	106
Utah	0	494	43	537	0	56	4	60
Virgin Islands	0	11	4	15	0	1	0	1
Virginia	0	1,960	393	2,353	0	27	3	30
Washington	0	970	166	1,136	0	1	0	1
Wisconsin	3	1,095	215	1,313	0	58	1	59
Wyoming	0	213	38	251	0	10	0	10
BOP	0	9,245	2,485	11,730	0	100	15	115
Across Jurisdictions	144	70,710	12,895	83,749	0	1,345	113	1,458

Included in SCDC' 4.29.19 letter to LOC

Table 14 – Age Cohorts by Percentage of Female Total Custodial Population and of Female Restricted Housing Population (n = 40)

	Total Female Custodial Population			Female Restricted Housing Population		
	Under 18	**18-49**	**50+**	**Under 18**	**18-49**	**50+**
Alabama	0%	83%	17%	0%	95%	5%
Alaska	9%	84%	8%	0%	100%	0%
Arizona	0%	87%	13%	0%	95%	5%
Colorado	0%	88%	12%	0%	100%	0%
Connecticut	0%	86%	14%	0%	100%	0%
Delaware	0%	86%	14%	0%	100%	0%
Florida	0%	82%	18%	0%	95%	5%
Hawaii	0%	86%	14%	0%	100%	0%
Idaho	0%	88%	12%	0%	73%	27%
Indiana	0%	89%	11%	0%	88%	12%
Iowa	0%	87%	13%	0%	80%	20%
Kansas	2%	86%	12%	0%	100%	0%
Kentucky	0%	87%	13%	0%	90%	10%
Louisiana	0%	78%	22%	0%	88%	12%
Maryland	0%	84%	16%	0%	100%	0%
Massachusetts	0%	85%	15%	0%	81%	19%
Michigan	0%	82%	18%	0%	83%	17%
Minnesota	0%	88%	12%	0%	85%	15%
Mississippi	0%	86%	14%	0%	100%	0%
Missouri	0%	88%	12%	0%	95%	5%
Nebraska	0%	87%	13%	0%	100%	0%
New Jersey	0%	84%	16%	0%	96%	4%
New York	0%	83%	16%	0%	95%	5%
North	2%	84%	15%	0%	95%	5%
North Dakota	0%	93%	7%	0%	100%	0%
Ohio	0%	89%	11%	0%	100%	0%
Oklahoma	0%	86%	14%	0%	97%	3%
Oregon	0%	84%	16%	0%	90%	10%
Pennsylvania	0%	83%	17%	0%	93%	7%
South	0%	84%	16%	0%	91%	9%
South Dakota	0%	91%	9%	0%	100%	0%
Tennessee	0%	86%	13%	0%	73%	27%
Texas	0%	86%	14%	0%	94%	6%
Utah	0%	92%	8%	0%	93%	7%
Virgin Islands	0%	73%	27%	0%	100%	0%
Virginia	0%	83%	17%	0%	90%	10%
Washington	0%	85%	15%	0%	100%	0%
Wisconsin	0%	83%	16%	0%	98%	2%
Wyoming	0%	85%	15%	0%	100%	0%
BOP	0%	79%	21%	0%	87%	13%
Across Jurisdictions	0%	84%	15%	0%	92%	8%

Included in SCDC' 4.29.19 letter to LOC

D. *Vulnerable Populations: Mentally Ill, Pregnant, and Transgender Prisoners*

Concerns have been raised about especially vulnerable individuals. The information that we obtained about juveniles (described as individuals under 18 years of age) is discussed above, in the context of age cohorts. Here, we turn to other vulnerable populations, specifically the mentally ill, pregnant women, and transgender individuals.[208]

1. *Prisoners with Serious Mental Health Issues (according to each jurisdiction's own definition)*

The view that the "seriously mentally ill" (SMI) ought not to be in restricted housing is widely shared and longstanding. In 1995, a federal judge concluded that placing seriously mentally ill prisoners into what he termed "solitary confinement" violated their Eighth Amendment rights.[209]

In the last few years, legislation in some jurisdictions, class action settlements, and policies in the federal prison system[210] and in some states have prohibited or limited correctional facilities' authority to put seriously mentally ill individuals in restricted housing.[211] As discussed above, the American Correctional Association (ACA) approved new standards on restricted housing,[212] including recommendations that prisoners with serious mental illness not be placed in "Extended Restrictive Housing."[213] The 2016 ACA Standards also called for all prisoners to be evaluated by a mental health provider within seven days of their placement in restricted housing.[214] Further, the ACA standards stated that prisoners with diagnosed behavioral health disorder in restricted housing for 22 hours a day or more be assessed by a mental health provider "at least every 30 days," and prisoners without such a diagnosis be assessed every 90 days.[215] In addition, the ACA standards call for all prisoners in restricted housing to be visited by mental health staff weekly and by health care personnel daily.[216] The Department of Justice has similarly altered its standards to make it clear that seriously mentally ill individuals should generally not be placed in restricted housing.[217]

Yet how jurisdictions defined what constituted "serious mental illness" varied widely. The 2015 survey made plain that correctional agencies do not have a uniform definition of either "mental illness" or "serious mental illness." We did not impose a definition when surveying but instead invited each jurisdiction to provide its own definition of a "serious mental health issue" and to provide data on the numbers of people with such mental health issues in restricted housing.

Forty jurisdictions provided definitions. Five other jurisdictions provided data on the use of restricted housing for prisoners with mental health issues without providing a corresponding definition of "serious mental health issue."[218] Seven of the 40 jurisdictions that provided a definition did not provide data on prisoners with mental health issues.[219]

Some jurisdictions' definitions had a narrower range than others. A sense of the variation is apparent from a few examples. The District of Columbia limited its definition to Axis I diagnoses under the Diagnostic and Statistical Manual of Mental Disorders (DSM-4).[220] Iowa included "chronic and persistent mental illnesses in the following categories: § Schizophrenia

Included in SCDC' 4.29.19 letter to LOC

§ Recurrent Major Depressive Disorders § Bipolar Disorders § Other Chronic and Recurrent Psychosis § Dementia and other Organic Disorders." Mississippi defined "serious mental illness" as "a diagnosable disorder of thought, mood, perception, orientation, or memory that significantly impairs a person's judgment, behavior, capacity to recognize reality, and/or ability to meet the ordinary demands of life currently or at any time during the past year." Vermont's definition included a "disorder of thought, mood, perception, orientation, or memory as diagnosed by a qualified mental health professional, which substantially impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life and which substantially impairs the ability to function within the correctional setting or any developmental disability, traumatic brain injury or other organic brain disorder, or various forms of dementia or other neurological disorders, as diagnosed by a qualified mental health professional, which substantially impairs the ability to function in the correctional setting." In Appendix C, we provide additional details of the various definitions for "serious mental health issue" or "serious mental illness" that were provided by the responding jurisdictions.

Seeking to understand the placement of mentally ill people in restricted housing, we asked jurisdictions to provide the number of people in the total population with mental illness, as well as the number of prisoners with mental illness in restricted housing, by race and gender. Jurisdictions varied in their ability to provide data in this detail. Thirty-four jurisdictions[221] provided data about male prisoners with mental illness. These jurisdictions reported a total of 54,025 male prisoners with serious mental health issues in their general prison populations, and a total of 5,146 male prisoners with serious mental health issues held in restricted housing. The 32 jurisdictions responding on women prisoners reported a total of 9,573 female prisoners with serious mental health issues, and a total of 297 female prisoners with serious mental health issues in restricted housing. We provide the jurisdiction-by-jurisdiction information in Tables 15 and 16 below.

Given the variation in definitions, we did not create a chart comparing percentages of mentally ill prisoners in restricted housing; any variation may reflect broader or narrower definitions of "serious mental health issue." Rather, we report on the total number of men and of women (with information on race and ethnicity where available) whom jurisdictions identified as of the fall of 2015 as having such mental health issues and whether these individuals were housed in general population or in restricted housing.

Included in SCDC' 4.29.19 letter to LOC

Table 15 – Male Prisoners with a Serious Mental Health Issue (Variously Defined) in Restricted Housing (*n* = 34)

	Male Custodial Population	Male Custodial Population with Serious Mental Health Issues	Percentage of Male Custodial Population with Serious Mental Health Issues	Male Custodial Population with Serious Mental Health Issues in Restricted Housing	Percentage of Male Custodial Population with Serious Mental Health Issues in Restricted Housing
Alabama	23,062	573	2.5%	53	9.2%
Colorado	16,719	1,302	7.8%	8	0.6%
Connecticut	14,993	419	2.8%	11	2.6%
District of Columbia	1,153	89	7.7%	1	1.1%
Florida	92,679	10,442	11.3%	1,283	12.3%
Idaho	7,001	525	7.5%	71	13.5%
Iowa	7,575	1,972	26.0%	87	4.4%
Kansas	9,132	1,999	21.9%	294	14.7%
Kentucky	10,664	1,849	17.3%	98	5.3%
Louisiana	17,577	1,583	9.0%	612	38.7%
Maryland	18,736	435	2.3%	69	15.9%
Massachusetts	9,313	677	7.3%	21	3.1%
Minnesota	8,674	874	10.1%	98	11.2%
Mississippi	17,516	274	1.6%	7	2.6%
Missouri	29,028	4,191	14.4%	600	14.3%
Nebraska	5,018	1,455	29.0%	250	17.2%
New Jersey	17,027	217	1.3%	1	0.5%
New Mexico	6,613	111	1.7%	0	0.0%
New York	50,189	2,087	4.2%	59	2.8%
North Carolina	35,228	320	0.9%	34	10.6%
North Dakota	1,582	83	5.2%	3	3.6%
Ohio	46,115	3,288	7.1%	97	3.0%
Oklahoma	24,722	1,618	6.5%	141	8.7%
Oregon	13,451	2,764	20.5%	163	5.9%
Pennsylvania	47,551	3,468	7.3%	23	0.7%
South Carolina	19,575	2,632	13.4%	319	12.1%
South Dakota	3,132	128	4.1%	14	10.9%
Tennessee	18,630	490	2.6%	27	5.5%
Texas	135,580	1,275	0.9%	0	0.0%
Utah	5,960	2,646	44.4%	486	18.4%
Virgin Islands	324	25	7.7%	22	88.0%
Washington	15,172	2,458	16.2%	82	3.0%
Wisconsin	19,221	1,388	7.2%	90	6.5%
Wyoming	1,877	368	19.6%	22	6.0%

Included in SCDC' 4.29.19 letter to LOC

Table 16 – Female Prisoners with a Serious Mental Health Issue (Variously Defined) in Restricted Housing (*n* = 32)

	Female Custodial Population	Female Custodial Population with Serious Mental Health Issues	Percentage of Female Custodial Population with Serious Mental Health Issues	Female Custodial Population with Serious Mental Health Issues in Restricted Housing	Percentage of Female Custodial Population with Serious Mental Health Issues in Restricted Housing
Alabama	1,487	93	6.3%	5	5.4%
Colorado	1,512	565	37.4%	0	0.0%
Connecticut	1,063	28	2.6%	0	0.0%
Florida	6,909	2,258	32.7%	69	3.1%
Idaho	1,012	100	9.9%	4	4.0%
Iowa	727	294	40.4%	3	1.0%
Kansas	820	435	53.0%	8	0.2%
Louisiana	938	274	29.2%	36	13.1%
Maryland	951	14	1.5%	0	0.0%
Massachusetts	691	83	12.0%	3	3.6%
Minnesota	647	95	14.7%	2	2.1%
Mississippi	1,350	2	0.1%	0	0.0%
Missouri	3,238	979	30.2%	30	3.1%
Nebraska	438	216	49.3%	7	3.2%
New Jersey	722	34	4.7%	0	0.0%
New Mexico	776	0	0.0%	0	0.0%
New York	2,432	199	8.2%	1	0.5%
North Carolina	2,811	62	2.2%	3	4.8%
North Dakota	218	19	8.7%	0	0.0%
Ohio	4,133	707	17.1%	4	0.6%
Oklahoma	2,928	387	13.2%	6	1.6%
Oregon	1,273	659	51.8%	19	2.9%
Pennsylvania	2,798	681	24.3%	3	0.4%
South Carolina	1,403	540	38.5%	18	3.3%
South Dakota	394	17	4.3%	2	11.8%
Tennessee	1,465	38	2.6%	2	5.3%
Texas	12,785	80	0.6%	0	0.0%
Utah	537	375	69.8%	52	13.9%
Virgin Islands	15	1	6.7%	0	0.0%
Virginia	2,353	0	0.0%	0	0.0%
Washington	1,136	274	24.1%	1	0.4%
Wisconsin	1,313	387	29.5%	23	5.9%
Wyoming	251	112	44.6%	4	3.6%

Included in SCDC' 4.29.19 letter to LOC

We also sought to learn about the intersection of race, ethnicity, gender, and mental health. Thirty-three jurisdictions provided information about male prisoners, and 30 jurisdictions provided information about women prisoners. [222] The jurisdiction-by-jurisdiction information is detailed in Tables 17 and 18 below.

Table 17 – Male Prisoners with a Serious Mental Health Issue by Race and Ethnicity (*n* = 33)

	White	Black	Hispanic	Asian	Other	Total
Alabama	225	343	0	0	5	573
Arizona	807	334	433	6	72	1,652
California	2,259	3,053	1,976	75	499	7,862
Colorado	683	281	286	7	45	1,302
Connecticut	181	153	82	1	2	419
District of Columbia	2	83	3	0	1	89
Florida	4,211	5,010	1,193	2	26	10,442
Idaho	439	21	37	1	27	525
Indiana	0	0	0	0	0	0
Iowa	1,452	394	88	5	33	1,972
Kansas	1,217	583	155	10	34	1,999
Kentucky	1,330	421	14	2	82	1,849
Louisiana	549	1,032	1	1	0	1,583
Maryland	159	252	8	0	16	435
Minnesota	506	267	0	19	82	874
Mississippi	90	182	0	0	2	274
Missouri	2,969	1,156	46	4	16	4,191
Nebraska	973	297	113	6	66	1,455
New Jersey	63	116	36	0	2	217
New Mexico	26	5	74	0	6	111
New York	559	1,037	427	11	53	2,087
North Carolina	153	134	10	4	19	320
North Dakota	60	6	0	2	15	83
Ohio	2,007	1,209	53	3	16	3,288
Oklahoma	966	434	51	2	165	1,618
Oregon	2,291	230	146	29	68	2,764
Pennsylvania	1,677	1,485	282	7	17	3,468
South Carolina	1,128	1,455	24	3	22	2,632
South Dakota	83	7	2	0	36	128
Utah	1,912	151	402	57	124	2,646
Virgin Islands	3	16	6	0	0	25
Wisconsin	692	528	117	9	42	1,388
Wyoming	284	18	44	1	21	368

Included in SCDC' 4.29.19 letter to LOC

Table 18 – Female Prisoners with a Serious Mental Health Issue by Race and Ethnicity (*n* = 30)

	White	Black	Hispanic	Asian	Other	Total
Alabama	60	33	0	0	0	93
Arizona	196	54	70	1	29	350
California	71	76	62	4	17	230
Colorado	291	81	162	5	26	565
Connecticut	13	11	4	0	0	28
District of Columbia	0	0	0	0	0	0
Florida	1,509	630	116	0	3	2,258
Idaho	82	0	11	0	7	100
Iowa	215	59	13	2	5	294
Louisiana	151	123	0	0	0	274
Maryland	8	6	0	0	0	14
Minnesota	52	22	0	1	20	95
Mississippi	2		0	0	0	2
Missouri	785	150	34	4	6	979
Nebraska	141	35	20	0	20	216
New Jersey	17	12	2	2	1	34
New Mexico	0	0	0	0	0	0
New York	62	111	22	2	2	199
North Carolina	37	23	0	0	2	62
North Dakota	17	0	0	0	2	19
Ohio	510	187	8	1	1	707
Oklahoma	246	82	11	1	47	387
Oregon	554	49	23	8	25	659
Pennsylvania	432	201	37	2	9	681
South Carolina	366	161	6	0	7	540
South Dakota	12	0	0	0	5	17
Utah	283	8	52	7	25	375
Virgin Islands	0	1	0	0	0	1
Wisconsin	242	108	12	0	25	387
Wyoming	92	5	8	0	7	112

Included in SCDC' 4.29.19 letter to LOC

2. *Pregnant Prisoners*

We asked specifically about pregnant women in general prison populations and in restricted housing. Of the 33 jurisdictions that had sufficiently detailed and consistent information on which to report,[223] 10 said that, as of the fall of 2015, no pregnant prisoners were in their total custodial population.[224] The remaining 23 jurisdictions, listed below in Table 19, reported that within their general populations as of the fall of 2015, they counted a total of 396 pregnant women prisoners. Nineteen jurisdictions reported that they had no pregnant prisoners in restricted housing. The remaining four jurisdictions—Delaware, Florida, Kentucky and North Carolina—reported holding a total of five pregnant prisoners in restricted housing.

Table 19 – Pregnant Prisoners in Restricted Housing (*n* = 23)

	Women in Total Custodial Population	Pregnant Women in Total Custodial Population	Pregnant Women in Restricted Housing
Alabama	1,487	9	0
Arizona	3,972	27	0
Colorado	1,512	18	0
Connecticut	1,063	23	0
Delaware	223	6	1
Florida	6,909	52	2
Hawaii	738	2	0
Kansas	820	4	0
Kentucky	1,005	34	1
Maryland	951	2	0
New Jersey	722	3	0
New York	2,432	11	0
North Carolina	2,811	35	1
Ohio	4,133	14	0
Oklahoma	2,928	8	0
Oregon	1,273	9	0
Pennsylvania	2,798	16	0
South Carolina	1,403	16	0
South Dakota	394	8	0
Texas	12,785	88	0
Utah	537	5	0
Virginia	2,353	3	0
Wyoming	251	3	0

Included in SCDC' 4.29.19 letter to LOC

3. *Transgender Prisoners*

We asked about transgender prisoners in the general population and in restricted housing. Of the 33 jurisdictions providing data on transgender prisoners,[225] 10 reported having no transgender prisoners in their total custodial population. The remaining 23 jurisdictions reported a total of 754 transgender prisoners in their prison systems. Of these, eight jurisdictions reported that no transgender prisoners were in restricted housing. In the 15 jurisdictions that had transgender prisoners in their restricted housing population, we tallied a total of 55 transgender prisoners in restricted housing.[226] In sum, of the 754 transgender prisoners reported by 33 jurisdictions, 55 (7.3%) were reported to be housed in restricted housing.

VII. Planned or Proposed Policy Changes in Restricted Housing: 2013-2016

In ASCA-Liman's prior 2015 *Time-In-Cell* Report, 40 jurisdictions reported that they had reviewed their policies and practices of administrative segregation within the prior three years, that is, between 2011 and 2014. Many discussed efforts to make changes, including by reducing isolation, using less restrictive means of confinement, improving mental health services, and adding staff training.[227]

For this 2016 Report, we asked jurisdictions to report policies implemented or plans to revise policies on restricted housing, and we focused on the time period between 2013 and the fall of 2015. Thereafter, at the request of some correctional administrators, ASCA-Liman circulated a follow-up questionnaire in March of 2016 to inquire about any more recent changes. Some jurisdictions provided additional information, including after the August meeting, and thus this discussion includes materials received through the early fall of 2016.

We specifically inquired about changes in policies regarding restricted housing related to the "criteria for entry to restricted housing," "criteria for release to restricted housing," "oversight in restricted housing," "mandated time out-of-cell for restricted housing prisoners," "programming in restricted housing," "opportunities for social contact in restricted housing," "physical environment of restricted housing," "programming for mentally ill prisoners who have been in restricted housing," "policies or training related to staffing of restricted housing," and "other." We also asked jurisdictions to send the underlying policies related to placement in restricted housing. We did not ask questions about the reasons for changes, but as reflected in answers, some revisions to policies have come in the wake of litigation and legislative mandates.

Jurisdictions' responses to these policy questions included varying levels of detail. Further, we did not provide or ask for measures of implementation, such as whether revised entry criteria had resulted in a decline in the number of entrants or whether increased out-of-cell time opportunities were used in practice. Thus, we know how correctional systems *described* their efforts, but we do not have independent metrics of the impact of changes made.

Of the 53 jurisdictions surveyed, 45 provided responses to these questions.[228] Twelve of these 45 jurisdictions provided copies of policies or court-based settlement agreements as well.[229] A few jurisdictions responded with reports of reduced populations in restricted housing or with other kinds of information. Several jurisdictions that reported policy changes later

Included in SCDC' 4.29.19 letter to LOC

provided additional information.

Most of the responding corrections departments reported making or considering policy changes. Areas of revision included narrowing the criteria for entry; creating different forms of restricted housing; developing alternative housing options that removed individuals from the general population, but without such restrictive conditions; increasing oversight over the process of deciding who is to be placed in restricted housing; and creating pathways for release or limits on the time to be spent in restricted housing. Several jurisdictions reported that, for those people remaining in segregation, they sought to diminish the degrees of isolation by increasing out-of-cell time; improving access to programs, education, work, and exercise; and creating opportunities for social interaction with people in and outside of prison. In terms of the process for making changes, some jurisdictions reported that they had consulted with outside institutions—from prisoner and disability advocacy groups to organizations such as the Vera Institute of Justice—in their planning efforts.[230]

Below, we first provide an overview of what correctional systems reported they were trying to do to reduce their use of long-term isolation. We then describe changes underway in the federal system at the direction of the U.S. Department of Justice and in five states, all of which were putting into place new policies focused on reducing the use of restricted housing. We detail the proposals in the DOJ report on restricted housing that the March 2016 Presidential order indicated should be implemented within 180 days.[231] Thereafter, we provide information from five states—Colorado, North Dakota, Ohio, South Carolina, and Utah—that indicated that they were making substantial changes in restricted housing policies and procedures.

A. *Reducing Placement in Restricted Housing: Narrowing Criteria for Entry and Creating Alternatives*

Many jurisdictions reported changing the criteria for placement in restricted housing. For example, Colorado stated that it no longer allowed "female or youthful offenders" to be placed into "Restricted Housing – Maximum Security Status."[232] Texas reported that members of what it called the "Texas Mafia" were "no longer placed in restrictive housing based solely on their affiliation." California reported many changes in restricted housing policies, including no longer placing prisoners in restricted housing "solely based" on gang membership.[233] Pennsylvania reported that it had "eliminated self-injurious behaviors, self-mutilation, other forms of self-injury, and behaviors associated with these sentinel events from the list of rule violations that could lead to segregation or other types of informal sanctions."[234] A few of these states have also been involved with litigation regarding restricted housing prisoners, and some of the changes interact with provisions of settlement agreements.

Other jurisdictions described taking steps to alter criteria for placement in restricted housing. North Dakota said that it was in the "process of [a] policy review related to using restrictive housing as a last resort." South Dakota stated that it was revising the criteria for placement in restricted housing "to be based on more clearly defined violent/dangerous behaviors." Utah, as detailed below in Part VII, changed both the criteria for placement and created an individualized review process for each prisoner in restricted housing.

Included in SCDC' 4.29.19 letter to LOC

Along with narrowing criteria for entry to restricted housing, some jurisdictions explained that they were seeking ways to divert prisoners from restricted housing, while also removing prisoners from the general population. Ohio, for example, reported that it planned to expand what it termed "Limited Privilege Housing," described as "a non-restrictive housing alternative" for some individuals who would otherwise have been placed in restrictive housing. Oregon stated that it was revising policies to allow "low level" misbehavior to be addressed through some alternative to restricted housing. New York (another jurisdiction in which major litigation related to these issues was resolved in 2016) stated that it was planning "[a]lternative programming units," including drug and alcohol treatment programs and step-down programs, "to reduce the number of inmates being held in restrictive housing." Pennsylvania related that it had recently developed several diversionary treatment units. Texas reported expanding its "Mental Health Therapeutic Diversion Program" to 420 beds.

B. Focusing on Release: Time Caps, Step-Down Programs, and Increased Oversight of Retention Decisions

Many jurisdictions reported having implemented or planning to change criteria and procedures for release from restricted housing or to the oversight of decisions to continue to house individuals in restricted housing. Reported efforts included placing limits on the amount of time in segregation, implementing structured programs to transition prisoners back to the general population ("step-down" or "step-up" programs), and increasing oversight or reviews of prisoners who were placed in segregation.

A few jurisdictions reported imposing a limit on the total time prisoners could spend in at least some forms of restricted housing. For example, Colorado described a 12-month limit on placement in Maximum Security restricted housing, which could be extended if "approved by the director of Prisons as well as the deputy executive director, and . . . based upon documented exigent circumstances." South Dakota stated that it has made changes to "Disciplinary Segregation to reduce maximum duration in disciplinary segregation."[235] Ohio reported that it had adopted a policy under which prisoners in "long-term restrictive housing (Level 5 or 4B)" were to be presumptively released after a set period of time unless they were found to "have committed an offense so dangerous it exempts them from this policy." Under Ohio's plan, prisoners in the most restrictive housing environment were presumptively downgraded to a lower level of restriction after 90 days, after which they were presumptively released to a lower restriction level after 15 months.

Several jurisdictions referenced implementing step-down or similar programs that create a series of stages to facilitate the transition of individuals from restricted housing back to the general population.[236] For example, South Carolina (discussed in greater detail below) reported that it had implemented a minimum year-long step-down program for prisoners requiring "intensive management," and a minimum six-month-long step-down program for prisoners who commit less serious infractions. The Virginia Department of Corrections described its efforts at implementing "Steps to Achieve Reintegration" (STAR), a program for prisoners who refused to leave segregated housing "because of their fear of living with others"[237] so as to equip prisoners with "skills to safely enter [general] population housing."[238] Utah (also detailed below) created a

Included in SCDC' 4.29.19 letter to LOC

tiered program aimed at moving people from restricted housing to general population within a year or less.

Several jurisdictions reported adding reviews of decisions to keep individuals in restricted housing. For example, New Jersey described the formation of a committee to conduct "a formal review of each inmate" housed in a management control unit (MCU) every three months "to determine whether an inmate's release from MCU is appropriate."[239] Oregon stated that it was implementing a "90-day review process" to ensure prisoners do not remain segregated longer than necessary.

A few jurisdictions described adding new administrative positions at various levels to oversee their restricted housing programs and units. New York said that it had "added an Assistant Commissioner position for oversight."[240] South Dakota reported that it added the position of "Restrictive Housing Manager" in order "to oversee the development and maintenance of the level program and to ensure institutional compliance with new policy changes regarding restrictive housing." Pennsylvania reported "many systemic changes to the ways mental health services are provided to state inmates housed in various types of restricted housing units," including reorganizing the central office responsible for mental health care and augmenting oversight to enhance "the delivery of mental health services." Utah added a new committee, the Placement/Advancement Review Board, to consider each prisoner in restricted housing on a regular basis.

Another form of oversight can come from improving data collection. A few jurisdictions described changing their information tracking systems. For example, Illinois explained that its Department of Corrections regulations were revised to require creation of a new file for each person in restricted housing to track "all relevant documentation pertaining to the administrative detention placement."[241]

Jurisdictions have also sought to prevent the release of individuals from segregation directly to the community. *Time-In-Cell* described 30 jurisdictions that, as of 2013, reported that 4,400 people had been released to their communities without any transition from isolation.[242] A few jurisdictions responding to the 2015 survey described taking steps to prohibit or discourage the direct release of individuals from restricted housing to the outside world. Connecticut stated that it prohibited release of prisoners to the community directly from administrative segregation. Similarly, Colorado policy required the Department to "make every attempt to ensure offenders will not release directly to the community from Restrictive Housing Maximum Security Status" and to do so by considering transition in the 180 days preceding release to the community.

C. Mandated Time Out-of-Cell

Another strategy described by several jurisdictions was mandating a certain number of hours per day or week that prisoners in segregation would spend outside of their cells. Several jurisdictions reported reforming policies to increase time out-of-cell for prisoners removed from the general population.[243]

Included in SCDC' 4.29.19 letter to LOC

For example, Ohio stated that it had a pilot program to provide "10 hours out-of-cell time for structured activity and 10 hours out-of-cell time for unstructured activity for severely mentally ill prisoners who must be held in restrictive housing for safety reasons." Pennsylvania stated that prisoners in particular segregated units were scheduled for a minimum of 20 hours of out-of-cell activity per week. California noted that certain segregated prisoners were granted either 15 or 20 hours out-of-cell per week. Utah related increasing mandated time out-of-cell per week.

D. Conditions: The Physical Environment and Programming

In addition to criteria for entry to and release from restricted housing, jurisdictions reported revisiting conditions *within* restricted housing. Oregon, for example, reported that it created a "blue room" in its Intensive Management Unit in one prison, where images of nature were projected onto the walls. South Dakota described several changes, including building "outdoor recreation enclosures," installing windows to provide additional natural light to prisoners, and installing televisions outside of cells, so that segregated prisoners could watch "news/weather channel" during "the daytime hours."

Other jurisdictions described efforts to increase programming opportunities for prisoners in restricted housing, sometimes in groups. New Jersey stated that it planned to build modules for programming in administrative segregation units. Missouri described its new "reintegration unit" for people in restricted housing, which had additional programming. Texas reported on programs allowing administratively segregated prisoners to "participate in group recreation and group treatment."

Several jurisdictions mentioned using "security desks" or "security chairs," which physically restrain prisoners to enable them to sit together in small groups and share in programs or activities. For example, South Dakota described its step-down program as incorporating "out-of-cell group programming." Some jurisdictions, including South Dakota, related installing security desks to permit small group activities. Washington reported that security chairs installed in its Intensive Management Unit classrooms enabled "up to eight offenders at a time [to] interact with other offenders and staff facilitators while participating in programming." Nebraska planned to install such chairs to allow some segregated prisoners to have congregate programming.

E. Staffing: Policies and Training

As the *Time-In-Cell* Report detailed, the staffing of restricted housing units poses challenges for both institutions and individual correctional officers.[244] In the 2015 survey, we returned to these issues to learn about policy changes focused on staff, and several jurisdictions described focusing on these issues. For example, New Jersey reported that it had established a special training module for restricted housing staff. Pennsylvania stated that it had added training for employees who work with seriously mentally ill prisoners and for employees who staff restricted housing units. Utah said that it had completed a new policy to direct particular training for officers working in restricted housing facilities. The District of Columbia reported that it did not permit officers with less than 18 months of experience to work in these special units.

Included in SCDC' 4.29.19 letter to LOC

Wisconsin stated that it rotated staff out of restricted housing units every 14 weeks and that restricted housing staff received special training in subjects including suicide prevention and professional communication.

F. Jurisdictions Seeking Substantial Reductions in Restricted Housing Use

We asked all jurisdictions to provide additional information on efforts to reform restricted housing. Below, we provide brief descriptions of changes, drawn from reports provided by the Department of Justice (DOJ) and from five states—Colorado, North Dakota, Ohio, South Carolina, and Utah—all of which describe themselves as seeking to achieve major shifts in the use of restricted housing.

1. The Federal Prison System: Changes Recommended in the 2016 Department of Justice Restricted Housing Report

As noted at the outset, the Justice Department issued a report in January of 2016 that included numerous specific recommendations for changes in how the federal government handles restricted housing.[245] That month, the President discussed the findings of the report and the harms of "solitary confinement," and called for the practice to be "limited, applied with constraints and used only as a measure of last resort."[246] In March of 2016, the President issued a Presidential Memorandum, "Limiting the Use of Restrictive Housing by the Federal Government,"[247] that directed prompt implementation of the DOJ's recommendations by the Justice Department, which was required to rewrite many of its policies. Below we summarize some of the major changes recommended by the DOJ report.[248]

The DOJ organized its mandates under certain "Guiding Principles" followed by "Policy Recommendations."[249] Central changes included limiting the placement of juveniles, pregnant women, and seriously mentally ill individuals in restricted housing, absent exigent circumstances, and banning the use of restricted housing for lesbian, gay, bisexual, transgender, intersex, and gender nonconforming individuals, where such placement is based solely on sexual or gender identity. The Justice Department also mandated the use of the least restrictive alternative, revised the in-prison infractions that could result in placement in restricted housing, and lowered the numbers of days individuals could spend in restricted housing. Thus, the DOJ called for the BOP to end the practice of placing juveniles (defined as "those adjudicated as juveniles, and those under age 18 who were convicted and sentenced as adults") in restricted housing, except as a "temporary response to a behavioral issue that poses a serious and immediate risk to any individual."[250]

A change with a wider application was the goal that all prisoners be housed "in the least restrictive setting necessary" to ensure their safety and that of others.[251] The DOJ stated that correctional systems "should always be able to clearly articulate the specific reason(s)" for placement in restricted housing, that these reasons should be supported by "objective evidence," and that prisoners should remain in restricted housing "no longer than necessary to address the specific reason(s) for placement."[252] The DOJ also called for initial and ongoing reviews of any placement in restricted housing and recommended that, for every prisoner, correctional staff develop "a clear plan for returning the inmate to less restrictive conditions as promptly as possible."[253] Further, to divert individuals placed in protective custody, the DOJ recommended

Included in SCDC' 4.29.19 letter to LOC

that the Bureau of Prisons expand its use of "Reintegration Housing Units," which allow certain prisoners to be removed from the general population but continue to live in conditions less restrictive than solitary confinement.[254]

The DOJ recommended that prisoners not be sent to restricted housing as sanctions for certain kinds of misbehaviors, organized in the federal system by "levels." Thus, a low level offense would no longer result in a sanction of disciplinary segregation, and a moderate level offense would not result in a sanction of disciplinary segregation for a first violation or more than 15 days of segregation for a subsequent violation. Previously, moderate offenses could have resulted in 90 days for the first violation or 180 days for a subsequent violation.[255]

The DOJ also called for significant reductions to the time prisoners could be held in restricted housing for disciplinary infractions. For example, the DOJ urged that the maximum time a prisoner be placed in disciplinary segregation for the most serious category of offense be reduced from 365 days for a first offense and 545 days for a subsequent offense to 60 days for a first offense and 90 days for a subsequent offense.[256]

The DOJ also urged that, whenever possible, the BOP seek "to avoid releasing inmates directly from restrictive housing back to the community."[257] To implement this goal, the DOJ recommended revising policies to discourage placing prisoners in restricted housing near the end of their prison terms and to consider releasing prisoners from segregation beginning 180 days before the end of their sentences, if that movement could be done safely.[258]

Like some other jurisdictions, the DOJ recommended changes that would increase total time out-of-cell for individuals in restricted housing. According to the DOJ's recommendations, wardens should be directed to "develop individualized plans for maximizing out-of-cell time for restrictive housing inmates."[259] The DOJ also reported that the BOP was revising its rules governing the use of "secure programming chairs" and "intends to purchase 610 of these chairs" to allow "in-person educational and mental health programming in a less restrictive manner than currently used."[260]

For mentally ill prisoners, the DOJ recommended additional investment to hire mental health staff and expand diversion programs. Under these recommendations, the BOP would create "108 additional psychology positions," which would allow the BOP to "dedicate at least one staff psychologist to each" restricted housing unit.[261] The DOJ also recommended expanded use of "secure mental health units" to divert seriously mentally ill prisoners from solitary confinement into "less restrictive housing."[262] To this end, the DOJ recommended that the BOP "expand its network of residential mental health treatment programs" with the goal of "building sufficient capacity to divert inmates with [serious mental illness] from all forms of restrictive housing . . . whenever it is clinically appropriate and feasible to do so."[263]

The DOJ recommended some measures to increase oversight of the use of restricted housing, including initial and ongoing reviews of a prisoner's placement in restricted housing by "a multi-disciplinary staff committee" which would include institutional leadership and medical and mental health professionals.[264] The DOJ also recommended that the BOP publish monthly system-wide restricted housing data on its external website (to allow the public to track the

Included in SCDC' 4.29.19 letter to LOC

number of prisoners in federal restricted housing) and upgrade its data-collection software.[265] (As noted in the introductory materials, in the fall of 2016, several senators introduced a Solitary Confinement Reform Act which, if enacted, would have requirements additional to those outlined above.

2. Colorado

According to an article by Rick Raemisch, Director of the Colorado Department of Corrections (CDOC) and Kellie Wasko, Deputy Director of the CDOC, efforts to reduce the use of profound isolation were initiated in Colorado by Tom Clements, who served as the Executive Director of the CDOC from 2011 until 2013. Director Clements was murdered by a person who was released into the community directly from a CDOC restricted housing unit. In 2011, about 1,500 people (7% of the state's prison population) were in restricted housing. Under Director Clements, the population was reduced to 700 people.[266] At that time, 49% of those released went directly to the outside community.

When Rick Raemisch, who had previously served as the Director of Corrections in Wisconsin, assumed the leadership of Colorado's correction system in 2013, he sought to continue to limit the use of isolation. Raemisch and Wasko reported that, as of the spring of 2016, policy changes had produced a 67% reduction in CDOC's restricted housing population. As the data in Section IV indicated, in the fall of 2015, Colorado recorded 217 people, or 1.2% of its population, in restricted housing.

CDOC reported that it used what it termed a "progressive Management (Step down) Process," to provide prisoners with social contact within a highly structured and controlled close custody environment.[267] New units—the Close Custody Management Control Unit (MCU) and Close Custody Transition Unit (CCTU)—were "designed specifically to assist offenders with pro-social stabilization and cognitive intervention programming" before these individuals could enter the general population.[268] The CDOC system required that prisoners in these two units have Behavior Modification Plans, designed, implemented, and monitored by a multidisciplinary team.[269]

CDOC stated that individuals assigned to the MCU were allowed out of their cells for a minimum of four hours per day, seven days per week and that prisoners could be in groups along with several other prisoners when out-of-cell.[270] MCU prisoners could participate in recreational, social, and programming activities, including a minimum of three hours of indoor or outdoor recreation each week. Every 30 days, CDOC reviewed the mental health and management plans for such individuals.[271] According to Raemisch and Wasko, CCTU prisoners were permitted outside their cells six hours per day, seven days per week, in a group of 16 or fewer prisoners.[272] CCTU prisoners were required to participate in the program "Thinking for a Change," described as aiming to increase awareness of and alter criminal thought processes, promote positive peer interactions, and improve problem-solving skills.[273]

Raemisch and Wasko described the most restrictive offender management status—Maximum Security Status (MSS)—as reserved for prisoners who had "demonstrated through their behavior that they pose a significant risk to the safety of staff and other offenders."[274] The length of time spent in the Maximum Security unit was reported not to exceed 12 months.[275]

Included in SCDC' 4.29.19 letter to LOC

Those prisoners were permitted one hour a day, five days a week out of their cells and monthly out-of-cell "meaningful contact" visits with case managers and mental health clinicians.[276]

Further, CDOC described installing restraint tables (which, as noted, some jurisdictions describe as "security chairs") to facilitate group programming in the Maximum Security Units.[277] After three months of good behavior, CDOC stated that Maximum Security prisoners could earn a television in their cell.[278] In the fall of 2015, CDOC reported three women in restricted housing. In its spring 2016 report, CDOC stated that it has adopted policies prohibiting the placement of female or youthful offenders into Maximum Security Restrictive Housing status.[279]

The question of the treatment of the mentally ill has drawn attention from the state legislature as well as from CDOC, which helped to shape legislation reducing isolation for mentally ill offenders. In June 2014, Governor John Hickenlooper signed Senate Bill 14-064,[280] which prohibits the placement of seriously mentally ill prisoners (SMI) in "long-term isolated confinement except when exigent circumstances are present."[281] Before this legislation was enacted, CDOC reported that in 2014 all prisoners with SMI had been evaluated and "moved out of administrative segregation to either a Residential Treatment Program or a general population setting."[282] SMI prisoners in the residential treatment units were, according to Colorado, permitted to leave their cells for 10 hours of structured therapeutic interventions and 10 hours of non-structured recreational programming each week.[283] Again, CDOC said it relied on restraint tables, which accommodate up to four prisoners, for group interactions with therapists and clinicians.[284]

CDOC described using screenings of prisoners upon entry to prison in order to identify individuals with serious mental illness.[285] Further, if prisoners violated prison rules, assessing committees were charged with determining whether mental illness contributed to the person's committing a violation; if so, the person was to be assigned to a Residential Treatment Program that entailed significant restrictions on time out-of-cell but was not the same kind of management control unit to which non-mentally ill violators were assigned.

Like other departments, CDOC reported that some individuals who had been in profound isolation had difficulty leaving it.[286] CDOC described its Divisions of Clinical Services and Prison Operations staff as developing programs to encourage individuals to leave their cells; initiatives including having dogs in treatment groups, constructing de-escalation rooms with soothing music, and art therapy classes.[287]

CDOC characterized these policy changes as successful, reporting that the two facilities with Residential Treatment Programs have experienced significant declines in forced cell entries and in prisoner-on-staff assaults.[288] CDOC explained that its senior executives provided weekly messages to the entire department to describe ongoing reforms, explain their rationale, and invite feedback. Further, Raemisch and Wasko described giving management teams at the facility level the autonomy to determine what methods to use to engage staff in and gain their commitment to change.[289] CDOC also reported that there were no suicides in restricted housing in 2015.[290] The average length of time spent in restricted housing by CDOC prisoners was approximately 7.5 months.[291]

Included in SCDC' 4.29.19 letter to LOC

3. North Dakota

Reports of reforms in the North Dakota Department of Correction and Rehabilitation (ND-DOCR) come from its director, Leann Bertsch, whose essay, *The History of Restricted Housing at the ND-DOCR*, details the evolution of using segregation from the era of "dark cells" where no light could reach prisoners to modern-day segregation.[292] She described the expanding use of segregation despite the absence of any "apparent correlation between institutional violence, escapes, weapons, or riots that would account for" that increase.[293] Thus, North Dakota has identified segregation as a *problem* to be solved and outlined how the Department aimed to reduce dramatically its reliance on isolation.[294] In a March 2016 discussion of "strategic planning" to reduce segregation, the Department listed what segregation "can't do," (improve institutional behavior, reduce violence or recidivism) and what segregation had been "proven to do" (increase violence, aggression, self-harm, psychosis, and other physical and mental health harms in men who have spent time there).[295]

Thus, the aim was to use the least "restrictive housing level,"[296] and the new "goal of segregation" was "to separate, assess, and equip people to function at a reduced risk to themselves, the institution, and others."[297] ND-DOCR's strategy was to "divert people from segregation and strictly limit the types of behaviors that can result in segregation."[298]

At the front end, ND-DOCR reported that it had limited the behaviors that could result in placement[299] and had encouraged alternative interventions, such as increasing monitoring in general population or restricting prisoners within their general population cells, so as to use segregation as a last resort.[300]

The ND-DOCR also implemented reforms to reduce the population in their restricted housing units. Leadership identified over 30 people in the Administrative Segregation Unit who no longer required restricted housing, and moved them into a new Administrative Transition Unit (ATU) to prepare them for the transition to general population.[301] People housed in the new ATU were permitted more opportunities for social interaction and special programming to help them prepare for the return to general population.[302] The Special Assistance Unit (SAU), the housing unit for people with mental illness, also expanded opportunities for socialization by allowing its residents to engage in group treatment and to spend days visiting the general population floor.[303] The SAU also created a new transition floor, with supportive services, to help improve reentry outcomes for this population.[304]

In addition, through a psychological assessment process, the ND-DOCR identified the "most acutely impulsive and dangerous people" in their restricted housing units.[305] These people were assigned behavior management plans to help them develop the skills and behaviors needed to transition out of restricted housing. For those remaining in restricted housing, these plans "have increased the amount of interaction, out-of-cell time, enrichment, and reinforcement . . . ." All new admissions to Administrative Segregation are assessed immediately by a multi-disciplinary team and provided with a personalized behavior management plan that indicates what progress is necessary to begin the transition out of restricted housing.[306]

Like Colorado, North Dakota indicated that it sought to engage correctional officers in all stages of program development, which included surveying staff to identify perceived problems,

Included in SCDC' 4.29.19 letter to LOC

educating correctional officers about the psychological and physical harms of solitary confinement, and stressing rehabilitation as a means of achieving security within facilities.[307]

Since implementing these reforms, North Dakota's DOCR reported that it has reduced its segregated population from 82 prisoners in April 2015 to 27 in April 2016.[308] Director Bertsch highlighted staff support[309] and prisoner reports of more positive exchanges with staff.[310] North Dakota also reported a reduction in the use of force[311] and no increase in incidents of violence since shifting its approach.[312]

4. Ohio

In the fall of 2015, ODRC described a "[m]ajor overhaul of the entire system as part of a comprehensive reform." In a May 2016 Executive Briefing by staff to Director Gary Mohr, the ODRC outlined reforms at three facilities—the Grafton Correctional Institution (GCI), the Belmont Correctional Institution, and the Ohio State Penitentiary.[313] Those efforts were part of making "a substantive change to our entire disciplinary process and the types/kinds of sanctions we use to address inmate misbehavior."[314]

According to the Department, the GCI has converted half of its Special Management Unit (SMU) cells into Limited Privilege Unit (LPU) cells, for use by prisoners who are deemed not to pose "a significant threat to the safety and security of the facility."[315] These prisoners are given "more out-of-cell time, access to telephones and email, as well as additional recreational time activities."[316] Most significantly, prisoners on LPU were offered the opportunity to gain early release from restricted housing by participating in pro-social structured and unstructured activities.[317] The Department reported that these activities included programming on problem-solving, community service, recovery, anger management, and mental and physical wellness. The Department enabled LPU prisoners to attend these programs in general population classrooms and to leave the unit for mental health and medical appointments.[318]

Ohio reported that, at its Belmont Correctional Institution (BeCI), it launched a pilot program on "alternative disciplinary sanctions" adapted from the HOPE Model (Hawaii Opportunity Probation with Enforcement).[319] The premise of the model, which Ohio adapted to fit the corrections environment, is that violations should result in sanctions that are prompt, proportionate to the severity of the offense, and take into consideration the individual behavioral history of the prisoner.[320]

In addition to adopting the HOPE Model, BeCI introduced other reforms intended to reduce the population in restricted housing, including new pro-social programming, congregate activities, and targeted case planning.[321] BeCI also introduced new programming to address the specific needs of prisoners with mental illness, including group psychotherapy, medication education, and programs promoting adjustment.[322]

BeCI also introduced alternative sanctions to reduce reliance on restricted housing, such as imposing bunk restrictions, commissary restrictions, and personal electronics restrictions.[323] Like North Dakota, Ohio's BeCI has reassessed its response to certain offenses that previously would have led to placement in restricted housing.[324] Instead of placing "Rule 39" violators in restricted housing—that is, prisoners who use or possess drugs and alcohol—BeCI has created

Included in SCDC' 4.29.19 letter to LOC

special "Rule 39 Unit" dormitories.[325] No individual is placed in restricted housing until a third positive drug test.[326] Ohio also explained that, while at first it put all prisoners who tested positive for substance use in the same unit, concerns emerged that placing casual users with addicts encouraged drug use. As a result, BeCI redesigned the unit to create two different tracks: a disciplinary track for more addicted users, and a programming track for casual users.[327]

The Department described efforts at Ohio State Penitentiary (OSP) to alter criteria for releasing prisoners from restricted housing. OSP houses the system's most dangerous prisoners, and as of April 1, 2016, there were 335 prisoners in this facility housed in extended restricted housing.[328] Ohio reported that in the fall of 2015, it instituted a new policy, under which each prisoner's security level is presumptively reduced within a set time period, with the exception of prisoners who committed "very serious" offenses such as "murdering another inmate" or "taking a staff member hostage."[329] Absent such circumstances, however, Ohio reported that each prisoner is given an individually-tailored Behavior Management Plan (BMP) that specifies the maximum time that the prisoner will spend in each restricted housing status.[330] Each status brings increased privileges and prisoners can accelerate their progress through the levels by demonstrating pro-social behaviors and participating in programs.[331]

For those prisoners who were ineligible for presumptive reduction, the Department reported that OSP had "developed a separate management strategy based on good conduct, increased quality of life, and social interaction."[332] For these prisoners, Ohio reported increasing out-of-cell time by 30 minutes, five days a week; increasing telephone access from 30 minutes a month to two hours per month; and increasing the number of permitted visits from two to three per month.[333] In addition, OSP reported that it offered prisoners the ability to have a tablet in-cell and to email and download games through a kiosk in the unit; the ability to purchase a keyboard for in-cell and congregate programming; and the opportunity to participate in a monthly incentive program to earn more privileges.[334] Ohio reported that these prisoners are evaluated annually for release, with consideration given to recent behavior and programmatic involvement.[335]

Ohio also reported efforts to update its data collection system to monitor its prisoners' placements. As of May 2016, Ohio was seeking weekly updates from its facilities on prisoners in restricted housing.[336] Ohio reported that it had reduced the use of restricted housing and that violence had likewise fallen. Belmont Correctional Institution described a 90% reduction in the use of restricted housing since 2010, coupled with a 25% reduction in the violence rate since 2014.[337] Ohio's leadership reported that "there is cause to believe that these reforms have made [their] prison[s] safer."[338]

5. South Carolina

South Carolina provided policies on entry into, activities in, and oversight of restricted housing.[339] To reduce the use of restricted housing, South Carolina's Department of Corrections (SCDC) adopted a Step-Down Program (SDP) "to create a pathway for offenders to 'step down' from the Restricted Housing Unit (RHU) to general population in a manner that maintains public, staff, and offender safety, while also reducing their criminogenic risk factors."[340]

Included in SCDC' 4.29.19 letter to LOC

Director Bryan Stirling provided materials tracking the number of prisoners in Restricted Housing from 2012 to March of 2016. The total "lockup" numbers in 2012 were 1,691 (including 1,251 individuals described as non-mentally ill and 420 people termed "mentally ill"). In March of 2016, the total number was 755, of which 266 were "mentally ill."[341]

SCDC launched its Step-Down initiative at McCormick Correctional Institution in June 2015 and, by March of 2016, reported that the program had expanded to 17 of the state prison system's 26 facilities.[342] SCDC explained that prisoners accepted into the Step-Down program are divided into two categories: Intensive Management (IM) and Restrictive Management (RM). IM prisoners were those with "the potential for extreme and deadly violence that have been a threat to the physical safety of other inmates or staff at one time."[343] RM prisoners, by contrast, were individuals who were "continually" placed in restricted housing due to "poor adjustment in general population" but who "do not pose a deadly threat to staff or inmates."[344]

SCDC reported that prisoners in the IM program had to complete a minimum yearlong, three-phase program before rejoining the general population.[345] The program's timeframe could be extended if the individual had "disciplinary infractions or poor adjustment."[346] Like most step-down programs, prisoners received incremental privileges as they progressed. In the most restrictive Phase I, prisoners were granted certain privileges, referred to as "Phase I incentives," which include out-of-cell time each day from 8:00 a.m. until 4:00 p.m.; lunch in the cafeteria (breakfast and dinner were provided in-cell); and recreation time in the gym twice a week.[347]

Phase I was designed to span at least three months, during which time prisoners were required to participate in programming.[348] To advance to Phase II, prisoners could not be involved in assaultive behavior during the time they were in Phase I.[349] In Phase II, incentives included out-of-cell time from 8:00 a.m. to 6:00 p.m.; lunch and dinner in the cafeteria; and the ability to have one visit per month even if on visitation restriction.[350] To advance from Phase II, prisoners were required to meet all Phase I requirements, complete an additional 90 days of programming, demonstrate "openness to constructive feedback" and "[d]emonstrate management and control of impulsive behavior."[351] Prisoners who successfully completed Phase II could move to Phase III. In Phase III, incentives included out-of-cell time from 5:30 a.m. to 8 p.m.; job assignments outside of their dorm; all meals in the cafeteria; and two visits per month, if on visitation restriction.[352] After six months in Phase III, prisoners were to be considered for placement in general population.[353]

As South Carolina staff also explained, the Phase I incentives were automatic when a prisoner entered the program; if a prisoner misbehaved repeatedly, that prisoner would be required to repeat the first phase or be returned to restricted housing, and thereafter, be able to start the step-down program again.

SCDC explained that the RM program was similar to the IM program, but ran for six months rather than a year.[354] RM prisoners had more incentives earlier, more recreation time each week, more visitation opportunities, and more out-of-cell opportunities.[355] For example, in Phase I, incentives in the RM program included schooling for prisoners who did not have their high school diploma, three visits per month, and job assignments.[356]

Included in SCDC' 4.29.19 letter to LOC

SCDC's Step-Down Program also included educational programming. If accepted to the SDP, prisoners were to be screened for completion of a GED or high school diploma. Prisoners who had not obtained either were enrolled in education courses beginning in Phase III (IM) or Phase II (RM).[357] If prisoners had not completed educational requirements by the end of the SDP, they continued their education upon return to general population.[358]

SCDC described its Step-Down Program as including a wide array of classes, such as art and music, philosophy, creative writing, foreign languages, and some other life-skills programs, as well as anger management, managing anxiety and depression, and budgeting for individuals and families.[359] Upon graduation from the Step-Down Program, prisoners had restrictions on canteen, telephone, and visitation privileges lifted.[360] Further, prisoners were given the option of transferring to other programs within SCDC or remaining to become a facilitator for incoming prisoners in the Step-Down Program.[361]

In terms of program administration, decisions on prisoner movement through the steps were made by the SDP Review Team, which consisted of a Warden or his/her designee, the SDP unit manager, the SDP caseworker, and a mental health counselor.[362] SCDC reported that for prisoners who did not advance, the team informed them of what was required to do so.[363]

Further, if any prisoner was found to have committed a serious, major disciplinary infraction or refused to participate in any part of the program, that prisoner could be returned to the previous phase, as decided by the SDP Review Team. Consideration was given to time spent in restricted housing, the reason the prisoner was originally placed in restricted housing, the prisoner's mental health status, his/her risk level, his/her willingness to participate in the program, and the safety and security of staff and other prisoners.[364]

Issues of mental illness have been a part of the concerns of the SCDC, which on January 12, 2015, entered into a settlement with Protection and Advocacy for People with Disabilities, Inc., and agreed to improve conditions for mentally ill prisoners incarcerated at the SCDC.[365] In 2015, the Department agreed to seek $8.6 million in funding for three years to increase the number of mental health personnel and to improve facilities. Some planned facility improvements included adding a recreation yard to the Behavioral Management Unit, cordoning off a Crisis Intervention Unit for prisoners arriving with or developing a condition that warrants an immediate response, and adding cameras in cells for monitoring/surveillance.[366] The Department was also developing a program for screening and evaluating prisoners to identify those in need of mental health care, as well as a training curriculum that included crisis-intervention training for staff.[367]

The Step-Down Program operated in the context of the SCDC policies governing restricted housing. For example, prisoners classified as "Level 1" Substantiated Security Risk (SSR), who were permitted to exercise outside of cells five days a week, one hour per day,[368] were to be "restrained according to their status; and "strip-searched prior to being removed from their cell and at the conclusion of exercise," for most levels.[369] SCDC policy also encourages an "in-cell exercise program"—providing directions on forms of exercise inside cells and to be distributed to prisoners in any form of restricted housing.

Included in SCDC' 4.29.19 letter to LOC

6. Utah

Utah revised its rationale for restricted housing in 2016, according to the Director of the Division of Institutional Operations, Jerry Pope, who was charged by Executive Director Rollin Cook to oversee changes but, prior to the adoption of its 2016 policy, Director Pope described, restricted housing was a way to warehouse people whom the prison viewed as problems. In contrast, Utah has changed that approach to limit the reasons for placement in restricted housing and to develop a program for those placed in restricted housing to move back to the general population as soon as possible. As Director Pope explained, this new approach was "the right thing to do," especially because most people in restricted housing would eventually be released back into the community.[370]

The 2016 policy, promulgated in January,[371] was finalized after consultation with the American Civil Liberties Union of Utah (ACLU), the Disability Law Center of Utah, and Utah Prisoners Advocate Network.[372] The 2016 policy statement explained that its purpose was to provide the "procedure, rationale and guidelines for the management and operation of Restricted Housing," which was that "when circumstances make it necessary to place an inmate in Restricted Housing that a structured, progressive program be available that creates an opportunity for an inmate to progress out of Restricted Housing to general population within 12 months."[373]

The policy's "Vision Statement" described a commitment to "becoming industry leaders in restricted housing management" that fostered "positive change."[374] The "Mission Statement" explained that the "team will provide inmates with opportunities for education, mental health, programming, recreation, religious services, and visiting in a safe, secure, and cost-effective environment," that encouraged "transition to less restrictive housing through a structured and progressive program."[375] Director Pope reported that staff posted the Mission Statement and Vision Statement on placards in each unit in order to raise and maintain awareness about changes to restricted housing.[376]

Central to the new policy was an individualized review of decisions to move people in and out of restricted housing. This review also narrowed the criteria for placement in restricted housing. To do so, the 2016 policy created an "Objective Review Panel" to conduct an initial review of each individual placed in restricted housing.[377] Thereafter, a multi-disciplinary team (the Placement/Advancement Review Board) was to have a weekly review of each person placed in restricted housing to determine whether he or she met—and continued to meet—specified criteria for restricted housing.[378]

The Placement/Advancement Review Board was initially planned to include several correctional officials, including the Division Director, the Director of Inmate Placement Programs, wardens, deputy wardens, and captains from the Central Utah Correctional Facility and Utah State Prison, as well as a "qualified health professional," a representative of the ACLU, and a representative of the Utah Disability Law Center."[379] Thereafter, the staff determined that confidentiality concerns precluded the outside organizations from having relevant information, and decided instead to conduct an "annual policy review" with those organizations.[380]

Included in SCDC' 4.29.19 letter to LOC

The criteria for placement were revised to provide that the bases for placement in restricted housing included, but were not limited to, "Security Threat Group activity," "riot," "serious safety concerns," and "involvement in a serious threat to life, property, staff or to the orderly operation of a unit or facility."[381] The policy provided that if the Placement/Advancement Review Board deemed that an individual was inappropriately housed in restricted housing, the individual "shall be referred to his/her respective Offender Management Review for reassessment and proper housing."[382]

Further, under the 2016 policy, individuals placed in restricted housing were to have a mental health assessment within 72 hours, and receive a review by the Placement/Advancement Review Board within 10 days.[383] Further, if a prisoner was found to have a serious mental illness, that person "shall be moved to a mental health treatment unit."[384]

As Director Pope reported to us, Utah's first step was to complete an evaluation of every prisoner in restricted housing. After that review, the Department concluded that many individuals should be moved out or, for those with serious mental health needs, transferred to a mental health unit. As of the fall of 2016, implementation was underway to provide for what has come to be known as "ten and ten" in the mental health unit—10 hours of time out-of-cell for mental health treatment and an additional 10 hours out-of-cell per week for other activities.

In addition to reviewing why a person was initially placed in restricted housing, Utah's 2016 policy provided means, through its "Step-Up Tier Program," for people to leave restricted housing. As its title reflected, the policy was designed to return people to general population within one year; it also allowed for an earlier return if an individual successfully completed the steps earlier.[385]

Under this policy, a prisoner in restricted housing was to begin at Tier 1, with a "minimum of 5 hours out-of-cell each week," as well as "in-cell programming, in-cell education, volunteer work, . . . [and] individual mental health counseling."[386] Further, prisoners "on Tier 1 with little or no contact with other individuals" were to be "monitored daily by medical staff and at least once a week by mental health staff."[387]

After 45 days, a prisoner so confined could, after a review, be advanced to Tier 2, where he or she would become eligible for two-cell recreation at 5-10 hours per week, as well as work opportunities, "group education," and "group programming."[388] After another review at 120 days, a prisoner could advance to Tier 3, in which "quad cell recreation" is permitted out-of-cell for 10 to 14 hours per week.[389] Security desks were installed for education and group therapy, and recreation center enclosures were also added to allow more time out-of-cell.[390] The policy permitted visiting and phone privileges based on a reward system, and provided that all visits be conducted through a barrier.[391] After another 150 days, another review could make a prisoner eligible for a return to the general population.[392]

The 2016 policy also included a provision that prioritized staff working in Restricted Housing units for "Crisis Intervention Training."[393] Utah reported that all custody staff received two hours of in-service training on restricted housing.[394] In addition, Utah revised its data collection system to track information on restricted housing. Those changes were underway as of

Included in SCDC' 4.29.19 letter to LOC

this writing. The state's Research and Planning Bureau was identifying metrics based on the guiding principles of the new restricted housing policy in order to generate quarterly reports that would help determine the effectiveness of the restricted housing program and provide bases for modifying the program as well.[395]

Utah further explained that, had it answered the 2015 survey with data from the summer of 2016, its numbers would have been different. Rather than 14% of its population in restricted housing, 6% were in-cell for 22 hours or more (380 out of 6,112, of whom seven (1.6%) were women). Further, 268 people were in-cell for 20-21 hours, resulting in a total of 648 or 10.6% of the population confined in those settings.[396] In addition, Utah had detailed information on the demographics of the populations.[397] In short, as a result of these substantive policy changes, the number of prisoners in restricted housing dropped from 912 in the fall of 2015 to 380 in August, 2016, with another 268 prisoners in-cell for 20-21 hours.

VIII. Reflecting on Efforts to Reduce Time-In-Cell

In the course of conducting this research and writing this Report, correctional administrators repeatedly contacted us to discuss their efforts to reduce the numbers of persons confined in restricted housing. In addition, many Directors stressed the efforts to shift from the 22 or more hours in-cell model to forms of restrictions that provided more time out-of-cell. Indeed, as this Report was circulated in draft, system administrators sought us out to explain how the numbers detailed were out of date, for they had succeeded in reducing restricted housing prison populations from the levels described here.

These efforts reflect the profound shift that has occurred in the last few years, since ASCA and Liman began this series of research projects. While once restricted housing was seen as central to prison management, by 2016 many prison directors and organizations such as the ACA and ASCA had defined restricted housing as a practice to use as little as possible for as short a duration as possible. Moreover, the large numbers of people in restricted housing are enduring conditions that are harmful not only to them, but also to staff and the communities to which prisoners will return. Indeed, some prison administrators are "abolitionists," in the sense that they would—if they could—end solitary confinement and find methods to ensure that no person remain for more than 15 days in 22-in-cell hours continuously.

Yet, as the data in this Report reflect, unraveling the practices of isolation requires sustained work. This Report identified 67,442 prisoners in restricted housing and that number, as noted at the outset, excludes most jails in the United States. Some 5,909 prisoners in 32 jurisdictions have been kept in-cell for 22 hours a day or more for three years or more. Yet the Nelson Mandela Rules—formulated with input from U.S. correctional officials—call more than 15 days a form of prolonged isolation that should be understood as degrading and inhumane treatment.

Moreover, a question emerges about why 22 hours or more should be definitional of isolation. The question is whether a move to 21 (rather than 22) hours in-cell responds to alleviate the harms of isolation. Equally important is the length of time a person is subjected to isolating conditions, and how to assess the number of hours in-cell within the context of the

Included in SCDC' 4.29.19 letter to LOC

length of time confined in that manner. How many hours in continual confinement in a cell for how many days should be seen as impermissible? Moreover, prisoners may be held in their cells for days (if not 15 consecutive days) for 22 hours or more. Further, in many systems, the small amount of time out-of-cell that is permitted is spent in enclosed cubicles, sometimes without any natural light.

In short, neither a shift to 21 hours nor time out-of-cell in very tight spaces responds to the goals—expressed by ASCA, the ACA, among many others—of changing the conditions of confinement in significant ways. Thus, at its core, the issue is whether—as the proposed 2016 Senate solitary confinement reform legislation reflects—the isolation denoted by solitary confinement should be ended. Doing so would reflect that the *separation* of individuals to promote safety and well-being need not be accompanied by *deprivation* of all opportunities for social contact, education, programming, and other activities.

We return as we began—to the larger context. From the inception of this joint work by ASCA and Liman, we have always understood that isolation ought not itself be understood "in isolation." Restricted housing practices are on a continuum with the placement of prisons in rural settings, far from the homes of many of the prisoners and imposing difficulties in having both able staff and volunteers, as well as regular visits by family members.

As the nation revisits its decades of over-incarceration, it must address restricted housing in the context of prison policies and criminal justice practices in general. This Report makes plain that correctional leaders in many jurisdictions are reconsidering their own systems, and joining with prisoners, their families, advocates, and members of all branches of government, the academy, and many others—who are seeking to achieve lasting changes in the use of incarceration itself.

Included in SCDC' 4.29.19 letter to LOC

Endnotes

---

[1] Hope Metcalf, Jamelia Morgan, Samuel Oliker-Friedland, Judith Resnik, Julia Spiegel, Haran Tae, Alyssa Work & Brian Holbrook, *Administrative Segregation, Degrees of Isolation, and Incarceration: A National Overview of State and Federal Correctional Policies*, YALE LAW SCHOOL ARTHUR LIMAN PUBLIC INTEREST PROGRAM (June 2013) [hereinafter ASCA-Liman 2013 *Administrative Segregation Policies*], https://www.law.yale.edu/system/files/area/center/liman/document/Liman_overview_segregation_June_25_2013_TO_POST_FINAL(1).pdf.

[2] Sarah Baumgartel, Corey Guilmette, Johanna Kalb, Diana Li, Josh Nuni, Devon Porter & Judith Resnik, *Time-In-Cell: The ASCA-Liman 2014 National Survey of Administrative Segregation in Prison*, YALE LAW SCHOOL ARTHUR LIMAN PUBLIC INTEREST PROGRAM 54-57 (Aug. 2015) [hereinafter *Time-In-Cell*], https://www.law.yale.edu/system/files/documents/pdf/asca-liman_administrative_segregation_report_sep_2_2015.pdf.

[3] Daniel P. Mears, *Evaluating The Effectiveness of Supermax Prisons*, URBAN INSTITUTE (March 2006), http://www.urban.org/research/publication/evaluating-effectiveness-supermax-prisons; see also *Davis v. Ayala*, 135 S. Ct. 2187, 2210 (2015) (Kennedy, J., concurring).

[4] *Time-In-Cell*, *supra* note 2, at 3.

[5] *Id.* at 37-38.

[6] *Id.* at 39.

[7] *Id.* at 43-49.

[8] *Id.* at 44-46.

[9] *Id.* at 49.

[10] *Id.* at 29-30.

[11] The ASCA-Liman Report relied on answers from those who run prisons. In the fall of 2015, the Bureau of Justice Statistics (BJS) released a survey drawn from another source—prisoners. See Allen J. Beck, *Use of Restrictive Housing in U.S. Prisons and Jails, 2011-12*, BUREAU OF JUSTICE STATISTICS (Oct. 2015), http://www.bjs.gov/content/pub/pdf/urhuspj1112.pdf [hereinafter Beck, *Use of Restrictive Housing*]. Based on responses during 2011-2012 from 91,177 prisoners in 233 state and federal prisons and in 357 jails, BJS found that almost 20% of those prisoners and detainees had been held in restricted housing within the prior year. The individuals more likely to have been placed in restricted housing were younger, lesbian, gay, bisexual, or mentally ill, and without a high school diploma. The BJS study found that expansive use of restricted housing correlated with institutional disorder, such as gang activity and fighting, rather than with calmer environments. *Id.* at 1.

[12] *New Report on Prisoners in Administrative Segregation Prepared by the Association of State Correctional Administrators and the Arthur Liman Public Interest Program at Yale Law School*, ASSOCIATION OF STATE CORRECTIONAL ADMINISTRATORS (Sept. 2015), http://www.asca.net/system/assets/attachments/8895/ASCA%20LIMAN%20Press%20Release%208-28-15.pdf?1441222595.

Included in SCDC' 4.29.19 letter to LOC

[13] *Id.*

[14] *See, e.g.*, Jess Bravin, *Study Fuels Doubts Over Solitary Jailing,* WALL STREET JOURNAL, A3 (Sept. 3, 2015); Ray Hardman, *New Yale Survey Estimates Nearly 100,000 in Solitary Confinement in the U.S.*, WNPR (Sept. 2, 2015), http://wnpr.org/post/new-yale-survey-estimates-nearly-100000-solitary-confinement-us#stream/0; Timothy Williams, *Prison Officials Join Movement to Curb Solitary Confinement*, N.Y. TIMES (Sept. 2, 2015), http://www.nytimes.com/2015/09/03/us/prison-directors-group-calls-for-limiting-solitary-confinement.html; Dana Liebelson, *97 Percent of DC's Prisoners in One Type of Solitary Confinement are Black*, HUFFINGTON POST (Sept. 2, 2015), http://www.huffingtonpost.com/entry/solitary-confinement-prison-report_us_55e71effe4b0aec9f3556937; Tony Mauro, *Prison Officials Push to Reduce Number of Inmates in Isolation*, THE NATIONAL LAW JOURNAL (Sept. 2, 2015), http://www.nationallawjournal.com/id=1202736243843/Prison-Officials-Push-to-Reduce-Number-of-Inmates-in-Isolation?slreturn=20160924232512; Simon McCormack, *Even Prison Officials Want to Curb Solitary Confinement*, HUFFINGTON POST (Sept. 3, 2015), http://www.huffingtonpost.com/entry/prison-officials-solitary-confinement_us_55e8530ce4b0 c818f61ace30; Gregory Korte, *Obama Restricts Use of Solitary Confinement*, USA TODAY (Jan. 25, 2016), http://www.usatoday.com/story/news/politics/2016/01/25/obama-restricts-use-solitary-confinement/79327230/; Daniela Altimari, *Report: Fewer State Prisoners Held in Solitary Confinement*, HARTFORD COURANT (Sept. 4, 2015), http://www.courant.com/politics/hc-solitary-confinement-0905-20150904-story.html.

[15] *See Collection of Reactions to Time-In-Cell*, YALE LAW JOURNAL FORUM, Vol. 125 (Jan. 15, 2016). Essays include Reginald Dwayne Betts, *Only Once I Thought About Suicide*, http://www.yalelawjournal.org/forum/only-once-i-thought-about-suicide; Alex Kozinski, *Worse than Death,* http://www.yalelawjournal.org/forum/worse-than-death; Jules Lobel, *The Liman Report and Alternatives to Prolonged Solitary Confinement,* http://www.yalelawjournal.org/forum/alternatives-to-prolonged-solitary-confinement; Ashbel T. (A.T.) Wall, *Time-In-Cell: A Practitioner's Perspective*, http://www.yalelawjournal.org/forum/Time-In-Cell-a-practitioners-perspective; Marie Gottshalk, *Staying Alive: Reforming Solitary Confinement in U.S. Prisons and Jails*, http://www.yalelawjournal.org/forum/reforming-solitary-confinement-in-us-prisons-and-jails; and Judith Resnik, Sarah Baumgartel, and Johanna Kalb, *Time-In-Cell: Isolation and Incarceration*, http://www.yalelawjournal.org/forum/Time-In-Cell-isolation-and-incarceration.

[16] The four jurisdictions whose reports were limited in many areas were Arkansas, Nevada, Rhode Island, and West Virginia. Additional details are provided *infra* note 165.

[17] Unless otherwise indicated, data about jurisdictions came from jurisdictions' responses to the initial ASCA-Liman survey and follow-up questions. The initial report was circulated in the fall of 2015. States responded and provided follow-up information through the summer of 2016. All data reflects the prison population as of October 1, 2015 unless otherwise noted.

[18] *See infra* Section IV.A.

[19] *Id.*

[20] *See infra* Section IV.B.

[21] *Id.*

Included in SCDC' 4.29.19 letter to LOC

[22] A few jurisdictions did provide information on jail facilities. For example, the information from the District of Columbia exclusively concerns the municipal facility that it operated. As noted, Louisiana asked for inclusion of parish jail population numbers on some measures. *See infra* Section IV.A.

[23] Sallie Clark, *Five Voices on Reforming the Front End of Justice: Where the Buck—$93 Billion a Year—Stops*, MARSHALL PROJECT (July 18, 2016), https://www.themarshallproject.org/2016/07/17/five-voices-on-reforming-the-front-end-of-justice?utm_medium=email&utm_campaign=newsletter&utm_source=opening-statement&utm_term=newsletter-20160717-542#.LaAES0RVz. Clark wrote in her capacity as President of the National Association of Counties.

Jails also have restricted housing; the 2015 report by the Bureau of Justice Statistics, relying on surveys from more than 90,000 prisoners in 233 state and federal prisons and 357 jails, found that almost 20% of the respondents described being held in restricted housing within the year before the survey. *See* Beck, *Use of Restrictive Housing*, *supra* note 11, at 1.

[24] See *infra*, Section V.A and Chart 3.

[25] Peter Baker & Erica Goode, *Critics of Solitary Confinement Are Buoyed as Obama Embraces Their Cause*, N.Y. TIMES (July 21, 2015), http://www.nytimes.com/2015/07/22/us/politics/critics-of-solitary-confinement-buoyed-as-obama-embraces-cause.html?rref=collection%2Ftimestopic%2FSolitary%20 Confinement.

[26] DEPARTMENT OF JUSTICE, REPORT AND RECOMMENDATIONS CONCERNING THE USE OF RESTRICTIVE HOUSING (Jan. 2016) [hereinafter DOJ RESTRICTIVE HOUSING 2016 REPORT], https://www.justice.gov/dag/file/815551/download. That work relied for some aspects of its discussion on data from the ASCA-Liman Report, *Time-In-Cell*.

[27] Barack Obama, *Why We Must Rethink Solitary Confinement*, WASH. POST (Jan. 25, 2016), https://www.washingtonpost.com/opinions/barack-obama-why-we-must-rethink-solitary-confinement/2016.

01/25/29a361f2-c384-11e5-8965-0607e0e265ce_story.html.

[28] DOJ RESTRICTIVE HOUSING 2016 REPORT, *supra* note 26, at 114.

[29] *Id*. at 99-102.

[30] *Id*. at 109-10.

[31] *Id*. at 94.

[32] *Id*. at 95.

[33] *Id*.

[34] *Id.* at 95.

[35] *Id*. at 116.

[36] *Id.* at 117.

Included in SCDC' 4.29.19 letter to LOC

[37] Presidential Memorandum on Limiting the Use of Restrictive Housing by the Federal Government from President Barack Obama to the Heads of Executive Departments and Agencies (Mar. 1, 2016) [hereinafter Presidential 2016 Memorandum on Limiting Restrictive Housing], https://www.whitehouse.gov/the-press-office/2016/03/01/presidential-memorandum-limiting-use-restrictive-housing-federal.

[38] *Id.*

[39] Gary Mohr & Rick Raemisch, *Restrictive Housing: Taking the Lead*, 77 CORRECTIONS TODAY (Mar. 2015), ttp://www.aca.org/aca_prod_imis/Docs/Corrections%20Today/2015%20Articles/March%202015/Guest%20Editorial.pdf. Other correctional leaders shared this concern. *See, e.g.,* Jeri Zeder, *Thinking Outside the Box*: *How a prison manager changed his mind about solitary confinement*. NORTHEASTERN LAW MAGAZINE (Summer 2016).

[40] Mohr & Raemisch, *Restrictive Housing: Taking the Lead*, *supra* note 39, at 2.

[41] *New Standard 7*, in ACA RESTRICTIVE HOUSING PROPOSED STANDARDS, AMERICAN CORRECTIONAL ASSOCIATION (Approved Aug. 2016), http://online.wsj.com/public/resources/documents/Restrictive_housing.pdf.

[42] *Id.*, *New Standard 5*.

[43] *Id.*, *New Standard 6*.

[44] *ACA Restrictive Housing Standard 4-4250 & 4-4253*, STANDARDS FOR ADULT CORRECTIONAL INSTITUTIONS, AMERICAN CORRECTIONAL ASSOCIATION (4th ed. 2003).

[45] ACA RESTRICTIVE HOUSING PROPOSED STANDARDS, *supra* note 41, *New Standard 2*.

[46] *Id.*, *New Standard 1*.

[47] *Restrictive Housing Standards Open Hearing*, AMERICAN CORRECTIONAL ASSOCIATION (Jan. 19, 2016), http://online.wsj.com/public/resources/documents/Restrictive_housing.pdf. Individuals and organizations providing comments included the Liman Program, the American Civil Liberties Union, and law professors; these statements commended the work that has been done and called for more specificity. See Letter from American Civil Liberties Union to American Correctional Association Standards Committee (Jan. 15, 2016), http://online.wsj.com/public/resources/documents/Restrictive_housing.pdf; Letter from Judith Resnik, Sarah Baumgartel & Johanna Kalb, Arthur Liman Public Interest Program, Yale Law School, to American Correctional Association Standards Committee (Jan. 19, 2016), https://www.law.yale.edu/system/files/area/center/liman/liman_comments_on_aca_restrictive_housing_standards_jan_19_2016_final.pdf; Letter from Margo Schlanger, Professor, University of Michigan, on behalf of Law Professors, to American Correctional Association Standards Committee (Jan. 15, 2016), http://online.wsj.com/public/resources/documents/Restrictive_housing.pdf. In addition, several people spoke at the hearing, including Sarah Baumgartel and Judith Resnik, on behalf of the Liman Program.

[48] ACA RESTRICTIVE HOUSING STANDARDS, AMERICAN CORRECTIONAL ASSOCIATION (Approved Aug. 2016), ttp://www.aca.org/ACA_Prod_IMIS/ACA_Member/Standards___Accreditation/Standards/Restrictive_Housing_Committee/ACA_Member/Standards_and_Accreditation/Restrictive_Housing_Committee/Restrictive_Housing_Committee.aspx?hkey=458418a3-8c6c-48bb-93e2-b1fcbca482a2 [Hereinafter ACA Restrictive Housing Standards 2016.]

Included in SCDC' 4.29.19 letter to LOC

[49] *Id.*, ACA Restrictive Housing Standards 2016, 4-RH-0035; *id.*, ACA Restrictive Housing Standards 2016, 4-ALDF-RH-027.

[50] *Id.,* ACA Restrictive Housing Standards 2016, 4-RH-0033; *id.*, ACA Restrictive Housing Standards 2016, 4-ALDF-RH-024.

[51] *Id.*, ACA Restrictive Housing Standards 2016, 4-RH-0034; *id.*, ACA Restrictive Housing Standards 2016, 4-ALDF-RH-025.

[52] *Id.*, ACA Restrictive Housing Standards 2016, 4-RH-0031; *id.*, ACA Restrictive Housing Standards 2016, 4-ALDF-RH-028. Extended Restrictive Housing was defined as "[h]ousing that separates the offender from contact with general population while restricting an offender/inmate to his/her cell for at least 22 hours per day and for more than 30 days for the safe and secure operation of the facility." *Id.* at 3. Serious Mental Illness was defined as "Psychotic Disorders, Bipolar Disorders, and Major Depressive Disorder; any diagnosed mental disorder (excluding substance use disorders) currently associated with serious impairment in psychological, cognitive, or behavioral functioning that substantially interferes with the person's ability to meet the ordinary demands of living and requires an individualized treatment plan by a qualified mental health professional(s)" *Id.* Additional discussion of the 2016 ACA Restrictive Housing Standards related to mental illness is provided below. See *infra* note 55.

[53] Removal from general population "will be approved, denied, or modified within 24 hours by an appropriate and higher authority who is not involved in the initial placement." *Id.*, ACA Restrictive Housing Standards 2016, 4-RH-0002; *Id.*, ACA Restrictive Housing Standards 2016, 4-ALDF-RH-002.

[54] "The purpose for placement of inmates in Restrictive Housing is reviewed by a supervisor every seven days for the first 60 days and at least every 30 days thereafter." *Id.*, ACA Restrictive Housing Standards 2016, 4-ALDF-RH-004.

[55] The amended standards now recommend that prisoners be evaluated by a mental health care professional at least every 30 days, considerably increasing the frequency of mental health assessments from the previous policy, which only provided for an evaluation once every three months. *Id.*, ACA Restrictive Housing Standards 2016, 4-RH-0010. The amended standards also called for all prisoners in restricted housing to be visited by mental health staff weekly and by health care personnel daily. *Id.*, ACA Restrictive Housing Standards 2016, 4-RH-0012; *Id.* ACA Restrictive Housing Standards 2016, 4-ALDF-RH-0029.

[56] *Id.*, ACA Restrictive Housing Standards 2016, 4-RH-0013.

[57] *Id.*, ACA Restrictive Housing Standards 2016, 4-RH-0004. Further, Standard 4-RH-0006 detailed that cells should measure at least 80 square feet. Additionally, Standard 4-RH-0005 states that restrictive housing units should provide outdoor exercise areas. *Id.*

[58] The new standards recommend that prisoners be offered step-down programs, including opportunities for increasing out-of-cell time, group interaction, and programming opportunities in order "to facilitate the reintegration of the inmate into general population or the community." *Id.*, ACA Restrictive Housing Standards 2016, 4-RH-0032. The ACA also now recommends that detention facilities "attempt to ensure offenders are not released directly into the community from Restrictive Housing" and take precautions

Included in SCDC' 4.29.19 letter to LOC

when direct release is imminent, including developing an individualized "release plan" and notifying local law enforcement. *Id.*, ACA Restrictive Housing Standards 2016, 4-RH-0030.

[59] *Restrictive Status Housing Policy Guidelines*, ASSOCIATION OF STATE CORRECTIONAL ADMINISTRATORS (Aug. 9, 2013), http://www.asca.net/system/assets/attachments/6145/B.%20ASCA%20Restrictive%20Status%20Housing%20Policy%20Guidelines-Final%2008092013.pdf. The thirteen guidelines, endorsed August 9, 2013, can also be found in the Liman volume, *Isolation and Reintegration: Punishment Circa 2014*, YALE LAW SCHOOL ARTHUR LIMAN PUBLIC INTEREST PROGRAM 88 (Jan. 6, 2015), https://www.law.yale.edu/system/files/area/center/liman/document/Liman_Colloquium_2014_Isolation_and_Reintegration_Punishment_Circa_2014_revised_Jan_8_2015.pdf.

[60] *Agencies' Top Five Critical Issues, 2014*, ASSOCIATION OF STATE CORRECTIONAL ADMINISTRATORS (June 2014), http://www.asca.net/system/assets/attachments/7363/ASCA-Critical%20issues-6-14-2014%20V4.pdf.

[61] *See* Brief of Amici Curiae Corrections Experts in Support of Petitioner at 6-7, *Prieto v. Clarke*, 136 S. Ct. 319 (2015) (No. 15-21). The group included Reginald A. Wilkinson, the former director of Ohio's Department of Rehabilitation and Corrections and of both ASCA and the American Correctional Association.

[62] *Prieto v. Clarke*, 780 F.3d 245 (4th Cir. 2015), *cert. denied*, 136 S. Ct. 319 (2015).

[63] *See* Brief of Amici Curiae Professors and Practitioners of Psychiatry and Psychology in Support of the Petitioner at 3, *Prieto v. Clarke*, 136 S. Ct. 319 (2015) (No. 15-21).

[64] *See, e.g.*, Cyrus Ahalt & Brie Williams, *Reforming Solitary-Confinement Policy—Heeding a Presidential Call to Action*, 374 NEW ENG. J. MED. 1704 (2016). A recent review of two meta-analyses of various studies challenged the view that isolation has been demonstrated to be especially harmful. Robert D. Morgan, Paul Gendreau, Paula Smith, Andrew L. Gray, Ryan M. Labrecque, Nana MacLean, Stephanie A. Van Horn, Angelea D. Bolanos, Ashley B. Batastini & Jeremy Mills, *Quantitative Syntheses of the Effects of Administrative Segregation on Inmates' Well-Being*, 22 PSYCHOLOGY, PUBLIC POLICY, AND LAW, 439 (2016), http://dx.doi.org/10.1037/law0000089. That paper argued that its review of several studies of administrative segregation (defined as 23 hours or more in a cell but without a duration specified) did not produce solid evidence of that population suffering "lasting emotional damage." Rather, the analysis argued that the population was as harmed as were prisoners held in "routine incarceration." *Id.* The paper argued that a lack of data on prisoners in general and on individuals' mental and physical health before incarceration, as well as questions about how to measure over-reporting and under-reporting of injuries, hampered the ability to identify particular harms (if imposed) by restricted housing. *Id.*

[65] Andrea D. Lyon & Mark D. Cunningham, *"Reason Not the Need": Does the Lack of Compelling State Interest in Maintaining a Separate Death Row Make It Unlawful?*, 33 AM. J. CRIM. L. 1, 4-5 (2005); *see also* Mark D. Cunningham, Thomas J. Reidy & Jon R. Sorensen, *Wasted Resources and Gratuitous Suffering: The Failure of a Security Rationale for Death Row*, 22 PSYCHOL. PUB. POL'Y & L. 185 (2016); Marah Stith McLeod, *Does the Death Penalty Require Death Row? The Harm of Legislative Silence*, 77 OHIO STATE L.J. 525 (2016). See also Celina Aldape, Ryan Cooper, Katie Haas, April Hu, Jessica Hunter, Johanna Kalb, Shelle Shimizu & Judith Resnik, *Rethinking "Death Row": Variations in the Housing of Individuals Sentenced to Death*, YALE LAW SCHOOL ARTHUR LIMAN PUBLIC INTEREST PROGRAM (July 2016). That report discussed the experiences in three jurisdictions where individuals

Included in SCDC' 4.29.19 letter to LOC

sentenced to death row were not housed in isolation but placed either in a separated but shared area with others who had capital sentences or with other prisoners.

[66] *See, e.g*, Burke Butler, Matthew Simpson & Rebecca L. Robertson, *A Solitary Failure: The Waste, Cost and Harm of Solitary Confinement*, ACLU of TEX. (2015), http://www.aclutx.org/2015/02/05/a-solitary-failure; *Boxed In: The True Cost of Extreme Isolation in New York's Prisons*, N.Y. CIVIL LIBERTIES UNION (2012), http://www.nyclu.org/files/publications/nyclu_boxedin_final.pdf.

[67] Joseph Shapiro & Christine Thompson, *The Deadly Consequences of Solitary with a Cellmate,* THE MARSHALL PROJECT (March 24, 2016), https://www.themarshallproject.org/2016/03/24/the-deadly-consequences-of-solitary-with-a-cellmate#; Joseph Shapiro & Christine Thompson, *Doubling Up Prisoners in 'Solitary' Creates Deadly Consequences*, NATIONAL PUBLIC RADIO (March 24, 2016), http://www.npr.org/2016/03/24/470824303/doubling-up-prisoners-in-solitary-creates-deadly-consequences.

[68] *See* Martin Horn & Ann Jacobs, *Solitary Confinement: Report on a Colloquium to Further a National Consensus on Ending the Over-Use of Extreme Isolation in Prisons*, JOHN JAY COLLEGE OF CRIM. JUSTICE (2016) [hereinafter "*Solitary Confinement Report 2016*"].

[69] *Id.* at 1.

[70] *Id.* at 30-33.

[71] S.B. 51, 217th Leg. Sess. (N.J. 2016), "An Act concerning restrictions on isolated confinement in correctional facilities and supplementing Title 30 of the Revised Statutes," § (4) (a) (9). The limit on isolated confinement to no more than 15 consecutive days, and to no more than 20 days during any 60-day period, does not apply during a facility-wide lock down. *Id*.

[72] *Id*. at § 3.

[73] *Id*. at §§ 3, 4b.

[74] H.B. 5417, 99th G.A. (Ill. 2016). The proposed bill would limit solitary confinement to no more than five consecutive days and five total days during a 150-day period. The bill was introduced on February 9, 2016 and, as of October 2016, remained pending.

[75] S. 1255, 189th Gen. Ct. (Mass. 2015). The bill was introduced on April 15, 2015 and accompanied a study order in the Senate on June 23, 2016, when it was replaced by S.2362, which remained pending as of October 2016.

[76] H.B. 7481, Jan. 2016 Leg. Sess. (R.I. 2016). The bill would limit solitary confinement to no more than 15 consecutive days, with no more than 20 days within a 60-day period. The bill was introduced on February 5, 2016 and remained pending as of October 2016.

[77] Order Granting Final Approval of Class Action Settlement Agreement, Ashker v. Governor of California, No. C09-05796 CW (N.D. Cal. Jan. 26, 2016), ECF No. 488. http://www.clearinghouse.net/chDocs/public/PC-CA-0054-9001.pdf. The settlement imposed limits on the amount of time that prisoners may be confined in the Security Housing Unit at Pelican Bay State Prison, one of the state's maximum security prisons; provided for review of prisoners then in security housing units on the basis of gang affiliation within 12 months of the settlement agreement; and set forth

Included in SCDC' 4.29.19 letter to LOC

a presumption that all prisoners detained in Security Housing Units for more than 10 years would be moved into the general population. *See also* Ian Lovett, *California Agrees To Overhaul Use of Solitary Confinement*, N.Y. TIMES (Sept. 1, 2015), http://www.nytimes.com/2015/09/02/us/solitary-confinement-california-prisons.html.

[78] Indiana Prot. & Advocacy Servs. Comm'n v. Comm'r, Indiana Dep't of Correction, No. 1:08-CV-01317-RLYJMS, (S.D. Ind. Mar. 24, 2016), ECF No. 508; Stipulation To Enter into Private Settlement Agreement Following Notice to the Class and Fairness Hearing, Indiana Prot. & Advocacy Servs. Comm'n v. Comm'r, Indiana Dep't of Correction, No. 1:08-CV-01317-RLYJMS (S.D. Ind. Jan. 27, 2016), ECF No. 496. The agreement prohibited, with some exceptions, the placement of mentally ill prisoners in restricted housing and provided standards for the minimum adequate treatment of those prisoners, including provision of recreation, showers, additional out-of-cell time, and therapeutic programming.

[79] Opinion and Order, *Peoples v. Anthony Annucci*, No. 11-cv-2694 SAS (S.D.N.Y. Mar. 31, 2016), ECF No. 329. The court wrote, "Solitary confinement is a drastic and punitive designation, one that should be used only as a last resort and for the shortest possible time to serve the penal purposes for which it is designed." The Settlement Agreement included reforms to limit the frequency and duration of solitary confinement, including a detailed modification of the Department's guidelines for restricted housing sentencing aimed at limiting the length of restricted housing sentences, alternatives to restricted housing programs designed to address causes of disciplinary issues, and increased opportunities for prisoners to earn sentence reductions and lesser restricted housing sanctions.

The settlement also provided greater protections for vulnerable populations such as prisoners with special needs, juvenile prisoners, and prisoners in need of substance abuse treatment, while continuing a "presumption against restricted housing for pregnant inmates." The settlement also mandated improvements to the conditions of confinement in restricted housing, including the abolishment of the "loaf," a food product previously served to those in solitary; increased movement privileges based on good behavior; increased phone privileges; improved library services; access to correspondence courses and radio programing; and increased access to mental health consultations and treatment.

[80] Doris J. James & Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates*, BUREAU OF JUSTICE STATISTICS (2006), http://www.bjs.gov/content/pub/pdf/mhppji.pdf.

[81] *See, e.g.*, Ahalt & Williams, *supra* note 64; Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax" Confinement*, 49 CRIME & DELINQUENCY 124, 130 (2003); Craig Haney, *The Social Psychology of Isolation: Why Solitary Confinement Is Psychologically Harmful*, 181 PRISON SERVICE JOURNAL 12 (2009); Arthur J. Lurigio, Craig Haney, Joanna Weill, Shirin Bakhshay & Tiffany Lockett, *Examining Jail Isolation: What We Don't Know Can Be Profoundly Harmful*, 96 PRISON JOURNAL 126 (Jan. 2016); *see also Callous and Cruel: Use of Force Against Inmates with Mental Disabilities in US Jails and Prisons*, HUMAN RIGHTS WATCH (May 12, 2015), https://www.hrw.org/report/2015/05/12/callous-and-cruel/use-force-against-inmates-mental-disabilities-us-jails-and.

[82] "Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates. If an inmate with serious mental illness is placed in segregation, out-of-cell structured therapeutic activities (i.e., mental health/psychiatric treatment) in appropriate programming space and adequate unstructured out-of-cell time should be permitted. Correctional mental health authorities should work closely with administrative custody staff to maximize

Included in SCDC' 4.29.19 letter to LOC

access to clinically indicated programming and recreation for these individuals." *Position Statement on Segregation of Prisoners with Mental Illness*, AMERICAN PSYCHIATRIC ASSOCIATION (Dec. 2012), http://www.dhcs.ca.gov/services/MH/Documents/2013_04_AC_06c_APA_ps2012_PrizSeg.pdf. *See also Solitary Confinement (Isolation)*, NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE (Apr. 2016) [hereinafter NCCHC, *Solitary Confinement*] (stating that it is "well established that persons with mental illness are particularly vulnerable to the harms of solitary confinement" and that "[j]uveniles, mentally ill individuals, and pregnant women should be excluded from solitary confinement of any duration").

[83] *See Solitary Confinement as a Public Health Issue*, AMERICAN PUBLIC HEALTH ASSOCIATION, https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/14/13/30/solitary-confinement-as-a-public-health-issue; *see also* Psychiatric Services in Correctional Facilities, 3d ed. 2016, https://www.appi.org/Psychiatric_Services_in_Correctional_Facilities_Third_Edition.

[84] *See* NCCHC, *Solitary Confinement*, *supra* note 82.

[85] *See, e.g.*, MASS. GEN. LAWS ch. 127, § 39A(b) (2015) (requiring the Department of Corrections to screen for mental illness and prohibiting the segregation of an individual diagnosed with a serious mental illness for more than 30 days absent exigent circumstances).

[86] *See, e.g.*, Stipulation, *Peoples v. Fischer*, No. 11-CV-2694 (S.D.N.Y. Feb. 19, 2014), ECF No. 124, at 3-4 § 2(C)(1) (providing that cognitively impaired individuals were not to be put in isolation); *Parsons v. Ryan*, 754 F.3d 657, 690 (9th Cir. 2014) (affirming the district court's order that the Arizona Department of Corrections be required to develop and implement a plan to remedy, among other things, its constitutionally deficient solitary confinement policy governing prisoners with serious mental illness). The revised ADC policy required that prisoners with mental illness had a minimum of 19 hours a week outside the cell, and this time was to include mental health treatment and other programming. Stipulation, *Parsons v. Ryan*, No. 12-00601-PHXDJH (D. Ariz. Oct. 14, 2014), ECF No. 1185; *see also Arizona Agrees to Major Improvements in Health Care, Crucial Limits on Solitary Confinement in Landmark Settlement*, AMERICAN CIVIL LIBERTIES UNION (Oct. 14, 2014), https://www.aclu.org/news/arizona-agrees-major-improvements-prison-health-care-crucial-limits-solitary-confinement.

In January of 2016 the Indiana Department of Corrections announced a settlement with the ACLU regarding the treatment of mentally ill individuals; included was a prohibition on the use of solitary confinement for people with mental illness. The settlement came in response to an order from the U.S. District Court for the Southern District of Indiana to create a policy to improve conditions for mentally ill individuals. Stipulation, *Indiana Prot. & Advocacy Servs. Comm'n v. Comm'r, Indiana Dep't of Correction*, No. 1:08-CV-01317-TWP, (S.D. Ind. Dec. 31, 2012), ECF No. 496.

[87] *Memorandum of Understanding Between the Oregon Department of Corrections and Disability Rights Oregon*, OREGON DEPARTMENT OF CORRECTIONS (2016), http://media.oregonlive.com/pacific-northwest-news/other/DRO-DOC-MOU-2016.pdf.

[88] *JH v. Dallas*, No. 1:15-cv-02057-SHR (M.D. Pa. Oct. 2016).

[89] *Pennsylvania Corrections Department Reaches Milestone in Crisis Intervention Team Training*, PENNSYLVANIA DEPARTMENT OF CORRECTIONS (May 02, 2016), http://www.prnewswire.com/news-releases/pennsylvania-corrections-department-reaches-milestone-in-crisis-intervention-team-training-300260260.html. *See also* Settlement Agreement, *Disability Rights Network of Pennsylvania v. Wetzel*, No. 1:13-CV-00635-JEJ (M.D. Pa. Jan. 9, 2015), ECF No. 59.

Included in SCDC' 4.29.19 letter to LOC

In New Mexico, a previously incarcerated man suffering from bipolar disorder reached a settlement of $750,000 with a county facility that, he alleged, had denied him medication and neglected him when he was placed in solitary confinement. *See* Stipulated Order Granting Unopposed Motion to Dismiss All Claims With Prejudice, *Faziani v. Sierra County Board of County Commissioners*, No. 1:2014cv00592 (D.N.M. Dec. 2015), ECF No. 122; Dan Schwartz, *$750K Settlement Reached in Solitary Confinement Suit*, SANTA FE NEW MEXICAN (Dec. 23, 2015), http://www.santafenewmexican.com/news/local_news/k-settlement-reached-in-solitary-confinement-suit/article_67a5526e-a992-11e5-8656-0f0b225140de.html.

[90] *See Model Juvenile Justice Stop Solitary Act*, AMERICAN CIVIL LIBERTIES UNION, https://www.aclu.org/files/assets/6%20Model%20Juvenile%20Justice%20Stop%20Solitary%20Act.pdf; *see also* Mikah Owen & Jeffrey Goldhagen, *Children and Solitary Confinement: A Call to Action*, 137 PEDIATRICS (Apr. 5, 2016).

[91] An Act Concerning the Use of Seclusion on Individuals, H.B. 16-1328 (Colo. May 2016).

[92] An Act To Add Section 208.3 to the Welfare and Institutions Code, Relating to Juveniles, S.B. 1143, (Cal. Mar. 29, 2016, enacted August 25, 2016 and signed by the Governor September 27, 2016), http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB1143.

[93] *Statement of Proceedings*, LOS ANGELES BOARD OF SUPERVISORS (May 03, 2016), http://file.lacounty.gov/bos/sop/cms1_243824.pdf.

[94] S. 2123, 114th Cong. § 212 (2015).

[95] *Justice Department Settles Lawsuit Against State of Ohio To End Unlawful Seclusion of Youth in Juvenile Correctional Facilities*, U.S. DEPARTMENT OF JUSTICE (May 21, 2014), https://www.justice.gov/opa/pr/justice-department-settles-lawsuit-against-state-ohio-end-unlawful-seclusion-youth-juvenile.

[96] A group of detainees filed a class action against New York City alleging a "pattern of brutality" at Rikers Island. Amended Complaint at 2, *Nunez v. City of New York*, No. 11-cv-5845 (S.D.N.Y. May 24, 2012). In December 2014, the U.S. Attorney for the Southern District of New York intervened in the class action. United States' Proposed Complaint-in-Intervention, *Nunez v. City of New York*, No. 11-cv-5845 (S.D.N.Y. Dec. 18, 2014).

In October of 2015, the parties entered into a consent decree which had included a prohibition on solitary confinement for people under the age of 18 and restrictions on the use of solitary confinement for 18-year-olds; the consent judgment did not include a ban on solitary confinement for people ages 21 and under. Consent Judgment at 44, *Nunez v. City of New York*, No. 11-cv-5845 (S.D.N.Y. Oct. 21, 2015).

In January 2015, New York City's mayor announced a plan to end—by January of 2016—the use of solitary confinement for people ages 21 and younger. *See* Michael Winerip & Michael Schwirtz, *Rikers to Ban Isolation for Inmates 21 and Younger*, N.Y. TIMES (Jan. 13, 2015), http://www.nytimes.com/2015/01/14/nyregion/new-york-city-to-end-solitary-confinement-for-inmates-21-and-under-at-rikers.html. However, in July 2016, the *New York Times* reported that the New York City Department of Correction continued to hold 21-year-olds in solitary confinement. Michael Winerip & Michael Schwirtz, *"Time in the Box": Young Rikers Inmates, Still in Isolation*, N. Y. TIMES (July 8, 2016), http://www.nytimes.com/2016/07/08/nyregion/rikers-island-solitary-confinement.html.

Included in SCDC' 4.29.19 letter to LOC

[97] NATIONAL INSTITUTE OF JUSTICE, *Restrictive Housing in the U.S.: Issues, Challenges, and Future Directions* (2016), https://www.ncjrs.gov/pdffiles1/nij/250315.pdf*; Projects Funded Under Fiscal Year 2016 Solicitations.* NATIONAL INSTITUTE OF JUSTICE (September, 2016), http://www.nij.gov/funding/awards/Pages/2016.aspx#.

[98] *Id*.

[99] *Justice Department Awards Over $6.3 Million to Study Effects of Incarceration,* DEPARTMENT OF JUSTICE, OFFICE OF JUSTICE PROGRAMS, OFFICE OF COMMUNICATIONS (September 26, 2016), http://ojp.gov/newsroom/pressreleases/2016/ojp09262016_2.pdf.

[100] Solitary Confinement Reform Act, S.3432, 114th Cong. (2d Sess. 2016) [hereinafter SCRA 2016].

[101] SCRA 2016, S.3432, § 2(b)(1)(A)

[102] SCRA 2016, S.3432, § 2(b)(4)(A)

[103] SCRA 2016, S.3432, § 2(b)(4)(B)

[104] *Id.*

[105] *Id.*

[106] SCRA 2016, S.3432, § 2(b)(1)(A)(i)-(ii); S.3432(b)(4)(A)(i)-(ii)

[107] SCRA 2016, S.3432, § 2(b)(4)(C)

[108] SCRA 2016, S.3432, § 2(b)(5)(A)(ii)(I)-(II)

[109] SCRA 2016, S.3432, § 2(b)(1)(C)

[110] SCRA 2016, S.3432, § 2(b)(5)(C)-(D)

[111] SCRA 2016, S.3432, § 2(b)(8)(B)(i)-(iii)

[112] SCRA 2016, S.3432, § 2(e)(1)

[113] SCRA 2016, S.3432, § 2(e)(6)

[114] SCRA 2016, S.3432, § 2(e)(8)

[115] SCRA 2016, S.3432, § 2(e)(3)

[116] SCRA 2016, S.3432, § 2(e)(3)(A)-(B)

[117] SCRA 2016, S.3432, § 2(e)(7)(A)-(B)

[118] SCRA 2016, S.3432, § 5(d)(2)

[119] SCRA 2016, S.3432, § 6(b)

Included in SCDC' 4.29.19 letter to LOC

[120] *Solitary Confinement Report* 2016, JOHN JAY COLLEGE OF CRIM. JUSTICE, *supra* note 68.

[121] United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules), U.N. ESC Committee on Crime Prevention and Criminal Justice, 24th Sess., U.N. Doc. E/CN.15/2015/L.6/Rev.1 (May 22, 2015) [hereinafter Nelson Mandela Rules], http://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6_Rev1/ECN152015_L6Rev1_e_V1503585.pdf; *see also General Assembly Adopts 64 Third Committee Texts Covering Issues Including Migrants, Children's Rights, Human Rights Defenders*, UNITED NATIONS (Dec. 17, 2015), http://www.un.org/press/en/2015/ga11745.doc.htm.

[122] Nelson Mandela Rules, *supra* note 121 (Rule 44).

[123] *Id.* (Rule 45(1)).

[124] *Id.*

[125] *Id.* (Rule 43(1)).

[126] *Id.* (Rule 45(2)).

[127] *Factsheet on Detention Conditions and Treatment of Prisoners*, EUROPEAN COURT OF HUMAN RIGHTS (Apr. 2016), http://www.echr.coe.int/Documents/FS_Detention_conditions_ENG.pdf.

[128] Convention for the Protection of Human Rights and Fundamental Freedoms, Nov. 4, 1950, 213 U.N.T.S. 221 (entered into force Sept. 3, 1953).

[129] *Öcalan v. Turkey* (No. 2), App. No. 462221/99, Eur. Ct. H.R. (2005).

[130] *Breivik v. Ministry of Justice*, Oslo District Court (Nor.), No. 15-107496TVl-OTIR/02 (Apr. 20, 2016) (appeal pending), https://www.domstol.no/contentassets/cd518ea4a48d4f8fa2173db1b7a4bd20/dom-i-saken-om-soningsforhold---15-107496tvi-otir---abb---staten-eng.pdf.

Other national initiatives included the proposal by the Prime Minister of Canada to implement a series of recommendations banning solitary confinement for prisoners in federal detention. *See Trudeau Calls for Ban on Long-Term Solitary Confinement in Federal Prisons*, GLOBE & MAIL (Nov. 15, 2015), http://www.theglobeandmail.com/news/national/trudeau-calls-for-implementation-of-ashley-smith-inquest-recommendations/article27256251.

[131] Sharon Shalev, *A Sourcebook on Solitary Confinement*, MANNHEIM CENTRE FOR CRIMINOLOGY, LONDON SCHOOL OF ECONOMICS (2008), www.solitaryconfinement.org/sourcebook.

[132] Juan E. Méndez, *Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment* (Aug. 2011), http://solitaryconfinement.org/uploads/SpecRapTortureAug2011.pdf.

[133] Sharon Shalev & Kimmett Edgar, *Deep Custody: Segregation Units and Close Supervision Centres in England and Wales*, PRISON REFORM TRUST (Oct. 2015), http://solitaryconfinement.org/uploads/DeepCustodyShalevAndEdgar.pdf

Included in SCDC' 4.29.19 letter to LOC

[134] *Seeing into Solitary: Review of the Laws and Policies of Certain Nations around the World with Regard to Solitary Confinement of Detainees* (2016), on behalf of Professor Juan E. Méndez, United Nations Special Rapporteur on Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment; in collaboration with Weil Gotshal & Manges LLP, the Cyrus R. Vance Center for International Justice, and the American University Washington College of Law Center for Human Rights & Humanitarian Law's Anti-Torture Initiative, http://www.weil.com/~/media/files/pdfs/2016/un_special_report_solitary_confinement.pdf. [hereinafter *Seeing into Solitary* (2016)].

[135] *Id*. at 21.

[136] *Id*.

[137] *Id*.

[138] *Id*. at 22.

[139] *Id*. at 22.

[140] *Id*.

[141] *Id*.

[142] *See* Leann K. Bertsch, *The History of Restricted Housing at the ND-DOCR* (Mar. 15, 2016) (unpublished manuscript).

[143] In the original distribution of the survey, the only territory included was the District of Columbia. When we presented a draft of the report at the 2016 ASCA summer meeting, the Virgin Islands requested to participate. We then sent questionnaires to Guam and Puerto Rico, which are the other territories that are members of ASCA; these jurisdictions did not respond.

[144] *See* Appendix A, ASCA-Liman Survey of Extended Restricted Housing (Fall 2015).

[145] For example, seven jurisdictions (Alabama, Arizona, Idaho, Kentucky, Massachusetts, Montana, and Vermont) told us that, while they tracked whether prisoners were held in a cell for 22 hours per day or more, they did not track the numbers of days for which a person was held under those conditions. Vermont indicated that the changes to its database system made it difficult to retrieve this data but that moving forward, it will be able to determine the length of days in-cell that average 22 hours per day.

In five of these seven (Alabama, Idaho, Kentucky, Montana, and Vermont), we included responses with the caveat that numbers from these jurisdictions may include prisoners who were in-cell for 22 or more hours a day but for less than 15 days. Responses from Arizona and Massachusetts to questions about prisoners' length of stay enabled us to derive the number of individuals falling within the 22-hour/15-day definition.

[146] For example, California reported that most of its segregated environments permitted prisoners at least 10 hours per week out-of-cell and distributed those 10 hours throughout the week such that several days a week, prisoners were allowed more than three hours out-of-cell at a time. Therefore, on some days, these prisoners were in-cell for less than 22 hours. California did not include prisoners in these units when tallying the number in the category of 22 hours or more for 15 or more consecutive days. After exchanges

Included in SCDC' 4.29.19 letter to LOC

with that state's correctional staff, we have identified and grouped prisoners in categories that are detailed in Table 3. *See also infra* note 177.

A few other states also raised questions about the definition while responding. Iowa indicated that it could not confirm that all of the prisoners included in its reported total number of prisoners in restricted housing were in cells for 22 hours or more. Washington also said it could not confirm that the definition it used matched the one that we provided. With these caveats, we included information as reported from these states.

[147] *Time-In-Cell*, *supra* note 2, at 14.

[148] *Id.* at 11.

[149] At least one jurisdiction reported that it defined restricted housing as 22 hours or more in-cell for 30 days or more, rather than 15 days or more. Colorado stated:

> "Although the submission of the survey applies the LIMAN-ASCA definition of ERH of 15 or more continuous days, Colorado's definition of Extended Restricted Housing matches that of ASCA-PBMS: Extended Restrictive Housing—Placement in housing that separates the offender from contact with general population while restricting an offender/inmate to his/her cell for 22 hours per day and for 30 days or longer for the safe and secure operation of the facility. Colorado does not consider 15 days being the window for extended restrictive housing. All offenders under policy and direction from executive staff are required to be removed from disciplinary segregation or removal from population by the 30th day, regardless of the reason for placement in the restrictive housing environment. The only exceptions are those offenders that are placed in our Restrictive Housing Maximum Security Status (formerly known as Administrative segregation)."

ASCA-Liman Survey: Colorado Follow-up Response, March 2016 at 8.

[150] The United Nations Standard Minimum Rules for the Treatment of Prisoners which are, as noted, known as the "Nelson Mandela Rules," defined "prolonged solitary confinement" as the placement of "prisoners for 22 hours or more a day without meaningful human contact" for "a time period in excess of 15 consecutive days." Nelson Mandela Rules, *supra* note 121.

[151] *Time-In-Cell*, *supra* note 2, at 38.

[152] Typically, prisons house sentenced prisoners, serving one year or more for a felony conviction, while jails house pretrial detainees or people sentenced pursuant to misdemeanor convictions. However, variation exists. For example, Louisiana reported that "nearly 18,000 state prisoners" were held in "local jails in Louisiana" (and that the state did "not have access to specific numbers" of those prisoners held in restricted housing.) Conversely, some states such as Rhode Island operate unified systems, which include both jails and prisons. The numbers that California Department of Corrections and Rehabilitation provided were for prisons only. California's Realignment policy has expanded the number of people held in county jails rather than in state prisons.

[153] We asked: Please indicate the facilities for which you have data on the use of Extended Restricted Housing (check all that apply). We did not define "types of facilities" but provided the list included in Table 1 and a category of "Other" where responders could specify any other type of facility.

Included in SCDC' 4.29.19 letter to LOC

[154] According to the website of the Department of Corrections for the District of the Columbia, the majority of male inmates housed in the D.C. jail "are awaiting adjudication of cases or are sentenced for misdemeanor offenses." *Correctional Facilities*, D.C. DEPARTMENT OF CORRECTIONS, http://doc.dc.gov/page/correctional-facilities. Individuals convicted in D.C. and serving longer sentences are housed at the Correctional Treatment Facility, a private facility operated by the Corrections Corporation of America that is an annex to the jail, while sentenced felons are transferred to the Federal Bureau of Prisons. *Id.*

[155] Those 12 jurisdictions were Connecticut, Delaware, the District of Columbia, Hawaii, Idaho, Kansas, Louisiana, Mississippi, Rhode Island, Vermont, the Virgin Islands, and the Federal Bureau of Prisons. Vermont indicated that it operates a combination of prisons for sentenced prisoners and jails for detainees, in which offenders are housed jointly.

[156] As discussed, Louisiana data were not included in this number; in August of 2016 that jurisdiction obtained information on the number of prisoners in restrictive housing in local jails, but in response to the survey as noted in the fall of 2015, Louisiana replied that it did not collect such information routinely.

[157] We did not define control.

[158] Those seven jurisdictions that had restrictive housing data on the jails in their correctional system were Connecticut, Delaware, District of Columbia, Hawaii, Idaho, Vermont, and the Virgin Islands. Vermont reported that information on restricted housing prior to 2016 was limited, but that it was making changes and would be better able to provide more detailed information about restricted housing in the future. In the meantime, Vermont reported that it was maintaining and aggregating manual reports.

In the follow-up exchanges in the summer of 2016, Louisiana reported that it housed some 18,000 prisoners in state jails and that it had done a special audit in the summer of 2016, and identified 314 people in restricted housing as of that date. Louisiana also indicated that it did not control conditions in jails but that if its prisoners were in need of restricted housing conditions, those prisoners would be returned to the state prisons.

[159] These jurisdictions were Arizona, Kansas, North Carolina, and the Federal Bureau of Prisons. The Federal Bureau of Prisons reported that juveniles are housed in a special facility that is a "community contract facility," which is not a prison. According to the Federal Bureau of Prisons website, 58 juveniles are housed in this facility. *Generate Inmate Population reports,* FEDERAL BUREAU OF PRISONS, https://www.bop.gov/about/statistics/population_statistics.jsp. The Federal Bureau of Prisons did not provide information on the use of restricted housing in its juvenile facilities. The other three jurisdictions with juvenile facilities did.

Section VI of this Report discusses in greater detail the number of individuals under the age of 18 reported to be held in restricted housing. The number of juveniles held in restricted housing reported by Arizona, Kansas, and North Carolina in that section reflect the total number in both juvenile and adult correctional facilities, while other jurisdictions' reported totals do not include juvenile facilities.

[160] Those seven jurisdictions reporting separate facilities for the mentally ill were Arizona, California, Colorado, Kansas, Texas, Wisconsin, and the Virgin Islands. Both Montana and the Federal Bureau of Prisons have special units within facilities for mentally ill and for death-sentenced prisoners. The majority of federal death-sentenced prisoners are housed at Terre Haute USP, a high security penitentiary. *Find an*

Included in SCDC' 4.29.19 letter to LOC

Inmate, FEDERAL BUREAU OF PRISONS, https://www.bop.gov/inmateloc. Arizona and Oklahoma also reported specialized facilities for death-sentenced prisoners.

[161] Examples of "other" types of facilities that jurisdictions reported include county correctional facilities, jail contracting facilities, medical facilities, and transitional work programs.

[162] For information on juvenile facilities, see Sarah Hockenberry, *Juveniles in Residential Placement, 2013*, JUVENILE JUSTICE STATISTICS NATIONAL REPORT SERIES (May 2016), http://www.ojjdp.gov/pubs/249507.pdf. For information on the use of restricted housing in juvenile facilities, see *Growing Up Locked Down: Youth in Solitary Confinement in Jails and Prisons Across the United States*, HUMAN RIGHTS WATCH & ACLU (2012), https://www.aclu.org/sites/default/files/field_document/us1012webwcover.pdf.

[163] *See* DOJ RESTRICTIVE HOUSING 2016 REPORT, *supra* note 26, at 3. That report "define[d] 'restrictive housing' as any type of detention that involves three basic elements: removal from the general inmate population, whether voluntary or involuntary; placement in a locked room or cell, whether alone or with another inmate; and inability to leave the room or cell for the vast majority of the day, typically 22 hours or more." *Id*.

[164] Due to the way we phrased the survey question, we did not obtain information about how many of these prisoners had bunkmates and how many were alone in a double cell. Nor did we gather information on the sizes and conditions of the double cells in any given jurisdiction as compared with the sizes and conditions of single cells. For articles on the practice of double-celling, *see supra* note 67.

[165] Arkansas, Rhode Island, and West Virginia did not provide information about the number of prisoners in restricted housing. Nevada provided information that was facility-specific; that information is not included in this section because the answers to sub-numbers for each facility did not match the total for that facility.

As noted earlier, Rhode Island gave us the following clarification about its data: "Currently the structure of our data systems does not allow for us to extract data on the Restrictive Housing population in an aggregate manner. In some cases, this data is tracked manually which allows us to determine the status of individual inmates, but makes it impossible to aggregate data on all inmates in this status. Therefore we are unable to provide data on our restrictive housing population at this time. RIDOC is working to rectify this problem but it requires significant IT programming changes which will take some time to complete."

[166] According to the Bureau of Justice Statistics (BJS), the five jurisdictions not included in our data for this section accounted for 42,908 prisoners, or 2.7% of the total custodial population in the United States in 2014. E. Ann Carson, *Prisoners in 2014*, BUREAU OF JUSTICE STATISTICS 3 Tbl.2 (Sept. 2015), http://www.bjs.gov/content/pub/pdf/p14.pdf. Specifically, Arkansas housed 17,874 prisoners; Rhode Island housed 3,359 prisoners; West Virginia had 6,896 prisoners; Nevada housed 12,537 prisoners; and Maine housed 2,242 prisoners. *Id.* Additionally, the four territories not included in our data for this section accounted for 13,468 prisoners. *Id.* at 32 app. tbl.7. Specifically, American Samoa housed 212 prisoners; Guam housed 754 prisoners; the Commonwealth of the Northern Mariana Islands housed 175 prisoners; and Puerto Rico housed 12, 327 prisoners. *Id.*

[167] *Id.* at 3 tbl.2. The most recent available BJS data, as of October 2016, were gathered in 2014; our survey asked about total custodial and restricted housing populations as of the fall of 2015.

Included in SCDC' 4.29.19 letter to LOC

---

[168] The total custodial population of the 52 responding jurisdictions rises to 1,470,687 if we include the nearly 18,000 state prisoners that Louisiana, as noted, asked that we count, although they were held in jails. We have separately noted this request and incorporated it in several parts with the caveat that Louisiana did not regularly track information on the use of restricted housing in the parish jails over which it had no direct control.

[169] Hawaii reported a total of 4,200 prisoners in-state, and an additional 1,388 prisoners out-of-state. The out-of-state prisoners were not included in this report, as Hawaii did not provide information on restricted housing for its out-of-state prison population.

[170] *See supra* note 165.

[171] Alabama indicated that it was unable to provide restricted housing data for privately-contracted facilities, which accounted for 735 prisoners. Thus, Alabama reported a total custodial population of 25,284 prisoners, but a total of 24,549 prisoners in facilities for which the state could provide data in response to the survey. California reported a total custodial population of 128,164 prisoners, but a total of 117,171 prisoners for which it could provide data. Delaware stated that it was unable to provide restricted housing data for "detentioners," which it defined as individuals detained while awaiting sentencing; Delaware reported a total custodial population of 5,824 prisoners, but a total of 4,342 prisoners for which it could provide data.

Louisiana indicated in the fall of 2015 that it was unable to provide restricted housing data for prisoners housed in local jails, which accounted for almost 18,000 prisoners. Thus, Louisiana reported a total custodial population of 36,511 prisoners, and a total of 18,515 prisoners for which it could provide data. As noted above, in the late summer of 2016, Louisiana conducted an audit and identified 314 prisoners in those local jails that were in restricted housing, and asked that we assume the same number of people were held in restricted housing in the fall of 2015 and include that number in the percentage calculation. Utah likewise reached out to us in the late summer of 2016. Utah provided updated information for the summer of 2016 because it had revised its policies to change the way placements in restricted housing were made and to review those so confined. We describe these changes in Part VII; we also have added a second bar in Chart 1 for Louisiana to reflect different denominators and for Utah to reflect the decline in numbers. *See also infra* note 178.

Wisconsin indicated that it was unable to provide restricted housing data for prisoners in mental health facilities or minimum-security correctional centers. Thus, Wisconsin reported a total custodial population of 22,965 prisoners and a total of 20,535 prisoners for which it could provide data. The Federal Bureau of Prisons stated that the total custodial population included prisoners housed in "community corrections" facilities, such as halfway houses and home confinement. Excluding these facilities, BOP reported a total custodial population of 205,508 prisoners, but a total of 189,181 prisoners for which restricted housing data would be relevant.

Arkansas, Rhode Island, West Virginia, and Nevada are not included in Table 2 and Chart 1. *See* note 165, *supra.* For instance, as noted there, Rhode Island gave us the following clarification about its data: "Currently the structure of our data systems does not allow for us to extract data on the Restrictive Housing population in an aggregate manner. In some cases, this data is tracked manually which allows us to determine the status of individual inmates, but makes it impossible to aggregate data on all inmates in this status. Therefore we are unable to provide data on our restrictive housing population at this time. RIDOC is working to rectify this problem but it requires significant IT programming changes which will take some time to complete."

Included in SCDC' 4.29.19 letter to LOC

In addition, some jurisdictions provided answers to a few questions that did not match up completely with others, and hence there are minor variations between this section and discussions of other questions in the survey. In two states, the number provided for the total restricted housing population and the numbers provided regarding demographic composition differed slightly. Alaska reported 352 prisoners in restricted housing when asked for the total restricted housing population, but in response to later questions about the demographic composition and length of time spent by prisoners in restricted housing, Alaska provided numbers that totaled to 355 prisoners. Kentucky reported 487 prisoners in restricted housing when asked for the total restricted housing population; in response to demographic questions, Kentucky provided numbers that totaled more than 100 less—382 prisoners. Montana also presented a difference in the total numbers and the demographic composition, but indicated that seven prisoners were housed in "off-site" detention, for which the jurisdiction was unable to provide demographic data. We included the data as reported for each segment, and we flagged these limitations throughout.

[172] In September of 2016, the California Department of Corrections and Rehabilitation (CDCR) corrected this number from 1,079 to 1,104 prisoners in restricted housing as of September 30, 2015. CDCR also reported that as of August of 2016, the number had decreased to 427 prisoners. In addition to these 1,104 prisoners who were held in-cell for 22 or more hours for 15 consecutive days or more, California held 7,225 prisoners in other types of segregated housing. These prisoners are counted in Table 3 in response to our question for the numbers of prisoners held between 16-19 and 20-21 hours.

[173] Colorado reported using "restricted housing" to describe prisoners housed under two conditions, which were formerly known as punitive segregation and administrative segregation; prisoners in both conditions are included in its restricted housing number. Colorado reported that more than 50 of the prisoners in its total number of prisoners in restricted housing referred to those in punitive segregation, which meant that such individuals were held for a maximum of 15 to 30 days.

[174] As noted, Utah provided updated information reflecting policy changes that went into effect in 2016. Thus, it gave new data on its total custodial population and on its new rules aimed at lowering the number of prisoners held in-cell for 22 hours or more.

[175] As noted for Table 2, in the summer of 2016, Louisiana requested that the numbers and percent be recalculated because the denominator should include prisoners held in local jails – which were not directly under the control of the state level department. Earlier, Louisiana had noted that about 18,000 people were in held in local jails and also noted that the state did not have information on the numbers in those jails held in restricted housing. Thus, we have retained the original data from the fall and have as well, at the request of the jurisdiction, also revised the equation through adding a second bar to include the nearly 18,000 people held in the summer of August 2016 in jails, as well as the 314 prisoners that the state identified as in restricted housing through a special audit of those jails in August 2016.

Utah likewise reached out to us and provided updated information for the summer of 2016 because it had revised its policies to change the way placements in restricted housing were made and to review those so confined. We describe these changes in Part VII; also added is a second bar for Utah to reflect how the numbers decreased.

[176] Alabama, Arizona, Arkansas, Delaware, Florida, Georgia, Illinois, Kentucky, Minnesota, Nevada, Ohio, Rhode Island, South Carolina, Tennessee, Vermont, West Virginia, Wisconsin, and the Federal Bureau of Prisons participated in the survey, but are not included in Table 2 and Chart 2 because they did not provide information about the number of prisoners in-cell for 16-19 or for 20-21 hours. As noted

Included in SCDC' 4.29.19 letter to LOC

earlier in footnote 165, Rhode Island gave us the following clarification about their data: "Currently the structure of our data systems does not allow for us to extract data on the Restrictive Housing population in an aggregate manner. In some cases, this data is tracked manually which allows us to determine the status of individual inmates, but makes it impossible to aggregate data on all inmates in this status. Therefore we are unable to provide data on our restrictive housing population at this time. RIDOC is working to rectify this problem but it requires significant IT programming changes which will take some time to complete."

Iowa is included because it reported numbers for those in-cell from 20-21 hours; Iowa later indicated that it was unable to confirm that the numbers it provided for restricted housing were limited to prisoners who had been in-cell for more than 22 hours per day.

[177] California informed us that it had a total of 8,329 prisoners in its eight forms of segregated housing. These eight forms include the Administrative Segregation Unit, "Condemned" Housing, Enhanced Outpatient Program ASU Hub, Long-Term Restricted Housing, Non-Disciplinary Segregation Unit, Psychiatric Services Unit, Security Housing Unit, Security Housing Unit at Pelican Bay State Prison, and Short-Term Restricted Housing. Of these, the 1,104 prisoners in the Security Housing Unit at Pelican Bay State Prison meet our definition of restricted housing. The 597 prisoners categorized as "condemned" are housed in two forms of housing, Grade A and Grade B. The history of Pelican Bay State Prison is detailed in Keramet Reiter, 23/7: PELICAN BAY PRISON AND THE RISE OF LONG-TERM SOLITARY CONFINEMENT (2016)

Using definitions of housing categories provided by the California Department of Corrections and Rehabilitation (CDCR), prisoners in Grade A housing would fall under the 16-19 hours category. In Grade B housing, some prisoners would fall under the 16-19 hours category while others would fall under the 20-21 hours category. Because CDCR did not provide a breakdown of how many of the 597 condemned prisoners were in each grade, we included all 597 prisoners in the 16-19 hours per day category. We included the 6,628 prisoners in the remaining six forms of housing in the 20-21 hours category. In some of these forms of housing, prisoners are held in-cell for 22 or more hours a day at least some days of the week. For example, in the Administrative Segregation Unit, Non-Disciplinary Segregation Unit, and Security Housing Unit (not in Pelican Bay), CDCR reported: "Inmates . . . are offered a minimum of 10 hours of outside exercise per week. The 10 hours of outside exercise are distributed throughout the week such that at least three days a week, inmates are allowed more than three hours out-of-cell at a time." Thus, during the remaining days of the week, the prisoners in these housing units may be in-cell for 22 or more hours a day.

[178] As noted, we reflected how Utah's numbers would have looked, were data reported as of the summer of 2016, in Table 2 and in Chart 1. Here and elsewhere in this Report, we note the efforts Utah has undertaken to make changes. Utah informed us that as of the summer of 2016, it had 380 people in-cell for 22 hours or more, 268 in-cell for 20-21 hours, and 648 people in-cell for 16-24 hours, for a total of 10.6% (of the 6,112 prisoners in its total custodial population at the time) in restricted housing.

[179] Maine, Georgia, and New Hampshire did not respond to the question of whether they regularly gather information on length-of-stay in restricted housing.

[180] In responding to whether it regularly tracked the amount of time that prisoners spend in restricted housing, the Federal Bureau of Prisons stated that it keeps monthly reports, and that "[t]here is a publication that tracks aggregate reports at the individual facility level. They can compile this type of data

Included in SCDC' 4.29.19 letter to LOC

and did for the data in this report, but this is not something they regularly do." ASCA-Liman Survey: Federal Bureau of Prisons Follow-up Response, May 2016 at 9.

[181] Oregon and Wisconsin indicated that they planned to begin regularly tracking the amount of time that prisoners spend in restricted housing. Further, as noted earlier, Rhode Island asked we provide the clarification that: "Currently the structure of our data systems does not allow for us to extract data on the Restrictive Housing population in an aggregate manner. In some cases, this data is tracked manually which allows us to determine the status of individual inmates, but makes it impossible to aggregate data on all inmates in this status. Therefore, we are unable to provide data on our restrictive housing population at this time. RIDOC is working to rectify this problem but it requires significant IT programming changes which will take some time to complete."

[182] New Mexico and Nevada provided numbers of people who spent various periods of time in restricted housing, but we did not report these numbers due to inconsistencies in the information provided. Ten states did not provide numbers on the amount of time that prisoners spent in restricted housing: Alabama, Arkansas, Georgia, Illinois, Maine, Michigan, Missouri, New Hampshire, Rhode Island, and West Virginia.

[183] Of the 17 jurisdictions that did not regularly track length-of-stay data, the following nine jurisdictions did provide length-of-stay data based on a specific review in Fall, 2015: Alaska, Florida, Delaware, Louisiana, Nebraska, Oklahoma, Oregon, Pennsylvania, and Wisconsin. All 34 jurisdictions that did regularly track length-of-stay data, provided length-of-stay data for Fall, 2015, but one of those jurisdictions (New Mexico) is not reported here due to different kinds of information inconsistencies.

[184] The total number of prisoners (355) that Alaska reported to be in restricted housing was greater than the number of prisoners (352) for which Alaska provided length-of-stay data.

[185] The numbers reported here for California included only prisoners housed in Security Housing Units in Pelican Bay State Prison and did not include prisoners housed in other types of segregation. *See supra* note 177. Further, the total number of prisoners (1,104) that California reported to be in the Security Housing Unit in Pelican Bay was greater than the number of prisoners (1,073) for which California reported length-of-stay data. *See supra* note 172.

[186] The total number of prisoners (128) that Connecticut reported to be in restricted housing was greater than the total number of prisoners (121) for which Connecticut reported length-of-stay data. The difference was likely due to the fact that Connecticut reported length-of-stay data for male prisoners in restricted housing and not for female prisoners in restricted housing.

[187] The total number of prisoners (404) that Idaho reported to be in restricted housing was larger than the total number of prisoners (275) for which Idaho provided length-of-stay data.

[188] As noted, Louisiana reported that it had begun keeping length-of-stay information in May 2012, and thus information was not available for prisoners held in restricted housing for more than three years. Further, the total number of prisoners (2,689) that Louisiana reported to be in restricted housing was larger than the total number of prisoners (2,185) for which Louisiana provided length-of-stay data.

[189] The total number of prisoners (235) that Massachusetts reported to be in restricted housing was greater than the total number of prisoners (220) for which Massachusetts provided length-of-stay data.

Included in SCDC' 4.29.19 letter to LOC

[190] The total number of prisoners (622) that Minnesota reported to be in restricted housing was larger than the total number of prisoners (567) for which Minnesota provided length-of-stay data. Minnesota provided length-of-stay information for only those prisoners held in disciplinary segregation and reported that length-of-stay data for administrative segregation was not available electronically.

[191] The total number of prisoners (134) that Montana reported to be in restricted housing was greater than the total number of prisoners (90) for which Montana provided length-of-stay data. Montana reported that it could not provide information on prisoners held in "off-site" facilities.

[192] New York provided the number of people who were in restricted housing for zero days up to 30 days (rather than 15 up to 30 days), and the number of people who were in restricted housing for three years or more (rather than distinct categories for three up to six years, and for six years or more). Further, the numbers provided by New York for length of stay excluded 368 prisoners, whom the state reported were kept in separate "Keep Lock" units for which it reported that it could not retrieve length-of-stay data.

[193] The total number of prisoners (1,374) that Ohio reported to be in restricted housing was greater than the total number of prisoners (1,140) for which Ohio had length-of-stay data. Ohio added explanations about its reported numbers, including that it had excluded data from the Offender Tracking System used by the state due to its concern about accuracy. Ohio also reported that it did not house prisoners in protective custody in restricted housing and that it did not have "disciplinary custody." Instead Ohio provided data from its Local Control Units for the disciplinary custody section; those units were "a form of extended restricted housing which may be used for disciplinary or pre-transfer detention to a higher security level when the inmate's continued presence in general population is likely to disrupt orderly operations." *See* ASCA-Liman Survey: Ohio Follow-up Response, November 4, 2015 at 4.

[194] The total number of prisoners (1,768) that Tennessee reported to be in restricted housing was greater than the total number of prisoners for which Tennessee reported it had length-of-stay data (1,774).

[195] The total number of prisoners (106) that Vermont reported to be in restricted housing was greater than the total number of prisoners (22) for which Vermont reported it had length-of-stay data.

[196] "Other" was a category that jurisdictions noted and had varied responses to what it referenced. In several jurisdictions, "Other" referred to maximum security units or death row. In Florida, "Other" referred to Close Management I, Close Management II, Maximum Management, and Death Row. In Louisiana, "Other" referred to Death Row and Medical Segregation. In Montana, "Other" referenced Maximum Security. In Nebraska, "Other" was noted for prisoners sentenced to death. In Oklahoma, "Other" referred to death-sentenced prisoners. In Washington, "Other" referred to "max custody" prisoners.

In addition, "Other" was used for special housing units, specific administrative segregation units, or special handling units for safety and security concerns. For the Federal Bureau of Prisons, "Other" referred to Florence ADMAX and SMU Units. In Indiana, "Other" referred to Department Wide Administrative Segregation. In Oregon, "Other" referred to the Intensive Management Unit, the Behavioral Housing Unit, and the Special Housing Unit. In Texas, "Other" referred to a Special Housing Unit at the women's prison that combined administrative segregation, the behavioral management unit, and an intensive management unit. In the District of Columbia, "Other" referred to High Profile, Total Separation, Special Handling, and Risk of Abusiveness. In New Jersey, "Other" referred to MCU and Rule 30 prisoners. Rule 30 prisoners are prisoners from county jails transferred to State Correctional Facilities due to medical or security reasons. In Pennsylvania, "Other" referred to an Intensive

Included in SCDC' 4.29.19 letter to LOC

Management Unit, a maximum-custody program unit that housed prisoners who have demonstrated behaviors that present serious management concerns. In New York, "Other" referred to pending protective custody, pending disciplinary hearing, special watches (contraband and/or mental health), and pending investigation. In Virginia, "Other" referred to intensive management and special management. In Wisconsin, "Other" referred to Temporary Lock-up and controlled separation. In Wyoming, "Other" referred to the Reintegration Program.

[197] The 37 jurisdictions that provided length of stay data by type of custody were: Alaska, California, Colorado, Connecticut, District of Columbia, Florida, Hawaii, Idaho, Indiana, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, Montana, Nebraska, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, Wisconsin, Wyoming, Federal Bureau of Prisons, and the Virgin Islands.

[198] The percentage of men held in restricted housing in Louisiana was calculated from the data that Louisiana provided in the fall of 2015. The information provided subsequently by Louisiana in the summer of 2016 did not include data delineating populations by gender.

[199] The total custodial population (male and female) of 4,727 provided by Hawaii described in this section did not match the total custodial population of 4,200 provided by Hawaii for other sections of this report.

[200] For Chart 5 and Table 5, the "Total" category was calculated by adding the numbers for the total population in restricted housing in all of the responding jurisdictions and dividing that by the numbers for the total custodial population added together from all of the responding jurisdictions. Thus, this number is the percentage of the total prisoners in all 43 responding jurisdictions who were in restricted housing.

[201] The data provided in Table 5 require explanation. Some jurisdictions provided numbers for the total custodial population in response to the questions on demographic information that were not consistent with numbers provided in other segments. Other jurisdictions included individuals relying on a somewhat different definition of restricted housing.

Specifically, the total custodial population (male and female) of 17,749 provided by New Jersey in response to the questions on demographic information did not match the total custodial population provided by New Jersey for other sections of this report. The same was true for Hawaii. *See supra* note 199. Additionally, both Arizona and Massachusetts reported that they could not provide race and ethnicity data based on the restricted housing definition of the survey, which asked about prisoners in cells for 22 hours or more a day for more than 15 continuous days. The data these two jurisdictions provided on race and ethnicity included individuals housed in-cell for 22 hours or more per day, some of whom may have been held in restricted housing for less than 15 days. In terms of age, California did not provide data about prisoners under the age of 18 in their numbers for the total custodial population and in the restricted housing population.

[202] We discuss only jurisdictions that reported at least one woman in restricted housing. Thus, for example, California was not listed because it reported it had no women in-cell for 22 hours or more for 15 consecutive days or more. California reported that it held 186 women in-cell for 20-21 hours.

[203] The data about the number of women in restricted housing in Louisiana comes from data that Louisiana provided in the fall of 2015, which included gender delineations. Once again, these data are

Included in SCDC' 4.29.19 letter to LOC

from materials focused on prisons provided by Louisiana, as the data given in the summer of 2016 about state prisoners housed in jails did not delineate the numbers by gender.

[204] As noted for the purposes of Chart and Table 6, we included only jurisdictions that reported a non-zero number of women in restricted housing.

[205] The survey did not define the "Other" category, but jurisdictions were asked to specify what they included, and often listed in the "Other" category were Alaskan Native, Hawaiian, Native American, Pacific Islander, as well as a description of "Unknown."

[206] Alabama was not included for the Hispanic category for men because it did not use Hispanic as a category for tracking individuals.

[207] Alabama was not included for the Hispanic category for women because it did not use Hispanic as a category for tracking individuals.
[208] This list is not an exhaustive list of the vulnerable populations in prison. For example, there are also elderly prisoners, prisoners with mental or physical disabilities, prisoners with serious medical conditions, and prisoners with auditory or visual impairments.

[209] *See Madrid v. Gomez*, 889 F. Supp. 1146, 1265 (N.D. Cal. 1995) ("[P]lacing [certain mentally ill prisoners] in the SHU [or solitary] is the mental equivalent of putting an asthmatic in a place with little air to breathe. The risk is high enough, and the consequences severe enough, that we have no hesitancy in finding that the risk is plainly unreasonable.") (internal quotations omitted). More recently, Justice Kennedy discussed the literature on solitary confinement causing mental illness. *See Davis v. Ayala*, 135 S. Ct. 2187, 2208-2210 (2015) (Kennedy, J., concurring).

[210] DOJ RESTRICTIVE HOUSING 2016 REPORT, *supra* note 26, at 46.

[211] *See* COLO. REV. STAT. ANN. § 17-1-113.8(1) (West 2015); MASS. GEN. LAWS ANN. ch. 127 § 39A(b) (West 2015). *See also* Settlement Agreement, *Disability Rights Network of Pennsylvania v. Wetzel*, No. 1:13-CV-00635 (M.D. Pa. Jan. 5, 2015).

[212] *See* ACA Restrictive Housing Standards 2016, *supra* note 48.

[213] *Id.*, ACA Restrictive Housing Standards 2016, 4-RH-0031; *id.*, Standard 4-ALDF-RH-028.

[214] *Id*., ACA Restrictive Housing Standards 2016, 4-RH-0010.

[215] *Id*.

[216] *Id.*, ACA Restrictive Housing Standards 2016, 4-ALDF-RH-0029

[217] DOJ RESTRICTIVE HOUSING 2016 REPORT, *supra* note 26, at 99-101.

[218] The five jurisdictions that provided data about prisoners with "serious mental illness" but did not include a definition of "serious mental illness" were Idaho, New Mexico, North Carolina, the Virgin Islands, and Washington.

Included in SCDC' 4.29.19 letter to LOC

[219] Georgia, Hawaii, Montana, New Hampshire, Rhode Island, West Virginia, and the Federal Bureau of Prisons were the seven jurisdictions that provided a definition of "serious mental health issue" but did not provide data on mentally ill prisoners. Illinois and Massachusetts each provided a total number of prisoners with serious mental health issues, but did not provide data on prisoners with serious mental health issues by race. Rhode Island provided the total number of male and female prisoners with serious mental health issues, but did not provide numbers of prisoners with serious mental health issues by race or provide data on the number of prisoners with serious mental health issues in restricted housing. As noted earlier, Rhode Island asked us to note: "Currently the structure of our data systems does not allow for us to extract data on the Restrictive Housing population in an aggregate manner. In some cases, this data is tracked manually which allows us to determine the status of individual inmates, but makes it impossible to aggregate data on all inmates in this status. Therefore, we are unable to provide data on our restrictive housing population at this time. RIDOC is working to rectify this problem but it requires significant IT programming changes which will take some time to complete."

[220] The American Psychiatric Association updated the Diagnostic and Statistical Manual (DSM) in 2013 and published DSM-5 to replace DSM-4. Some of the language in the DSM-4 was changed, and some terms were no longer used in DSM-5.

As noted, our survey did not specify a definition of serious mental illness. In response to our question asking for each jurisdiction's own definition of a "serious mental health issue," some jurisdictions referenced DSM-4 and others DSM-5. Specifically, the District of Columbia, Pennsylvania, and South Dakota referred to DSM-4, and Kentucky, Maryland, Massachusetts, and Nebraska referred to DSM-5. A few jurisdictions (Colorado, Illinois, Montana, New York, Ohio, Tennessee, and Utah) mentioned "DSM" but did not specify an edition. The remaining jurisdictions that reported definitions did not refer directly to the DSM.

[221] Jurisdictions were excluded from Table 15 (Male Prisoners with a Serious Mental Health Issue) and Table 16 (Female Prisoners with a Serious Mental Health Issue) if those jurisdictions provided no data about prisoners with "serious mental illness" either in their total custodial population, in restricted housing, or both. The two jurisdictions that provided no data about prisoners with "serious mental illness" in their total custodial population were Hawaii and New Hampshire. The four jurisdictions that provided no data about prisoners with "serious mental illness" in restricted housing were Arizona, California, Indiana, and Rhode Island. California informed us that it did not do so because it did not segregate such persons in "Restricted Housing." The nine jurisdictions that provided no data about prisoners with "serious mental illness" in both their total custodial population and their restricted housing population were Alaska, Arkansas, Delaware, Georgia, Michigan, Montana, Nevada, and West Virginia, and the Federal Bureau of Prisons. As noted earlier, Rhode Island asked us to note: "Currently the structure of our data systems does not allow for us to extract data on the Restrictive Housing population in an aggregate manner. In some cases, this data is tracked manually which allows us to determine the status of individual inmates, but makes it impossible to aggregate data on all inmates in this status. Therefore, we are unable to provide data on our restrictive housing population at this time. RIDOC is working to rectify this problem but it requires significant IT programming changes which will take some time to complete." Vermont noted that changes in its database system prevented it from being able to report on this measure. As of the summer of 2016, Vermont had resumed data collection and aimed to be able to answer questions such as this in the future.

In several other instances, number mismatches resulted in exclusion from tables. For example, Vermont was excluded from Tables 15 and 16 because of number mismatches concerning its total

Included in SCDC' 4.29.19 letter to LOC

custodial population. The District of Columbia was excluded from Table 16 (Female Prisoners with a Serious Mental Health Issue) because it did not provide data regarding female prisoners with serious mental illness. Illinois was excluded from Table 15 (Male Prisoners with a Serious Mental Health Issue) and Table 16 (Female Prisoners with a Serious Mental Health Issue) because the state did not provide data on the total custodial population in the demographics section of the report. Kentucky was excluded from Table 16 (Female Prisoners with a Serious Mental Health Issue) because they reported more women with "serious mental illness" in restricted housing than total women in restricted housing. Kentucky reported 34 women with serious mental illness in restricted housing and 20 women with serious mental illness in its total restricted housing population.

[222] The jurisdictions excluded from Table 17 (Male Prisoners with a Serious Mental Health Issue by Race and Ethnicity) and Table 18 (Female Prisoners with a Serious Mental Health Issue by Race and Ethnicity) were those that did not provide data about prisoners with "serious mental illness" intersecting with race/ethnicity. That group of 19 included Alaska, Arkansas, Delaware, Georgia, Hawaii, Illinois, Massachusetts, Michigan, Montana, New Hampshire, Nevada, Rhode Island, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, and the Federal Bureau of Prisons.

Indiana was excluded from Table 18 (Female Prisoners with a Serious Mental Health Issue by Race and Ethnicity) because the number of prisoners with mental illness by race that it reported did not match the total number of prisoners with mental illness that the state provided. Indiana reported that it detained two prisoners with serious mental illness and had data by race, but gave a total number of zero. Kansas and Kentucky were excluded from Table 18 because these two jurisdictions reported more women with "serious mental illness" in restricted housing than total women in restricted housing. Kansas reported 16 women with serious mental illness in restricted housing and eight women with serious mental illness in its total restricted housing population. Kentucky reported 34 women with serious mental illness in restricted housing and 20 women with serious mental illness in its total restricted housing population.

Vermont indicated that due to its database changes, it was unable to provide demographic information in response to the survey. However, with the new database system, Vermont reported that it would be able to provide information on gender, medical and mental health status, race, and ethnicity, as well as on self-harming behaviors in the future.

[223] Seven jurisdictions provided some data about pregnant prisoners but were not included because the data was not sufficiently detailed to report. Specifically, Illinois, Montana, New Mexico, and Vermont provided mismatched numbers concerning the number of women in their total custodial population. Massachusetts did not provide the number of pregnant prisoners in its total custodial population. Minnesota provided an average number of pregnant prisoners, but did not provide the exact number of pregnant prisoners in its total custodial population. Wisconsin reported that it housed five pregnant prisoners in its total custodial population, but it did not provide the number of pregnant prisoners held in restricted housing.

[224] The ten jurisdictions that reported no pregnant prisoners in their total custodial population were the District of Columbia, Indiana, Iowa, Louisiana, Mississippi, New Hampshire, North Dakota, Tennessee, Washington, and the Virgin Islands.

[225] Illinois reported 10 transgender prisoners in restricted housing but reported that they do not track the number of transgender prisoners in their total custodial population. Massachusetts reported one

Included in SCDC' 4.29.19 letter to LOC

transgender prisoner in restricted housing but did not report the number of transgender prisoners in its total custodial population.

[226] The jurisdictions that reported transgender prisoners in restricted housing were: Arizona (5 prisoners), Colorado (1 prisoner), the District of Columbia (1 prisoner), Florida (1 prisoner), Kentucky (1 prisoner), Louisiana (2 prisoners), Maryland (1 prisoner), New Hampshire (1 prisoner), New Jersey (1 prisoner), New York (10 prisoners), Ohio (2 prisoners), Oregon (3 prisoners), Pennsylvania (5 prisoners), Texas (19 prisoners), and Washington (2 prisoners).

[227] *Time-In-Cell, supra* note 2, at 55-56.

[228] The jurisdictions that did not reply to this set of questions were Arkansas, Louisiana, Maine, Massachusetts, Michigan, New Hampshire, the Virgin Islands, and West Virginia.

[229] Alaska, Illinois, Indiana, Kentucky, Montana, North Dakota, Washington, Wisconsin, Ohio, D.C., and Virginia provided some policies governing the use of restricted housing. New York directed us to a recently approved settlement agreement.

[230] For example, Oregon reported that in "March 2015, we were selected as one of five correctional systems across the country to participate in the Vera Institute's Safe Alternatives to Segregation Initiative. As part of the grant, we are receiving up to two years of technical assistance focused on analyzing our use of segregated housing and developing recommendations for its safe reduction, as well as initial assistance with implementation of those recommendations." Washington stated that it had consulted a national expert on solitary confinement. In its update in the summer of 2016, Louisiana's Director also indicated the state had been working with The Pew Charitable Trusts on issues related to incarceration.

[231] Presidential 2016 Memorandum on Limiting Restrictive Housing, *supra* note 37.

[232] Rick Raemisch & Kelli Wasko, *Open the Door—Segregation Reforms in Colorado, Part 2 of 3*, COLORADO DEPARTMENT OF CORRECTIONS (Jan. 11, 2016), http://www.corrections.com/news/article/42046-open-the-door-segregation-reforms-in-colorado.

[233] *See also* Settlement Agreement, *Ashker v. Governor of California*, No: 4:09-cv-05796-CW (N.D. Cal. Sept. 1, 2015) at *4.

[234] These changes were also related to litigation involving a challenge to the use of isolation for the seriously mentally ill. *See Disability Rights Network of Pennsylvania v. Wetzel*, Civil Case No. 1:13-CV-00635 (M.D. Pa. Jan. 5, 2015).

[235] This limit on duration appeared to apply to disciplinary segregation, but not to other forms of restricted housing.

[236] Alaska, Arizona, Connecticut, Illinois, New Jersey, North Carolina, Oklahoma, South Carolina, Virginia, and Washington, among others, reported implementing or modifying a form of step-down program for return from segregation to the general prison population.

[237] Virginia Department of Corrections, Local Operating Procedure 830.A, effective December 1, 2013.

Included in SCDC' 4.29.19 letter to LOC

[238] *Id*. Virginia stated that the program had included 485 individuals since it began in 2013, and that it had an 85% success rate, measured in people returned to the general population.

[239] New Jersey Survey response to Question 14, May 12, 2016.

[240] New York Survey response to Question 14, May 12, 2016.

[241] Illinois Department of Corrections, Administrative Directive 05.12.101, effective May 1, 2014, at 2.

[242] *Time-In-Cell*, *supra* note 2.

[243] Jurisdictions that reported adopting or planning policies that required a certain number of hours out-of-cell per day or week included California, Colorado, Ohio, Utah, and Washington.

[244] *Time-In-Cell, supra* note 2, at 50-51.

[245] The report also included 50 "Guiding Principles" intended to serve as "best practices for correctional facilities within the American criminal justice system." DOJ RESTRICTIVE HOUSING 2016 REPORT, *supra note* 26, at 94.

[246] Obama, *Why We Must Rethink Solitary Confinement*, (Jan. 25, 2016), *supra* note 27.

[247] Presidential 2016 Memorandum on Limiting Restrictive Housing, *supra* note 37.

[248] The DOJ also recommended various procedural changes for investigating and reporting alleged disciplinary violations and for segregation of prisoners during disciplinary investigations. DOJ RESTRICTIVE HOUSING 2016 REPORT, *supra note* 26, at 96-97.

[249] DOJ RESTRICTIVE HOUSING 2016 REPORT, *supra* note 26, at 94, 104.

[250] *Id.* at 114 (internal quotations omitted). The federal prison system has few juveniles within the system.

[251] *Id.* at 105.

[252] *Id.* at 94-95.

[253] *Id.* at 95.

[254] *Id.* at 110. In one such unit in Louisiana, for example, prisoners live, work, and receive programming in their unit, while spending approximately 16 hours out of their cells per day. *Id.*

[255] *Id.* at 109-10.

[256] *Id.* at 110.

[257] *Id.* at 106-07.

[258] *Id*.

Included in SCDC' 4.29.19 letter to LOC

[259] *Id.* at 116.

[260] *Id.*

[261] *Id.* at 113.

[262] *Id.* at 112.

[263] *Id.* at 113.

[264] *Id.* at 95.

[265] *Id.* at 117.

[266] Raemisch & Wasko, *supra* note 232, at 2.

[267] *Id.* at 4.

[268] *Id.*

[269] *Id.* at 9.

[270] *Id.* at 5.

[271] *Id*. at 5.

[272] *Id.* at 6.

[273] *Id.* at 6.

[274] *Id.* at 4.

[275] *Id.* at 5.

[276] *Id.* at 5.

[277] *Id.* at 12.

[278] *Id.* at 5.

[279] *Id.* at 9. In June of 2016, Colorado enacted a bipartisan bill, HB 1328, which limited the placement of juveniles in solitary confinement to four hours, except in emergency situations and with the approval of a physician and a mental health professional. A court order was required to keep a child in solitary confinement for more than eight hours. The bill further required the Colorado Department of Youth Corrections to document its use of solitary confinement and to make regular reports to an oversight board. HB 16-1328 (Colo. 2016).

[280] COLO. REV. STAT. § 17-1-113.8 (2014).

[281] *Id.* The law did not define long-term isolated confinement.

Included in SCDC' 4.29.19 letter to LOC

[282] Raemisch & Wasko, *supra* note 232, at 6.

[283] *Id.* at 7.

[284] *Id.*

[285] *Id.* at 5.

[286] *Id.* at 8.

[287] *Id.*

[288] *Id.* at 9. At San Carlos Correctional Facility, forced cell entries in the last year declined by 77%, while offender-on-staff assaults declined by 46%. In Centennial Correctional Facility, forced cell entries in the last year declined by 81%, while offender-on-staff assaults were reduced by 50%. *Id.*

[289] *Id.* at 10-11.

[290] *Id.* at 12.

[291] *Id.* at 12.

[292] Bertsch, *History of Restricted Housing*, *supra* note 142.

[293] *Id.* at 3.

[294] Administrative Segregation Unit Redesign 1 (March 8, 2016).

[295] *Id.*

[296] *Id.*

[297] Bertsch, *History of Restricted Housing*, *supra* note 142, at 4.

[298] *Id.*

[299] Leann K. Bertsch, *Humanity in North Dakota: Learning from Norway to Make Better Neighbors, Not Better Prisoners*, presented at the conference, International and Interdisciplinary Perspectives on Prolonged Solitary Confinement, University of Pittsburgh School of Law (Apr. 16, 2016) (unpublished manuscript) [hereinafter Bertsch, *Humanity in North Dakota*]. According to Director Bertsch and reflected in the policies provided, North Dakota revised the list of behaviors that permitted placement in administrative segregation to "Level III infractions," which included (1) homicide; (2) escape from a maximum- or medium-custody facility; (3) taking hostages; (4) "assault or battery on staff which causes significant bodily injury or exposure to a biological contaminate, to include aggravated assault or predatory behavior resulting in sexual assault;" (4) "assault or battery on an inmate which causes significant intentional bodily injury or exposure to a biological contaminate, to include aggravated sexual assault or predatory behavior resulting in sexual assault;" (5) arson; (6)"inciting or participation in riots, work strikes, or disturbances;" and (7) "trafficking/smuggling contraband" into a maximum- or medium-security facility. *See* ASCA-Liman Survey: North Dakota Response with Statement of Policy,

Included in SCDC' 4.29.19 letter to LOC

Segregation Placement Strategic Planning at 1-2 (March 8, 2016). In addition, those policies also noted a few other offenses, including possession of guns or knives, and of behaviors that could put someone into segregation but only if evidence existed of the need to do so and the reasons for doing so. Discussed were "24 hour placements," and efforts to understand tiered options. *Id.*

[300] *Id.* at 15.

[301] *Id*. at 4.

[302] *Id*.

[303] *Id.*

[304] *Id.*

[305] *Id.*

[306] *Id.*

[307] Bertsch, *Humanity in North Dakota*, *supra* note 299, at 20.

[308] *Id.* at 21.

[309] According to Director Bertsch, staff described more friendly interactions with prisoners, reportedly saying things like: "I used to hate working down here when all we did was fight with these guys—this is so much better," and "I actually feel like we are rehabilitating people, not just locking them up and hoping they don't do the same thing again." *Id.* at 23.

[310] Prisoners have had similar reactions: "Staff just used to rush past my door. Now they stop and talk and I'm seeing they're kind of like us, I mean, we're the same," and "I'm learning to be more understanding of the officers, like, I don't take it so personal when they forget something I asked for." *See id.* at 22-26 (describing results and reactions from staff, wardens, and prisoners).

[311] *Id.* at 27.

[312] Bertsch, *History of Restricted Housing*, *supra* note 142, at 4.

[313] Memorandum from Brian Wittrup, Chief, Bureau of Classification, to Gary Mohr, Director, Ohio Dep't of Rehabilitation & Correction 1 (May 12, 2016).

[314] *Id.*

[315] *Id.* at 2.

[316] *Id*.

[317] *Id.*

[318] *Id.*

Included in SCDC' 4.29.19 letter to LOC

[319] *Id*. at 3.

[320] *Id.*

[321] *Id.* at 4.

[322] *Id.*

[323] *Id.* at 5.

[324] *Id*.

[325] *Id.*

[326] *Id*. at 6.

[327] *Id.* at 5-6.

[328] *Id*. at 7.

[329] *Id.*

[330] *Id*.

[331] *Id.* at 8.

[332] *Id*.

[333] *Id.* at 9.

[334] *Id.*

[335] *Id.* at 9-10.

[336] *Id.* at 1.

[337] *Id.* at 6.

[338] *Id.*

[339] SCDC, *Operating Policy 22.38; South Carolina, Step-Down Program*, November 5, 2015, http://www.doc.sc.gov/pubweb/policy/OP-22-38.htm1479337241122.pdf [hereinafter SCDC, *Step-Down Program*].

[340] *Id.* at 1.

[341] SCDC, *Inmates Housed in Restricted Housing on the Following Dates by Institution and Mental Health Status, from December 2012-March 2016*. In a follow-up in August of 2016, Director Stirling detailed the 15 subcategories for a "mental health classification," which included substance abuse and

Included in SCDC' 4.29.19 letter to LOC

major mental illness, and detailed the breakdown of the population of the prisons with various kinds of mental health problems.

[342] Daniel J. Gross, *Prisons work to limit use of solitary confinement*, HERALD J. OF SPARTANBURG (Apr. 24, 2016), http://www.thestate.com/news/local/crime/article73689037.html.

[343] SCDC, *Step-Down Program*, *supra* note 339, at 3.

[344] *Id.*

[345] *Id*. at 4.

[346] *Id.*

[347] *Id.* at 4, 7. In a follow-up email with Director Stirling, SCDC explained that the incentives are automatically provided at each phase, but a prisoner showing "chronic negative behavior" would be required to repeat the phase or be placed back in restricted housing.

[348] *Id.* at 4.

[349] *Id.*

[350] *Id.* at 6.

[351] *Id.* at 4-5.

[352] *Id.* at 6.

[353] *Id.* at 6-7.

[354] *Id.* at 5.

[355] *Id.* at 7.

[356] *Id.*

[357] *Id*. at 8.

[358] *Id.*

[359] *Id.*

[360] *Id.* at 7.

[361] *Id.*

[362] *Id.*

[363] *Id.*

Included in SCDC' 4.29.19 letter to LOC

[364] *Id.*

[365] *See* Settlement Agreement, *T.R. v. South Carolina Department of Corrections*, No. 4855-6615-1984 v.8 (May 31 2016), http://www.pandasc.org/wp-content/uploads/2016/06/Settlement-Agreement-May-31-2016.pdf; Term Sheet, *T.R. v. South Carolina Department of Corrections*, No. 4855-6615-1984 v.8 (Jan. 12, 2015) [hereinafter SCDC Term Sheet], http://ftpcontent4.worldnow.com/wistv/pdf/SCDCtermsheet.pdf; *see also* Tim Smith, *Agreement Reached to Reform SC Prison Treatment of Mentally Ill*, GREENVILLE NEWS (Jan. 16, 2015),http://www.thestate.com/news/local/article13937666.html.

[366] *See* SCDC Term Sheet, *supra* note 365, at 12-13.

[367] *See id.* at 1.

[368] SCDC, *Step-Down Program*, *supra* note 339, § 25.

[369] *Id.*

[370] Phone conversation with Utah Director of the Division of Institutional Operations Jerry Pope (Sept. 9, 2016).

[371] See General Order No. DIOGO 16-001, FCO7 Restricted Housing, issued by Utah Division of Institutional Operations (Jan. 19, 2016) [hereinafter Utah FC07 Restricted Housing Order 2016].

[372] See Letter from Utah Director of the Division of Institutional Operations Jerry Pope to Co-Executive Director of ASCA George Camp, Re: Restricted Housing Update (Aug. 25, 2016) [hereinafter Pope Restrictive Housing Update 2016.]

[373] See Utah FC07 Restricted Housing Order 2016, *supra* note 371, §§ 01.01, 01.03.

[374] *Id.*, § 02.01.

[375] *Id.*, § 02.02.

[376] Phone conversation with Director Pope (Sept. 9, 2016), *supra* note 370.

[377] *See* Utah FC07 Restricted Housing Order 2016, *supra* note 371, § 03.01.

[378] *Id.*, § 03.02.

[379] *Id.*

[380] Phone conversation with Director Pope (Sept. 9, 2016), *supra* note 370; Pope Restrictive Housing Update 2016, *supra* note 372.

[381] Section 03.06(B) of the Utah FC07 Restricted Housing Order 2016 provides that "Behaviors that may result in an inmate being placed in Restricted Housing may include, but are not limited to: 1) involvement in a serious threat to life, property, staff or other inmates, or to the orderly operation of a unit or facility; 2) escape/attempted escape; 3) riot; 4) fight with serious injuries, weapons used, or group of three or more

Included in SCDC' 4.29.19 letter to LOC

participants; 5) Security Threat Group activity; 6) homicide; 7) assault on staff; 8) serious assault on inmate; 9) serious safety concerns; and/or 10) scores based on assessment for Level 2 housing."

[382] *Id.*, § 03.01(B).

[383] Utah FC07 Restricted Housing Order 2016, *supra* note 371, § 03.03. In a written summary of the changes, Utah reported doing such reviews generally within 24 hours. *See* Pope Restrictive Housing Update 2016, *supra* note 372.

[384] Utah FC07 Restricted Housing Order 2016, *supra* note 371, § 03.04.

[385] *Id.*, § 04.05.

[386] *Id.*, § 04.02.

[387] *Id.*, § 03.04, (B)(1).

[388] *Id.*, § 04.03.

[389] *Id.*, § 04.04.

[390] *See* Pope Restrictive Housing Update 2016, *supra* note 372.

[391] Utah FC07 Restricted Housing Order 2016, *supra* note 371, § 04.06.

[392] *Id.*, §§ 03.03, 04.04.

[393] *Id.*, § 06.01.

[394] *See* Pope Restrictive Housing Update 2016, *supra* note 372.

[395] Utah FC07 Restricted Housing Order 2016, *supra* note 371, § 06.02.

[396] *See* Pope Restrictive Housing Update 2016, *supra* note 372.

[397] *Id.* Utah reported that of the 380 people kept in-cell 22 or more hours per day, 373 were men and seven were women. Utah also reported 683 people in units labeled as restricted housing but not necessarily in-cell 22 hours or more. Of these 683 people, 611 were men between the ages of 18 and 49, 65 were men over the age of 50, and seven were women between the ages of 18 and 49. Of the men in units labeled as restricted housing but not necessarily in-cell 22 hours or more, 47% were White, 34% were Hispanic, 7% were Black, 4% were Asian, and 8% were Other. The total male custodial population was 64% White, 20% Hispanic, 7% Black, 3% Asian, and 6% Other. Of the women in units labeled as restricted housing but not necessarily in-cell 22 hours or more, 57% were White, 43% were Hispanic, and zero were Black, Asian, or Other. The total female custodial population was 75% White, 13% Hispanic, 2% Black, 3% Asian, and 7% Other. Utah also reported that there were 367 men in its custodial population who had a "serious mental health issue" and that 71 of them were in restricted housing units. There were 57 women in Utah's custodial population who had a "serious mental health issue" and none of them were in a restricted housing unit.

Included in SCDC' 4.29.19 letter to LOC

Appendix A: ASCA-Liman Restricted Housing Survey – Fall 2015

This survey aims to provide a national picture of the number of people in all forms of extended restricted housing, the length of their stay, and information on jurisdictions' policies in terms of changes underway or recently completed.

For purposes of this survey, "Extended Restricted Housing" is defined as separating prisoners from the general population and holding them in their cells for 22 hours per day or more, for 15 or more continuous days. The definition includes prisoners held in both single- or double-cells, if held for 22 hours per day or more in a cell, for 15 or more continuous days.

This survey requests information regarding all prisoners in your jurisdiction's correctional facilities, including both sentenced prisoners and pre-trial detainees. The goal is to have information on all of the facilities for which you have data on extended restricted housing, including facilities operated by private entities on behalf of the State, if that information is available. Therefore, in the first questions, we ask you to identify all the facilities in your jurisdiction—and then to identify all the facilities for which you have accessible data on the use of extended restricted housing.

Please answer all the questions with information about your jurisdiction that is current as of on or about **October 1, 2015.**

Please complete and return this survey by October 19, 2015.

1) **Please indicate the jurisdiction for which you are filling out the survey:**
   ____

2) **Does your correctional system include the following facilities (check all that apply)?**
   Prisons Jails Juvenile facilities
   Mental health facilities Privately-contracted facilities
   Separate facilities for death-sentenced prisoners Other (please specify) ___

3) **Please provide the total custodial population for all facilities in your system as identified in Question 2 (for example, if you indicated in Question 2 that your system includes prisons, jails, juvenile facilities, and mental health facilities, you would provide the total custodial population for those four types of facilities).**

4) **Please indicate the facilities for which you have data on the use of Extended Restricted Housing (check all that apply).**
   Prisons Jails Juvenile facilities
   Mental health facilities Privately-contracted facilities
   Separate facilities for death-sentenced prisoners Other (please specify) ____

Included in SCDC' 4.29.19 letter to LOC

Below are a series of questions about Extended Restricted Housing for the facilities that you identified in Question 4. We understand that you may not be able to answer all questions for all types that you identified in Question 4. (For example, you may have data on demographics or mental health for people in extended restricted housing in prisons but not in jails.) Please provide the information that you do have. After each question, you will be asked to indicate which types of facilities are included in your responses to that question.

5) **Please provide the total custodial population (including men and women) in each type of facility identified in Question 4. (For example, if you indicated in Question 4 that you have data on the use of Extended Restricted Housing in prisons, jails, and juvenile facilities, you would provide the custodial population in these three types of facilities.)**

   Prisons _______ Jails _________ Juvenile facilities _________

   Mental health facilities _____ Privately-contracted facilities ________

   Separate facilities for death-sentenced prisoners ______ Other (please specify) ____

6) **Please provide the total custodial population (including men and women) in Extended Restricted Housing for all facilities identified in Question 4 (For example, if you indicated in Question 4 that you have data on the use of Extended Restricted Housing in prisons, jails, and juvenile facilities, you would provide the total custodial population in Extended Restricted Housing for each of these three types of facilities.)**

   Prisons _______ Jails _________ Juvenile facilities _________

   Mental health facilities _____ Privately-contracted facilities ________

   Separate facilities for death-sentenced prisoners ______ Other (please specify) _____

7) **Demographic Information**
   Part I of the table requests information on the total custodial population for all facilities that you identified in Question 4.
   Part II of the table requests information regarding the number of prisoners in Extended Restricted Housing in those facilities.

Included in SCDC' 4.29.19 letter to LOC

	White	Black	Hispanic	Asian	Other	Total	Specify the groups included in "Other"
I. Total Prisoners							
Male (under 18 years old)							
Male (18-49 years old)							
Male (50 years or older)							
Female (under 18 years old)							
Female (18-49 years old)							
Female (50 years or older)							
Total							
II. Prisoners in Extended Restricted Housing							
Male (under 18 years old)							
Male (18-49 years old)							
Male (50 years or older)							
Female (under 18 years old)							
Female (18-49 years old)							
Female (50 years or older)							
Total							

8) How many prisoners, if any, (including both male and female, of every age) in Extended Restricted Housing are housed in double cells?

Included in SCDC' 4.29.19 letter to LOC

9) Mental Health Status

	White	Black	Hispanic	Asian	Other	Total	Specify the groups included in "Other"
I. Total Prisoners Identified as Having a Serious Mental Health Issue							
Male							
Female							
II. Prisoners in Extended Restricted Housing Identified as Having a Serious Mental Health Issue							
Male							
Female							

10) How many transgender prisoners or pregnant prisoners are in Extended Restricted Housing?

	Pregnant	Identified as Transgender
I. Total Prisoners		
II. Prisoners in Extended Restricted Housing		

11) Please provide the total number of prisoners, if any, who as of October 1, 2015 are not in Extended Restricted Housing as defined in this survey, but who have been segregated from the general population and held in cell (either in single- or double-cells) for the following periods:

	Number of Male and Female Prisoners
16-19 hours per day	
20-21 hours per day	

12) Do you regularly gather, collect, or report information on each prisoner's length of stay in Extended Restricted Housing?

Included in SCDC' 4.29.19 letter to LOC

13) Types of Extended Restricted Housing— Please provide the number of prisoners held in each type of Extended Restricted Housing for the specified period. Include both male and female prisoners.

Continuous/ Consecutive Days	Protective Custody	Disciplinary Custody	Administrative Segregation	Other Form of Restricted Housing	Total
15 days up to 1 month					
1 month up to 3 months					
3 months up to 6 months					
6 months up to 1 year					
1 year up to 3 years					
3 years up to 6 years					
6 year or more					

If the data includes prisoners in the "Other" form of Extended Restricted Housing category, please specify the type of Extended Restricted Housing _____________.

14) Changes to Restricted Housing

From January 1, 2013 through October 1, 2015, has your jurisdiction changed any of its policies regarding Restricted Housing?
If so, please select the appropriate category. Please explain the change in policy and, if possible, email a copy of the relevant policies . . . .

Criteria for entry to Extended Restricted Housing ___
Oversight in Extended Restricted Housing ___
Criteria for release from Restricted Housing ___
Mandated time out of cell for Restricted Housing prisoners ___
Programming in Restricted Housing ___
Opportunities for social contact in Restricted Housing ___
Policies or training related to staffing of Restricted Housing ____
Physical environment of Restricted Housing___
Programming for mentally ill prisoners who have been in Restricted Housing ____
Other _____

Please explain _________________________________

15) Proposed Changes to Restricted Housing

Is your jurisdiction planning any changes to its policies regarding Restricted Housing?
If so, please select the appropriate category and explain the contemplated change in policy.

Criteria for entry to Restricted Housing ___

Included in SCDC' 4.29.19 letter to LOC

Oversight in Extended Restricted Housing ___
Criteria for release from Restricted Housing ___
Mandated time out of cell for Restricted Housing Prisoners ___
Programming in Restricted Housing ___
Opportunities for social contact in Restricted Housing ___
Policies or training related to staffing of Restricted Housing ____
Physical environment of Restricted Housing___
Programming for mentally ill prisoners who have been in Restricted Housing _____________
Other _____

Please explain ________________________________

16) We may have follow-up questions to clarify the information reported in this survey. Please provide the name, contact information, and title for the person to whom such questions should be directed.

Included in SCDC' 4.29.19 letter to LOC

Appendix B: List of the Report's Charts and Tables

CHARTS

Chart 1 Percentages of Men and Women in Custodial Population in Restricted Housing by Jurisdiction (15 Consecutive Days or Longer, 22 Hours or More per Day)

Chart 2 Percentage of Men and Women in Custodial Population In-Cell for 16 or More Hours per Day and for 15 Consecutive Days or Longer by Jurisdiction

Chart 3 Prisoners in Restricted Housing by Length of Time and by Percent of the 54,382 Prisoners for Which Length-of-Stay Data Were Provided

Chart 4 Prisoners in Restricted Housing by Length of Time and by Classification of the Type of Restrictive Custody

Chart 5 Percentage of Male Custodial Population in Restricted Housing

Chart 6 Percentage of Female Custodial Population in Restricted Housing

Chart 7 Demographic Percentage Composition of Total Male Custodial Population and Male Restricted Housing Population

Chart 8 Demographic Percentage Composition of Total Female Custodial Population and Female Restricted Housing Population

Chart 9 Age Cohorts of Male Total Custodial Population and of Male Restricted Housing Population

Chart 10 Age Cohorts of Female Total Custodial Population and of Female Restricted Housing Population

TABLES

Table 1 Types of Facilities Within State and Federal Corrections Systems

Table 2 Numbers and Percentages of Men and Women in Custodial Population in Restricted Housing by Jurisdiction (15 Consecutive Days or Longer, 22 Hours or More per Day)

Table 3 Numbers and Percentages of Men and Women in Custodial Population In-Cell for 16 or More Hours per Day and for 15 Consecutive Days or Longer by Jurisdiction

Table 4 Numbers of Prisoners in Restricted Housing by Length of Time and by Jurisdiction

Table 5 Number and Percentage of Male Custodial Population in Restricted Housing

Included in SCDC' 4.29.19 letter to LOC

Table 6 Number and Percentage of Female Custodial Population in Restricted Housing

Table 7 Demographic Composition of Total Male Custodial Population and of Male Restricted Housing Population

Table 8 Demographic Percentage Composition of Total Male Custodial Population and of Male Restricted Housing Population

Table 9 Demographic Composition of Total Female Custodial Population and Female Restricted Housing Population

Table 10 Demographic Percentage Composition of Total Female Custodial Population and Female Restricted Housing Population

Table 11 Age Cohorts of Male Total Custodial Population and of Male Restricted Housing Population

Table 12 Age Cohorts by Percentage of Male Total Custodial Population and of Male Restricted Housing Population

Table 13 Age Cohorts of Female Total Custodial Population and of Female Restricted Housing Population

Table 14 Age Cohorts by Percentage of Female Total Custodial Population and of Female Restricted Housing Population

Table 15 Male Prisoners with a Serious Mental Health Issue (Variously Defined) in Restricted Housing

Table 16 Female Prisoners with a Serious Mental Health Issue (Variously Defined) in Restricted Housing

Table 17 Male Prisoners with a Serious Mental Health Issue by Race and Ethnicity

Table 18 Female Prisoners with a Serious Mental Health Issue by Race and Ethnicity

Table 19 Pregnant Prisoners in Restricted Housing

Included in SCDC' 4.29.19 letter to LOC

Appendix C: Jurisdictions' Definitions of Serious Mental Illness

	Definition
Alabama	"Mental Disorder. A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual."
Arizona	"[T]hose inmates who possess a qualifying mental health diagnosis and a severe functional impairment directly relating to their mental illness." It also includes those inmates who were deemed SMI in the community, but who do not necessarily meet the criteria in our system. SMI inmates are not housed in detention; they are grouped together in Restrictive Status Housing using a step program for out of cell time and privileges."
Colorado	"The current diagnosis of any of the following DSM diagnoses accompanied by the P-code qualifier of M, denoting the presence of a major mental disorder: schizophrenia, schizoaffective disorder, delusional disorder, schizophreniform disorder, brief psychotic disorder, substance-induced psychotic disorder (excluding intoxication and withdrawal), unspecified schizophrenia spectrum and other psychotic disorder (previously psychotic disorder not otherwise specified), major depressive disorders, and bipolar disorders. Offenders, regardless of diagnosis, indicating a high level of mental health needs based upon high symptom severity and/or high resource demands, which demonstrate significant impairment in their ability to function within the correctional environment." Colorado does NOT allow offenders with Serious Mental Illness to remain in Restricted Housing over 30 days.
Connecticut	"Inmates that are assessed by Mental health staff as having a mental health score of level 4 or 5. MH5 Assessment: Crisis level mental disorder (acute conditions, temporary classification). Requires 24 hour nursing care. MH4 Assessment: Mental Health disorder severe enough to require specialized housing or ongoing intensive mental health treatment; usually on psychotropic medications."

Included in SCDC' 4.29.19 letter to LOC

District of Columbia	"People with DSM 4 Axis I disorders."
Florida	"For the purpose of responding to these questions, the following definitions are provided: S-3 inmates are those that show impairment in adaptive functioning due to a diagnosed mental disorder. The S-4, S-5, and S-6 grades indicate severe impairment in adaptive functioning that is associated with a diagnosed mental disorder and require inpatient mental health treatment in a transitional care unit (TCU), a crisis stabilization unit (CSU), or the Correctional Mental Health Treatment Facility (CMHTF). Admission to a CMHTF requires judicial commitment."
Georgia	"Offenders who have been diagnosed with a serious mental illness by a mental health professional and have a mental health level 3 or 4 classification profile."
Hawaii	"A diagnosable mental disorder characterized by alternation in thinking, mood, or impaired behavior associated with distress and/or impaired functioning: primarily inclusive of schizophrenia, severe depression and bipolar disorder, and severe panic disorder, obsessive compulsive disorder, and post-traumatic stress disorder."
Illinois	"A person shall be considered to be 'Seriously Mentally Ill' ('SMI') if he or she, as a result of a mental disorder as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders ('DSM') of the American Psychiatric Association, exhibits impaired emotional, cognitive, or behavioral functioning that interferes seriously with his or her ability to function adequately except with supportive treatment or services. These individuals also must either currently have, or have had within the past year, a diagnosed mental disorder, or must currently exhibit significant signs and symptoms of a mental disorder. A diagnosis of alcoholism or drug addiction, developmental disorders, or any form of sexual disorder shall not, by itself, render an individual seriously mentally ill. The combination of either a diagnosis or significant signs and symptoms of a mental disorder and an impaired level of functioning, as outlined above, is necessary for one to be considered Seriously Mentally Ill."
Iowa	"Serious mental illness is defined as chronic and persistent mental illnesses in the following categories: § Schizophrenia § Recurrent Major Depressive Disorders § Bipolar Disorders § Other Chronic and Recurrent Psychosis § Dementia and other Organic Disorders"
Kansas	"Mental Health Levels 3-7 and anyone under behavioral healthcare with medication"

Included in SCDC' 4.29.19 letter to LOC

Kentucky	"Serious Mental Illness means a current diagnosis by a Department of Corrections psychological or psychiatric provider or a recent significant history of any of the following DSM-V (or most current revision thereof) diagnoses: Schizophrenia, Delusional Disorder, Schizophreniform Disorder, Schizoaffective Disorder, Brief Psychotic Disorder, Substance-Induced Psychotic Disorder (excluding intoxication and withdrawal), psychotic disorder Not Otherwise Specified, Bipolar I and Bipolar II disorders or a current diagnosis by a Department of Corrections psychological or psychiatric provider of a serious personality disorder that includes breaks with reality and results in significant functional impairment, or a current diagnosis by a Department of Corrections psychological or psychiatric providers of either an intellectual disability, a neurodevelopmental disability, or an amnestic or neurocognitive disorder that results in significant functional impairment. Per CPP 13.13"
Maryland	"In our manual, we use SMI to mirror the meaning defined in COMAR10.21.17.02 and in accordance with the most recent edition of the Diagnostic and Statistical Manual. These diagnoses include psychotic disorders, major mood disorders, and specifically identified personality disorders. These disorders would be: Schizophrenic disorder; Major Affective disorder; Other psychotic disorder; Borderline schizotypal personality disorder with the exclusion of an abnormality that is manifested only to be repeat criminal or otherwise antisocial conduct."
Massachusetts	"The designation of SMI indicates the presence of nine mental illness from DSM 5 which are serious psychotic or mood disorders. In addition, serious character pathology which results in depressive or psychotic episodes, intellectual disabilities or other disorders that result in significant functional impairment may be designated as SMI."
Minnesota	"The adult: (i) has a diagnosis of schizophrenia, bipolar disorder, major depression, schizoaffective disorder, or borderline personality disorder; (ii) indicates a significant impairment in functioning; and (iii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided"
Mississippi	"Serious mental illness is a diagnosable disorder of thought, mood, perception, orientation, or memory that significantly impairs a person's judgment, behavior, capacity to recognize reality, and/or ability to meet the ordinary demands of life currently or at any time during the past year."

Included in SCDC' 4.29.19 letter to LOC

Missouri	"Serious mental health offenders included all of our MH scores of 3, 4, and 5 which are defined below. MH5: Offenders requiring frequent mental health contacts, psychotropic medications and a structured living unit in a correctional institution. MH4: Offenders requiring intensive or long-term inpatient or residential psychiatric treatment at a social rehabilitation unit or special needs unit OR requires frequent psychological contacts and psychotropic medications to be maintained in a general population setting. MH3: Offender requires regular psychological services and/or psychotropic medication (or psychiatric monitoring)."
Montana	"Serious Mental Illness—a clinical disorder of thought, mood or anxiety included under Axis I of the DSM, *e.g.*, schizophrenia, major depression, bi-polar disorder, PTSD, or panic disorder, and inmates who were previously diagnosed with such mental illness, unless there is certification in the record that the diagnosis has been changed or altered as a result of a subsequent mental health evaluation by a licensed mental health professional. It does not include personality disorders, *i.e.*, borderline, antisocial, or paranoid personality disorders."
Nebraska	"Serious Mental Health Needs—defines patients with basic psychotic disorders or mood disorders, those who self-injure, the aggressive mentally ill, those with post-traumatic stress disorders, and suicidal inmates. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Mental Illness (MI)—defined as it is referenced by the DSM-5. A syndrome characterized by clinically significant disturbance in an individual's cognition, emotional regulation or behavior that reflects a dysfunction in the psychological, biological, or developmental process underlying mental functioning. Mental illness is usually associated with significant distress or a disability in social, occupational, or other important activities."
New Hampshire	"Defined by policy #6.31. This policy can be found on the NH-DOC website: http://www.nh.gov/nhdoc/policies/documents/6-31.pdf
New Jersey	"NJDOC defines it as any inmate having a mental health problem which impairs the functioning of the inmate to the extent which the MH clinical team determines that treatment warrants admission to a mental health unit. The below mentioned numbers represent the total number of inmates in the mental health units for both males and females. It incorporates those on the SU, RTU and TCU units."
New York [recheck]	"New York Correction Law states: An inmate has a serious mental illness when he or she has been determined by a mental health clinician

Included in SCDC' 4.29.19 letter to LOC

	to meet at least one of the following criteria: (i) he or she has a current diagnosis of, or is diagnosed at the initial or any subsequent assessment conducted during the inmate's segregated confinement with, one or more of the following types of Axis I diagnoses, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, and such diagnoses shall be made based upon all relevant clinical factors, including but not limited to symptoms related to such diagnoses: (A) schizophrenia (all sub-types), (B) delusional disorder, (C) schizophreniform disorder, (D) schizoaffective disorder, (E) brief psychotic disorder, (F) substance-induced psychotic disorder (excluding intoxication and withdrawal), (G) psychotic disorder not otherwise specified, (H) major depressive disorders, or (I) bipolar disorder I and II; (ii) he or she is actively suicidal or has engaged in a recent, serious suicide attempt; (iii) he or she has been diagnosed with a mental condition that is frequently characterized by -s with reality, or perceptions of reality, that lead the individual to experience significant functional impairment involving acts of self-harm or other behavior that have a seriously adverse effect on life or on mental or physical health; (iv) he or she has been diagnosed with an organic brain syndrome that results in a significant functional impairment involving acts of self-harm or other behavior that have a seriously adverse effect on life or on mental or physical health; (v) he or she has been diagnosed with a severe personality disorder that is manifested by frequent episodes of psychosis or depression, and results in a significant functional impairment involving acts of self-harm or other behavior that have a seriously adverse effect on life or on mental or physical health; or (vi) he or she has been determined by a mental health clinician to have otherwise substantially deteriorated mentally or emotionally while confined in segregated confinement and is experiencing significant functional impairment indicating a diagnosis of serious mental illness and involving acts of self-harm or other behavior that have a serious adverse effect on life or on mental or physical health."
North Dakota	"Our psychiatrist determined the below diagnoses for the definition of 'Serious Mental Health Issue.' Any psychotic disorder to include references to the below: • Schizophrenia • Schizoaffective • Schizophreniform • Brief Psychotic • Any reference to thought disorder • Any Bipolar Disorder • Major Depressive Disorder, Severe (with or without psychotic features)

Included in SCDC' 4.29.19 letter to LOC

	• Borderline Personality Disorder"
Ohio	"Adults with a serious mental illness are persons who are age eighteen (18) and over, who currently or at any time during the past year, have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most current Diagnostic and Statistical Manual of Mental Disorders and that has resulted in functional impairment which substantially interferes with or limits one or more major life activities. These disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects."
Oklahoma	"Offenders diagnosed as having mental illness, who require medication and who cycle in and out of stable functioning and Offenders with serious cognitive impairment due to developmental disorders, traumatic brain injury or medical illness and offenders who because of their mental illness require 24X7 monitoring and special housing."
Oregon	"We included inmates who are coded as MH2 or MH3 in our system. The definitions can be found here: http://www.oregon.gov/doc/OPS/HESVC/docs/policies_procedures/Section_G/PG04%20Basic%20Mental%20Health%20Services%202014.pdf "
Pennsylvania	"Inmates determined by the Psychiatric Review Team (PRT) to have a current diagnosis or a recent significant history of any of the DSM-IV-TR diagnoses: a. Schizophrenia (all types) b. Delusional Disorder c. Schizophreniform Disorder d. Schizoaffective Disorder e. Brief Psychotic Disorder f. Substance-Induced Psychotic Disorder (excluding intoxication and withdrawal) g. Psychotic Disorder Not Otherwise Specified h. Major Depressive Disorders i. Bipolar I and II"
Rhode Island	"Per our Director of Behavioral Health: A serious mental illness is defined as a mental disorder that causes "substantial functional impairment (i.e., substantially interfered with or limited one or more major life activities). Such disorders as Schizophrenia, Paranoid and other psychotic disorders, Bipolar disorders (hypomanic, manic, depressive, and mixed), Major Depressive disorders (single episode or recurrent), Schizoaffective disorders (bipolar or depressive), Borderline Personality disorder and Schizotypal Personality disorder."
South Carolina	"For this section we included inmates with any SCDC mental health classification indicating mental illness which ranges from stable (mentally ill but not requiring treatment) to hospitalization. Inmates with a SCDC mental health classification of substance abuse or intellectual disabilities/delays were not included in this group."

Included in SCDC' 4.29.19 letter to LOC

South Dakota	"The criteria for participation in the comprehensive assistance with recovery and empowerment (CARE) program are used to identify severely mentally ill inmates. 46:20:31:01. Eligibility criteria. To be eligible for CARE services the client must be 18 years of age or older and must meet the following SMI criteria: (1) The client must meet at least one of the following: (a) The client has undergone psychiatric treatment more intensive than outpatient care and more than once in a lifetime, such as, emergency services, alternative residential living, or inpatient psychiatric hospitalization; (b) The client has experienced a single episode of psychiatric hospitalization with an Axis I or Axis II diagnosis per the DSM-IV pursuant to subdivision 46:20:18:01(13); (c) The client has been treated with psychotropic medication for at least one year; or (d) The client has frequent crisis contact with a community mental health center, or another mental health provider, for more than six months as a result of a mental illness; and (2) The client must meet at least three of the following criteria: (a) The client is unemployed or has markedly limited job skills or poor work history; (b) The client exhibits inappropriate social behavior which results in concern by the community or requests for mental health or legal intervention; (c) The client is unable to obtain public services without assistance; (d) The client requires public financial assistance for out-of-hospital maintenance or has difficulty budgeting public financial assistance or requires ongoing training in budgeting skills or needs a payee; (e) The client lacks social support systems in a natural environment, such as close friends and family, or the client lives alone or is isolated; or (f) The client is unable to perform basic daily living skills without assistance."
Tennessee	"According to Tennessee Department of Correction policy: Serious Mental Illness is a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality or cope with the ordinary demands of life within the correctional environment and is manifested by substantial impairment or disability. Serious mental illness requires a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most current Diagnostic and Statistical Manual (DSM) or their International Classification of Disease (ICD) equivalent (and subsequent revisions) in accordance with an individualized treatment plan."
Texas	"Serious Mental Health Issue includes offenders receiving inpatient mental health services."
Utah	"If the offender had a DSM Axis I or II mental health diagnosis."
Vermont	"Seriously Functionally Impaired Designation per 28 V.S.A. Subsection

Included in SCDC' 4.29.19 letter to LOC

	906(1): (A) A disorder of thought, mood, perception, orientation, or memory as diagnosed by a qualified mental health professional, which substantially impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life and which substantially impairs the ability to function within the correctional setting. (B) A developmental disability, traumatic brain injury or other organic brain disorder, or various forms of dementia or other neurological disorders, as diagnosed by a qualified mental health professional, which substantially impairs the ability to function in the correctional setting."
Virginia	"VADOC uses mental health codes that indicate level of functioning and not diagnoses—26% of VADOC's total offender population maintain a mental health code."
Washington	"All offenders who meet the criteria for the Active Treatment Group AND who have had one Mental Health or Psychiatry encounter coded with a Serious Mental Illness (SMI) diagnosis code in the 6 months prior to the report end date."
West Virginia	"WVDOC uses NCCHC definition of SMI which states that those individuals that have basic psychotic or mood disorders (manic, depressive, self-injurious, PTSD, suicidal), would be classified as having Serious Mental Illness."
Wisconsin	"Our definition of 'Serious Mental Health Issue' includes the following: MH-2A - Inmates with serious mental illness based on Axis I conditions A. Inmates with a current diagnosis of, or are in remission from, the following conditions: • Schizophrenia (all sub types) • Delusional disorder • Schizophreniform disorder • Schizoaffective disorder • Psychosis NOS • Major depressive disorders • Bipolar disorder 1 & 2 B. Inmates with current or recent symptoms of the following conditions: • Brief psychotic disorder • Substance induced psychotic disorder C. Inmates with head injury or other neurologic impairments that result in behavioral or emotional control. D. Inmates with chronic and persistent mood or anxiety disorders or other conditions that lead to significant functional disability. MH-2B - Inmates with serious mental illness based on Axis II

Included in SCDC' 4.29.19 letter to LOC

	conditions A. Inmates with a primary personality disorder that is severe, accompanied by significant functional impairment, and subject to periodic decompensation (i.e. psychosis, depression, or suicidality). Note: Those who qualify for both MH-2A and MH-2B are coded MH-2A."
Wyoming	"Schizophrenia (all sub types) • Delusional disorder • Schizophreniform disorder• Schizoaffective disorder • Psychosis NOS • Major depressive disorders • Bipolar disorder 1 & 2"
Federal Bureau of Prisons	"Inmates with current or recent symptoms of the following conditions: • Brief psychotic disorder • Substance induced psychotic disorder"
Virgin Islands	"Severe mental illness is characterized by one or more of the following: • cognitive impairment, • a break with reality, including hallucinations and/or delusions. These symptoms may be acute or chronic in their presentation, cause functional impairment, and could pose a threat to the patients safety in the general population in a correctional setting."

Included in SCDC' 4.29.19 letter to LOC

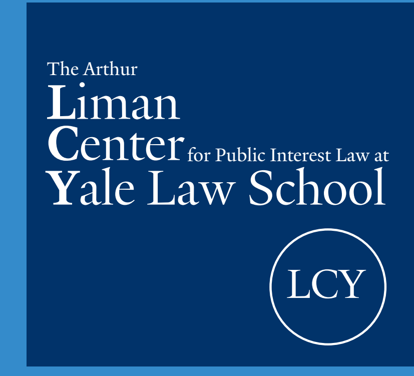
Reforming Restrictive Housing: The 2018 ASCA-Liman Nationwide Survey of Time-in-Cell

October 2018

Reforming Restrictive Housing: The 2018 ASCA-Liman Nationwide Survey of Time-in-Cell

The Association of State Correctional Administrators
The Liman Center for Public Interest Law
at Yale Law School

October 2018



Included in SCDC' 4.29.19 letter to LOC

Reforming Restrictive Housing: The 2018 ASCA-Liman Nationwide Survey of Time-in-Cell

The Association of State Correctional Administrators
The Liman Center for Public Interest Law
at Yale Law School

October 2018

Association of State Correctional Administrators (ASCA)

ASCA is the most exclusive correctional association in the world. ASCA members are the leaders of each U.S. state corrections agency, Los Angeles County, the District of Columbia, New York City, Philadelphia, the Federal Bureau of Prisons, U.S. Military Correctional Services (Army, Navy, Air Force, Marines), and United States territories, possessions, and commonwealths. ASCA members lead over 400,000 correctional professionals and supervise approximately eight million prisoners, probationers, and parolees. ASCA's goal is to increase public safety by utilizing correctional best practices, accountability, and providing opportunities for people to change.

The Arthur Liman Center for Public Interest Law, Yale Law School

The Liman Center was endowed to honor Arthur Liman, who graduated from Yale Law School in 1957. Throughout his distinguished career, he demonstrated how dedicated lawyers, in both private practice and public life, can respond to the needs of individuals and of causes that might otherwise go unrepresented. The Liman Center, which began as the Liman Program in 1997, continues the commitments of Arthur Liman by supporting work, in and outside of the academy, dedicated to public service in the furtherance of justice.

Acknowledgements

This report is based on a survey co-authored by ASCA and the Liman Center at Yale Law School. The research and report teams were led at ASCA by Leann Bertsch, Kevin Kempf, Bob Lampert, Gary Mohr, Rick Raemisch, A.T. Wall, and Wayne Choinski, and at Yale by Judith Resnik, Anna VanCleave, Kristen Bell, and Alexandra Harrington. Yale Law students Greg Conyers, Catherine McCarthy, Jenny Tumas, and Annie Wang played major roles in the research, analysis, and drafting of this Report. Yale Law students Faith Barksdale, Stephanie Garlock, and Daniel Phillips reviewed and edited the final drafts. We also received helpful suggestions from the Vera Institute of Justice.

Thanks are due to all the jurisdictions that responded to the survey and provided comments and reviews thereafter. This research has been supported by Yale Law School, the Liman Center, the Vital Projects Fund, and the Oscar M. Ruebhausen Fund at Yale Law School. This monograph was also made possible in part by a grant from Carnegie Corporation of New York to Judith Resnik, who is a 2018–2020 Andrew Carnegie Fellow. The Vital Projects Fund, the Ruebhausen Fund, and Carnegie Foundation are not responsible for the research and views expressed here. Special thanks are due to Bonnie Posick of Yale Law School's staff for expert editorial advice and to Elizabeth Keane, Program Coordinator of the Liman Center.

To download copies of this Report, please visit the website of the Liman Center at https://law.yale.edu/centers-workshops/arthur-liman-center-public-interest-law/liman-center-publications. The report can also be found on ASCA's website at: http://asca.net/documents/. This Report may be reproduced free of charge and without the need for additional permission. All rights reserved, 2018.

Inquiries:

Kevin Kempf
Executive Director, ASCA
kkempf@asca.net

Wayne Choinski
Project Manager, ASCA
wchoinski@asca.net

Judith Resnik
Arthur Liman Professor of Law
Yale Law School
judith.resnik@yale.edu

Anna VanCleave
Liman Center Director
anna.vancleave@yale.edu

Reforming Restrictive Housing: The 2018 ASCA-Liman Nationwide Survey of Time-in-Cell

Table of Contents

Executive Summary **4**

I. UNDERSTANDING RESTRICTIVE HOUSING OVER TIME AND ACROSS JURISDICTIONS

The ASCA-Liman Research Agenda **7**
The 2017–2018 Survey's Design and Distribution **8**
Research Challenges and Caveats **9**

II. THE DATA FROM THE 2017–2018 ASCA-LIMAN SURVEY

The Numbers and Percentages of Prisoners in Restrictive Housing: Counting and Comparing General and Restrictive Populations **10**
Length of Time in Restrictive Housing **14**
The Demographics of Restrictive Housing **17**
Sex / Gender **17**
Race and Ethnicity **22**
Age **36**
Subpopulations **46**
Prisoners with Mental Health Issues **46**
Pregnant Women **55**
Transgender Prisoners **55**
A Snapshot of Two Jails **56**

III. REVISING POLICIES ON RESTRICTIVE HOUSING

Entry and Oversight **60**
Time Out-of-Cell, Sociability, and Programming **61**
Staff Training **62**
Release **62**
Implementing the 2016 ACA Restrictive Housing Performance Based Standards **63**
Evaluating the Effects of Policy Changes **65**
Aspiring for More Time Out-of-Cell **65**

Included in SCDC' 4.29.19 letter to LOC

IV. WORKING TO LIMIT RESTRICTIVE HOUSING: FOUR JURISDICTIONS MAKING CHANGES

Colorado Reforms: What Do You Mean "Culture"?
Rick Raemisch, Executive Director, Colorado Department of Corrections **67**

Idaho: Efforts to Reform Restrictive Housing
Henry Atencio, Director, Idaho Department of Correction and
Keith Yordy, Warden, Idaho State Correctional Institution **69**

Reflections on North Dakota's Sustained Solitary Confinement Reform
Leann Bertsch, Director, North Dakota Department of
Corrections and Rehabilitation **72**

Restrictive Housing: The Challenge of Reforming the Fabric of an Agency
Gary Mohr, Director, Ohio Department of Rehabilitation
and Correction **75**

V. CALLS FOR REFORM AND FOR ABOLITION: RESTRICTIVE HOUSING IN 2018

Correctional Systems Making Changes **82**
Understanding the Harms of Isolation **84**
Legislative Regulations **87**
Litigation and Consent Decrees **88**
Restrictive Housing as a Global Concern **92**

VI. COMPARING THE NUMBERS OF PEOPLE IN RESTRICTIVE HOUSING IN 2015–2016 AND IN 2017–2018 **95**

Endnotes **104**

Appendices
Appendix A: ASCA-Liman 2017–2018 Restrictive Housing Survey **153**
Appendix B: This Report's Tables and Figures **181**
Appendix C: Definitions of "Serious Mental Illness" in 43 Jurisdictions **184**

Included in SCDC' 4.29.19 letter to LOC

Executive Summary

Reforming Restrictive Housing: The 2018 ASCA-Liman Nationwide Survey of Time-in-Cell

This Report is the fourth in a series of research projects co-authored by the Association of State Correctional Administrators (ASCA) and the Arthur Liman Center at Yale Law School. These monographs provide nationwide data on "restrictive housing," defined in this Report as separating prisoners from the general population and holding them in their cells for an average of 22 hours or more per day for 15 continuous days or more. This practice is often termed "solitary confinement." *Reforming Restrictive Housing* documents the changes underway as prison administrators aim to limit the use of segregation and find alternatives to the isolation of restrictive housing.

In 2013, the first report of the series, *Administrative Segregation, Degrees of Isolation, and Incarceration*, analyzed the restrictive housing policies of 47 jurisdictions. The 2013 Report found that the criteria for placement in isolation were broad. Getting into segregation was relatively easy, but few policies addressed release. In contrast, in 2018, directors around the country reported narrowing the bases for placement in restrictive housing, increasing oversight, and limiting time spent in isolation. In some places, behaviors that once put people into restrictive housing—from "horse play" to possession of small amounts of marijuana—no longer do. And for those people in restrictive housing, efforts are reportedly underway in some jurisdictions to create more out-of-cell time and more group-based activities.

Since 2013, ASCA and the Liman Center have conducted national surveys of the number of people in restrictive housing. The 2015 report, *Time-in-Cell*, estimated that 80,000 to 100,000 prisoners were in segregation across the country. The 2016 report, *Aiming to Reduce Time-in-Cell*, identified almost 68,000 people held in isolation.

For the 2017–2018 data collection, ASCA-Liman sent surveys to the 50 states, the Federal Bureau of Prisons (FBOP), the District of Columbia, and four jail systems in large metropolitan areas. The 43 prison systems that provided data on prisoners in restrictive housing held 80.6% of the U.S. prison population. They reported that 49,197 individuals—4.5% of the people in their custody—were in restrictive housing. Across all the reporting jurisdictions, the median percentage of the population held in restrictive housing was 4.2%; the average was 4.6%. The percentage of prisoners in restrictive housing ranged from 0.05% to 19%. Extrapolating from these numbers to the systems not reporting, we estimate that some 61,000 individuals were in isolation in prisons in the fall of 2017.

Thirty jurisdictions reported when they began to track how long people had been in restrictive housing. Some jurisdictions began tracking this information as recently as 2017. Within the responding jurisdictions, most people were held in segregation for a year or less. Twenty-five

Included in SCDC' 4.29.19 letter to LOC

jurisdictions counted more than 3,500 individuals who were held for more than three years. Almost 2,000 of those individuals had been there for more than six years.

The 2017–2018 survey also gathered information about gender, race and ethnicity, and age. Men were much more likely than women to be in solitary confinement. Black prisoners comprised a greater percentage of the restrictive housing population than they did the total custodial population. The reverse was true for White prisoners. Likewise, in the jurisdictions reporting on ethnicity, Hispanic male prisoners represented a greater percentage of the restrictive housing population than they did the total custodial population. Prisoners between the ages of 18 and 36 were more likely to be segregated than were older individuals.

Reforming Restrictive Housing also documents the many and varying definitions of "serious mental illness." Using each jurisdiction's own definition, we learned that more than 4,000 people with serious mental illness are in restrictive housing.

Other subpopulations counted were pregnant prisoners and transgender individuals. Responses indicated a total of 613 pregnant prisoners, none of whom were in restrictive housing. Prison systems reported incarcerating roughly 2,500 transgender individuals, of whom about 150 were reported to be in segregation.

In addition to the prison systems responding, the jail systems in Los Angeles County and Philadelphia provided restrictive housing data. In these two systems, the restrictive housing population ranged from 3.6% to 6.2 % of the total jail population. Both jurisdictions described revising their restrictive housing policies, including by limiting its use for people with serious mental illness. One of the jail systems explained that, given the turnover in some jail populations, the administrators faced challenges in avoiding direct release from restrictive housing into the community.

The 2018 Report tracks the impact of the 2016 American Correctional Association's (ACA) Restrictive Housing Performance Based Standards. Thirty-six prison systems reported reviewing their policies since the release of the ACA Standards. More than half had implemented one or more reforms to align with the ACA. Those Standards reflect the national consensus to limit the use of restrictive housing for pregnant women, juveniles, and seriously mentally ill individuals, as well as not to use a person's gender identity as the sole basis for segregation.

In this Report and the related 2018 ASCA-Liman monograph, *Efforts in Four Jurisdictions to Make Changes*, the directors of the prison systems in Colorado, Idaho, Ohio, and North Dakota detail how they were limiting and, in Colorado, abolishing holding people in cells 22 hours or more for 15 days or more. These individual accounts reflect the broader trend of policy changes.

This Report puts the data collected from the 2017–2018 survey in the context of national and international actions regulating the use of restrictive housing. Correctional systems around the country are engaging in targeted efforts to reform their practices of isolating prisoners. Examples

of such efforts are contained in the Vera Institute of Justice's 2018 monograph, *Rethinking Restrictive Housing*.

In other instances, reforms have come from state legislatures. Some statutes now place limits on the length of time individuals can be held in segregation, require reviews of placement decisions, and ban the use of isolation for juveniles and other subpopulations. Litigation has also resulted in decisions that highlight the harms of restrictive housing and, in some cases, prohibit its use. Parallel efforts and mandates can be found outside the United States—from implementation of the Nelson Mandela Rules to litigation and reform through policy changes.

The ASCA-Liman surveys provide a longitudinal database to enable evidence-based analysis of the practice of holding people in isolation. This Report compares the responses of the 40 prison systems that answered the ASCA-Liman surveys in both 2015 and 2017. In those 40 systems, we learned about 56,000 people in restrictive housing in 2015. The number of prisoners reported to be in restrictive housing decreased by almost 9,500 to 47,000 people in 2017. The percentage of individuals in isolation decreased from 5.0% to 4.4%.

The changes are not uniform. In more than two dozen states, the numbers of people in restrictive housing decreased. In 11 states, the numbers went up. What accounts for the changing numbers is unclear. Variables include new policies and practices, litigation, legislation, fluctuations in the overall prison population, and staffing patterns. For example, in 20 of the 29 jurisdictions in which restrictive housing numbers declined, so too did the total prison population. In two of the 11 jurisdictions that had an increase in restrictive housing numbers, the total prison population increased as well.

The amount of time spent in restrictive housing is of increasing concern. Not all correctional systems track length of confinement. Nineteen jurisdictions reported that they began tracking in 2013 or thereafter. In 31 jurisdictions responding to questions about length of time in both 2015 and 2017, the number of individuals in restrictive housing for three months or less increased. The number of people in isolation for longer than three months decreased. The decreases were greatest for time periods longer than six months.

Correctional administrations' efforts to reduce the numbers of people in restrictive housing are part of a larger picture in which legislatures, courts, and other institutions are seeking to limit holding people in cells 22 hours or more for 15 days or more. These endeavors reflect the national and international consensus that restrictive housing imposes grave harms on individuals confined, on staff, and on the communities to which prisoners return. Once solitary confinement was seen as a solution to a problem. Now prison officials around the United States are finding ways to solve the problem of restrictive housing.

Included in SCDC' 4.29.19 letter to LOC

I. Understanding Restrictive Housing Over Time and Across Jurisdictions

The ASCA-Liman Research Agenda

ASCA and the Liman Center at Yale Law School have worked together on a variety of projects and seminars related to the interactions among prisoners, correctional departments, communities, and courts. Research studies have included 50-state surveys of correctional departments' policies on visiting incarcerated people[1] and on restrictive housing, and we have joined together to convene workshops and make presentations at conferences.[2]

This report is the fourth in a series of ASCA-Liman research projects focused on "restrictive housing" (known in the general literature as "solitary confinement"), defined in this report as placing individuals in cells for an average of 22 hours or more per day for 15 continuous days or more. Our goals have been to gather information and to build a database so that discussions of these practices are informed by accurate information on the use of restrictive housing that permits evidence-based analyses of policies and practices.

Over the course of the past several years, ASCA and the Liman Center have asked each of the correctional departments in the fifty states, the Federal Bureau of Prisons, and a few jail systems to answer survey questions about their populations and to provide policies so as to paint a composite picture at particular intervals and to have the ability to do longitudinal assessments. Through surveys every two years, we can learn about changes in the rules governing restrictive housing and the impact of changes on the people who live and who work in prisons and on the communities to which prisoners return.

Our first report of the series, *Administrative Segregation, Degrees of Isolation, and Incarceration: A National Overview of State and Federal Correctional Policies*,[3] in 2013 was based on responses from 47 jurisdictions. By analyzing the policies, we learned that criteria for entry were generally broad, permitting confinement based on nonspecific concerns about "threats to security." Staff had broad discretion to determine both the placement and the duration of confinement.[4] Getting in was easy, but few of the policies detailed how individuals were to be released from isolation, once segregated.[5]

In 2014, the ASCA-Liman survey asked departments of corrections more than 130 questions about the numbers of people in restrictive housing and the conditions in which they lived. Our 2015 *Time-In-Cell* Report provided an overview of the data collected.[6] Answers came from 34 jurisdictions, housing 73% of the prison population, where more than 66,000 individuals were held in various types of restrictive housing.[7] We thus estimated that approximately 80,000 to 100,000 prisoners were in isolation in prison systems across the country.[8] The U.S. Department of Justice relied on the ASCA-Liman research when formulating its rules for federal facilities,[9] and many news outlets, including the *Wall Street Journal*,[10] the *New York Times*,[11] and *USA Today*,[12] discussed the findings.

Included in SCDC' 4.29.19 letter to LOC

The 2016 Report, *Aiming to Reduce Time-in-Cell*,[13] sought updated numbers and information on the demographics and duration of confinement among prisoners in restrictive housing. We learned that, as of the fall of 2015, 67,442 people were held in restrictive housing in 48 jurisdictions, which housed about 96% of the United States prison population.[14] Data on duration of confinement came from a subset of 41 jurisdictions, housing 54,382 people in segregation.[15] Of the people for whom we had duration data, 9,638 or 18% were held in restrictive housing for 15 to 30 days; 15,725 or 29% for one to three months; 15,978 or 29% for three months to one year; 7,132 or 13% for one to three years; and 5,909 or 11% were in isolation for three years or more.[16] As the 2016 Report's title reflects, several corrections department were changing policies governing the criteria for placement in restrictive housing, oversight, programs for prisoners, and pathways to release.[17] The 2016 Report was also widely distributed and discussed.[18]

The 2017–2018 Survey's Design and Distribution

For the 2017–2018 data collection, a subcommittee of ASCA members and Liman Center staff worked together to refine the survey questions. Again, we sought to gather information about the numbers and demographics of people held in restrictive housing, the length of time people spent in restrictive housing, and whether, how, and why policies governing restrictive housing were changing. While the questions generally followed their prior format, we had learned that some inquiries were insufficiently clear, and we identified new topics about which to ask.

For example, because our focus is on the people held in isolation for almost the entire day, the definition of restrictive housing for the 2016 survey needed to be improved. Instead of defining restrictive housing as "separating prisoners from the general population and holding them in their cells for 22 hours per day or more for 15 or more continuous days,"[19] we shifted from the "22 hours per day" formulation to "an average of 22 hours."[20] In addition, because the American Correctional Association (ACA) adopted new Standards on restrictive housing in August of 2016,[21] we also sought to learn about whether jurisdictions relied on the ACA Standards in formulating their own policies.

As in the past, ASCA-Liman used a Qualtrics online platform to distribute the survey to the corrections departments in all 50 states, the District of Columbia, and the Federal Bureau of Prisons. In addition, because of the large numbers of individuals detained in jails, we sent surveys to the four large metropolitan jail systems that are ASCA members.[22] Asking 76 questions, we sought data as of the fall of 2017 from each jurisdiction.[23]

Responses to at least some of the questions came in the fall of 2017 from 46 of the 52 prison jurisdictions[24] and from two of the four major metropolitan area jails;[25] materials related to the two jails are discussed separately. Thereafter, we emailed each jurisdiction a customized follow-up survey, seeking clarifications of specific responses. Forty-three jurisdictions responded with information on the total number of people in restrictive housing. According to statistics on prison populations from the Bureau of Justice Statistics (BJS), those jurisdictions housed about 80 percent of the total prison population.[26] Thirty-four jurisdictions completed follow-up surveys. We

then followed up again via email and telephone calls with jurisdictions from which clarifications were needed.

Research Challenges and Caveats

As in past reports, the analyses are based on self-reports from each jurisdiction, describing its population, its policies, and their impact. We did not do site visits or obtain information from other data sources.[27] By way of conclusion, we put the data collected here in context through an overview of some of the recent research, legislation, and court decisions that are part of national and international work on restrictive housing.

We remind readers that sketching a national picture is made complex because of variations across jurisdictions in definitions, the kinds of restrictive housing, and methods of keeping information. In an effort to standardize answers across jurisdictions, we provided definitions of restrictive housing, age cohorts, and the like. However, in light of the various definitions used for identifying individuals with "serious mental illness," we asked each jurisdiction to provide its own definition, listed in Appendix C. Further, in many instances we have information from a subset of jurisdictions, in that some respondents reported that they either did not keep or could not provide responses to all the inquiries.

Another important reminder is that, while we have gathered more national data than are otherwise available, we cannot account for all the persons held in restrictive housing. Our materials come primarily from prison system administrators, and most prison systems do not include jails, which are often run at the local level, or juvenile facilities. We know that as of midyear 2016, about 740,700 people were confined in county and city jails in the United States; some of these detainees were held in isolation.[28] As noted, we did send surveys to four major metropolitan jail systems that are ASCA members. We received information from two, which enabled us to provide a snapshot of restrictive housing in the jails in Los Angeles and in Philadelphia. We also did not gather data on restrictive housing in immigration and military facilities. Moreover, some jurisdictions gave information on less than all of their prison population as of the fall of 2017, and, in some jurisdictions, large numbers of state prisoners are sent to local jails, to private facilities, or to other venues about which information on restrictive housing was not available.

II. The Data from the 2017–2018 ASCA-Liman Survey

The Numbers and Percentages of Prisoners in Restrictive Housing: Counting and Comparing General and Restrictive Populations

The survey asked jurisdictions to report, as of the fall of 2017, both on their total prison populations and on the number of prisoners held in restrictive housing. The definition provided of restrictive housing was "separating prisoners from the general population and holding them in their cells for an average of 22 or more hours per day for 15 or more continuous days."[29]

Of the 46 responding jurisdictions, 43 provided data on both the total custodial population and the numbers of prisoners in restrictive housing.[30] These 43 jurisdictions reported housing a total of 1,087,671 prisoners, of whom 49,197 were in restrictive housing—or 4.5% of the prisoners confined across this set.[31]

According to the Bureau of Justice Statistics, as of December 31, 2016, the total state and federal prison population in the United States was 1,506,757.[32] Using that baseline, the 43 responding jurisdictions housed 80.6% of the total prison population in the United States.

By assuming that the same percentage of prisoners are placed in restrictive housing in the jurisdictions for which we lack data as those for which we do have data and that the distribution of prisoners across states was the same in December 2016 and fall 2017, we estimate that approximately 61,000 prisoners were in restrictive housing across the United States in the fall of 2017.[33]

One clarification is in order. This Report uses "total custodial population" to refer to the number of people under each system's direct control and for whom the jurisdiction provided 2017 restrictive housing data. The 2016 BJS overview used a broader definition that reflected the total number of people under the legal authority of a prison system. In this report, 43 jurisdictions told us about 1,087,671 prisoners in their total custodial populations, which is less than the BJS December 2016 aggregate of those systems. When using the total custodial population as counted by the 43 jurisdictions, this report describes not 80.6% of the U.S. prison population, but rather data on 72.2%.

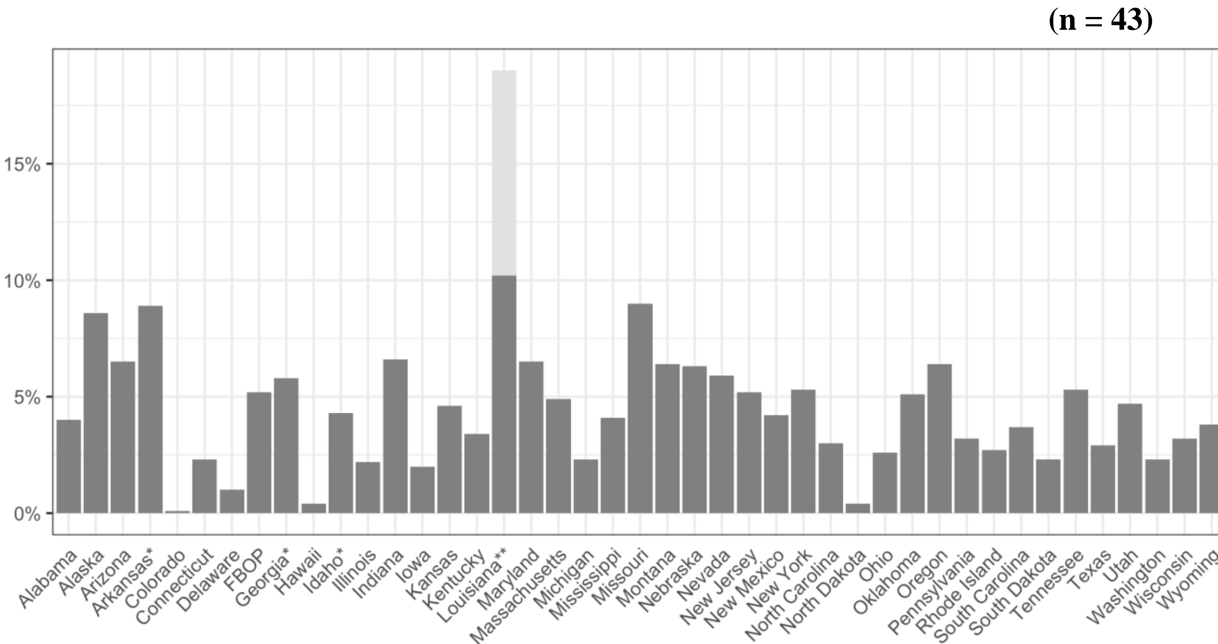
We provide jurisdiction-specific data on the numbers of prisoners in restrictive housing in Figure 1, Figure 2, and Table 1, below. The numbers are taken from responses to two survey questions about the restrictive housing population and the total custodial population: "How many people are in restrictive housing in those facilities?" and "Please provide the total custodial population under your direct control." The survey asked about both "short-term restrictive housing," (15–29 days) and "extended restrictive housing" (30 or more days). Figure 1, Figure 2, and Table 1 include the sum of both of these forms of restrictive housing. In responses to other questions, some jurisdictions provided numbers that did not add up to the same totals reflected in the answers that are the basis for Figure 1. We note such variations in endnotes to the relevant tables and figures.

The percentage of prisoners in restrictive housing—calculated as the number in restrictive housing divided by the total custodial population reported by each respective jurisdiction—ranged

Included in SCDC' 4.29.19 letter to LOC

from 0.05% to 19.0%.[34] Across all the reporting jurisdictions, the median percentage of the population held in restrictive housing was 4.2%; the average was 4.6%. To make readily accessible the numbers on restrictive housing, we provide one figure ordered alphabetically and another ordered by the percentage of prisoners in restrictive housing.

Figure 1 Percentages of Prisoners in Restrictive Housing by Jurisdiction
(n = 43)



* A caveat is in order for Figure 1, Figure 2, and Table 1. Responding jurisdictions were not consistent in using our definition of short-term restrictive housing, 15–29 days, as contrasted with the definition of 1–29 days. Jurisdictions were asked about both "short-term" and "extended" restrictive housing. Some jurisdictions understood the definition of "short-term" to refer to 15–29 days, while others understood the definition to refer to 1–29 days. The majority of jurisdictions were able to clarify their answer after their initial survey response and, if they utilized the 1–29 day definition, provide the restrictive housing population number consistent with the definition of 15–29 days. We note with an asterisk those jurisdictions that were unable to clarify which definition they used, as well as Idaho, which used the definition of 1–29 days.[35]

** Louisiana counted 14,291 men in its custody in prisons and 20,122 prisoners in local jails. Thus, as of fall 2017, 34,413 individuals were serving prison sentences, and 58.5% of these prisoners were in jails rather than in prisons. Louisiana reported that 2,709 (19%) of the men in its prisons were in restrictive housing. Louisiana did not provide restrictive housing data for its female prison population. Louisiana staff identified 784 "restrictive housing beds" in the jails. The number of beds that were occupied was not reported. If one assumed that all the restrictive housing beds for state-sentenced prisoners in the jails were full and combined the jail and prison population, the percentage of people in restrictive housing would go down from 19% to 10.2%. Shaded bars in the figures mark the different possibilities.

Included in SCDC' 4.29.19 letter to LOC

Figure 2 Percentages of Prisoners in Restrictive Housing by Percentage (n = 43)*

* See notes to Figure 1

Table 1 Numbers and Percentages of Men and Women in Restrictive Housing (RH) by Jurisdiction (n = 43)*

Jurisdiction	Total Custodial Population for Facilities Reporting RH Data[36]	Population in Restrictive Housing[37]	Percentage in Restrictive Housing
Alabama	21,592	855	4.0%
Alaska	4,393	378	8.6%
Arizona	42,146	2,723	6.5%
Arkansas*	15,905	1,418	8.9%
Colorado	18,297	10	0.1%
Connecticut	14,137	328	2.3%
Delaware	4,333	43	1.0%
FBOP	153,839	7,974	5.2%
Georgia*	54,723	3,200	5.8%
Hawaii	3,713	13	0.4%
Idaho*	7,161	310	4.3%
Illinois	42,177	921	2.2%
Indiana	26,317	1,741	6.6%
Iowa	8,283	167	2.0%

Kansas	9,886	459	4.6%
Kentucky	12,000	408	3.4%
Louisiana**	14,291	2,709	19.0%
Maryland	21,785	1,417	6.5%
Massachusetts	9,047	443	4.9%
Michigan	39,858	903	2.3%
Mississippi	12,940	529	4.1%
Missouri	33,204	2,990	9.0%
Montana	1,769	113	6.4%
Nebraska	5,178	328	6.3%
Nevada	13,718	810	5.9%
New Jersey	19,368	1,011	5.2%
New Mexico	7,047	294	4.2%
New York	50,764	2,666	5.3%
North Carolina	37,259	1,109	3.0%
North Dakota	1,830	8	0.4%
Ohio	49,954	1,282	2.6%
Oklahoma	26,895	1,368	5.1%
Oregon	14,574	938	6.4%
Pennsylvania	46,920	1,498	3.2%
Rhode Island	2,852	76	2.7%
South Carolina	19,938	737	3.7%
South Dakota	3,927	90	2.3%
Tennessee	22,160	1,181	5.3%
Texas	145,409	4,272	2.9%
Utah	6,293	296	4.7%
Washington	17,046	387	2.3%
Wisconsin	22,589	713	3.2%
Wyoming	2,154	81	3.8%
Total	**1,087,671**	**49,197**	**4.5%**

* See notes to Figure 1

Length of Time in Restrictive Housing

The survey asked jurisdictions about how many prisoners were held in-cell for different lengths of time. The intervals ran from 15–30 days to six years or more. Answers came from 36 jurisdictions that, in total, held 41,061 prisoners in restrictive housing.

More than a fifth (9,345 or 22.8%) of those prisoners were in restrictive housing for 15 days to one month. Almost 32% (12,968 people or 31.6%) were in restrictive housing for one to three months. About a quarter (11,055 or 26.9%) were in restrictive housing for three months to a year. Almost 10% (3,972 or 9.7%) were held for one to three years. The responses identified 3,721 people (9.1% of 41,061 people) were held for more than three years. Of that number, 1,950 were reported to have been in restrictive housing for more than six years.

The survey also asked whether jurisdictions "regularly gather, collect, or report information on each prisoner's length of stay in restrictive housing." Forty-five jurisdictions answered this question,[38] and 37 reported collecting data individually, in aggregate, or grouped by reason for placement or by another measure.[39] Eight jurisdictions reported that they do not regularly track information on length of stay,[40] yet some of this subgroup supplied numbers for the fall of 2017.[41]

Thus, the data on length of stay come both from jurisdictions that reported tracking length of stay regularly and from a few that did not. In addition, some jurisdictions have begun to keep such data in more recent years, and hence their numbers may reflect the time period for which they have gathered the data, rather than the actual length of time that individuals were held in restrictive housing.[42] The length-of-time intervals are reported in Figure 3 below and by jurisdiction in Table 2. Table 3 details responses from thirty jurisdictions providing information on when they began to collect length-of-time data, which may or may not include retrospective information.

Figure 3 Prisoners in Restrictive Housing by Length of Time (n = 36)

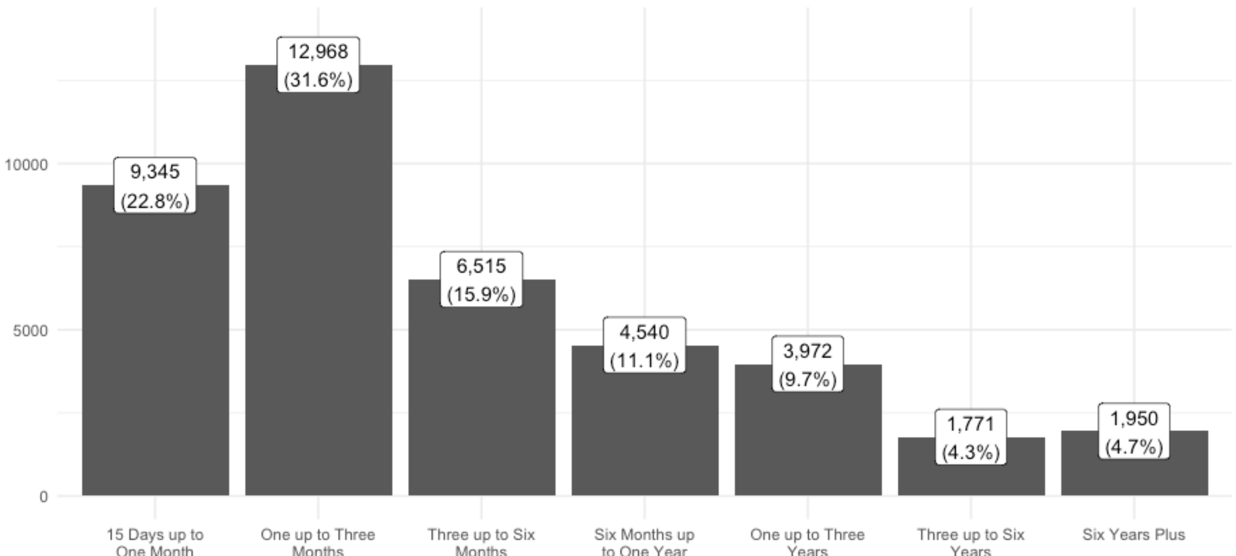


Table 2 Numbers of Prisoners in Restrictive Housing by Length of Time and by Jurisdiction (n = 36)[43]

	15 Days up to One Month	One up to Three Months	Three up to Six Months	Six up to Twelve Months	One up to Three Years	Three up to Six Years	Six Years Plus
Alabama	222	355	166	65	41	1	5
Alaska	72	78	50	25	31	0	0
Arizona	428	831	433	462	489	72	8
Colorado	10	0	0	0	0	0	0
Delaware	5	25	6	7	0	0	0
FBOP	1,764	3,690	1,382	609	254	120	155
Hawaii	23	0	9	0	0	0	0
Illinois[44]	335	342	122	136	113	34	16
Indiana	131	348	281	354	391	121	115
Iowa	56	98	10	3	0	0	0
Kansas	176	207	61	15	0	0	0
Kentucky	671	130	45	14	1	0	0
Louisiana	332	630	449	445	517	346	0
Massachusetts	76	118	50	28	31	5	4
Michigan	256	409	171	50	16	1	0
Mississippi	399	69	40	12	7	1	1
Missouri	1,122	842	215	229	80	20	2
Montana	8	34	30	24	11	6	0
Nebraska	19	94	102	81	32	1	3
New Jersey	150	398	178	100	79	36	70
New York	757	1,218	416	182	73	13	7
North Carolina	602	205	280	21	1	0	0
North Dakota	3	4	2	0	0	0	0
Ohio	226	288	243	271	183	49	22
Oklahoma	384	481	224	156	106	17	0
Oregon	126	291	152	41	30	7	1
Pennsylvania	305	517	252	126	106	41	151
Rhode Island	31	23	13	5	4	0	0
South Carolina	138	207	105	131	102	12	42
South Dakota	18	6	10	16	21	12	7
Tennessee	110	276	237	280	244	31	3
Texas	141	263	326	474	931	811	1,326
Utah	2	33	232	29	0	0	0
Washington	5	82	107	106	64	11	12
Wisconsin	221	345	91	41	13	2	0
Wyoming	21	31	25	2	1	1	0
Total	9,345	12,968	6,515	4,540	3,972	1,771	1,950

Table 3 Years When Tracking Length of Time in Restrictive Housing Began in Thirty Jurisdictions*

Year that Jurisdiction Began Tracking	Jurisdiction
1985	Colorado
1990	Nevada
1991	Kansas
1993	Alabama
1999	New Mexico
2000	Oklahoma
2006	Kentucky
2010	Iowa
2011	Connecticut
	Wisconsin
2012	Pennsylvania
2013	FBOP
2014	Hawaii
	Louisiana
	New York
	South Dakota
2015	Maryland
	Montana
	North Dakota
	Texas
	Washington
	Wyoming
2016	Nebraska
	New Jersey
	Rhode Island
	South Carolina
2017	Delaware
	Massachusetts
	Oregon
	Utah

*Information was not provided on whether, when the tracking began, data included retrospective analysis.

The Demographics of Restrictive Housing

As in prior reports, we sought to learn about the people placed in restrictive housing in terms of their sex/gender, race, and age, and whether they were identified as having serious mental illness. Below, we provide a composite picture drawn from the jurisdictions that responded about the populations under their direct control. Once again, we note when jurisdictions provided data that varied from the questions posed.

Sex/Gender

Thirty-four jurisdictions provided data on men in restrictive housing and 32 of those systems did so for women. As shown in Figure 4 below, 4.6% of the total male custodial population was in restrictive housing, and 1.2% of the total female custodial population was in restrictive housing in these jurisdictions.

Figure 4 Percent of Total Population in Restrictive Housing by Gender

(Male: n = 34; Female: n = 32)

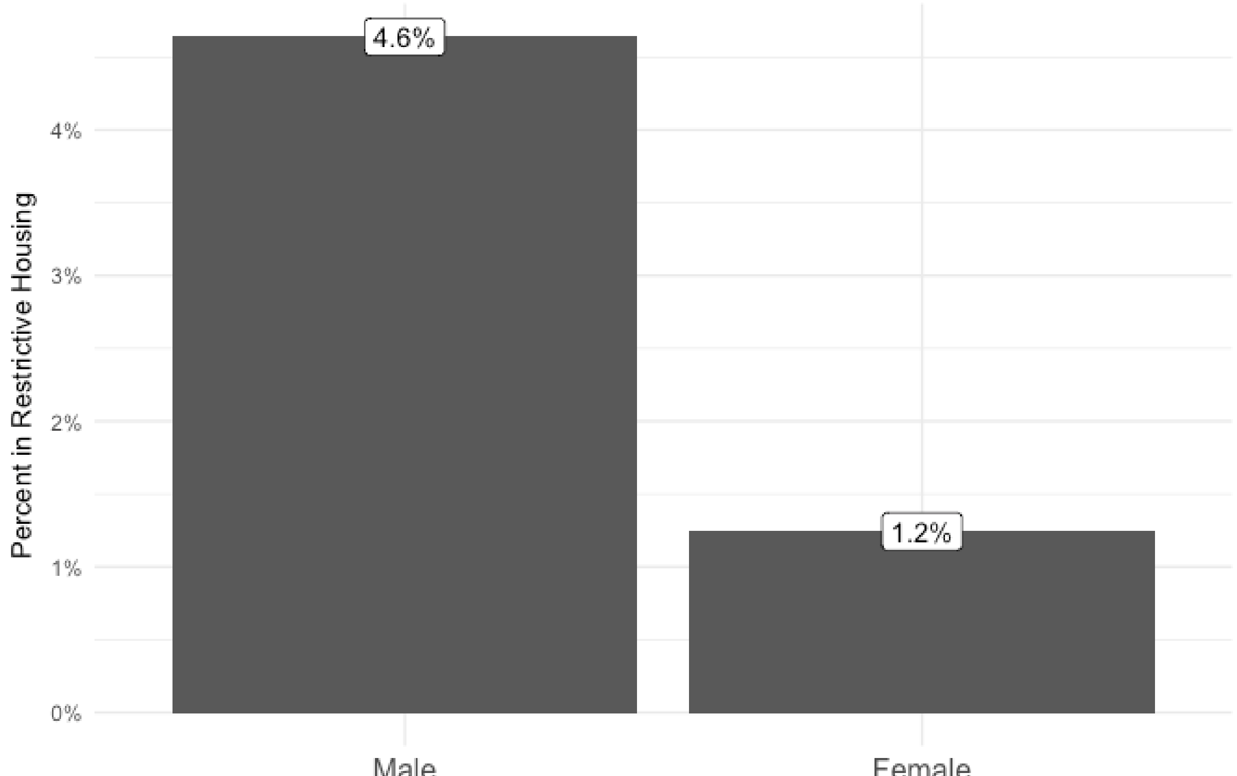


Figure 5, Figure 6, and Table 4 provide jurisdiction-by-jurisdiction information about the number of men in restrictive housing. Across the 34 jurisdictions providing data about the numbers of men, a total of 37, 690 men were reported in restrictive housing. The median percentage of male prisoners in restrictive housing was 4.2%. The percentage held in restrictive housing ranged from 19% of the male custodial population (2,709 out of 14,291 male prisoners) to under 0.1% (10 out of 16,624 male prisoners).[45] To make the information readily accessible, Figure 5 and Figure 6 provide the same information, arranged alphabetically and then in decreasing order of the percentage of the male custodial population in restrictive housing.

Figure 5 Percentage of Male Prisoners in Restrictive Housing by Jurisdiction* (n = 34)

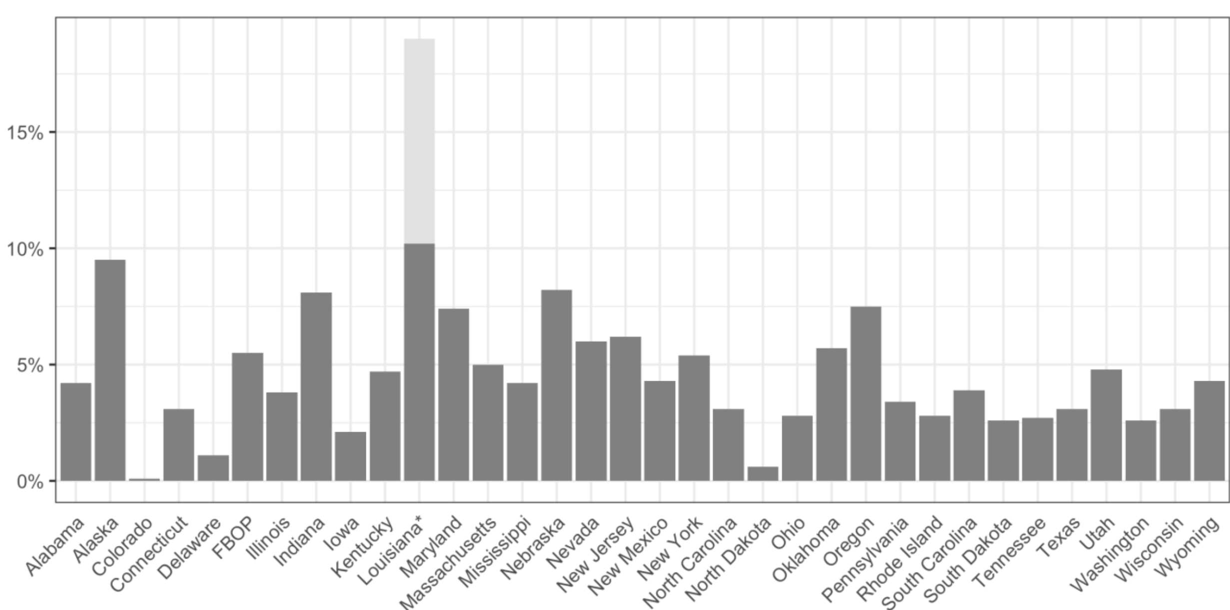
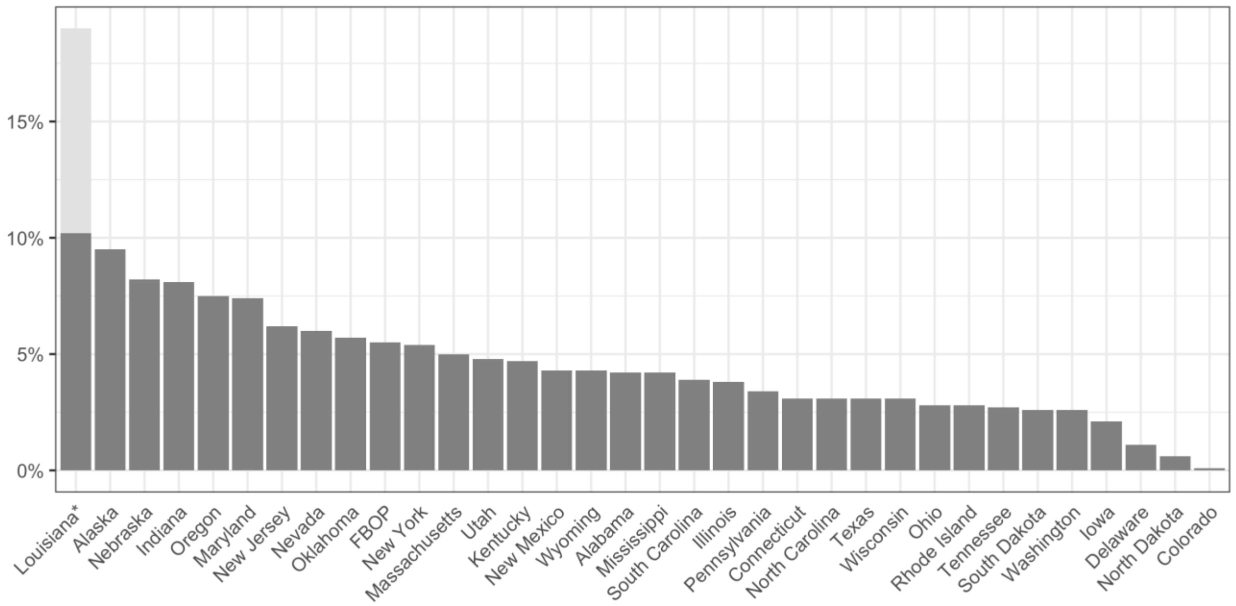


Figure 6 Percentage of Male Prisoners in Restrictive Housing by Percentage * (n = 34)



* As discussed in the notes to Figure 1, the bar for Louisiana represents two different calculations for Louisiana's percentage of male prisoners in restrictive housing,.

Table 4 Number and Percentage of Male Custodial Population in Restrictive Housing (n = 34) [46]

Jurisdiction	Total Custodial Population	Restrictive Housing Population	Percentage in Restrictive Housing
Alabama	20,282	852	4.2%
Alaska	3,990	378	9.5%
Colorado	16,624	10	0.1%
Connecticut	13,182	403	3.1%
Delaware	4,100	43	1.1%
FBOP	142,762	7,873	5.5%
Illinois	39,767	1,510	3.8%
Indiana	23,847	1,923	8.1%
Iowa	7,578	159	2.1%
Kentucky	20,427	951	4.7%
Louisiana	14,291	2,709	19.0%
Maryland	20,723	1,536	7.4%
Massachusetts	8,459	420	5.0%
Mississippi	12,038	504	4.2%
Nebraska	4,762	389	8.2%
Nevada	12,434	751	6.0%
New Jersey	18,594	1,143	6.2%
New Mexico	6,306	273	4.3%
New York	48,407	2,630	5.4%
North Carolina	34,326	1,076	3.1%
North Dakota	1,606	9	0.6%
Ohio	45,796	1,273	2.8%
Oklahoma	23,816	1,349	5.7%
Oregon	13,302	1,003	7.5%
Pennsylvania	44,300	1,492	3.4%
Rhode Island	2,722	76	2.8%
South Carolina	18,483	718	3.9%
South Dakota	3,402	89	2.6%
Tennessee	20,214	546	2.7%
Texas	133,229	4,176	3.1%
Utah	5,822	277	4.8%
Washington	15,744	407	2.6%
Wisconsin	21,050	661	3.1%
Wyoming	1,894	81	4.3%
Total	**824,279**	**37,690**	**4.2% (Median)**

Among the 32 jurisdictions that provided data about the number of women in restrictive housing, a total of 790 women were reported in isolation. The median percentage of female prisoners in restrictive housing in responding jurisdictions was 1.1%. The percentage held in restrictive housing ranged from 4.6% of the female custodial population (59 out of 1,280 female prisoners) to 0% of the female custodial population.[47] Jurisdiction-by-jurisdiction information is provided in Figure 7 and Figure 8, arranged by jurisdiction and by percentages, and in Table 5.

Figure 7 Percentage of Female Prisoners in Restrictive Housing By Jurisdiction (n = 32)

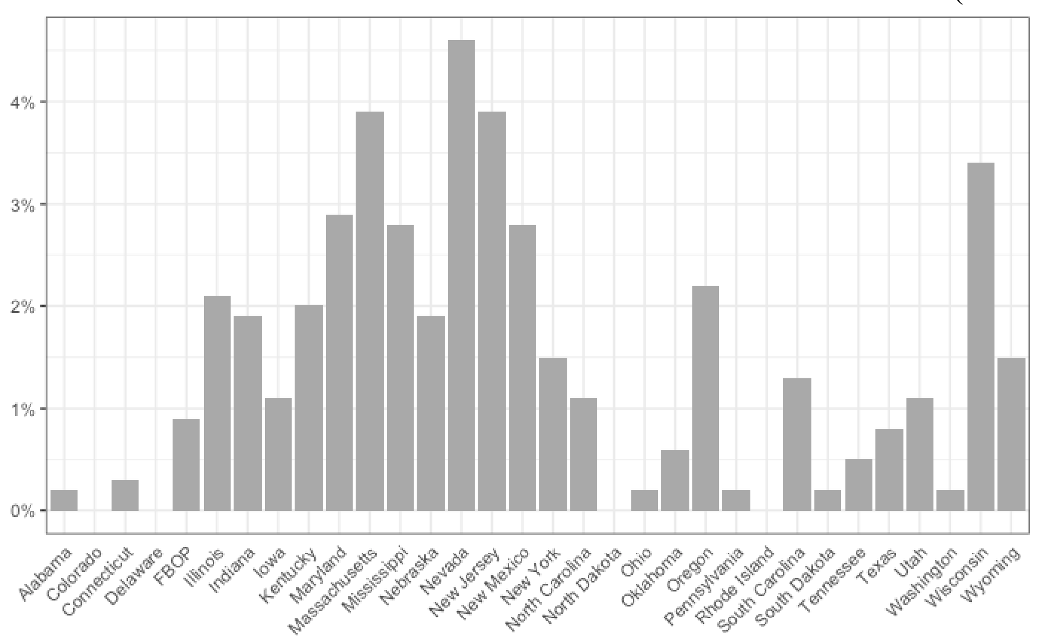


Figure 8 Percentage of Female Prisoners in Restrictive Housing by Percentage (n = 32)

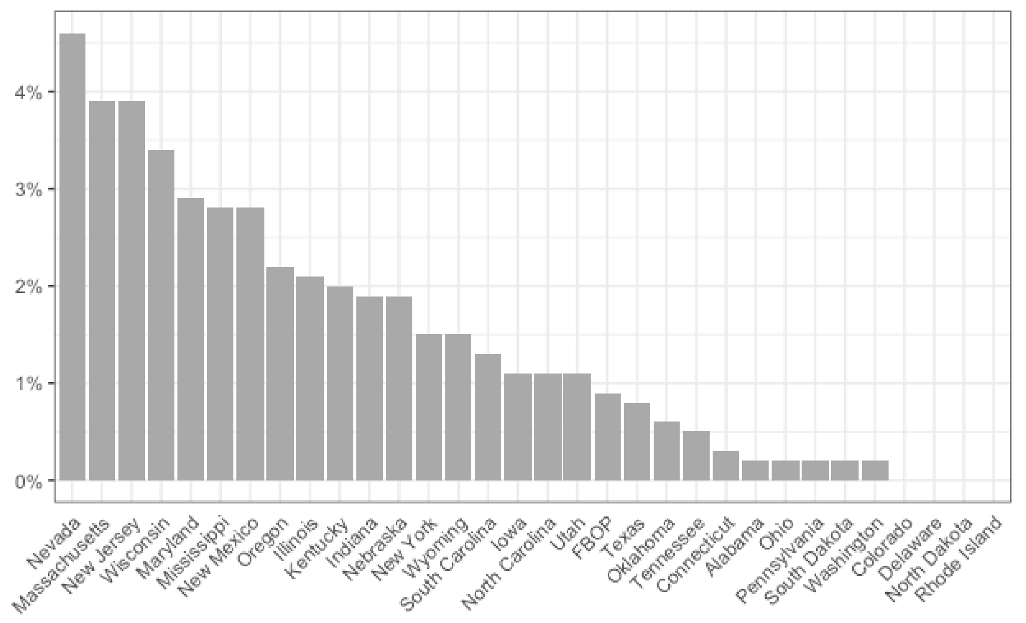


Table 5 Number and Percentage of Female Custodial Population in Restrictive Housing (n = 32)[48]

Jurisdiction	Total Custodial Population	Restrictive Housing Population	Percentage in Restrictive Housing
Alabama	1,310	3	0.2%
Colorado	1,673	0	0.0%
Connecticut	955	3	0.3%
Delaware	233	0	0.0%
FBOP	11,077	101	0.9%
Illinois	2,410	50	2.1%
Indiana	2,470	48	1.9%
Iowa	705	8	1.1%
Kentucky	3,139	64	2.0%
Maryland	1,062	31	2.9%
Massachusetts	588	23	3.9%
Mississippi	902	25	2.8%
Nebraska	416	8	1.9%
Nevada	1,280	59	4.6%
New Jersey	774	30	3.9%
New Mexico	741	21	2.8%
New York	2,357	36	1.5%
North Carolina	2,933	33	1.1%
North Dakota	224	0	0.0%
Ohio	4,158	9	0.2%
Oklahoma	3,079	19	0.6%
Oregon	1,272	28	2.2%
Pennsylvania	2,620	6	0.2%
Rhode Island	130	0	0.0%
South Carolina	1,455	19	1.3%
South Dakota	525	1	0.2%
Tennessee	1,946	9	0.5%
Texas	12,180	93	0.8%
Utah	471	5	1.1%
Washington	1,302	2	0.2%
Wisconsin	1,539	52	3.4%
Wyoming	260	4	1.5%
Total	**66,186**	**790**	**1.1% (Median)**

Race and Ethnicity

The survey asked about race and ethnicity data by sex/gender for the total custodial and the restrictive housing populations. Thirty-three jurisdictions responded to questions about the racial and ethnic composition of male prisoners in restrictive housing, and 32 jurisdictions responded to questions about race and ethnicity among female prisoners in restrictive housing. Figure 9 and Figure 10 describe the number of prisoners by sex/gender in each racial group in the total custodial population and in restrictive housing.

We asked jurisdictions about the categories of White, Black (African-American), Hispanic or Latino, Asian, Native American or Alaskan Native, Native Hawaiian or Pacific Islander, and Other. Table 6 details the number of jurisdictions that used each category. Endnotes explain the differences when jurisdictions varied their categories.[49] As detailed, some jurisdictions relied on self-reports, and others categorized individuals based on correctional records or on appearance.[50]

Table 6 Number of Jurisdictions Reporting on Racial or Ethnic Groups (n = 33)

Category	Number of Jurisdictions
White	33
Black (African-American)	33
Hispanic or Latino	32
Asian	30
Native American or Alaskan Native	29
Native Hawaiian or Pacific Islander	16
Other	25

Figure 9 Racial and Ethnic Composition of Male Prisoners in Total Custodial Population and in Restrictive Housing Population (n = 33)

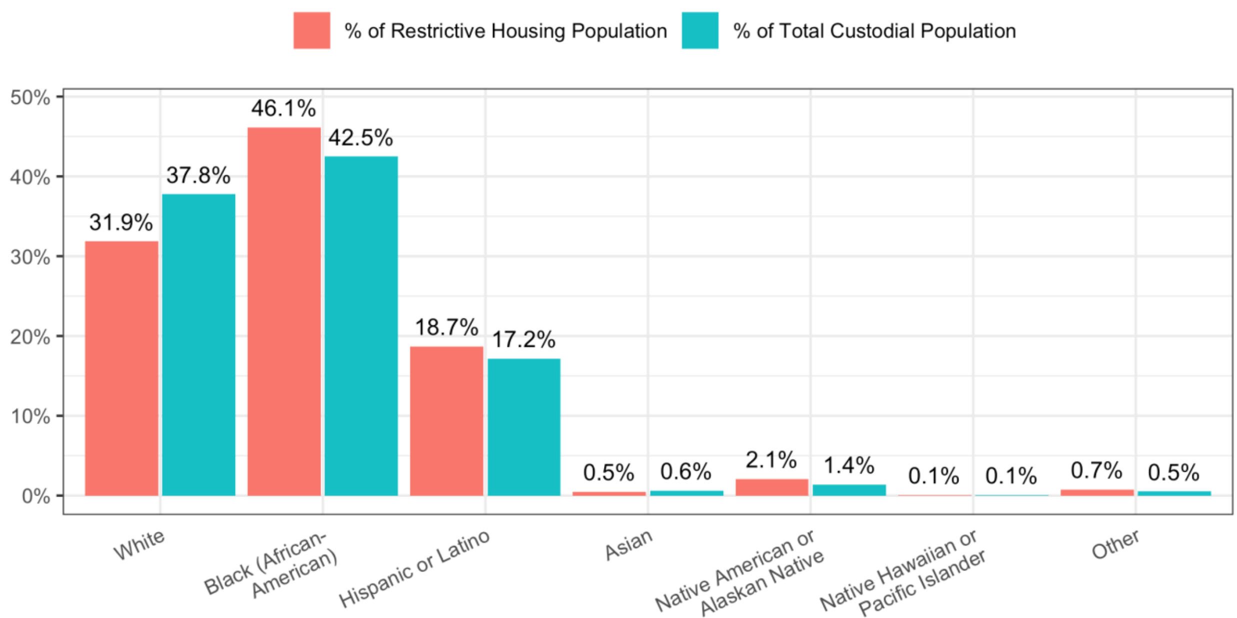
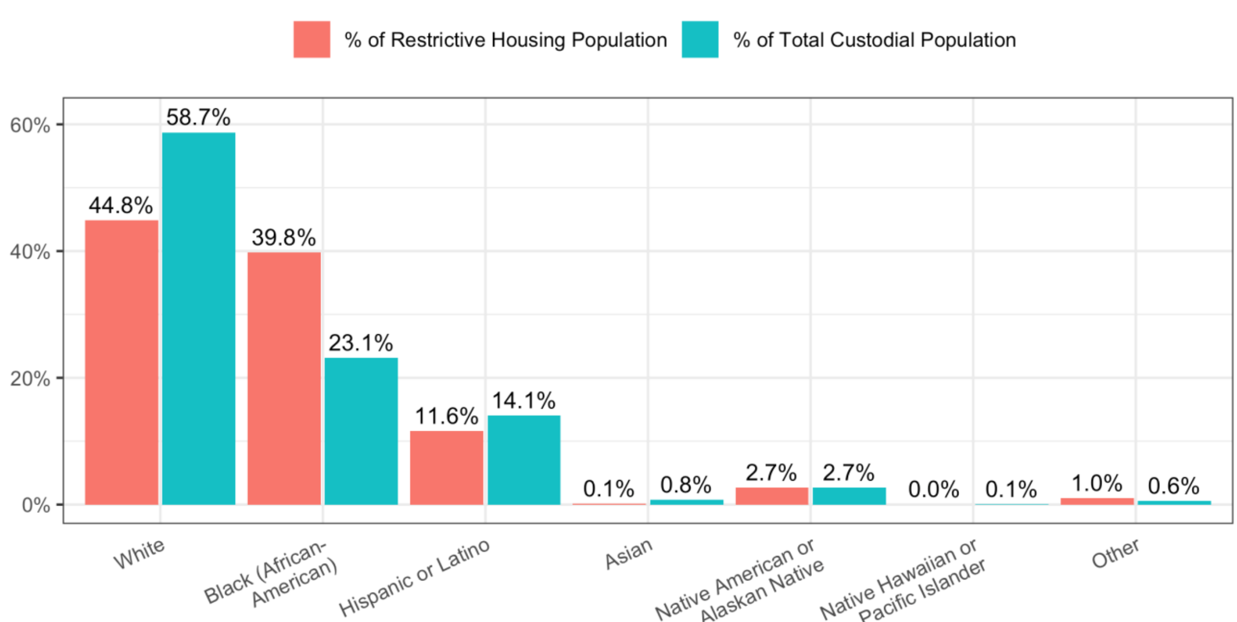


Figure 10 Racial and Ethnic Composition of Female Prisoners in Total Custodial Population and in Restrictive Housing Population (n = 32)

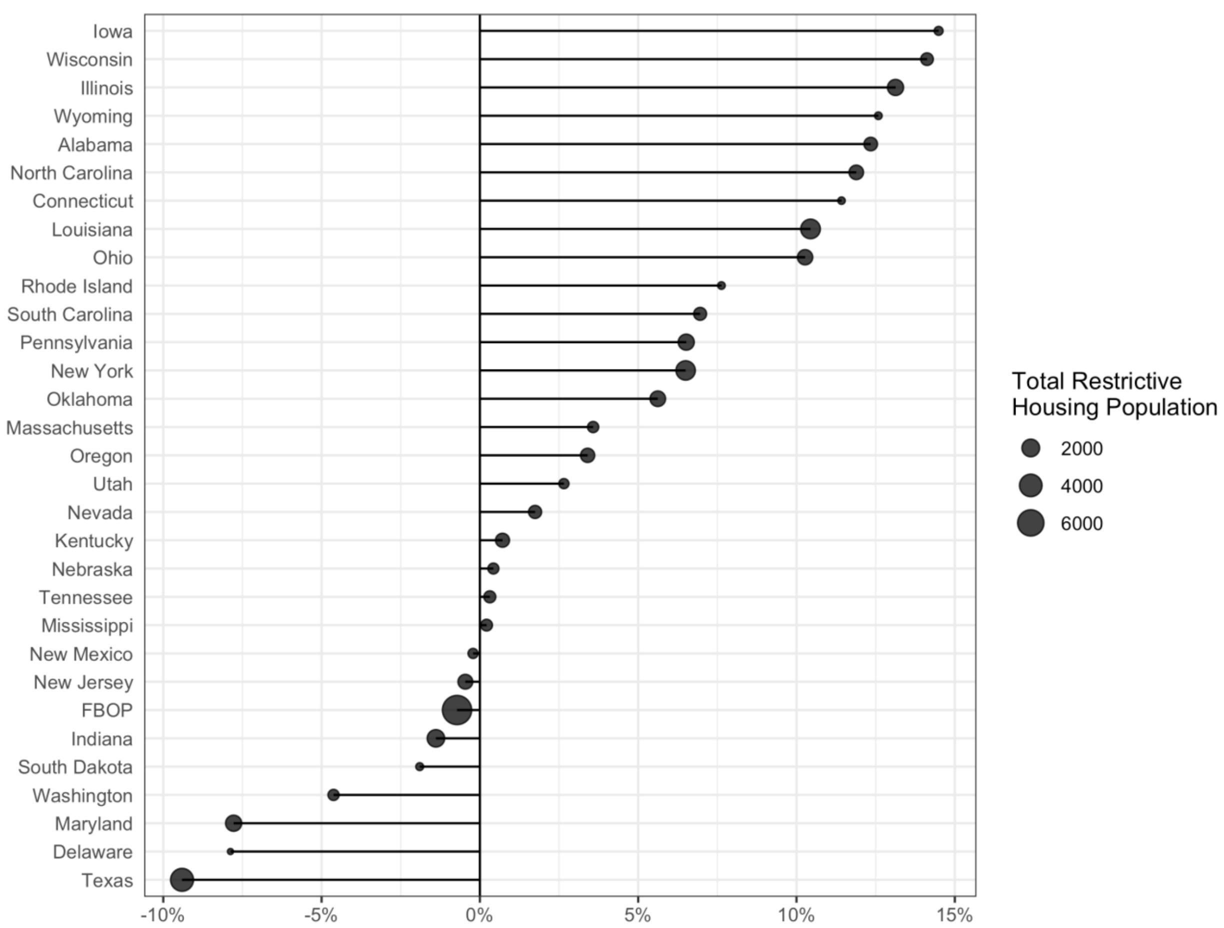


Among the 33 jurisdictions reporting on race and ethnicity among male prisoners in the total custodial population and in restrictive housing, Black men comprised 46.1% of the male restrictive housing population, as compared to 42.5% of the total male custodial population in those jurisdictions. In 24 of the 33 jurisdictions reporting on the racial composition of male prisoners in the total custodial population and in restrictive housing, the male restrictive housing population had a greater percentage of Black prisoners than did the total male custodial population in each of those jurisdictions. In 9 of the 33 jurisdictions, the male restrictive housing population had a lower percentage of Black prisoners than did the total male custodial population in each of those jurisdictions. Across all jurisdictions, the difference between the percentage of the male restrictive housing population that was Black and the percentage of the total male custodial population that was Black ranged from +14.5 percentage points to -9.4 percentage points. Figure 11 maps those spreads in the 31 jurisdictions where 25 or more people were reported in restrictive housing.

One of the 33 reporting jurisdictions did not use "Hispanic" as a racial category.[51] Among the remaining 32, Hispanic male prisoners comprised 18.7% of the male restrictive housing population, as compared to 17.2% of the total male custodial population. In 17 of the 32 reporting jurisdictions, the male restrictive housing population had a greater percentage of Hispanic prisoners than did the total male custodial population in each of those jurisdictions. In 14 of the 32 jurisdictions, the male restrictive housing population had a lower percentage of Hispanic prisoners than did the total male custodial population in each of those jurisdictions. In one jurisdiction, the percentage was the same.

Across all jurisdictions, the difference between the percentage of the male restrictive housing population that was Hispanic and the percentage of the total male custodial population that was Hispanic ranged from +15.8 percentage points to -3.8 percentage points. Figure 12 maps those spreads in the 30 jurisdictions where 25 or more people were reported in restrictive housing.

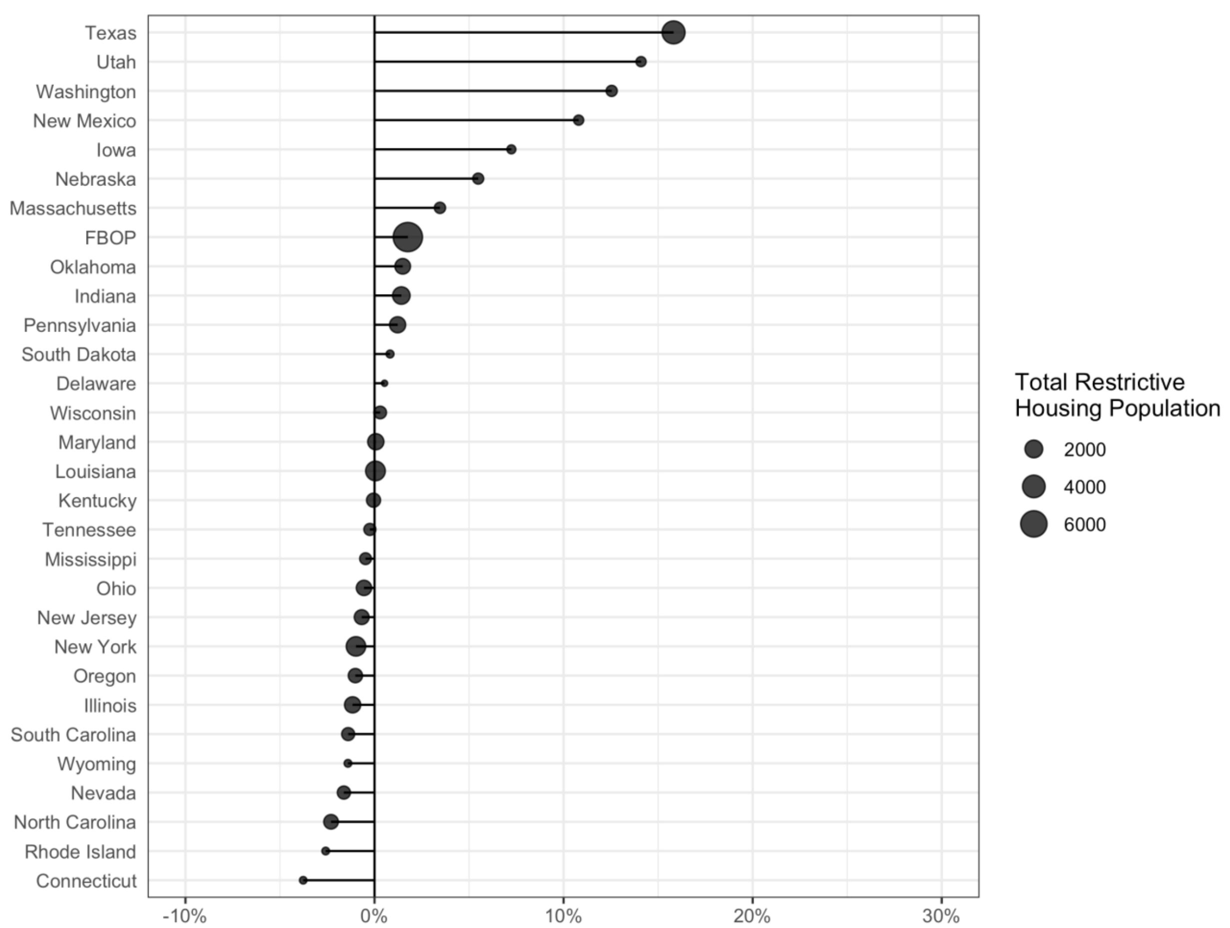
Figure 11 Differences in Restrictive Housing and Total Male Custodial Population for Black Male Prisoners (n = 31)*



*The jurisdictions included in this graph reported more than 25 people in restrictive housing.

Included in SCDC' 4.29.19 letter to LOC

Figure 12 Differences in Restrictive Housing and Total Male Custodial Population for Hispanic Male Prisoners (n = 30)*



*The jurisdictions included in this graph reported more than 25 people in restrictive housing.

In 29 of the 33 reporting jurisdictions, the male restrictive housing population contained a smaller percentage of White prisoners than the total male custodial population. As detailed below, jurisdictions reported a small percentage of Asian, Native American or Alaskan Native, and Native Hawaiian or Pacific Islander prisoners in their general prison populations and a similarly small percentage in their populations in restrictive housing.[52] Those categorized as "Other" appeared to be comparable in percentages in the general and in the restrictive housing populations. Given the small numbers of individuals, we do not provide details.

Table 7 lists by jurisdiction and by race/ethnicity the number of male prisoners in the general population and in restrictive housing. Table 8 compares the percentages by race and ethnicity of all male prisoners and of those in restrictive housing.

Table 7 Demographic Composition of Total Male Custodial Population and Male Restrictive Housing Population (n = 33) [53]

	Total Custodial Population								Restrictive Housing Population							
	White	Black	Hisp.	Asian	NHPI	Am. Ind.	Other	Total	White	Black	Hisp.	Asian	NHPI	Am. Ind.	Other	Total
Alabama	8,115	12,033					120	20,268	240	611					1	852
Colorado	7,489	3,025	5,396	190		523	1	16,624	2	2	6	0	0	0	0	10
Connecticut	3,970	5,563	3,554	57		38		13,182	15	37	16	0	0	1	0	69
Delaware	1,408	2,516	169	5		0	2	4,100	17	23	2	1		0	0	43
FBOP	41,116	57,914	38,629	1,902		3,201		142,762	2,126	3,137	2,269	64		277		7,873
Illinois	11,505	22,827	5,228	142	0	43	22	39,767	257	1,065	181	3	0	1	3	1,510
Indiana	14,070	8,553	1,026	59	12	41	86	23,847	1,131	663	110	3	2	5	9	1,923
Iowa	4,890	2,000	500	60		128		7,578	67	65	22	3		2		159
Kentucky	15,063	4,760	312			11	318	20,464	698	228	14			1	10	951
Louisiana	10,393	22,420	81	38	0	21		32,953	569	2,126	8	4	0	2	0	2,709
Maryland	4,702	14,829	753	59	9	98	273	20,723	400	965	56	2	1	6	83	1,513
Massachusetts	3,618	2,356	2,245	121	0	56	63	8,459	149	132	126	9	0	1	3	420
Mississippi	3,922	7,976	105	20		14	1	12,038	166	335	2			1		504
Nebraska	2,469	1,363	657	36	5	196	36	4,762	174	113	75	1	0	23	3	389
Nevada	5,117	3,939	2,768	342		219	49	12,434	302	251	155	18		22	3	751
New Jersey	3,801	11,489	2,908	113	1	7	275	18,594	245	701	171	5	1	0	20	1,143
New Mexico	1,560	544	3,679	13	18	447	35	6,296	50	23	189			9	2	273
New York	11,337	23,561	11,979	236	0	397	897	48,407	476	1,451	625	6	0	21	51	2,630
North Carolina	12,841	18,729	1,683	93			980	34,326	279	715	28	1			53	1076
North Dakota	1,063	160	99	7	0	273	4	1,606	4	1				4		9
Ohio	22,765	21,378	1,263	60		71	259	45,796	509	725	28	2		2	7	1,273
Oklahoma	12,545	6,677	1,905	71	23	2,555	40	23,816	547	454	128	2	5	210	3	1,349
Oregon	9,804	1,245	1,713	196	4	339	1	13,302	697	128	119	13	1	45	0	1,003
Pennsylvania	17,995	21,460	4,536	118		27	164	44,300	489	820	171	5	0	0	7	1,492
Rhode Island	1,083	831	715	44		19	30	2,722	28	29	18	1	0	0	0	76

South Carolina	6,338	11,534	438	26	1	21	125	18,483	207	498	7	1	0	0	5	718
South Dakota	1,944	294	125	17	2	1,015	5	3,402	34	6	4	0	0	44	1	89
Tennessee	10,659	9,007	457	66	0	25	0	20,214	288	245	11	2				546
Texas	41,571	45,170	45,734	453	0	97	204	133,229	1,051	1,023	2,094	7	0	1		4,176
Utah	3,665	413	1,176	62	118	291	97	5,822	110	27	95	3	12	24	6	277
Washington	9,210	2,977	2,091	647		699	150	15,774	208	58	105	14		19	3	407
Wisconsin	9,392	8,806	1,879		234	719	10	21,040	197	370	61	4	0	29	0	661
Wyoming	1,413	106	248	5	0	122	0	1,894	40	14	9	0	0	14	0	77
Total	**316,833**	**356,455**	**144,051**	**5,258**	**427**	**11,713**	**4,247**	**838,984**	**11,772**	**17,041**	**6,905**	**174**	**22**	**764**	**273**	**36,951**

Table 8 Demographic Percentage Composition of Total Male Custodial Population and Male Restrictive Housing Population (n = 33)

	Total Custodial Population							Restrictive Housing Population						
	White	Black	Hisp.	Asian	NHPI	Am. Ind.	Other	White	Black	Hisp.	Asian	NHPI	Am. Ind.	Other
Alabama	40.0%	59.4%					0.6%	28.2%	71.7%					0.1%
Colorado	45.0%	18.2%	32.5%	1.1%		3.1%	0.0%	20.0%	20.0%	60.0%	0.0%	0.0%	0.0%	0.0%
Connecticut	30.1%	42.2%	27.0%	0.4%		0.3%		21.7%	53.6%	23.2%	0.0%	0.0%	1.4%	0.0%
Delaware	34.3%	61.4%	4.1%	0.1%		0.0%	0.0%	39.5%	53.5%	4.7%	2.3%		0.0%	0.0%
FBOP	28.8%	40.6%	27.1%	1.3%		2.2%		27.0%	39.8%	28.8%	0.8%		3.5%	
Illinois	28.9%	57.4%	13.1%	0.4%	0.0%	0.1%	0.1%	17.0%	70.5%	12.0%	0.2%	0.0%	0.1%	0.2%
Indiana	59.0%	35.9%	4.3%	0.2%	0.1%	0.2%	0.4%	58.8%	34.5%	5.7%	0.2%	0.1%	0.3%	0.5%
Iowa	64.5%	26.4%	6.6%	0.8%		1.7%		42.1%	40.9%	13.8%	1.9%		1.3%	
Kentucky	73.6%	23.3%	1.5%			0.1%	1.6%	73.4%	24.0%	1.5%			0.1%	1.1%
Louisiana	31.5%	68.0%	0.2%	0.1%	0.0%	0.1%		21.0%	78.5%	0.3%	0.1%	0.0%	0.1%	0.0%
Maryland	22.7%	71.6%	3.6%	0.3%	0.0%	0.5%	1.3%	26.4%	63.8%	3.7%	0.1%	0.1%	0.4%	5.5%
Massachusetts	42.8%	27.9%	26.5%	1.4%	0.0%	0.7%	0.7%	35.5%	31.4%	30.0%	2.1%	0.0%	0.2%	0.7%
Mississippi	32.6%	66.3%	0.9%	0.2%		0.1%	0.0%	32.9%	66.5%	0.4%			0.2%	
Nebraska	51.8%	28.6%	13.8%	0.8%	0.1%	4.1%	0.8%	44.7%	29.0%	19.3%	0.3%	0.0%	5.9%	0.8%
Nevada	41.2%	31.7%	22.3%	2.8%		1.8%	0.4%	40.2%	33.4%	20.6%	2.4%		2.9%	0.4%
New Jersey	20.4%	61.8%	15.6%	0.6%	0.0%	0.0%	1.5%	21.4%	61.3%	15.0%	0.4%	0.1%	0.0%	1.7%
New Mexico	24.8%	8.6%	58.4%	0.2%	0.3%	7.1%	0.6%	18.3%	8.4%	69.2%			3.3%	0.7%
New York	23.4%	48.7%	24.7%	0.5%	0.0%	0.8%	1.9%	18.1%	55.2%	23.8%	0.2%	0.0%	0.8%	1.9%
North Carolina	37.4%	54.6%	4.9%	0.3%			2.9%	25.9%	66.4%	2.6%	0.1%			4.9%
North Dakota	66.2%	10.0%	6.2%	0.4%	0.0%	17.0%	0.2%	44.4%	11.1%				44.4%	
Ohio	49.7%	46.7%	2.8%	0.1%		0.2%	0.6%	40.0%	57.0%	2.2%	0.2%		0.2%	0.5%
Oklahoma	52.7%	28.0%	8.0%	0.3%	0.1%	10.7%	0.2%	40.5%	33.7%	9.5%	0.1%	0.4%	15.6%	0.2%
Oregon	73.7%	9.4%	12.9%	1.5%	0.0%	2.5%	0.0%	69.5%	12.8%	11.9%	1.3%	0.1%	4.5%	0.0%
Pennsylvania	40.6%	48.4%	10.2%	0.3%		0.1%	0.4%	32.8%	55.0%	11.5%	0.3%	0.0%	0.0%	0.5%
Rhode Island	39.8%	30.5%	26.3%	1.6%		0.7%	1.1%	36.8%	38.2%	23.7%	1.3%	0.0%	0.0%	0.0%

South Carolina	34.3%	62.4%	2.4%	0.1%	0.0%	0.1%	0.7%	28.8%	69.4%	1.0%	0.1%	0.0%	0.0%	0.7%
South Dakota	57.1%	8.6%	3.7%	0.5%	0.1%	29.8%	0.1%	38.2%	6.7%	4.5%	0.0%	0.0%	49.4%	1.1%
Tennessee	52.7%	44.6%	2.3%	0.3%	0.0%	0.1%	0.0%	52.7%	44.9%	2.0%	0.4%			
Texas	31.2%	33.9%	34.3%	0.3%	0.0%	0.1%	0.2%	25.2%	24.5%	50.1%	0.2%	0.0%	0.0%	
Utah	63.0%	7.1%	20.2%	1.1%	2.0%	5.0%	1.7%	39.7%	9.7%	34.3%	1.1%	4.3%	8.7%	2.2%
Washington	58.4%	18.9%	13.3%	4.1%		4.4%	1.0%	51.1%	14.3%	25.8%	3.4%		4.7%	0.7%
Wisconsin	44.6%	41.9%	8.9%		1.1%	3.4%	0.0%	29.8%	56.0%	9.2%	0.6%	0.0%	4.4%	0.0%
Wyoming	74.6%	5.6%	13.1%	0.3%	0.0%	6.4%	0.0%	51.9%	18.2%	11.7%	0.0%	0.0%	18.2%	0.0%
Median	**41.2%**	**35.9%**	**11.6%**	**0.4%**	**0.0%**	**0.7%**	**0.4%**	**35.5%**	**39.8%**	**11.9%**	**0.3%**	**0.0%**	**0.6%**	**0.5%**

Thirty-two jurisdictions provided data about race and ethnicity among women in restrictive housing. As with the male restrictive housing population, the percentage of Black female prisoners among all female prisoners in restrictive housing (39.8%) was higher than the percentage of Black female prisoners among all female prisoners in the total custodial population (22.8%). In 19 of the 32 reporting jurisdictions, the female restrictive housing population contained a greater percentage of Black prisoners in restrictive housing than were in the total female custodial population. In 13 of the 32 jurisdictions, the female restrictive housing population had a lower percentage of Black prisoners than did the total female custodial population.

One of the 32 reporting jurisdictions did not use "Hispanic" as a racial category.[54] Among the remaining 31, Hispanic prisoners comprised 11.6% of the female restrictive housing population, as compared to 14.3% of the total female custodial population. In 14 of the 31 reporting jurisdictions, the female restrictive housing population contained a greater percentage of Hispanic prisoners than the total female custodial population. In 17 jurisdictions, the female restrictive housing population had a lower percentage of Hispanic prisoners than did the total female custodial population.

In 24 of the 32 reporting jurisdictions, the female restrictive housing population contained a smaller percentage of White prisoners than the total female custodial population. The percentages of other ethnicities were small and roughly comparable in both general and restrictive housing populations. Figure 10 provides an overview of these numbers, and Table 9 and Table 10 provide information by jurisdiction. Because in many jurisdictions the total number of women in restrictive housing is under 25, we do not display pictorially the relative differences across jurisdictions.

Included in SCDC' 4.29.19 letter to LOC

Table 9 Demographic Composition of Total Female Custodial Population and Female Restrictive Housing Population (n = 32) [55]

	Total Custodial Population								Restrictive Housing Population							
	White	Black	Hisp.	Asian	NHPI	Am. Ind.	Other	Total	White	Black	Hisp.	Asian	NHPI	Am. Ind.	Other	Total
Alabama	909	414					1	1,324	1	2					0	3
Colorado	925	196	462	16		73	1	1,673	0	0	0	0		0	0	0
Connecticut	520	240	184	7		4		955	0	3	2	0	0	0	0	5
Delaware	135	91	5	1		1	0	233	0	0	0	0		0	0	0
FBOP	4,365	2,462	3,667	237		346		11,077	36	37	25	0		3		101
Illinois	1,243	920	189	16	0	16	26	2,410	14	34	1	1	0	0	0	50
Indiana	2,016	367	49	4	2	9	23	2,470	32	15	0	0	0	0	1	48
Iowa	538	109	34	0	0	24		705	6	1	1	0		0		8
Kentucky	2,875	207	18			2	38	3,140	51	11	1			0	1	64
Maryland	484	539	12	3	0	6	18	1,062	12	17	0	0	0	0	2	31
Massachusetts	397	90	49	1	0	0	51	588	16	2	4	0	0	0	1	23
Mississippi	536	357	3	3		2	1	902	8	17						25
Nebraska	267	79	40	1	1	22	6	416	1	3	1	0	0	1	2	8
Nevada	757	303	148	44		23	5	1,280	25	24	9	0		1	0	59
New Jersey	277	376	101	10	1	0	9	774	9	20	1	0	0	0	0	30
New Mexico	222	45	410	1	0	57	6	741	7	1	12			1		21
New York	1,149	812	323	13	0	21	39	2,357	21	10	5	0	0	0	0	36
North Carolina	1,977	814	52	6			84	2,933	13	19	0	0			1	33
North Dakota	132	11	5	0	0	76	0	224	0	0	0	0	0	0	0	0
Ohio	3,093	1,014	34	9		3	5	4,158	3	6	0	0		0	0	9
Oklahoma	1,892	451	163	5	7	553	8	3,079	4	6	2	0	0	7	0	19
Oregon	1,077	84	50	23	0	38	0	1,272	24	3	0	0	0	1	0	28
Pennsylvania	1,660	734	187	11		13	15	2,620	4	1	1	0	0	0	0	6

Rhode Island	83	23	17	1		3	3	130	0	0	0	0		0	0	0
South Carolina	939	471	27	0	0	6	12	1455	11	8	0	0	0	0	0	19
South Dakota	243	10	16	3	0	252	1	525	1	0	0	0	0	0	0	1
Tennessee	1,491	423	19	5	0	8	0	1,946	7	1	1					9
Texas	6,219	2,985	2,915	31	0	18	12	12,180	20	51	22	0	0	0		93
Utah	341	18	60	3	13	30	6	471	4	0	1	0	0	0	0	5
Washington	820	131	190	52		97	12	1,302	1		1					2
Wisconsin	1,033	325	39		19	122	1	1,539	23	22	2	0	0	5	0	52
Wyoming	205	4	26	2	0	23	0	260	1	1	0	0	0	2	0	4
Total	**38,820**	**15,105**	**9,494**	**508**	**43**	**1,848**	**383**	**66,201**	**355**	**315**	**92**	**1**	**0**	**21**	**8**	**792**

Table 10 Demographic Percentage Composition of Total Female Custodial Population and Female Restrictive Housing Population (n = 32)

	Total Custodial Population							Restrictive Housing Population						
	White	**Black**	**Hisp.**	**Asian**	**NHPI**	**Am. Ind.**	**Other**	**White**	**Black**	**Hisp.**	**Asian**	**NHPI**	**Am. Ind.**	**Other**
Alabama	68.7%	31.3%					0.1%	33.3%	66.7%					0.0%
Colorado	55.3%	11.7%	27.6%	1.0%		4.4%	0.1%	0.0%	0.0%	0.0%	0.0%		0.0%	0.0%
Connecticut	54.5%	25.1%	19.3%	0.7%		0.4%		0.0%	60.0%	40.0%	0.0%	0.0%	0.0%	0.0%
Delaware	57.9%	39.1%	2.1%	0.4%		0.4%	0.0%	0.0%	0.0%	0.0%	0.0%		0.0%	0.0%
FBOP	39.4%	22.2%	33.1%	2.1%		3.1%		35.6%	36.6%	24.8%	0.0%		3.0%	
Illinois	51.6%	38.2%	7.8%	0.7%	0.0%	0.7%	1.1%	28.0%	68.0%	2.0%	2.0%	0.0%	0.0%	0.0%
Indiana	81.6%	14.9%	2.0%	0.2%	0.1%	0.4%	0.9%	66.7%	31.2%	0.0%	0.0%	0.0%	0.0%	2.1%
Iowa	76.3%	15.5%	4.8%	0.0%	0.0%	3.4%		75.0%	12.5%	12.5%	0.0%			
Kentucky	91.6%	6.6%	0.6%			0.1%	1.2%	79.7%	17.2%	1.6%			0.0%	1.6%
Maryland	45.6%	50.8%	1.1%	0.3%	0.0%	0.6%	1.7%	38.7%	54.8%	0.0%	0.0%	0.0%	0.0%	6.5%
Massachusetts	67.5%	15.3%	8.3%	0.2%	0.0%	0.0%	8.7%	69.6%	8.7%	17.4%	0.0%	0.0%	0.0%	4.3%
Mississippi	59.4%	39.6%	0.3%	0.3%		0.2%	0.1%	32.0%	68.0%					
Nebraska	64.2%	19.0%	9.6%	0.2%	0.2%	5.3%	1.4%	12.5%	37.5%	12.5%	0.0%	0.0%	12.5%	25.0%
Nevada	59.1%	23.7%	11.6%	3.4%		1.8%	0.4%	42.4%	40.7%	15.3%	0.0%		1.7%	0.0%
New Jersey	35.8%	48.6%	13.0%	1.3%	0.1%	0.0%	1.2%	30.0%	66.7%	3.3%	0.0%	0.0%	0.0%	0.0%
New Mexico	30.0%	6.1%	55.3%	0.1%	0.0%	7.7%	0.8%	33.3%	4.8%	57.1%			4.8%	
New York	48.7%	34.5%	13.7%	0.6%	0.0%	0.9%	1.7%	58.3%	27.8%	13.9%	0.0%	0.0%	0.0%	0.0%
North Carolina	67.4%	27.8%	1.8%	0.2%			2.9%	39.4%	57.6%	0.0%	0.0%			3.0%
North Dakota	58.9%	4.9%	2.2%	0.0%	0.0%	33.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Ohio	74.4%	24.4%	0.8%	0.2%		0.1%	0.1%	33.3%	66.7%	0.0%	0.0%		0.0%	0.0%
Oklahoma	61.4%	14.6%	5.3%	0.2%	0.2%	18.0%	0.3%	21.1%	31.6%	10.5%	0.0%	0.0%	36.8%	0.0%
Oregon	84.7%	6.6%	3.9%	1.8%	0.0%	3.0%	0.0%	85.7%	10.7%	0.0%	0.0%	0.0%	3.6%	0.0%
Pennsylvania	63.4%	28.0%	7.1%	0.4%		0.5%	0.6%	66.7%	16.7%	16.7%	0.0%	0.0%	0.0%	0.0%

Rhode Island	63.8%	17.7%	13.1%	0.8%		2.3%	2.3%	0.0%	0.0%	0.0%	0.0%		0.0%	0.0%
South Carolina	64.5%	32.4%	1.9%	0.0%	0.0%	0.4%	0.8%	57.9%	42.1%	0.0%	0.0%	0.0%	0.0%	0.0%
South Dakota	46.3%	1.9%	3.0%	0.6%	0.0%	48.0%	0.2%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Tennessee	76.6%	21.7%	1.0%	0.3%	0.0%	0.4%	0.0%	77.8%	11.1%	11.1%				
Texas	51.1%	24.5%	23.9%	0.3%	0.0%	0.1%	0.1%	21.5%	54.8%	23.7%	0.0%	0.0%	0.0%	
Utah	72.4%	3.8%	12.7%	0.6%	2.8%	6.4%	1.3%	80.0%	0.0%	20.0%	0.0%	0.0%	0.0%	0.0%
Washington	63.0%	10.1%	14.6%	4.0%		7.5%	0.9%	50.0%		50.0%				
Wisconsin	67.1%	21.1%	2.5%		1.2%	7.9%	0.1%	44.2%	42.3%	3.8%	0.0%	0.0%	9.6%	0.0%
Wyoming	78.8%	1.5%	10.0%	0.8%	0.0%	8.8%	0.0%	25.0%	25.0%	0.0%	0.0%	0.0%	50.0%	0.0%
Median	**63.2%**	**21.4%**	**7.1%**	**0.4%**	**0.0%**	**1.4%**	**0.6%**	**37.2%**	**31.2%**	**3.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**

Age

The question of the placement of juveniles, variously defined as from under 18 to under 24, has come to the fore in a variety of contexts. For example, the ACA has called for the prohibition of confinement of persons under the age of 18.[56] The elderly incarcerated are yet another locus of concern.

To understand the age distribution in restrictive housing, we asked jurisdictions to provide information about the age of prisoners in cohorts ranging from under 18 to over 50. We sought to understand the distribution of age cohorts within restrictive housing populations as well as in the total custodial population. Thirty-four jurisdictions responded with the numbers of male prisoners in the respective age cohorts, and 32 jurisdictions provided the numbers of female prisoners.

The 34 responding jurisdictions housed a total of 842,941 male prisoners in their total custodial populations, delineated by age cohorts as follows: 105,827 male prisoners were between the ages of 18 to 25; 269,179 male prisoners were between the ages of 26 to 35; 306,980 male prisoners were between the ages of 36 to 50; and 158,298 male prisoners were over the age of 50. Four jurisdictions reported holding a total of 18 individuals (16 boys and two girls) under the age of 18 in restrictive housing.[57]

Within these 34 jurisdictions, 6.4% (6,734) of male prisoners between the ages of 18 to 25 in the total custodial population were in restrictive housing; 5.6% (14,957) of male prisoners between the ages of 26 to 35 were in restrictive housing, 4.0% (12,339) of male prisoners between the ages of 36 to 50 were in restrictive housing, and 2.3% (3,605) of male prisoners over the age of 50 were in restrictive housing.

The 32 jurisdictions that provided information about the age distribution of women in restrictive housing housed a total of 66,189 female prisoners in their total custodial populations in the following age cohorts: 8,024 female prisoners between the ages of 18 to 25; 24,960 female prisoners between the ages of 26 to 35; 24,146 female prisoners between the ages of 36 to 50; and 8,880 female prisoners over the age of 50.

Of those, 2.2% (173) of women between the ages of 18 to 25 in the total custodial population were in restrictive housing, 1.4% (352) of women between the ages of 26 to 35 were in restrictive housing, 0.9% (215) of women between the ages of 36 to 50 were in restrictive housing, and 0.9% (77) of women over the age of 50 were in restrictive housing.

We provide the aggregate information in Figure 13 and Figure 14. We provide jurisdiction-by-jurisdiction data in Table 11, Table 12, Table 13, and Table 14.

Figure 13 Age Distribution of Male Prisoners in Restrictive Housing and Total Custodial Population (n = 34)

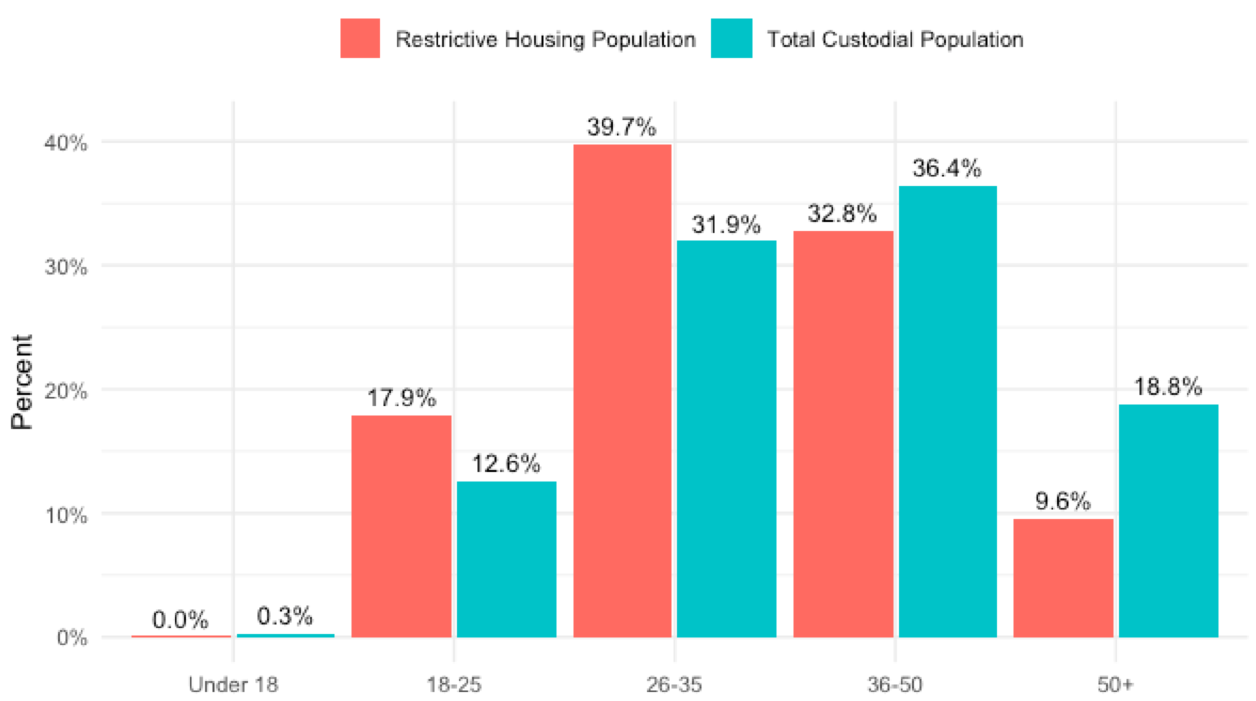


Figure 14 Age Distribution of Female Prisoners in Restrictive Housing and Total Custodial Population (n = 32)

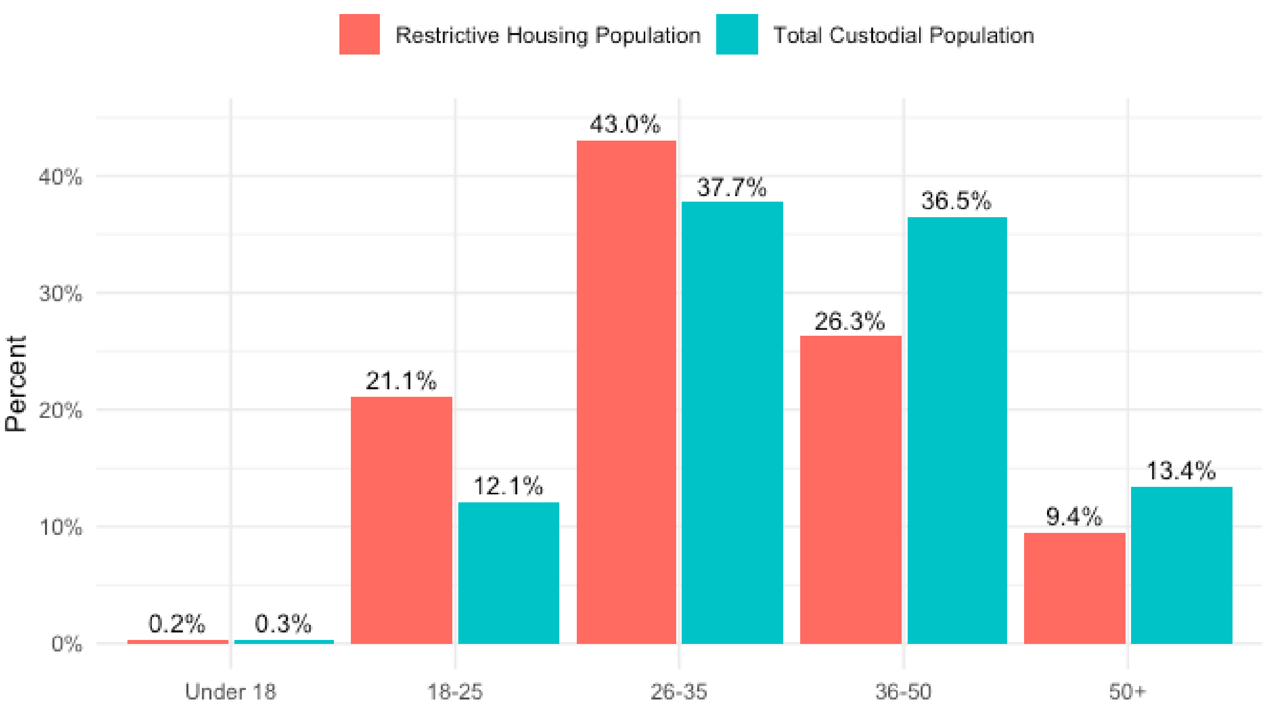


Table 11 Age Cohorts of Male Total Custodial Population and of Male Restrictive Housing Population (n = 34)[58]

	Total Custodial Population						Restrictive Housing Population					
	<18	18–25	26–35	36–50	50+	Total	<18	18–25	26–35	36–50	50+	Total
Alabama	8	1,908	5,736	7,946	4,684	20,282	0	143	330	298	81	852
Alaska	12	569	1,413	1,270	726	3,990	7	78	151	99	43	378
Colorado	4	1,709	5,484	6,099	3,328	16,624	0	2	3	5	0	10
Connecticut	58	2,322	4,532	4,360	1,910	13,182	0	148	185	54	16	403
Delaware	10	641	1,324	1,270	855	4,100	0	12	19	9	3	43
FBOP	0	9,157	42,291	64,205	27,109	142,762	0	761	3,095	3,275	742	7,873
Illinois	0	4,794	12,639	14,552	7,782	39,767	0	422	573	401	114	1,510
Indiana	1	3,454	7,944	8,564	3,884	23,847	0	276	820	641	186	1,923
Iowa	8	1,496	2,514	2,266	1,294	7,578	0	48	64	31	16	159
Kentucky	0	2,603	7,486	7,396	2,942	20,427	0	158	406	311	76	951
Louisiana	104	3,263	9,952	12,357	7,277	32,953	4	353	944	978	430	2,709
Maryland	76	3,336	7,392	6,182	3,737	20,723	1	349	720	359	97	1,526
Massachusetts	0	711	2,544	3,056	2,148	8,459	0	82	183	127	28	420
Mississippi	0	1,741	3,817	4,191	2,289	12,038	0	92	218	163	31	504
Nebraska	4	589	1,640	1,649	880	4,762	0	118	176	78	17	389
Nevada	14	1,752	3,836	4,181	2,651	12,434	0	154	256	245	96	751
New Jersey	0	3,170	6,455	6,193	2,776	18,594	0	247	458	339	99	1,143
New Mexico	0	684	2,308	2,249	1,065	6,306	0	26	109	110	28	273
New York	68	7,409	15,600	16,259	9,071	48,407	0	855	1,039	567	169	2,630
North Carolina	279	3,744	10,463	13,358	6,482	34,326	4	298	456	248	70	1,076
North Dakota	0	149	620	504	333	1,606	0	1	5	3	0	9
Ohio	27	7,379	15,206	15,044	8,140	45,796	0	352	555	299	67	1,273
Oklahoma	8	2,966	7,838	8,470	4,534	23,816	0	206	555	475	113	1,349
Oregon	0	1,589	4,186	4,480	3,047	13,302	0	229	407	266	101	1,003

Pennsylvania	28	5,451	14,732	15,040	9,049	44,300	0	259	632	419	182	1,492
Rhode Island	0	544	914	850	414	2,722	0	19	30	20	7	76
South Carolina	40	2,686	6,119	6,320	3,318	18,483	0	181	324	170	43	718
South Dakota	0	633	1,183	1,032	554	3,402	0	25	32	19	13	89
Tennessee	9	2,363	6,549	7,723	3,570	20,214	0	87	259	168	32	546
Texas	27	17,542	41,366	47,280	27,014	133,229	0	357	1,343	1,815	661	4,176
Utah	1	566	1,933	2,145	1,177	5,822	0	70	143	59	5	277
Washington	1,871	5,338	5,691	2,844		15,744	0	84	185	105	33	407
Wisconsin	0	3,290	6,882	7,054	3,824	21,050	0	221	246	160	5	632
Wyoming	0	279	590	591	434	1,894	0	21	36	23	1	81
Total	**2,657**	**105,827**	**269,179**	**306,980**	**158,298**	**842,941**	**16**	**6,734**	**14,957**	**12,339**	**3,605**	**37,651**

Included in SCDC' 4.29.19 letter to LOC

Table 12 Age Cohorts Percentage of Male Total Custodial Population and of Male Restrictive Housing Population (n = 34)

	Total Custodial Population					Restrictive Housing Population				
	<18	18–25	26–35	36–50	50+	<18	18–25	26–35	36–50	50+
Alabama	0.0%	9.4%	28.3%	39.2%	23.1%	0.0%	16.8%	38.7%	35.0%	9.5%
Alaska	0.3%	14.3%	35.4%	31.8%	18.2%	1.9%	20.6%	39.9%	26.2%	11.4%
Colorado	0.0%	10.3%	33.0%	36.7%	20.0%	0.0%	20.0%	30.0%	50.0%	0.0%
Connecticut	0.4%	17.6%	34.4%	33.1%	14.5%	0.0%	36.7%	45.9%	13.4%	4.0%
Delaware	0.2%	15.6%	32.3%	31.0%	20.9%	0.0%	27.9%	44.2%	20.9%	7.0%
FBOP	0.0%	6.4%	29.6%	45.0%	19.0%	0.0%	9.7%	39.3%	41.6%	9.4%
Illinois	0.0%	12.1%	31.8%	36.6%	19.6%	0.0%	27.9%	37.9%	26.6%	7.5%
Indiana	0.0%	14.5%	33.3%	35.9%	16.3%	0.0%	14.4%	42.6%	33.3%	9.7%
Iowa	0.1%	19.7%	33.2%	29.9%	17.1%	0.0%	30.2%	40.3%	19.5%	10.1%
Kentucky	0.0%	12.7%	36.6%	36.2%	14.4%	0.0%	16.6%	42.7%	32.7%	8.0%
Louisiana	0.3%	9.9%	30.2%	37.5%	22.1%	0.1%	13.0%	34.8%	36.1%	15.9%
Maryland	0.4%	16.1%	35.7%	29.8%	18.0%	0.1%	22.9%	47.2%	23.5%	6.4%
Massachusetts	0.0%	8.4%	30.1%	36.1%	25.4%	0.0%	19.5%	43.6%	30.2%	6.7%
Mississippi	0.0%	14.5%	31.7%	34.8%	19.0%	0.0%	18.3%	43.3%	32.3%	6.2%
Nebraska	0.1%	12.4%	34.4%	34.6%	18.5%	0.0%	30.3%	45.2%	20.1%	4.4%
Nevada	0.1%	14.1%	30.9%	33.6%	21.3%	0.0%	20.5%	34.1%	32.6%	12.8%
New Jersey	0.0%	17.0%	34.7%	33.3%	14.9%	0.0%	21.6%	40.1%	29.7%	8.7%
New Mexico	0.0%	10.8%	36.6%	35.7%	16.9%	0.0%	9.5%	39.9%	40.3%	10.3%
New York	0.1%	15.3%	32.2%	33.6%	18.7%	0.0%	32.5%	39.5%	21.6%	6.4%
North Carolina	0.8%	10.9%	30.5%	38.9%	18.9%	0.4%	27.7%	42.4%	23.0%	6.5%
North Dakota	0.0%	9.3%	38.6%	31.4%	20.7%	0.0%	11.1%	55.6%	33.3%	0.0%
Ohio	0.1%	16.1%	33.2%	32.9%	17.8%	0.0%	27.7%	43.6%	23.5%	5.3%
Oklahoma	0.0%	12.5%	32.9%	35.6%	19.0%	0.0%	15.3%	41.1%	35.2%	8.4%
Oregon	0.0%	11.9%	31.5%	33.7%	22.9%	0.0%	22.8%	40.6%	26.5%	10.1%

Pennsylvania	0.1%	12.3%	33.3%	34.0%	20.4%	0.0%	17.4%	42.4%	28.1%	12.2%
Rhode Island	0.0%	20.0%	33.6%	31.2%	15.2%	0.0%	25.0%	39.5%	26.3%	9.2%
South Carolina	0.2%	14.5%	33.1%	34.2%	18.0%	0.0%	25.2%	45.1%	23.7%	6.0%
South Dakota	0.0%	18.6%	34.8%	30.3%	16.3%	0.0%	28.1%	36.0%	21.3%	14.6%
Tennessee	0.0%	11.7%	32.4%	38.2%	17.7%	0.0%	15.9%	47.4%	30.8%	5.9%
Texas	0.0%	13.2%	31.0%	35.5%	20.3%	0.0%	8.5%	32.2%	43.5%	15.8%
Utah	0.0%	9.7%	33.2%	36.8%	20.2%	0.0%	25.3%	51.6%	21.3%	1.8%
Washington	11.9%	33.9%	36.1%	18.1%		0.0%	20.6%	45.5%	25.8%	8.1%
Wisconsin	0.0%	15.6%	32.7%	33.5%	18.2%	0.0%	35.0%	38.9%	25.3%	0.8%
Wyoming	0.0%	14.7%	31.2%	31.2%	22.9%	0.0%	25.9%	44.4%	28.4%	1.2%
Median	**0.0%**	**13.7%**	**33.0%**	**34.1%**	**18.9%**	**0.0%**	**21.1%**	**41.8%**	**27.4%**	**7.8%**

Table 13 Age Cohorts of Female Total Custodial Population and of Female Restrictive Housing Population (n = 32)[59]

	Total Custodial Population						Restrictive Housing Population					
	<18	**18–25**	**26–35**	**36–50**	**>50**	**Total**	**<18**	**18–25**	**26–35**	**36–50**	**>50**	**Total**
Alabama	0	118	467	520	205	1,310	0	0	2	1	0	3
Colorado	0	172	700	606	195	1,673	0	0	0	0	0	0
Connecticut	4	147	390	316	98	955	0	1	2	0	0	3
Delaware	0	44	87	72	30	233	0	0	0	0	0	0
FBOP	0	912	3,465	4,563	2,137	11,077	0	11	53	31	6	101
Illinois	0	216	844	911	439	2,410	0	24	12	13	1	50
Indiana	0	339	1,032	886	213	2,470	0	14	17	13	4	48
Iowa	0	128	267	237	73	705	0	4	4	0	0	8
Kentucky	0	380	1,393	1,149	217	3,139	0	9	31	20	4	64
Maryland	2	160	418	336	146	1,062	0	4	15	9	3	31
Massachusetts	0	76	238	188	86	588	0	4	10	9	0	23
Mississippi	0	101	352	324	125	902	0	6	10	6	3	25
Nebraska	0	42	156	153	65	416	0	1	3	4	0	8
Nevada	0	182	478	467	153	1,280	0	17	22	17	3	59
New Jersey	0	90	286	268	130	774	0	6	13	9	2	30
New Mexico	0	70	328	259	84	741	0	4	10	6	1	21
New York	2	329	871	803	355	2,360	0	9	22	4	1	36
North Carolina	27	285	1,050	1,183	388	2,933	1	6	17	8	1	33
North Dakota	0	49	99	64	12	224	0	0	0	0	0	0
Ohio	0	663	1,728	1,360	407	4,158	0	4	4	1	0	9
Oklahoma	2	356	1,226	1,139	356	3,079	1	7	8	3	0	19
Oregon	0	137	488	454	193	1,272	0	4	12	10	2	28
Pennsylvania	1	308	1,019	886	406	2,620	0	1	3	2	0	6

Rhode Island	0	20	55	45	10	130	0	0	0	0	0	0
South Carolina	2	179	539	531	204	1,455	0	3	11	3	2	19
South Dakota	0	82	256	157	30	525	0	0	1	0	0	1
Tennessee	0	147	769	808	222	1,946			4	2	3	9
Texas	6	1,468	4,587	4,487	1,632	12,180	0	21	35	30	7	93
Utah	0	51	196	182	42	471	0	3	2	0	0	5
Washington	133	530	457	182		1,302	0	1	1	0	0	2
Wisconsin	0	210	632	505	192	1,539	0	9	25	13	34	81
Wyoming	0	33	87	105	35	260	0	0	3	1	0	4
Total	179	8,024	24,960	24,146	8,880	66,189	2	173	352	215	77	819

Table 14 Age Cohorts Percentage of Female Total Custodial Population and of Female Restrictive Housing Population (n = 32)

	Total Custodial Population					Restrictive Housing Population				
	<18	18–25	26–35	36–50	>50	<18	18–25	26–35	36–50	>50
Alabama	0.0%	9.0%	35.6%	39.7%	15.6%	0.0%	0.0%	66.7%	33.3%	0.0%
Colorado	0.0%	10.3%	41.8%	36.2%	11.7%	0.0%	0.0%	0.0%	0.0%	0.0%
Connecticut	0.4%	15.4%	40.8%	33.1%	10.3%	0.0%	33.3%	66.7%	0.0%	0.0%
Delaware	0.0%	18.9%	37.3%	30.9%	12.9%	0.0%	0.0%	0.0%	0.0%	0.0%
FBOP	0.0%	8.2%	31.3%	41.2%	19.3%	0.0%	10.9%	52.5%	30.7%	5.9%
Illinois	0.0%	9.0%	35.0%	37.8%	18.2%	0.0%	48.0%	24.0%	26.0%	2.0%
Indiana	0.0%	13.7%	41.8%	35.9%	8.6%	0.0%	29.2%	35.4%	27.1%	8.3%
Iowa	0.0%	18.2%	37.9%	33.6%	10.4%	0.0%	50.0%	50.0%	0.0%	0.0%
Kentucky	0.0%	12.1%	44.4%	36.6%	6.9%	0.0%	14.1%	48.4%	31.2%	6.2%
Maryland	0.2%	15.1%	39.4%	31.6%	13.7%	0.0%	12.9%	48.4%	29.0%	9.7%
Massachusetts	0.0%	12.9%	40.5%	32.0%	14.6%	0.0%	17.4%	43.5%	39.1%	0.0%
Mississippi	0.0%	11.2%	39.0%	35.9%	13.9%	0.0%	24.0%	40.0%	24.0%	12.0%
Nebraska	0.0%	10.1%	37.5%	36.8%	15.6%	0.0%	12.5%	37.5%	50.0%	0.0%
Nevada	0.0%	14.2%	37.3%	36.5%	12.0%	0.0%	28.8%	37.3%	28.8%	5.1%
New Jersey	0.0%	11.6%	37.0%	34.6%	16.8%	0.0%	20.0%	43.3%	30.0%	6.7%
New Mexico	0.0%	9.4%	44.3%	35.0%	11.3%	0.0%	19.0%	47.6%	28.6%	4.8%
New York	0.1%	13.9%	36.9%	34.0%	15.0%	0.0%	25.0%	61.1%	11.1%	2.8%
North Carolina	0.9%	9.7%	35.8%	40.3%	13.2%	3.0%	18.2%	51.5%	24.2%	3.0%
North Dakota	0.0%	21.9%	44.2%	28.6%	5.4%	0.0%	0.0%	0.0%	0.0%	0.0%
Ohio	0.0%	15.9%	41.6%	32.7%	9.8%	0.0%	44.4%	44.4%	11.1%	0.0%
Oklahoma	0.1%	11.6%	39.8%	37.0%	11.6%	5.3%	36.8%	42.1%	15.8%	0.0%
Oregon	0.0%	10.8%	38.4%	35.7%	15.2%	0.0%	14.3%	42.9%	35.7%	7.1%
Pennsylvania	0.0%	11.8%	38.9%	33.8%	15.5%	0.0%	16.7%	50.0%	33.3%	0.0%
Rhode Island	0.0%	15.4%	42.3%	34.6%	7.7%	0.0%	0.0%	0.0%	0.0%	0.0%

South Carolina	0.1%	12.3%	37.0%	36.5%	14.0%	0.0%	15.8%	57.9%	15.8%	10.5%
South Dakota	0.0%	15.6%	48.8%	29.9%	5.7%	0.0%	0.0%	100.0%	0.0%	0.0%
Tennessee	0.0%	7.6%	39.5%	41.5%	11.4%	0.0%	0.0%	44.4%	22.2%	33.3%
Texas	0.0%	12.1%	37.7%	36.8%	13.4%	0.0%	22.6%	37.6%	32.3%	7.5%
Utah	0.0%	10.8%	41.6%	38.6%	8.9%	0.0%	60.0%	40.0%	0.0%	0.0%
Washington	10.2%	40.7%	35.1%	14.0%		0.0%	50.0%	50.0%	0.0%	0.0%
Wisconsin	0.0%	13.6%	41.1%	32.8%	12.5%	0.0%	11.1%	30.9%	16.0%	42.0%
Wyoming	0.0%	12.7%	33.5%	40.4%	13.5%	0.0%	0.0%	75.0%	25.0%	0.0%
Median	**0.0%**	**12.2%**	**39.0%**	**35.8%**	**12.9%**	**0.0%**	**17.8%**	**44.0%**	**24.1%**	**2.0%**

Subpopulations

The rules governing the placement of individuals in restrictive housing reflect concerns about its harms to individuals. Certain subpopulations may face additional challenges, as evidenced by regulations focused on limiting the placement of these groups in restrictive housing. In this section, we provide an overview of data on incarcerated people identified as mentally ill as well as on the use of restrictive housing for pregnant women and transgender individuals.

Prisoners with Mental Health Issues

Reports identify a large number of incarcerated people who have mental health issues, with a recent estimate as high as one-third of the prison population.[60] Even as debate exists as to what level of distress should create buffers to placement in restrictive housing, a consensus has emerged that individuals identified as having serious mental illness should not be placed into restrictive housing.

Illustrative of these concerns are the 2016 ACA Restrictive Housing Performance Based Standards, which called for regular "behavioral health assessments" for individuals placed in restrictive housing. Standard 4-RH-0010 provides that corrections departments should have written policies to ensure that "a mental health practitioner/provider" evaluates and files written reports on prisoners "placed in restrictive housing within 7 days of placement."[61] If an individual is held "beyond 30 days, a behavioral health assessment by a mental health practitioner/provider" is to be completed "at least every 30 days" for individuals diagnosed with a "behavioral health disorder and more frequently if clinically indicated." If an assessment concludes that a person has no "behavioral health disorder," reassessments are to occur "every 90 days and more frequently if clinically indicated." Those evaluations are to take place in "a confidential area."[62]

Further, the ACA Standards detail that, "at a minimum," the mental health provider is to inquire into whether a person has a present "suicide ideation" or a "history of suicidal behavior," is on "prescribed psychotropic medication," has a current "mental health complaint," is being treated for "mental health problems," has "a history of inpatient and outpatient psychiatric treatment," or has a history of "treatment for substance abuse." The mental health provider must also observe an individual's "general appearance and behavior" and look for "evidence of abuse and/or trauma" or "current symptoms of psychosis, depression, anxiety, and/or aggression."[63] The provider is then to conclude whether a referral to mental health care is necessary and whether "emergency treatment" is needed.[64]

The ACA Standards also provide that once a person is placed in restrictive housing, both written policies and practices should require that prisoners are "personally observed by a correctional officer twice per hour, but no more than 40 minutes apart, on an irregular schedule."[65] Individuals who are "violent or mentally disordered or who demonstrate unusual or bizarre behavior or self-harm" are to be observed more often.[66] Prisoners who are "suicidal" are to be under continuous observation, all of which is to be logged.[67] The need for observation is a decision for a "qualified mental health professional."[68] Unless "medical attention is needed more frequently," each person in restrictive housing is to be visited daily by health care personnel in an

announced and recorded visit[69] and weekly by a "mental health staff" member, unless more frequent visits are called for by health personnel.[70]

The ACA Standards also state that "the agency will not place a person with serious mental illness in Extended Restrictive Housing," defined as "housing that separates the offender from contact with the general population while restricting an offender/inmate to his/her cell for at least 22 hours per day and for more than 30 days for the safe and secure operation of the facility."[71] The ACA defines serious mental illness as "Psychotic Disorders, Bipolar Disorders, and Major Depressive Disorder; any diagnosed mental disorder (excluding substance use disorders) currently associated with serious impairment in psychological, cognitive, or behavioral functioning that substantially interferes with the person's ability to meet the ordinary demands of living and requires an individualized treatment plan by a qualified mental health professional(s)."[72]

To gather information about the use of restrictive housing for persons identified as facing mental health challenges, the 2017–2018 ASCA-Liman survey asked each jurisdiction about people whom it deemed to have "serious mental illness" (SMI), including the total number as well as the gender and race of the seriously mentally ill population both in the total custodial population and in restrictive housing.[73] Thirty-three jurisdictions provided data on both the total custodial population with SMI and the population with SMI in restrictive housing for male prisoners, and 31 for female prisoners.[74]

An additional word of explanation is needed about this aspect of the questionnaire. After surveying jurisdictions in 2015 and again in 2017, we learned that the definitions of serious mental illness vary substantially, as do the policies governing placement of individuals with mental health issues—classified as "serious" or otherwise—in restrictive housing. In addition to correctional department rules, some legislatures provide statutory direction and, in some jurisdictions, litigation has resulted in specified definitions and constraints.[75]

For example, some jurisdictions provide a sentence or two explaining their definition of serious mental illness, such as, "chronic mental health treatment or inpatient mental health treatment."[76] Other jurisdictions have more detailed descriptions, such as any "mental health condition that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person with the serious mental illness. Serious mental illness includes but is not limited to (i) schizophrenia, (ii) schizoaffective disorder, (iii) delusional disorder, (iv) bipolar affective disorder, (v) major depression, and (vi) obsessive compulsive disorder."[77] Yet others have several paragraphs or pages of descriptions.[78]

Given this variation in scope and detail, a person could be classified as seriously mentally ill in one jurisdiction but not in another. We therefore have neither aggregated nor scaled the data but rather provide, in Table 15 and Table 16, the numbers of persons in the general population with serious mental illness and the numbers placed in restrictive housing, as provided by each jurisdiction's own account. We provide the definitions used in 43 jurisdictions in Appendix C.

Table 15 Male Prisoners with Serious Mental Illness (SMI, variously defined) in Restrictive Housing (RH) (n = 33)

	Total Male Custodial Population	Male Custodial Population with SMI	% Male Custodial Population with SMI	Male Population with SMI in RH	%Male Population with SMI in RH
Alabama	20,282	1,064	5.3%	248	23.3%
Arizona	38,117	1,559	4.1%	284	18.2%
Arkansas	14,561	397	2.7%	21	5.3%
Colorado	16,624	1,234	7.4%	1	0.1%
Connecticut	13,182	28	0.2%	3	10.7%
Delaware	4,100	354	8.6%	3	0.9%
Illinois	39,767	3,998	10.1%	356	8.9%
Indiana	23,847	4,762	20.0%	567	11.9%
Iowa	7,578	1,009	13.3%	24	2.4%
Kansas	8,999	2,677	29.7%	43	1.61%
Kentucky	20,427	386	1.9%	66	17.1%
Louisiana	32,953	2,113	6.4%	417	19.7%
Massachusetts	8,459	608	7.2%	10	1.6%
Mississippi	12,038	61	0.5%	10	16.4%
Missouri	29,675	3,768	12.7%	703	18.7%
Nebraska	4,762	192	4.0%	50	26%
New Jersey	18,594	208	1.1%	1	0.5%
New Mexico	6,306	36	0.6%	23	63.9%
New York	48,407	2,420	5.0%	47	1.9%
North Carolina	34,326	385	1.1%	27	7.0%
North Dakota	1,606	345	21.5%	5	1.5%
Ohio	45,796	3,477	7.6%	150	4.3%
Oklahoma	23,816	7,011	29.4%	615	8.8%
Oregon	13,302	812	6.1%	112	13.8%
Pennsylvania	44,300	3,691	8.3%	0	0.0%
Rhode Island	2,722	140	5.1%	16	11.4%
South Dakota	3,402	111	3.3%	12	10.8%
Tennessee[79]	20,214			98	
Texas[80]	133,229	1,440	1.1%	0	0.0%
Utah	5,822	199	3.4%	11	5.5%
Washington	15,744	1,628	10.3%	99	6.1%
Wisconsin	21,050	1,654	7.9%	90	5.4%
Wyoming	1,894	204	10.8%	41	20.1%
Total	**735,901**	**47,971**	**6.1% (median)**	**4,153**	**7.9% (median)**

Table 16 Female Prisoners with Serious Mental Illness (SMI, variously defined) in Restrictive Housing (RH) (n = 31)

	Total Female Custodial Population	Female Custodial Population with SMI	% Female Custodial Population with SMI	Female Population with SMI in RH	% Female Population with SMI in RH
Alabama	1,310	86	6.6%	1	1.2%
Arizona	4,029	313	7.8%	14	4.5%
Arkansas	1,344	2	0.1%	0	0.0%
Colorado	1,673	497	29.7%	0	0.0%
Connecticut	955	8	0.8%	0	0.0%
Delaware	233	64	27.5%	0	0.0%
Illinois	2,410	619	25.7%	24	3.9%
Indiana	2,470	954	38.6%	36	3.8%
Iowa	705	167	23.7%	3	1.8%
Kansas	897	525	58.5%	0	0.0%
Kentucky	3,139	163	5.19%	8	4.9%
Massachusetts	588	46	7.82%	0	0.0%
Missouri	3,529	1,102	31.2%	48	4.4%
Nebraska	416	71	17.1%	4	5.6%
New Jersey	774	24	3.1%	0	0.0%
New Mexico	741	9	1.2%	0	0.0%
New York	2,357	188	8.0%	3	1.6%
North Carolina	2,933	80	2.7%	2	2.5%
North Dakota	224	37	16.5%	0	0.0%
Ohio	4,158	1,113	26.8%	10	0.9%
Oklahoma	3,079	2,086	67.7%	14	0.7%
Oregon	1,272	168	13.2%	11	6.6%
Pennsylvania	2,620	529	20.2%	0	0.0%
Rhode Island	130	9	6.9%	0	0.0%
South Dakota	525	40	7.6%	1	2.5%
Tennessee	1,946			1	
Texas	12,180	84	0.7%	0	0.0%
Utah	471	21	4.5%	0	0.0%
Washington	1,302	193	14.8%	0	0.0%
Wisconsin	1,539	414	26.9%	19	4.6%
Wyoming	260	64	24.6%	2	3.1%
Total	**60,209**	**9,676**	**13.2% (median)**	**201**	**0.8% (median)**

We also sought to learn about the intersection of race, ethnicity, gender, and mental illness. Thirty-one jurisdictions provided information by race and ethnicity about male prisoners with serious mental illness, and 28 jurisdictions provided information by race and ethnicity about female prisoners with serious mental illness. Table 17 and Table 18 provide the information, jurisdiction-by-jurisdiction.

Table 17 Male Prisoners with Serious Mental Illness by Race and Ethnicity in the Total Custodial Population and in the Restrictive Housing Population (n = 31)

	Total Custodial Population								Restrictive Housing Population							
	White	Black	Hisp.	Asian	NHPI	Am. Ind.	Other	Total	White	Black	Hisp	Asian	NHPI	Am. Ind.	Other	Total
Alabama	497	564					3	1,064	75	172					1	248
Arizona	743	339	393	7		53	24	1,559	105	52	99	0		15	13	284
Arkansas	206	180	0	0	0	0	11	397	3	18	0	0	0	0	0	21
Colorado	633	270	276	9		46	0	1,234	0	1	0	0	0	0	0	1
Connecticut	10	10	8	0		0		28	3	0	0	0		0		3
Delaware	110	236	7	1		0	0	354	1	2	0	0		0	0	3
Illinois	1,415	2,283	286	8	0	4	2	3,998	69	263	23	0	0	0	1	356
Indiana	3,297	1,294	125	10	3	13	20	4,762	379	150	33	0	0	2	3	567
Iowa	717	215	50	5	5	17		1,009	18	4	2					24
Kansas	1,679	697	235	19	0	47	0	2,677	33	9	0	0	0	1	0	43
Kentucky	307	76	1				2	386	52	9	2		2	0	1	66
Louisiana	766	1,342	4	1	0	0		2,113	110	307	0	0	0	0	0	417
Massachusetts	336	155	96	5	0	6	10	608	4	4	2	0	0	0	0	10
Mississippi	21	38				2		61	0	9				1		10
Missouri	2,676	1,074		3		8	7	3,768	452	246				4	1	703
Nebraska								192	25	12	11			1	1	50
New Jersey	80	93	33	2	0	0	0	208	0	1	0	0	0	0	0	1
New Mexico	15	2	18	0	0	1	0	36	6	1	15	0	0	1	0	23
New York	638	1,155	546	0	0	0	81	2,420	8	23	14	0	0	1	1	47
North Carolina	189	164	11	3			18	385	10	14	1				2	27
North Dakota	235	32	14	2	0	61	1	345	3	0	0	0	0	2	0	5
Ohio	2,149	1,237	56	3		9	23	3,477	92	55	1	1		0	1	150
Oklahoma	4,303	1,609	321	16	2	746	14	7,011	292	193	47	0	3	79	1	615

Pennsylvania	1,696	1,692	277	11	0	2	13	3,691	0	0	0	0	0	0	0	0
Rhode Island	72	40	24	1	0	2	1	140	8	3	5	0	0	0	0	16
South Dakota	71	9	1	1	0	29	0	111	6	1	1	0	0	4	0	12
Tennessee									61	36	1	0	0	0	0	98
Utah	137	21	28	2	3	7	1	199	5	2	3			1		11
Washington	1,000	372	130	47		64	15	1,628	62	16	11	5		3	2	99
Wisconsin	869	581	124		13	66	1	1,654	35	36	14	0	0	5	0	90
Wyoming	166	8	20	0	2	8	0	204	17	3	1	0	0	4	0	25
Total	**25,033**	**15,788**	**3,084**	**156**	**28**	**1,191**	**247**	**45,719**	**1,934**	**1,642**	**286**	**6**	**5**	**124**	**28**	**4,025**

Table 18 Female Prisoners with Serious Mental Illness by Race and Ethnicity in the Total Custodial Population and in the Restrictive Housing Population (n = 28)

	Total Custodial Population								Restrictive Housing Population							
	White	Black	Hisp.	Asian	NHPI	Am. Ind.	Other	Total	White	Black	Hisp	Asian	NHPI	Am. Ind.	Other	Total
Alabama	60	26						86	0	1						1
Arizona	181	57	44	2		24	5	313	8	1	5	0		0	0	14
Arkansas	0	2	0	0	0	0	0	2	0	0	0	0	0	0	0	0
Colorado	269	73	122	5		28	0	497	0	0	0	0	0	0	0	0
Connecticut	3	4	1	0		0		8	0	0	0	0		0		0
Delaware	37	26	0	1		0	0	64	0	0	0	0		0	0	0
Illinois	294	270	50	4	0	1	0	619	7	14	3	0	0	0	0	24
Indiana	757	166	17	1	0	4	9	954	24	12	0	0	0	0	0	36
Kansas	370	87	44	5	0	19	0	525	0	0	0	0	0	0	0	0
Kentucky	135	22					6	163	8	0	0				0	8
Massachusetts	27	12	3	1	0	0	3	46	0	0	0	0	0	0	0	0
Missouri	932	156	3	1		10		1,102	34	14	0	0		0		48
Nebraska								71		2				1	1	4
New Jersey	12	9	2	1	0	0	0	24	0	0	0	0	0	0	0	0
New Mexico	7	0	2	0	0	0	0	9	0	0	0	0	0	0	0	0
New York	52	109	24	0	0	0	3	188	1	1	1	0	0	0	0	3
North Carolina	43	34	0	1			2	80	1	1	0	0			0	2
North Dakota	20	0	3	0	13	0	1	37	0	0	0	0	0	0	0	0
Ohio	833	270	7	2		1	0	1,113	4	6	0	0		0	0	10
Oklahoma	1,353	274	90	3	6	355	5	2,086	2	5	2	0	0	5	0	14
Pennsylvania	295	188	35	4	0	2	5	529	0	0	0	0	0	0	0	0
Rhode Island	7	2	0	0	0	0	0	9	0	0	0	0	0	0	0	0
South Dakota	21	0	2	0	0	17	0	40	1	0	0	0	0	0	0	1

Tennessee									1	0	0	0	0	0	0	1
Utah	16	0	1	0	0	4	0	21	0	0	0	0	0	0	0	0
Washington	116	29	24	9		11	4	193	0	0	0	0		0	0	0
Wisconsin	268	98	9		4	35	0	414	8	9	0	0	0	2	0	19
Wyoming	51	3	6	0	0	4	0	64	0	1	0	0	0	1	0	2
Total	**6,159**	**1,917**	**489**	**40**	**23**	**515**	**43**	**9,257**	**99**	**67**	**11**	**0**	**0**	**9**	**1**	**187**

Pregnant Women

Restrictive housing has sometimes been used as a placement for prisoners identified as "different" on various metrics, including being pregnant. In 2016, the ACA Standards provided that "female inmates determined to be pregnant"[81] should not be housed in extended restrictive housing.

We sought to learn how many pregnant prisoners were in the custodial population as a whole and how many were placed in restrictive housing. In the 41 jurisdictions that had sufficiently detailed and consistent information to describe, three reported that, as of the fall of 2017, they housed no pregnant prisoners in their total custodial populations.[82] The other 38 jurisdictions reported that they counted a total of 613 pregnant women prisoners.[83] None of the 41 jurisdictions reported that, as of the fall of 2017, any pregnant prisoners were held in restrictive housing.

Transgender Prisoners

As with pregnancy, "protection" has been a basis for putting other persons with specific needs in restrictive housing. Concerns about the misuse of restrictive housing as a placement for transgender individuals prompted the ACA to promulgate a Standard that prisoners not be "placed in Restrictive Housing on the basis of Gender Identity alone."[84] Therefore, the ASCA-Liman survey sought to learn about transgender prisoners in the total custodial population and in restrictive housing.

Of the 43 jurisdictions responding about transgender prisoners in the total custodial population,[85] four indicated that they either did not track or could not report the number of transgender prisoners in their total custodial populations.[86] One jurisdiction reported having no transgender prisoners in its total custodial population.[87] The remaining 38 jurisdictions reported a total of 2,444 transgender prisoners in their total custodial populations. When jurisdictions described different methods to identify transgender prisoners, those differences are documented in endnotes.[88]

Five of these 43 jurisdictions indicated that they either did not track or could not report the number of transgender prisoners in their restrictive housing populations.[89] Of the remaining 38 jurisdictions, 17 reported that no transgender prisoners were in restrictive housing.[90] The other 21 jurisdictions identified a total of 157 transgender prisoners in restrictive housing. Within those 21 systems, nine states each counted one to three transgender prisoners in segregation, another nine states reported six to ten, and three states identified 19–24 people in this category.[91]

A Snapshot of Two Jails

According to the Bureau of Justice Statistics (BJS), as of 2016, the 2,850 jail systems in the United States held an average daily population of 731,300 people.[92] According to an earlier BJS report based on survey responses from people confined in jails in 2011–2012, on an average day, some 2.7% of these individuals were held in administrative segregation or solitary confinement.[93]

BJS has identified six jurisdictions (Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont) as "integrated systems," in which correctional departments are in charge of prisons and jails.[94] Of the 46 state jurisdictions responding to the survey, four—Delaware, Hawaii, Maryland, and Rhode Island—indicated that they had included jail populations in their counts of total custodial populations.[95] Alaska and Connecticut, also responding, did not discuss jails as under their "direct control" and did not count people in jails in their responses. Given that these integrated jurisdictions are predominately prison systems and we have some but not comprehensive data delineating the characteristics of their jail populations, this section focuses on the information from the two jail systems that separately responded to our survey.

Demographics

We sent surveys to the four major metropolitan jails that are ASCA members, and we received responses from Los Angeles and Philadelphia.[96] Los Angeles reported that, as of March 2018, it had 17,278 people in its jails, or about 2.4% of the national jail population. As of September 2017, Philadelphia held 6,695 people, or about 0.9% of the national jail population. Thus, these two systems accounted for about 3.3% of the people in jails across the country. Each system also provided demographic information (detailed in Tables 19 and 20) about the sex/gender, race, ethnicity, and age of those in their jails.

Table 19 Total Custodial Population by Race and Ethnicity and Delineated by Sex/Gender in Los Angeles and Philadelphia Jails

Men

	White	Black	Hisp.	Asian	NHPI	Am. Ind.	Other	Total
Los Angeles	2,200	4,468	7,784	29	30	5	541	15,057
Philadelphia	627	4,127	1,205	46			91	6,096

Women

	White	Black	Hisp.	Asian	NHPI	Am. Ind.	Other	Total
Los Angeles	467	672	981	7	6	0	88	2,221
Philadelphia	146	342	99	2			10	599

The 2017–2018 ASCA-Liman survey defined short-term restrictive housing as "separating prisoners from the general population and holding them in their cells for an average of 22 or more hours per day," for 15–29 continuous days. The survey defined long-term restrictive housing as "separating prisoners from the general population and holding them in their cells for an average of 22 or more hours per day," for longer than 29 days. Both jurisdictions relied on the definition of 15–29 days in confinement for short-term restrictive housing.

Los Angeles reported that 619 people (3.6%) out of its total custodial population of 17,278 were in restrictive housing, and it provided delineations of those populations by age and gender. Philadelphia reported that 416 detainees (6.2%) out of its total custodial population of 6,695 were in restrictive housing, but did not provide demographic information on these individuals.[97] Neither jurisdiction provided information on how long individuals stayed in restrictive housing.[98] Table 20 details the gender and the age of both the custodial population and, for Los Angeles,[99] the restrictive housing population.

Table 20 Age Cohorts of Men and Women in the Total Custodial Population in Los Angeles and Philadelphia Jails and in the Restrictive Housing Population in Los Angeles Jails

Men

Total Custodial Population

	<18	**18–25**	**26–35**	**36–50**	**50+**
Los Angeles	0	3,706	4,971	3,386	2,994
Philadelphia	36	1,730	2,180	1,577	573

Restrictive Housing Population

	<18	**18–25**	**26–35**	**36–50**	**50+**
Los Angeles	0	90	192	148	49

Women

Total Custodial Population

	<18	**18–25**	**26–35**	**36–50**	**50+**
Los Angeles	0	497	837	489	398
Philadelphia	1	107	235	186	70

Restrictive Housing Population

	<18	**18–25**	**26–35**	**36–50**	**50+**
Los Angeles	0	8	14	8	2

Mental Illness in Jails

The survey also asked the jails for information about certain subpopulations. As in the survey of prison systems, we asked each jurisdiction for its own definition of serious mental illness. Los Angeles, referencing the outcome of a lawsuit in its definition, [100] stated that

> "Serious mental illness" includes psychotic disorders, major mood disorders (including major depression and bipolar disorders), and any other conditions (excluding personality disorders, substance abuse and dependence disorders, dementia, and developmental disability) that is associated with serious or recurrent significant self-harm, suicidal ideation, imminent danger to others, current grave disability, or that prevents access to available programs. Although personality disorders alone generally do not qualify as serious mental illness, personality disorders associated with serious or recurrent significant self-harm do qualify as serious mental illness.

Los Angeles reported that, of its 17,278-person jail population, 4,000 people—23.2%—had serious mental illness, and that no one was in restrictive housing whom it identified as having serious mental illness and who "also displayed signs of suicidal ideations, was gravely disabled," was in danger of "recurrent self-harm, or had an active psychosis."

Philadelphia defined serious mental illness as "having a diagnosis from one of the following categories: Bipolar, Schizophrenia, Psychosis, Depression, Borderline Personality." Philadelphia reported that it housed 1,136 people—17.0%—with serious mental illness in its custodial population. The jail system also reported that of the 6,096 men who were in jail, 939—15.4%—were classified as seriously mentally ill, and that of the 599 women who were in jail, 197—32.9%—were classified as seriously mentally ill. Philadelphia did not report the number of individuals in restrictive housing with a serious mental illness.

Pregnant and Transgender People

Los Angeles reported "approximately" 60 transgender individuals in its total custodial population, and that fewer than five transgender individuals were in short-term restrictive housing (15–29 days), and fewer than five people were in long-term restrictive housing (longer than 29 days). Philadelphia reported that it does not track transgender individuals "in a manner that is easily reportable."

Los Angeles reported 12 pregnant individuals, none of whom were in restrictive housing. Philadelphia explained that, in terms of pregnant people, that "data could not be sorted to respond to this question."[101]

Revising Policies

Although Philadelphia indicated that it had not made any changes to its policies regarding restrictive housing since January 1, 2016, it explained that it had reviewed its policies after the ACA released its 2016 Performance Based Standards and had relied on them. Philadelphia

reported implementing the ACA prohibition on extended restrictive housing (more than 29 continuous days) for individuals under the age of 18. Philadelphia said that it had substantially implemented, with exceptions, ACA prohibitions on the use of extended restrictive housing for those diagnosed as seriously mentally ill. Philadelphia stated that it also aimed not to release individuals from restrictive housing directly into the community. Philadelphia responded that, before the 2016 ACA revisions, its policy had been not to use extended restrictive housing for females determined to be pregnant.

Los Angeles detailed several changes in its policies. Los Angeles stated that it had shifted its entry criteria from those based on general information about prisoners ("intel based") to those based on prisoners' "behavior." In terms of process, placement required approval from a "Restrictive Housing Panel" and pre-entry mental health screening prior to moving an individual into restrictive housing. Within five days of initial placements, Los Angeles stated that it required individualized needs assessments.[102]

Los Angeles reported increasing the total time out-of-cell by three hours per week. Los Angeles stated that its programs included activities focused on self-help, religion, education, and anger-management. Los Angeles said it had added "self-directed educational programs for volunteers," and access to more "entertainment" or literary materials to "those who show positive behavior."

Los Angeles reported it had developed a "STEP program" for release from restrictive housing in which an individual who had demonstrated positive behavior would participate for two to four months in "several graduated programming groups in increasing size." Although Los Angeles did not change its policy to mandate that detainees be told the criteria for their release, it indicated that the pamphlets it gave detainees included this information.

Los Angeles stated that it had reviewed its policies since the ACA released its 2016 Performance Based Standards, and that it uses these Standards "as a guide." Los Angeles reported implementing the ACA Standard prohibiting the use of extended restrictive housing (more than 29 continuous days) for females determined to be pregnant. Los Angeles said that it had not implemented the ACA Standard about direct release from restrictive housing into the community. Los Angeles stated that it "found this standard to be extremely difficult to implement in a jail setting due to the unknown and often short stays of jail inmates." Los Angeles indicated that, by providing "an increase in out-of-cell time," it had substantially implemented, with exceptions, the policy prohibiting the placement of those diagnosed as seriously mentally ill in extended restrictive housing. Los Angeles noted that it provided 32 hours of mental health training for staff and two-year staff rotations for those working in restrictive housing units.

Both jails were asked, "In an ideal situation (i.e. if you had the necessary resources, and if you could do so consistent with institutional safety), what number of hours out-of-cell do you believe is desirable for prisoners?" Los Angeles responded that it believed six to eight hours out-of-cell per day is desirable. Philadelphia responded, "General population inmates generally get 9–11 hours each day out of their cells."

III. Revising Policies on Restrictive Housing

ASCA-Liman surveys have sought to learn about changes in the restrictive housing policies of corrections departments. As reflected below, dozens of departments have expressed concerns about restrictive housing and reported policy revisions, some of which aim to reduce and, in some instances, to eliminate holding people in cells an average of 22 hours or more per day for 15 days or more.

In the 2014 Report, *Time-in-Cell*, we noted that the majority of the jurisdictions surveyed had convened or planned to convene a task force to review their use of isolation.[103] Two years later, jurisdictions reported more efforts underway, as reflected in the title of the 2016 Report, *Aiming to Reduce Time-in-Cell*. Jurisdictions described narrowing criteria for placement in restrictive housing and increasing oversight; creating step-down and release procedures; and increasing time out-of-cell and opportunities for activities inside restrictive housing.[104]

In the 2017–2018 ASCA-Liman survey, we again asked about reforms. Our questions focused on entry, oversight, programs, and release, as well as on the impact of the 2016 ACA Performance Based Standards. The survey also queried jurisdictions about what they would like to do, if resources were available, in terms of time out-of-cell. Forty-four jurisdictions responded to at least some of the questions about changes in policies.[105] Several jurisdictions provided their regulations and additional materials.[106] Some jurisdictions also noted that they were influenced by guidance from the U.S. Department of Justice, the National Institute of Corrections, the National Commission on Correctional Health Care, and the Vera Institute of Justice. Below, we synthesize the answers to detail the changes reported,

Entry and Oversight

In 2014, we learned that the criteria for placing prisoners in isolation were broad, as was the discretion afforded correctional staff to place individuals in administrative segregation. Few policies focused on pathways out of isolation.[107] For the 2017–2018 survey, we sought to learn about whether and how criteria for placement in restrictive housing had changed since 2016. Thirty-nine jurisdictions responded to at least one of the questions discussed below, and 23 reported making revisions to placement processes.[108]

We asked whether jurisdictions had removed "behaviors . . . from the list of infractions qualifying prisoners for restrictive housing placement" or had otherwise narrowed the criteria for entry.[109] Sixteen jurisdictions reported that they had done so.[110] Examples included eliminating some behaviors from categories prompting isolation. One jurisdiction had deleted "horse play, possession of small amounts of marijuana, etc." from infractions leading to restrictive housing.[111] As another explained, it has shifted its rules so that acts which "qualify an inmate for RH are those that are considered violent or compromise security in a significant manner."[112] A third jurisdiction noted that non-violent behavior was less likely to result in being sent to restrictive housing,[113] and another stated it no longer used restrictive housing when prisoners misbehaved in ways that did not "pose a direct threat."[114] Similarly, one jurisdiction reported that it had "discontinued the use

of solitary confinement as a punishment for disciplinary infractions" altogether.[115] In contrast, one jurisdiction reported that, because of increased prison violence, it had changed criteria to increase the length of stay in what it called "long-term RHU."[116] Another jurisdiction had "added three more behaviors, when 'chronic' or severe": fighting, possession of "gang-related material," and "disobeying staff directive/insolence to staff."[117]

We also inquired about decision-making by asking about the authority and the steps taken in the decision-making process. Sixteen jurisdictions reported that they had created policies requiring senior-level approval of restrictive housing decisions.[118] Twenty jurisdictions reported that the outcomes of mental health screenings affected their decisions to put individuals into restrictive housing.[119] Fourteen jurisdictions reported that they conducted mental health screenings prior to placement in restrictive housing.[120] Four jurisdictions stated that they performed mental health screenings upon placement in restrictive housing.[121] Jurisdictions also mentioned screenings before placement for issues such as medical status,[122] disability, and PREA (Prison Rape Elimination Act) requirements.[123]

Twenty-one jurisdictions reported having put in place policies requiring consideration of less restrictive alternatives prior to placement in restrictive housing.[124] Examples were use of a "Restricted Privileges dorm"[125] and mental health special housing.[126] One jurisdiction had a set of alternatives: "confinement" in general population cells "for a specified period," "'blue room' placement," meetings with a counselor, and placement in a "protective custody housing unit."[127] Another jurisdiction considered, for drug trafficking and related offenses, placement in a special "Drug Suppression Unit" within its general population.[128]

Twenty-eight jurisdictions also reported changes in how they monitored placements in restrictive housing.[129] Changes included the frequency of reviews[130] (from weekly, to every 30 days, to every 90 days, to annually, to as needed); the individuals or groups undertaking reviews;[131] and a new grievance procedure for prisoners in restrictive housing.[132] Twenty-two jurisdictions reported increased monitoring of the mental health of prisoners in restrictive housing[133] through regular rounds or visits from mental health care professionals (from daily to weekly[134]) and placement reviews every 30 days.[135]

Time Out-of-Cell, Sociability, and Programming

We asked a number of questions about whether time out-of-cell had increased and what types of out-of-cell activities or unstructured time were organized. Forty jurisdictions responded to at least one of these questions. Twenty reported that they had implemented policies to increase time out-of-cell for prisoners, and many others described changing how that time was structured.[136]

Twenty jurisdictions reported adding more structured time out-of-cell,[137] such as programs or therapy, and six described permitting meals in social settings.[138] Eleven jurisdictions noted increasing "unstructured (recreational)" time out-of-cell,[139] and ten referenced more outdoor recreation opportunities.[140] Eleven jurisdictions stated that some classes were available.[141]

Thirteen reported adding an out-of-cell GED or diploma program for prisoners in restrictive housing.[142]

A focus for many jurisdictions was sociability and group programming. Nine jurisdictions reported that they had increased times for visitors.[143] Ten jurisdictions said that they had increased phone time for prisoners.[144] Twenty-four jurisdictions stated that they had added out-of-cell group programming or classes,[145] such as "career readiness,"[146] correspondence courses,[147] horticulture,[148] and classes on "thinking errors" and "criminal attitudes."[149] Sixteen jurisdictions noted more group recreation opportunities.[150]

Twenty-two jurisdictions reported that they had added "in-cell learning opportunities."[151] Among these 22 jurisdictions, new in-cell educational opportunities included distance learning at both the GED and post-secondary levels,[152] as well as vocational certification testing.[153] Materials available for in-cell use included videos,[154] tablets or smartboards,[155] and paper packets.[156]

Staff Training

Twenty-nine jurisdictions (out of 35 responding to the question) reported adding some form of mental health training for staff.[157] Several jurisdictions described receiving guidance on this issue from groups such as the Department of Justice, the National Institute of Corrections, other government agencies, and the National Commission on Correctional Health Care.[158]

Education programs for staff included topics such as the functioning of a restrictive housing unit,[159] basic general training on mental health,[160] understanding risks of suicide,[161] crisis intervention,[162] and what is called "motivational interviewing"—a style of clinical counseling.[163] One jurisdiction reported that its "Behavioral Intervention Unit staff" received "training on the risks of mental health deterioration for those who are exposed to prolonged stays in isolation and the importance of reducing isolation by having an increase in out-of-cell activities, structured activities, and staff interaction."[164] Another reported that "staff working with offenders under age 18 receive specialized training on youth brain development."[165] One jurisdiction noted that it helped pay for training if mental health personnel sought "additional training on their own."[166] Fourteen jurisdictions said that they had implemented staff rotation policies,[167] with intervals ranging from 56 days[168] to five years.[169]

Release

The survey also sought to learn about how individuals exit restrictive housing. Thirty-seven jurisdictions responded to at least one of these questions.

Twenty jurisdictions reported that they had implemented policies "mandating that prisoners be told the criteria for their release in advance."[170] Twenty-one jurisdictions reported making changes to their policies on who decides whether a prisoner exits restrictive housing so that "the decision to release or transition an individual from restrictive housing" was "now made by a committee, rather than by an individual."[171]

Included in SCDC' 4.29.19 letter to LOC

Over half of the jurisdictions surveyed reported that they had added step-down[172] or transitional programs to the release process.[173] Some of these programs involved progressive levels or phases with increasingly less-restrictive conditions;[174] and some entailed separate housing units.[175] For example, one jurisdiction reported that its step-down plan, which ranged "from 30 to 360 days" included "increasing privileges, amenities, and movement," was "individually tailored to the offender's needs and may include education, cognitive skills, and/or mental health programming."[176] Another jurisdiction reported:

> Generally, behavior intervention unit residents who served more than 30 days disciplinary segregation or who have been on administrative segregation status will have a period of time residing in a transition unit. The transition unit is a step down program to help prepare people who have been living in the behavior intervention unit for general population. A person may be eligible for transition based on their placing behavior, assessment of risk, and participation and progress in the behavior modification wing. Individuals residing in the transition unit have access to general population activities and the opportunity to attend a regular treatment group and receive support from the unit staff. Individuals residing on the transition unit are reviewed weekly for general population housing options by the placement and review team. Opportunities for structured enrichment activities, development and implementation of success plans and increased support from facility staff exist while being housed in the transition unit.[177]

Twenty-eight jurisdictions responded with information about step-down programs they had implemented or were developing.[178]

The survey asked jurisdictions whether, since January of 2016, they had put into place "maximum durations on restrictive housing" and to specify what they were. Thirteen jurisdictions reported establishing some kind of limit on length of stay in restrictive housing, based on factors such as subpopulation, category of restrictive housing, or type of infraction.[179] For example, one jurisdiction described establishing a maximum duration for "locked housing."[180] Another stated it had implemented a 30-day maximum length of stay for prisoners with serious mental illness.[181] Other jurisdictions said they had implemented maximums for disciplinary restrictive housing ranging from 60 days to 10 years.[182] Some jurisdictions reported implementing maximum durations for the phases of restrictive housing.[183] A few other jurisdictions reported a limit for a given offense but did not preclude consecutive sanction.[184] Some jurisdictions required administrative review of continued placement in restrictive housing. The frequency of reviews varied from a few months to almost a year.[185]

Implementing the 2016 ACA Restrictive Housing Performance Based Standards

The ACA, an accrediting body for "correctional facilities, detention centers and community correctional programs" as well as "probation and parole agencies, health care programs and electronic monitoring programs,"[186] assesses compliance with its Performance Based Standards

Included in SCDC' 4.29.19 letter to LOC

by reviewing accredited systems every three years.[187] In 2016, the ACA adopted new Standards on restrictive housing.[188] The 2017–2018 ASCA-Liman survey asked whether jurisdictions had reviewed their internal restrictive housing policies since the ACA revisions and, if so, whether jurisdictions relied on the ACA Standards when developing policies.[189] We also focused on four ACA Standards related to release to the community, mental health, juveniles, and pregnancy, and asked whether jurisdictions had implemented each policy; "substantially implemented this policy with exceptions;" already had the policy in place prior to the 2016 ACA revisions; or had not implemented the policy.

Thirty-six jurisdictions reported that they had reviewed their restrictive housing policies since the release of the 2016 ACA Standards.[190] Twenty-five jurisdictions reported that they relied on the ACA Standards when making jurisdiction-specific policies;[191] nine jurisdictions reported that they considered the Standards, relied on them in part, or used them as a resource in making policies.[192] Eight jurisdictions reported that they did not consult or rely on the ACA Standards.[193]

Under the 2016 ACA Standard 4-RH-0030, a jurisdiction's "written policy, procedure and practice require that the agency will attempt to ensure offenders are not released directly into the community from Restrictive Housing."[194] Forty-one jurisdictions responded to the survey question about this Standard. Twenty-six of the 41 jurisdictions reported that they had implemented this policy,[195] and five jurisdictions reported that they had "substantially implemented this policy, with exceptions."[196] Some of the jurisdictions reporting that they had partially implemented this Standard explained that release directly to the community could not always be avoided.[197]

With regard to mental health, the 2016 ACA Standards defined "serious mental illness" as:

> Psychotic Disorders, Bipolar Disorders, and Major Depressive Disorder; any diagnosed mental disorder (excluding substance use disorders) currently associated with serious impairment in psychological, cognitive, or behavioral functioning that substantially interferes with the person's ability to meet the ordinary demands of living and requires an individualized treatment plan by a qualified mental health professional(s).[198]

ACA Standard 4-RH-0031 states that a jurisdiction's correctional "agency will not place a person with serious mental illness in Extended Restrictive Housing."[199] Twenty-one jurisdictions told us that they had implemented this Standard.[200] Four jurisdictions reported that they had "substantially implemented this policy, with exceptions."[201] We should note that it is not clear if jurisdictions used the ACA definition of serious mental illness or their own definitions which varied widely. *See* Appendix C..[202]

As for age, the 2016 ACA Standard 4-RH-0034 states that confining individuals "under the age of 18 years of age in Extended Restrictive Housing is prohibited."[203] Of the 40 jurisdictions responding, 22 reported that they had implemented the Standard,[204] and two jurisdictions reported that they had "substantially implemented this policy, with exceptions."[205]

With regard to pregnancy, ACA Standard 4-RH-0033 states that prisoners "determined to be pregnant will not be housed in Extended Restrictive Housing."[206] Twenty-five of the 41 jurisdictions that responded to this question said that they had implemented it.[207] Four jurisdictions reported that they had "substantially implemented this policy, with exceptions."[208]

Evaluating the Effects of Policy Changes

The survey asked whether jurisdictions had studied the effects of reforms in terms of incidents of violence, prisoner self-harm, prisoner and staff morale, the numbers of persons (or subsets of persons) placed in restrictive housing, the length of time spent confined, successes of prisoners on release to the general population and in returning to communities, and the costs of restrictive housing.

The 14 jurisdictions responding to this question reported that they had or were undertaking studies.[209] Nine jurisdictions reported a focus on incidents of violence in prison.[210] Six had studied the effects on prisoner self-harm,[211] three on prisoner morale,[212] five on staff morale,[213] six on prisoner success upon return to the community,[214] six on prisoner success with coping with life in prison,[215] seven on duration of time in restrictive housing,[216] and two on administrative costs.[217] Four jurisdictions reported studying the numbers or subsets of people placed in restrictive housing.[218]

Conducting research on the many variables affecting restrictive housing is complex and requires significant funding. One jurisdiction described working with the Vera Institute of Justice to collect data.[219] Another jurisdiction stated that it had "completed a study on the impacts of restrictive housing. The study permitted grant funding for empirical research on long-term effects of Restrictive Housing on both inmates and staff."[220] One prison system reported receiving a Bureau of Justice grant to study "interventions in restrictive housing settings" such as group programming and an "individualized Success Plan" for each inmate that "details how he plans to apply skills in high risk future situations."[221] Another jurisdiction directed us to published research based on its collection of data about restrictive housing. The 2018 study suggested that "a more therapeutic restrictive status housing program has the potential to improve the future behavior of program graduates," but cautioned that more research was needed.[222] Another prison system stated that it had "revised its data collection system to track information on restricted housing," such as "the effectiveness of the restricted housing program," in order to "provide bases for modifying the program."[223]

Aspiring for More Time Out-of-Cell

The survey also sought information on the number of hours out-of-cell that jurisdictions believed was desirable for prisoners in an "ideal situation"—i.e., with sufficient resources and no problems regarding institutional safety.[224] Thirty-eight prison jurisdictions provided answers to this question,[225] and 31 specified a desirable number of hours out-of-cell.[226]

Some jurisdictions specified a certain number of hours per day or per week.[227] The responses that were given in hours per day ranged from three hours[228] to 15–16 hours per day[229]

out-of-cell. The responses given in hours per week ranged from 7.5 hours[230] to 56 hours per week out-of-cell.[231] A few jurisdictions noted that different times out-of-cell would depend on prisoners' custody level.[232] For example, one jurisdiction replied that for the general population a minimum of 12 hours daily would be desirable, while for those in disciplinary segregation two hours daily would be desirable.[233]

Ten jurisdictions described the kinds of activities that would, in an ideal situation, be reasons for having time out-of-cell.[234] For example, one jurisdiction explained that all prisoners:

> should have a productive work or program assignment that occupies 6.5 to 10 hours per day. Assigned offenders have an additional 2–4 hours of free/recreation time per day plus movement for meals and medications. The majority of offenders are in their cells from about 10 pm to 6 am . . . .We aim to maximize out-of-cell time, but there must be productive activities. We have learned that too much unstructured out-of-cell time leads to increased disruptive behavior.[235]

Another jurisdiction explained that an hour or two of daily out-of-cell time "during the sunlight hours would be good."[236] The jurisdiction elaborated: "Preferably, prisoners should get one hour in the morning and one hour in the afternoon of sunlight. This practice would allow the inmate enough time in direct sunlight to allow the human body to manufacture Vitamin D."[237] One jurisdiction prefaced its answer with the comment that, "ultimately, no confinement would be the goal, however, realistically that will not happen."[238]

Six jurisdictions stated that they could not provide a concrete number of ideal hours out-of-cell because it would depend on a variety of factors.[239] One of those jurisdictions explained:

> Regrettably, this question is too overbroad and vague to answer specifically as it varies depending on the type and kind of inmate being managed and, in addition to dozens of other variables, their historic, recent, and immediate behavior. It also can vary based on individual preference by the inmate. There are many inmates who do not want out of cell time, so the term desirable is subjective to the inmate themselves. In addition, the meaning, content, and quality of the out of cell time is also a considerable variable that makes it impossible to make a single statement about the amount of out of cell time which is desirable for prisoners. Finally, it is a topic that is more rooted in a sociological and philosophical discussion, especially because it is phrased as a hypothetical.[240]

IV. Working to Limit Restrictive Housing: Four Jurisdictions Making Changes

We move from an overview of policy changes across the jurisdictions responding to the survey to reports from four jurisdictions—Colorado, Idaho, North Dakota, and Ohio—in which correctional leaders describe efforts to make profound changes in the use of restrictive housing. Below, we provide what correctional leaders wrote about the ways in which they have revised policies, the challenges they have faced, and the impact of their efforts.

Colorado Reforms: What Do You Mean "Culture"?

Rick Raemisch,
Executive Director, Colorado Department of Corrections

During the fall of 2017, Colorado became the first, and thus far, the only state in the United States to limit the use of Restrictive Housing to 15 days maximum, and this use is only for the most serious violations. Extended Restrictive Housing, the former Administrative Segregation, has been abolished. Following the United Nations Mandela Rules, this change means that a person in the Colorado prison system who was involved in a serious violation will be in Restrictive Housing for 22 hours per day, 7 days per week for a maximum of 15 days. Violations are not to be "stacked." In other words, no one will be placed in Restrictive Housing for 15 days, removed, then immediately placed back in.

This change comes on top of others. Through the Department's policy and then by statute, Colorado had already ended Restrictive Housing for seriously mentally ill prisoners. In fact, Colorado developed the policy that, if a person is involved in a disciplinary incident, and it is determined by a team consisting of correctional officers and clinicians that mental illness was the cause of the incident, the offender is taken out of the disciplinary process and given treatment. In addition, Colorado policies prohibit placing pregnant females and juveniles in Restrictive Housing under any circumstances.

When we initially started our reforms we adopted the philosophy "just open the door." We control it. Open it. Of course many discussions, debates, committee work, and staff input were completed in order to develop the proper procedures and programs to allow us to open the door. As I have explained elsewhere, when we went in the direction of abolishing extended restrictive housing, there was no map, and there was no road. Dedicated staff were challenged to complete the reforms, and they not only accepted the challenge but excelled at it.

When the decision was made to finally go to the 15 day maximum Restrictive Housing, we adopted a new philosophy: "You can restrain, but you don't have to isolate." We were unable to find proper restraint tables, and we have never used cages, nor would we. Once again, staff answered the challenges, and we built our own furniture to fit our needs. Formerly dangerous, restrictive housing prisoners are now out of their cells for a minimum of four hours per day, at restraint tables with up to four other inmates, for programing and other activities.

Included in SCDC' 4.29.19 letter to LOC

We have all heard the adage: "You can lead a horse to water, but can't make them drink." I don't believe that. I believe that: "If you throw the horse in the pond they are going to get some water just trying to get the hell out of the pond." The point is to give them programming regardless of whether they want it or not. Although this practice is new, it appears to be working. The goal of course is first to get them at the table, then give programming, and work towards safely removing the restraints. The goal is to have the programming be successful to the point where they can be back in general population.

We have been asked numerous times how we were able to accomplish this. How were you able to change the culture? When we have responded, we have heard: "That won't work here, the culture is too embedded in the way we are doing business now." Culture was never an issue with us. Of course our staff was used to using segregation on a regular if not overused basis. It's not a question of culture. It's a question of leadership. There is debate as to whether or not Henry Ford actually made this famous quote, but he is credited with saying: "If I had asked my customers what they wanted, they'd have said a faster horse."

The point obviously is that sometimes the vision needs to come directly from the leader. I gave the Colorado Department of Corrections the vision of where the Department would go. My approach was not "should we or would we?" Rather, it was: "This is what we are going to do." I put together an executive team that believed in my vision. My other philosophy is that if you have someone who wants to try something different, and it makes sense, give it a try. I've stated many times that if what we do doesn't work, we can always go back to the way things were before.

I consider my Executive Team and the other corrections leaders here as jet fighter pilots. I give them the target and then allow them to figure out how to get there. Not all of our staff believed in our reforms. Some retired, some transferred, but the results of our reforms have changed a good number of those who did not think it would work. At our two mental health prisons, where restrictive housing is completely banned, assaults, self-harm, and suicides have decreased dramatically. Staff enjoy work more because prisoners are acting in a more positive manner. It is quiet and safer. Safer facilities mean safer communities when they are released.

In the past, we had a waiting list for people with mental illness to be transferred to our facility for the seriously mentally ill. Today we have over fifty vacant beds. Our other facility for those with mental health issues has over 45 empty beds. It is too early to tell if the reason for this is because we have stopped manufacturing or multiplying mental illness by the overuse of segregation, but before our reforms there were none.

The bottom line: We have one vacant super max, and one re-purposed super max. We are back on track with our mission of public safety.

Idaho: Efforts to Reform Restrictive Housing

Henry Atencio
Director, Idaho Department of Correction
Keith Yordy
Warden, Idaho State Correctional Institution,
Idaho Department of Correction

Idaho Department of Correction [IDOC] made a decision to reform restrictive housing because it was the right thing to do for public and for community safety. Given that ninety-eight percent of prisoners in IDOC will return to the community, it is inconsistent with IDOC's mission to keep a prisoner in long-term restrictive housing, which results in no access to programming or educational opportunities, until they are released back into the community. Moreover, reforming restrictive housing has many benefits. It encourages safe and humane practices for the prison population. Reform permits compliance with international and national law, as the United Nations has declared that being confined in a cell 23 hours a day for more than 15 days is considered torture. Prison-based reform reduces IDOC's exposure to litigation regarding restrictive housing.

IDOC's reform process began in 2016 and was guided by nationwide standards addressing restrictive housing, which included principles of the U.S. Department of Justice and the thirteen guiding principles provided by the Association for State Correctional Administrators (ASCA).[1] Early on in the process, IDOC made the decision to include staff from multiple disciplines and at various leadership levels in the command structure. IDOC formed a command staff group comprised of agency and division leadership and reached out to external entities, who agreed to provide feedback and guidance to the agency during the reform process. The external partners included staff from the State Appellate Public Defenders' Office, the Office of the Federal Defenders of Idaho, and the Idaho Chapter of the American Civil Liberties Union. They have been an integral part of the process, as they have provided feedback on policy revisions, suggested language to use, and identified areas where the policy was unclear.

IDOC's path to reform also entailed having individual members of the department attend trainings and go on site visits to other states. Wardens, joined by correctional and mental health staff, visited Arizona and Washington Departments of Correction to see firsthand how reforms were implemented and to have discussions with those jurisdictions' staff about challenges and innovative ideas. In addition, several IDOC agency and facility leaders participated in training at the National Institute of Corrections (NIC) on restrictive housing reform. Idaho was selected as a pilot for an on-site NIC restrictive housing training that took place in August of 2017. Attendance at the training by wardens from facilities that housed men and women and that had long-term restrictive housing was crucial, as they both gained insight and learned about the importance and implementation of the restrictive housing guidelines of the U.S. Department of Justice.

---

[1] The ASCA principles are available here: https://www.asca.net/pdfdocs/9.pdf.

Included in SCDC' 4.29.19 letter to LOC

As a result of this process, Idaho wardens began reviewing all prisoners who had been in long-term restrictive housing to reevaluate them with the goal that placement in restrictive housing should be reserved only for individuals who posed an imminent threat to the security of the institution. Doing so entailed taking a comprehensive approach to restrictive housing reform. The agency decided that two key policies, addressing restrictive housing and the disciplinary process, had to be updated. As a consequence, a revamped disciplinary policy added an alternative sanction process and changed the Disciplinary Offense Report (DOR) codes, and the restrictive housing policy was split into three separate policies—a short-term restrictive housing policy, a long-term restrictive housing policy, and a protective custody policy. The new policies[2] reflect and implement a shift in the purposes and in the practices, and the result has been that fewer people are placed in restrictive housing.

A few specifics are in order. The short-term restrictive housing policy begins with a statement of purpose reflecting IDOC's mission statement on restrictive housing reform: "Restrictive housing protects staff and inmates by segregating those who are the most violent or present the greatest danger to the safe operations of the facilities." The policy provides that time spent in short-term restrictive housing is capped at fifteen days. Past that point, prisoners must be afforded, at a minimum, three hours of out-of-cell time a day and provided with personal property as they would have in general population. The policy also requires prisoners who have a language barrier, physical/sight/hearing impairment, or medical or mental health issues to have accommodations when placed in restrictive housing or an alternative placement, as needed.

Further, IDOC has limited the behaviors that can result in short-term restrictive housing placement to those that pose an imminent risk to safety. This change in the criteria for entry has reduced the number of short-term restrictive housing beds at some facilities, and, at others, the people put into such beds. In addition, some facilities have implemented "calm down" areas for prisoners to de-escalate, while others have implemented diversionary tiers for those in possession of drugs or alcohol or who have tested positive on urinalysis tests.

The long-term restrictive housing policy (addressing individuals in such housing for fifteen days or more) also begins with a statement of purpose, again stemming from IDOC's mission statement. "Restrictive housing is a structured program that protects staff and inmates by segregating those who are the most violent or present the greatest danger to the safe operations of the facilities." The policy requires that all prisoners placed into long-term restrictive housing programs are in Idaho's "Step Up Program," which consists of five stages designed to provide behavioral expectations to prisoners, teach them to identify concepts and skills to assist in behavior change, and assess their behavior to determine if placement in long-term restrictive housing is necessary. The policy requires that prisoners identified as having a serious mental illness be exempted from long-term restrictive housing placement and instead be placed in an alternative setting, which is usually a mental health unit. Further, the policy adds an administrative review

[2] Idaho's policies can be found at www.idoc.idaho.gov.

committee for all long-term restrictive housing placements. That committee is at the prisons' division leadership level and includes both of the deputy chiefs of prisons and the chief psychologist, who is a non-voting member.

As of the writing of this report in the spring of 2018, the new disciplinary policy is in effect; the short-term and long-term restrictive housing and the protective custody policies are in the final drafting stage. The command staff is doing a policy review, and the goal is to have training in place during the summer of 2018 to complete a rollout of the reforms. And even before the full implementation, IDOC has seen the impact in the reduction in the numbers of people in long-term restrictive housing and new methods of responding to problems. One example comes from Idaho Maximum Security Institution (IMSI), a facility whose operating capacity was 412 inmates prior to restrictive housing reform and which had included 320 single-occupancy restrictive housing cells. IMSI has expanded its capacity to house 564 prisoners and as of the end of June, IMSI has 134 prisoners in long-term restrictive housing and 24 in short-term restrictive housing. The facility has revised its practices to have more prisoners in close-custody general population.

At Pocatello Women's Correctional Center (PWCC), the facility operating capacity was 313 prisoners prior to restrictive housing reform, with a total of 20 single-occupancy restrictive housing cells. The current operating capacity has increased to 333. Today, one prisoner under the sentence of death is in what is termed long-term restrictive housing status, but, in practice, she is out of her cell three or more hours per day. At the South Idaho Correctional Institution (SICI), 17 short-term restrictive housing beds were taken off line, which enabled the placement of 34 minimum custody general population prisoners to be housed there. As of the end of June 2018, the population in restricted housing had declined from 294 long-term restrictive housing prisoners to 134 people held in long-term restrictive housing.

Reflections on North Dakota's Sustained Solitary Confinement Reform

Leann Bertsch
Director, North Dakota Department of Corrections and Rehabilitation

Since late 2015, the North Dakota Department of Corrections and Rehabilitation (ND DOCR) has maintained an approximately 60–70% reduction in the population of its Administrative Segregation Unit (renamed the Behavioral Intervention Unit or BIU) at the North Dakota State Penitentiary (NDSP). The number of people residing in BIU as of April 5, 2018 was 24. The daily count within this unit has remained under 40 people over more than two years, down from over 100 people in 2015. The average length of stay in BIU has fluctuated between 30 and 60 days, although there are a few people who reside in the unit much longer based on the severity of violence, their expression of continued risk for violence, or their own preference for the BIU setting.

This population reduction has been sustained by continuing to adhere to a multi-faceted screening and assessment process. In fact, NDSP was able to convert one of the tiers within BIU to a preferred housing tier, which is home to 20 of the most consistently pro-social residents within the facility. Another 20-cell unit was converted to the Administrative Transition Unit, where people live when they are in the process of moving from BIU to a general population setting. ND DOCR continues to focus on those who commit any of 10 of the most serious in-custody offenses that may make a person eligible for BIU placement, with some exceptions for fighting and other harmful behaviors when they become severe or chronic. ND DOCR also continues to avoid placing people diagnosed with serious mental illnesses in BIU when possible and divert them to the Special Assistance Unit for more individualized services when it is determined that it is not safe to keep them in general population.

The sustained decrease in the number of people in the BIU setting has allowed for staff to make much better use of their time and to have a greater impact. Corrections officers engage each resident in friendly conversation, change-oriented discussion, or practice of a cognitive or behavioral skill at least twice per day. The unit Sergeant is also tasked with planning one pro-social, structured recreational activity each weekend to increase positive engagement with staff and out-of-cell socialization. Unit staff also provides reinforcement in the form of tangible property items, extra recreation time, extra showers, and the like, based on the person's participation in therapeutic and social activities, as well as the parameters of individualized behavior plans. Currently, BIU residents can access up to two hours and 40 minutes of recreation per day when they engage in skill practices and therapeutic groups, in addition to time spent in groups, individual sessions, and specially-planned enrichment activities.

Behavioral health staff also provides at least one structured leisure activity each week, such as an art project, mindfulness practice, or a movie. Three times per week they facilitate a group that focuses on applying skills to reduce or eliminate the use of violence, manage trauma reactions,

Included in SCDC' 4.29.19 letter to LOC

and cope with segregation. Each resident completes an individualized Success Plan, detailing how he plans to apply skills in high-risk future situations, prior to or soon after moving to the Administrative Transition Unit. Once the person has moved to the Administrative Segregation Unit, he has the opportunity to continue to participate in group two times per week to work on skills application as the amount of time spent in general population settings increases. These group curricula and the Success Plan served as the foundation to inform a curriculum developed by Dr. Paula Smith for a Bureau of Justice Assistance Encouraging Innovation Grant related to applying interventions in restrictive housing settings, which ND DOCR will continue to implement as a data collection site related to that grant project.

Over the past two and a half years, ND DOCR has sustained a substantial reduction in the use of the Special Operations Response Team within the BIU (no use of the team at all in this unit since October 2017), along with a reduction in overall uses of force. The prevalence of negative behaviors by residents of the unit has also dramatically decreased. ND DOCR believes the focus on reinforcement of positive change, building friendly relationships between staff and residents, and allowing residents access to pro-social coping skills (music, television, puzzle books, etc.) are collectively responsible for these changes. Perhaps our most exciting outcome to date is the fact that, of the 149 residents placed on BIU program status from October of 2015 to February of 2018, only 26 have returned to BIU program status. That is a 17% "recidivism" rate into the BIU program. ND DOCR is working to collect more precise data regarding these outcomes, but we are very encouraged by these initial results.

These changes, while overwhelmingly positive, have not been without challenges. NDSP did see a significant increase in physical fights between residents in mid-2016 to mid-2017. This increase occurred at the same time that our overall prison population was the highest it has ever been and we have some suspicions that this may be correlated more strongly with the population increase than the changes in the use of restrictive housing. As the population has slowly stabilized and begun to decrease, the prevalence of fighting has decreased as well. While most staff members have been supportive of the changes, there has been a perception that the overall safety of the facility has been compromised. Factually, there has been no increase in assaults on staff, assaults on residents by peers, or the overall level of violence perpetrated within the institution. There has also been a perception that residents are not "held accountable" for rule violations. In reality, residents continue to receive significant sanctions—the only difference is those sanctions are much less likely to include lengthy placements in restrictive housing, especially for non-violent offenses.

In order to address the problem of institutional violence more thoroughly, ND DOCR is excited to begin assessing people entering prison using the Risk of Administrative Segregation Tool (Labrecque & Smith, 2017) in order to identify those at highest risk for displaying institutional violence resulting in placement in restrictive housing. A copy of the tool is below.

BEHAVIORAL INTERVENTION UNIT REPORT CARD
DEPARTMENT OF CORRECTIONS AND REHABILITATION
DIVISION OF ADULT SERVICES
(04-2018)

☐ SMI

Group Attendance				
Monday	Tuesday	Wed	Thurs	Friday

A (Attended); R (Refused); C (Cancelled)

Inmate Name	Inmate Number	Date of Arrival	Release Date

Placing Behavior

Status ☐ Investigative Segregation ☐ Disciplinary Segregation ☐ Administrative Segregation ☐ Administrative Transition Unit

Intervention Needs Assessment Referral ☐ Yes ☐ No | Requested Date | Completion Date

Target Behavior

Skill Practice/Skill Demonstration

DATE	SHIFT	KEEPS TRAYS/THROWS TRAYS	DOESNT ALLOW TRAY SLOT CLOSURE	COVERS FRONT WINDOW	DOESN'T COMPLY WITH STAFF DIRECTIVES	INTERACTS BY YELLING, NAME CALLING OR THREATS	ENGAGED IN CHECK IN WITH STAFF	NUMBER OF SKILL PRACTICES/ SKILL DEMO DONE	COMMENTS	STAFF INITIALS
	AM						Yes No			

Those identified as high risk will then be offered a 10-session group intervention program focused on establishing a pro-social adjustment to prison and managing high-risk situations for violence in an effective, non-violent manner. This program will begin in April 2018. Dr. Paula Smith and Dr. Ryan Labrecque will evaluate the effectiveness of this intervention in preventing future violence as compared to a no-treatment control group. Another future direction is to develop a peer support specialist certification program for prison residents, with the goal of providing additional support to those at risk for placement or placed in BIU.

One way to provide an overview of the outcomes, as of the spring of 2018, is by the chart below.

Type of Seg.	Investigative	Disciplinary	BIU Program	Total Unit
Avg. # of days	5.55	7.63	18.97	32.14

Type of Seg.	Investigative	Disciplinary	BIU Program	Total Unit
Total # Stays Over 14 Days	30	38	60	128

Restrictive Housing: The Challenge of Reforming the Fabric of an Agency

Gary Mohr,
Director, Ohio Department of Rehabilitation and Correction

Restrictive housing reform represents one of the most extensive reforms in the history of corrections in the United States. The use of restrictive housing to respond to prisoner misbehavior has been the foundation of correctional management philosophy for over a century. The practice is embedded in the philosophy and logic of nearly all agency staff and is interwoven into the fabric of any correctional agency's culture.

The use of restrictive housing remains an essential part of managing safe and secure prisons. Changing the way a correctional organization uses restrictive housing requires a delicate balancing act of improving conditions of confinement for prisoners who are more conducive to rehabilitative ends, while simultaneously ensuring we protect our staff and prisoners from individuals whose behavior indicates they are poised to harm others. Further, for most of my 44 years in this work, restrictive housing has been used as the default penalty for all types of rule violations, whether violent or not. Changing practices associated with the use of restrictive housing is a delicate operation because our staff, those who work in the trenches of our prisons, firmly believe the use of restrictive housing as a default disciplinary sanction is tied directly to their safety. Reforming the system to use restrictive housing only when there is a threat to safety and security, rather than as punishment, often becomes viewed as an attempt to jeopardize safety.

Today, that cultural belief has been reinforced by the horrific incidents in prisons throughout our country from North and South Carolina, to Pennsylvania, Arizona and many other jurisdictions including Ohio. In 2018, an Ohio Correctional Officer was stabbed 32 times by two prisoners who were in extended restrictive housing; miraculously, he survived. This event not only magnified the challenge of continuing to reform restrictive housing, but also changed my life, as it was a vivid reminder of how precious life is and how we as leaders carry the heavy responsibility for the welfare of so many. As we continue the much-needed reform regarding the practice of placing prisoners in confined settings, an area where there is still much work to be done, the realities and images of individuals who have experienced serious, life-changing incidents cannot be ignored. The impact on their lives, as well as on the lives of their loved ones and fellow staff members, must be of paramount concern.

Ohio can clearly report success in reducing prisoners in restrictive housing as evidenced by data comparing the use of restrictive housing between 2013 to 2017. In fact, there has been a 45% reduction in the number of prisoners in restrictive housing during that time period. While this reduction is meaningful and significant, it is also a reminder of the need for restrictive housing now and in the future. The reality is that there are people in prison who pose a serious and direct threat to others, and we have a duty to protect others from these prisoners. As agency leaders, we count on our staff in all correctional systems to carry out post orders and follow our directives 24

Included in SCDC' 4.29.19 letter to LOC

hours a day, 7 days a week. Those dedicated public servants must acknowledge and trust their leaders, even though they will not always agree, or the overall agency goals will not be achieved. Leaders cannot merely issue edicts directing a course of action when those directives are contrary to the will of the workforce if they expect the vision of the policy to be realized. In matters that challenge the foundational beliefs and values of the staff, change must occur over time through consistent reinforcement of the philosophy underlying the policy direction.

Operational Challenges to Restrictive Housing Reform: The Ohio Department of Rehabilitation and Corrections (DRC) began restrictive housing reform in late 2013 by conducting wide-ranging discussions on how and why correctional supervisors/executives use restrictive housing. In 2014 and 2015, the DRC examined all policies and procedures, even hiring external consultants to provide insight into current practices, assess areas for improvement, and recommend a pathway for reform. In 2015, it became apparent restrictive housing reform was intrinsically linked to discipline reform. As such, the DRC needed to re-examine the entire way prisoner rule violations were addressed. Below, I outline our reforms.

Reform Initiative A: Prison Disciplinary Reform (Swift, Certain, and Fair): In late 2015 and early 2016, the DRC began to change the philosophy associated with the offender disciplinary system to encourage sanctions that adhere to swift, certain, and fair (SCF) principles of discipline. Most importantly, this change included using alternative sanctions to reduce the use of restrictive housing. Implementation required, and continues to require, ongoing changes to organizational culture.

> Challenge 1: Operationalizing the changes in sanctioning practices remains an on-going challenge by trying to achieve consistency, fairness, and immediacy of application across all prisons.

Reform Initiative B: Alternatives to Restrictive Housing—Limited Privilege Housing: The DRC has the option in Ohio's Administrative Regulations to use limited privilege housing. Limited privilege housing is a condition of confinement that significantly limits a prisoner's privileges, so it can be used to respond to low-to-moderate severity rule violations. Limited privilege housing is not restrictive housing. It is, however, a meaningful sanction that adheres to swift, certain, and fair principles of sanctioning. It also removes prisoners from the housing area where they committed their offense. In late 2015 and lasting until today, the DRC greatly expanded the use of limited privilege housing and encouraged staff to not use restrictive housing as the default placement for prisoners who have misbehaved unless they posed a danger to the prison or to others.

> Challenge 2: Proper utilization of the limited privilege housing sanction has been a challenge. DRC continues to experience under-utilization and over-utilization of the sanction as an alternative to restrictive housing, and there is inconsistency in the security practices between areas.

Challenge 3: One of the greatest cultural challenges was passive resistance by staff who, in frustration over being asked not to use "segregation" for many offenses, assumed an "all or nothing" stance towards security. Simply put, if they could not place a prisoner in segregation (restrictive housing), then they just had to let prisoners do "whatever they wanted" and could take no meaningful action. Others felt a limited privilege housing unit could have a "relaxed" security posture when in reality limited privilege housing units can be just as secure as a restrictive housing unit if the type/kind of prisoner needs such levels of supervision. The critical difference is the out of cell time and access to programming and services which require all staff to change the way they work.

Challenge 4: A cultural myth developed that restrictive housing reform's goal was to reduce the use of restrictive housing regardless of the prisoner's behavior. DRC leadership was compelled to constantly remind staff that restrictive housing reform never meant prisons could not use restrictive housing to address violence or seriously disruptive behavior. This myth was persistent and remains even when policies were released providing staff the option of stronger and lengthier disciplinary sanctions. The written words contained in the policy, as well as emails sent to all staff, were overshadowed by this mythology that is still persistent five years into reform.

Reform Initiative C: Widespread Training/Communication on Restrictive Housing: Throughout 2016 and carrying into 2018, the DRC has revised dozens of policies, lesson plans, and in-service training on restrictive housing Reform and its related components within the DRC.

Challenge 5: Communication of the "why" behind restrictive housing Reform remains our prevailing challenge. A significant number of staff still report they do not understand the reasons for reform despite training, memos, policies, and emails that have tried to explain all aspects of the reform effort. More importantly, many of them do not understand the permanence of these changes and are "waiting to go back to the way it was." Finally, it cannot be ignored that there are some staff who simply believe prisoners should be severely restricted while in prison and especially when they commit any rule violations. It is reasonable to say that when an organization operates for nearly a century in one manner, it will take a very long time to change the fundamental beliefs of the staff who operate that organization. These individuals who, regrettably, exist at all levels in our agency continue to passively, or sometimes actively, resist restrictive housing reform, likely in the hope the reform will fail and the DRC will have to return to the status quo which existed in 2013.

Challenge 6: The volume and pace of change is a significant, on-going challenge for staff at all levels. Change for any organization is difficult, but the root nature of

this change coupled with the fact the change requires a shift in personal, organizational, and leadership philosophy makes it incredibly challenging.

Challenge 7: Staff perceptions exist by some at all levels (line, supervisor, and executive staff) that are less than supportive of/favorable to restrictive housing reform efforts thus far. There is a strong feeling these policies are making people less safe and reform values prisoners over staff safety. The serious incident of the stabbing of our correctional officer mentioned earlier has kept this belief alive.

Challenge 8: There is substantial message dilution in training and communication. As information is passed down from each level of leadership and supervision, the message gets changed and altered, greatly affected by the cultural resistance outlined in previous challenges. As such, the DRC must continually improve the content and delivery of the restrictive housing Reform "communication plan."

Reform Initiative D: Serious Misconduct Panels and External Oversight of Extended Restrictive Housing: Prior to reform, local wardens possessed the authority independently to place prisoners into restrictive housing for six months, and in some cases, for a year or more. There was no centralized oversight for these two review processes. Wardens applied this power based on their individual perspective about misbehavior rather than an organizational view. In response, the DRC established the "serious misconduct panel" (SMP) as the only process by which offenders can be referred to "extended restrictive housing" and implemented centralized oversight of all placements and releases. The SMP referral is still made by a warden but is approved by a regional director and the panel is comprised of two exempt employees from a prison other than the one where the offense occurred.

Challenge 9: There have been concerns expressed that the use of the SMP implies a mistrust of the professional judgment of local teams who know the prisoners best. The delicate balancing act of ensuring consistency across all prisons while respecting local decision makers becomes interpreted as a form of heavy-handed oversight. In addition, prison leaders believe the new policies curtailed their ability to control violence and disruption at their prisons.

Challenge 10: The procedural aspects of the SMP are cumbersome and time consuming. The ongoing challenge is to streamline the SMP process without hindering the objectivity, due process, or thoroughness of the review.

Reform Initiative E: Conditions of Confinement and Programming for Extended Restrictive Housing: The DRC examined the conditions of confinement for offenders in extended restrictive housing and implemented additional programming, meaningful activities, and out-of-cell time. This process includes enhanced release preparation programs as best exemplified by the Ohio State Penitentiary [OSP] reversion program. This program introduces pro-social elements such as

employer engagement, family activities/events, and meals in group settings, including meals with the warden, into our highest security setting.

> Challenge 11: The physical plant and infrastructure of all DRC facilities were not designed to provide a lot of out-of-cell time for prisoners in restrictive housing. The facilities were designed according to the philosophy of corrections in the United States at the time. The last prisons constructed were designed in the mid-1990s, almost a quarter of a century ago. The only way to offset some of these design issues is with significant staffing resources, which are very costly and difficult to appropriate in challenging budgetary environments.

> Challenge 12: Self-imposed isolation, even when out-of-cell opportunities are granted, remains a considerable challenge. Prisoners choose these environments in a significant number of circumstances.

> Challenge 13: It is a continuing challenge to ensure conditions of confinement differ between restrictive housing, limited privilege housing, and general population in a meaningful way that sufficiently deters prisoners from engaging in misbehavior. The more you give prisoners in restrictive housing/extended restrictive housing/limited privilege housing, the less appealing rule compliant behavior becomes for prisoners in general population. Over-compensating to assist restrictive housing/extended restrictive housing prisoners can exacerbate the problems associated with Challenge 12 and, as has been proven by some cases in Ohio, actively encourage prisoner misbehavior to achieve a placement into extended restrictive housing.

Reform Initiative F: Limiting Extended Restrictive Housing for Seriously Mentally Ill Prisoners and Enhanced Monitoring: The DRC recognizes the potential effects of restrictive housing on the seriously mentally ill. However, seriously mentally ill prisoners, like others, can commit very serious acts of violence and disruption unrelated to their mental illness. Furthermore, even if the violence is related to their mental illness, the threat to the safety of others cannot be ignored. Therefore, the DRC has implemented practices to closely monitor the utilization of extended restrictive housing for prisoners with serious mental illness, and placement in extended restrictive housing for a person with serious mental illness must be approved at the departmental level. We also use and have expanded high security Residential Treatment Units [RTUs] as an assessment/diversion opportunity to avoid placement in extended restrictive housing for some people with serious mental illness.

> Challenge 14: The single greatest challenge in this effort is to develop and implement a "space between" restrictive housing and general population for dangerous, disruptive, and violent seriously mentally ill prisoners. Efforts to operate a "secure adjustment unit" for violent, seriously mentally ill offenders were

unsuccessful. We have added a significant number of Residential Treatment Unit [RTU] beds for the seriously mentally ill. There remain prisoners who are seriously mentally ill and violent/disruptive, but do not meet the standard of our mental health staff for an RTU level of care.

Challenge 15: DRC has expanded the number of high security RTUs, but there remains a substantial need for more beds and staff.

Challenge 16: Although philosophically we understand the need to treat seriously mentally ill prisoners differently, if one lessens the sanctions on prisoners solely because they are seriously mentally ill, other prisoners may perceive a tremendous injustice. This can cause disruption in housing units where both seriously mentally ill and non-caseload prisoners are held. In addition, as we attempt to grant more out-of-cell time and increased staff engagement for seriously mentally ill prisoners even after they have committed serious acts of violence against staff, we experience a growing cultural resistance to reform. Staff who are victimized, sometimes repeatedly, by these prisoners perceive these acts as being unfair and proof there is lack of care for staff and for the impact that violence by prisoners has on them. Thus the challenge continues.

Reform Initiative G: Tracking and Data Collection: The DOTS system, our tracking system, in present form, cannot effectively track people placed in restrictive housing or limited privilege housing. Since 2013, the DRC has continually developed new methods for measuring restrictive housing, primarily by using snapshots. Currently, Operations and IT staff are developing a restrictive housing/limited privilege housing Disciplinary Tracking System integrated into the DOTS system that, once completed, will provide a comprehensive system for examining disciplinary sanctions and their utilization, as well as profiles and real-time data on prisoners in restrictive housing/limited privilege housing. It will track the work flows associated with major job processes which may affect length of stay in restrictive housing/limited privilege housing including, but not limited to:

1) Hearing Officer and RIB Decisions
2) SMP referrals, extended restrictive housing placements, and extended restrictive housing reviews
3) Investigations regarding prison administrative functions such as misbehavior, protective control, separations, and staff nexus
4) Security Classification Reviews and Increases/Decreases
5) Prisoner Movement and Transfers

> Challenge 17: While waiting for these changes, it is not acceptable to forgo efforts to track restrictive housing. Reporting mechanisms have changed somewhat over time and to get accurate data is a cumbersome process that is very labor-intensive.

Conclusion: On December 27, 2010, when I met with Governor Kasich and decided to accept this journey to oversee the Ohio Department of Rehabilitation and Correction, he asked me to do two things. First, we could not afford another Lucasville, the riot that lasted 11 days and resulted in 10 deaths. Secondly, "Go reform the most unreformed part of government." While we have made some very progressive changes in creating reintegration environments, expanded programming including treatment of the addicted both in and outside our prison walls, expanded residential treatment beds for the mentally ill, employment partnerships with employers with experiences both inside the prisons and out in the communities, and engagement with community faith partners, the challenge of reforming restrictive housing is at the core of that challenge. Restrictive housing reform remains a challenge to us in Ohio and many other jurisdictions around our great country.

V. Calls for Reform and for Abolition: Restrictive Housing in 2018

In this section, we put the data collected through the 2017–2018 ASCA-Liman survey in the context of actions, in and outside of prison systems, focused on regulating the use of restrictive housing. As reflected in the analyses thus far, efforts by prison officials to reform isolating conditions have intensified.

Below we provide a sample of initiatives, legislation, litigation, and public discussion in the United States and abroad. From these many vectors, we can see that a consensus has emerged about the harms to individuals held in deeply isolating conditions; to staff working in restrictive housing;[241] and to community safety.[242] The reiterated theme is that 22 hours or more of confinement in a small cell for days on end is unwise, unjust, and inefficient. As a result, rules of correctional systems, statutes, litigation, and research—shaped by prison and health professionals, prisoners, their families, and their communities—have produced a nationwide commitment to limit and, in some instances, to abolish, the practices that fall under the rubric of restrictive housing.

Correctional Systems Making Changes

In addition to changes chronicled in responses to our survey, targeted efforts are underway in several other jurisdictions. Support for some of these efforts comes from the National Institute of Corrections and the U.S. Department of Justice, Bureau of Justice Assistance. Many reforms have garnered media attention.

As described in its 2018 monograph, *Rethinking Restrictive Housing: Lessons from Five U.S. Jails and Prisons Systems*, the Vera Institute of Justice worked on site with the state prison systems of Nebraska, Oregon, and North Carolina, and with two local jails in New York City and Middlesex County, New Jersey, all of which were "committed to change."[243]

Vera's 2018 study echoes many of the findings from ASCA-Liman analyses of the policies governing administrative segregation.[244] In the 2013 monograph, we described the broad discretion afforded correctional officials in placing individuals in restrictive housing,[245] and in 2014 and 2016, we provided a database of the impact, in terms of the widespread use of restrictive housing.[246] As Vera's 2018 report recounted, when Vera began working in the five jurisdictions, it found that restrictive housing conditions were typically "stark, isolated environments with little sensory stimulation or social interaction."[247] Vera detailed the heavy reliance on disciplinary segregation, often imposed for non-violent offenses, such as "disobeying an order,"[248] using "profane language," or "disruption."[249] Individuals placed in administrative segregation were not given "predetermined" release dates or frequently considered for release.[250]

Vera also raised concerns that some jurisdictions lacked methods to appropriately identify individuals with mental health needs. In those that did, "high levels of placement in restrictive housing" were common.[251] As in the ASCA-Liman 2014 *Time-in-Cell* report, Vera identified thousands of individuals with mental health needs who were placed in restrictive housing.[252] Further, akin to the findings in this Report,[253] Vera concluded that people of color were "placed in

restrictive housing at higher rates than white people were."[254] Vera also determined that people of color were "underrepresented in more treatment-oriented forms of restrictive housing and in less-stringent alternatives."[255] In addition, Vera found, as does this report, that young people were "more likely than older people to be placed in restrictive housing."[256] And, as ASCA-Liman had found in its 2014 survey,[257] thousands of people in the jurisdictions Vera studied were sent directly from restrictive housing to the community.[258]

Vera's recommendations likewise reflect the goals of many correctional departments, courts, legislatures, and prisoners—to reduce "the flow of people into various types of restrictive housing," to "shorten the length of time people spend in restrictive housing," and to improve conditions of restrictive housing.[259] Vera recommended using restrictive housing only "as a last resort; as a response to the most serious and threatening behavior; for the shortest time possible; and with the least restrictive conditions possible."[260]

Examples of what might improve conditions by providing more stimulation were stark reminders of the isolation that was the ordinary state of conditions. Thus, digital music players and "blue rooms" in which prisoners could see nature videos were illustrations of what could be added.[261] Vera proposed that prisons and jails "minimize social isolation and provide access to programming and mental health treatment" and aim to maximize "out-of-cell time," reduce "sensory deprivation and isolation," and increase "access to medical, mental health, and program staff."[262] As for specific subpopulations, "Vera recommended that its partner corrections agencies prohibit the placement of youth (younger than 18), pregnant women, and people who have serious mental illness, developmental disabilities, or neurodegenerative diseases in any form of restrictive housing that limits meaningful access to social interaction, exercise, environmental stimulation, and therapeutic programming."[263] According to the report, as of 2018, the five correctional sites with which Vera worked were implementing many of these recommendations. [264]

Several media reports in 2017 and 2018 highlighted reforms of restrictive housing. For example, in July of 2018, the news program *60 Minutes* aired an episode with Oprah Winfrey on the conditions in solitary confinement in California's Pelican Bay Prison.[265] Winfrey interviewed men currently in segregation, former prisoners who had been held in isolation, and prison officials who explained how the use of restrictive housing had been changed. The broadcast described how, after a 2015 legal settlement, California ended indefinite isolation and stopped using gang affiliation as a basis for sending people to segregation. The program reported 80% fewer prisoners in the state's restrictive housing units than had been there a few years ago.

Changes in North Dakota and in Colorado have also been covered in the national media. *Morning Edition*, a weekday news program on National Public Radio (NPR), devoted a segment in July of 2018 to North Dakota's restrictive housing reforms.[266] The piece featured interviews with Director Leann Bertsch and with correctional staff members. Prison administrators described implementing group therapeutic sessions for people in segregation and changing how officers interact with prisoners. For example, officers reported writing up positive prisoner behavior, not

just citing negative conduct. Prison staff described the improvements they saw, as a result of these changes, in how prisoners behaved and in prisoner-staff rapport. The same month as the NPR broadcast, Dashka Slater, a reporter for the magazine *Mother Jones*, wrote about the state's reforms.[267] The article described how North Dakota's changes were inspired by a visit Director Bertsch and her staff made to a Norway prison. At that facility, prisoners were allowed relative freedom of movement, the use of solitary confinement was rare, and violent behavior was uncommon. North Dakota prison administrators related how, after the visit, they set out to reform their system, including by limiting time spent in restrictive housing. In October of 2017, the *New York Times* published an op-ed by Director Rick Raemisch on the decision in Colorado to end long-term solitary confinement.[268] He wrote about his conviction that "long-term isolation manufactures and aggravates mental illness." He explained that, because the vast majority of prisoners "eventually leave prison," ending long-term isolation was "simply the right thing to do—for the inmates and for their communities."

Other state reforms have been featured in local media. In May of 2018, Oregon news station KTVZ covered the correctional system's work with Vera to reduce the use of restrictive housing.[269] The broadcast cited Vera's *Rethinking Restrictive Housing*, which found that Oregon's Department of Corrections had reduced the percentage of people in restrictive housing from 8.8% to 7.7% over the course of a year. The segment quoted Department of Corrections Director Colette Peters: "We are committed to both reducing the number of men and women in special housing and the length of time spent in these units in a safe manner for staff and other adults in custody." In September of 2017, Keri Blakinger of the *Houston Chronicle* reported on the Texas prison system's elimination of solitary confinement as punishment.[270] Blakinger stated that the change would affect the roughly 75 people in isolation for disciplinary reasons, but would not affect those in administrative segregation for reasons like gang affiliation or security threats. The article framed the state's reform in the context of a national trend to reduce the use of solitary confinement.

Understanding the Harms of Isolation

Researchers have sought to identify the impact of living in isolation for long periods of time, and many professionals have concluded that doing so is harmful to physical health, well-being, and mental health. Further, young individuals, older adults, and those with physical and mental disabilities or challenges experience these harms acutely.[271]

Age—being young or old—is a factor that exacerbates the dislocations of isolating conditions. In 2017, when supporting federal legislation to restrict the use of solitary confinement of juveniles, the American Psychological Association explained that isolation had "especially devastating consequences to youth whose developmental immaturity leaves them more vulnerable to adverse reactions to prolonged isolation." These "effects may be exacerbated for children with disabilities or histories of trauma or abuse."[272] Older adults face other challenges, given that when subjected to "a lack of physical exercise, and loneliness," they have an "elevated risk for the earlier onset of dementia, physical deconditioning resulting in a heightened subsequent risk of falls, Vitamin D deficiency, and cardiovascular disease."[273]

For individuals with physical disabilities, isolation can have a "devastating impact," as detailed in a 2017 report from the American Civil Liberties Union, *Caged In: Solitary Confinement's Devastating Harm on Prisoners with Physical Disabilities*.[274] As that report explained, no national data were available on the numbers of persons with disabilities in restrictive housing; state studies had found that ten to twenty percent of the general prison population had forms of impairment, including to sight, mobility, and hearing.[275]

To learn about the impact of isolating conditions, *Caged In* researchers interviewed prisoners and staff and reviewed grievances filed by individuals with disabilities in 10 state systems.[276] As the report recounts, restrictive housing generally provided no accommodations for people unable to hear or see or in need of wheelchairs and other devices to enable them to manage basic daily tasks.[277] Many people went without hearing aids, Braille materials, sign language interpreters, and physical therapy.[278]

To respond, the report proposed that correctional officials: 1) "End all placements of prisoners with physical disabilities into solitary confinement where their disabilities will be worsened by such placements;" 2) "Prohibit all placements of individuals with physical disabilities into solitary confinement due to a lack of accessible cells;" 3) "Provide all accommodations, including assistive devices and auxiliary aids, to prisoners with physical disabilities who are held in solitary confinement, unless substantial and immediate security threat is documented," in which case, "alternative arrangements must be made and documented;" 4) "Establish data procedures to improve tracking and monitoring of prisoners with physical disabilities in prisons and jails, including the number of people with disabilities and those in solitary confinement, or other forms of restrictive housing, and the reasons for their placement."[279] As that report also noted, litigation under the Americans with Disabilities Act (ADA) and section 504 of the Rehabilitation Act[280] has been brought to respond to some of the problems.[281]

Depriving individuals of virtually all normal sociability has long been understood as disabling. For individuals whose mental well-being is already impaired, restrictive housing has come to be seen as adding injury to insult. Illustrative is the 2012 statement, adopted by the American Psychiatric Association, that "prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates."[282] In 2014, the Committee on Causes and Consequences of High Rates of Incarceration, an ad hoc committee of the National Research Council, concluded that isolation in prisons "can create or exacerbate serious psychological change in some inmates and make it difficult for them to return to the general population of a prison or to the community outside prison . . . . Long-term segregation is not an appropriate setting for seriously mentally ill inmates."[283]

In 2016, the National Commission on Correctional Health Care (NCCHC) issued a "position statement," to "assist health care professionals in addressing the use of solitary confinement in the facilities" in which they worked.[284] Defining solitary confinement as housing with "minimal to rare meaningful contact with other individuals," NCCHC promulgated

"principles," including that what it termed "prolonged (greater than 15 consecutive days) solitary confinement" was cruel, inhumane, and degrading treatment, and harmful to an individual's health,[285] and that correctional health professionals ought not to "condone or participate" in its use.[286] NCCHC also called for solitary confinement not to "exceed 15 days,"[287] and that health care professionals not "be involved in determining whether adults or juveniles are physically or psychologically able to be placed in isolation."[288] Further, the organization called for those placed in solitary confinement to have "as much human contact as possible with people from outside the facility and with custodial, educational, religious, and medical staff."[289]

As reflected in these statements, health care experts (some of whom have participated in litigation challenging restrictive housing) have concluded that solitary confinement is harmful to individuals. Those views have been predicated on clinical judgments and academic research, some of which has been summarized in overview essays that take different views about how to synthesize the research. One synthesis, published in 2016, concluded that prisoners in isolation suffered no greater psychological deterioration over time as compared to general population prisoners and, in fact, showed some improvement. [290] A 2017 overview disagreed, in part because the 2016 meta-analysis was not a complete account of the existing research[291] and included some studies that had serious flaws.[292] The 2017 essay noted that one of the prominent sources for the no-comparative-harm point of view had not controlled for the prior experience of prisoners in segregation before being placed in the less severe form of restrictive housing, and that prisoners moved in and out of different levels of isolation.[293] In contrast, other research has documented a set of stress-related reactions, sleep disturbances, anxiety, panic, rage, anger, and aggression associated with profoundly isolating conditions.[294]

Another researcher termed this impact a "SHU Post-Release Syndrome," entailing a sense of "disorientation following release, anxiety in unfamiliar places, a tendency to retreat into small spaces and limit social interactions, hyper-vigilance and heightened suspicion of others, and difficulty expressing feelings or trusting others." [295] Further, he and other researchers have investigated the physiological impact of solitary confinement, and focused on adrenaline and cortisol levels, neuron pathways, and brain waves.[296] In other studies, researchers have concluded that isolation created a greater risk of self-harm among prisoners[297] and that, during and after release, individuals were significantly more likely to show signs of post-traumatic stress disorder (PTSD) than those not held in isolating conditions.[298]

The Minnesota Department of Corrections and Minnesota Department of Public Safety sought to understand the effects of restrictive housing on recidivism. [299] The study's authors selected a sample of 6,500 cases from all adult prisoners released in 2014 in Minnesota.[300] The report examined "three different forms of recidivism: supervision revocations (also known as technical violations), new arrests, and new felony convictions within three years of release."[301],The researchers concluded that time spent in restrictive housing "increased the risk of supervision violations," which are infractions that break the rules set for supervised release but do not necessarily break the law; however, time in isolation "did not significantly affect the risk of rearrest

or reconviction."[302] The study also found that "being released to the outside world directly from" restrictive housing "did not have a large or significant impact" on recidivism. The authors wrote that future research "should disentangle the relationship" among restrictive housing, mental health, and recidivism, and should "examine the factors that increase, as well as decrease," the risk of placement in segregation.[303]

Legislative Regulations

Many legislatures have proposed and, in a few jurisdictions, enacted statutes to regulate and limit the use of restrictive housing. The bills are directed at the process of entry and oversight to make long-term stays less likely, [304] at lessening isolation by mandating activities akin to those available to the general population for persons held for 60 days or more in restrictive housing, and at improving data collection and reporting on the use of restrictive housing.[305] As of the summer of 2018, statutes on restrictive housing were enacted in Massachusetts, [306] voted out of the legislature for signature by the governor in New York, [307] and introduced in several jurisdictions across the U.S. — from Hawaii[308] to Nebraska,[309] New Jersey,[310] Virginia,[311] and the United States Senate.[312]

An example of a comprehensive reform comes from Massachusetts, which in April of 2018 put a packet of restrictive housing reforms into place for state and county correctional facilities.[313] After becoming effective at the end of 2018, the legislation will eliminate the use of restrictive housing to protect individuals beyond 72 hours, "unless the commissioner, the sheriff or a designee of the commissioner or sheriff certifies in writing: (i) the reason why the prisoner may not be safely held in the general population; (ii) that there is no available placement in a unit comparable to general population; (iii) that efforts are being undertaken to find appropriate housing and the status of the efforts; and (iv) the anticipated time frame for resolution."[314] Once appropriate housing is located for a prisoner in need of protection, that housing must afford the prisoner "approximately the same conditions, privileges, amenities and opportunities as in general population."[315]

The Massachusetts legislation will also change the decision-making process for placing people in restrictive housing. The statute will require "placement reviews" by a "multidisciplinary" team [316] and will establish a restrictive housing oversight committee,[317] to which reports are to be made monthly on the number of prisoners in restrictive housing in each state and county correctional facility.[318] For those held 60 days or more, the correctional department is to provide "access to vocational, educational, and rehabilitative programming, to the maximum extent possible consistent with the safety and security of the unit."[319]

In addition, Massachusetts's 2018 law will bar using a person's gender identity or sexual orientation as a ground for placing a person in restrictive housing.[320] The legislation will also ban restrictive housing for pregnant prisoners.[321] The statute will impose limits on placement of people found to have "a serious mental illness," as discussed below.

As of the spring of 2018, legislation to eliminate or to limit restrictive housing for subpopulations had been enacted in California, Colorado, Washington, D.C., and Tennessee, and proposed in several other jurisdictions, including Connecticut, Hawaii, Nebraska, New Jersey, New York, and Virginia.[322] One focus is on juveniles, where "room confinement" is the term used to describe isolating young people.[323] For example, beginning in 2016, California prohibited placing juveniles in room confinement "for the purposes of punishment, coercion, convenience, or retaliation by staff"[324] and required that before using room confinement, "other less restrictive options have been attempted and exhausted, unless attempting those options poses a threat to the safety or security of any minor, ward, or staff."[325] Room confinement is presumptively to be less than four hours, with renewed authorization from a facility supervisor required every four hours.[326]

Colorado's 2016 statute provides that "a youth may not be held in seclusion under any circumstances for more than eight total hours in two consecutive calendar days without a written court order."[327] In 2017, Washington, D.C. enacted legislation requiring that room confinement for juveniles "be used for the briefest period of time possible and not for a time to exceed 6 hours,"[328] and prohibiting "room confinement on a juvenile for the purposes of discipline, punishment, administrative convenience, retaliation, or staffing shortages."[329] The Tennessee Juvenile Justice Reform Act of 2018 includes a provision prohibiting seclusion of children in detention.[330] A bill in Nebraska proposes a limit of three hours of room confinement "in the case of a juvenile who poses a substantial and immediate risk of physical harm to others" and 30 minutes "in the case of a juvenile who poses a serious and immediate risk of physical harm to himself or herself."[331] The bill would also prohibit room confinement as punishment.[332] Proposed legislation in Connecticut would limit the use of solitary confinement for children in pre-trial detention.[333]

Other statutes focus on the use of restrictive housing for individuals with mental health issues. Statutes enacted or proposed generally provide for prohibitions, coupled with clauses permitting brief stays under exigent circumstances. For example, in 2017, Colorado prohibited the placement of "a person with a behavioral or serious mental health disorder in long-term isolated confinement except when exigent circumstances are present."[334] In Massachusetts, a "prisoner shall not be held in restrictive housing if the prisoner has a serious mental illness or a finding has been made . . . that restrictive housing is clinically contraindicated,"[335] and within 72 hours after such a placement, the custodian certifies that the prisoner cannot "be safely held in the general population," that no space is available in a "secure treatment unit," that efforts are underway to identify alternative, "appropriate housing," and that a "time frame" to do so is laid out.

Litigation and Consent Decrees

Challenges to correctional systems as well as to decisions in individual cases continue to bring the harms of restrictive housing to the attention of judges. The case law is voluminous; the discussion here offers a few highlights of rulings since 2016. We begin with institutional cases focused on subpopulations of individuals with mental health issues, juveniles, and persons confined to restrictive housing solely because of their capital sentences.

A major ruling came from the District Court for the Middle District of Alabama,[336] which had certified a class of "all persons with a serious mental illness who are now, or will in the future be, subject to defendant's mental health care policies and practices" within the Alabama Department of Corrections facilities.[337] At the time of the litigation, the Alabama system included 19,500 prisoners, of whom 3,400 were receiving "some type of mental-health treatment."[338] After a seven-week trial, the federal district court in 2017 found that "inadequacies in the mental-health care system start . . . with intake screening" in which "likely thousands" of prisoners with mental illness are missed.[339] The court concluded that even when mental health issues were identified, "prisoners receive significantly inadequate care," including for those who had discussed committing suicide.[340] The court held that the care provided to mentally ill persons violated the constitutional obligation not to be deliberately indifferent to the "serious medical needs of prisoners." [341] Included as Eighth Amendment violations were the placement of "seriously mentally ill prisoners in segregation without extenuating circumstances and for prolonged periods of time; placing prisoners with serious mental-health needs in segregation without adequate consideration of the impact of segregation on mental health; and providing inadequate treatment and monitoring in segregation."[342] Since its ruling, the court has accepted proposed remedies, including a process to identify prisoners with serious mental illness so that they are not placed in segregation, absent extenuating circumstances.[343]

The South Carolina Department of Corrections recently agreed to a settlement in a class action lawsuit by incarcerated individuals with serious mental illness.[344] The plaintiffs had claimed that the department's failure "to provide reasonably adequate medical treatment" to prisoners with serious mental illness violated the state constitutional prohibition against cruel and unusual punishment.[345] The suit alleged that mentally ill prisoners were often punished by being placed for long periods of time in administrative segregation, which, the complaint stated, exacerbated mental illness.[346] The complaint asserted that the prison system did not "have adequate treatment space or staff to adequately monitor or evaluate" mentally ill individuals in segregation.[347] A state trial court judge held that South Carolina's treatment of seriously mentally ill prisoners violated the state constitution.[348] One of the court's findings was that the "inappropriate and extended reliance on segregation to manage inmates with serious mental illness, particularly those in crisis, exposes them to a substantial risk of serious harm," which "contributed to the deaths" of multiple people in segregation.[349] After the state and the plaintiffs reached an agreement, the state's appeal was dismissed.[350] The settlement addressed the six areas of serious deficiencies that the trial court's ruling had outlined, including ending "inappropriate segregation of offenders in mental health crisis."[351]

South Carolina reported a number of changes to its restrictive housing regime since agreeing to these reforms. As South Carolina explained, the settlement contemplated "a multi-year compliance process with phased-in implementation," that will be assessed by "an Implementation Panel of two experts who conduct periodic site visits and review reports and records." The prison

system described hiring a deputy director to oversee compliance with the settlement. The plan included the following measures:

> (1) the development of a comprehensive mental health treatment program that prohibits the inappropriate segregation of inmates in mental health crisis; (2) access for segregated inmates to group and individual therapy to include more out of cell time for segregated mentally ill inmates; (3) timely sessions for segregated inmates with qualified mental health practitioners; (4) improvement in the cleanliness and temperature of segregation cells; (5) implementation of a formal quality management program under which segregation practices and conditions are reviewed; and (6) development of a training program for officers concerning appropriate methods of managing mentally ill inmates.

South Carolina also reported creating a "Quality Improvement and Risk Management Division within the Office of Legal and Compliance to monitor and report compliance with the settlement requirements." The correctional system further described implementing a "Behavioral Management Unit policy" in August 2016, "with the purpose of providing inmates whose mental health needs likely contribute to their segregation status with programming, treatment, and structure as an alternative to long term placement in restrictive housing."[352] Despite stating that it was "making steady progress" to comply with the agreement, South Carolina explained that it was "hampered by staffing deficits," which it was addressing with "retention teams to mentor new officers and work with officers considering leaving the agency."

In New York City, a settlement of a class action involving isolation of pre-trial detainees resulted in awards to individuals confined there.[353] The plaintiffs, former detainees at Rikers Island, had alleged that the New York City Department of Corrections violated the U.S. Constitution by holding pretrial detainees in solitary confinement or punitive segregation for no legitimate purpose and without providing due process.[354] The city agreed to pay a total of $5 million to 470 individuals placed in solitary confinement between 2012 and 2015.[355] Each member of the class was to receive a minimum of $175 per day spent in solitary confinement or punitive segregation. Individuals diagnosed as having a serious mental illness or who were under the age of 18 at the time of confinement were to receive $200 per day spent in confinement.[356]

In August 2018, a federal district court judge approved a $240,000 settlement for four teenagers held in solitary confinement in Washington state.[357] The youths had been held in adult detention facilities while awaiting trial. In October 2017, they filed a class action lawsuit alleging that King County's practice of holding them in long-term solitary confinement violated the Eighth and Fourteenth Amendments of the United States Constitution and Article 1, section 14 of the Washington Constitution, which provides that "cruel punishment" shall not be inflicted.[358] Under the terms of the settlement, King County agreed that, in addition to compensating the four individuals, it would institute a ban on solitary confinement of juveniles in all of its detention facilities. The settlement provided for exceptions "when based on the juvenile's behavior," when "necessary to prevent imminent and significant physical harm" to the juvenile or others, and when

"less restrictive alternatives were unsuccessful."[359] The settlement further stipulated that solitary confinement for all juvenile detainees "may not be used for disciplinary or punishment purposes."[360] In addition, the county consented to having mental health or medical staff assess any juvenile within eight hours of placement, and to notify a parent or legal guardian when a juvenile is held in isolation for longer than eight consecutive hours.[361]

Many courts have determined that isolation of juveniles is unlawful. For example, in Tennessee in 2017, a federal district court held that a class of incarcerated youth were "likely to succeed on their claims that juveniles being detained in solitary confinement or isolation for punitive or disciplinary purposes constitutes . . . inhumane treatment"[362] and issued a preliminary injunction barring all solitary confinement for juveniles as punishment or discipline.[363] In another case, citing the "broad consensus among the scientific and professional community that juveniles are psychologically more vulnerable than adults,"[364] the federal district court for the Northern District of New York concluded that the plaintiffs were substantially likely to succeed on their claim that punitive solitary confinement of youth violated the Eighth Amendment.[365] In 2017, the Juvenile Law Center and the ACLU of Wisconsin filed a lawsuit challenging state officials' use of solitary confinement, shackling, and pepper spray in two youth detention facilities[366] and won a ruling barring the use of those forms of restraint for youths.[367] In January of 2018, the Wisconsin legislature enacted legislation to close, by 2021, the two juvenile detention facilities at issue in the lawsuit.[368] The case ended with a settlement to eliminate punitive juvenile solitary confinement within the coming year.[369]

Another set of cases focus on the practice of placing individuals in restrictive housing solely because they have capital sentences. That practice has repeatedly drawn the attention of U.S. Supreme Court justices. In 2015, in *Davis v. Ayala*, Justice Anthony Kennedy wrote a concurrence to underscore that "years on end of near-total isolation" impose "a terrible price."[370] Further, he noted that judges putting a person in long-term solitary confinement ought to reflect on the harm to mental health entailed.[371] In 2017, Justice Breyer responded to his colleagues' denial of a petition for a stay of execution in Texas by questioning the constitutionality of extended solitary confinement for death row prisoners: "If extended solitary confinement alone raises serious constitutional questions, then 20 years of solitary confinement, all the while under threat of execution, must raise similar questions, and to a rare degree, and with particular intensity."[372]

In the lower courts, several lawsuits have challenged the use of a capital sentence to place people into restrictive housing. Lawsuits filed in Arizona[373] and in California[374] sparked changes in the use of automatic solitary confinement for death-row prisoners. Other cases challenging automatic use of restrictive housing for individuals sentenced to death are pending in Florida,[375] Louisiana,[376] and Pennsylvania.[377] In another case involving two individuals whose capital sentences were vacated and who remained in solitary confinement for years thereafter, the Court of Appeals for the Third Circuit held that "inmates on death row whose death sentences have been vacated have a due process right to avoid continued placement in solitary confinement on death row, absent . . . meaningful protections" that the decision outlined.[378]

We should note that not all departments of corrections place individuals with capital sentences in restrictive housing. As detailed in *Rethinking Death Row: Variations in the Housing of Individuals Sentenced to Death*,[379] most states give discretion to prison systems to decide how to house prisoners.[380] This 2016 report provided accounts from correctional leaders in North Carolina, Missouri, and Colorado who had housed capital-sentenced prisoners in settings offering them meaningful opportunities to interact with others.[381] Researchers on "mainstreaming" death-sentenced prisoners in Missouri concluded more than two decades ago that, while integration of these prisoners entailed some challenges, "integration was a viable, effective approach."[382] Moreover, a 2016 study found no evidence that integrating such prisoners was a source of more violence in prisons.[383]

Other cases, filed by individuals, have resulted in decisions about the harms of placement in restrictive housing for years, and in some instances, for decades. In one Pennsylvania case, a prisoner who had served 36 years in solitary confinement challenged the constitutionality of his continued confinement and won an injunction to release him to general population.[384] The federal district court for the Middle District of Pennsylvania found that the "the extraordinary duration" of the prisoner's confinement, combined with "the harsh consequences of involuntary isolation" amount to a "deprivation of a constitutional proportion;"[385] "retention in the RHU will protract his extant injuries and expose him to an imminent and probable risk of even greater psychological damage."[386]

Restrictive Housing as a Global Concern

The close attention to restrictive housing practices in the United States is part of a worldwide trend of concern about this practice,[387] which was addressed in the United Nations Standard Minimum Rules for the Treatment of Prisoners, commonly known as the "Nelson Mandela Rules."[388] The Rules define solitary confinement as being held for 22 hours or more a day for longer than 15 days without "meaningful human contact."[389] The rules state that "solitary confinement shall be used only in exceptional cases as a last resort, for as short a time as possible and subject to independent review, and only pursuant to the authorization by a competent authority," and "shall not be imposed by virtue of a prisoner's sentence."[390] In addition, the Rules provide that "solitary confinement should be prohibited in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures."[391] Further, "indefinite" and "prolonged solitary confinement" should not be used,[392] and women and children should not be held in solitary confinement.[393]

Litigation in various national courts, transnational commissions, and non-governmental organizations continues to document and in some instances circumscribe the harms of isolating confinement. In Canada, trial courts in Ontario and in British Columbia in 2017 found aspects of administrative segregation unlawful.[394] The Ontario decision concluded that the lack of independent review of a decision to place a prisoner in restrictive housing violated the Charter of Rights and Freedoms because of failures "to provide the procedural safeguards required by the principles of fundamental justice."[395] The court found that putting people into "administrative

segregation amounts to a significant deprivation of liberty"[396] and that "placing an inmate in administrative segregation imposes a psychological stress, quite capable of producing serious permanent observable negative health effects."[397] The court did not, however, find that prolonged administrative segregation for more than 15 days constitutes "cruel and unusual treatment or punishment," as prohibited under Section 12 of the Charter of Rights and Freedoms.[398] The court also did not conclude that segregation of young adults and the mentally ill violated that prohibition.[399] As of this writing, the decision has been stayed pending appeal.[400]

In British Columbia, after hearing from dozens of witnesses including experts on administrative segregation and prisoners in administrative segregation,[401] a trial court declared that Canadian statutes and regulations providing for segregation violated Section 7 of the Charter's "right to life, liberty, and security of the person." The court based its finding on the fact that the relevant laws authorized "prolonged, indefinite administrative segregation," that internal review depended on the institutional head (warden), and that prisoners were deprived of "right to counsel at segregation hearings and reviews."[402] The court found that use of segregation also violated the Charter's Section 15 right to "equal protection and equal benefit of the law."[403] The court reached this determination based on the laws' authorization of "administrative segregation for the mentally ill and/or disabled" and "a procedure that resulted in discrimination against Aboriginal inmates."[404] The court concluded that "administrative segregation . . . is a form of solitary confinement that places all Canadian federal inmates subject to it at significant risk of serious psychological harm, including mental pain and suffering, and increased incidence of self-harm and suicide." The court stated that the "risks of these harms are intensified in the case of mentally ill inmates, but that all prisoners "subject to segregation are subject to the risk of harm to some degree."[405] The court held, however, that "not every application of the impugned legislation will" "amount to cruel and unusual punishment."[406] The court also found that the segregation laws were not "arbitrary."[407] As of this writing, the judgment was stayed pending appeal.[408]

In Europe, supranational and non-governmental organizations have called for reforms of restrictive housing practices. The Council of Europe's European Committee on Crime Problems issued a report in May 2018 analyzing the need to update the European Prison Rules[409] so as to increase regulation of solitary confinement. Doing so would entail bringing the European Prison Rules in line with the standards of the Council of Europe's Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) and with the Nelson Mandela Rules.[410] That report called for a new rule on solitary confinement in accordance with the 2011 CPT standards to address administrative segregation as a form of solitary confinement.[411] Those rules set forth principles of proportionality, lawfulness, accountability, necessity, and non-discrimination in the use of solitary confinement, and called for the "material conditions" of such confinement to include "access to natural light," sufficient artificial light for reading, communication mechanisms, and showers as often as prisoners in the "normal regime."[412]

In 2017, the CPT published a report on detention conditions in Germany.[413] One of the areas of concern was the use of prolonged solitary confinement and solitary confinement for

juveniles. The CPT recommended that prisoners be held for no more, and preferably fewer, than 14 days in disciplinary solitary confinement.[414] In addition, the CPT endorsed the Nelson Mandela Rules' prohibition on solitary confinement for juveniles.[415] The CPT also observed significant differences among institutions: in some prisons, disciplinary solitary confinement was imposed only rarely and usually for a short period of time, while in others, it was imposed much more frequently and in many cases for up to four weeks.[416]

In February 2018, the Irish Penal Reform Trust (IPRT) published a study on the use of solitary confinement and restricted regimes.[417] The report defined "solitary confinement" as 22 or more hours of confinement a day in a cell, and "restricted regimes" as 19 hours a day or more in cell.[418] The report found that while the number of prisoners in solitary confinement decreased from July 2013 to October 2017, the overall number of prisoners in restricted regimes had increased, with 428 individuals in restricted regimes, most subject to 21 hours in cell, in October 2017.[419] The report made many recommendations including "full compliance with the Mandela Rules" and that provisions be made to "set the minimum out-of-cell time at 8 hours per day." The report also recommended that separation "not be permitted for reasons of punishment, but only for reasons of safety in emergency situations, and for the shortest possible period of time"; that "adults with mental health difficulties or mental or physical disabilities" not be put into solitary confinement; and that a parallel "absolute prohibition" be in place for "children."[420] Further, the report called for the Irish Prison Service to "regularly collect and publish data relating to the length of time prisoners spend on restricted regimes in all prisons."[421]

VI. Comparing the Numbers of People in Restrictive Housing in 2015–2016 and in 2017–2018

As we noted, we have data from 43 jurisdictions, housing collectively about 80.6% of the U.S. prison population and reporting 49,197 people in restrictive housing. We therefore estimated that, if the proportion of those held in restrictive housing in jurisdictions that did not provide information mirrored that of those that did, 61,000 people were in restrictive housing in the fall of 2017.

In this concluding section, we put together materials from the 2015–2016 and the 2017–2018 ASCA-Liman surveys by analyzing some of the data provided by the 40 jurisdictions that responded with information on restrictive housing populations in *both* surveys.[422] That comparison permits insights into if and how the use of restrictive housing changed during the interval between the two surveys. As detailed below, the numbers of prisoners in restrictive housing decreased in some jurisdictions and increased in others.[423]

As displayed in Table 21, across these 40 jurisdictions, the aggregate number of prisoners reported to be in restrictive housing decreased by 9,444 prisoners, from 56,337 in 2015 to 46,893 in 2017. In 29 of these 40 jurisdictions, the number of prisoners reported in restrictive housing decreased from 2015 to 2017.[424] The five jurisdictions with the largest decreases in numbers of prisoners in restrictive housing population accounted for about three-quarters of the aggregate reduction across jurisdictions.[425] In 11 jurisdictions, the number of prisoners reported in restrictive housing increased from 2015 to 2017.[426]

Across these 40 jurisdictions, the percentage of prisoners in restrictive housing decreased from 5.0% in 2015 to 4.4% in 2017. In 28 jurisdictions, the percentage of prisoners reported to be in restrictive housing decreased from 2015 to 2017.[427] The largest reduction in the percentage of prisoners in restrictive housing in a single jurisdiction was from 14.0% in 2015 to 4.7% in 2017.[428] In 12 jurisdictions, the percentage of prisoners reported to be in restrictive housing increased during this time period.[429] The largest increase in the percentage of prisoners in restrictive housing in a single jurisdiction grew from 14.5% in 2015 to 19.0% in 2017.[430] Figure 15 and Figure 16 detail the percentage of prisoners in restrictive housing by jurisdiction in two ways: Figure 15 displays the percentages in both years, and Figure 16 provides change in percentages.

What accounts for the changing numbers is unclear. Variables include new policies and practices on restrictive housing, changes in facilities and budgets, litigation, statutes, and the overall numbers of people in prison systems as prisoners and staff. For example, in the 40 jurisdictions analyzed here, the total custodial population for which we also have data on restrictive housing decreased by 69,499 people from 1,124,695 incarcerated persons in 2015 to 1,055,196 in 2017.[431] In 20 of the 29 jurisdictions in which restrictive housing numbers declined, so too did the total prison population.[432] In two of the 11 jurisdictions that had an increase in restrictive housing, the total prison population increased as well.[433]

Those two variables—total prison population and restrictive housing population—do not always match up or move in the same direction. In the Federal Bureau of Prisons, for example, the total prison population decreased to a larger extent than did the restrictive housing population. In 2015, 4.7% of the federal prison population was reported to be in restrictive housing. In 2017, 5.2% of the federal prison population was reported to be in restrictive housing. Thus while the total number of federal prisoners in restrictive housing decreased, the percentage of federal prisoners in restrictive housing increased.

Table 21 Jurisdiction-by-Jurisdiction Comparisons of Restrictive Housing Populations in 2015–2016 and in 2017–2018 (n = 40)

	2015 Total Custodial Population for Facilities Reporting Restrictive Housing Data	2015 Population in Restrictive Housing	2015 Percentage in Restrictive Housing	2017 Total Custodial Population for Facilities Reporting Restrictive Housing Data	2017 Population in Restrictive Housing	2017 Percentage in Restrictive Housing
Alabama*	24,549	1,402	5.7%	21,592	855	4.0%
Alaska	4,919	352	7.2%	4,393	378	8.6%
Arizona	42,736	2,544	6.0%	42,146	2,723	6.5%
Colorado	18,231	217	1.2%	18,297	10	0.1%
Connecticut	16,056	128	0.8%	14,137	328	2.3%
Delaware*	4,342	381	8.8%	4,333	43	1.0%
FBOP*	189,181	8,942	4.7%	153,839	7,974	5.2%
Georgia	56,656	3,880	6.8%	54,723	3,200	5.8%
Hawaii	4,200	23	0.5%	3,713	13	0.4%
Idaho	8,013	404	5.0%	7,161	310	4.3%
Illinois	46,609	2,255	4.8%	42,177	921	2.2%
Indiana	27,508	1,621	5.9%	26,317	1,741	6.6%
Iowa	8,302	247	3.0%	8,283	167	2.0%
Kansas	9,952	589	5.9%	9,886	459	4.6%
Kentucky	11,669	487	4.2%	12,000	408	3.4%
Louisiana*	18,515	2,689	14.5%	14,291	2,709	19.0%
Maryland	19,687	1,485	7.5%	21,785	1,417	6.5%
Massachusetts	10,004	235	2.3%	9,047	443	4.9%
Michigan	42,826	1,339	3.1%	39,858	903	2.3%
Mississippi	18,866	185	1.0%	12,940	529	4.1%
Missouri	32,266	2,028	6.3%	33,204	2,990	9.0%
Montana	2,554	90	3.5%	1,769	113	6.4%

Nebraska	5,456	598	11.0%	5,178	328	6.3%
New Jersey	20,346	1,370	6.7%	19,368	1,011	5.2%
New Mexico	7,389	663	9.0%	7,047	294	4.2%
New York	52,621	4,498	8.5%	50,764	2,666	5.3%
North Carolina	38,039	1,517	4.0%	37,259	1,109	3.0%
North Dakota	1,800	54	3.0%	1,830	8	0.4%
Ohio	50,248	1,374	2.7%	49,954	1,282	2.6%
Oklahoma	27,650	1,552	5.6%	26,895	1,368	5.1%
Oregon	14,724	630	4.3%	14,574	938	6.4%
Pennsylvania	50,349	1,716	3.4%	46,920	1,498	3.2%
South Carolina	20,978	1,068	5.1%	19,938	737	3.7%
South Dakota	3,526	106	3.0%	3,927	90	2.3%
Tennessee	20,095	1,768	8.8%	22,160	1,181	5.3%
Texas	148,365	5,832	3.9%	145,409	4,272	2.9%
Utah	6,497	912	14.0%	6,293	296	4.7%
Washington	16,308	274	1.7%	17,046	387	2.3%
Wisconsin*	20,535	751	3.7%	22,589	713	3.2%
Wyoming	2,128	131	6.2%	2,154	81	3.8%
Totals	**1,124,695**	**56,337**	**5.0%**	**1,055,196**	**46,893**	**4.4%**

* In 2015, the number used for total custodial population was the number of prisoners for which the jurisdiction had restrictive housing data. For the current survey, we used the total custodial population for which the jurisdiction had restrictive housing data and that was under the direct control of the jurisdiction. In 2015, some jurisdictions had restrictive housing data for facilities that were not under their direct control and included those prisoners in their 2015 survey response. Those jurisdictions are marked with an asterisk. Differences between the 2015 and 2017 total custodial population for these jurisdictions may therefore result from changes in the calculation of the total custodial population rather than changes in the jurisdictions' numbers of prisoners.

Included in SCDC' 4.29.19 letter to LOC

Figure 15 Jurisdiction-by-Jurisdiction Comparisons of Percentages of Prisoners in Restrictive Housing Populations in 2015–2016 and in 2017–2018 (n = 40)

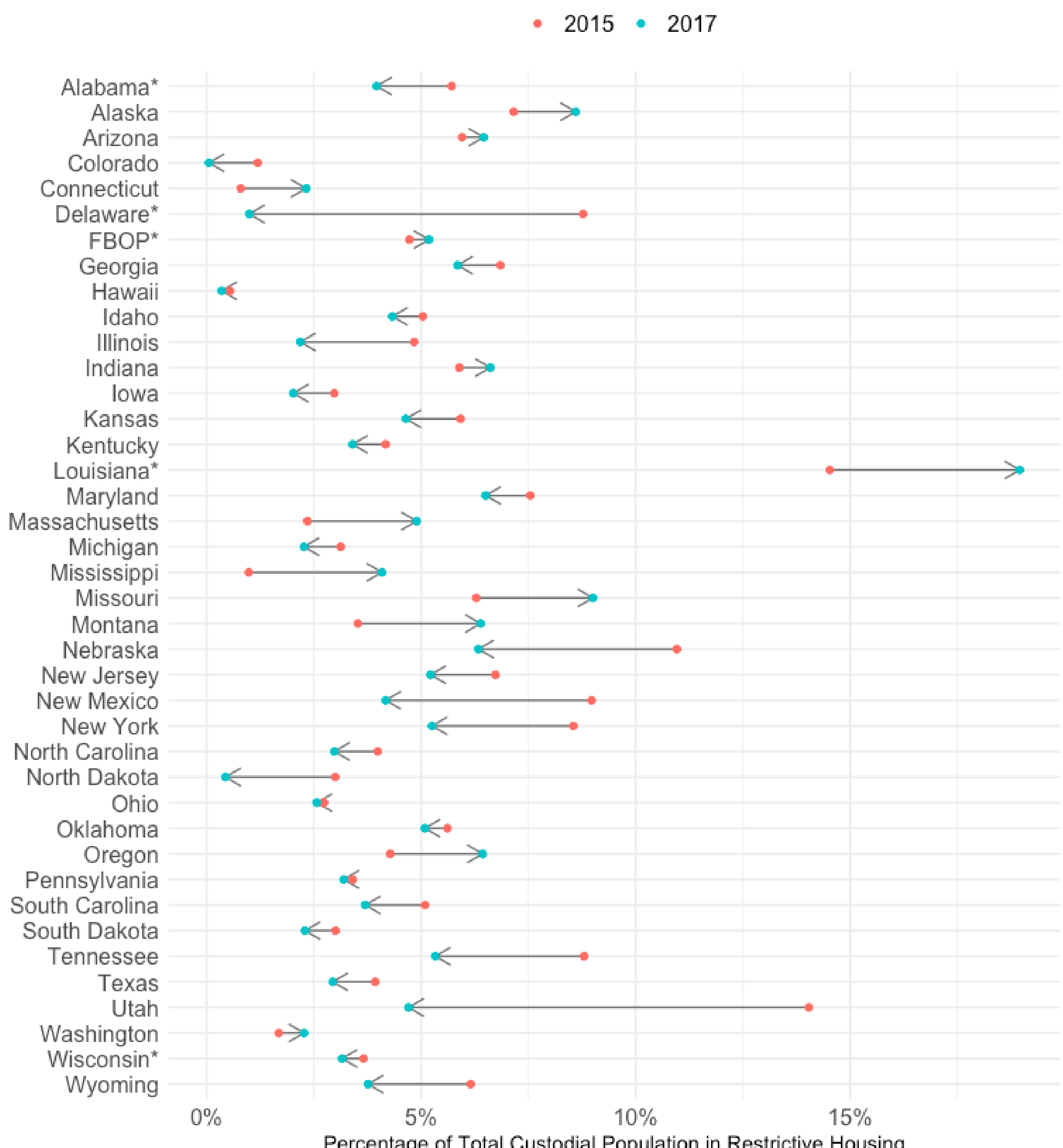
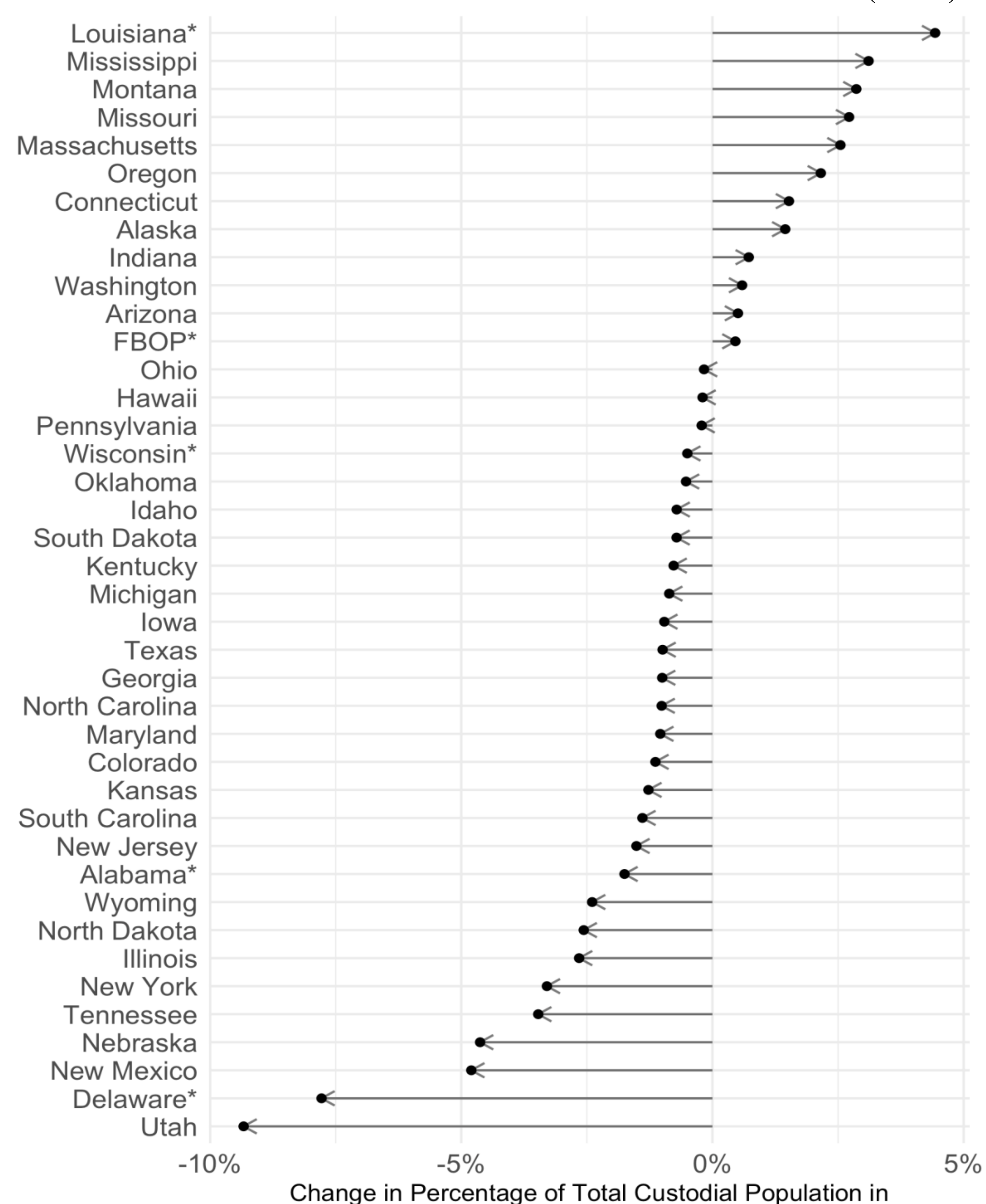


Figure 16 Jurisdiction-by-Jurisdiction Comparisons of the Changes in Percentage of Prisoners in Restrictive Housing Populations in 2015–2016 and in 2017–2018 (n = 40)



Another window into changes over time comes from the numbers on length of time in restrictive housing provided by the 31 jurisdictions responding to those questions in both surveys.[434] Table 22 and Table 23 show that, overall, the numbers of individuals in restrictive housing across most time periods decreased from 2015 to 2017. The number of individuals in restrictive housing for 15 days to one month increased by 6.5%; one to three months increased by 0.8%; three to six months decreased by 13.2%; six months to one year decreased by 30.0%; one to three years decreased by 40.4%; three to six years decreased by 33.1%; and six or more years decreased by 25.9%.

As shown in Table 22, the number of prisoners in restrictive housing for six months or less decreased in about as many jurisdictions as it increased. The number of prisoners in restrictive housing for time periods longer than six months decreased in more jurisdictions than it increased.

The number of individuals in restrictive housing who were being held from 15 days to one month decreased in 15 jurisdictions, stayed the same in one jurisdiction, and increased in 15 jurisdictions. The number of individuals in restrictive housing from one month to three months decreased in 14 jurisdictions, and increased in 17 jurisdictions. The number of individuals in restrictive housing from three months to six months decreased in 17 jurisdictions, stayed the same in one jurisdiction, and increased in 13 jurisdictions.

The number of individuals in restrictive housing from six months to one year decreased in 23 jurisdictions, stayed the same in one jurisdiction, and increased in seven jurisdictions. The number of individuals in restrictive housing from one year to three years decreased in 23 jurisdictions, stayed the same in one jurisdiction, and increased in seven jurisdictions. The number of individuals in restrictive housing from three years to six years decreased in 20 jurisdictions, stayed the same in four jurisdictions, and increased in seven jurisdictions. The number of individuals in restrictive housing over six years decreased in 18 jurisdictions, stayed the same in eight jurisdictions, and increased in five jurisdictions.

Table 22 Comparing the Numbers of Prisoners in Restrictive Housing by Length of Time in 2015–2016 and in 2017–2018* (n=31)

	15 days – 1 month		1–3 months		3–6 months		6 months – 1 year		1–3 years		3–6 years		6+ years	
Alaska	124	72	74	78	49	50	60	25	43	31	5	0	0	0
Arizona	140	428	472	831	530	433	809	462	488	489	34	72	71	8
Colorado	64	10	65	0	64	0	23	0	1	0	0	0	0	0
Delaware	25	5	99	25	84	6	76	7	67	0	12	0	18	0
FBOP	1,690	1,764	3,802	3,690	1,449	1,382	929	609	731	254	183	120	158	155
Hawaii	21	23	2	0	0	9	0	0	0	0	0	0	0	0
Indiana	212	131	224	348	388	281	496	354	175	391	80	121	46	115
Iowa	97	56	80	98	30	10	24	3	16	0	0	0	0	0
Kansas	125	176	146	207	87	61	105	15	94	0	22	0	10	0
Kentucky	139	671	222	130	52	45	41	14	28	1	4	0	1	0
Louisiana	327	332	551	630	334	449	302	445	450	517	221	346	0	0
Massachusetts	2	76	3	118	12	50	65	28	71	31	24	5	43	4
Mississippi	3	399	21	69	29	40	41	12	69	7	17	1	5	1
Montana	58	8	0	34	67	30	2	24	4	11	0	6	3	0
Nebraska	48	19	121	94	158	102	87	81	106	32	48	1	30	3
New Jersey	54	150	247	398	295	178	354	100	184	79	128	36	108	70
New York	1,615	757	1,454	1,218	671	416	257	182	101	73	32	13	0	7
North Carolina	461	602	579	205	460	280	12	21	4	1	1	0	0	0
North Dakota	8	3	13	4	12	2	17	0	4	0	0	0	0	0
Ohio	119	226	360	228	181	243	253	271	162	183	43	49	22	22
Oklahoma	169	384	270	481	206	224	270	156	490	106	77	17	70	0
Oregon	90	126	152	291	277	152	81	41	26	30	4	7	0	1
Pennsylvania	349	305	524	517	288	252	156	126	157	106	52	41	190	151
South Carolina	238	138	370	207	128	105	114	131	151	102	67	12	0	42
South Dakota	18	18	16	6	10	10	15	16	27	21	12	12	8	7
Tennessee	89	110	239	276	222	237	353	280	500	244	166	31	205	3
Texas	109	141	204	263	277	326	537	474	1,840	931	1,278	811	1,587	1,326
Utah	233	2	169	33	173	232	125	29	166	0	35	0	11	0
Washington	16	5	55	82	68	107	70	106	37	64	16	11	12	12
Wisconsin	278	221	285	345	88	91	60	41	36	13	4	2	0	0
Wyoming	8	21	30	31	24	25	59	2	9	1	0	1	1	0
Totals	**6,929**	**7,379**	**10,849**	**10,937**	**6,713**	**5,828**	**5,793**	**4,055**	**6,237**	**3,718**	**2,565**	**1,715**	**2,599**	**1,927**

* Shaded cells contain values from the 2015–2016 survey. Unshaded cells contain values from the 2017–2018 survey.

We also calculated the distribution across time intervals—i.e., what percentage of individuals in restrictive housing were held for each time interval—for the populations in these 31 jurisdictions, as Table 23 reflects. The percentage of prisoners in restrictive housing for less than six months increased in more jurisdictions than it decreased, while the percentage of prisoners in restrictive housing for more than six months decreased in more jurisdictions than it increased.

The percentage of individuals in restrictive housing who were being held from 15 days to one month decreased in 12 jurisdictions, and increased in 19 jurisdictions. The percentage of individuals in restrictive housing from one month to three months decreased in nine jurisdictions and increased in 22 jurisdictions. The percentage of individuals in restrictive housing from three months to six months decreased in 12 jurisdictions, stayed the same in three jurisdictions, and increased in 16 jurisdictions.

The percentage of individuals in restrictive housing from six months to one year decreased in 20 jurisdictions, stayed the same in two jurisdictions, and increased in nine jurisdictions. The percentage of individuals in restrictive housing from one year to three years decreased in 20 jurisdictions, stayed the same in five jurisdictions, and increased in six jurisdictions. The percentage of individuals in restrictive housing from three years to six years decreased in 16 jurisdictions, stayed the same in nine jurisdictions, and increased in six jurisdictions. The percentage of individuals in restrictive housing over six years decreased in 14 jurisdictions, stayed the same in 14 jurisdictions, and increased in three jurisdictions.

Table 23 Comparing the Distributions of Prisoners in Restrictive Housing by Length of Time in 2015–2016 and in 2017–2018* (n=31)

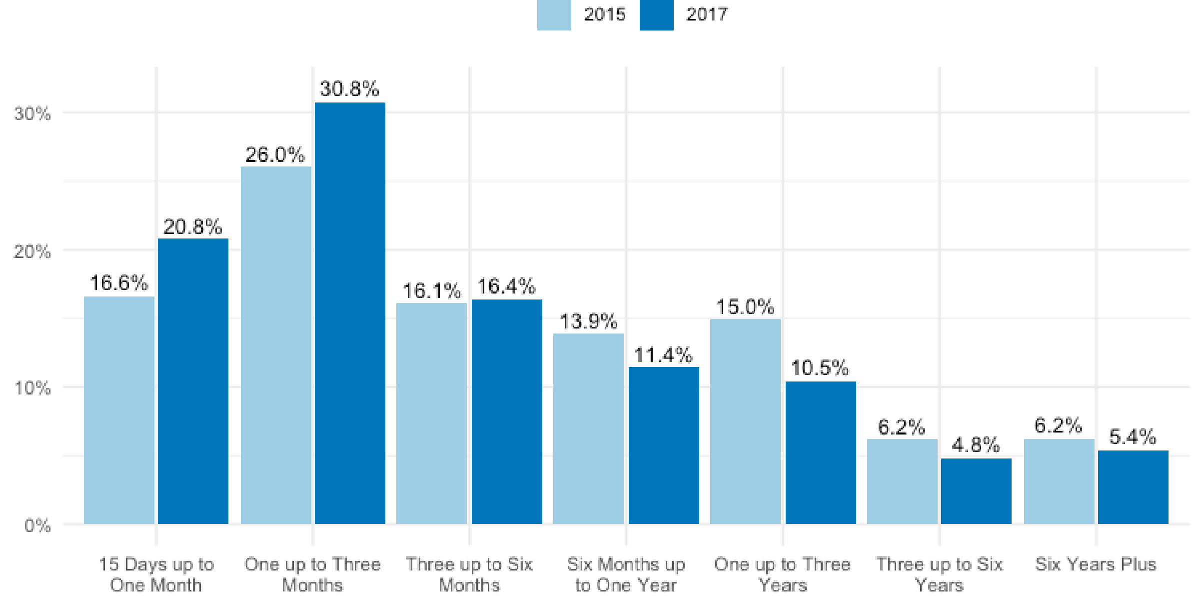
	15 Days up to One Month		One up to Three Months		Three up to Six Months		Six up to Twelve Months		One up to Three Years		Three up to Six Years		Six Years Plus	
Alaska	35%	28%	21%	30%	14%	20%	17%	10%	12%	12%	1%	0%	0%	0%
Arizona	6%	16%	19%	31%	21%	16%	32%	17%	19%	18%	1%	3%	3%	0%
Colorado	29%	100%	30%	0%	29%	0%	11%	0%	0%	0%	0%	0%	0%	0%
Delaware	7%	12%	26%	58%	22%	14%	20%	16%	18%	0%	3%	0%	5%	0%
FBOP	19%	22%	43%	46%	16%	17%	10%	8%	8%	3%	2%	2%	2%	2%
Hawaii	91%	72%	9%	0%	0%	28%	0%	0%	0%	0%	0%	0%	0%	0%
Indiana	13%	8%	14%	20%	24%	16%	31%	20%	11%	22%	5%	7%	3%	7%
Iowa	39%	34%	32%	59%	12%	6%	10%	2%	6%	0%	0%	0%	0%	0%
Kansas	21%	38%	25%	45%	15%	13%	18%	3%	16%	0%	4%	0%	2%	0%
Kentucky	29%	78%	46%	15%	11%	5%	8%	2%	6%	0%	1%	0%	0%	0%
Louisiana	15%	12%	25%	23%	15%	17%	14%	16%	21%	19%	10%	13%	0%	0%
Massachusetts	1%	24%	1%	38%	5%	16%	30%	9%	32%	10%	11%	2%	20%	1%
Mississippi	2%	75%	11%	13%	16%	8%	22%	2%	37%	1%	9%	0%	3%	0%
Montana	43%	7%	0%	30%	50%	27%	1%	21%	3%	10%	0%	5%	2%	0%
Nebraska	8%	6%	20%	28%	26%	31%	15%	24%	18%	10%	8%	0%	5%	1%
New Jersey	4%	15%	18%	39%	22%	18%	26%	10%	13%	8%	9%	4%	8%	7%

New York	39%	28%	35%	46%	16%	16%	6%	7%	2%	3%	1%	0%	0%	0%
North Carolina	30%	54%	38%	18%	30%	25%	1%	2%	0%	0%	0%	0%	0%	0%
North Dakota	15%	33%	24%	44%	22%	22%	31%	0%	7%	0%	0%	0%	0%	0%
Ohio	10%	18%	32%	19%	16%	20%	22%	22%	14%	15%	4%	4%	2%	2%
Oklahoma	11%	28%	17%	35%	13%	16%	17%	11%	32%	8%	5%	1%	5%	0%
Oregon	14%	19%	24%	45%	44%	23%	13%	6%	4%	5%	1%	1%	0%	0%
Pennsylvania	20%	20%	31%	35%	17%	17%	9%	8%	9%	7%	3%	3%	11%	10%
South Carolina	22%	19%	35%	28%	12%	14%	11%	18%	14%	14%	6%	2%	0%	6%
South Dakota	17%	20%	15%	7%	9%	11%	14%	18%	25%	23%	11%	13%	8%	8%
Tennessee	5%	9%	13%	23%	13%	20%	20%	24%	28%	21%	9%	3%	12%	0%
Texas	2%	3%	3%	6%	5%	8%	9%	11%	32%	22%	22%	19%	27%	31%
Utah	26%	1%	19%	11%	19%	78%	14%	10%	18%	0%	4%	0%	1%	0%
Washington	6%	1%	20%	21%	25%	28%	26%	27%	14%	17%	6%	3%	4%	3%
Wisconsin	37%	31%	38%	48%	12%	13%	8%	6%	5%	2%	1%	0%	0%	0%
Wyoming	6%	26%	23%	38%	18%	31%	45%	2%	7%	1%	0%	1%	1%	0%

* Shaded cells contain values from the 2015–2016 survey. Unshaded cells contain values from the 2017–2018 survey.

To conclude, Figure 17 provides a summary of the comparison of the lengths of time that individuals spent in restrictive housing. This graph is one way to capture that the many efforts to limit the use and duration of restrictive housing are having effects on people's lives.

Figure 17 Comparing the Distributions of Prisoners in Restrictive Housing by Length of Time in 2015–2016 and in 2017–2018* (n=31)



[1] *See, e.g.*, Chesa Boudin, Trevor Stutz & Aaron Littman, *Prison Visitation Policies: A Fifty State Survey*, 32 YALE LAW & POLICY REVIEW: 149 (2013), *available at* http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1654&context=ylpr; Giovanna Shay, *Visiting Room: A Response to Prison Visitation Policies: A Fifty-State Survey*, 32 YALE LAW & POLICY REVIEW 191 (2013), *available at* http://digitalcommons.law.yale.edu/ylpr/vol32/iss1/6/; Ashbel T. Wall II, *Why Do They Do It That Way?: A Response to Prison Visitation Policies: A Fifty-State Survey*, 32 YALE LAW & POLICY REVIEW 199 (2013), *available at* http://digitalcommons.law.yale.edu/ylpr/vol32/iss1/7/; David Fathi, *An Endangered Necessity: A Response to Prison Visitation Policies: A Fifty-State Survey,* 32 YALE LAW & POLICY REVIEW 205 (2013), *available at* http://digitalcommons.law.yale.edu/ylpr/vol32/iss1/8/; Philip M. Genty, *Taking Stock and Moving Forward to Improve Prison Visitation Practices: A Response to Prison Visitation Policies: A Fifty-State Survey,* 32 YALE LAW & POLICY REVIEW 211 (2013), *available at* http://digitalcommons.law.yale.edu/ylpr/vol32/iss1/9/.

[2] See, e.g, The Ninth Circuit Corrections Summit, Sacramento, California, November 4–6, 2015; The Ninth Circuit Corrections Summit, Santa Ana, California, April 25–27, 2018, Santa Ana, California; Racial Disparities in Prisons: A Seminar (Yale Law School, 2017).

[3] HOPE METCALF, JAMELIA MORGAN, SAMUEL OLIKER-FRIEDLAND, JUDITH RESNIK, JULIA SPIEGEL, HARAN TAE, ALYSSA WORK, & BRIAN HOLBROOK, ADMINISTRATIVE SEGREGATION, DEGREES OF ISOLATION, AND INCARCERATION: A NATIONAL OVERVIEW OF STATE AND FEDERAL CORRECTIONAL POLICIES (June 2013), *available at* https://law.yale.edu/system/files/area/center/liman/document/Liman_overview_segregation_June_25_2013_TO_POST_FINAL(1).pdf [hereinafter ASCA-LIMAN ADMINISTRATIVE SEGREGATION NATIONAL OVERVIEW 2013].

[4] *Id.* at 5–11.

[5] *Id.* at 14–17.

[6] ASSOCIATION OF STATE CORRECTIONAL ADMINISTRATORS & ARTHUR LIMAN PUBLIC INTEREST PROGRAM AT YALE LAW SCHOOL, TIME-IN-CELL: THE ASCA-LIMAN 2014 NATIONAL SURVEY OF ADMINISTRATIVE SEGREGATION IN PRISON (Aug. 2015), *available at* https://law.yale.edu/system/files/documents/pdf/asca-liman_administrative_segregation_report_sep_2_2015.pdf [hereinafter ASCA-LIMAN ADMINISTRATIVE SEGREGATION 2014].

[7] *Id.* at 3.

[8] *Id*.

[9] U.S. DEPARTMENT OF JUSTICE, REPORT AND RECOMMENDATIONS CONCERNING THE USE OF RESTRICTIVE HOUSING (Jan. 2016), *available at* https://www.justice.gov/archives/dag/report-and-recommendations-concerning-use-restrictive-housing.

[10] Jess Bravin, *Large Number of Inmates in Solitary Poses Problem for Justice System, Study Says*, THE WALL STREET JOURNAL, Sept. 2, 2015, *available at* https://www.wsj.com/articles/large-number-of-inmates-in-solitary-poses-problem-for-justice-system-study-says-1441209772.

[11] Timothy Williams, *Prison Officials Join Movement to Curb Solitary Confinement*, THE NEW YORK TIMES, Sept. 2, 2015, *available at* https://www.nytimes.com/2015/09/03/us/prison-directors-group-calls-for-limiting-solitary-confinement.html.

[12] Kevin Johnson, *More than a Decade after Release, They All Come Back*, USA TODAY, Nov. 4, 2015, *available at* https://www.usatoday.com/story/news/nation/2015/11/04/solitary-confinement-prisoners-impact/73830286/.

Included in SCDC' 4.29.19 letter to LOC

---

[13] ASSOCIATION OF STATE CORRECTIONAL ADMINISTRATORS & ARTHUR LIMAN PUBLIC INTEREST PROGRAM AT YALE LAW SCHOOL, AIMING TO REDUCE TIME-IN-CELL: REPORTS FROM CORRECTIONAL SYSTEMS ON THE NUMBERS OF PRISONERS IN RESTRICTED HOUSING AND ON THE POTENTIAL OF POLICY CHANGES TO BRING ABOUT REFORMS (NOV. 2016), *available at* https://law.yale.edu/system/files/area/center/liman/document/aimingtoreducetic.pdf [hereinafter ASCA-LIMAN AIMING TO REDUCE TIME-IN-CELL 2016].

[14] *Id*. at 20.

[15] *Id.* at 28.

[16] *Id.* at 27–28.

[17] *Id.* at 55–60. In the 2016 report, 45 jurisdictions provided information about policies related to restrictive housing.

[18] *See, e.g.*, Anna Flag, Alex Tatusian, & Christie Thompson, *Who's in Solitary Confinement*, THE MARSHALL PROJECT, Nov. 2016, *available at* https://www.themarshallproject.org/2016/11/30/a-new-report-gives-the-most-detailed-breakdown-yet-of-how-isolation-is-used-in-u-s-prisons; Daniel Teehan, *What Chris Christie Got Wrong About Solitary Confinement*, THE MARSHALL PROJECT, Dec. 2016, *available at* https://www.themarshallproject.org/2016/12/14/what-chris-christie-got-wrong-about-solitary-confinement; Juleyka Lantigua-Williams, *More Prisons Are Phasing Out the 'Box,'* THE ATLANTIC, Dec. 2016, *available at* https://www.theatlantic.com/politics/archive/2016/12/more-prisons-are-phasing-out-the-box/509225/; Juleyka Lantigua-Williams, *The Link Between Race and Solitary Confinement,* THE ATLANTIC, Dec. 2016, *available at* https://www.theatlantic.com/politics/archive/2016/12/race-solitary-confinement/509456/; Cassandra Basler, *Yale Report Tries to Count People Held in Solitary Confinement*, WSHU, Dec. 2016, *available at* http://wshu.org/post/yale-report-tries-count-people-held-solitary-confinement#stream/0.

[19]ASCA-LIMAN AIMING TO REDUCE TIME-IN-CELL 2016, *supra* note 13, at 16.

[20] The 2017–2018 survey asked about "separating prisoners from the general population and holding them in their cells for an average of 22 or more hours per day for 15 or more continuous days." Under this definition, for example, a person in cell for 24 hours per day for four days, 21 hours per day for three days, 23 hours a day for five days, and 21-and-a-half hours a day for 8 days would be included as held in restrictive housing. The 2016 survey did not include "average" in its definition, and thus a jurisdiction may or may not have included such persons in their count of restrictive housing.

[21] AMERICAN CORRECTIONAL ASSOCIATION RESTRICTIVE HOUSING PERFORMANCE BASED STANDARDS AUGUST 2016, *available at* https://www.asca.net/pdfdocs/8.pdf [hereinafter ACA 2016 RESTRICTIVE HOUSING STANDARDS].

[22] The jails were the District of Columbia, Los Angeles County, New York City, and Philadelphia.

[23] Most jurisdictions provided initial data as of September 2017. Other jurisdictions responded using different initial dates. Minnesota Department of Corrections provided data as of July 2017. Colorado Department of Corrections, Pennsylvania Department of Corrections, and Texas Department of Corrections provided data as of August 2017. Georgia Department of Corrections, Indiana Department of Corrections, Mississippi Department of Corrections, New Hampshire Department of Corrections, New York Department of Corrections, North Carolina Department of Corrections, Rhode Island Department of Corrections, and Utah Department of Corrections provided data as of October 2017. New Mexico Department of Corrections provided data as of November 2017. Idaho Department of Corrections, Illinois Department of Corrections, and Michigan Department of Corrections provided data as of December 2017. Alaska Department of Corrections provided data as of February 2018. Los Angeles County Jail provided data as of March 2018.

---

[24] The jurisdictions that did not provide any responses were California, Florida, Maine, Vermont, Virginia, and the District of Columbia.

[25] The responding jails were Los Angeles County and Philadelphia.

[26] The data we gathered focused on the fall of 2017. National data on the baseline prison population comes from 2016 and became available in 2018, with revisions in April 2018. *See* E. Ann Carson, *Prisoners in 2016*, BUREAU OF JUSTICE STATISTICS 4, Tbl.2 (Jan. 2018), https://www.bjs.gov/content/pub/pdf/p16.pdf [hereinafter BJS *Prisoners in 2016*].

[27] Other organizations have done site visits or worked with jurisdictions to evaluate their policies. *See e.g.,* LEON DIGARD, ELENA VANKO & SARA SULLIVAN, RETHINKING RESTRICTIVE HOUSING: LESSONS FROM FIVE U.S. JAILS AND PRISON SYSTEMS, VERA INSTITUTE OF JUSTICE (May 2018), *available at* https://www.vera.org/rethinking-restrictive-housing [hereinafter VERA RETHINKING RESTRICTIVE HOUSING 2018]. *See also* Vera Institute of Justice, Reducing Segregation, https://www.vera.org/projects/reducing-segregation.

[28] Zhen Zeng, *Jail Inmates in 2016*, BUREAU OF JUSTICE STATISTICS 1 (Feb. 2018), https://www.bjs.gov/content/pub/pdf/ji16.pdf [hereinafter BJS *Jail Inmates in 2016*].

[29] The full survey is set forth in Appendix A. A few jurisdictions, noted in Table 1, responded that their information was based on a definition different from that of the survey.

[30] Of the 46 jurisdictions that responded, three states (Minnesota, New Hampshire, and West Virginia) did not provide data on the number of prisoners in restrictive housing.

[31] This total custodial population comes from requests for information about prisoners held under the direct control of the jurisdictions. The survey defined direct control as "your jurisdiction hires and supervises staff (even if some are through subcontracts, such as health care services) and provides the governing rules and policies."

A few jurisdictions raised questions about the definition of direct control. Three jurisdictions commented either about the definition or that their answers included individuals held by the jurisdiction but in facilities whose personnel were not hired by the jurisdiction. For example, Ohio noted that it did "not differentiate" its "custodial population" based on whether or not it hired the staff, as the prisoners were "under our direct control whether or not they are in a private prison, or whether or not the staff are state employees." Rather, Ohio was "responsible for" all prisoners incarcerated in Ohio, and it reported data on all of them, whether in private facilities or not. Similarly, Idaho replied that its restrictive housing numbers included prisoners at "private prisons and contract facilities," which was to say its "whole population," not only those under its "direct control."

Almost all jurisdictions reported that some prisoners are housed not under their control—in local jails or out of state under the Interstate Compact Agreement—but states that have a substantial number (more than 10%) not housed under their direct control are listed in the endnotes to Table 1. The 43 responding jurisdictions reported a total of 111,094 (10%) of prisoners sentenced by their jurisdictions but not under the direct control of each state's correctional system.

[32] BJS *Prisoners in 2016*, *supra* note 26, at 4, Tbl.2.

[33] We calculate this estimate by dividing the number of people in restrictive housing based on the survey responses (49,197) by the percentage of the U.S. prison population that the responding jurisdictions represented according to the BJS data (80.6%). However, as noted above, this may be an undercount because some jurisdictions provided restrictive housing data for fewer people than their entire custodial population. That is, the population over which the systems had direct control and for which they had restrictive housing data, which is the total custodial population we used, may not have represented the entire custodial population. To mitigate this issue, another estimation method could be

used. The second method would apply the overall percentage of people in restrictive housing (4.5%) to the number of people in prisons, according to BJS statistics, in the jurisdictions that did not respond to the survey, and then add that figure to the number of individuals in restrictive housing in the responding jurisdictions. This method results in a total of almost 62,400 people in restrictive housing across the country. The different methods of estimation result in numbers that are relatively similar.

[34] The jurisdiction at the lowest part of that range was Colorado, and the jurisdiction at the highest was Louisiana. Louisiana reported taking "numerous steps over the last year to address the use of restrictive housing." Louisiana reported that these "efforts have led to a decrease in the number of restrictive housing beds by 1,168."

Louisiana joined with the Vera Institute of Justice in the Safe Alternatives to Segregation initiative. Louisiana reported that doing so entailed evaluating what was driving placements and the amounts of time spent in isolation. The state then wrote new restrictive housing regulations, which were "being piloted at a couple of institutions with positive results." Louisiana described the most significant changes as "using terminology consistent with the Department of Justice," and using "a disciplinary matrix that specifies definitive sanctions" including the time that will be spent in segregation and the violations that will lead to isolation. Louisiana stated that these reforms "will lead to" fewer prisoners "being placed in RH and for shorter durations."

Louisiana also described implementing "a pilot at Elayn Hunt Correctional Center totally eliminating the use of restrictive housing." Louisiana explained that the facility was "allowing all offenders greater than two hours out of cell time per day. The time spent out of cell is a combination of recreational, educational, and treatment driven." In addition Louisiana reported that on February 11, 2018, it closed "Camp J," which "previously served as a disciplinary camp located at Louisiana State Penitentiary." This closure eliminated "416 RH beds. The facility that once housed the inmates with the most significant disciplinary history is being evaluated to be re-purposed into an assisted living / medical housing area." Louisiana also stated that it had put into place "a pilot at Louisiana State Penitentiary allowing inmates on Death Row to be out of cell for greater than 2 hours per day (70 beds)." This program "allows all offenders the opportunity to be out of their cells for at least 4 hours per day. They are allowed congregate for recreational activities and are afforded treatment programs such as Thinking for a Change."

[35] For some jurisdictions unable to clarify which definition they used, when constructing Figure 1, Figure 2, and Table 1, we used their responses to the question about length of time in restrictive housing, which provided again the 15–29 day definition. These jurisdictions were Arizona, Kansas, Maryland, Michigan, Montana, and Utah. Maryland's figure came from an aggregate number provided in response to the question about length of time in restrictive housing. Maryland was unable to provide numbers by periods of time, so we used only the aggregate number. The jurisdictions that are marked with an asterisk did not provide responses to the question about length of time in restrictive housing.

[36] The column "Total Custodial Population" presents jurisdictions' answers to the question about the total custodial population under the jurisdiction's direct control. In addition, below we note variations coming from responses from specific jurisdictions.

Alabama reported that it housed an additional 5,258 prisoners in local jails and "Community Corrections" facilities over which it did not have direct control; these prisoners were not included in the data on total custodial population or the population in restrictive housing.

Alaska's data were as of February 2018 rather than the fall of 2017.

Arizona reported that it housed an additional 8,740 prisoners in facilities over which it did not have direct control; these prisoners were not included in the data on total custodial population or the population in restrictive housing.

Included in SCDC' 4.29.19 letter to LOC

Arkansas reported that it housed an additional 2,245 prisoners in facilities over which it did not have direct control; these prisoners were not included in the data on total custodial population or the population in restrictive housing.

Delaware's reported total custodial population of 4,333 came from its answer to the questions about the number of people in its total custodial population by age and by race. In answer to the general question about its total custodial population, Delaware counted 5,556 people, which included non-sentenced individuals. Because Delaware did not report restrictive housing data for non-sentenced individuals, we used the 4,333 number, which excluded that population. Because Delaware is a unified system with direct control over its jail system, the total custodial population included jail data for sentenced individuals.

The Federal Bureau of Prisons reported that it housed an additional 18,941 prisoners in private facilities over which it did not have direct control; these prisoners were not included in the data on total custodial population or the population in restrictive housing.

Georgia's figure was taken from a question regarding the gender and age of the total custodial population. Georgia reported that it housed an additional 7,862 prisoners in private facilities and 4,550 in local jails over which it did not have direct control; these prisoners were not included in the data on total custodial population or the population in restrictive housing.

As of the fall of 2017, Hawaii reported placing 1,617 inmates at Saguaro Detention Center, a private prison in Arizona, over which it did not have direct control; these prisoners were not included in the data on total custodial population or the population in restrictive housing. Further, Hawaii noted that it collected data on restrictive housing totals for only part of its restrictive housing population: "We collect data for Admin Segregation and not disciplinary segregation or protective custody housing." Hawaii is a unified system with direct control over its jail system; the totals therefore included jail data.

Idaho's figure was taken from an answer to a question regarding the gender and age of the total custodial population.

Kentucky reported that it housed an additional 11,556 prisoners in county jails over which it did not have direct control; these prisoners were not included in the data on total custodial population or the population in restrictive housing.

Louisiana reported housing an additional 20,122 prisoners in county jails over which it did not have direct control; these prisoners were not included in the data on total custodial population or the population in restrictive housing. Louisiana noted that it was unable to provide restrictive housing data for female inmates due to a "2016 flood that impacted our women's facility," resulting in the women being "displaced to multiple locations."

Montana reported housing an additional 922 prisoners in facilities over which it did not have direct control; these prisoners were not included in the data on total custodial population or the population in restrictive housing.

Nebraska's figure was taken from a question regarding the gender and age of the total custodial population.

New Jersey reported housing an additional 2,660 prisoners in facilities over which it did not have direct control; these prisoners were not included in the data on total custodial population or the population in restrictive housing.

Ohio's total custodial population figure was from Sept. 21, 2017, and its restrictive housing data was from Sept. 14, 2017.

Rhode Island is a unified system with direct control over its jail system; the totals therefore included jail data.

Tennessee reported housing an additional 8,277 prisoners in county jails over which it did not have direct control; these prisoners were not included in the data on total custodial population or the population in restrictive housing. Tennessee's count of its total custodial population and its restrictive housing population included people in private prisons.

Utah reported housing an additional 1,346 "county jail inmates," four prisoners at Utah State Hospital, an additional five prisoners in "Hospital," and one prisoner in "Youth Corrections," as individuals in facilities over which it did not have direct control. These prisoners are not included in the data on total custodial population or the population in restrictive housing.

Washington noted it defined "short term" as 47 days or less. This definition did not affect the reports on the total restrictive housing population. Washington also reported that "up to 75 female offenders may be housed in county jail" over which it does not have direct control. These prisoners were not included in the data on the total custodial population or the data on restrictive housing.

Wyoming reported that it housed an additional 244 prisoners in facilities over which it did not have direct control; these prisoners were not included in the data on total custodial population or the population in restrictive housing.

[37] The column "Population in Restrictive Housing" presents jurisdictions' answers to a question about the total number of people in short-term and extended (more than 29 days) restrictive housing, with the exceptions noted at Figure 1. Additional notes for specific states follow.

Alaska's data were as of February 2018 rather than fall 2017. Alaska noted that "reported data was compiled from 12 facilities with somewhat different recording systems in place. While we do have a common electronic database, not all of the requested information was inputted or available. Unfortunately, some facilities were not able to provide numbers in all areas," which resulted in different sums for different questions. The number of prisoners reported to be in RH varied from 256 for the length-of stay question to 287 for the short-term and long-term restrictive housing question to 378 for the gender and age question.

Delaware is a unified system with direct control over its jail system; the totals here therefore include jail data.

Iowa noted that "restrictive housing for us means that an offender is held in their cell for at least 23 hours." This is higher than the standard definition of 22 or more hours. Kentucky similarly reported that all prisoners in restrictive housing were "housed in for 23 hours per day."

Montana's figure was taken from the question on length of stay.

Nevada's figure was taken from a question regarding the gender and age of the restrictive housing population.

New Mexico's figure was taken from a comment related to the question on length of time in restrictive housing. New Mexico noted that "we don't define short-term and long-term. The longest you can be in disciplinary RHU is 30 days. We have a long-term RHU program that is a step down program. That is a one year program but time can be enhanced for assaulting staff or returning to the program as a habitual. We do have inmates in RHU for periods of time less than 30 days."

[38] Of the 46 responding jurisdictions, Indiana did not respond to this question.

[39] Six jurisdictions did not provide data on length of time in restrictive housing for this report despite stating that they regularly collect it. These jurisdictions were Arkansas, Connecticut, Nevada, New Hampshire, New Mexico, and West Virginia.

[40] The jurisdictions that reported not regularly collecting data on length of time in restrictive housing were Arizona, Georgia, Idaho, Louisiana, Michigan, Minnesota, Ohio, and Wisconsin. Arizona explained, "Data regarding length of stay in restrictive housing is managed through our Adult Information Management System (AIMS). Data is utilized as needed to develop reports on an individual basis."

[41] The five jurisdictions that reported not regularly collecting data on length of time in restrictive housing but that provided data on length of time for this report were Arizona, Louisiana, Michigan, Ohio, and Wisconsin.

[42] For example, a prisoner held for three years could be counted as having been in restrictive housing for only one year if the jurisdiction has kept data for one year and did not include information on years before data collection began. Of the 30 jurisdictions responding, 18 reported starting to collect data in 2014 or later, including four jurisdictions in 2017 and four in 2016.

[43] Some jurisdictions responding to the question about length of time in restrictive housing filled in a number for certain time periods and left other time periods blank. Some jurisdictions filled in zeros rather than leaving blanks. For this table, we filled in zeros for all time periods left blank as long as the jurisdiction had filled in numbers for some time periods.

When counting the numbers of prisoners in restrictive housing for various lengths of time, the following caveats apply. Alaska reported 378 people in restrictive housing and 256 people in restrictive housing by length of time. When responding to the question about length of stay, Alaska noted, "The numbers are the best estimate as the tracking is informal and not broken down in these quantities. Each facility maintains a separate roster for holding hearings. The required review and hearing for prisoners is: initial review is 24 hours from placement in segregation. The prisoner can be released at that time, the second review is 36 hours, and then every 30 days. Generally though a prisoner can be reviewed and released at any time the unit management team determines the prisoner can be released from segregation." Hawaii reported 13 people in restrictive housing and 32 people in restrictive housing by length of time. Further, Hawaii noted that it collected data on restrictive housing totals for only part of its restrictive housing population: "We collect data for Admin Segregation and not disciplinary segregation or protective custody housing." Illinois reported 921 people in restrictive housing and 1,098 people in restrictive housing by length of time. Kentucky reported 408 people in restrictive housing and 861 people in restrictive housing by length of time. Louisiana reported 2,709 people in restrictive housing and 2,719 people in restrictive housing by length of time. Massachusetts reported 443 people in restrictive housing and 312 people in restrictive housing by length of time. Missouri reported 2,990 people in restrictive housing and 2,510 people in restrictive housing by length of time. Nebraska reported 328 people in restrictive housing and 332 people in restrictive housing by length of time. North Dakota reported eight people in restrictive housing and nine people in restrictive housing by length of time. Oregon reported 938 people in restrictive housing and 638 people in restrictive housing by length of time.

Michigan noted that its length of stay data "reflects the number of days a prisoner spent in his/her current cell and does not account for the number of days in restrictive housing prior to placement in their current cell."

Washington reported, "Short term duration for us is 47 days. The numbers provided for the survey in regards to short term were 47 days or less."

[44] The numbers for Illinois were calculated by subtracting the numbers of people in protective custody by length of time from the total numbers of people reported to be in restrictive housing by length of time. Illinois reported that prisoners identified as being in protective custody "are job assignments such as barber, clerk, maintenance, etc., and are not in RH." The number of prisoners reported to be in protective custody was 601.

[45] The high end of the range was Louisiana. The low end of the range was Colorado.

[46] When counting the number of men in the total custodial population, the following caveats apply. Kansas reported 9,886 prisoners in the total custodial population and 9,896 prisoners by gender. Kentucky reported 12,000 prisoners in the total custodial population and 23,566 prisoners by gender. This discrepancy is accounted for by Kentucky's inclusion of its 11,566 person jail population in the calculations by gender. Louisiana reported 14,291 prisoners in the total custodial population and 34,987 prisoners by gender. This discrepancy is partially accounted for by Louisiana's inclusion of its 20,122 person jail population in the calculations by gender. Nevada reported 13,718 prisoners in the total custodial population and 13,714 prisoners by gender.

Connecticut reported 328 prisoners in the restrictive housing population and 406 prisoners in the restrictive housing population by gender. Connecticut's reported overall number of people in restrictive housing came from data as of September 2017 while the reported number of people in restrictive housing by gender came from data as of April 2018. Illinois reported 921 prisoners in the restrictive housing population and 1,560 prisoners in the restrictive housing population by gender. This discrepancy may be a result of counting people in isolation from one to 14 days. Indiana reported 1,741 prisoners in the restrictive housing population and 1,971 prisoners in the restrictive housing population by gender. This discrepancy may be a result of counting people in isolation from one to 14 days. Kentucky reported 408 prisoners in the restrictive housing population and 1,015 prisoners in the restrictive housing population by gender. Maryland reported 1,417 prisoners in the restrictive housing population and 1,567 prisoners in the restrictive housing population by gender. Nebraska reported 328 prisoners in the restrictive housing population and 397 prisoners in the restrictive housing population by gender. New Jersey reported 1,011 prisoners in the restrictive housing population and 1,173 prisoners in the restrictive housing population by gender. New Mexico reported 550 prisoners in the restrictive housing population and 294 prisoners in the restrictive housing population by gender. North Dakota reported eight prisoners in the restrictive housing population and nine prisoners in the restrictive housing population by gender. Oregon reported 938 prisoners in the restrictive housing population and 1,031 prisoners in the restrictive housing population by gender. The 938 number came from a population snapshot as of September 2017. The 1,031 number came from a population snapshot in December 2017 after a follow-up. Tennessee reported 1,181 prisoners in the restrictive housing population and 555 prisoners in the restrictive housing population by gender. The 1,181 number came from data as of October 2017. The 555 number came from data as of January 2018. Tennessee did not provide data for the restrictive housing population by gender for the 1,181 number. Texas reported 4,272 prisoners in the restrictive housing population and 4,269 prisoners in the restrictive housing population by gender. Utah reported 296 prisoners in the restrictive housing population and 282 prisoners in the restrictive housing population by gender. Washington reported 387 prisoners in the restrictive housing population and 409 prisoners in the restrictive housing population by gender. Wyoming reported 81 prisoners in the restrictive housing population and 85 prisoners in the restrictive housing population by gender.

Oregon explained that restrictive housing data based on length of stay and by type of restrictive housing was to be provided quarterly from a reporting tool that it was building with the help of the Vera Institute, while other data were a one-day snapshot.

In response to a later inquiry, Missouri wrote: "Missouri doesn't define segregation the same as the survey defines restrictive housing. When the initial survey was submitted, each facility had to review their offenders assigned to segregation to determine if they met the definition of restrictive housing for the survey. This was a cumbersome task. There is no way to go back now and provide the demographics of the offenders identified in the original survey."

[47] The high end of the range (4.6% of the female custodial population, or 59 out of 1,280 female prisoners) was in Nevada; Colorado, Delaware, North Dakota, and Rhode Island housed no women in restrictive housing.

[48] When counting the number of women in the total custodial population, the same caveats as listed in note 47, *supra*, about data on men apply. In addition, as mentioned earlier, Louisiana noted in a follow-up email that it was unable to provide restrictive housing data for female prisoners.

Included in SCDC' 4.29.19 letter to LOC

[49] Most jurisdictions were able to report data in each of these categories, but some jurisdictions used different race and ethnicity categories that did not match the categories that we provided. For example, Connecticut and Illinois did not use the racial category Native Hawaiian/Pacific Islander, and Kentucky uses the category Asian/Pacific Islander, instead of Native Hawaiian/Pacific Islander and Asian as separate categories. Where these varying definitions created challenges in understanding the data reported, we followed up with the jurisdictions and have reported definitional differences in the relevant sections of the report.

[50] We reported based on correctional systems' methods for categorizing prisoners into racial and ethnic groups. Twenty-four correctional systems identified race and ethnicity based on prisoners' self-identification. Seventeen jurisdictions identified race and ethnicity based on a combination of self-report, court documentation, and police documentation. Alabama explained that "race is certified to us on a sentencing transcript, which comes from the circuit clerk's office of the sentencing county." Arizona stated that identification was "based on self-reporting and/or court documents." Arkansas reported using "the Inmate's Judgment & Commitment Order." Delaware reported that race and ethnicity was "imported/received as part of individual's electronic file received from Court" and that it could "be manually updated." The Federal Bureau of Prisons stated, "this information comes to the BOP from the Pre-Sentence Investigation report," and that it "is believed to be self-report in most instances." Kansas reported that race and ethnicity is "self selected," and that while "Hispanic ethnicity is recorded in addition to self selected race, for purposes of this survey those identifying as Hispanic ethnicity have been separated from their self selected race." Los Angeles responded it relied on "self identification and law enforcement records." Louisiana related using "LA State Police criminal records and birth certificate." Minnesota reported using "self reports and/or from court/arrest documents." Mississippi reported it relied on "court documents and/or NCIC [National Crime Information Center]." Missouri stated it utilized "the race captured in their criminal history." Montana responded that it followed "the NCIC standards for race reporting." Nevada stated that the information was "mostly, self reported or available from the pre-sentence investigation report." New Jersey said it used "an inmate's pre-sentencing information which provides nationality and race information in conjunction with self reporting during the classification process upon an inmate's transfer to the department." Oregon stated it relied on information from "LEDS [Law Enforcement Data System] or self report." Tennessee reported, "as offenders enter the diagnostic centers, we use the Judgment Orders from the courts, NCIC data, government issued identification, and self reporting." Utah stated, "staff are obtaining the information from our Bureau of Criminal Identification (BCI)."

Three jurisdictions reported specific policies on Hispanic ethnicity. Colorado stated, "ethnicity information is forwarded from Colorado Judicial and sent to us electronically along with mittimus information," and that "DOC determines which prisoners are included in the Hispanic demographic during the Intake process." New York related:

> An inmate's self-reported race and ethnicity are both examined to determine into which racial/ethnic category he or she should be placed. An inmate is first categorized as white, black, other (this category includes Asian, Native American, and Other) or unknown based on self-reported race. Then, the inmate's ethnicity is determined; if the inmate's self-reported ethnicity is Hispanic, he or she is included in the "Hispanic" category. Next, the inmate's place of birth is examined; if he or she is born in a Spanish-speaking country or Puerto Rico, he or she is included in the "Hispanic" category, regardless of the inmate's self-reported ethnicity. Finally, the inmate's mother's place of birth and father's place of birth are examined; if either parent was born in a Spanish-speaking country or Puerto Rico, he or she is included in the "Hispanic" category, regardless of the inmate's self-reported ethnicity. So, an inmate's Hispanic ethnicity (as determined by inmate self-report, place of birth, or parental place of birth) is the overriding factor in determining race/ethnicity on the ETHNIC2 variable. The one exception to this is if the inmate's self-reported race is Asian; if so, he or she is included in the "Other" category, and not in the "Hispanic" category.

Washington responded that it used "offender self report," and that "race is self-identified separately from Hispanic origin. Ethnicity is self-identified separately from Race or Hispanic origin and relates to subpopulations such as specific Asian country of familial origin or Tribal affiliation."

Included in SCDC' 4.29.19 letter to LOC

Iowa did not clarify how identifications were made, stating, "by race or ethnicity." Texas made identifications based on physical appearance: "Race is determined by physical appearance, not ethnicity or offender preference." New Hampshire and West Virginia and did not provide answers.

[51] Alabama reported that "Other" included people "other than Black, White, and Indian. Hispanics are grouped as Caucasian, and Asians are Grouped in 'Other.'"

[52] Iowa reported that "Native Hawaiian or Pacific Islander" prisoners were counted under "Asian."

[53] When counting the number of men in the total custodial population, the following caveats apply. Kansas reported 9,886 prisoners in the total custodial population and 9,896 prisoners by race. Kentucky reported 12,000 prisoners in the total custodial population and 23,604 prisoners by race. This discrepancy is partially accounted for by Kentucky's inclusion of its 11,566 person jail population in the calculations by race. Louisiana reported 14,291 prisoners in the total custodial population and 34,987 prisoners by race. This discrepancy is partially accounted for by Louisiana's inclusion of its 20,122 person jail population in the calculations by race. Nevada reported 13,718 prisoners in the total custodial population and 13,714 prisoners by race. New Mexico reported 7,047 prisoners in the total custodial population and 7,037 prisoners by race. Washington reported 17,046 prisoners in the total custodial population and 17,076 prisoners by race. Wisconsin reported 22,589 prisoners in the total custodial population and 22,579 prisoners by race.

In addition, Alabama reported 21,592 prisoners in the total custodial population and the same number by race. However, Alabama reported 20,282 men in the total custodial population, and 20,268 men by race. Alabama reported 1,310 women in the total custodial population, and 1,324 women by race.

Connecticut reported 328 prisoners in the restrictive housing population and 74 prisoners in the restrictive housing population by race. Illinois reported 921 prisoners in the restrictive housing population and 1,560 prisoners in the restrictive housing population by race. This discrepancy may be a result of counting people in isolation from one to 14 days. Indiana reported 1,741 prisoners in the restrictive housing population and 1,971 prisoners in the restrictive housing population by race. This discrepancy may be a result of counting people in isolation from one to 14 days. Kentucky reported 408 prisoners in the restrictive housing population and 1,015 prisoners in the restrictive housing population by race. Maryland reported 1,417 prisoners in the restrictive housing population and 1,544 prisoners in the restrictive housing population by race. Nebraska reported 328 prisoners in the restrictive housing population and 397 prisoners in the restrictive housing population by race. New Jersey reported 1,011 prisoners in the restrictive housing population and 1,173 prisoners in the restrictive housing population by race. New Mexico reported 550 prisoners in the restrictive housing population and 294 prisoners in the restrictive housing population by race. North Dakota reported eight prisoners in the restrictive housing population and nine prisoners in the restrictive housing population by race. Oregon reported 938 prisoners in the restrictive housing population and 1,031 prisoners in the restrictive housing population by race. The 938 number came from a population snapshot as of September 2017. The 1,031 number came from a population snapshot in December 2017 after a follow-up. Tennessee reported 1,181 prisoners in the restrictive housing population and 555 prisoners in the restrictive housing population by race. The 1,181 number came from data as of October 2017. The 555 number came from data as of January 2018. Tennessee did not provide data for the restrictive housing population by race for the 1,181 number. Texas reported 4,272 prisoners in the restrictive housing population and 4,269 prisoners in the restrictive housing population by race. Utah reported 296 prisoners in the restrictive housing population and 282 prisoners in the restrictive housing population by race. Washington reported 387 prisoners in the restrictive housing population and 409 prisoners in the restrictive housing population by race.

As mentioned earlier, Oregon explained that restricted housing data based on length of stay and by type of restrictive housing was to be provided quarterly from a reporting tool that it was building with the help of the Vera Institute, while other data were a one-day snapshot.

Throughout this report, Iowa's definition of Asian includes Native Hawaiian/Pacific Islander.

[54] As previously mentioned, Alabama reported that "Other" included people "other than Black, White, and Indian. Hispanics are grouped as Caucasian, and Asians are Grouped in 'Other'."

[55] When counting the number of women in the total custodial population, the same caveats as listed in note 54, *supra*, with regards to men apply. In addition, as mentioned, Louisiana noted in a follow-up email that it was unable to provide restrictive housing data for female prisoners.

[56] ACA Standard 4-RH-0034, ACA 2016 RESTRICTIVE HOUSING STANDARD, *supra* note 21, at 39.

[57] Alaska, Louisiana, Maryland, and North Carolina were the jurisdictions reporting juveniles in restrictive housing.

[58] Some jurisdictions responding to the questions about prisoners' ages filled in a number for certain age ranges and left other age ranges blank. Some jurisdictions filled in zeros rather than leaving blanks. For the tables relating to age, we filled in zeros for all age ranges left blank as long as the jurisdiction had filled in numbers for some age ranges.

When counting the number of men in the total custodial population, the following caveats apply. Kansas reported 9,886 prisoners in the total custodial population and 9,896 prisoners by age. Kentucky reported 12,000 prisoners in the total custodial population and 23,566 prisoners by age. This discrepancy is accounted for by Kentucky's inclusion of its 11,566 person jail population in the calculations by age. Louisiana reported 14,291 prisoners in the total custodial population and 34,987 prisoners by age. This discrepancy is partially accounted for by Louisiana's inclusion of its 20,122 person jail population in the calculations by age. Nevada reported 13,718 prisoners in the total custodial population and 13,714 prisoners by age. New York reported 50,764 prisoners in the total custodial population and 50,767 prisoners by age.

Connecticut reported 328 prisoners in the restrictive housing population and 406 prisoners in the restrictive housing population by age. Connecticut's reported overall number of people in restrictive housing came from data as of September 2017 while the reported number of people in restrictive housing by age came from data as of April 2018. Illinois reported 921 prisoners in the restrictive housing population and 1,560 prisoners in the restrictive housing population by age. This discrepancy may be a result of counting people in isolation from one to 14 days. Indiana reported 1,741 prisoners in the restrictive housing population and 1,971 prisoners in the restrictive housing population by age. This discrepancy may be a result of counting people in isolation from one to 14 days. Kentucky reported 408 prisoners in the restrictive housing population and 1,015 prisoners in the restrictive housing population by age. Maryland reported 1,417 prisoners in the restrictive housing population and 1,557 prisoners in the restrictive housing population by age. Nebraska reported 328 prisoners in the restrictive housing population and 397 prisoners in the restrictive housing population by age. New Jersey reported 1,011 prisoners in the restrictive housing population and 1,173 prisoners in the restrictive housing population by age. New Mexico reported 550 prisoners in the restrictive housing population and 294 prisoners in the restrictive housing population by age. North Dakota reported eight prisoners in the restrictive housing population and nine prisoners in the restrictive housing population by age. Oregon reported 938 prisoners in the restrictive housing population and 1,031 prisoners in the restrictive housing population by age. The 938 number came from a population snapshot as of September 2017. The 1,031 number came from a population snapshot in December 2017 after a follow-up. Tennessee reported 1,181 prisoners in the restrictive housing population and 555 prisoners in the restrictive housing population by age. The 1,181 number came from data as of October 2017. The 555 number came from data as of January 2018. Tennessee did not provide data for the restrictive housing population by age for the 1,181 number. Texas reported 4,272 prisoners in the restrictive housing population and 4,269 prisoners in the restrictive housing population by age. Utah reported 296 prisoners in the restrictive housing population and 282 prisoners in the restrictive housing population by age. Washington reported 387 prisoners in the restrictive housing population and 409 prisoners in the restrictive housing population by age. Wyoming reported 81 prisoners in the restrictive housing population and 85 prisoners in the restrictive housing population by age.

In addition, Wisconsin reported 713 prisoners in the restrictive housing population and the same number by age. However, Wisconsin reported 661 men in the restrictive housing population and 632 men by age. Wisconsin reported 52 women in the restrictive housing population and 81 women by age.

As previously mentioned, Oregon explained that restrictive housing data based on length of stay and by type of restrictive housing was to be provided quarterly from a reporting tool that it was building with the help of the Vera Institute, while other data were a one-day snapshot.

Washington originally reported 2,844 men ages 50+ and 182 women ages 50+. These were the same numbers as were reported for men ages 36–50 and women ages 36–50. Washington later explained that the numbers were inadvertently repeated and that the correct totals excluded the repeated numbers. We included 2,844 under the column for men ages 36–50 and 182 under the column for women ages 36–50. However, these numbers may include men and women ages 36–50 and older than 50.

[59] When counting the number of women in the total custodial population, the same caveats as listed in note 59, *supra*, with regards to men apply. As mentioned earlier, Louisiana noted in a follow-up email that it was unable to provide restrictive housing data for female prisoners.

[60] According to a 2017 report by the Bureau of Justice Statistics, 37% of prisoners were told in the past by a mental health professional that they had a "mental disorder," and 14% of state and federal prisoners "reported experiences that met the threshold for serious psychological distress" within 30 days prior to a survey in 2011 and 2012. Jennifer Bronson & Marcus Berzofksy, Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011–12, NCJ 250612 1 (June 2017), *available at* https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf.

[61] ACA Standard 4-RH-0010, ACA 2016 RESTRICTIVE HOUSING STANDARDS, *supra* note 21, at 15.

[62] *Id*.

[63] *Id*.

[64] *Id*.

[65] ACA Standard 4-RH-0011, ACA 2016 RESTRICTIVE HOUSING STANDARDS, *supra* note 21, at 16.

[66] *Id*.

[67] *Id*.

[68] *Id*.

[69] ACA Standard 4-RH-0029, ACA 2016 RESTRICTIVE HOUSING STANDARDS, *supra* note 21, at 34.

[70] *Id*.

[71] ACA Standard 4-RH-0031, ACA 2016 RESTRICTIVE HOUSING STANDARDS, *supra* note 21, at 35; *Id*. at 3.

[72] *Id*.

[73] Some jurisdictions answered the question, "Please provide data on how many prisoners are classified as seriously mentally ill in your jurisdiction's general population." The question was later clarified to read: "Please provide data on how many prisoners are classified as seriously mentally ill in your total custodial population." Total custodial population means all individuals housed in general population, restrictive housing, or any other units within the correctional department. General population is sometimes used interchangeably with total custodial population, but

refers to a subset of the total custodial population, usually those who are not in restrictive or other specialized housing units. Where there was ambiguity in which definition of general population a jurisdiction was using, we followed up to clarify.

[74] The Federal Bureau of Prisons reported that it does not track numbers on prisoners with serious mental illness. South Carolina explained that it did not have data to provide on seriously mentally ill prisoners because it had recently implemented a special tracking system:

> The South Carolina Department of Correction (SCDC) implemented a special indicator the latter part of 2017, to easily identify prisoners who are seriously mentally ill. Due to how recently this indicator was added to our system, there has not been sufficient time to review the entire mental health caseload to determine which prisoners should be identified as seriously mentally ill. Any numbers reported would not be an accurate representation/reflection of our Seriously Mentally Ill population.

[75] *See* Appendix C: Definitions of "Serious Mental Illness" in 43 Jurisdictions.

[76] Mississippi Definition of Serious Mental Illness, Appendix C.

[77] Nebraska Definition of Serious Mental Illness, Appendix C.

[78] *See, e.g.*, New York Definition of Serious Mental Illness ("New York State DOCCS Definition of Serious Mental Illness (Section 137 Correction Law) (e) An inmate has a serious mental illness when he or she has been determined by a mental health clinician to meet at least one of the following criteria: (i) he or she has a current diagnosis of, or is diagnosed at the initial or any subsequent assessment conducted during the inmate's segregated confinement with, one or more of the following types of Axis I diagnoses, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, and such diagnoses shall be made based upon all relevant clinical factors, including but not limited to symptoms related to such diagnoses: (A) schizophrenia (all sub-types), (B) delusional disorder, (C) schizophreniform disorder, (D) schizoaffective disorder, (E) brief psychotic disorder, (F) substance-induced psychotic disorder (excluding intoxication and withdrawal), (G) psychotic disorder not otherwise specified, (H) major depressive disorders, or (I) bipolar disorder I and II; (ii) he or she is actively suicidal or has engaged in a recent, serious suicide attempt; (iii) he or she has been diagnosed with a mental condition that is frequently characterized by breaks with reality, or perceptions of reality, that lead the individual to experience significant functional impairment involving acts of self-harm or other behavior that have a seriously adverse effect on life or on mental or physical health; (iv) he or she has been diagnosed with an organic brain syndrome that results in a significant functional impairment involving acts of self-harm or other behavior that have a seriously adverse effect on life or on mental or physical health; (v) he or she has been diagnosed with a severe personality disorder that is manifested by frequent episodes of psychosis or depression, and results in a significant functional impairment involving acts of self-harm or other behavior that have a seriously adverse effect on life or on mental or physical health; or (vi) he or she has been determined by a mental health clinician to have otherwise substantially deteriorated mentally or emotionally while confined in segregated confinement and is experiencing significant functional impairment indicating a diagnosis of serious mental illness and involving acts of self-harm or other behavior that have a serious adverse effect on life or on mental or physical health.").

[79] Tennessee reported 505 prisoners with serious mental illness in its total custodial population. This number is not included in Tables 15, 16, 17 or 18 because it is not known how many of the 505 prisoners are female and how many are male.

[80] Texas stated that it did "not define 'serious mental illness.'" Its numbers in Table 15 and Table 16 reflect prisoners who were "on an inpatient mental health caseload."

Included in SCDC' 4.29.19 letter to LOC

[81] ACA Standard 4-RH-0033, ACA 2016 RESTRICTIVE HOUSING STANDARDS, *supra* note 21, at 38.

[82] These jurisdictions were Arkansas, Montana, and North Dakota.

[83] The other 38 jurisdictions were Alabama, Alaska, Arizona, Colorado, Connecticut, Delaware, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, Wisconsin, and Wyoming.

[84] ACA Standard 4-RH-0035, ACA 2016 RESTRICTIVE HOUSING STANDARDS, *supra* note 21, at 40. The National Standards under the Prison Rape Elimination Act (PREA) also call for careful attention to the needs and safety of transgender individuals, defined as "a person whose gender identity (i.e., internal sense of feeling male or female) is different from the person's assigned sex at birth." NATIONAL STANDARDS TO PREVENT, DETECT, AND RESPOND TO PRISON RAPE UNDER THE PRISON RAPE ELIMINATION ACT (PREA) 28 C.F.R. § 115.5 (2012); *see generally* 28 C.F.R. §§ 115.15, 115.31, 115.41, 115.42, 115.86.

[85] Those jurisdictions were Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, the Federal Bureau of Prisons, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, Wisconsin, and Wyoming.

[86] These jurisdictions were Hawaii (responding "N/A"), Indiana ("not tracked"), Rhode Island ("RIDOC does not maintain these statistics electronically—only on a case by case basis and maintained in the inmates medical record"), and Utah ("We do not track transgender inmates").

[87] That jurisdiction was North Dakota.

[88] Four jurisdictions did not provide information beyond the definition they used for transgender: Kansas, Minnesota, Nebraska, and Utah. Twenty-one jurisdictions reported that prisoners self-report whether they are transgender: Alaska, Arizona, Colorado, Delaware (may self-identify at intake), the Federal Bureau of Prisons, Iowa, Louisiana, Maryland, Missouri, Montana (may self-identify at intake), New York, North Carolina (may self-identify at intake or upon transfer to another facility), North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Texas (may self-identify at any point), Washington (may self-identify at any point), and Wisconsin (may self-identify at any point during incarceration). An additional nine jurisdictions indicated that transgender prisoners were identified through a combination of self-reporting and diagnosis: Connecticut, Illinois, Kentucky, Massachusetts, Michigan, Nevada, New Jersey, New Mexico, and Wyoming.

[89] These jurisdictions were the Federal Bureau of Prisons, Hawaii, Indiana, Rhode Island, and Utah.

[90] These 17 jurisdictions were Alabama, Colorado, Connecticut, Delaware, Iowa, Kansas, Massachusetts, Minnesota, Mississippi, Montana, Nebraska, New Mexico, North Carolina, North Dakota, South Carolina, Tennessee, and Wyoming.

[91] Maryland and South Dakota each reported one transgender prisoner in restrictive housing. Alaska, Louisiana, Nevada, New Jersey, and Oklahoma each reported two transgender prisoners in restrictive housing. Arkansas and Idaho each reported three transgender prisoners in restrictive housing. Kentucky and Michigan each reported six transgender prisoners in restrictive housing. New York reported seven transgender prisoners in restrictive housing. Ohio reported eight transgender prisoners in restrictive housing. Pennsylvania and Washington each reported nine transgender prisoners in restrictive housing. Arizona, Oregon, and Wisconsin each reported ten transgender prisoners

in restrictive housing. Illinois reported 19 transgender prisoners in restrictive housing. Missouri reported 21 transgender prisoners in restrictive housing. Texas reported 24 transgender prisoners in restrictive housing.

[92] BJS *Jail Inmates in 2016*, *supra* note 28, at Tbls. 1, 4.

[93] *See* Allen J. Beck, *Use of Restrictive Housing in U.S. Prisons and Jails, 2011–12*, BUREAU OF JUSTICE STATISTICS (Oct. 2015), http://www.bjs.gov/content/pub/pdf/urhuspj1112.pdf.

[94] BJS *Prisoners in 2016*, *supra* note 26, at 4, Tbl.2. Maryland, which reported on the survey that it has control over jails, was not included in the BJS description. Vermont did not respond to the survey.

[95] These populations are included in the total custodial populations of Table 1.

[96] We did not receive responses from the District of Columbia and New York City.

[97] Philadelphia's total custodial population numbers included privately contracted facilities.

[98] Philadelphia noted: "Each of the Philadelphia Department of Prisons facilities that have inmates in restrictive housing has a Deputy Warden for Administration that oversees all RHU inmates. The Deputy Warden reviews each inmate in segregated housing weekly (for those in segregation under 30 days) or monthly (for those in segregated housing more than 30 days). The Warden also reviews the case files for those inmates using the same schedule. Because we are a local (jail) jurisdiction, our length of stay overall is much lower than the state facilities, and, as such, our length of stay in segregated housing is much lower, also."

[99] Los Angeles's numbers on people by age in restrictive housing population totaled 511, while its total restrictive housing population count in response to another question was 619.

[100] Los Angeles cited *United States v. County of Los Angeles and Los Angeles County Sheriff Jim McDonnell*, CV 15-5903 (C.D. Cal. 2015), Settlement Agreement, available at https://www.justice.gov/crt/file/761256/download.

[101] In its initial response, Philadelphia had reported two pregnant individuals in its total custodial population, with both reported to be housed in short-term restrictive housing.

[102] When asked to explain other changes, Los Angeles noted a "major overhaul" of its "classification policies."

[103] ASCA-LIMAN ADMINISTRATIVE SEGREGATION 2014, *supra* note 6, at 54–57.

[104] ASCA-LIMAN AIMING TO REDUCE TIME-IN-CELL 2016, *supra* note 13, at 55–60.

[105] The jurisdictions responding to questions on policies were: Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, FBOP, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, Wisconsin, and Wyoming. The Federal Bureau of Prisons did so by linking to its revised policies.

[106] The jurisdictions providing supplemental information were Alabama, Colorado, FBOP, Idaho, Massachusetts, New York, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, and Utah.

[107] ASCA-LIMAN ADMINISTRATIVE SEGREGATION NATIONAL OVERVIEW 2013, *supra* note 3, at 4–5.

[108] Thirty-eight jurisdictions responded to this question. The jurisdictions that changed their criteria were: Alabama, Alaska, Arkansas, Colorado, Hawaii, Idaho, Illinois, Kentucky, Maryland, Massachusetts, Minnesota, Missouri,

Included in SCDC' 4.29.19 letter to LOC

Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oregon, South Carolina, South Dakota, Utah, and Washington.

[109] Thirty-two jurisdictions answered this question.

[110] The jurisdictions that reported removing some behaviors from the list of infractions prompting placement in restrictive housing were Arkansas, Delaware, Idaho, Illinois, Maryland, Massachusetts, Minnesota, Nebraska, Nevada, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, Texas, and Washington.

[111] That jurisdiction was Washington.

[112] That jurisdiction was North Carolina.

[113] That jurisdiction was Maryland.

[114] That jurisdiction was Arkansas.

[115] That jurisdiction was Texas.

[116] New Mexico reported that it had, "due to an increase in prison violence, . . . added enhancements to stays in long-term" restrictive housing "if the incident was a repeat violation (habitual offender type charge), was a violent assault on staff and/or was gang-related."

[117] That jurisdiction was North Dakota.

[118] The jurisdictions that had created such a policy were Alaska, Colorado, Hawaii, Maryland, Massachusetts, Minnesota, Mississippi, Montana, Nebraska, North Carolina, North Dakota, Ohio, Pennsylvania, South Carolina, Utah, and Washington.

[119] Those jurisdictions were Alabama, Alaska, Arizona, Arkansas, Colorado, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Mississippi, Montana, Nebraska, Nevada, North Carolina, North Dakota, Ohio, South Carolina, Utah, and Wisconsin.

[120] Those jurisdictions were Alabama, Alaska, Arizona , Colorado, Maryland, Massachusetts, Minnesota, Mississippi, Nevada, North Carolina, North Dakota, Ohio, Utah, and Wisconsin. Arizona explained that a "screening upon arrival occurs for inmates arriving into detention status. Prior to placement if feasible."

[121] Nebraska reported that it had added screening "by medical and mental health within 24 hours of placement" in restrictive housing, effective July 1, 2016. South Carolina reported that it had added mental health screenings for prisoners "classified as mentally ill . . . within 72 hours of initial placement" in restrictive housing and "within 30 days" of placement for other prisoners. Illinois and Montana also reported that they had added screenings after placement in restrictive housing.

[122] Those jurisdictions were Hawaii, Maryland, Ohio, and Washington.

[123] Alaska reported this form of screening.

[124] The jurisdictions that had created policies requiring consideration of less-restrictive alternatives were Alabama, Alaska, Arizona, Colorado, Delaware, Illinois, Kentucky, Maryland, Massachusetts, Mississippi, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oregon, Utah, Washington, and Wisconsin. Other alternatives included, in Massachusetts, placement in a unit "which is not a locked-in unit but has less privileges" or, in Ohio, "Limited Privilege Housing, which requires congregate activity, out-of-cell dining, access to programming, and at least 2.5 hours of out-of-cell time daily." Ohio explained that this had "become the new default placement for

Included in SCDC' 4.29.19 letter to LOC

low to moderate misbehavior." Arizona described converting restrictive-housing beds to "close custody"—specifically, "152 beds from restrictive housing," "192 restrictive-housing sex offender beds," "192 restrictive housing PC beds," "72 CB7 restrictive-housing beds, and "42 Central Unit restrictive-housing beds."

Michigan had not created such a policy at the time of the survey but reported that there were "plans in process to implement an alternative to restrictive housing by utilizing 'Start Units'."

[125] That jurisdiction was Alabama.

[126] That jurisdiction was Oregon.

[127] That jurisdiction was Alaska.

[128] That jurisdiction was New Mexico.

[129] The 28 jurisdictions that reported making changes were Alabama, Alaska, Arizona, Arkansas, Colorado, Delaware, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, Texas, Utah, and Washington.

[130] Iowa, Minnesota, North Dakota, and Ohio reported requiring weekly reviews. Iowa reported that restrictive housing status was reviewed weekly "by the Long Term Restrictive Housing Committee." Minnesota reported that prisoners in restrictive housing were "now reviewed weekly." North Dakota reported that it administered reviews "once a week by the chief of security, Director of Treatment and Deputy Warden—Programs. If on restrictive housing for a year, the resident is reviewed by the DOCR Director. All severely mentally ill cases are staffed with the warden on a weekly basis. If placement is contraindicated, the resident's case is reviewed and staffed with the Clinical Director." Ohio reported that "every 7 days a member of the unit classification committee reviews the status of the inmate and has the power to initiate release procedures."

Alaska, Arkansas, Delaware, Hawaii, Kentucky, Montana, and New York reported requiring monthly reviews. Alaska reported that it conducted initial reviews at 24 hours and 72 hours, with subsequent reviews "every 30 days as needed," and also noted that "our facilities are reviewing prisoners sooner than the 30 day hearing standard. If the prisoner is believed not to be a threat he/she will be returned to general population." Arkansas reported that it conducted initial reviews every seven days for the first 60 days and every 30 days thereafter; at every other 30-day review, "the inmate will be personally interviewed by the Classification Committee or authorized staff;" and the warden must approve continued placement in restrictive housing for any inmate confined for more than one year. Arkansas specified that mental health review occurred within seven days of placement in restrictive housing and at least every 30 days afterward for prisoners with behavioral health diagnoses, at least every 90 days afterward for prisoners without diagnoses, and "more frequently if clinically indicated." Delaware reported every-seven-day reviews for the first 60 days, and "at least every 30 days thereafter," with review by the warden for inmates in restrictive housing for 90 days or more. Hawaii reported initial placement reviews within 24 hours, personal interviews with the warden or designee within 72 hours, and review every 30 days thereafter. Kentucky reported that the restrictive housing status of a prisoner was reviewed "at least every 30 days but often more frequently." Montana reported that "monthly reviews are now done by the unit management teams." New York explained that "inmates housed in restricted housing for other than disciplinary reasons (protection, administrative segregation, etc.) have their status reviewed by a facility three-member committee (consisting of a representative of the facility executive staff, a security supervisor, and a member of the guidance and counseling staff) every 7 days for the first 2 months, and then every 30 days thereafter. Prior to 7/18/2017, reviews were conducted every 60 days."

Arizona, Illinois, Nebraska, New Mexico, and Oregon reported requiring reviews over longer time periods. Arizona reported reviewing placement "at 180 days of initial placement followed by annual review." Illinois reported

Included in SCDC' 4.29.19 letter to LOC

that prisoners could "request a review for reduction in their disciplinary segregation terms every 90 days," and that the Deputy Director or Director must review placement in restrictive housing "every 180 days after the initial review if the segregation term is more than one year." Nebraska reported that "Wardens review and approve the immediate placement," and the "central office MDRT reviews all" restrictive housing cases "every 90 days." New Mexico reported reviewing restrictive housing status "annually or as needed." Oregon reported that restrictive housing status of a prisoner was reviewed "at least every 90 days" for certain types of restrictive housing, and that the policy was under review.

[131] Jurisdictions were asked whether they had made changes to the "decision-making authority to continue individuals in restrictive housing" and whether they had implemented "centralized monitoring." Thirteen of 26 jurisdictions reported that they had implemented "centralized monitoring" (Alaska, Colorado, Delaware, Illinois, Kentucky, Maryland, Massachusetts, Minnesota, Nebraska, New Jersey, New Mexico, Ohio, and South Carolina), and 16 of 28 jurisdictions reported changes in decision-making authority (Alaska, Delaware, Hawaii, Illinois, Iowa, Kentucky, Minnesota, Montana, Nebraska, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oregon, and South Carolina).

[132] The jurisdictions that reported new grievance policies were Hawaii, Maryland, Montana, Nebraska, Nevada, New Jersey, and New Mexico.

[133] Twenty-six jurisdictions responded to this question. The 22 jurisdictions that reported increased monitoring of the mental health of prisoners in restrictive housing were Alabama, Alaska, Arizona, Colorado, Georgia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Massachusetts, Missouri, Montana, Nebraska, Nevada, North Dakota, Ohio, Pennsylvania, Rhode Island, South Carolina, Utah, and Washington.

[134] Three jurisdictions reported requiring daily mental health rounds. Alaska reported, "all prisoners in segregation are contacted by mental health on a daily basis and monitored for indications of issues." Montana reported that "daily rounds are done on each block by our mental health staff." Washington reported:

> Per policy, offenders in restrictive housing receive a visit from a health care provider at a minimum of daily. Mental Health staff will conduct rounds in restricted housing at least once a week. An offender can request to be seen by mental health and will be seen in person within 48 hours . . . . If there is concern for a person when . . . rounds are conducted, the person will have a face-to-face evaluation. If the evaluation determines the restrictive housing environment is detrimental to their mental health, an alternative setting will be recommended with greater access to mental health services.

Eight jurisdictions reported rounds once or more per week. Alabama reported that "Mental Health staff tour" the restrictive housing unit "4 times per week." Arizona reported, "weekly rounds occur to assess for decompensation"; "If mental health needs are identified, the inmate is placed on a caseload and seen routinely . . . . Alternative placements are considered to determine if placement into a mental health program is required." Georgia reported that prisoners in restrictive housing are "monitored weekly and per request." Idaho reported that "clinicians walk the units weekly and immediately make notification to administration if someone is found to be decompensating." Illinois reported that "DR 504 changes require mental health to make visits to segregation not less than 1 time/week." Massachusetts reported requiring "rounds by a consistent qualified mental health professional twice weekly who monitors for any changes in mental status and/or behavior that would suggest additional assessment for signs and symptoms of mental illness"; "if status changes," a "full mental health assessment is completed and determination of treatment needs of that evaluation." Ohio reported, any prisoner "in Restrictive Housing is seen by Mental Health every week and has a review conducted every 30 days." South Carolina reported, "one year ago SCDC went from Monthly rounds to Weekly rounds."

Included in SCDC' 4.29.19 letter to LOC

[135] Massachusetts reported that people with serious mental illness in restrictive housing "for more than 30 days are reviewed monthly by a high level central office multi-disciplinary team." Ohio reported a similar policy of "review conducted every 30 days." Pennsylvania described implementing clinical "contacts by psychology for all RHU/DTU [Restricted Housing Units / Diversionary Treatment Units] . . . for three consecutive days after admission . . . to focus on suicidality" and had also made available "on the RHU/DTU 24 hours per day" "Certified Peer Specialists" who "shall be informed of new receptions so they can check in with them."

[136] The jurisdictions that reported increasing restrictive-housing prisoners' time out-of-cell were Alaska, Arizona, Arkansas, Colorado, Delaware, Georgia, Idaho, Illinois, Maryland, Massachusetts, Minnesota, Montana, Nebraska, New Jersey, New York, North Carolina, Oregon, Texas, Utah, and Washington.

[137] The jurisdictions reporting adding more structured time out-of-cell were Alaska, Colorado, Delaware, Georgia, Idaho, Illinois, Kentucky, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Rhode Island, Utah, and Washington. Two jurisdictions indicated that they were in the process of increasing their structured out-of-cell time. Montana explained that it was "still in the production phase right now and will be completed in the next year." Oregon reported it was "working to increase structured out-of-cell time in certain types of RH." Examples of initiatives to increase out-of-cell time included a "peer group led by community mental health peers" in Nebraska, and twice-a-month game nights or movie nights in North Dakota.

[138] The jurisdictions that reported that they had enabled restrictive-housing prisoners to eat meals in social settings were Arizona (for Step 2 and Step 3 prisoners), Delaware, Kentucky, Maryland, Minnesota, and South Dakota.

[139] The jurisdictions that reported adding more "unstructured (recreational)" time out-of-cell were Alaska, Arizona ("Step 3 inmates are permitted out of cell leisure time"), Delaware, Georgia, Illinois, Massachusetts, Minnesota, Montana, North Dakota, Oregon, and Texas.

[140] Those jurisdictions were Alaska, Arizona, Georgia, Kentucky, Maryland, Montana, Nevada, New York, North Dakota, and Texas.

[141] The jurisdictions that reported adding classes were Alaska, Arizona, Delaware, Georgia, Kentucky, Maryland, Montana, Nebraska, New Mexico, North Dakota, and Oregon.

[142] The jurisdictions that reported adding a GED or diploma program were Alabama, Arizona, Colorado, Georgia, Idaho, Kentucky, Maryland, Massachusetts, North Carolina, North Dakota, Oregon, Utah, and Washington. These 13 jurisdictions did not include Alaska, Minnesota, New Jersey, or Ohio, all of which reported having a GED or diploma program prior to the 2016 ACA revisions. Montana stated such a program was "under review and production."

[143] The jurisdictions that reported increased visitation hours were Colorado, Iowa, Minnesota, Nevada, New York, North Carolina, North Dakota, Ohio, and Washington. Montana reported it was reviewing its visiting policy.

[144] The jurisdictions that reported increased phone time were Colorado, Delaware, Iowa, Maryland, Minnesota, Nevada, New York, North Carolina, North Dakota, and South Dakota. Montana reported it was reviewing its visiting policy.

[145] The jurisdictions that reported increased out-of-cell group programming and/or classes were Alabama, Alaska, Arizona, Arkansas, Colorado, Delaware, Georgia, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oregon, Utah, Washington, and Wisconsin. Among these jurisdictions, the topics of such group classes included anger management in Alaska, Arkansas, Delaware, and North Carolina; life skills in North Carolina and Utah; group educational programming in Colorado, Missouri, New Jersey, North Carolina, and Ohio; substance use recovery in North Carolina and Ohio; and other mental health or therapeutic programming in Alaska, Delaware, Illinois, Iowa, Kentucky, Maryland, Minnesota,

Included in SCDC' 4.29.19 letter to LOC

Missouri, Nebraska, New Jersey, New Mexico, North Carolina, North Dakota, and Ohio. Examples of other mental health or therapeutic programming included "behavior modification" and "self-reflection" in Delaware; "Thinking for change" in Iowa and North Dakota, which reported using a modified program; and "EAGLE (Emotions, Attitude, Growth, Learning, and Excelling)" in Missouri. Maryland reported its programming was a "recent implementation," and noted that it was "in the process of developing further programming opportunities with case management, psychology and social work."

[146] That jurisdiction was North Carolina.

[147] That jurisdiction was Missouri.

[148] That jurisdiction was North Carolina.

[149] That jurisdiction was Alaska.

[150] The jurisdictions that reported adding more group recreation opportunities were Alaska, Arizona, Colorado, Delaware, Georgia, Iowa, Kentucky, Maryland, Missouri, Montana, New Jersey, North Carolina, North Dakota, Ohio, Utah, and Washington.

[151] The jurisdictions that reported increased in-cell learning opportunities were Alabama, Alaska, Arizona, Arkansas, Colorado, Georgia, Idaho, Iowa, Kentucky, Maryland, Massachusetts, Montana, Nebraska, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Texas, Utah, Washington, and Wisconsin. Twenty-two of 36 jurisdictions also reported increased access to resources such as reading materials, videos, and music for prisoners in restrictive housing. Those 22 jurisdictions were Alabama, Alaska, Colorado, Delaware, Georgia, Idaho, Iowa, Kentucky, Maryland, Minnesota, Missouri, Montana, Nebraska, Nevada, New York, North Carolina, North Dakota, Rhode Island, South Carolina, South Dakota, Utah, and Washington. Eight of these 22 jurisdictions reported distributing to prisoners personal devices such as tablets, televisions, MP3 players, or radios. Those eight jurisdictions were Alaska, Delaware, Montana, Nebraska, New York, Rhode Island, South Carolina, and South Dakota. Alaska, Colorado, Georgia, Maryland, and Nevada described allowing access to "literary materials," and Georgia, North Carolina, and Washington reported allowing access to a common television. Maryland and Nevada specifically reported adding access to legal materials. Montana reported that it was "in the process of implementing a tablet system with in cell learning opportunities."

[152] Those jurisdictions were Alaska; Colorado, which provided for post-secondary education; Georgia, which provided for GED education; and New York, which noted that cell study was available at the prisoners' own expense.

[153] That jurisdiction was Texas.

[154] Arizona reported having "CCTV in-cell self-help study programs." Maryland reported having "video opportunities." Ohio reported allowing "use of television" in some cases. Texas reported that prisoners in restrictive housing had the ability to "watch videos."

[155] Idaho reported that prisoners "in restrictive housing can access kiosk with JP5 device." Ohio reported allowing "the JPlayer." Wisconsin reported that "portable smartboards were purchased in addition to computers for improved access to education for <20-year-old at risk special needs inmates in restrictive housing."

[156] North Carolina reported that prisoners "receive in-cell learning opportunities by use of interactive journals published by the Change Companies." Ohio reported providing "paper based programs."

[157] The jurisdictions that had added some form of mental health training for staff were Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, Illinois, Iowa, Kansas, Kentucky, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Rhode Island, South

Carolina, Tennessee, Texas, Utah, Washington, and Wisconsin. Montana reported that its mental health training for staff was still being reviewed. Idaho's draft revised policies, to be implemented in summer 2018, established additional mental health training for restrictive housing staff.

[158] Alabama reported training with the Department of Justice, the National Institute of Corrections, and the National Commission on Correctional Health Care. Arizona explained that it had "contracted with NIC concluding training for 40 key staff that work in restrictive housing in Mental Health First Aid." Delaware stated: "DOC has sent staff to ACA and NIC sponsored trainings on behavioral health and mental health first aid. DOC offers educational assistance to employees who wish to pursue additional studies in a chosen relevant field. DOC has partnered with other state agencies in Delaware to provide training on behavioral health issues."

[159] Thirty-one jurisdictions responded to this question. The jurisdictions that reported having opportunities for staff education related to restrictive housing were Arkansas, Connecticut, Delaware, Illinois, Iowa, Kentucky, Maryland, Mississippi, North Carolina, North Dakota, Ohio, and Wisconsin. Two jurisdictions, Montana and Nebraska, reported that they were reviewing their policies.

[160] Arizona reported having "specialized 24-hour mental health training with classes starting in October 2017," and contracting with NIC for "training for 40 key staff that work in restrictive housing in Mental Health First Aid." Connecticut reported "Mental Health Training is organized by Correctional Managed Health Care." Delaware reported that "mental health first aid" was "a part of Correctional Employee Initial Training class and offered to existing correctional staff on a voluntary basis." Delaware also explained that it "sent staff to ACA and NIC sponsored trainings on behavioral health and mental health first aid." Illinois stated that "IDOC was mandated to train ALL staff in NAMI training per Rasho agreement." Maryland reported that "Mental Health First Aid" training was provided to staff. Massachusetts related that "MADOC staff receive centralized annual in-service training on Recognizing the Signs and Symptoms of Mental Illness and Suicide Prevention and Intervention. At the site level, Mental Health Directors provide specific mental health training tailored to the needs of the facility and its population." Missouri stated that it provided "annual mental health training to staff," and "has been expanding the use of Crisis Intervention Training for staff, especially those staff assigned to segregation." North Carolina reported that staff "are required to have training in Motivational Interviewing and Crisis Intervention," and that "TDU staff have completed the ACA Behavioral Health Certification training." Rhode Island stated that mental health training "is part of normal in-service training but is not specific to" restrictive housing. South Carolina reported that all "security staff receive Mental Health training. Tennessee reported that staff receive "Correctional Behavioral Health Training." Texas explained that the "Pre-Service Training Academy . . . includes 32 hours of mental health/crisis intervention training," and that additional "mental health/crisis intervention training has been incorporated into annual in-service training." In addition, Texas reported that each unit "provides turnout training regarding suicide prevention and mental health/crisis intervention on a regular and frequent basis." Utah stated that the "UDC certified staff received basic annual training on mental health." Washington reported that a "large portion of restricted housing staff have received 'Working with Offenders with Mental Health' training, Individual Behavioral Management Plan (IBMP) training, and in some cases Motivational Interviewing."

[161] Those jurisdictions were Colorado, Kansas, Maryland, Massachusetts, Minnesota, South Carolina, and Texas. Colorado, Massachusetts, and Minnesota reported providing these programs annually for all staff. Texas stated that each "unit provides turnout training regarding suicide prevention . . . on a regular and frequent basis."

[162] Those jurisdictions were Maryland, Minnesota, Missouri, Nevada, North Carolina, North Dakota, Ohio, South Carolina, and Texas.

[163] Those jurisdictions were Arizona, North Carolina, and Washington.

[164] That jurisdiction was North Dakota.

Included in SCDC' 4.29.19 letter to LOC

---

[165] That jurisdiction was Minnesota.

[166] That jurisdiction was Alabama.

[167] Thirty-one jurisdictions responded to this question. The 14 jurisdictions that reported a staff rotation policy were Alaska, Arizona, Arkansas, Connecticut, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Missouri, Montana, North Dakota, South Carolina, and Wisconsin. Alaska explained, "generally staff are rotated out after a year in the segregation unit." Arizona reported that "ADC rotates staff as a statewide measure every five years or by request." Arkansas reported having a staff rotation policy related to staffing of restrictive housing. Connecticut stated that "Correctional Officer post rotations occur every 56 or 112 days depending on the facility and shift." Idaho noted that job postings for restrictive housing were "exempt from seniority bidding and staff must apply to work in these units." Kentucky stated that staff rotations were "considered annually and by request." Maryland explained that staff rotations varied "from facility to facility." Massachusetts reported that "security staff are rotated annually" in restrictive housing units and "specialized units." Minnesota stated that "officers in restrictive housing units are rotated out of the assignment for a minimum of 3 months after 2 years." Missouri explained that "uniformed custody staff are not rotated," but that "case management staff are rotated at a minimum of every two years." Montana stated it provided staff rotations "once every 2 to 3 years if staffing allows." North Dakota explained it tried "not to allow" staff "to work past 18 months in the Behavioral Health Unit." South Carolina reported that staff rotate "every 18 months" and "may request to remain in RHU longer with 24 months being the maximum." Wisconsin stated that staff rotations varied "depending on the institution."

[168] That jurisdiction was Connecticut.

[169] That jurisdiction was Arizona.

[170] Thirty-eight jurisdictions responded to this question. The 20 jurisdictions that required this advance information be given to prisoners were Alabama, Alaska, Arkansas, Colorado, Georgia, Kentucky, Maryland, Mississippi, Montana, Nebraska, Nevada, New Mexico, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Utah, Washington, and Wisconsin.

Kentucky, Maryland, Montana, Nevada, and Utah stated that they made their restrictive housing handbook or disciplinary manual accessible to prisoners. Mississippi required prisoners to "familiarize themselves with the offender handbook and acknowledge participation and understanding of the rules and regulations of the program by signing a written contract." Alaska, Colorado Maryland, New York, North Dakota, Ohio, and Washington provided information about the criteria directly to prisoners through an orientation or meeting. North Dakota noted that the "behavioral plan" is not shared with the "resident" "if doing so would jeopardize the safety of the resident, staff, other residents, or the public."

[171] Thirty-five jurisdictions answered this question. The 21 jurisdictions that reported that they have already implemented this change were Alaska, Arizona, Arkansas, Colorado, Delaware, Georgia, Hawaii, Kentucky, Maryland, Massachusetts, Montana, Nebraska, New Mexico, New York, North Carolina, North Dakota, Ohio, Pennsylvania, South Carolina, Texas, and Utah. In addition to these 21 jurisdictions, Mississippi reported that its process involved a "committee recommendation" but that the "offender services director" made the "final decision." North Carolina reported that it was developing a policy, "targeted for implementation November, 2017," that would "move classification decisions to a committee process."

[172] The 2016 ACA Standards offer the definition of a step-down program as "a program that includes a system of review and establishes criteria to prepare an inmate for transition to general population or the community." ACA 2016 RESTRICTIVE HOUSING STANDARDS, *supra* note 21, at 4.

Included in SCDC' 4.29.19 letter to LOC

---

[173] Twenty-seven jurisdictions reported having added step-down or transition programs. Those jurisdictions were Alabama, Alaska, Arizona, Arkansas, Colorado, Delaware, Georgia, Illinois, Iowa, Kentucky, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Carolina, Utah, and Washington.

Three jurisdictions—Idaho, Massachusetts, and Oregon—noted they were developing step-down programs. Idaho reported it was "in the draft phase of a mandatory step up program." Massachusetts reported it piloted "a step-down unit in our largest medium security prison in November, 2017" in the form of "a 90-day program targeting the criminogenic needs that originally created the pathway" to restrictive housing. "It is a dorm style housing unit so no one is locked in cells at all, just restricted privileges with a clear pathway back to general population." Oregon reported that a step-down program was "in development."

[174] For example, Alaska reported using "progressive reduction of restrictions . . . awarded after periods of demonstrated good behavior and programming." Colorado stated that its "close custody units/designations" allowed for "increasing privileges/incentives as offenders progress." Maryland explained that its restrictive housing policy had "a level-system built in that provides for the increase of both programs and privileges to make for a smooth transition into general population." Minnesota reported that its step-down plan included increasing privileges, amenities, and movement." Montana stated that "step downs occur as inmates progress through a 6 level system where their privileges increase." New Mexico described a progressive four-step program. Oklahoma reported a pilot step-down program, which consisted of "four phases that are progressively less restrictive." Pennsylvania stated it had created a "step down unit and portal program, which used "a progressive four-tiered phase system based on the inmate's adjustment and attainment of goals/objectives." Utah reported that prisoners in restrictive housing must "progress through three phases" of restrictive housing.

[175] Colorado reported having a "Management Control Unit High Risk, Management Control Unit, and Close Custody Transition Unit (CCTU)." Nebraska stated it "established several mission specific housing units," which included "protective management, active senior unit, veterans unit, and the challenge program," as alternatives to or "transition out of" restrictive housing. Nevada reported adding a Behavior Modification Unit. North Carolina reported having two different units, the "Therapeutic Diversion Unit" and the "Rehabilitative Diversion Unit." North Dakota stated it had a "transition unit . . . to help prepare people who have been living in the behavior intervention unit for general population." Ohio described a "hybrid sanctioning system" with a "Limited Privilege Housing" step-down. Oklahoma explained its "Step-Down Program" was a separate housing unit. Pennsylvania stated its PORTAL program was housed in a separate unit. Washington reported that one of its facilities added a "transition pod," which allowed two prisoners "assigned to Maximum custody to be on the tier with each other without restraints on for several hours a day," and to be "around custody staff on the tier without restraints as well."

[176] That jurisdiction was Minnesota.

[177] That jurisdiction was North Dakota.

[178] Alabama reported that step-down programs were "in use at 2 facilities. The inmates must be in medium custody and have shown a pattern of improved behavior to be considered for return to population."

Alaska stated its facilities had "a step-down program for Maximum Custody prisoners which allows progressive reduction of restrictions that are awarded after periods of demonstrated good behavior and programming."

Arizona explained that there were five step-down segments: upon entry in restrictive housing, prisoners are "evaluated and placed into a step reduction system based on behavior and/or reason for placement. Inmates begin the process at Browning, (our most restrictive and secure) and reduce to our Special Management Unit (SMU). SMU is considered an intermediary placement with increased programing and interaction opportunity. From SMU, inmates transition to Central Unit where they are offered more group program/recreational opportunity."

Arkansas reported it had created a step-down program.

Colorado related that all prisoners in extended restrictive housing were "eligible for progression and placement in the step-down/transition program based upon their actions/behaviors. The close custody units/designations allow for increasing privileges/incentives as offenders progress . . . . The cognitive programming provided within CCTU normally takes 12 weeks to complete."

Delaware related that its policy required a step-down program, but it had "not yet been implemented into practice." Georgia reported it had "Tier II step down units for offenders on phase 3+, who have been in restrictive housing for 270+ days."

Idaho reported a "step-up program" in which prisoners in "long-term restrictive housing are automatically enrolled." Idaho provided its policy on the step-up program, which stated: "During the first 30-day review, the chairperson must provide written goals required to move from step one to step two. Inmates will continue to receive goals in writing for each successive step as they progress, until completion of the step-up program . . . . The designated deputy chief of prisons must develop a tracking process with the assistance of the research and analysis group at headquarters to measure effectiveness of the step-up program . . . ."

Iowa reported that "small modifications" "connected to recreation time, out of cell time and property modifications" had occurred in its step-down program.

Kentucky reported step-down programs at three institutions (two male, one female): "Each program lasts 6-12 months. Inmates are eligible based on treatment team and classification referral."

Maryland explained that its restrictive housing policy had "a level-system built in that provides for the increase of both programs and privileges to make for a smooth transition into general population. Within the review process alternative programs and incentives are considered, such as drug counseling or cognitive aimed at reducing violence. Within the MaxII Structured Housing there are phases and incentives geared to transition the inmate to a less restrictive environment. Once sanction is completed, individual moves to structured, less restrictive housing and has opportunity to progress with out of cell activities in small group settings. As behavior dictates, he continues to progress (or regress) with available programming."

Massachusetts stated it was piloting "a step down unit in our largest medium security prison in November, 2017. It is a 90 day program targeting the criminogenic needs that originally created the pathway to RH. It is a dorm style housing unit so no one is locked in cells at all, just restricted privileges with a clear pathway back to general population."

As noted above, Minnesota related that prisoners "who have a history of staff or offender assault, or who have served more than 90 days in disciplinary segregation are evaluated for a step-down plan to general population."

Mississippi reported having a "High Risk Incentive Tier" that provided the opportunity for prisoners to "receive services and privileges as part of a program to encourage and promote good institutional behavior."

Missouri reported that it had not changed its policy but that several of its facilities had "created step-down or transition programs."

Montana stated that "step downs occur as inmates progress through a 6 level system where their privileges increase. Treatment programs are also coordinated through their case managers in association with the levels."

Nebraska explained it had "established several mission specific housing units which are alternatives to RH or act as a transition out of RH."

Nevada described a "Behavior Modification Unit" "intended to transition an inmate from a segregation unit to one that is similar to general population. Placement in BMU provides the inmate with a period of adjustment to interact with staff and other inmates and work towards the development of proper social skills. Inmates who are still serving disciplinary sanctions and are within 30 days of the projected release date to the community are transferred to a BMU, depending on the inmates propensity for misconduct."

New Jersey reported: "Inmates placed in administrative segregation as a result of a sanction may be assigned to a SDU by a centralized committee for transition to GP or the community. The placement phases are Reception/Initial, Congregate and Extended Congregate. Therapeutic activity and services are available. A SDU committee will review and advance the inmate through each phase."

New Mexico described a four step program: "Step 1 Evaluation 30 days. Step 2 Self Accountability 90 days but if enhancements needed up to 240 days. Step 3 is Cultural Competency which is 120 days but up to 360 days with enhancements. Step 4 is reintegration with 120 days but up to 300 days with enhancements. For females step 1 is 15 days. Step 2 is 30 days. Step 3 is 45 days and Step 4 is 90 days. No enhancements with the females."

New York stated that, effective October 2016, "SHU Step-down to the Community Programs" were "established at Green Haven Correctional Facility ("Green Haven") and Wende Correctional Facility ("Wende") to provide re-entry programming to inmates who have been in a SHU cell for 60 days or more serving a SHU or keep lock sanction and who have a minimum of 45 days and a maximum of 60 days to release . . . . The program goal is to assist participants with the development of a comprehensive release plan, incorporating social skills practice, relapse prevention, family reintegration and employment readiness. Behavior modification and relapse prevention will be addressed by modalities such as identifying high-risk behaviors, emotional regulation exercises, social skills practice, discussing how to deal with fear and the feelings of others, and how to ask and respond to questions."

North Carolina related it had two step-down programs available: "the Therapeutic Diversion Units for those with a higher mental health acuity, and the Rehabilitative Diversion Unit. The inmates eligible for the RDU are close custody males over 21 years old, who have received a sanction of RH for Control Purposes for assaultive or violent infractions. This program takes a minimum of 13 months to complete, and incorporates three phases. In each phase, the step-down includes less restrictions and increased out-of-cell time and privileges, such as more options in canteen, increase in phone calls, movement throughout the facility and program opportunities such as high school equivalency. The first inmates to participate began 2/22/16. The TDUs are intended to enhance the care and custody for individuals diagnosed with mental illness, decrease incidents involving violence and/or self-harm, decrease the need for placement in a restrictive housing setting and improve the quality of life for this population. The TDU assists individuals with mental illness in developing effective emotional regulation and self-management skills, understanding their symptom presentation and patterns, and helps prepare for re-entry into a less restrictive environment within the prison and ultimately successful transition to the community."

North Dakota's description of its step-down program is reported in the text above.

Ohio reported it had a "transition from Extended Restrictive Housing to General Population for 6 years." Ohio explained: "We have concluded that short-term Restrictive Housing does not need a mandatory step down, but we do have a hybrid sanctioning system where an inmate can be first placed in short-term Restrictive Housing and then stepped down into Limited Privilege Housing."

Oklahoma provided a detailed program of its piloted step-down program at Oklahoma State Penitentiary. The policy, adopted in September 2017, stated that the "purpose of Step-Down Programs are to provide inmates transferred to maximum security a safe and secure way to earn their return to lower security. Upon arrival, inmates will be evaluated to determine appropriate housing needs and assessed to identify their level of social functioning and motivation to change . . . . Step-Down Programs will be comprised of components that are designed to address criminal

Included in SCDC' 4.29.19 letter to LOC

thinking and encourage pro-social behaviors. Programs will consist of four phases that are progressively less restrictive with Phase I being the most restrictive and Phase IV the least restrictive . . . ."

Pennsylvania also provided a detailed overview of its step-down unit and PORTAL program. That summary stated, that the "Department established a Positive Outcome Restructuring Through Assessments and Learning (PORTAL) program designed specifically to provide therapeutic programming, education, and socialization opportunities for individuals confined to a Level 5 (L-5) setting for extended periods. The goal of the program is to provide the skills necessary to gain recommendation for placement into a step down unit and return to general population . . . . After facility recommendation and approval by the Executive staff, the inmate will transfer to an approved institution to complete re-integration into general population. The program will use a progressive four-tiered phase system based on the inmate's adjustment and attainment of goals/objectives noted in his/her Individual Treatment Plan (ITP)."

South Carolina reported "The Step-Down Program is an incentive-based offender management program which creates a pathway for offenders to transition from Restrictive Housing. The Intensive Management Program is a one year program. And Restrictive Management Step-Down is a six month program for inmates in Security Detention, Disciplinary Detention or Short Term Detention."

Utah explained that prisoners in restrictive housing "must progress through the three phases of RH to reach completion. Each phase is 45 days and each phase has a corresponding program. The inmate must also remain discipline free to successfully complete the RH phases."

Washington stated that a "transition pod" had been "developed and implemented at the Monroe Correctional Complex (MCC) Intensive Management Unit (IMU). The transition pod allows for two offenders assigned to Maximum custody to be on the tier with each other without restraints on for several hours a day. The offenders are around custody staff on the tier without restraints as well."

[179] Those jurisdictions were Arkansas, Colorado, Illinois, Iowa, Massachusetts, Minnesota, Montana, North Carolina, Ohio, South Carolina, South Dakota, Utah, and Wisconsin.

[180] That jurisdiction was Montana.

[181] That jurisdiction was North Carolina, which reported that "mentally ill inmates have a 30 day maximum as determined by the multidisciplinary team. This time can be extended if it is determined that the inmate poses a safety or security risk and RH is not considered detrimental to their health."

[182] Those jurisdictions were Iowa, which reported "60 days DD maximum prior to moving through the programming"; Massachusetts, which reported "the maximum for our disciplinary unit is ten years. Short term, non-disciplinary segregation does not have a duration attached to it"; Minnesota, which reported a maximum of "90 days for disciplinary segregation"; and South Carolina, which reported that "Disciplinary Detention is a maximum of 60 days."

[183] Montana reported a total length of stay of 1.7 years in restrictive housing across all stages. Utah reported a 45-day maximum for each of its three restrictive-housing stages. South Dakota reported shortening the maximum duration for two of its restrictive-housing stages, from 90 and 120 days to 60 and 90 days, respectively. South Dakota stated, "on March 7, 2017, changes were made in the duration for two levels in the administrative restrictive housing Level System. Level 2 was changed from 90 to 60 days and Level 4 was changed from 120 to 90 days. This change reduced the overall duration for the program to 360 days instead of 420 for those completing the program on a timely basis."

[184] Those jurisdictions were Colorado, Illinois, Kentucky, and Ohio. Colorado reported that the "maximum durations for specific infractions/behavior" were "either up to 6 months or up to 12 months." Illinois reported that maximum "penalties per charge" had been "reduced," resulting in a reduction of "the total, maximum amount of restrictive

housing time for all offenses by 107 months (8.9 years)," although there was "no maximum duration" to a prisoner's placement in restrictive housing if the prisoner received "continuous sanctions for separate incidents that would run consecutively." Kentucky reported that its "disciplinary penalty structure has been altered to reduce the amount of days to be issued per offense." Ohio reported a prisoner could "only be given a maximum of 29 days" in restrictive housing "for an individual offense," which was "the extent of authority any local official" had "to place an inmate into" restrictive housing. "In rare cases, an inmate can be housed" in restrictive housing "longer than 29 days for an investigation or pending classification action, but these must be reviewed by a higher authority."

[185] Those jurisdictions were Wisconsin, which reported maximum durations on restrictive housing of up to "120 days without review" and "up to 360 days with review"; and South Carolina, which reported that "Security Detention" prisoners were "reviewed every 90 days to determine eligibility for removal from RHU."

[186] *Seeking Accreditation*, AMERICAN CORRECTIONAL ASSOCIATION, *available at* http://www.aca.org/ACA_Prod_IMIS/ACA_Member/Standards_and_Accreditation/Seeking_Accreditation_Home.aspx.

[187] AMERICAN CORRECTIONAL ASSOCIATION, MANUAL OF ACCREDITATION POLICY & PROCEDURE 6, 9–10 (Mar. 15, 2017), *available at* http://www.aca.org/ACA_Prod_IMIS/docs/standards%20and%20accreditation/ALM-1-3_15_17-Final.pdf.

[188] ACA 2016 RESTRICTIVE HOUSING STANDARDS, *supra* note 21.

[189] *Id.* at 4. The ASCA-Liman Survey asked: "Has your jurisdiction reviewed its policies since then on restrictive housing?" "Does your jurisdiction rely on these standards to make policies?" We also asked about whether jurisdictions had implemented the ACA Standards regarding juveniles, pregnant women, and individuals diagnosed with serious mental illness and regarding the release of prisoners from restrictive housing directly into the community. We further sought to learn whether any other policies had been "revised in light of the 2016 ACA restrictive housing standards."

[190] Forty-three jurisdictions responded to this question. The 36 jurisdictions that reported that they reviewed their policies since the release of the ACA Standards were Alabama, Arkansas, Colorado, Connecticut, Delaware, Georgia, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Washington, Wisconsin, and Wyoming. Both Illinois and Nevada responded that they had not revised their policies since 2016. However, Illinois elaborated that in April 2017 it had worked "to institute changes to the Corrections' Administrative Codes, changing policies as related to discipline and restrictive housing." Similarly, Nevada reported that the "Nevada Legislature mandated that the NDOC evaluate its restrictive housing policies. The NDOC's leadership has also voluntarily instituted regulations and practices that are intended to improve the wellbeing of inmates and reduce the length of stay in prison." Nebraska reported that it would be reviewing its policies again by July 1, 2018.

Of the 43 jurisdictions that responded, Arizona, Indiana, Missouri, and Utah reported that they were undergoing review of their restrictive housing policies in the fall of 2017, when the survey was underway. Missouri reported that it had not revised its policies since 2016 but that "this survey and revised 2016 ACA standards have provided guidance and are assisting the Missouri Department of Corrections in improving our automation, as well as policy changes related to restrictive housing. The department has established a team for this purpose and it is our intent that this team will be able to develop a policy that will put us better in compliance with the 2016 ACA standards." Utah likewise reported that it had not revised its policies since 2016 but that its "Division of Prison Operations" was working with the Vera Institute of Justice "to look at alternatives to segregation," and was "using NIC guidelines and reviewing ACA guidelines for comparison to NIC, and adjusting policy as necessary." In addition, Colorado noted it had piloted "the standards prior to implementation" and had since "codified all standards in policy."

[191] Those jurisdictions were Alabama, Arkansas, Colorado, Connecticut, Delaware, Indiana, Iowa, Kentucky, Maryland, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, and Wyoming.

[192] Those jurisdictions were Illinois, Louisiana, Missouri, New Jersey, Rhode Island, Texas, Utah, Washington, and Wisconsin.

[193] Those jurisdictions were Alaska, Arizona, Georgia, Hawaii, Idaho, Kansas, Mississippi, and South Carolina. Of these eight, Georgia responded that it intended to rely on the ACA Standards in the future.

[194] ACA Standard 4-RH-0030, ACA 2016 RESTRICTIVE HOUSING STANDARDS, *supra* note 21, at 35.

[195] Twenty jurisdictions of the 42 reported that they implemented the policy after the ACA Standards were issued. Those jurisdictions were Arkansas, Connecticut, Delaware, Idaho, Illinois, Indiana, Iowa, Maryland, Massachusetts, Minnesota, Nebraska, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, South Dakota, Utah, and Wisconsin. Six jurisdictions reported that not releasing prisoners directly to the community from restrictive housing had been their policy prior to the ACA revisions. Those jurisdictions were Colorado, Georgia, Kentucky, Mississippi, Rhode Island, and Texas.

[196] Those jurisdictions were Kansas, North Carolina, Oregon, Pennsylvania, and Washington. Alabama, Alaska, Arizona, Louisiana, Missouri, Montana, Oklahoma, South Carolina, Tennessee, and Wyoming reported that they had not implemented this Standard. Hawaii responded, "N/A."

[197] North Carolina reported that it had established two step-down units: a Rehabilitative Diversion Unit (RDU) and Therapeutic Diversion Units (TDUs). The RDU was for "close custody males over 21 years old who have received a sanction" of restrictive housing "for Control Purposes for assaultive or violent infractions. This program takes a minimum of 13 months to complete and incorporates three phases. In each phase, the step-down includes less restrictions and increased out-of-cell time and privileges, such as more options in canteen, increase in phone calls, movement throughout the facility and program opportunities such as high school equivalency." The TDUs were "intended to enhance the care and custody for individuals diagnosed with mental illness, decrease incidents involving violence and/or self-harm, decrease the need for placement in a restrictive housing setting and improve the quality of life for this population. The TDU assists individuals with mental illness in developing effective emotional regulation and self-management skills, understanding their symptom presentation and patterns, and helps prepare for re-entry into a less restrictive environment within the prison and ultimately successful transition to the community."

Oregon reported that it did its best to avoid directly releasing people from restrictive housing into the community but that "there are situations in which the safety of the individual or others would be compromised if he/she were removed from" restrictive housing "prior to release." Pennsylvania explained that this "policy was in place as part of" its January 2015 "Disability Rights Network settlement" with the Department of Corrections. Washington stated that it did its best to ensure prisoners transition back to general population before they are released to the community, but that there were "times and situations" where direct release to the community could not be avoided, such as when people in restrictive housing had six months or less remaining time in their sentences. In such cases, it focused "on ensuring all services that are available can be provided upon release, housing vouchers, medication, access to treatment, etc." Kansas reported that it had "addressed" this Standard "through practices" but had not made a corresponding "policy change."

Sixteen jurisdictions reported that they had not implemented this Standard. Those jurisdictions were Alaska, Arizona, Idaho, Louisiana, Minnesota, Missouri, Nebraska, New Mexico, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Washington, Wisconsin, and Wyoming.

[198] ACA Standard 4-RH-0033, ACA 2016 RESTRICTIVE HOUSING STANDARDS, *supra* note 21, at 9.

Included in SCDC' 4.29.19 letter to LOC

---

[199] ACA Standard 4-RH-0031, *id.* at 36.

[200] Forty-one jurisdictions responded to this question. Twelve jurisdictions reported that they had implemented the Standard after the ACA Standards were issued. Those jurisdictions were Alabama, Arkansas, Connecticut, Delaware, Indiana, Iowa, Kentucky, Massachusetts, Montana, Nevada, North Dakota, and Utah. Nine jurisdictions indicated that it was their policy before the ACA Standards. Those jurisdictions were Colorado, Georgia, Kansas, Maryland, Mississippi, New Jersey, New York, Oregon, and Texas. Colorado explained that before "the 2016 ACA revisions all offenders with serious mental illness were removed from administrative segregation and placed in a Residential Treatment Program in January 2014. There have been no exceptions." Alabama reported that it had "substantially implemented this policy, with exceptions" but explained that "inmates diagnosed with serious mental illness have been removed from RH and are housed in a RTU. Additional MH staff are being hired."

[201] Those jurisdictions were Illinois, North Carolina, Ohio, and Pennsylvania. Illinois reported involving mental health resources. It described notifying a mental health professional when placement in disciplinary restrictive housing was possible for a mentally ill prisoner. The mental health professional "reviews if the offender's mental health condition may have been a factor in the incident, or if placement in restrictive housing may be detrimental to the mental health. They may also make a recommendation as to the maximum amount of restrictive housing an offender may serve." North Carolina reported using extended restrictive housing as a safety measure when no alternative was available. North Carolina reported that it considered placement in a less-restrictive therapeutic diversion unit (TDU). It also reported taking into account whether confinement will have a "detrimental impact" on individuals with mental illness and that a "multidisciplinary team" reviewed placements of this population in restrictive housing every 30 days "to determine if continuation of RH is indicated based on safety and security factors." Ohio reported that it had "dramatically reduced" the use of extended restrictive housing for prisoners with serious mental illness. Pennsylvania stated that this "policy was in place as part of the Disability Rights Network settlement" with the Department of Corrections.

[202] The data described in Section II of this report (discussing placement of those with serious mental illness in restrictive housing) relied on each jurisdiction's own definition of serious mental illness.

[203] ACA Standard 4-RH-00004, ACA 2016 RESTRICTIVE HOUSING STANDARDS, *supra* note 21, at 9.

[204] Eleven of these 22 jurisdictions implemented the policy after the ACA Standards were issued. Those jurisdictions were Arkansas, Colorado, Delaware, Indiana, New Jersey, New Mexico, North Carolina, Ohio, Pennsylvania, Washington, and Wisconsin. North Carolina explained that "Restrictive Housing was totally eliminated from this population effective June 2016," and that it had "a Youthful Offender Program" where prisoners under age 18 were "placed on Modified Housing when serious incidents occur." Washington explained that "WDOC has jurisdiction over individuals sentenced as adults. Those under age 18 sentenced as adults are managed by a different agency and will not come to our facilities until sometime after age 18. It is rare to have an individual come to a DOC facility while they are under age 18 for more than a short amount of time." Another 11 jurisdictions stated that this was their policy before 2016. Those jurisdictions were Connecticut, Georgia, Kansas, Mississippi, Montana, Nevada, New York, Oregon, South Dakota, Tennessee, and Texas.

[205] Those jurisdictions were Minnesota and Oklahoma. Fifteen jurisdictions responded that they had not implemented this Standard. Those jurisdictions were Alabama, Alaska, Idaho, Illinois, Iowa, Kentucky, Louisiana, Massachusetts, Missouri, Nebraska, North Dakota, Rhode Island, South Carolina, Utah, and Wyoming. Idaho explained that its draft revised policies, to be implemented in the summer of 2018, would prevent placement of individuals under 18 years old in restrictive housing.

Oklahoma reported that, "consistent with PREA standards, specific facilities and housing units within these facilities have been designated for inmates under 18 years of age." Minnesota reported a seven-day maximum duration

for juveniles in disciplinary restrictive housing, except "for offenders who continue to assault staff," and explained that "offenders under 18 housed in adult facilities participate in incentive programs to deter disruptive behavior."

[206] ACA 2016 RESTRICTIVE HOUSING STANDARDS, *supra* note 21, at 3. The survey results regarding the placement of pregnant prisoners in restrictive housing are discussed in Section II of this Report.

[207] Seventeen jurisdictions said they had implemented the policy after the ACA Standards were issued. Those jurisdictions were Alabama, Arkansas, Delaware, Indiana, Iowa, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, North Carolina, Ohio, Oregon, Pennsylvania, Tennessee, and Wyoming. Eight jurisdictions reported that this was their policy before 2016. Those jurisdictions were Colorado ("CDOC does not have Extended Restrictive Housing for female offenders and does not have restrictive housing for any female offenders."), Connecticut, Georgia, Idaho, Mississippi, New York, Oklahoma, and Texas.

[208] Those jurisdictions were Illinois, New Jersey, South Dakota, and Washington. Among these four jurisdictions that had "substantially implemented this policy, with exceptions," South Dakota reported that it complied with this Standard in practice and was currently revising its written policy accordingly. Illinois responded that "medical conditions of offenders shall be considered at the time of the committing offense." Two jurisdictions explained that, in "rare" or "extreme" cases, placement of a pregnant prisoner in restrictive housing was necessary for safety reasons: New Jersey reported that it "prohibits" the placement of pregnant prisoners in administrative segregation but that "in extreme cases an inmate who is pregnant, is postpartum, recently had a miscarriage, or recently had a terminated pregnancy may be placed in MCU [the Management Control Unit] for repeated infractions." At the time of the survey, New Jersey reported that no pregnant women were in its MCU. Washington reported that in "very rare situations, a woman who is pregnant, is postpartum, recently had a miscarriage, or recently had a terminated pregnancy may be placed in restrictive housing as a temporary response to behavior that poses a serious and immediate risk of physical harm." Washington reported that procedural safeguards were involved when a pregnant or recently-pregnant woman was placed in restrictive housing: "this decision must be approved by the agency's senior official overseeing women's programs and services, in consultation with senior officials in health services, and must be reviewed every 24 hours."

Twelve jurisdictions indicated that they had not implemented this Standard. Those jurisdictions were Alaska, Arizona, Kansas, Louisiana, Missouri, Montana, Nebraska, North Dakota, Rhode Island, South Carolina, Utah, and Wisconsin.

We also asked jurisdictions to describe any other changes to their restrictive-housing policies in light of the revised ACA Standards. Nine of 20 jurisdictions that responded to the question indicated that they had or were in the process of doing so. Those jurisdictions were Arkansas, Colorado, Maryland, Montana, Ohio, Oregon, Pennsylvania, Utah, and Wisconsin. Three jurisdictions of the nine reported additional broad policy changes. Arkansas had "made changes to our Protective Custody, Disciplinary Court Review, Punitive-Segregation Policies as well as our Inmate Disciplinary Manual." Colorado had updated 16 department policies: 100-19 Communication with Offenders, 100-40 Prison Rape Elimination Procedure, 300-01 Offender Visiting Program, 500-02 Library Services, 550-11 Offender Release, 600-01 Offender Classification, 600-09 Management of Close Custody Offenders, 700-03 Mental Health Scope of Service, 700-29 Mental Health Interventions, 750-01 Legal Access, 850-10 Emergency Notification, 850-12 Telephone Regulations for Offenders, 850-07 Offender Reception and Orientation 1, 000-01 Recreation and Hobby Work 1, 350-02 Victim Notification Program 1, and 550-02 Food Service Menu Planning and Service. Ohio had "updated over 30 policies, including medical, mental health, classification, special management, recreation, education, business, Reentry, Health and Safety, Unit Management, Security, and a myriad of other policies." Montana reported structural changes to its restrictive-housing system: "Our special management policy has been changed and our classification policy has been changed as we used to have Administrative segregation for long term and then Max custody for our extended stay in segregation. Now all are under the Maximum custody following a 6-level system."

---

[209] Fourteen jurisdictions responded to this question. The jurisdictions that reported new or changed data collection practices were Arizona, Delaware, Hawaii, Kentucky, Massachusetts, Minnesota, Nebraska, New Jersey, New Mexico, North Dakota, Ohio, Oregon, South Carolina, and Washington.

[210] Those jurisdictions were Arkansas, Iowa, Kentucky, Maryland, Massachusetts, Minnesota, Nebraska, New Mexico, and Washington.

[211] Those jurisdictions were Arizona, Iowa, Kentucky, Maryland, Massachusetts, and Washington.

[212] Those jurisdictions were Arkansas, Iowa, and Washington.

[213] Those jurisdictions were Arizona, Arkansas, Iowa, Massachusetts, and Washington.

[214] Those jurisdictions were Iowa, Kentucky, Massachusetts, Nebraska, Nevada, and Washington.

[215] Those jurisdictions were Arizona, Arkansas, Iowa, Kentucky, Nebraska, and Washington.

[216] Those jurisdictions were Delaware, Iowa, Kentucky, Nebraska, Nevada, Washington, and Wisconsin.

[217] Those jurisdictions were Iowa and Wisconsin.

[218] Those jurisdictions were Alabama, Delaware, Nebraska, and Washington. Of these four, Nebraska referenced a "new data system effective November 2017" that was "tracking a number of metrics" but that had not yet yielded "reportable data." Washington reported that it "has started to evaluate the effectiveness of congregate classroom programming within restricted housing." Delaware explained that, pursuant to a settlement agreement, it would for the next five years conduct monthly audits of the "number of inmates" in restrictive housing and of "demographics and out of cell data (structured and unstructured), disciplinary info, and mental health status for that population."

[219] That jurisdiction was Oregon.

[220] That jurisdiction was Arizona.

[221] That jurisdiction was North Dakota.

[222] The jurisdiction was Arizona, which referred to Travis J. Meyers, Arynn Infante & Kevin Wright, *Addressing Serious Violent Misconduct in Prison: Examining an Alternative Form of Restrictive Housing*, __ INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 1, 1 (2018). The article described its focus as "the future behavioral and mental health outcomes associated with completing an alternative approach to restrictive housing in the Arizona Department of Corrections." *Id.*

Other efforts to study the impact of changes were reported to be underway in Nebraska (reporting that it had redesigned its "housing data system" to be able to track individuals and what happened to them); Nevada (a study of "length of stay in prison due to a reduction in credits forfeited"); and Washington (indicating that it had "started to evaluate the effectiveness of congregate classroom programming within restricted housing").

[223] That jurisdiction was Utah.

[224] The question was open-ended: "In an ideal situation (i.e., if you had the necessary resources, and if you could do so consistent with institutional safety), what number of hours out-of-cell do you believe is desirable for prisoners?" The question did not direct jurisdictions to respond in hours per day or hours per week; nor did it ask about the ways in which time out-of-cell should be spent. Answers therefore varied, with some jurisdictions measuring time in hours per day and others in hours per week, and with some jurisdictions providing information on the way in which they believed prisoners should spend time out-of-cell.

[225] The jurisdictions that responded to this question were Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Wisconsin, and Wyoming.

[226] The jurisdictions that specified a certain number of hours were Alabama, Alaska, Arizona, Arkansas, Delaware, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Missouri, Montana, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Wisconsin, and Wyoming.

[227] Some of the jurisdictions that provided a certain number of hours did not specify whether this was measured as hours per day or hours per week, and the measurement could not be determined from the answer. The jurisdictions for which the measurement was unclear were Alaska, Iowa, Kansas, Louisiana, Massachusetts, Montana, New Mexico, Texas, and Wyoming.

[228] That jurisdiction was Pennsylvania, which responded that, at a minimum, three hours per day would be desirable.

[229] Those jurisdictions were North Carolina and Idaho. North Carolina responded 15–16 hours per day would be desirable. Idaho responded 16 hours per day would be desirable.

[230] That jurisdiction, Arizona, specified a three-step system: "Step 1 = 7.5 hours, Step 2 = 8.5 hours, and Step 3 = 9.5 hours per week. Inmates classified as SMI minimally offered 20 hours in out of cell time per week."

[231] That jurisdiction was Illinois.

[232] Those jurisdictions were Alabama, Arizona, and Maryland.

[233] That jurisdiction was Maryland, which stated: "General Population–minimum of 12 hours daily; Disciplinary Segregation–2 hours daily; Administrative Segregation–minimum of 3 hours daily; Maximum Security General Population–minimum of 8 hours daily."

[234] Those jurisdictions were Alabama, Colorado, Delaware, Minnesota, Nebraska, Nevada, New Jersey, New York, North Carolina, and North Dakota.

[235] That jurisdiction was Minnesota.

[236] That jurisdiction was Nevada.

[237] That jurisdiction was Nevada.

[238] This response came from New York, which further explained: "The most desirable program would consist of 2 hours AM programming, 2 hours PM programming and an additional 2 hours exercise, with an incentive-based option to earn more and/or congregate recreation. This has worked well for us in our current SHU Alternative and Mental Health programs."

[239] Those jurisdictions were Colorado, Connecticut, Nebraska, New Jersey, Ohio, and South Dakota.

[240] That jurisdiction was Ohio. In response to this question, South Dakota stated that "the amount of out of cell time considered ideal varies by custody levels, housing type and arrangement, work and programming, and other out of cell activities so it is not possible for us to respond to this question."

[241] For example, the Vera Institute of Justice, with the "support of the National Institute of Justice, and in collaboration with the University of North Carolina School of Social Work and Oregon Health and Science University" has

undertaken a multi-year study in prisons in Oregon, North Carolina, and Missouri to "assess the impact of working in restrictive housing on correctional officers' mental, emotional, and physical wellbeing." *See* https://www.vera.org/projects/restrictive-housing-impact-officer-wellbeing/overview.

Vera also has a "Safe Alternatives to Segregation Initiative," and has worked on ways to reduce the use of segregation at "16 jurisdictions in total." *See* https://www.safealternativestosegregation.org/. As of the spring of 2018, Vera had projects in Louisiana, Minnesota, Nevada, Utah, and Virginia. Vera reported reductions in populations in restrictive housing in several sites, including over 85% in New York City; about 50% in Middlesex County, NJ; 27% in North Carolina; and 11% in Nebraska. *See* https://www.vera.org/rethinking-restrictive-housing#where-are-they-now.

[242] Thirty jurisdictions reported tracking in 2013 the numbers of individuals released directly to the community. Among those jurisdictions reporting, 4,400 people were released from administrative segregation to their communities. ASCA-LIMAN ADMINISTRATIVE SEGREGATION 2014, *supra* note 6, at 29. *See also* Christie Thompson, *From Solitary to the Street: What Happens when Prisoners Go from Complete Isolation to Complete Freedom in a Day?*, THE MARSHALL PROJECT, June 11, 2015, *available at* https://www.themarshallproject.org/ 2015/06/11/from-solitary-to-the-street.

[243] VERA RETHINKING RESTRICTIVE HOUSING 2018, *supra* note 27, at 10. Reports on the Findings and Recommendations specific to each site are available at https://www.vera.org /publications/safe-alternatives-segregation-initiative-findings-recommendations. Vera is currently working with additional states including Louisiana, Minnesota, Nevada, Utah, and Virginia.

[244] ASCA-LIMAN ADMINISTRATIVE SEGREGATION NATIONAL OVERVIEW 2013, *supra* note 3.

[245] *Id*. at 4–5, 11.

[246] ASCA-LIMAN ADMINISTRATIVE SEGREGATION 2014, *supra* note 6; ASCA-LIMAN AIMING TO REDUCE TIME-IN-CELL 2016, *supra* note 13.

[247] VERA RETHINKING RESTRICTIVE HOUSING 2018, *supra* note 27, at 14.

[248] *Id*. at 15

[249] *Id*. at 17.

[250] *Id*. at 18–19.

[251] *Id*. at 21.

[252] *See* ASCA-LIMAN AIMING TO REDUCE TIME-IN-CELL 2016, *supra* note 13, at 49. Among 34 jurisdictions providing data in 2016, 5,146 male prisoners with serious mental health issues were held in restrictive housing, and among 32 jurisdictions providing data on female prisoners in 2016, 297 female prisoners with serious mental health issues were held in restrictive housing. *See also* Section II, Subpopulations, Prisoners with Mental Health Issues.

[253] *See* Section II, The Demographics of Restrictive Housing, Race and Ethnicity. As noted there, among the 34 reporting jurisdictions, Black male prisoners comprised 45.7% of the restrictive housing populations and 42.3% of the total male custodial population. In 29 of the 34 jurisdictions, the male restrictive housing population contained a smaller percentage of White prisoners than in the total male custodial population. Among the 29 jurisdictions reporting numbers on women, Black female prisoners comprised 38.6% of the restrictive housing population and 22.6% of the total custodial population. In 21 of the 29 jurisdictions, the female restrictive housing population contained a smaller percentage of White prisoners than the total female custodial population.

Included in SCDC' 4.29.19 letter to LOC

[254] Vera Rethinking Restrictive Housing 2018, *supra* note 27, at 23.

[255] *Id*. at 24.

[256] *Id*. at 25.

[257] Thirty jurisdictions reported that 4,400 people were released from administrative segregation directly to their communities. ASCA-Liman Administrative Segregation 2014, *supra* note 6, at 29.

[258] Vera identified 348 people in Oregon and 1,892 people in North Carolina released from restrictive housing directly to the community. Vera Rethinking Restrictive Housing 2018, *supra* note 27, at 28.

[259] *Id*. at 28–29.

[260] *Id.* at 8.

[261] *Id.* at 29.

[262] *Id.* at 30.

[263] *Id.* at 34.

[264] *Id*. at 38–39.

[265] 60 Minutes, *Reforming Solitary Confinement at an Infamous California Prison*, Jul. 22, 2018, https://www.cbsnews.com/news/60-minutes-reforming-solitary-confinement-at-an-infamous-california-prison/.

[266] Cheryl Corley, *North Dakota Prison Officials Think Outside the Box to Revamp Solitary Confinement*, Morning Edition, NPR, Jul. 31 2018, *available at* https://www.npr.org/2018/07/31/630602624/north-dakota-prison-officials-think-outside-the-box-to-revamp-solitary-confineme.

[267] Dashka Slater, *North Dakota's Norway Experiment: Can Humane Prisons Work in America? A Red State Aims to Find Out*, Mother Jones, July/Aug. 2017, *available at* https://www.motherjones.com/crime-justice/2017/07/north-dakota-norway-prisons-experiment/.

[268] Rick Raemisch, *Why We Ended Long-Term Solitary Confinement in Colorado*, New York Times, Oct. 12 2017, *available at* https://www.nytimes.com/2017/10/12/opinion/solitary-confinement-colorado-prison.html.

[269] *Oregon Prisons Cut Use of Solitary Confinement*, KTVZ.COM, *available at* https://www.ktvz.com/news/oregon-prisons-cut-use-of-solitary-confinement/746191882.

[270] Keri Blakinger, *Texas Prisons Eliminate Use of Solitary Confinement for Punitive Reasons*, Houston Chronicle, Sep. 21 2017, *available at* https://www.houstonchronicle.com/news/houston-texas/houston/article/Texas-prisons-eliminate-use-of-solitary-12219437.php.

[271] *See* Craig Haney, *Restricting the Use of Solitary Confinement*, 1 Ann. Rev. Criminology 285, 298 (2018), *available at* https://www.annualreviews.org/doi/pdf/10.1146/annurev-criminol-032317-092326. In his view, the "research consistently documents and details the risk of psychological harm that social isolation creates, including mental pain and suffering and the increased incidence of self-harm and suicide."

[272] American Psychological Association, Letter to Senator Booker, June 8, 2017, *available at* https://www.apa.org/advocacy/criminal-justice/juvenile-solitary-confinement.pdf.

[273] Cyrus Ahalt, Craig Haney, Sarah Rios, Matthew P. Fox, David Farabee & Brie Williams, *Reducing the Use and Impact of Solitary Confinement in Corrections*, 13 INTERNATIONAL JOURNAL OF PRISONER HEALTH 41, 43 (2017) (*citing* Carla M. Perissinotto, Irena Stijacic Cenzer & Kenneth E. Covinsky, *Loneliness in Older Persons: A Predictor of Functional Decline and Death*, 172 ARCHIVES OF INTERNAL MEDICINE, 1078–83 (2012); BRIE A. WILLIAMS, ANNA CHANGE, CYRUS AHALT, HELEN CHEN, REBECCA CONANT, C. SETH LANDEFELD, CHRISTINE RITCHIE & MICHI YUKAWA, CURRENT DIAGNOSIS & TREATMENT: GERIATRICS, 2E (2014); Brie A. Williams, *Older Prisoners and the Physical Health Effects of Solitary Confinement*, 106 AMERICAN JOURNAL OF PUBLIC HEALTH, 2126–2127 (2016)).

[274] American Civil Liberties Union, *Caged In: Solitary Confinement's Devastating Harm on People with Physical Disabilities* (2017), *available at* https://www.aclu.org/sites/default/files/field_document/010916-aclu-solitarydisabilityreport-single.pdf.

[275] *Id*. at 7, Table 1.

[276] *Id*. at 12.

[277] *Id*. at 10, 28–34, 35–39.

[278] *Id*. at 4, 28–35.

[279] *Id.* at 9.

[280] 42 U.S.C. § 12101 et seq.; 29 U.S.C. § 794.

[281] *See, e.g.*, *Dunn v. Dunn*, 318 F.R.D. 652 (M.D. Ala. 2016); *Pierce v. District of Columbia*, 128 F. Supp. 3d 250 (D.D.C. 2015).

[282] American Psychiatric Association, Position Statement on Segregation of Prisoners with Mental Illness (2012), *available at* http://www.dhcs.ca.gov/services/MH/Documents/2013_04_AC_06c_APA_ps2012_PrizSeg.pdf.

[283] COMMITTEE ON CAUSES AND CONSEQUENCES OF HIGH RATES OF INCARCERATION, THE GROWTH OF INCARCERATION IN THE UNITED STATES: EXPLORING CAUSES AND CONSEQUENCES 201 (Jeremy Travis, Bruce Western, and Steve Redburn eds.) (2014).

[284] *See* National Commission Correctional Health Care, Position Statement, Solitary Confinement (Isolation), adopted April 2016, *available at* https://www.ncchc.org/filebin/Positions/Solitary-Confinement-Isolation.pdf.

[285] *Id*. at 4, principle 1.

[286] *Id*. at 4, principle 3.

[287] *Id*. at 4, principle 5.

[288] *Id*. at 4, principle 9.

[289] *Id*. at 5, principle 15.

[290] Robert Morgan, Paul Gendreau, Paula Smith, Andrew Gray, Ryan Labrecque, Nina MacLean, Stephanie Van Horn, Angelea Bolanos, Ashley Batastini & Jeremy Mills, *Quantitative Synthesis of the Effects of Administrative Segregation on Inmates' Well-Being*, 22 PSYCHOLOGY, PUBLIC POLICY, AND LAW 439, 455 (2016). A central reference in this essay was a study, O'Keefe, Maureen, Kelli Klebe, Alysha Stucker, Kristin Sturm & William Leggett, *One Year Longitudinal Study of the Psychological Effects of Administrative Segregation, Final Report to the National Institute of Justice*, US Department of Justice, National Institute of Justice (2010).

[291] *See* Craig Haney, *The Psychological Effects of Solitary Confinement: A Systemic Critique*, 47 CRIME AND JUSTICE 365, 399–402 (2018). This essay noted that the 2016 discussion, which described doing a synthesis, did not include a fair representation of studies finding that solitary confinement caused serious psychological harms.

[292] *Id*. at 402–07.

[293] *Id*. at 378–98.

[294] *Id*. at 372.

[295] Terry Kupers, *The SHU-Post Release Syndrome: A Preliminary Report*, 17 CORRECTIONAL MENTAL HEALTH REPORT 81 (2016), *available at* https://www.civicresearchinstitute.com/online/article_abstract.php?pid=14&iid=1172&aid=7652. *See generally* TERRY ALLEN KUPERS, SOLITARY: THE INSIDE STORY OF SUPERMAX ISOLATION AND HOW WE CAN ABOLISH IT (2017). These findings parallel those of a 2018 report, Human Rights in Trauma Mental Health Lab, Stanford University, *Mental Health Consequences Following Release from Long-Term Solitary Confinement in California*, *available at* https://handacenter.stanford.edu/sites/default/files/publications/mental_health_consequences_following_release_from_long-term_solitary_confinement_in_california.pdf [hereinafter *Mental Health Consequences in California*]. This study concerned the mental health consequences of long-term solitary confinement, and was conducted by Stanford University's Human Rights in Trauma Mental Health Laboratory, working at the behest of the Center for Constitutional Rights, which represented a class of California prisoners held in isolation. *See Ashker v. The Governor of California*, 09-CV-05796-CW (N.D. Cal. 2009). After interviewing individuals, the Lab concluded that the men "experienced severe psychological disturbances with lasting detrimental consequences," with the most common responses to isolation being "emotional numbing and desensitization," which continued "to be problematic for prisoners following the transition to the general population." *Mental Health Consequences in California* at 2.

[296] Research in animals has raised concerns that isolation results in brain wave and behavioral changes. *See* Huda Akil, Panel on Solitary Confinement: Legal, Clinical, and Neurobiological Perspectives, American Association for the Advancement of Science 2014 Annual Meeting, Feb. 14, 2014, https://thinkprogress.org/solitary-confinement- may-dramatically-alter-brain-shape-in-just-days-neuroscientist-says-ae939f8e7685/. *See also* Michael Zigmond & Richard Jay Smeyne, *Neurobiological Effects of Isolation: Historical and Current Perspectives, in* Solitary Confinement: Effects, Practices and Pathways Towards Reform (Jules Lobel & Peter Scharff Smith eds., Oxford University Press, forthcoming 2018).

[297] Fatos Kaba, Andrea Lewis, Sarah Glowa-Kollisch, James Hadler, David Lee, Howard Alper, Daniel Selling, Ross MacDonald, Angela Solimo, Amanda Parsons & Homer Venters, *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 AMERICAN JOURNAL OF PUBLIC HEALTH 442 (2014).

[298] Brian O. Hagan, Emily A. Wang, Jenerius A. Aminawung, Carmen E. Albizu-Garcia, Nickolas Zaller, Sylviah Nyamu, Shira Shavit, Joseph Deluca & Aaron D. Fox, *History of Solitary Confinement Is Associated with Post-Traumatic Stress Disorder Symptoms among Individuals Recently Released from Prison*, 95 JOURNAL OF URBAN HEALTH 141 (2018).

[299] Valerie Clark & Grant Duwe, *The Effects of Restrictive Housing on Recidivism*, Minnesota Department of Corrections, December 2017, *available at* https://mn.gov/doc/assets/Effects%20of%20Restrictive%20Housing%20on%20Recidivism_tcm1089-320093.pdf.

[300] *Id*. at 10.

[301] *Id*. at 4.

---

[302] *Id.*

[303] *Id.* at 23. Minnesota reported that the Justice Research and Statistics Association (JRSA) awarded the study its Excellence in Research/Policy Award in 2018.

[304] *See* 2017 Hawaii Senate Bill No. 2859, Hawaii Twenty-Ninth Legislature – Regular Session of 2018 [hereinafter Hawaii Senate Bill 2859]. Section 1(b)(2) of the bill would require that "on every third day, or sooner, following initial placement in administrative segregation, the facility program committee shall hold a hearing to determine if continued placement in administrative segregation is warranted." Section § 1(c)(2) would require that "on every tenth day, or sooner, of disciplinary segregation, an adjustment committee shall hold a hearing and any recommendations to extend the disciplinary segregation shall be approved by the institutions division administrator, medical director, and staff psychiatrist." *See also* 2018 New Jersey Assembly Bill No. 314, New Jersey Two Hundred Eighteenth Legislature – First Annual Session [hereinafter New Jersey Assembly Bill 314]. Section 4a(4) of the bill would require that, with exceptions for lockdown, "an inmate shall only be held in isolated confinement pursuant to initial procedures and reviews which provide timely, fair and meaningful opportunities for the inmate to contest the confinement. These procedures shall include the right to an initial hearing within 72 hours of placement and a review every 15 days thereafter, in the absence of exceptional circumstances, unavoidable delays, or reasonable postponements; the right to appear at the hearing; the right to be represented at the hearing; an independent hearing officer; and a written statement of reasons for the decision made at the hearing." *See also* 2018 Virginia House Bill No. 795, Virginia 2018 Regular Session [hereinafter Virginia House Bill 795]. Section 53.1-39.1(F) of the bill would provide that "the Department shall create an administrative process by which an inmate may contest his isolated confinement within 72 hours of being placed in isolated confinement. The process shall include a hearing before an independent hearing officer. The inmate shall have the right to appear at the hearing, present evidence, and be represented by counsel."

[305] *See, e.g.*, 2017 Nebraska Legislative Bill No. 560, Nebraska One Hundred Fifth Legislature – First Regular Session [hereinafter Nebraska Legislative Bill 560]. Section Four of the bill would provide that:

> The director shall issue an annual report on or before September 15 to the Governor and the Clerk of the Legislature . . . . For all inmates who were held in restrictive housing during the prior year, the report shall contain the race, gender, age, and length of time each inmate has continuously been held in restrictive housing. The report shall also contain: (a) The number of inmates held in restrictive housing; (b) The reason or reasons each inmate was held in restrictive housing; (c) The number of inmates held in restrictive housing who have been diagnosed with a mental illness or behavioral disorder and the type of mental illness or behavioral disorder by inmate; (d) The number of inmates who were released from restrictive housing directly to parole or into the general public and the reason for such release; (e) The number of inmates who were released from restrictive housing based upon an order of a district judge under subsection (2) of section 83-173.03; (f) The number of inmates who were placed in restrictive housing for his or her own safety and the underlying circumstances for each placement; (g) To the extent reasonably ascertainable, comparable statistics for the nation and each of the states that border Nebraska pertaining to subdivisions (4)(a) through (f) of this section; and (h) The mean and median length of time for all inmates held in restrictive housing.

See also New Jersey Assembly Bill 314, *supra* note 304. Section 7(e) would

> Requir[e] posting on the official website of the Department of Corrections of quarterly reports on the use of isolated confinement, by age, sex, gender identity, ethnicity, incidence of mental illness, and type of confinement status, at each facility, including a county correctional facility; these reports shall include the population on the last day of each quarter and a non-duplicative cumulative count of people exposed to isolated confinement for each fiscal year. These inmate reports also shall include the incidence of emergency confinement, self-harm, suicide, and assault in any isolated confinement unit, as well as explanations for each instance of facility-wide lockdown.

See also 2017 New York Senate Bill No. 4784, New York Two Hundred Fortieth Legislative Session [hereinafter New York Senate Bill 4784]. Section 4(n) would require that:

> The department shall make publicly available monthly reports of the number of people as of the first day of each month, and semi-annual and annual cumulative reports of the total number of people, who are (i) in segregated confinement; and (ii) in residential rehabilitation units; along with a breakdown of the number of people (iii) in segregated confinement and (iv) in residential rehabilitation units by (A) age; (B) race; (C) gender; (D) mental health level; (E) health status; (F) drug addiction status; (G) pregnancy status; (H) lesbian, gay, bisexual, transgender, or intersex status; and (I) total continuous length of stay, and total length of stay in the past sixty days, in segregated confinement or a residential rehabilitation unit.

The New York legislature passed the bill, which is awaiting signature by the governor. *See also* Virginia House Bill 795, *supra* note 304. Section 53.1-39.1 (H) would require that:

> The Department shall report to the Governor and the General Assembly on or before June 30 and December 31 of each year the following information: 1. The total prison population; 2. The number of inmates who have been placed in isolated confinement and the age, sex, gender identity, and ethnicity of such inmates; 3. The number of inmates who are a member of a vulnerable population who have been placed in isolated confinement and the category of vulnerable population of such inmates; 4. The average length and median length of isolated confinement for (i) inmates placed in isolated confinement and (ii) inmates who are a member of a vulnerable population who have been placed in isolated confinement, calculated for each category of vulnerable population; 5. The number of inmates who have been placed in isolated confinement who have attempted to harm themselves or others; and 6. The number of inmates who have been placed in isolated confinement who have been released from the correctional facility while placed in isolated confinement.

[306] CRIMES AND OFFENSES, 2018 Mass. Legis. Serv. Ch. 69 (S.B. 2371) [hereinafter CRIMES AND OFFENSES].

[307] New York Senate Bill 4784, *supra* note 305, § 4(h) would prohibit holding any person "in segregated confinement for longer than necessary and never more than fifteen consecutive days nor twenty total days within any sixty day period. At these limits, persons must be released from segregated confinement or diverted to a separate secure residential rehabilitation unit." Section 4(j)(iv) provides "No person may be held in segregated confinement for protective custody."

[308]Hawaii Senate Bill 2859, *supra* note 304. One facet of the proposal would limit the "the maximum length of time" a prisoner could be held in administrative segregation to no more than 14 days in any 30 day period. *Id*. at § 1(b)(1). Another provision would limit placement in disciplinary segregation to no more than 60 days in 180. *Id*. at § 1(c)(1). Both provisions would require oversight with hearings, for administrative segregation on every third day, and for disciplinary segregation, on every tenth day. *Id*. at § 1(b)(2), § 1(c)(2). Extensions of time for disciplinary segregation would require approval by "the institutions division administrator, medical director, and staff psychiatrist." *Id*. at § 1(c)(1).

[309] Nebraska Legislative Bill 560, *supra* note 305, § 4(3) provides that "no person shall be placed in solitary confinement," which is defined as confinement to cell for an average of 22 or more hours per day. Section 3(1) limits the use of restrictive housing, defined as confinement that provides limited contact with other offenders, strictly controlled movement while out-of-cell, and out-of-cell time less than 24 hours per week, such that "no inmate shall be held in restrictive housing unless done in the least restrictive manner consistent with maintaining order in the facility and pursuant to rules and regulations adopted and promulgated by the department pursuant to the Administrative Procedure Act." Section 2(2) would provide for a review process by the district court for any prisoner placed in restrictive housing for 90 days. The bill is set to be reintroduced in 2019.

Included in SCDC' 4.29.19 letter to LOC

[310] New Jersey Assembly Bill 314, *supra* note 304, places limitations on the use of "isolated confinement," defined as "confinement of an inmate in a correctional facility, pursuant to disciplinary, administrative, protective, investigative, medical, or other classification, in a cell or similarly confined holding or living space, alone or with other inmates, for approximately 20 hours or more per day with severely restricted activity, movement, and social interaction." Section 4.a(1) provides that "an inmate shall not be placed in isolated confinement unless there is reasonable cause to believe that the inmate would create a substantial risk of immediate serious harm to himself or another, as evidenced by recent threats or conduct, and a less restrictive intervention would be insufficient to reduce this risk." Section 4.a (2) prohibits placing a prisoner "in isolated confinement for non-disciplinary reasons," with exceptions for facility-wide lockdowns, emergency confinement, medical isolation, and protective custody.

[311] Virginia House Bill 795, *supra* note 304, § 53.1-39.1(A) defines isolated confinement as "confinement of an inmate to his cell for more than 20 hours per day" and § 53.1-39.1(B) provides that "an inmate who is not a member of a vulnerable population shall not be placed in isolated confinement for longer than 15 consecutive days or in excess of 20 days in any 60-day period." Section 53.1-39.1(F) requires the Department of Corrections to "create an administrative process by which an inmate may contest his isolated confinement within 72 hours of being placed in confinement," and Section 53.1-39.1(D) requires a "comprehensive medical and mental health evaluation conducted by a medical professional within 12 hours of confinement."

[312] 2017 U.S. Congress S. 2724, 115th CONGRESS, 2nd Session.

[313] CRIMES AND OFFENSES, *supra* note 306, at § 93f.

[314] *Id.* at § 39A(b).

[315] *Id.* at § 39A(b).

[316] *Id.* at § 39B: "(a) All prisoners confined to restrictive housing shall receive placement reviews at the following intervals, and may receive them more frequently, if a prisoner: (i) is being confined to restrictive housing pursuant to subsection (a) of section 39A, every 72 hours; (ii) is being confined to restrictive housing pursuant to subsection (b) of section 39A, every 72 hours; (iii) is awaiting adjudication of an alleged disciplinary breach, every 15 days;(iv) has been committed to disciplinary restrictive housing, not later than 6 months and every 90 days thereafter; and (v) is being held for any other reason, every 90 days."

[317] The committee is to include "the secretary of the executive office of public safety and security or a designee, who shall serve as chair; the commissioner of the department of correction or a designee; the commissioner of mental health or a designee; and 9 members to be appointed by the governor, 1 of whom shall be a correctional administrator with expertise in prison discipline or prison programming, 1 of whom shall be a member of a correctional officers union, 1 of whom shall have significant and demonstrated experience in criminal justice or corrections policy research; 1 of whom shall be the president of Massachusetts Sheriffs Association, Inc. or a designee, 1 of whom shall be a former judge designated by the chief justice of the supreme judicial court, 1 of whom shall be the executive director of Disability Law Center, Inc. or a designee, 1 of whom shall be the executive director of Prisoners' Legal Services or a designee, 1 of whom shall be the executive director of the Massachusetts Association for Mental Health, Inc. or a designee and 1 of whom shall be a licensed social worker designated by the Massachusetts chapter of the National Association of Social Workers, Inc." *Id.* at § 39G.

[318] *Id.* at § 39D: "(a) The commissioner shall publish monthly and provide directly to the restrictive housing oversight committee the number of prisoners held in each restrictive housing unit within each state and county correctional facility. (b) The commissioner shall publish a report quarterly and provide directly to the restrictive housing oversight committee, as to each restrictive housing unit within each state correctional facility, and annually, as to each restrictive housing unit within each county correctional facility: (i) the number of prisoners as to whom a finding of serious mental illness has been made and the number of such prisoners held for more than 30 days; (ii) the number of prisoners

who have committed suicide or committed non-lethal acts of self-harm; (iii) the number of prisoners according to the reason for their restrictive housing; (iv) as to prisoners in disciplinary restrictive housing, a listing of prisoners with names redacted, including an anonymized identification number that shall be consistent across reports, age, race, gender and ethnicity, whether the prisoner has an open mental health case, the date of the prisoner's commitment to discipline, the length of the prisoner's term and a summary of the reason for the prisoner's commitment; (v) the number of placement reviews conducted pursuant to clause (iv) and (v) of subsection (a) of section 39B and the number of prisoners released from restrictive housing as a result of such placement reviews; (vi) the length of original assignment to and total time served in disciplinary restrictive housing for each prisoner released from disciplinary restrictive housing as a result of a placement review; (vii) the count of prisoners released to the community directly or within 30 days of release from restrictive housing; (viii) the known disabilities of every prisoner who was placed in restrictive housing during the previous 3 months; (ix) the number of mental health professionals who work directly with prisoners in restrictive housing; (x) the number of transfers to outside hospitals directly from restrictive housing; and (xi) such additional information as the commissioner may determine. (c) The committee shall gather information regarding the use of restrictive housing in correctional institutions to determine the impact of restrictive housing on inmates, rates of violence, recidivism, incarceration costs and self-harm within correctional institutions."

[319] *Id.* at § 39E.

[320] *Id.* at § 39A(c): "The fact that a prisoner is lesbian, gay, bisexual, transgender, queer or intersex or has a gender identity or expression or sexual orientation uncommon in general population shall not be grounds for placement in restrictive housing."

[321] *Id*. at § 39A(d): "A pregnant inmate shall not be placed in restrictive housing."

[322] Hawaii Senate Bill 2859, *supra* note 304, at § 1(d) would prohibit placement of a member of a "vulnerable population" in restrictive housing unless all other less restrictive means of intervention have been attempted and only after a mental and physical exam. New Jersey Assembly Bill 314, *supra* note 304, § 3 would limit placement of members of "vulnerable population" in restrictive housing. New York Senate Bill 4784, *supra* note 305, § 4(g) would prohibit placement in restrictive housing of person in a "special population." The New York legislature passed the bill, which is awaiting signature by the governor. Virginia House Bill 795, *supra* note 304, § 53.1-39.1 (B) would prohibit, with some exceptions, placement of a member of a "vulnerable population" in restrictive housing.

[323] *See e.g.*, Cal Welf. & Inst. Code § 208.3 (West), which states: "Room confinement means the placement of a minor or ward in a locked sleeping room or cell with minimal or no contact with persons other than correctional facility staff and attorneys. Room confinement does not include confinement of a minor or ward in a single-person room or cell for brief periods of locked room confinement necessary for required institutional operations."; Neb. Rev. Stat. § 83-4,125, which states: "Room confinement means the involuntary restriction of a juvenile to a cell, room, or other area, alone, including a juvenile's own room, except during normal sleeping hours."

[324] Cal. Welf. & Inst. Code § 208.3(b)(2).

[325] *Id.* at § 208.3(b)(1).

[326] *Id.* at § 208.3(c), (d).

[327] Colo. Rev. Stat. Ann. § 26-20–104.5 (West).

[328] Comprehensive Youth Justice Amendment Act of 2016, 2017 District of Columbia Law 21-238 § 203(e). The Act provided:

> Except for room confinement occurring under subsection (c) of this section, room confinement shall be used for the briefest period of time possible and not for a time to exceed 6 hours. After 6 hours, the youth shall be returned to the general population, transported to a mental health facility upon the recommendation of a mental health professional, transferred to the medical unit in the facility, or provided special individualized programming.

[329] *Id.* at § 203(a).

[330] Tennessee Public Chapter No. 1052, House Bill No. 2271, Juvenile Justice Reform Act of 2018 § 13. The Act provided that the "use of seclusion for punitive purposes pre-adjudication or post-adjudication for any child detained in any facility pursuant to § 37-1-114 is prohibited."

[331] Nebraska Legislative Bill 870, *supra* note 305, at § 2(5).

[332] *Id*. at § 2(a).

[333] 2018 Connecticut House Bill No. 5041 § 33(e), Connecticut General Assembly – February Session, 2018. The bill would require that "no child shall at any time be held in solitary confinement or held for a period that exceeds six hours."

[334] Colo. Rev. Stat. Ann. § 17-1-113.8 (West).

[335] CRIMES AND OFFENSES, *supra* note 306, at § 39A(a). The law provided:

> A prisoner shall not be held in restrictive housing if the prisoner has a serious mental illness or a finding has been made, pursuant to subsections (c) or (d) of section 39 or otherwise, that restrictive housing is clinically contraindicated unless, not later than 72 hours after the finding, the commissioner, the sheriff or a designee of the commissioner or sheriff certifies in writing: (i) the reason why the prisoner may not be safely held in the general population; (ii) that there is no available placement in a secure treatment unit; (iii) that efforts are being undertaken to find appropriate housing and the status of the efforts; and (iv) the anticipated time frame for resolution. A copy of the written certification shall be provided to the prisoner. A prisoner in restrictive housing shall be offered additional mental health treatment in accordance with clinical standards adopted by the department of correction.

[336] *Braggs v. Dunn*, 257 F. Supp. 3d 1171 (M.D. Ala. 2017).

[337] *Braggs v. Dunn*, 317 F.R.D. 634, 673–74 (M.D. Ala. 2016). Excluded were those at "work release centers and Tutwiler Prison for Women." A co-plaintiff, the Alabama Disabilities Advocacy Program (ADAP), which is a designated protection agency under federal law, pursued claims on behalf of women at Tutwiler. *See Braggs v. Dunn*, 257 F. Supp. 3d at 1181.

[338] *Braggs v. Dunn*, 257 F. Supp. 3d at 1181.

[339] *Id*. at 1184–85.

[340] *Id*. at 1185–86. Two people committed suicide during the course of the trial, including one of the named plaintiffs who testified in the case. *Id*.

[341] *Id*. at 1267–68. The standard comes from *Estelle v. Gamble*, 429 U.S. 97, 104 (1976), which held that "deliberate indifference to serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain proscribed by the Eighth Amendment" (internal citations and quotation marks omitted).

[342] *Braggs v. Dunn*, 257 F. Supp. 3d at 1268.

[343] *See Braggs v. Dunn*, 2018 WL 985759 (M.D. Ala. Feb 20, 2018); *Braggs v. Dunn*, 2018 WL 2057467 (M.D. Ala. Mar 30, 2018); *Braggs v. Dunn*, 2018 WL 1805594 (M.D. Ala. Apr 9 2018); *Braggs v. Dunn*, 2018 WL 2168705 (M.D. Ala. Apr. 25, 2018); *Braggs v. Dunn*, 2018 WL 2440287 (M.D. Ala. Apr. 25, 2018).

[344] *See* South Carolina Department of Corrections, Protection & Advocacy for People with Disabilities, Inc., *SCDC, Mental Health Advocates Reach Historic Agreement*, June 1, 2016, *available at* http://www.pandasc.org/wp-content/uploads/2016/06/PA-and-SCDC-Press-Release-6-1-16.pdf.

[345] *T.R., et al. v. South Carolina Department of Corrections*, 2005-CP-40-02925 (S.C. Com. Pl. Oct. 6, 2011), Fifth Amended Complaint, p. 21, *available at* https://www.clearinghouse.net/chDocs/public/PC-SC-0006-0001.pdf.

[346] *Id*. at 16–17.

[347] *Id*. at 18.

[348] *Id*., Order Granting Judgment in Favor of Plaintiffs, Jan. 8, 2014, p. 3, 5, *available at* https://www.clearinghouse.net/chDocs/public/PC-SC-0006-0006.pdf.

[349] *Id*. at 6.

[350] *T.R. v. South Carolina Department of Corrections*, Appellate Case No. 2014-001080 (S.C. Dec. 14, 2016), Order Dismissing Appeal.

[351] *Id*., Settlement Agreement, *available at* http://www.pandasc.org/wp-content/uploads/2016/06/ Settlement-Agreement-May-31-2016.pdf. *See also* South Carolina Department of Corrections; Protection & Advocacy for People with Disabilities, Inc.; *SCDC, Mental Health Advocates Reach Historic Agreement*, June 1, 2016, *available at* http://www.pandasc.org/wp-content/uploads/2016/06/PA-and-SCDC-Press-Release-6-1-16.pdf.

[352] South Carolina elaborated on the Behavioral Management Unit policy:

> The Behavioral Management Units (BMUs) are designed as a possible alternative to long-term segregation placement for inmates designated as having a mental health classification who are suffering from severe personality disorders and associated disruptive disorders. BMUs are therapeutic programs aimed to disrupt the cycle of repeated disciplinary infractions resulting in frequent, repetitive sanctions that result in long-term segregation placement. The goal of placement in BMUs is to assist inmates in achieving their highest level of functionality by developing alternative coping skills that result in behavioral stability sufficient to return safely to general population. In some cases, the goal will be preparation for re-entry to the community at the expiration of their sentence.

The prison system further explained that it planned "to open a specially designed yard" for prisoners in restrictive housing "due to their safety concerns." South Carolina described the plan:

> The focus will be segregation reduction and re-entry preparation for general population and society. Inmates will be screened for participation using specific criteria and a contract will require disagreements to be resolved through a community meeting or small staff/inmate forum. The program will consist of reception phases to introduce the program, functions, and expectations to incoming inmates. Upon completion of the reception requirements, inmates will be placed in housing units. Each inmate will be assigned a job function within the housing unit aimed at assuming responsibility and learning acceptable work habits. One program to be offered is designed to work with inmates fearful of general population environments with the goal of returning them to a yard as well as preparing them for re-entry into society. The program will determine the

reason for maladapted behavior or refusal to be housed in general population, develop a specific management plan, and thereafter move inmates to one of the therapeutic units.

South Carolina also noted that "an on-going RHU committee" was convening "a special session" to review prisoners with "high mental health needs" in restrictive housing to determine whether restrictive housing placement "is correct or whether the housing assignment should be adjusted."

[353] *Roy Parker et al. v. City of New York*, 15 CV 6733 (CLP) (E.D.N.Y. Settlement Dec. 2017) (Memorandum and Order), *available at* https://cases.justia.com/federal/district-courts/new-york/nyedce/1:2015cv06733/378243/58/0.pdf?ts=1517255506.

[354] *Id*. They alleged that after having been placed in solitary confinement while serving one sentence, released from custody, and then returned to custody on another charge, they were placed back in solitary confinement solely on the basis of having been there previously. *Id*. at 2.

[355] *See* Ashley Southall, *City Agrees to Pay Rikers Inmates It Forced Back into Solitary Confinement*, New York Times (Dec. 12 2017), https://www.nytimes.com/2017/12/12/nyregion/rikers-settlement-solitary-confinement.html.

[356] *Id*.

[357] *C.S., et al., v. King County*, 2:17-CV-01560-JCC (W.D. Wa. 2017), Order, *available at* http://www.columbialegal.org/sites/default/files/KingCounty-OrderGrantingMotionforDismissal.pdf. *See also* https://www.seattletimes.com/seattle-news/crime/king-county-reaches-deal-to-ban-placing-jailed-juveniles-in-solitary-confinement/.

[358] *Id.*, First Amended Complaint for Injunctive and Declaratory Relief, *available at* http://www.columbialegal.org/sites/default/files/17_1023_Complaint_CS-v-KingCounty.pdf.

[359] *Id*., Exhibit A, *available at* http://www.columbialegal.org/sites/default/files/KC_Isolation_24-1.%20Exhibit%20A _RedactedSM.pdf.

[360] *Id*.

[361] *Id*.

[362] *Doe by & through Frazier v. Hommrich*, No. 3-16-0799, 2017 WL 1091864, at *2 (M.D. Tenn. Mar. 22, 2017).

[363] *Id.* at *3. Thereafter, Tennessee enacted a law that defined seclusion as "the intentional, involuntary segregation of an individual from the rest of the resident population for the purposes of preventing harm by the child to oneself or others; preventing harm to the child by others; aiding in de-escalation of violent behavior; or serving clinically defined reasons," and prohibited the "use of seclusion for punitive purposes pre-adjudication or post-adjudication for any child detained in any facility." Tennessee Public Chapter No. 1052, House Bill No. 2271, Juvenile Justice Reform Act of 2018 § 13, signed into law by the governor on May 21, 2018.

[364] *V.W. v. Conway*, 236 F. Supp. 3d 554, 583 (N.D.N.Y. Feb. 22, 2017). Plaintiffs in that case were supported by the Department of Justice, which submitted a brief discussing the harms of solitary confinement for juveniles. Statement of Interest of the United States, Jan. 3, 2017, *available at* https://www.justice.gov/opa/file/922386/download.

[365] *Id*.

[366] *J.J. v. Litscher*, No. 17-CV-47 (W.D. Wi. 2017), *available at* https://www.clearinghouse.net/chDocs/public/JI-WI-0004-0002.pdf.

[367] *Id.*, Preliminary Injunction, *available at* https://www.clearinghouse.net/chDocs/public/JI-WI-0004-0003.pdf.

[368] 2017 Wisconsin Act 1855. Laurel White, *Walker Signs Law Closing Lincoln Hills Youth Prison*, Wisconsin Public Radio, Mar. 30, 2018, https://www.wpr.org/walker-signs-law-closing-lincoln-hills-youth-prison.

[369] *J.J. v. Litscher*, No. 17-CV-47 (W.D. Wi. 2017), Stipulation for Consent Decree and Permanent Injunction, *available at* https://jlc.org/sites/default/files/attachments/2018-06/2018.6.1%20Decl%20RTM%20in%20Supp.%20Mo%20for%20Settlement%20Approval%20-%20Settl%20Agree.pdf.

[370] *Davis v. Ayala*, 135 S. Ct. 2187, 2210 (2015) (Kennedy, J., concurring). Justice Thomas concurred specifically to disagree, as he pointed to the harms that the prisoner had imposed by killing others. *Id.* at 2210 (Thomas, J., concurring).

[371] *Id.* at 2209. Justice Kennedy stated that it was "as if a judge had no choice but to say:

> 'In imposing this capital sentence, the court is well aware that during the many years you will serve in prison before your execution, the penal system has a solitary confinement regime that will bring you to the edge of madness, perhaps to madness itself.'"

[372] *Ruiz v. Texas*, 137 S. Ct. 1246 (2017) (Breyer, J., dissenting). *See also Glossip v.Gross*, 135 S. Ct 2726, 2765 (2015) (Breyer, J. & Ginsburg, J., dissenting). In 2018, Justice Breyer reiterated the concern in another dissent from a denial of certiorari. He commented that the death-sentenced prisoner had been incarcerated since 1977 and spent "most of the time on death row living in isolated, squalid conditions." *Jordan v. Mississippi*, 138 S.Ct. 2567, 2568 (2018) (Breyer, J., dissenting) (citing petition for certiorari).

[373] *Nordstrom v. Ryan*, CV-15-02176 (D. Ariz. 2015). *See also* https://deathpenaltyinfo.org/node/6824; http://www.abajournal.com/news/article/condemned_to_death_and_solitary_confinement1. As a result of a settlement reached in that case, the plaintiff and others with clear disciplinary records will be moved from solitary confinement.

[374] *Lopez v. Brown*, 4:15 CV 02725 (N.D. Ca 2015), a*vailable at* https://www.clearinghouse.net/chDocs/public/PC-CA-0071-0001.pdf. *See also* http://solitarywatch.com/2017/10/10/lawsuits-challenge-the-cruelty-of-decades-in-solitary-confinement-on-death-row/. A settlement reached in this suit placed a five-year limit on placement in restrictive housing on death row, and provided for more frequent placement reviews.

[375] *Davis et al. v. Jones et al.*, 3:17CV820J34PDB (M.D. Fl. 2017), *available at* https://www.venable.com/files/upload/Complaint-David-v-Jones.pdf. On July 19, 2017, a group of nine death-row prisoners filed a class-action lawsuit against the Florida Department of Corrections, and challenged its practice of automatically keeping death-row prisoners in solitary confinement until the prisoners' release or execution. Plaintiffs Mark Davis and others—whose stays in solitary confinement range from four to thirty years and total over 150 years—asked the United States District Court for the Middle District of Florida to hold the practice unconstitutional in violation of the Eighth Amendment prohibition against cruel and unusual punishment and the Due Process Clause of the Fourteenth Amendment.

[376] *Hamilton et al v. Vannoy et al*, 3:17CV00194 (M.D. La. 2017), *available at* https://cardozo.yu.edu/sites/default/files/Angola%20filed%5DNEW.pdf. In March 2017, prisoners on death row at Louisiana State Penitentiary filed a class-action lawsuit seeking to change the prison's policy of keeping all people sentenced to death in solitary confinement for the duration of their time in prison. The complaint alleged that Marcus Hamilton and his co-plaintiffs were in isolation "between twenty-five and thirty-one years." *Id.* at para. 1. The case is pending, and a settlement conference was set to take place in August 2018. Meanwhile, starting in May 2017, Louisiana began allowing death-row prisoners to be let out of their cells together for four hours a day. *See* Julia O'Donoghue, *Louisiana Tests Relaxed*

Restrictions on Death Row Inmates, The Times-Picayune, Oct. 25, 2017, https://www.nola.com/politics/index.ssf/2017/10/louisiana_death_row_changes.html.

[377] *Reid et al. v. Wetzel*, 1:18-CV-00176-JEJ (M.D. Pa 2018), *available at* https://www.aclupa.org/files/6915/1691/6235/1_Complaint.pdf. On January 25, 2018, prisoners held on death row filed a lawsuit challenging Pennsylvania's practices, alleging that holding "death-sentenced prisoners in permanent, degrading, and inhuman solitary confinement until their capital sentence is overturned, or they die by execution or natural causes." *Id.* at 1. Their complaint alleged that individuals had been held in solitary confinement "for between sixteen and twenty-seven years." *Id*. at 2.

[378] *Williams v. Sec'y Pennsylvania Dep't of Corr.*, 848 F. 3d 549, 576 (3d Cir.), *cert. denied sub nom. Walker v. Farnan*, 138 S. Ct. 357 (2017), and *cert. denied sub nom. Williams v. Wetzel*, 138 S. Ct. 357 (2017).

[379] JUDITH RESNIK, JOHANNA KALB, CELINA ALDAPE, RYAN COOPER, KATIE HAAS, APRIL HU, JESSICA HUNTER & SHELLE SHIMIZU, THE ARTHUR LIMAN PUBLIC INTEREST PROGRAM AT YALE LAW SCHOOL, RETHINKING DEATH ROW: VARIATIONS IN THE HOUSING OF INDIVIDUALS SENTENCED TO DEATH, July 2016, available at: https://law.yale.edu/system/files/documents/pdf/Liman/deathrow_reportfinal.pdf.

[380] *Id.* at Appendix A: Statutes, Administrative Regulations, and Case Law by Jurisdiction.

[381] *Id*. at 9–10, 11–13, 14–16.

[382] George Lombardi, Richard D. Sluder & Donald Wallace, *Mainstreaming Death-Sentenced Inmates: The Missouri Experience and its Legal Significance*, 61 FEDERAL PROBATION 3 (1997).

[383] Mark D. Cunningham, Thomas J. Reidy & Jon R. Sorenssen, *Wasted Resources and Gratuitous Suffering: The Failure of a Security Rationale for Death Row*, 22 PSYCHOLOGY PUBLIC POLICY AND LAW 185 (2016).

[384] *Johnson v. Wetzel*, 209 F. Supp. 3d 766, 770, 781 (M.D. Pa. 2016).

[385] *Id*. at 776.

[386] *Id*. at 781.

[387] *See generally* SHARON SHALEV, A SOURCEBOOK ON SOLITARY CONFINEMENT, Mannheim Centre for Criminology, London School of Economics and Political Science (Oct. 2008), *available at* http://solitaryconfinement.org/sourcebook.

[388] United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules), U.N. ESC Committee on Crime Prevention and Criminal Justice, 24th Sess., U.N. Doc. E/CN.15/2015/L.6/Rev.1 (May 22, 2015), https://www.unodc.org/documents/justice-and-prison-reform/GA-RESOLUTION/E_ebook.pdf [hereinafter Nelson Mandela Rules].

[389] Nelson Mandela Rules, *supra* note 388, Rule 44.

[390] *Id.* at Rule 45.1.

[391] *Id*. at Rule 45.2.

[392] *Id*. at Rule 43.1.

[393] *Id*. at Rule 45.2.

Included in SCDC' 4.29.19 letter to LOC

[394] *See Corporation of the Canadian Civil Liberties Association v. Canada* (Attorney General), 2017 ONSC 7491 (Dec. 18, 2017), *available at* https://ccla.org/cclanewsite/wp-content/uploads/2017/12/Corp-of-the-Canadian-Civil-Liberties-Association-v-HMQ-121117.pdf [hereinafter *CCLA v. Canada*], para. 272; *British Columbia Civil Liberties Association v. Canada* (Attorney General), 2018 BCSC 62 (Jan. 17, 2018), *available at* https://www.canlii.org/en/bc/bcsc/doc/2018/2018bcsc62/2018bcsc62.html [hereinafter *BCCLA v. Canada*], para. 2.

[395] *CCLA v. Canada*, *supra* note 394, at para. 272. In response to a suit brought by the Corporation of the Canadian Association of Civil Liberties (CCLA), the Ontario Superior Court of Justice ruled that so-called "fifth working day review" of a decision to place a prisoner in administrative segregation was insufficient. The court analyzed the claim under *Baker v. Canada (Minister of Citizenship and Immigration)* [1999] 2 S.C.R. 817. The *Baker* decision listed five factors affecting procedural fairness: the nature of the decision, and the process followed in making it; the nature of the statutory scheme; the importance of the decision to the individual; the legitimate expectations of the person challenging the decision; and the choices of procedure made by the agency. The court held that given that the institutional head (akin to a warden) controls the decision to place, maintain, and release a prisoner from administrative segregation—i.e. there is no independent review—"the decision to segregate is procedurally unfair." *Id*. at para. 155. This aspect of the decision relied on Section 7 of the Charter of Rights and Freedoms, which provides, "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice." *Canadian Charter of Rights and Freedoms*, § 7, Part I of *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11.

[396] *CCLA v. Canada,* supra note 394, at para. 87.

[397] *Id*. at para. 89.

[398] *Id*. at para. 230-232. Section 12 of the Charter of Rights and Freedoms provides, "Everyone has the right not to be subjected to any cruel and unusual treatment or punishment." *Canadian Charter of Rights and Freedoms*, § 12, Part I of *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11.

[399] *CCLA v. Canada*, *supra* note 394, at paras. 212, 228.

[400] *Id*. at para. 277. *See also* Canadian Civil Liberties Association, *Legal Fight Against Solitary Confinement Continues*, Jan. 17, 2018, *available at* https://ccla.org/legal-fight-solitary-confinement-continues/.

[401] *BCCLA v. Canada*, *supra* note 394, at para 2. The British Columbia Civil Liberties Association and the John Howard Society of Canada brought the suit, alleging that laws authorizing administrative segregation are contrary to the Canadian Charter of Rights and Freedoms and that these laws have a disproportionate impact on Aboriginal and mentally ill prisoners *Id*. at para. 9.

[402] *Id*. at para. 609.

[403] Section 15 provides, "Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability." *Canadian Charter of Rights and Freedoms*, §15, Part I of *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11. *See BCCLA v. Canada*, *supra* note 394, at para. 2.

[404] *Id*. at para. 609.

[405] *Id*. at para. 247.

[406] *Id*. at para. 533.

[407] *Id*. at para. 543.

[408] *Id*. at para. 610. *See also* Anna Mehler Paperny, *Canada's Government Appeals Court Ruling on Solitary Confinement*, Reuters, Feb. 19, 2018, https://www.reuters.com/article/us-canada-prison-solitary/canadas-government-appeals-court-ruling-on-solitary-confinement-idUSKCN1G321R.

[409] Council of Europe, European Committee on Crime Problems, *Updating the European Prison Rules: Analytical Report*, prepared by Professor Dirk Van Zyl Smit and Harvey Slade, (May 2, 2018), *available at* https://rm.coe.int/pc-c-2018-4rev-e-memo-to-cdpc-updating-the-european-prison-rules-analy/16807c0eba.

[410] *Id*. at 2.

[411] *Id*. *See* European Commission for the Prevention of Torture and Inhuman or Degrading Treatment of Prisoners CPT), Solitary Confinement of Prisoners, extract from the 21st General Report of the CPT, published in 2011 at 2–6, *available at* https://rm.coe.int/16806cccc6.

[412] *Id*.

[413] Council of Europe, Report to the German Government on the Visit to Germany Carried Out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 25 November 2015 to 7 December 2015, *available at* https://rm.coe.int/168071803e.

[414] *Id*. at 35.

[415] *Id*. at 36. During its visit, the CPT found that ten individuals had been held in solitary confinement for security reasons for more than one year, including one individual who had been subjected to solitary confinement for almost 20 years. *Id.*at 28.

[416] *Id*. at 35. In response to the CPT's report, the German government declined to make changes. It stated that instances in which disciplinary solitary confinement was ordered for more than 14 days were "exceptional and extremely rare cases to which the courts have never objected upon review." Council of Europe, Response of the German Government to the report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) on its visit to Germany from 25 November 2015 to 7 December 2015, p. 57, *available at* https://rm.coe.int/response-of-the-german-government-to-the-report-of-the-european-commit/16807182d1. The government reported it did not believe that amendments to the relevant statutory provisions to limit the time in segregation were necessary and that it would be "hard to get the large number of prisoners who abide by the prison rules to understand why effective disciplinary sanctions are being abandoned." *Id*. at 57–58.

[417] Irish Penal Reform Trust, *'Behind the Door': Solitary Confinement in the Irish Penal System*, *available at* http://www.iprt.ie/files/Solitary_Confinement_web.pdf.

[418] *Id*. at 6.

[419] *Id*.

[420] *Id*. at 8.

[421] *Id*. at 8–9.

[422] The 40 jurisdictions that provided numbers of prisoners in restrictive housing in both 2015 and 2017 were Alabama, Alaska, Arizona, Colorado, Connecticut, Delaware, FBOP, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, New Jersey,

New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, Wisconsin, and Wyoming.

Three jurisdictions (Arkansas, Nevada, and Rhode Island) responded to the survey in 2017 but not in 2015. Eight jurisdictions (California, D.C., Florida, Minnesota, New Hampshire, Vermont, Virgin Islands, and Virginia) responded in 2015 but not 2017.

[423] We clarified the definition of restrictive housing in 2017–2018. In 2015–2016, the survey defined restrictive housing as being in-cell for 22 hours or more for 15 continuous days or more; in 2017–2018, the survey defined restrictive housing as being in cell for *an average of* 22 hours or more for 15 continuous days or more. *See supra* note 20.

[424] The 29jurisdictions with decreases in the number of prisoners reported in restrictive housing were, in order of number of prisoners: New York (decrease of 1,832); Texas (1,560); Illinois (1,334); FBOP (968); Georgia (680); Utah (616); Tennessee (587); Alabama (547); Michigan (436); North Carolina (408); New Mexico (369); New Jersey (359); Delaware (338); South Carolina (331); Nebraska (270); Pennsylvania (218); Colorado (207); Oklahoma (184); Kansas (130); Idaho (94); Ohio (92); Iowa (80); Kentucky (79); Maryland (68); Wyoming (50); North Dakota (46); Wisconsin (38); South Dakota (16); and Hawaii (10).

[425] Together, New York, Texas, Illinois, FBOP, and Georgia accounted for a reduction of 6,374 prisoners in restrictive housing from 2015 to 2017.

[426] The 11 jurisdictions with increases in the number of prisoners reported in restrictive housing were, in order of number of prisoners: Missouri (increase of 962); Mississippi (344); Oregon (308); Massachusetts (208); Connecticut (200); Arizona (179); Indiana (120); Washington (113); Alaska (26); Montana (23); and Louisiana (20).

[427] Those 28 jurisdictions, starting with the largest decrease in percentage points, were Utah (from 14.0% to 4.7%); Delaware (from 8.8% to 0.8%); New Mexico (from 9.0% to 4.2%); Nebraska (from 11.0% to 6.3%); Tennessee (from 8.8% to 5.3%); New York (from 8.5% to 5.3%); Illinois (from 4.8% to 2.2%); North Dakota (from 3.0% to 0.4%); Wyoming (from 6.2% to 3.8%); Alabama (from 5.7% to 4.0%); New Jersey (from 6.7% to 5.2%); South Carolina (from 5.1% to 3.7%); Kansas (from 5.9% to 4.6%); Colorado (from 1.2% to 0.1%); Maryland (from 7.5% to 6.5%); Georgia (from 6.8% to 5.8%); North Carolina (from 4.0% to 3.0%); Texas (from 3.9% to 2.9%); Iowa (from 3.0% to 2.0%); Kentucky (from 4.2% to 3.4%); Michigan (from 3.1% to 2.3%); Idaho (from 5.0% to 4.3%); South Dakota (from 3.0% to 2.3%); Oklahoma (from 5.6% to 5.1%); Wisconsin (from 3.7% to 3.2%); Pennsylvania (from 3.4% to 3.2%); Ohio (from 2.7% to 2.6%); and Hawaii (from 0.5% to 0.4%).

[428] That jurisdiction was Utah.

[429] Those 12 jurisdictions, starting with the largest increase in percentage points, were Louisiana (from 14.5% to 19.0%); Mississippi (from 1.0% to 4.1%); Montana (from 3.5% to 6.4%); Missouri (from 6.3% to 9.0%); Massachusetts (from 2.3% to 4.9%); Oregon (from 4.3% to 6.4%); Connecticut (from 0.8% to 2.3%); Alaska (from (7.2% to 8.6%); Indiana (from 5.9% to 6.6%); Washington (from 1.7% to 2.3%); Arizona (from 6.0% to 6.5%); and FBOP (from 4.7% to 5.2%).

[430] That jurisdiction was Louisiana.

[431] The number used for total custodial population in 2015 is the total custodial population about which the jurisdiction had restrictive housing data. *See* ASCA-LIMAN AIMING TO REDUCE TIME-IN-CELL 2016, *supra* note 13, at 22.

[432] Those jurisdictions were Alabama, FBOP, Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Michigan, Nebraska, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, Texas, and Utah.

[433] Those jurisdictions were Missouri and Washington.

[434] As previously noted, we clarified the definition of restrictive housing in 2017–2018. In 2015–2016, the survey defined restrictive housing as being in-cell for 22 hours or more for 15 continuous days or more; in 2017–2018, the survey defined restrictive housing as being in cell for *an average of* 22 hours or more for 15 continuous days or more. *See supra* note 20.

The 31 jurisdictions that provided numbers on length of stay in restrictive housing in both 2015 and 2017 were Alaska, Arizona, Colorado, Delaware, FBOP, Hawaii, Indiana, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Mississippi, Montana, Nebraska, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, Wisconsin, and Wyoming.

Five jurisdictions (Alabama, Illinois, Michigan, Missouri, and Rhode Island) provided data on length of stay in 2017 but not in 2015. Ten jurisdictions (California, Connecticut, District of Columbia, Florida, Idaho, Maryland, Minnesota, Vermont, Virgin Islands, and Virginia) provided data in 2015 but not 2017.

Appendix A: ASCA-Liman 2017–2018 Restrictive Housing Survey

In the fall of 2017 we sent a survey in to the corrections departments in all 50 states, the District of Columbia, and the Federal Bureau of Prisons, and to four large metropolitan jail systems. We corrected the survey in February 2018 to eliminate errors in drafting. The survey reproduced below is a Word version of the full survey distributed on the Qualtrics platform.

Q1. As you know, ASCA and Yale's Liman Center have an ongoing data collection project to understand the use of restrictive housing in departments of corrections. The goal is to continue to map changes by keeping data current. Further, since the last survey, the American Correctional Association (ACA) has new standards for restrictive housing.

This brief questionnaire therefore gathers basic information about all forms of restrictive housing so as to provide a national picture of the number of people in all forms of restrictive housing, the length of their stay, policy reforms, and the impact of the ACA 2016 Standards. As we did in the 2014 and 2015 surveys, we ask for responses to this survey. Thereafter, ASCA members will receive a draft report of the analysis, and after we review the comments and corrections, the report will be finalized for publication. Much of the survey repeats questions from 2015, to which almost all of the ASCA membership responded.

Instructions and Definitions

The questionnaire need not be filled out in one sitting. The Qualtrics platform automatically saves your answers in your browser, so that you can return to the survey again at a later time, but ONLY if you use the same computer for inputting the answers. Most questions can be answered by checking boxes in a list; a few questions provide opportunities for open-ended responses. The Qualtrics Program alerts users when numbers do not add up to the total. If your answers prompt that flag, please recheck or explain the variations (such as subtotals not equaling the total). Because we may have follow-up questions to clarify the information provided, please include the name, contact information, and title for the person to whom such questions should be directed.

We ask first about all individuals in your jurisdiction's correctional facilities, including both sentenced prisoners and pre-trial detainees, as well as about whether you are reporting on facilities operated state-wide, and/or by either local entities housing state prisoners at your behest, or by private entities with whom your jurisdiction contracts. We also want to learn the numbers of prisoners held outside your jurisdiction. That background enables us to understand the context for the numbers provided on the facilities for which you have accessible data on the use of restrictive

Included in SCDC' 4.29.19 letter to LOC

housing, on the numbers in restrictive housing, the length of stay, and demographics. A section is also devoted to learning about policies and reforms.

Please answer all the questions with information about your jurisdiction that is current as of on or about September 24, 2017, and indicate the date on which the data was collected. (For example, some jurisdictions collect data on the first or the fifteenth of every month.)

Not all jurisdictions have information on all the questions. A general "not applicable" (N/A) answer can be confusing. Therefore, we have set up the questionnaire to enable you to clarify if your jurisdiction does not track the information at all, or the information is not available for other reasons. In contrast, if your jurisdiction tracks information and has no prisoners under these conditions, then answer with a "0."

For the purposes of this questionnaire, the term "restrictive housing" refers to separating prisoners from the general population and holding them in their cells for an average of 22 or more hours per day, for 15 or more continuous days. The definition includes prisoners held both in single cells and in double cells, if held for an average of 22 hours per day or more in a cell, for 15 or more continuous days. Thus, the questionnaire aims to gather data on all forms of restrictive housing populations, whether called administrative segregation, disciplinary segregation, protective custody, intensive management, or otherwise categorized.

Also provided is an email address (ascalimansurvey@yale.edu) and a phone number (203-436-3532) to use to let us know that you have questions and that you want a response for clarification.

PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE BY MARCH 2. THANK YOU.

Q2. To facilitate your completion of this survey across multiple sessions, here is a PDF of this survey for download (however, please be sure to enter your responses into this online form):

Q3. **SECTION 1.** Please indicate the jurisdiction for which you are filling out the survey and the date on which data are regularly collected; if the data are collected only for this survey, please indicate the last date on which you finished gathering the data to respond.

If it is possible for your jurisdiction to report data as of September 24, 2017, this would be appreciated in order to have consistency with other jurisdictions.

○ Jurisdiction: ____

○ Data current as of (MM/DD/YYYY): ____

Q4. **SECTION 2.** Please indicate whether the following types of facilities are under the direct control of your jurisdiction's Department of Corrections (check all that apply). By control, the survey means that your jurisdiction hires and supervises staff (even if some are through subcontracts, such as health care services) and provides the governing rules and policies.

○ Prisons

○ Jails

○ Juvenile facilities

○ Mental health facilities

○ Special facilities for death-sentenced prisoners

○ Private prisons

○ Immigration detention

○ Other (please specify) ____

Q5. Please provide the total custodial population for all facilities in your system as identified in Question 4 above (for example, if you indicated in Question 4 that your system includes prisons, jails, juvenile facilities, and mental health facilities, you would provide the total custodial population for those four types of facilities).

____

Q6. Does your jurisdiction have prisoners housed in privately contracted facilities?

○ Yes

○ No

Q7. Does your jurisdiction regularly collect data on prisoners in privately contracted facilities?

○ Yes

○ No (please explain) ____

Q8. Does your jurisdiction contract with the federal government to provide housing for immigration detention?

○ Yes

○ No

Q9. Answer only if you answered "Yes" to the above question. Does your jurisdiction keep data on the population and the use of restrictive housing in these facilities?

○ Yes

○ No (please explain) ____

Q10. **SECTION 2a.** This survey focuses on data in your jurisdiction in facilities under your control. We also want to understand the numbers of individuals not included to learn the size of the population for which we will not have the kinds of information provided by answers to the questions below.

Q11. Are there prisoners sentenced through the state system who are **NOT** under your control and who are housed in other facilities (such as out of state, private, jails, and community residential centers)?

○ Yes

○ No

Q12. Answer only if you answered "Yes" to Question 11 above. Are any of these prisoners housed in local or other facilities **WITHIN** your jurisdiction?

○ Yes

○ No

Q13. Answer only if you answered "Yes" to Question 12 above. Please provide data, if available, on the numbers of such prisoners.

____

____

Q14. Answer only if you answered "Yes" to Question 11 above. Are any of these prisoners housed **OUTSIDE** of your jurisdiction?

◯ Yes

◯ No

Q15. Answer only if you answered "Yes" to Question 14 above. Please indicate the numbers of such prisoners and to what jurisdictions they are sent.

____

Q16. **Section 2b.** Please indicate which facilities use restrictive housing (check all that apply).

◯ Prisons

◯ Jails

◯ Juvenile facilities

◯ Mental health facilities

◯ Privately contracted facilities

◯ Special facilities for death-sentenced prisoners

◯ Immigration detention contract facilities

◯ Other (please specify) ____

Q17. Please indicate the facilities for which you have data on the use of restrictive housing (check all that apply).

- ◯ Prisons
- ◯ Jails
- ◯ Juvenile facilities
- ◯ Mental health facilities
- ◯ Privately contracted facilities
- ◯ Special facilities for death-sentenced prisoners
- ◯ Immigration detention contract facilities
- ◯ Other (please specify) ____

Q18. Please provide the total custodial population in each type of facility for which you have data on the use of restrictive housing. (For example, if you indicated in the question above that you have data on the use of restrictive housing in prisons, jails, and juvenile facilities, you would provide the custodial population in these three types of facilities.)

Prisons : _______

Jails : _______

Juvenile facilities : _______

Mental health facilities : _______

Special facilities for death-sentenced prisoners : _______

Private prisons : _______

Immigration detention : _______

Other (please explain) : _______

Total : ________

Q19. **SECTION 2c.** Please provide available data on restrictive housing.

Note: For all questions in this survey, if your jurisdiction moves prisoners from one restrictive housing status or type to another without releasing them to a non-restrictive housing living unit, please provide the total number of days in restrictive housing REGARDLESS of status or type. In these cases, please include a comment noting that the total number of days includes time in two or more restrictive housing classifications or types.

Example: A prisoner is housed for 10 days in restrictive housing as a disciplinary sanction and upon completion of that sanction remains in restrictive housing for another 10 days for administrative reasons. For the purposes of the survey, the amount of time in restrictive housing would be 20 days, with a comment that the response reflects a time in both disciplinary and administrative statuses.

Q20. How many people are in restrictive housing in the facilities for which you have data?

	Short-term restrictive housing (15 up to 29 days)	Extended restrictive housing (> 29 days)
Prisons		
Jails		
Juvenile facilities		
Mental health facilities		
Special facilities for death-sentenced prisoners		
Privately contracted facilities		
Immigration detention contract facilities		
Other (please specify)		

Q21. Do you house persons in short-term restrictive housing (15 up to 29 days) with others in the same cell?

- ◯ Yes
- ◯ No (please explain) ____

Q22. Do you house persons in extended restrictive housing (> 29 days) with others in the same cell?

◯ Yes

◯ No (please explain) ____

Q23. Answer only if you answered "Yes" to Question 22 above. Of the restrictive-housing cells you have, how many are designed to hold MORE THAN one prisoner?

____

Q24. Answer only if you answered "Yes" to Question 22 above. Of the restrictive-housing cells you have, how many are designed to hold ONLY one prisoner?

____

Q25. Answer only if you answered "Yes" to Question 22 above. As of September 15th, 2017, how many prisoners (including males and females of all ages) were in restrictive housing and sharing a cell with another prisoner?

◯ Short-term restrictive housing (15 up to 29 days)

____

◯ Extended restrictive housing (> 29 days)

____

Q26. **SECTION 3**. Please provide available data regarding prisoners' duration in restrictive housing.

Q27. For all facilities for which you have data on the numbers of persons in restrictive housing, do you regularly gather, collect, or report information on each prisoner's length of stay in restrictive housing? Please select all that apply.

- ◯ Yes, for each individual prisoner
- ◯ Yes, in aggregate
- ◯ Yes, grouped by prisoners' reason for placement
- ◯ Yes, grouped by some other measure (please explain) ________________________________
- ◯ No (please explain) ________________________________

Q28. In what year did your jurisdiction begin to track length-of-stay data? (YYYY)

____

Q29. **SECTION 4.** Please provide the number of prisoners held in each type of restrictive housing for the specified period (under 1 month, under three months, etc. in continuous/consecutive days or months). Include both male and female prisoners.

Reminder: Please check that these totals comport with the information provided elsewhere in the questionnaire or if not, please explain the differences.

Note: If you collect duration data but not data on reason or type of housing, please provide what information is available.

Please enter "N/A" if data is not available.

	Protective	Disciplinary	Administrative	Other	**TOTAL**
15 days – 1 month					
1 month and 1 day – 3 months					
3 months and 1 day to 6 months					
6 months and 1 day – 12 months					
12 months and 1 day – 36 months (1–3 years)					
36 months and 1 day – 72 months (3–6 years)					
72 months and 1 day or more (more than 6 years)					

Q30. If you were not able to provide some of these numbers, please explain why.

____

____

____

Q31. If the data include prisoners in an "Other" category of restrictive housing, please specify and explain the type(s) of restrictive housing to which you are referring.

____

____

____

Q32. **SECTION 5.** Please provide available data regarding prisoners' demographics (age, race, ethnicity, gender, mental health, special populations).

Q33. What categories do you use?

- ○ White
- ○ Black (African American)
- ○ Native Hawaiian or Pacific Islander
- ○ Native American or Alaskan Native
- ○ Hispanic or Latino
- ○ Asian
- ○ Other

Q34. Please explain how you define each, as some jurisdictions have variation.

- ○ White: ____
- ○ Black (African American): ____
- ○ Native Hawaiian or Pacific Islander: _____________________________________
- ○ Native American or Alaskan Native: _____________________________________
- ○ Hispanic or Latino: ____
- ○ Asian: ____
- ○ Other: ____

Q35. What ethnic/racial categories fall within "Other"?

____

____

____

Q36. If you use additional categories, please list them and how you define them.

____

____

____

Q37. How are identifications of race and ethnicity made?

____

____

____

Q38. **SECTION 5a**. Please provide available data on the **TOTAL CUSTODIAL POPULATION** for all facilities that you identified.

Q39. Please provide information on the number of total male and female prisoners by age group.

	Male	Female
Under 18 years old		
18–25 years old		
26–35 years old		
36–50 years old		
Over 50 years old		
TOTAL		

Q40. If your system breaks down women and men by race and ethnicity, please give information on the number of male and female prisoners by those categories.

	White	Black	Native Hawaiian / Pacific Islander	Native American / Alaskan Native	Hispanic or Latino	Asian	Other
Male							
Female							
TOTAL							

Q41. **SECTION 5b.** Please provide available data on the RESTRICTIVE HOUSING POPULATION for all facilities that you identified.

Q42. Please provide information on the number of total male and female prisoners by age group who are in restrictive housing.

	Male	Female
Under 18 years old		
18–25 years old		
26–35 years old		
36–50 years old		
Over 50 years old		
TOTAL		

Q43. If your system breaks down women and men by race and ethnicity, please give information on the number of male and female prisoners by those categories who are in restrictive housing.

	White	Black	Native Hawaiian / Pacific Islander	Native American / Alaskan Native	Hispanic or Latino	Asian	Other
Male							
Female							
TOTAL							

Q44. **SECTION 5c.** Please provide available data on the population of prisoners with **SERIOUS MENTAL ILLNESS** for all facilities that you identified.

Q45. How does your jurisdiction define serious mental illness? Please provide the definition you use. If you use a manual, please identify the manual (with its date or edition) that you use.

____

____

Q46. Please provide data on how many prisoners are classified as **SERIOUSLY MENTALLY ILL** in your jurisdiction's **TOTAL CUSTODIAL POPULATION**.

	White	Black	Native Hawaiian / Pacific Islander	Native American / Alaskan Native	Hispanic / Latino	Asian	Other	**TOTAL**
Male								
Female								
TOTAL								

Q47. Using your definition of serious mental illness, what percentage of prisoners with serious mental illness are in restrictive housing in your jurisdiction?

○ Short-term restrictive housing (15 up to 29 days): (1) ________________

○ Extended restrictive housing (> 29 days): (2) ________________

Q48. Please provide data on how many prisoners are classified as **SERIOUSLY MENTALLY ILL** and are in RESTRICTIVE HOUSING in your jurisdiction.

	White	Black	Native Hawaiian / Pacific Islander	Native American / Alaskan Native	Hispanic / Latino	Asian	Other	**TOTAL**
Male, short-term restrictive housing (15 up to 29 days)								
Male, extended restrictive housing (> 29 days)								
Female, short-term restrictive housing (15 up to 29 days)								
Female, extended restrictive housing (> 29 days)								
TOTAL								

Q49. To understand the capacity of your jurisdiction to respond to the problems faced by the seriously mentally ill, the following questions focus on resources.

○ What resources does your system have to respond to prisoners with serious mental illness wherever such prisoners are housed?

____

○ How many trained clinicians does your system have to respond to prisoners with serious mental illness? ____

○ How many related health professionals (such as nurse practitioners) does your system have to respond to prisoners with serious mental illness?

____

○ What additional resources would you need to enable you to move prisoners with serious mental illness out of restrictive housing?

____

Q50. **SECTION 5d.** Please provide available data on the population of prisoners who are **TRANSGENDER** and who are in **RESTRICTIVE HOUSING** in your jurisdiction.

Note: Please enter N/A if you do not track this information. Enter “0” if you do track the information, and the answer to the question is zero.

○ How are prisoners identified as transgender within your system?

____

○ How many transgender prisoners are in your system?

____

○ How many transgender prisoners are in short-term restrictive housing (15 up to 29 days)?

____

○ How many transgender prisoners are in extended restrictive housing (> 29 days)?

____

Q51. **SECTION 5e.** Please provide available data on the population of prisoners who are PREGNANT and who are in RESTRICTIVE HOUSING in your jurisdiction.

Note: Please enter N/A if you do not track this information. Enter "0" if you do track the information, and the answer to the question is zero.

- ○ How many pregnant prisoners are in your system? ____________________________

- ○ How many pregnant prisoners in your system are in short-term restrictive housing (15 up to 29 days)? ____________________________

- ○ How many pregnant prisoners are in extended restrictive housing (> 29 days)? ____________________________

Q52. **SECTION 6.** Some jurisdictions house prisoners for most of the hours of the day in cells (in restrictive housing, segregated housing, or general population) for 15 days or more but for an average of less than 22 hours a day. Given this variation, the following section asks about the 20–22-hour interval, which reflects long amounts of time-in-cell not captured in the definition of restrictive housing, even if the placement approximates restrictive housing in other ways.

Q53. Please provide the total number of prisoners, if any, who as of the date the data were collected were not in restrictive housing as defined earlier in this survey but who have been otherwise held in cell (either in single or double cells) for an average of 20–22 hours a day for 15 days or more.

	Number of prisoners
Male	
Female	
TOTAL	

Q54. Please indicate which of the following facilities are included in the data in the above table. Select all that apply.

- ◯ Prisons
- ◯ Jails
- ◯ Juvenile facilities
- ◯ Mental health facilities
- ◯ Privately contracted facilities
- ◯ Special facilities for death-sentenced prisoners
- ◯ Immigration detention contract facilities
- ◯ Other (please specify) ____

Q55. In an ideal situation (i.e., if you had the necessary resources, and if you could do so consistent with institutional safety), what number of hours out of cell do you believe is desirable for prisoners?

____

Q56. **SECTION 7.** Since January 1, 2016, has your jurisdiction changed any of its policies regarding restrictive housing? If so, for the following questions, please check what changes apply, and specify when the policy change was made and whether it has been implemented. If applicable, please cite to the relevant policy statement or memorandum.

Q57. Entry Criteria

○ Whether the criteria for placement in restrictive housing have been changed, and if so, how the criteria have been changed

____

○ Whether behaviors were removed from the list of infractions qualifying prisoners for restrictive housing placement, and if so, what behavior

____

○ Whether the decision to place individuals in restrictive housing required approval from the central administration or other senior officials (please specify)

____

○ Whether pre-entry mental health screening affected placement in restrictive housing, and, if so, when those screenings were conducted

____

○ Whether individualized needs assessments were conducted prior to placement in RH, and when those were conducted ____

○ Whether placement in less restrictive alternatives to restrictive housing were considered

____

○ Other (please describe any policy changes not listed above)

____

Q58. Criteria for Release from Restrictive Housing

○ Creation of step-down or transition programs (if so, please describe the program/s, their implementation timeline, and which prisoners in restrictive housing are eligible)

____

○ Programs and policies prohibiting direct release from restrictive housing to the community and/or to the general population

____

○ Whether the decision to release or transition an individual from restrictive housing is now made by a committee, rather than by an individual

____

○ Whether maximum durations on restrictive housing are in place (if so, please specify what the maximum duration is) ____

○ Whether policies have been implemented mandating that prisoners be told the criteria for their release in advance (if so, please describe the policies)

____

Q59. Oversight and Review of Restrictive Housing Placement and Use

○ Changes in the frequency of review of the placement of prisoners in restrictive housing

○ Changes in the decision-making authority to continue individuals in restrictive housing

○ Whether a prisoner grievance policy has been added

○ Whether monitoring for mental illness has been increased (if so, how often are prisoners evaluated for mental illness, and what steps are taken if they are found to have developed mental health issues?) ____

○ Whether new oversight programs have been created (if so, please describe the oversight program) ____

○ Whether centralized monitoring has been implemented

○ Whether improved tracking services and data collection have been introduced

○ Other (please describe) ____

Q60. Please specify how often the restrictive housing status of a prisoner is reviewed and by whom. If the policy has changed, please specify how it has changed and when.

____

____

____

Q61. Mandated Time Out of Cell for Restrictive Housing Prisoners

○ Increased total time out of cell (if so, please specify how many additional hours out of cell and which prisoners in restrictive housing qualify)
____

○ Addition of structured time out of cell (therapeutic, programming) (if so, please specify how many additional hours of structured time out of cell and which prisoners in restrictive housing qualify) (if so, please specify how many additional hours out of cell and which prisoners in restrictive housing qualify)
____

○ Addition of unstructured (recreational) time out of cell

○ Addition of outdoor recreation

○ Addition of more classes

○ Addition of meals in social setting/cafeteria

○ Other (please specify) ____

Q62. Addition of Programming in Restrictive Housing

○ Addition of in-cell learning opportunities (if so, please describe which prisoners in restrictive housing qualify) ____

○ Access to more entertainment or literary materials (if so, please describe which prisoners in restrictive housing qualify) ____

○ More out-of-cell group programming (if so, please describe which prisoners in restrictive housing qualify) ____

○ Addition of GED/diploma program (if so, please describe which prisoners in restrictive housing qualify) ____

Q63. Additional Provisions for Social Contact in Restrictive Housing

Q64. Have visitation hours/opportunities been increased?

- ○ Yes
- ○ No

Q65. Answer only if answered yes to question 64. With regard to the increased visitation hours/opportunities:

- ○ For what number of hours is visitation now available? ________________
- ○ What use is there by individuals in restrictive housing? ________________
- ○ Which prisoners in restrictive housing qualify? ________________

Q66. Has phone time been increased?

- ○ Yes
- ○ No

Q67. Answer only if answered yes to question 66. With regard to the increased phone time:

- ○ By what frequency and length has it been increased? ________________
- ○ Which prisoners in restrictive housing qualify? ________________

Q68. Has group recreation been added?

- ○ Yes
- ○ No

Q69. Answer only if answered yes to question 68. With regard to the added group recreation:

- ◯ For what number of hours is group recreation now available?

  ____

- ◯ Is it available with Security Desks only?

  ____

- ◯ Which prisoners in restrictive housing qualify?

  ____

Q70. Have group classes or other programming been added?

- ◯ Yes
- ◯ No

Q71. Answer only if answered yes to question 70. With regard to the added group classes or other programming:

- ◯ What kind of programming is now available?

  ____

- ◯ For what number of hours is the programming now available?

  ____

- ◯ Is it available with Security Desks only?

  ____

- ◯ Which prisoners in restrictive housing qualify?

  ____

Q72. Policies or Training Related to Staffing of Restrictive Housing

- ◯ Mental health training ____
- ◯ Staff rotations (if so, please specify the intervals)

  ____

- ◯ Additional opportunities for education

  ____

Q73. Other

Q74. Has your jurisdiction studied the effects of the policy changes in terms of any of the following? Please select all that apply.

- ◯ Incidents of violence
- ◯ Incidents of prisoner self-harm
- ◯ Prisoner morale
- ◯ Staff morale
- ◯ Numbers of persons (or subsets of persons) placed in restrictive housing or subsets of individuals (if so, please provide specific numbers) ____
- ◯ Duration of placement
- ◯ Prisoner successes in coping with the general population, programs, and other activities
- ◯ Prisoner successes in returning to communities
- ◯ Changing costs
- ◯ Other (please explain) ____

Q75. If you have any research on your work in this area, please direct us to its place of publication, if applicable. Please note if you are able to email us (ascalimansurvey@yale.edu) both the policies and the research, if available.

____

____

____

Q76. **SECTION 8.** Please answer the following questions with regard to the revised ACA standards.

Q77. In August of 2016, the American Correctional Association (ACA) adopted new standards on restrictive housing. Has your jurisdiction reviewed its policies since then on restrictive housing?

- ○ Yes
- ○ No (please explain) ____

Q78. Does your jurisdiction rely on these standards to make policies?

- ○ Yes
- ○ No (please explain) ____

Q79. Below we ask whether four facets of the 2016 ACA standards have been implemented in your jurisdiction.

Q80. Has your jurisdiction implemented the requirements of ACA standard 4-RH-0034, which prohibits the use of extended restrictive housing (more than 29 continuous days) for offenders under the age of 18?

- ○ Yes
- ○ No
- ○ We have substantially implemented this policy, with exceptions
- ○ This was the policy before the 2016 ACA revisions

Q81. Answer only if you answered "We have substantially implemented this policy, with exceptions" to question 80. Please explain how you have implemented this policy (prohibiting extended restrictive housing for offenders under the age of 18) and what exceptions you have made.

____

____

Q82. Has your jurisdiction implemented the requirements of ACA standard 4-RH-0033, which prohibits the use of extended restrictive housing (more than 29 continuous days) for females determined to be pregnant?

- ○ Yes
- ○ No
- ○ We have substantially implemented this policy, with exceptions
- ○ This was the policy before the 2016 ACA revisions

Q83. Answer only if you answered "We have substantially implemented this policy, with exceptions" to question 82. Please explain how you have implemented this policy (prohibiting extended restrictive housing for prisoners who are pregnant) and what exceptions you have made.

____

____

____

Q84. Has your jurisdiction implemented the requirements of ACA standard 4-RH-0031, which prohibits the use of extended restrictive housing (more than 29 continuous days) for inmates diagnosed as seriously mentally ill?

- ○ Yes
- ○ No
- ○ We have substantially implemented this policy, with exceptions
- ○ This was the policy before the 2016 ACA revisions

Q85. Answer only if you answered "We have substantially implemented this policy, with exceptions" to question 84. Please explain how you have implemented this policy (prohibiting extended restrictive housing for inmates with serious mental illness) and what exceptions you have made.____

____

Q86. Has your agency implemented ACA standard 4-RH-0030, whereby it attempts not to release inmates from restrictive housing directly into the community?

- ◯ Yes
- ◯ No
- ◯ We have substantially implemented this policy, with exceptions
- ◯ This was the policy before the 2016 ACA revisions

Q87. Answer only if you answered "We have substantially implemented this policy, with exceptions" to question 86. Please explain how you have implemented this policy (attempting not to release inmates from restrictive housing directly into the community) and what exceptions you have made.

____

____

____

Q88. Please explain any other policies your jurisdiction has revised in light of the 2016 ACA restrictive housing standards.

____

____

____

END OF QUESTIONS

Appendix B: This Report's Table and Figures

List of Tables

Table 1 Numbers and Percentages of Men and Women in Restrictive Housing (RH) by Jurisdiction ... 12

Table 2 Numbers of Prisoners in Restrictive Housing by Length of Time and by Jurisdiction ... 15

Table 3 Years When Tracking Length of Time in Restrictive Housing Began in Thirty Jurisdictions ... 16

Table 4 Number and Percentage of Male Custodial Population in Restrictive Housing ... 19

Table 5 Number and Percentage of Female Custodial Population in Restrictive Housing ... 21

Table 6 Number of Jurisdictions Reporting on Racial or Ethnic Groups ... 22

Table 7 Demographic Composition of Total Male Custodial Population and Male Restrictive Housing Population ... 27

Table 8 Demographic Percentage Composition of Total Male Custodial Population and Male Restrictive Housing Population ... 29

Table 9 Demographic Composition of Total Female Custodial Population and Female Restrictive Housing Population ... 32

Table 10 Demographic Percentage Composition of Total Female Custodial Population and Female Restrictive Housing Population ... 34

Table 11 Age Cohorts of Male Total Custodial Population and of Male Restrictive Housing Population ... 38

Table 12 Age Cohorts Percentage of Male Total Custodial Population and of Male Restrictive Housing Population ... 40

Table 13 Age Cohorts of Female Total Custodial Population and of Female Restrictive Housing Population ... 42

Table 14 Age Cohorts Percentage of Female Total Custodial Population and of Female Restrictive Housing Population ... 44

Table 15 Male Prisoners with Serious Mental Illness (SMI, variously defined) in Restrictive Housing (RH) ... 48

Table 16 Female Prisoners with Serious Mental Illness (SMI, variously defined) in Restrictive Housing (RH) 49

Table 17 Male Prisoners with Serious Mental Illness by Race and Ethnicity in the Total Custodial Population and in the Restrictive Housing Population 51

Table 18 Female Prisoners with Serious Mental Illness by Race and Ethnicity in the Total Custodial Population and in the Restrictive Housing Population 53

Table 19 Total Custodial Population by Race and Ethnicity and Delineated by Sex/Gender in Los Angeles and Philadelphia Jails 56

Table 20 Age Cohorts of Men and Women in the Total Custodial Population in Los Angeles and Philadelphia Jails and in the Restrictive Housing Population in Los Angeles Jails 57

Table 21 Jurisdiction-by-Jurisdiction Comparisons of Restrictive Housing Populations in 2015–2016 and in 2017–2018 96

Table 22 Comparing the Numbers of Prisoners in Restrictive Housing by Length of Time in 2015–2016 and in 2017–2018 101

Table 23 Comparing the Distributions of Prisoners by Length of Time in Restrictive Housing in 2015–2016 and in 2017–2018 102

List of Figures

Figure 1 Percentages of Prisoners in Restrictive Housing by Jurisdiction 11

Figure 2 Percentages of Prisoners in Restrictive Housing by Percentage 12

Figure 3 Prisoners in Restrictive Housing by Length of Time 14

Figure 4 Percent of Total Population in Restrictive Housing by Gender 17

Figure 5 Percentage of Male Prisoners in Restrictive Housing by Jurisdiction 18

Figure 6 Percentage of Male Prisoners in Restrictive Housing by Percentage 18

Figure 7 Percentage of Female Prisoners in Restrictive Housing by Jurisdiction 20

Figure 8 Percentage of Female Prisoners in Restrictive Housing by Percentage 20

Figure 9 Racial and Ethnic Composition of Male Prisoners in Total Custodial Population and in Restrictive Housing Population 23

Figure 10 Racial and Ethnic Composition of Female Prisoners in Total Custodial Population and in Restrictive Housing Population 23

Figure 11 Differences in Restrictive Housing and Total Custodial Population for Black Male Prisoners 25

Figure 12 Differences in Restrictive Housing and Total Custodial Population for Hispanic Male Prisoners 26

Figure 13 Age Distribution of Male Prisoners in Restrictive Housing and Total Custodial Population 37

Figure 14 Age Distribution of Female Prisoners in Restrictive Housing and Total Custodial Population 37

Figure 15 Jurisdiction-by-Jurisdiction Comparisons of Percentages of Prisoners in Restrictive Housing Populations in 2015–2016 and in 2017–2018 98

Figure 16 Jurisdiction-by-Jurisdiction Comparisons of the Changes in Percentage of Prisoners in Restrictive Housing Populations in 2015–2016 and in 2017–2018 99

Figure 17 Comparing the Distributions of Prisoners by Length of Time in Restrictive Housing in 2015–2016 and in 2017–2018 103

Appendix C: Definitions of "Serious Mental Illness" in 43 Jurisdictions

Alabama	Psychotic disorders, bipolar disorders, and major depressive disorders; any diagnosed mental disorder currently associated with serious impairment in psychological, cognitive, or behavioral function that substantially interferes with the person's ability to meet the demands of living and requires an individualized treatment plan by a qualified mental health provider.
Alaska	Mental Illness is an organic mental or emotional impairment that reduces an individual's exercise of conscious control over the individual's actions and reduces an individual's ability to perceive reality, to reason or understand.
Arizona	ADC Mental Health Technical Manual, 06/18/2015 Defined: Those who according to a licensed mental health clinician or provider possess: 1) A qualifying mental health diagnosis as indicated on the SMI determination form, and 2) A severe functional impairment directly relating to their mental illness.
Arkansas	Serious Mental Illness-Psychotic, Bipolar and Major Depressive Disorders and any other diagnosed mental disorder (excluding substance use disorders) associated with serious behavioral impairment as evidenced by examples of acute decompensation, self-injurious behaviors, and mental health emergencies that require an individualized treatment plan by a qualified mental health professional.
Colorado	CDOC Clinical Services uses the Diagnostic and Strategic Manual of Mental Disorder, Fifth Edition (DSM-5) Serious Mental Illness: The current diagnosis of any of the following DSM diagnoses accompanied by the P-code qualifier of M or psychological coding of P4 or P5, denoting the presence of a major mental disorder: schizophrenia, schizoaffective disorder, delusional disorder, schizophreniform disorder, brief psychotic disorder, substance-induced psychotic disorder (excluding intoxication and withdrawal), unspecified schizophrenia spectrum and other psychotic disorder (previously psychotic disorder not otherwise specified), major depressive disorders, and bipolar disorders. Offenders, regardless of diagnosis, indicating a high level of mental health needs based upon high symptom severity and/or high resource demands, which demonstrate significant impairment in their ability to function within the correctional environment.
Connecticut	MH5 Assessment: Crisis level mental disorder (acute conditions, temporary classification). Requires 24 hour nursing care. Examples of mental health conditions meeting the MH-5 level include but are not limited to acute psychosis, severe depression, suicidal ideation, suicidal gestures or attempts, and overwhelming anxiety. Moreover, these inmates can be actively suicidal or self-mutilators. They require suicide watch, 15-minute watch or one-to-one

	monitoring. Refer to Appendix for further information. This is in accordance with the 2012 Offender Classification Manual
Delaware	Bureau of Prisons Policy 4.3, p. 3. DSM-5 is used.
FBOP	Serious Mental Illness includes offenders diagnosed with the following: Schizophrenia; Delusional Disorder; Schizophreniform Disorder; Schizoaffective Disorder; Brief Psychotic Disorder; Bipolar I, II Disorder; Substance-Induced Psychotic Disorder (excluding intoxication or withdrawal); Other Specified Psychotic Disorder; Major [D]epressive Disorder; Other Specified Bipolar Disorder. Anyone who has Significant Functional Impairment (see definition) due to their mental health (including severe Personality Disorders, Intellectual Disability, Autism Spectrum Disorder) defined as: Self-harming behaviors (i.e., cutting, head-banging, suicide attempts, self-strangulation, self-mutilation, swallowing foreign bodies, etc.); Demonstrated difficulty in his or her ability to engage in activities of daily living (i.e., eating, grooming, participation in recreation, etc.); Demonstrated a pervasive pattern of dysfunctional or disruptive social interactions (i.e., social isolation, bizarre behavior, disruptive behavior, etc.).
Hawaii	A diagnosable mental disorder characterized by alternation in thinking, mood, or impaired behavior associated with distress and/or impaired functioning; primarily inclusive of schizophrenia, severe depression, and bipolar disorder, and severe panic disorder, obsessive compulsive disorder, and post-traumatic stress disorder.
Idaho	IDOC does not have a formal definition of Serious Mental Illness. We do, however, assign inmates with Levels of Care. I believe our two highest levels of care (Acute Correctional Mental Health Services—ACMHS and Intermediate Correctional Mental Health Services—ICMHS) are generally housed in specialized mental health housing and serve as an appropriate analogue for Serious Mental Illness
Illinois	Gravely disabled—a condition where a person, as a result of a mental disorder, is in danger of serious physical harm, resulting from a failure to provide for his or her essential human needs of health or safety, or manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions.
Iowa	Schizophrenia, Recurrent Major Depressive Disorder, Bipolar Disorder, other Chronic and Recurrent Psychosis, Dementia and other Organic Disorder.
Kansas	DSM-V
Kentucky	Serious Mental Illness means a current diagnosis by a Department of Corrections psychological or psychiatric provider or a recent significant

	history of any of the following DSM-5 (or most current revision thereof) diagnoses: Schizophrenia, delusional disorder, schizophreniform disorder, schizoaffective disorder, brief psychotic, substance-induced psychotic disorder (excluding intoxication and withdrawal), Psychotic Disorder Not Otherwise Specified, Major Depression disorders, Bipolar I and Bipolar II disorders, or current diagnosis by a DOC psychological or psychiatric provider of a serious personality disorder that includes breaks with reality and /or results in significant functional impairment.
Louisiana	HC Policy # 36 defines as major depressive disorder, schizophrenia disorder, bipolar disorder, psychotic disorder, severe anxiety disorder, and severe personality disorder.
Maryland	The Department defines "Serious Mental Illness" (SMI) in accordance with the Code of Maryland Regulations (COMAR), as follows: COMAR 10.21.17.02 (76) (76) "Serious mental illness" means a mental disorder that is: (a) Manifest in an individual 18 years old or older; (b) Diagnosed, according to a current diagnostic classification system that is recognized by the Secretary as: (i) Schizophrenic disorder; (ii) Major affective disorder; (iii) Other psychotic disorder; or (iv) Borderline or schizotypal personality disorder, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; and (c) Characterized by impaired functioning on a continuing or intermittent basis, for at least 2 years, and includes at least three of the following: (i) Inability to maintain independent employment; (ii) Social behavior that results in interventions by the mental health system; (iii) Inability, due to cognitive disorganization, to procure financial assistance to support living in the community; (iv) Severe inability to establish or maintain a personal support system; or (v) Need for assistance with basic living skills.
Massachusetts	Serious Mental Illness (SMI) — For purposes of assessing whether Segregation may be clinically contraindicated, or whether an inmate in Segregation should be placed in a Specialized Treatment Unit, the term "Serious Mental Illness" shall be defined as the following: 1. Inmates determined by the Department's mental health vendor to have a current diagnosis or a recent significant history of any of the following types of DSM-V diagnoses: a. Schizophrenia b. Delusional Disorder c. Schizophreniform Disorder d. Schizoaffective Disorder e. Brief Psychotic Disorder f. Substance-Induced Psychotic Disorder (excluding intoxication and withdrawal) g. Psychotic Disorder Not Otherwise Specified h. Major Depressive Disorder i. Bipolar Disorder I and II. For purposes of this definition, "recent significant history" shall be defined as a diagnosis specified above in section (a)(1)-(9) upon discharge within the past year from an inpatient psychiatric hospital. 2. Inmates diagnosed with disorders that are commonly characterized by the mental health vendor with other DSM-V breaks with reality, or perceptions of reality, that lead the individual to

	experience significant functional impairment involving acts of self-harm or other behaviors that have a seriously adverse effect on life or on mental or physical health. 3. Inmates diagnosed by the Department's medical or mental health vendor with a developmental disability, dementia or other cognitive disorders that result in a significant functional impairment involving acts of self-harm or other behaviors that have a seriously adverse effect on life or on mental or physical health. 4. Inmates diagnosed by the Department's mental health vendor with a severe personality disorder that is manifested by episodes of psychosis or depression, and results in significant functional impairment involving acts of self-harm or other behaviors that have a seriously adverse effect on life or on mental or physical health. Significant Functional Impairment Factors for consideration when assessing significant functional impairment shall include the following: a. The inmate has engaged in self harm which shall be defined as a deliberate act by the inmate that inflicts damage to, or threatens the integrity of, one's own body. Such acts include but are not limited to the following behaviors: hanging, self-strangulation, asphyxiation, cutting, self-mutilation, ingestion of a foreign body, insertion of a foreign body, head banging, drug overdose, jumping and biting. b. The inmate has demonstrated difficulty in his or her ability to engage in activities of daily living, including eating, grooming and personal hygiene, maintenance of housing area, participation in recreation, and ambulation, as a consequence of any DSM-V disorder. c. The inmate has demonstrated a pervasive pattern of dysfunctional or disruptive social interactions including withdrawal, bizarre or disruptive behavior, etc. as a consequence of any DSM-V disorder.
Michigan	Prisoners with a mental illness have been diagnosed with a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality or cope with demands of basic living. We consider classifications of what we have called major mental illness including: psychotic schizophrenia, spectrum disorders, bipolar 1 and 2, major depressive disorders, neurocognitive disorders.
Minnesota	Minnesota has a statutory definition of Serious and Persistent Mental Illness that we use (MN Stat. 245.462 Subd. 20). (c) For purposes of case management and community support services, a "person with serious and persistent mental illness" means an adult who has a mental illness and meets at least one of the following criteria: (1) the adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months; (2) the adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months; (3) the adult has been treated by a crisis team two or more times within the preceding 24 months; (4) the adult: (i) has a diagnosis of schizophrenia, bipolar disorder, major depression, schizoaffective disorder, or borderline personality disorder; (ii) indicates a significant impairment in functioning; and (iii) has a written opinion from a mental health professional,

	in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided; (5) the adult has, in the last three years, been committed by a court as a person who is mentally ill under chapter 253B, or the adult's commitment has been stayed or continued; (6) the adult (i) was eligible under clauses (1) to (5), but the specified time period has expired or the adult was eligible as a child under section 245.4871, subdivision 6; and (ii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided; or (7) the adult was eligible as a child under section 245.4871, subdivision 6, and is age 21 or younger.
Mississippi	Chronic mental health treatment or inpatient mental health treatment
Missouri	The department does not define "serious mental illness" in policy. All offenders classified MH-3 and above (Form 931-0730 Classification Analysis – Mental Health Needs) are enrolled in mental health chronic care and are offenders with a serious mental illness. Our working definition is that defined by Substance Abuse and Mental Health Services Administration (SAMHSA, Department of Health and Human Services, https://www.samhsa.gov/disorders): Serious mental illness among people ages 18 and older is defined at the federal level as having, at any time during the past year, a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities.
Montana	No definition as of yet, still a work in progress.
Nebraska	Any mental health condition that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person with the serious mental illness. Serious mental illness includes but is not limited to (i) schizophrenia, (ii) schizoaffective disorder, (iii) delusional disorder, (iv) bipolar affective disorder, (v) major depression, and (vi) obsessive compulsive disorder. (Neb. Rev. Stat. 44-792)
Nevada	An individual is classified seriously mentally ill or SMI by a mental health professional when the individual has a condition of such a nature that is a threat to him or herself or others or is disruptive to the orderly operation of the facility or institution. The Department ensures that inmates are evaluated and a mental health diagnoses history is analyzed. The evaluation includes, at minimum, the following components: suicide potential, symptoms of mental illness, level of intellectual function, level of aggression, potential for escape,

	deviant sexual behavior, history of sexual abuse or aggression, and need of psychotropic medication. Seriously impaired individuals: a) require special housing and ongoing mental treatment; b) might be assigned to an extended care unit (ECU) or mental health unit (MHU), c) typically require single-celled housing, and d) are administered psychotropic medications monitored by a psychiatrist. The disorder is defined as a condition that affects an individual at least 18 years of age, and it must be of sufficient duration. The NDOC follows the guidelines provided in the Diagnostic and Statistical Manual of Mental Disorders (DSMS)5.
New Jersey	The NJDOC defines it as any inmate having a mental health problem which impairs the functioning of the inmate to the extent which the MH clinical team determines that treatment warrants admission to a mental health unit. The below mentioned numbers represent the total number of inmates in the mental health units for both males and females. It incorporates those on the SU, RTU and TCU units. It should be noted the Department currently utilizes the Diagnostic Statistical Manual, 5th Edition. The figure below reflects the inmates placed in these specialized mental health units.
New Mexico	We have no definition of seriously mentally ill. What we have is a Mental Health Treatment Center where we place inmates who have cognitive, affective, and/or behavioral functioning deficits inhibit them from functioning in general population. This could be long-term or short-term based on the needs of the individual inmate . . . . We have a unit in the MHTC that houses inmates in a segregated environment.
New York	New York State DOCCS Definition of Serious Mental Illness (Section 137 Correction Law) (e) An inmate has a serious mental illness when he or she has been determined by a mental health clinician to meet at least one of the following criteria: (i) he or she has a current diagnosis of, or is diagnosed at the initial or any subsequent assessment conducted during the inmate's segregated confinement with, one or more of the following types of Axis I diagnoses, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, and such diagnoses shall be made based upon all relevant clinical factors, including but not limited to symptoms related to such diagnoses: (A) schizophrenia (all sub-types), (B) delusional disorder, (C) schizophreniform disorder, (D) schizoaffective disorder, (E) brief psychotic disorder, (F) substance-induced psychotic disorder (excluding intoxication and withdrawal), (G) psychotic disorder not otherwise specified, (H) major depressive disorders, or (I) bipolar disorder I and II; (ii) he or she is actively suicidal or has engaged in a recent, serious suicide attempt; (iii) he or she has been diagnosed with a mental condition that is frequently characterized by breaks with reality, or perceptions of reality, that lead the individual to experience significant functional impairment involving acts of self-harm or other behavior that have a seriously adverse effect on life or on mental or physical health; (iv) he or she has been diagnosed with an organic

	brain syndrome that results in a significant functional impairment involving acts of self-harm or other behavior that have a seriously adverse effect on life or on mental or physical health; (v) he or she has been diagnosed with a severe personality disorder that is manifested by frequent episodes of psychosis or depression, and results in a significant functional impairment involving acts of self-harm or other behavior that have a seriously adverse effect on life or on mental or physical health; or (vi) he or she has been determined by a mental health clinician to have otherwise substantially deteriorated mentally or emotionally while confined in segregated confinement and is experiencing significant functional impairment indicating a diagnosis of serious mental illness and involving acts of self-harm or other behavior that have a serious adverse effect on life or on mental or physical health.
North Carolina	Psychotic Disorders, Bi-polar Disorders, Major Depressive Disorder, and any diagnosed mental disorder (excluding substance abuse disorders) currently associated with serious impairment in psychological, cognitive, or behavioral functioning that substantially interferes with the person's ability to meet the ordinary demands of living and requires an individualized treatment plan by a qualified Mental Health professional(s). M3 and above is inclusive of all inmates diagnosed with a mental illness receiving both psychological and psychiatric services.
North Dakota	Serious Mental Illness: People found to have current symptoms or who are currently receiving treatment for the following types of Diagnostic and Statistical Manual, 5th Edition diagnoses that cause or have caused significant functional impairment: Delusional Disorder, Psychotic Disorders of all types including Schizophrenia, Major Depressive Disorders, Bipolar I and II Disorders, Obsessive Compulsive Disorder (OCD), Panic Disorder, Post Traumatic Stress Disorder (PTSD) or Borderline Personality.
Ohio	Serious Mental Illness (SMI) — Adults with a serious mental illness are persons who are age eighteen (18) and over, who currently or at any time during the past year, have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most current Diagnostic and Statistical Manual of Mental Disorders and that has resulted in functional impairment which substantially interferes with or limits one or more major life activities. These disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects.
Oklahoma	OP-140201, Attachment B, November 2, 2006, defines serious mental illness as mental health levels B through D. Policy attachment emailed as supplemental materials to ascalimansurvey@yale.edu

Oregon	Serious Mental Illness: An inmate that, in the judgment of the department, because of a mental disorder is one or more of the following: (a) Dangerous to self or others; (b) Unable to provide for basic personal needs and would likely benefit from receiving additional care for the inmate's health or safety; (c) Chronically mentally ill, as defined in ORS 426.495; or (d) Will continue, to a reasonable medical probability, to physically or mentally deteriorate so to become a person described in (c) above unless treated.
Pennsylvania	Definition of Serious Mental Illness 1. Inmates determined by the PRT to have a current diagnosis or a recent significant history of any of the DSM5 diagnoses (using ICD10 codes and letter tags): a. Substance-Induced Psychotic Disorder (excluding intoxication and withdrawal) F10.159, Alcohol-Induced Psychotic Disorder, with mild use disorder, F10.259, Alcohol-Induced Psychotic Disorder, with moderate-severe use disorder, F10.959, Alcohol-Induced Psychotic Disorder, without use disorder Substance-Induced Psychotic Disorders employ the same specifiers (.159; .259; .959) With cannabis F12; sedative, hypnotic, anxiolytic F13; cocaine F14; amphetamine F15; other hallucinogen/ phencyclidine F16; inhalant F18; and other substance/unknown substance F19 b. Schizophreniform Disorder F20.81 c. Schizophrenia F20.9 d. Delusional Disorder F22a, Erotomanic type F22b, Grandiose type F22c, Jealous type F22d, Persecutory type F22e, Somatic type F22f, Mixed type F22g, Unspecified type e. Brief Psychotic Disorder F23 f. Schizoaffective Disorder F25.0, BIP type F25.1, DEP type g. Other Psychotic Disorders F06.0, Psychosis due med condition w/ delusions F06.2 Psychosis due med condition w/ hallucinations F28 Other specified schizophrenia spectrum and other Psychotic Disorder F29 Unspecified schizophrenia spectrum and other Psychotic Disorder h. Bipolar I and II F31.0, BIP I, current or most recent episode hypomanic F31.11, BIP I, current or most recent episode manic, mild F31.12, BIP I, current or most recent episode manic, moderate F31.13, BIP I, current or most recent episode manic, severe F31.2, BIP I, current or most recent episode manic, w/psychotic features F31.31, BIP I, current or most recent episode depressed, mild F31.32, BIP I, current or most recent episode depressed, moderate F31.4 BIP I, current or most recent episode depressed, severe F31.5 BIP I, current or most recent episode depressed, w/psychotic features F31.71, BIP I, current or most recent episode hypomanic, in partial remission F31.72, BIP I, current or most recent episode hypomanic, in full remission F31.73, BIP I, current or most recent episode manic, in partial remission F31.74, BIP I, current or most recent episode manic, in full remission F31.75, BIP I, current or most recent episode depressed, in partial remission F31.76, BIP I, current or most recent episode depressed, in full

	remission F31.81, BIP II disorder F31.9a, BIP I, current or most recent depressed, unspecified F31.9b, BIP I, current or most recent episode hypomanic, unspecified F31.9c, BIP I, current or most recent episode manic, unspecified F31.9d, BIP I, current most recent episode unspecified i. Major Depressive Disorder F32.0, MDD, single episode, mild F32.1, MDD, single episode, moderate F32.2, MDD, single episode, severe F32.3, MDD, single episode, w/psychotic features F32.4, MDD, single episode, in partial remission F32.5, MDD, single episode, in full remission F32.9a, MDD, single episode, unspecified F33.0, MDD, recurrent, mild F33.1, MDD, recurrent, moderate F33.2, MDD, recurrent, severe F33.3, MDD, recurrent, w/psychotic features F33.41, MDD, recurrent, in partial remission F33.42, MDD, recurrent, in full remission F33.9, MDD, recurrent, unspecified NOTE: For the purpose of this definition, the term "recent significant history" shall be defined as "currently in existence or within the preceding three months." 2. Inmates diagnosed by PRT with DSM5 disorders that are commonly characterized by breaks with reality, or perceptions of reality, that lead the individual to experience significant functional impairment involving acts of self-harm or other behaviors that have a seriously adverse effect on life or on mental or physical health. 3. Inmates diagnosed by PRT with Intellectual Disability, a dementia, or other cognitive disorders that result in a significant impairment involving acts of self-harm or other behaviors that have seriously adverse effect on life or on mental or physical health. 4. Any inmate sentenced GBMI. B. Clinical Guidelines for Functional Impairment Factors for consideration when assessing significant functional impairment shall include the following: 1. whether the inmate has engaged in self-harm which shall be defined as a "deliberate, intentional, direct injury of body tissue with or without suicidal intent." Such acts include, but are not limited to the following behaviors: hanging, self-strangulation, asphyxiation, cutting, self-mutilation, ingestion of a foreign body, insertion of a foreign body, head banging, drug overdose, jumping, and biting themselves; 2. the inmate has demonstrated significant difficulty in his or her ability to engage in activities of daily living, including eating, grooming and personal hygiene, maintenance of housing area, participation in recreation, and ambulation; and 3. the inmate has demonstrated a pervasive pattern of dysfunctional or disruptive social interactions including withdrawal, bizarre or disruptive behavior. C. Intellectual Disability Inmates scoring 70 or below on the BETA-III will be administered an individual IQ test (WASI-II or WAIS-IV) at the parent facility. If their WASI-II IQ is 70 or below then a full WAIS-IV will be administered. If this WAIS-IV comes out to 70 or below, a measurement of adaptive behavior including the following will be assessed: 1. conceptual skills—language and literacy; money, time and number concepts; and self-direction; 2. social skills—interpersonal skills, social responsibility, self-esteem, gullibility, naiveté, social problem solving, the ability to follow rules/obey laws and to avoid being victimized; and 3. practical skills—activities of daily living (personal care), occupational skills, healthcare, travel/transportation, schedules/routines, safety, use of money, and use of

	telephone. NOTE: An assessment to determine if the disability originated during the developmental period should be conducted to establish if the intellectual and adaptive deficits were present during childhood or adolescence. This assessment should include corroborative information obtained from complementary reliable and valid sources, which reflect functioning outside of the prison setting. Additional factors to take into account include the community environment typical of the individual's peers and culture, linguistic diversity, cultural differences in the way people communicate, move, and behave. Assessments must also assume that limitations often coexist with strengths, and that a person's level of life functioning will improve if appropriate personalized supports are provided over a sustained period. F70, Intellectual Disability (Intellectual Developmental Disorder) mild = 50/55-70 F71, IDD, moderate =35/40-50/55 F72, IDD, severe =20/25-35/40 F73, IDD, profound =<20/25 F74, IDD, severity unspecified
Rhode Island	The Rhode Island Department of Corrections (RIDOC) defines serious and persistent mental illness (SPMI) as being a condition that affects persons aged 18 or older who currently or at any time in the past year have had a diagnosed mental, behavioral or emotional disorder of sufficient duration to meet the criteria specified within DSM-V (with the exception of substance use disorders and developmental disorders) that has resulted in significant functional impairment that has occurred on either a continuous or intermittent basis. The qualifying diagnoses recognized by our jurisdiction are as follows: Schizophrenia, Schizoaffective Disorder, Other Specified Schizophrenia Spectrum and other Psychotic Disorders, Bipolar Disorder(s), Delusional Disorder, Major Depressive Disorder, Panic Disorder, Agoraphobia, Post-Traumatic Stress Disorder, Obsessive-Compulsive Disorder and Borderline Personality Disorder.
South Carolina	A Diagnosed Mental Health Disorder from the DSM 5 associated with serious behavioral impairment as evidenced by examples of acute decompensation or self-injurious behaviors affecting ability to function and requiring individualized treatment by a mental health professional.
South Dakota	The following are the criteria used by mental health staff to identify someone who has a serious mental illness (SMI) and would benefit from those higher levels of care. (1) The consumer's severe and persistent emotional, behavioral, or psychological disorder causes the consumer to meet at least one of the following criteria: (a) The consumer has undergone psychiatric treatment more intensive than outpatient care and more than once in a lifetime, such as, emergency services, alternative residential living, or inpatient psychiatric hospitalization; (b) The consumer has experienced a single episode of psychiatric hospitalization with an Axis I or Axis II diagnosis per the DSM-IV-TR as defined in § 46:20:01:01; (c) The consumer has been treated with psychotropic medication for at least one year; or (d) The

	consumer has had frequent crisis contact with a center, or another provider, for more than six months as a result of a severe and persistent mental illness; and (2) The consumer's severe and persistent emotional, behavioral, or psychological disorder meets at least three of the following criteria: (a) The consumer is unemployed or has markedly limited job skills or poor work history; (b) The consumer exhibits inappropriate social behavior which results in concern by the community or requests for mental health or legal intervention; (c) The consumer is unable to obtain public services without assistance; (d) The consumer requires public financial assistance for out-of-hospital maintenance; (e) The consumer lacks social support systems in a natural environment, such as close friends and family, or the consumer lives alone or is isolated; or (f) The consumer is unable to perform basic daily living skills without assistance.
Tennessee	TDOC Policy 113.87: Serious Mental Illness (SMI): A substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality or cope with ordinary demands of life within the correctional environment and is manifested by substantial impairment or disability. Serious mental illness requires a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most current Diagnostic and Statistical Manual (DSM) or International Classification of Disease (ICD) equivalent (and subsequent revisions) in accordance with an individualized treatment plan
Texas	TDCJ does not define "serious mental illness." The numbers provided below are those offenders who are on an inpatient mental health caseload.
Utah	SPMI: Generally well known to mental health, consistently requires "intensive level of mental health treatment, observation and services." Severe to significant impairment in functioning due to mental illness.
Washington	A substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality or cope with the ordinary demands of life within the prison environment and is manifested by substantial pain or disability. Serious mental illness requires a mental health diagnosis, prognosis and treatment, as appropriate, by mental health staff. It is expressly understood that this definition does not include inmates who are substance abusers, substance dependent, including alcoholics and narcotics addicts, or persons convicted of any sex offense, who are not otherwise diagnosed as seriously mentally ill.
West Virginia	A manifestation in a person of significantly impaired capacity to maintain acceptable levels of functioning in the areas of intellect, emotion, and physical wellbeing. W.Va. Code § 27-1-2.

Wisconsin	MH-2a—A current diagnosis of, or being in remission from, the following conditions: Schizophrenia, Delusional Disorder, Schizophreniform Disorder, Schizoaffective Disorder, Other Specified (and Unspecified) Schizophrenia Spectrum and Other Psychotic Disorder, Major Depressive Disorder, Bipolar I Disorder, and Bipolar II Disorder. MH2-a also includes inmates with current or recent symptoms of the following conditions: Brief Psychotic Disorder, Substance / Medication-Induced Psychotic Disorder, head injury or other neurological impairments that result in behavioral or emotional dyscontrol, chronic and persistent mood or anxiety disorders, and other conditions that lead to significant functional disability. MH-2b—Inmates with a primary personality disorder that is severe, accompanied by significant functional impairment, and subject to periodic decompensation; i.e., psychosis, depression, or suicidality. If an inmate has stable behavior for two years, the code may be reassessed. Excluded from MH-2B classification are inmates who have a primary diagnosis of Antisocial Personality Disorder and whose behavior is primarily the result of targeted goals rather than impairment from diagnosed mental illness.
Wyoming	Major Depressive Disorder, Bipolar Disorder, Schizophrenia, or any type of long term Psychosis. Psychosis due to a medical or substance use condition that resolved is not included.

CHANGE IS POSSIBLE:

A Case Study of Solitary Confinement Reform In Maine

Included in SCDC' 4.29.19 letter to LOC

CHANGE IS POSSIBLE:

A Case Study of Solitary Confinement Reform In Maine

MARCH 2013

Included in SCDC' 4.29.19 letter to LOC

CHANGE IS POSSIBLE:

A Case Study of Solitary Confinement Reform In Maine

MARCH 2013

AMERICAN CIVIL LIBERTIES UNION OF MAINE
121 Middle Street, Suite 301
Portland, ME 04101
www.aclumaine.org

Author:
Zachary Heiden, *Zheiden@aclumaine.org*
©2013

All photos except cover art Copyright ©2013 by Elizabeth Noble

Cover photo: ©istockphoto.com/tiero

Report Design by Catherine Cunningham

Included in SCDC' 4.29.19 letter to LOC

Table of Contents

Introduction 1

The Origins of Solitary Confinement 5

The Psychological Effects of Long-Term Isolation 7

Before the Reforms: Solitary Confinement in Maine 10

It Does Not Have To Be That Way: The Maine Reform Example 12
- What Happened 14
- How It Happened 18
  - Pre-History of the Solitary Reform Campaign 18
  - The Legislative Campaign 19
  - The Sherrets Report 23

Keys to Success 27
- Honest Assessment 27
- Organizing and Cooperation 28

Overcoming Institutional Inertia 30
- Is It Safe? 30
- Are There Any Alternatives? 31
- Is Reform Really Worth the Effort? 31
- Do Advocates Really Understand? 32

The Lessons of The Maine Reform Campaign 34
- Lesson One: Bring All the Pieces Together 34
- Lesson Two: The Importance of Leadership 35
- Lesson Three: The Judicious and Timely Application of Pressure 35

Conclusion 36

References 37

Included in SCDC' 4.29.19 letter to LOC

Introduction

Solitary confinement destroys lives. Over the past four decades, prisons across the country have increasingly relied on solitary confinement—isolating prisoners in small poorly-lit cells for 23-24 hours per day—as a disciplinary tool for prisoners who are difficult to manage in the general population. But research has shown that these conditions cause serious mental deterioration and illness. Prisoners in solitary confinement hallucinate, they deliberately injure themselves, and they lose the ability to relate to other human beings. When these prisoners are eventually released from solitary confinement, they have difficulties integrating into the general prison population or (especially when they are released directly onto the streets) into life on the outside.

Because of this, human rights advocates across the country are engaged in a campaign to reduce the use of solitary confinement and to improve conditions in solitary units and facilities. Lawsuits are being filed, bills and regulations are being proposed, and exposés are being written, all with the goal of bringing about a change to this barbaric practice. A number of organizations, including my own—the American Civil Liberties Union—have committed a great deal of thought, time, and money to identifying and deploying successful strategies for reforming solitary confinement. No one approach will get the job done, but advocates are trying multiple approaches, with as much coordination as possible, to bring about significant lasting change. Maine has been one of the success stories of this effort. The number of prisoners in solitary confinement has been cut in half; the duration of stays in Maine's solitary units is generally now measured in days rather than weeks or months; and the treatment of prisoners in these units includes substantially more meaningful human interaction and more opportunity for rehabilitation.

For seven years, I have been involved in Maine's campaign to reduce the use of solitary confinement. Many times over those years, it seemed that nothing would ever change. Reform measures were watered down, improved policies were ignored, and legislative proposals were flat-out rejected. Then, at some point, through a combination of will, skill, and luck, reforms began to take hold. While Maine's correction system is far from perfect, the dramatic reduction in the use of solitary confinement and the improvement in the manner in which solitary is employed are almost beyond what I could have imagined seven years ago.

The purpose of this report is twofold: first, to document those changes and the processes that led to them; and second, to inspire other prison reform advocates with Maine's example. There are times when every advocate for prison reform feels that change is not possible—that the legal and cultural barriers are too firmly rooted, or that the public's antipathy to prisoners and their families is too powerful. This despondency might lead reformers to settle for superficial measures or, worse yet, to give up the fight in favor of easier targets. It is my great hope that the message of this report—that reform of the use of solitary confinement is both necessary and possible—will provide some measure of encouragement in those difficult moments that every worthwhile campaign experiences.

Included in SCDC' 4.29.19 letter to LOC

This report (and the campaign it documents) would not have been possible without the generous support, advice, and encouragement of the ACLU National Prison Project and ACLU Center for Justice. In particular, Amy Fettig, David Fathi, and Vanita Gupta deserve enormous praise and gratitude for their commitment to Maine's reform efforts, and to my efforts to document them. Thank you also to Alysia Melnick, Rachel Myers Healy, Shenna Bellows and Alisha Goldblatt for editorial assistance, to Elizabeth Noble for generously donating her time and photography skills, and to Lance Tapley for his ongoing efforts to document abuses in Maine's prisons and jails and to prevent those abuses. Finally, thank you to Maine's Commissioner of Corrections Joseph Ponte and Maine State Prison Deputy Warden Charlie Charlton for their determination to reform the way prisoners in Maine are punished (which is as strong as any advocate's), and for their cooperation with this report. Though this report was written for an audience of lawyers, lobbyists, organizers, and advocates, the prisoners across America suffering alone, in pain, in tiny, harshly-lit cells, were never far from my mind, and it is to them that this report is dedicated.

Zachary L. Heiden
ACLU of Maine Legal Director
Portland, Maine
March 6, 2013

Included in SCDC' 4.29.19 letter to LOC

What Is Solitary Confinement?

"The entire time I was in the Supermax I was in a 7 x 14 reinforced concrete cell, 23 sometimes 24 hours a day. On the days I was allowed out for an hour, I was allowed to be escorted in handcuffs to a 40' long by 8' wide chain link enclosure where I would have the cuffs removed and be allowed to pace or do in-place calisthenics for an hour before I was brought back inside for a ten-minute shower, one of three I would receive each week. The lights in the cell were always on, just dimmed at night. The sound of slamming metal doors and jingling keys could be heard 24 hours a day. Each day I would read part of my book, but I had to limit how much I read, since I was only allowed three books from the library each week. If I was lucky, the three books would last me five days." [1]

More than two million people are currently incarcerated in prisons and jails in the United States.[2] The United States incarcerates more people, and a greater percentage of its population, than any other nation—more than twice as many people as Russia, the runner-up.[3] India has a population more than three times greater than the United States, but it imprisons fewer than one-fifth as many people.[4] With so many prisoners in America to supervise, prison and jail administrators have had to devise methods for attempting to house and manage the prisoners in their custody, and for the past two decades the management tool of choice has been solitary confinement.

Solitary confinement is the practice of isolating a prisoner in a cell for 22-24 hours per day, with extremely limited human contact; reduced (sometimes nonexistent) natural lighting; severe restrictions on reading material, televisions, radios, or other physical property that approximates contact with the outside world; restrictions or prohibitions on visitation; and denial of access to group activities, including group meals, religious services, and therapy sessions.

Solitary cells at Maine State Prison

Sometimes solitary confinement conditions are imposed in separate wings of existing prisons, while other times entire facilities are devoted to solitary confinement. The solitary facilities are generally referred to as "supermax" or "administrative maximum" (ADMAX). The separate solitary confinement units go by a variety of names. They are Special Management Units (SMU) in Maine, Control Units in Illinois, and

Included in SCDC' 4.29.19 letter to LOC

Special Housing Units (SHU) in New York and California. The American Bar Association has chosen to use "segregated housing" as an umbrella term.[5] Prisoners and their families generally call it "the hole".

Approximately 80,000 prisoners are held in solitary confinement in the United States.[6] The public perception has been that solitary confinement is reserved for "the worst of the worst"[7] —a perception that has been frequently nurtured by prison officials eager to avoid legislative or judicial oversight. In reality, though, the vast majority of prisoners subjected to solitary confinement are neither violent nor incorrigible.[8] Many suffer from severe mental illness, while others suffer from cognitive disabilities.[9] Both of these conditions make it difficult for people to understand prison rules or function in the prison setting. When these prisoners break the rules—even very minor rules—they are sent to solitary confinement, which only exacerbates their conditions and makes it less likely (for reasons that will be discussed) that they will be able to behave properly.

Solitary confinement accomplishes one thing: it allows corrections officials and politicians to *appear* tough on crime.[10] But, this appearance is purchased in lost safety (for the public and for those who live and work in prisons), lost funds (to pay for the operation costs that are twice as high as general population facilities), and the lost lives of prisoners who are driven to psychosis and suicide.

Included in SCDC' 4.29.19 letter to LOC

The Origins of Solitary Confinement

In 1890, the United States Supreme Court recognized that confining human beings for long periods of time can have a profoundly negative effect on their mental well-being. Discussing the practice of solitary confinement, the Court observed:

> *A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which its was next to impossible to arouse them and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community.*[11]

Long-term solitary confinement was first developed as a penological strategy in Philadelphia by Quaker reformers, who believed that if prisoners were left alone (with a Bible) and given time to reflect and pray, they would realize their mistakes and repent.[12] Philadelphia's Walnut Street Jail, established in 1790, became a model for the development of "penitentiaries" across the country, and the practice of isolating prisoners from all human contact (including speech, excepting that of religious advisors and official visitors) came to be known as the "Pennsylvania system."[13] Prisoners would be taken to their cells with black hoods over their heads, and would be kept in the same cell throughout the entire term of their sentence. They would have no contact with other prisoners and only the most limited contact with prison staff, so as to allow for the most possible time for personal reflection and self-improvement.[14] Due to overcrowding at Walnut Street Jail, the Pennsylvania legislature erected two new larger-scale facilities: the Western State Penitentiary, near Pittsburgh, in 1826, and the Eastern State Penitentiary, near Philadelphia, in 1829.[15] These facilities included more cells designed for solitary confinement.

The "Pennsylvania system" promised more than simply safety and repentance—solitary confinement (the reformers believed) would also save the state money, because there would be no need to specially train guards to manage prisoners, to escort prisoners to meals, or to supervise them in work projects.[16] And there would be cost savings associated with security as well, since isolated prisoners would not be able to concoct escape plans with other prisoners.[17]

That, in any case, was the theory. But, in practice, the prisoners kept in long-term solitary confinement according to the "Pennsylvania system" did not tend to discover a new positive socially responsible mode of existing in the world. Instead, they tended to go insane. This was Charles Dickens's observation of prisoners at Eastern State Penitentiary in 1842: "He is a man buried alive; to be dug out in the slow round of years; and in the meantime dead to everything but torturing anxieties and horrible despair."[18] The Quakers have long since apologized for their role in the development of solitary confinement, and, through the American Friends Service Committee, they are working to end the practice and shut down the Supermax facilities in which it is practiced.[19]

Included in SCDC' 4.29.19 letter to LOC

Due to the development of new modes of prison administration (most notably, the reformatory model, which included extensive forced labor), as well as the emergence of questions about the constitutionality of long-term isolation, the "Pennsylvania system" largely disappeared by the beginning of the twentieth century. It was reborn, though, in Marion, Illinois, site of the first modern "control unit" prison, which was established by the Federal Bureau of Prisons in 1973.[20] This facility eventually replaced Alcatraz as the prison of choice for the federal system's "bad apples."[21] Marion would be replaced by the ADX facility in Florence, Colorado in 1994, and supplemented by similarly-run "SMUs" and "SHUs" in nearly every state.

Included in SCDC' 4.29.19 letter to LOC

The Psychological Effects of Long-Term Isolation

> *"It's an awful thing, solitary... It crushes your spirit and weakens your resistance more effectively than any other form of mistreatment."*
> *- Senator John McCain*

Long-term isolation produces clinical effects that are similar to those produced by physical torture. It leads to increases in suicide rates, and even mentally healthy individuals find the experience extremely difficult to endure. For individuals with mental illness, solitary confinement can be worse than a death sentence.

Here is how the psychiatrist Terry Kupers summed up his own research, and the research of psychiatrist Stuart Grassian, into the effects of long-term isolation on the mental health of prisoners:

> *Every prisoner placed in an environment as stressful as a supermax unit, whether especially prone to mental breakdown or seemingly very sane, eventually begins to lose touch with reality and exhibit some signs and symptoms of psychiatric decompensation, even if the symptoms do not qualify for a diagnosis of psychosis. . . Even inmates who do not become frankly psychotic report a number of psychosis-like symptoms, including massive free-floating anxiety, hyper-responsiveness to external stimuli, perceptual distortions and hallucinations, a feeling of unreality, difficulty with concentration and memory, acute confusional states, the emergence of primitive aggressive fantasies, persecutory ideation, motor excitement, violent destructive or self-mutilatory outbursts, and rapid subsidence of symptoms upon termination of isolation.*[22]

Or, as a judge put it, placing inmates with mental illness in solitary confinement is *"the mental equivalent of putting an asthmatic in a place with little air to breathe."*[23] Long-term isolation units make healthy people sick, and make people with mental illness worse, because human beings are social creatures. We depend on contact with other people to maintain equilibrium and to chase out the unpleasant thoughts that naturally occur in everyone's mind from time to time.[24] More intelligent and emotionally stable prisoners may be more able to resist these effects, but even the most well-adjusted prisoner will experience adverse mental effects—*"a degree of stupor, difficulties with thinking and concentration, obsessional thinking, agitation, irritability, and difficulty tolerating external stimuli (especially noxious stimuli)"*—after just a few days of isolation.[25]

This is how one prisoner who spent two years in isolation at Pelican Bay State Prison in Northern California described the experience:

> *Sometimes I feel overwhelmed. I get trepidations, nervous, agitated, I go off the deep end... Here, I feel like I'm in a kennel, closed off from life itself. I feel like I live in a coffin, like a tomb.*[26]

Another man, who spent time in Maine's prison, described the effect that isolation had on his fellow prisoners, some of whom took extreme measures to harm themselves and disrupt the monotony:

Included in SCDC' 4.29.19 letter to LOC

I would have a hard time counting the times I have seen another inmate cut themselves to the point that the entire floor of their cell was coated in blood, and they were removed for medical treatment after losing consciousness. Suicide attempts were not uncommon. The mentally unstable were punished for their actions rather than treated for their illness. . . When I was finally released from the Supermax into general population after almost two years, it was overwhelming. There mere sensations of human contact was harsh on my nerves. I would break into cold sweats and shake. I was overly stimulated and anxious all the time. It was very difficult to concentrate on one thing. Even to this day, I have a very difficult time focusing on one thing for very long and I am very easily distracted. The effects of the Supermax reach beyond the confines of its walls and fences.[27]

Self-harm is, in some ways, the clearest illustration of the break from normal mental health that accompanies isolation. After all, even the most serene and well-adjusted people sometimes experience fear or loneliness or paranoia, if only fleetingly. Most people, though, do not cut themselves until they pass out from blood loss, or engage in the kind of destructive behavior that former hostage Terry Anderson experienced. Anderson was the chief Middle East correspondent for the Associated Press in 1985, when he was taken hostage in Beirut. Atul Gawande retold the story of his isolation in "Hellhole"—his article in the New Yorker discussing the effects of long-term isolation:

'I find myself trembling sometimes for no reason,' he wrote. 'I'm afraid I'm beginning to lose my mind, to lose control completely.' One day, three years into his ordeal, he snapped. He walked over to a wall and began beating his forehead against it, dozens of times. His head was smashed and bleeding before the guards were able to stop him.[28]

There is an additional level of complication for the use of long-term isolation. Not only does long-term isolation have disastrous effects on prisoners' mental health, but these effects are frequently irreversible. It is this dimension that makes solitary confinement such a terrible choice for corrections institutions, because it means that prisoners will return to society less able to control themselves and relate to their surroundings. This, combined with the well-known but seldom-acknowledged fact that almost all prisoners are eventually released from prison, means that prison practices are making life worse for people both inside and outside the prison walls.

The residual consequences of isolation most commonly manifest as *"a continued intolerance of social interaction,"* which makes it much more difficult for former prisoners to obtain jobs, establish social connections, nurture family relationships, or become productive members of communities.[29] And, as Dr.

Solitary cell at Maine State Prison

Included in SCDC' 4.29.19 letter to LOC

Kupers testified to the Maine Legislature's Committee on Criminal Justice and Public Safety, *"destroying a prisoner's ability to cope in the free world is the worst thing a prison can do."*[30] It is bad enough that we should destroy an individual's ability to cope and capacity for rational thought—bad enough in the ontological sense—but the overuse of long-term isolation also makes it is less likely that former prisoners will be able to take their place in society as responsible and productive members of our communities. That makes us all less safe and secure.

Included in SCDC' 4.29.19 letter to LOC

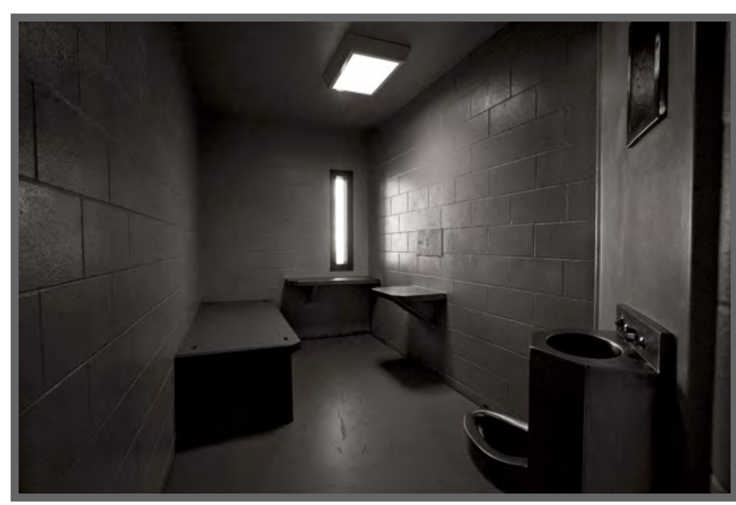
Before the Reforms: Solitary Confinement in Maine

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

> *"In all of England, there are now fewer prisoners in 'extreme custody' than there are in the state of Maine."*
>
> *-Atul Gawande, Hellhole, THE NEW YORKER, March 30, 2009*

The purported justifications for subjecting prisoners to isolation varied widely, and the nexus between such treatment and any legitimate penological goals was often impossible to discern. For example, prisoners at the Maine State Prison could be sent to the 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). And, despite the seriousness of solitary confinement, prisoners in disciplinary hearings were rarely provided assistance understanding the process or a meaningful opportunity to present a defense.

Other prisoners were sent to the SMU for "administrative segregation." In the event of a fight, for example, the prison might send both the aggressor and the victim to the SMU while the matter was investigated. The timeline for investigation was vague, and the depth and quality were suspect. A prisoner might spend days, weeks, or months in the SMU as a result of being attacked by another prisoner. Even after a prisoner had completed a term of disciplinary



Solitary cell at Maine State Prison

Included in SCDC' 4.29.19 letter to LOC

isolation or been adjudged the victim rather than the aggressor in a fight, he might remain in solitary confinement for additional days, weeks, or months because of a shortage of beds in the general population units.

There was also no policy of providing support or assistance to prisoners transitioning back into general population or out into the free world. In some cases, prisoners were released straight from the SMU onto the streets of Maine communities. Because of the destabilizing effects of isolation, releasing someone back into life on the "outside" abruptly and with no support leads to difficulty for both the former prisoner and the community. The cost of this practice was spread among family members, community members, and taxpayers who pay for court and corrections costs in the event of recidivism.

Included in SCDC' 4.29.19 letter to LOC

It Does Not Have To Be That Way: The Maine Reform Example

Maine State Prison

Across the country, pressure has been building to reform and reduce the use of solitary confinement. The motivation for reform has come from diverse directions: the realization that solitary confinement is overused; the awareness that it causes severe and lasting mental health consequences to prisoners; the concern that solitary confinement costs much more money than it is worth; and the belief that it actually makes our prisons and our communities less safe. These strands have come together in a number of state-level campaigns, and to date, Maine's has been one of the most successful.

Between 2011 and 2012, the Maine Department of Corrections ("MDOC") radically transformed the way that solitary confinement is used in Maine state facilities:

- Fewer people are sent to solitary;
- Prisoners sent to solitary spend less time there;
- Prisoners in solitary are held in better conditions;
- Prisoners in solitary are given access to more care and services to prevent decompensation and deterioration of mental health;
- Prisoners in solitary are given a clear path, based on achievable goals, for earning their way out of solitary.

The same pressures that led to the overuse of solitary confinement in Maine (and elsewhere in the United States)—the political desire to appear "tough on crime," the lack of awareness of other options for prisoner management—were still present during that time, but they were met with countervailing (and ultimately overpowering) pressure to reform. This kind of change is not easy, but many of the lessons of Maine's solitary reform experience are adaptable or even reproducible for other jurisdictions.

Included in SCDC' 4.29.19 letter to LOC

Maine's solitary reform efforts are an important example for the rest of the country because of how rapidly the transformation took place:

- February 26, 2010, there were 91 prisoners being held in the two pods (B & C) that made up Maine's SMU.
- May 2011, the C pod of the SMU was closed completely and new policies governing the operation of the remaining pod were put into effect.
- August 23, 2012, there were 46 prisoners being held in the SMU—approximately half the number of 18 months prior.[31]

In addition to the closing of one of the solitary confinement pods, the reduction in the solitary population was accompanied by a greater use of alternative forms of punishment, such as loss of privileges and confinement to a cell in the general population area. And, the prison enacted an incentive system that allows prisoners to earn access to more recreation while in solitary and earlier release from solitary.

The rapid reduction in the use of solitary confinement at the Maine State Prison was also accompanied by a rapid improvement in conditions for the isolated prisoners, including access to radios, televisions, and reading material, which psychiatrists believe reduces the likelihood of decompensation. Prisoners in solitary have also been given more opportunity to interact with other prisoners through group recreation and counseling sessions, and more opportunities to earn perks like additional hours of recreation through positive behavior.

Commissioner Joseph Ponte

Maine's example shows both that change to solitary confinement practice is possible, and also that these changes do not require years or decades for implementation. MDOC Commissioner Joseph Ponte had this to say with regard to the tendency of prison administrators to rely heavily on solitary confinement as a tool for keeping order and imposing discipline: "This is how people grew up. This is how we grew up in Corrections. This is how we did business. . . People don't want to look at other ways to do that."[32] But Commissioner Ponte was willing to look for other ways to keep order and protect prisoners and staff, and he was willing to implement those new ways of doing business without hesitation.

Included in SCDC' 4.29.19 letter to LOC

What Happened

> *I can promise you today, if you got up from your chairs and drove to a correctional facility right now, without letting any of them near a phone to call ahead, and you went into the segregation unit; you would find inmates there that were only supposed to be there a couple of week or months, but that have been there for months and months, sometimes more. Now the excuse is bed space. "Yes your time is up down here, but there is no bed space so you have to stay." I can tell you there is plenty of bed space.*
>
> *-Anonymous testimony of Maine prisoner, public hearing on solitary reform legislation.*[33]

The story of the success of the Maine solitary reform campaign is evidenced in the policies that have been put in place to govern discipline in Maine's prisons and administration of the Maine State Prison's SMU. Classification of prisoners has been transformed, and admission standards for the SMU have been tightened. Solitary confinement is no longer the default punishment at the Maine State Prison, but rather it is the punishment of last resort when no other option is adequate. Even in situations where prisoners are sent to solitary confinement, corrections staff is required to work with prisoners to develop a road map of behavior that will lead back to the general population. Staff have been given new training and skill-building opportunities for managing difficult prisoners and challenging situations. The administration has placed a greater emphasis on de-escalating situations before there is a serious problem, rather than extracting and punishing the perpetrators afterwards. In addition, it has removed incentives for supervisors to send difficult (but not dangerous) prisoners to the SMU.

The easiest way to understand these policy changes is by reference to the three different mechanisms by which solitary confinement was imposed at the Maine State Prison ("MSP"):

1. Disciplinary Segregation:

Formerly, Disciplinary Segregation was used for prisoners who were being punished for a concrete offense. According to policy, prisoners were only assigned to Disciplinary Segregation following a hearing, in which they had a meaningful opportunity to present a defense, and in which they would also be provided with assistance from a specially-trained prisoner advocate. In practice, though, prisoners were rarely (if ever) given any assistance, and most prisoners felt that the hearings were not meaningful. An investigation into the use of solitary (which is discussed in greater detail later in this report), made this finding about the availability of advocates at MSP, "At MSP reportedly no inmates are currently trained and the two trained staff are in the process of being transferred. In our observation of the hearings taking place . . . none were used or discussed with inmates at MSP."[34] In addition, Disciplinary Segregation terms were supposed to be of a definite duration, but in practice many prisoners spent longer

Included in SCDC' 4.29.19 letter to LOC

than ordered in Disciplinary Segregation, supposedly due to lacks of bed space in the general population pods.

Currently, the policy and practice favors disciplinary sanctions carried out within the general population environment, and Disciplinary Segregation is reserved for the most serious offenses. The MSP now uses a range of options for punishing prisoners that do not involve long-term isolation: confining the prisoner to his own cell; limiting contact visits; restricting the visitors allowed to immediate family; loss of work opportunities; et cetera. Segregation is only considered when responding to an extremely serious offense, such as a fight involving weapons. In addition to committing a serious offense, prisoners must also satisfy one of four requirements to be sent to Disciplinary Segregation: 1) 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 status.

Solitary confinement block at Maine State Prison

2. Administrative Segregation:

Formerly, Administrative Segregation was used anytime the prison wanted to isolate prisoners for an indefinite amount of time. New arrivals to the prison were frequently sent to Administrative Segregation while their status was being reviewed. In the event of a fight, all the prisoners involved in the fight (aggressors and victims alike) were sent to Administrative Segregation while the facts of the incident were sorted out and the officers decided who to charge with an offense. According to policy, Administrative Segregation status was subject to review and was only to be used for limited purposes. But, in practice the policies were ambiguous enough, and the reviews superficial enough, that prisoners had no real due process protection. As in Disciplinary Segregation hearings, prisoners were not actually provided with any assistance to understand the process or mount a defense (despite the promise of such assistance in policy).

Currently, Administrative Segregation is only used in extreme circumstances. Under current policy 15.01, prisoners are first placed under Emergency Observation Status in their usual housing environment. That prisoner may only be transferred to the SMU upon approval of supervisory staff, and the reasons for the transfer are documented and reviewed within 72 hours. Like Disciplinary Segregation, Administrative Segregation is only used when 1) the prisoner constitutes an escape risk in less restrictive status;

Included in SCDC' 4.29.19 letter to LOC

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 status.

3. High Risk Segregation:

Formerly, High-Risk segregation was, in theory, reserved for the "worst of the worst"—prisoners who were thought to be incorrigible threats to the safety of those around them. In reality, though, this was the status assigned when the prison officials gave up on their "corrections" responsibility. The status was broad enough to encompass a wide range of prisoners. According to the former MDOC Policy 15.04, High-Risk Segregation was appropriate when: 1) the prisoner had committed, attempted, or planned an act of violence or arson; 2) the prisoner had committed, attempted, or planned an escape; 3) the prisoner had engaged in (or planned to, attempted to, or threatened to engage in) trafficking in drugs or dangerous contraband; 4) the prisoner had committed at least three infractions resulting in disciplinary segregation; 5) the prisoner had served at least three months of administrative segregation; or 6) the prisoner was at risk of harm if housed in the general population. In effect, when prisoners lost the ability to control their behaviors or to cope with their surroundings because of long-term isolation in Disciplinary or Administrative Segregation, the prison's answer was to send them to more long-term isolation, by simply altering their designation to High-Risk Segregation. Status reviews were carried out only every six months.

Currently, the High-Risk Segregation status has been eliminated.

Small changes can make a remarkable difference. Previously, prisoners frequently found themselves serving extended periods in segregation because their bed in general population had been given to another prisoner. That prisoner would remain in the SMU for additional days, weeks, or months until another bed in general population opened up. This was not accidental. Unit supervisors were using the SMU as a way to get rid of prisoners that were challenging to manage. But now, MDOC policy 15.01 includes this requirement: "If a prisoner is moved out of his/her bed, the prisoner's bed shall be retained pending the review of emergency observation status."[35] Under the current policy, a prisoner may spend time in the SMU, but during that period the prisoner's bed in the general population remains open. This change accomplished two things: first, prisoners are not spending more time than planned in the SMU; and second, unit staff are now pressured to find ways to manage difficult prisoners within their units.

The new requirements for corrections staff have been accompanied by additional training opportunities in methods and techniques for managing difficult prisoners, as well as additional tools for disciplining prisoners in the general population. Commissioner Ponte believes that the training program should incorporate more tools and techniques, such as "verbal judo"—a verbal and emotional conflict management tool—and to reduce training that is not truly connected to the responsibilities of the corrections staff:

> *We spend a lot of time on firearms and self-defense—those kinds of things. We don't spend a lot of time on verbal judo and the kinds of interventions you would use most of the time.*

Included in SCDC' 4.29.19 letter to LOC

> *We really need to look at that. You're not shooting prisoners every day. If you fire a gun in your lifetime, it would be something. But you're talking to prisoners every day, so lets spend time on the kinds of things that really make a difference. We haven't done that yet.*[36]

One of the biggest advances, from both the perspective of constitutional rights and prisoner health, has been the dramatic curtailment of the use of Administrative Segregation pending the outcome of an investigation. For example, previously, if one prisoner attacked another and the second prisoner tried to defend himself, both prisoners would be sent to segregation while staff made a determination of who actually started the altercation. These investigations could take weeks or months, during which time the victim of an attack would be subjected to all of the negative health effects of long-term isolation, as well as interruption of educational or therapeutic programming and inability to earn or accrue "good time" credits. That practice was changed by Maine DOC Policy 20.1, which provides that:

> *No prisoner shall be detained pending investigation, hearing, or review or appeal of recommended disciplinary dispositions except as provided in Policy 15.1, Administrative Segregation, using the procedures and criteria for the placement of a prisoner on administrative segregation status.*

Finally, prisoners are made aware as soon as they arrive at the SMU that the prison wants their stay to be temporary and to last as little time as possible. For each prisoner in segregation, a team of staff made up of corrections and mental health professionals meets to create and document a plan for returning the prisoner to the general population.[37] The plans include specific requirements, which might include the following:

- Meet with mental health staff;
- Meet with correctional case worker;
- Meet with unit management team.

The plans also have specific goals for the prisoner to work towards, with the assistance of staff:

- No ideation or acts of harm to self;
- No ideation or acts of harm to others;
- Adequate control of impulses;
- Socially appropriate interactions with others.

This approach stands in marked contrast with the previous approach of either keeping prisoners locked up with no control over their future, or else moving prisoners from the SMU to the general population (and back again) with no attention to the kinds of skills and behaviors necessary for living in a society (either in or out of prison). The previous default assumption reflected circular logic about the role of the SMU: we only use the SMU for the "worst of the worst" so if a prisoner is in the SMU it must be because he is among the "worst of the worst." The current approach attempts to break that circle: the prisoner did something that resulted in him being sent to the SMU, but there is no reason that needs

Included in SCDC' 4.29.19 letter to LOC

to happen again. This approach also demonstrates awareness that long-term isolation itself can cause the exact kinds of anti-social or aggressive behaviors that would earn a prisoner the label "worst of the worst." Seen in that light, the reforms to Maine's SMU are more than a collection of policy changes; they are evidence of a deeper shift in attitude about the nature of human behavior, the impacts of isolation on that behavior, and the potential efficacy of corrections staff to make a positive contribution to an individual's life.

How It Happened

> *"Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted."*
>
> *-United States Constitution, Amendment Eight*
>
> *"[A]ll penalties and punishments shall be proportioned to the offense; excessive bail shall not be required, nor excessive fines imposed, nor cruel nor unusual punishments inflicted."*
>
> *-Maine Constitution, Article One, Section Nine*

Pre-History of the Solitary Reform Campaign

Maine was not an overnight success story. The early 1970s saw substantial class action litigation over the conditions in the segregation unit at the Maine State Prison in Thomaston. A federal consent decree was entered in 1973 in the matter of *Inmates of the Maine State Prison v. Mullaney*, which required that the MDOC adopt (and comply with) a new policy regarding "the use and management of solitary confinement cells."[38] That policy provided for basic due process for prisoners before they were sent to isolation cells, ensured that conditions in the cells met basic minimal standards, and capped the number of days that prisoners could spend in isolation.[39] Additional litigation followed in the late 1970s and early 1980s, including a class action lawsuit *Lovell v. Brennan*, brought by the ACLU National Prison Project, the Maine Civil Liberties Union (now the ACLU of Maine), and Pine Tree Legal Assistance.[40] That case, which was based in part on the earlier consent decree, "in large measure" sparked "substantial improvements" in the way prisoners were treated.[41] But, subsequent to those decisions, the State of Maine built a new "Supermax" facility down the road from the antiquated Thomaston prison, and—whether by operation of law or as a result of neglect—the earlier consent decree requirements were pushed aside.[42]

In 2005, the MCLU and ACLU National Prison Project took up the question of long-term isolation of prisoners with serious mental illness. Courts across the country were unanimous in the conclusion that subjecting prisoners with serious mental illness to long-term solitary confinement violates the Eighth Amendment's prohibition on "cruel and unusual punishment."[43] Courts had approved consent decrees across the country that

Included in SCDC' 4.29.19 letter to LOC

Maine State Prison

prohibited prisons from confining prisoners with schizophrenia, bipolar disorder, and other serious illnesses in solitary confinement units or facilities. If Maine would not agree to such a prohibition as well, the ACLU National Prison Project and the MCLU were prepared to take them to court.

The MDOC ultimately agreed, and the ACLU, MCLU, and Disability Rights Center of Maine negotiated a series of rule changes that resulted in the creation of a "Secure Mental Health Unit" where prisoners with serious mental illness could be given extra monitoring and treatment without compromising the safety of the facility.[44]

Unfortunately, good policies do not always result in good practice. Subsequent visits to the Maine State Prison by the MCLU and Amnesty International revealed that the "Secure Mental Health Unit" was simply being used as an SMU with a different name. Prisoners were still being warehoused, were still denied meaningful human contact, and were not being given any of the treatment or therapy (except for pharmaceuticals) that their conditions warranted. The advocates had hoped that the rule changes would lead first to better treatment for prisoners with serious mental illness and, later—after the prison administration had grown comfortable with a new way of thinking about prisoner well-being—to better treatment for all prisoners. Instead, the prison officials had kept the same punishment philosophy in place, while moving a few beds around and changing the name on the unit.

At that point—in early 2009—the MCLU and the ACLU National Prison Project began planning in earnest for a class action lawsuit aimed at reforming the use of solitary confinement in Maine.

The Legislative Campaign

At around the same time that the ACLU was preparing for litigation in Maine, other activists in Maine began developing plans for legislation aimed at curing a number of documented problems in the Maine State Prison—the overuse of restraint chairs and chemical agents, the lack of due process in prisoner discipline, and the

Question: Why is solitary confinement reform important?

Rev. Jill Saxby, Maine Council of Churches: "For us, it's a moral issue and human rights issue. It has to do with affirming the inherent worth and dignity of every person, who is made in the image of God. Everything we've learned about solitary and its effects on the human person (the prisoner, the jailer, the society) tells us that it is morally wrong and that society needs to be reminded of our moral responsibility to those whose behavior leads to imprisonment."[45]

Included in SCDC' 4.29.19 letter to LOC

inhumane effects of long-term isolation. Emily Posner was an early leader of that effort. She was inspired by Atul Gawande's New Yorker article[46] and by her correspondences with Herman Wallace, one of the "Angola Three" who was held in solitary confinement in Angola Prison in Louisiana for decades.[47]

> *Gawande mentioned that Maine had one of the highest rates in the country in regards to percentage of inmates in solitary confinement compared to the facility's total population. I was shocked and upset that my state was making such headlines. I wrote a letter to Jim Schatz, a member of the Maine state legislature's Criminal Justice Committee. I also sent him a copy of 'Hell Hole.' I asked if he would be interested in crafting a piece of legislation that addressed the use of long-term solitary confinement in Maine prisons. He agreed and we were off.*[48]

Posner and Rep. James Schatz (D-Blue Hill) ultimately drafted a bill, An Act to Ensure Humane Treatment for Special Management Prisoners,[49] which the MCLU and other advocates helped shape. The bill had a number of components:

- A 45-day cap on the number of days that a prisoner could spend in solitary confinement (with exceptions for prisoners who commit serious acts of violence, sexual assault or murder on staff or other prisoners; prisoners who escape or attempt to escape; or prisoners who present an immediate risk of harm to others);
- a prohibition on the placement of prisoners with serious mental illness in solitary confinement, and a process for removing formerly healthy prisoners who begin to exhibit symptoms of serious mental illness from solitary;
- a set of basic due process requirements for prisoner disciplinary proceedings and status reviews;
- a prohibition on the use of chemical agents or forcible extractions for the purpose of punishment; and
- a prohibition on the transfer of prisoners to out-of-state facilities lacking analogous protections.

MCLU Public Policy Counsel Alysia Melnick observed that the bill was not perfect,

> *But philosophically it was on the right track. It reflected the emerging understanding that solitary confinement, particularly when prolonged or when used with mentally ill prisoners, is ineffective, costly, and extremely damaging – both to the prisoners themselves and to the cell blocks and communities to which they return.*[50]

A coalition of organizations (the MCLU, NAACP, Maine Council of Churches, Disability Rights Center of Maine) and individuals (prison volunteers Jim Bergen and Judy Garvey, former prisoner Ray Luc Lavasseur, journalist Lance Tapley) came together to form the Maine Prisoner Advocacy Coalition (M-PAC) to advocate for the passage of the bill. As Bergen noted in recent written comments submitted to the U.S. Senate Judiciary

Included in SCDC' 4.29.19 letter to LOC

Committee's Subcommittee on the Constitution, Civil Rights and Human Rights, the original goals were modest:

> *The resulting Bill – LD 1611 – was modest in that given the DOC's intransigence, advocates were not optimistic in gaining a major transformation. It established necessary limits to the use of solitary based on the current research findings on this form of deprivation, presumably before the point where severe psychological damage can take place. Advocates also wanted to ensure that each prisoner in solitary would be checked at regular intervals for mental and physical deterioration by a trained mental health practitioner. We also hoped to enforce an end to 'cell extractions,' 'restraint chairs,"and other so-called 'tools.' With this Bill, it seemed that we were not pushing the envelope too far, and that our legislation would be viewed as moderate and politically capable of passing through the state legislative process successfully, despite views to the contrary on the part of Maine's DOC.*[51]

Despite the fact that the goals of the legislation were modest (from an administrative standpoint) and necessary (from a human rights standpoint), the legislation met with immediate and forceful opposition from the MDOC.

On February 17, 2010, the Maine Legislature's Joint Committee on Criminal Justice and Public Safety held a public hearing on LD 1611. The hearing began at 1:00 in the afternoon and continued until 11:00 that night and featured 45 witnesses. Of those, 29 spoke in favor of the bill, 14 spoke in opposition, and two spoke neither for nor against the bill.

Supporters included representatives from the Maine Association of Psychiatric Physicians, the Maine Psychological Association, the Maine Council of Churches, the Roman Catholic Diocese of Portland, the American Friends Service Committee, the Maine Prisoner Advocacy Coalition, the Immigrants Legal Advocacy Project, and the Maine Civil Liberties Union. Psychiatrist and author Dr. Stuart Grassian also testified in support, as did Prof. Richard Maiman of the University of Southern Maine political science department and Prof. Craig McEwan of Bowdoin College. Numerous former prisoners and parents of former prisoners also testified in support.

Opponents included representatives from the MDOC and the unions that represent prison staff (AFSCME and MSEA), and the Maine Sheriff's Association, as well as a number of corrections officers, a psychiatric nurse, and other members of the public.

A lawyer for the Maine Medical Association and a representative of the Healing Justice Program of the American Friends Service Committee testified neither for nor against.

The lead sponsor of the bill, Rep. Schatz, spoke first:

> *The passing of this bill will allow Maine citizens to be more informed and certain that what takes place in our institutions is consistent with our values as human beings and the need to return offenders to their communities as productive citizens.*[52]

Prisoners were unable to attend the hearing, so their testimony (in the form of letters and comments) was presented by Judy Garvey of M-PAC.

Numerous religious figures testified in support of the bill. Among them was Rev. Susan

Included in SCDC' 4.29.19 letter to LOC

Murphy, an Episcopal priest from Sanford, Maine:

> *There are those who say, prisoners deserve to be treated like animals and yet we arrest people for treating animals in the same way we are treating persons in segregation but we often just turn our eyes away because it will cost us something. We are already paying the price for the inhumane treatment of prisoners in solitary confinement. These persons—most of them—will return to society and what have we created?*[53]

and Eric C. Smith, Associate Director of the Maine Council of Churches:

> *Each of us is worthy of respect and dignity simply because we are human beings. This is the starting point for all laws that protect human life and mandate minimum standards by which we will live together in society. This principle is so foundational, that even when we violate those laws, even when we harm another person, even when we must be punished and removed from society, we do not negate our humanity.*[54]

Experts in corrections policy and peneology, including Maiman and McEwen, testified in support of the bill as an important step towards reversing long-term destructive priorities in the corrections industry:

> *In a well-functioning prison system, special management should be used as a last resort and applied for relatively short periods of time. Long applications of special management and their routine use as a punishment device fuel anger, resistance, and future bad conduct. They not only disable inmates from smooth adaptation to later release from prison, but more immediately, disable them from effective participation in the social system of the prison.*[55]

Some of the most compelling testimony came from parents and family members of prisoners or former prisoners. One mother, Daureen Stevens, told how she felt like she was experiencing the pain of solitary confinement with her son—a feeling familiar to parents:

> *My son spent many years in solitary confinement which seemed like an endless dark tunnel to me. Even though I had my freedom, I was also imprisoned within my desperation for him to survive. My thoughts and fears of losing my son is an unbearable gut-wrenching empty feeling whenever he is in solitary confinement. The thought of losing him to a delusional/mental state of mind, or even death sat in the deepest part of my soul and mind. . . Ask yourself, would you send your child to their room for a week, a month, or even years to punish them for something they did wrong?*[56]

Those concerns were echoed by mental health professionals. Dr. Janis Petzel testified as President of the Maine Association of Psychiatric Physicians:

> *When the extreme stressor of solitary confinement is layered on top of a pre-existing psychiatric condition, the results are disastrous for the individual: psychosis, suicide or self harming behaviors, complete emotional breakdown. This type of overwhelming experience can make permanent, negative changes in the brain.*[57]

And Dr. Grassian, one of the world's foremost experts on the psychological effects of long-term isolation, testified about the problems with Maine's facilities, programming, and lack of adequate mental health supervision:

Included in SCDC' 4.29.19 letter to LOC

> *Institutions like the SMU 'look' good; they make it seem like we are 'getting tough on crime.' But in reality, we are getting tough on ourselves. 95% of all incarcerated individuals are eventually released, some directly out of SMU settings. We have succeeded in making those individuals as sick, as internally chaotic, as we possibly can. Over the long term, the SMU does not create a safer environment; it creates a far more dangerous environment.*[58]

Civil rights advocates, including the MCLU's Melnick, drew the explicit connection between the harms caused by solitary confinement and the promise of change embodied in the proposed legislation:

> *We understand that change is hard. Supporters of reform must fight against formidable limits to training, staff and programmatic resources. And, in presentations before this Committee, OPEGA,*[59] *and the Board of Visitors noted the serious challenges in trying to change a long-standing and ingrained prison culture. But make no mistake, change is both possible and necessary.*[60]

Opposition to the solitary reform legislation was lead by then-Commissioner of the MDOC, Martin Magnusson:

> *This bill would seriously jeopardize the health and safety of both staff and inmates and require substantial additional costs to the Department and the State during a budgetary crisis. I can tell you with 100% certainty that more of our staff and inmates would be at serious risk to be injured or killed if this LD was passed.*[61]

That promise of future harm to prisoners and guards was enough to carry the day, and all but two members of the Committee (one of whom was the lead sponsor) ultimately voted against the legislation. When the bill came to the floors of the House and Senate, a number of legislators echoed the concerns expressed by the Commissioner that the safety of staff and prisoners would be jeopardized by a reduction and regulation of the use of solitary confinement, while others disputed the scientific basis for concern about long-term isolation.

Following that substantial setback, advocates for reform were able to achieve what they believed at the time was the most modest shred of a victory: the conversion of the thorough and detailed oversight bill (with strict prohibitions and clear requirements) into a legislative resolve requesting that a government entity hand-picked by the MDOC study the limited question of due process rights for prisoners with mental illness. It would be an overstatement to say that advocates were not terribly optimistic about the potential value of such a study. As the reform advocates awaited the study, they took comfort in the knowledge that they had forced lawmakers and those charged with overseeing corrections policy to have a real and deep conversation about solitary confinement in Maine's prisons.

The Sherrets Report

Maine's proposed solitary-reform legislation, LD 1611 (124th Legislature) was ultimately converted into Resolve Chapter 213, LD 1611. The legislation had been titled "An Act to Ensure Humane Treatment for Special Management Prisoners,"[62] but the resolve

Included in SCDC' 4.29.19 letter to LOC

was ultimately titled "Resolve, Directing the Department of Corrections to Coordinate Review of Due Process Procedures and To Ensure Transparency in Policies Regarding the Placement of Special Management Prisoners." The gap between those two titles provides a fair proxy for the gap in enthusiasm that the advocates (and their supporters in the legislature) felt between the original bill and its final approved form.

The Resolve was short:

> *Sec. 1 Commissioner of Corrections's review of due process and other policies related to placement of the special management prisoners at the Maine State Prison. Resolved: That the Commissioner of Corrections shall, in consultation with the mental health and substance abuse focus group of the State Board of Corrections, review due process procedures and other policies related to the placement of special management prisoners. In its review of due process procedures and placement policies, the commissioner shall also consider and propose an appropriate timeline for regular reporting to the joint standing committee of the Legislature having jurisdiction over corrections matters; and be it further.*
>
> *Sec. 2 Reporting date established. Resolved: That the Commissioner of Corrections shall report findings and recommendations pursuant to the report under section 1, including any suggested policy or legislative changes, to the joint standing committee of the Legislature having jurisdiction over corrections matters by January 15, 2011.*

The Mental Health and Substance Abuse Focus Group ("the Group") of the State Board of Corrections was comprised of staff members from the MDOC and the Department of Health and Human Services (MDHHS), as well as corrections and health care professionals from Maine jails. The Group was chaired by Dr. Steve Sherrets, a psychologist who served as the Mental Health/Criminal Justice Manager for MDHHS.

The Resolve was finally approved on April 15, 2010, but the Group did not begin its work until the summer of 2010. Once the Group began to work, though, it worked extremely diligently. By its own account, the Group went "beyond the required scope of the charge" to consider the broader implications of corrections procedure and practice on the mental health and well-being of prisoners, as well as the safety and administrative needs of staff.[63] The Group accepted suggestions from outside groups and individuals, including many of the advocates who had worked on the legislative campaign. The MCLU submitted multiple memoranda and kept in touch with Sherrets throughout the process. The Group spent "100s of hours doing the ground work" for the report, and it was given broad access and assistance by the MDOC.[64]

The Group's conclusions were shocking in their thoroughness and honesty, and they confirmed many of the claims that the advocacy community had made in support of the legislation. The report went beyond simply identifying serious problems to recommending necessary changes to address those problems.

The first problems that the report identified was the amount of discretion exercised by corrections officers in sending prisoners to the SMU, coupled with a lack of clear record keeping and reporting about the population of the SMU—why were prisoners there,

Included in SCDC' 4.29.19 letter to LOC

what had they done wrong, and when would they be returned to the general population. The Group's first recommendation—one that overlays and informs all subsequent recommendations—embodies the need for prison staff to get away from using long-term isolation as the punishment of choice:

- Recommendation 1 Overview: The Focus Group recommends consideration of exploration and development of alternatives developed for the general population of inmates so general population staff will have more alternatives for behavioral intervention than what is afforded by the use of Disciplinary Segregation, Administrative Segregation and the Protective Custody inmates. This should result in hopefully preventing many of them from being placed in an SMU. When an inmate is placed they frequently lose their bed and receive the most intensive/costly interventions available in the facility. The individual also has the experiences of the greatest degree of restriction and loss of liberty and rights. This could arguably be justifiable if the program worked at permanently changing behavior but current research and experience suggest that we achieve questionable positive effects on the inmate or their future behavior. One can even argue that repeated use of SMU's without the type of behavioral/prescriptive programming we are suggesting may well have a deleterious effect on future pro-social behavior. Better management of behavioral responses and contingent reinforcers, could well reduce not only the use of these units but result in an increase in appropriate behavior in the general population and hopefully a better transition to appropriate behavior in the community.[65]

Additional recommendations include the following:

- The hiring of professional behavioral health staff with backgrounds in behavior modification (Recommendation 2);
- regular periodic meetings between mental health staff from various facilities (Recommendation 3);
- ongoing collection of data concerning the SMU population, including the yearly cumulative time that any prisoner spends in the SMU (Recommendations 4 and 3U);
- review of the use of the SMU to house prisoners awaiting completion of investigations (Recommendation 7);
- keep the beds of prisoners sent to the SMU open in order to ensure that there is a place for them in the general population as soon as they are ready to be released from the SMU (Recommendation 1U);
- develop additional tools and sanctions for imposing discipline in the general population so that the SMU is only a last-resort punishment (Recommendation 2U);
- make sure that fully-trained "counsel substitutes" are available to assist all prisoners, especially prisoners with limited cognitive abilities (Recommendation 4U and 6U);

Included in SCDC' 4.29.19 letter to LOC

- improve the physical space in the SMU so that there is adequate airflow and enhanced sensory stimulation available (Recommendation 8U and 9U);
- flexibility in relaxing the conditions of confinement in the SMU when there are mental health concerns, including increased human contact, out-of-cell time, and access to therapy (Recommendation 11U);
- special training for SMU staff, including mental health treatment protocols, de-escalation techniques, and special cognitive challenges (such as brain injuries) (Recommendation 14U); and
- include mental health and security staff in joint planning sessions to develop intervention plans for prisoners (Recommendation MHU 20).[66]

Because the recommendations were so detailed, and because they were based on both insider knowledge and insider access by well-credentialed authors, they would have been difficult to ignore. Difficult, though, is not the same as impossible. Like all institutions, corrections departments naturally resist pressure to change. Advocates for reform at the MCLU viewed the report as the MDOC's last best chance to reform itself, or else the report would be Exhibit One in a federal civil rights case.

Commissioner Ponte, though, took the recommendations head on. In an interview conducted for this report, he noted that "the facts are the facts…clearly, that was our practice. That is how we ran prisons forever. So, I couldn't back away and say 'we don't do that.'"[67] The commissioner set up a second working group tasked with developing plans for implementing the recommendations, and the group was instructed that if they were opposed to implementing any of the particular recommendations, they needed to have a very good reason.

Jim Bergin, one of the advocates who leads the Maine Prisoner Advocacy Coalition, is a member of that group:

> *This Working Committee had weekly meetings through a year, meeting at Maine State Prison in Warren, Maine, and consisted of [staff and advocates]. The presence of the two Advocates on the Committee, at the suggestion of Commissioner Ponte, was a radical innovation for the MDOC that was in marked contrast to the previous MDOC Administration for which "transparency" was a dirty word, and M-PAC was a problem that wouldn't go away.*[68]

Bergin believes that the ultimate goal of the working group is "the potential of all but eliminating the use of solitary" and he sees the use of rigorous data collection as "a means to measure the success or failure of the Policy changes" in achieving that ultimate goal safely and efficiently.[69] Bergin continues to receive regular briefings on policy development, as well as data on prisoner discipline, which he in turn shares with the larger prisoner-advocacy community.

Included in SCDC' 4.29.19 letter to LOC

Keys to Success

Honest Assessment

Maine's solitary reform successes were built upon an honest assessment of how Maine's prison officials were using long-term isolation and the effect that isolation was having on prisoners. This is, in itself, remarkable. Most reform efforts are met with apologism and sophistry—"this is the only way to do things, it isn't as bad as you think, and you really don't understand how the system works." That is a very difficult barrier for advocates—most of whom, most of the time, are working outside the system they are trying to reform.

The second-to-last step that led to Maine's remarkable overhaul of its solitary system—right before Commissioner Ponte created and implemented the new governing policies, but after the long years of legislative advocacy, negotiations, and litigation threats—was an investigation of Maine's SMU by government officials. Normally, the prospect of government officials investigating themselves would not inspire a great deal of confidence or enthusiasm by advocates. At best, the investigators would normally be predisposed to present their co-workers and superiors in a favorable light, and at worst the investigatory impulses would normally be captured by the greater interest in maintaining the status quo. One would expect this to be especially true in a specialized field, such as corrections, where there is a sharp divide between insiders and outsiders and a strong concern over basic safety that permeates even the most modest policy challenges.

View of recreation area at Maine State Prison

Luckily, that was not the dynamic that emerged in Maine. As described before, the Maine Legislature charged the corrections commissioner to consult with a small subcommittee of a relatively-inactive policy setting board—the Mental Health and Substance Abuse Focus Group of the Maine Board of Corrections—in order to review "due process procedures and other policies related to the placement of special management prisoners." That group went deeper and further than anyone—advocates or corrections professionals—expected. Their report documented that there were, in fact, significant problems with the way that long-term isolation was used in Maine prisons, and it included many substantial recommendations for ways that solitary could be reformed. These findings and recommendations are discussed in greater detail in a separate section of the report,

Included in SCDC' 4.29.19 letter to LOC

but it is the existence of this honest self-critical report—independent of the information contained within it—that is almost more remarkable than the changes that stemmed from the report. After all, very little (if any) of the information in the report was news to the many experts and advocates who worked on solitary reform in Maine, and certainly none of it was news to the prisoners who were forced to endure brutal and dehumanizing treatment. What is news, and is important to note, is that the report – detailing the serious problems with solitary and recommending significant change – was produced by government officials, many of whom had worked in corrections.

It would have been easy for the Group to stick to its narrow mandate of reviewing due process procedures, and it would have been a surprise to nobody if the Group had said that those procedures were adequate or that they satisfied basic constitutional minimums. That, in fact, had been the conclusion of a Maine Assistant Attorney General who was asked to review and explain the due process implications of the Maine State Prison's procedures for imposing solitary confinement. But instead, the Group decided to take a serious and objective look at the entire operation of Maine's SMU—the policies, the actual practices, and the shortcomings in each. Their research reinforced many of the claims and concerns made by advocates, and because the group included both mental health and corrections personnel, their conclusions could not easily be dismissed.

Expert reports and reviews are frequently used in the solitary reform process, and advocates have been extremely fortunate to be able to rely on so many highly credentialed, deeply experienced medical, psychological, and penological experts to help conduct those investigations and produce those documents. Maine's experience, though, points out the value of a different kind of investigation—one conducted by government insiders of their own system. This is not to say that individuals with as much integrity and commitment as the group that conducted the Maine investigation will be easy to find—they will not. But advocates should begin the search and devote serious energy to nurturing any potential they find in government insiders, particularly those with mental health, corrections, or public safety backgrounds. The Maine report ended up being one of the most important components fueling the state's reform efforts – and it had the impact it did because of who the authors were (insiders) and where they were from (Maine).

Organizing and Cooperation

Most of the history of Maine's solitary reform campaign was antagonistic. Lawsuits were brought, and more lawsuits were threatened. Solitary reform legislation was proposed and debated, which the MDOC leadership viewed as a hostile and unjustified intrusion into their sphere of operations. They marshaled every available resource—lobbying, personal appeals, a media campaign, demonstrations by staff and their family members, dire warnings of riots and mayhem—to oppose it. Many legislators and other government officials were dismissive of the scientific and medical claims of advocates, and of those advocates themselves. As just one example: Dr. Grassian has studied the mental health

Included in SCDC' 4.29.19 letter to LOC

consequences of long-term isolation for decades. His testimony was challenged by the Maine Legislature's Criminal Justice and Public Safety Committee with derisive inquiries about what makes him an expert and why he thought his decades studying prisoners outside of Maine had any applicability to Maine prisoners. It was that kind of campaign.

For their part, the advocates were not shy about using the word "torture" to describe long-term isolation, which upset many corrections officials as well as sympathetic staff members. One staff member asked advocates, repeatedly and incredulously—"You are calling us torturers—how can we work with you after that?"

Harsh words were also accompanied by threats. Commissioner Ponte acknowledged that the threat of litigation by the MCLU played a significant role in creating a sense of urgency. In an interview with Lance Tapley, a Maine journalist who has documented the problems of long-term isolation in Maine's prison, Commissioner Ponte noted that he did not come to Maine looking to reform the use of solitary—the issue was waiting for him, in the form of "threats of lawsuits by the ACLU."

But, despite these antagonisms, the final stages of the Maine campaign were characterized by a great deal of cooperation between advocates and corrections professionals. In large part, this was due to the arrival of a new corrections commissioner, who felt no ownership over the prior policies, who had an interest in working with advocates, and who had not been scarred by previous years of contentiousness. For example, as described before, Commissioner Ponte established a working group with the directive of implementing the recommendations of the Mental Health/Substance Abuse Focus Group's report—not "reviewing and discussing" the recommendations, but "implementing" them. That group includes the commissioner and administrative staff from the MDOC, the warden and deputy warden of the Maine State Prison, the president of the Portland branch of the Maine NAACP, and the co-coordinator of the Maine Prisoner Advocacy Coalition. Outside groups, including the ACLU and the Maine Council of Churches, have had extensive meetings with staff at the Department of Corrections and at the Maine State Prison, and have been given the opportunity to speak with line officers and prisoners about changes to the use of solitary confinement.

Maine represents an example of the need for forceful advocacy (including, sometimes, litigation) and an openness to working collaboratively. Neither strategy on its own was able to bring about broad and deep changes to the entrenched views and practices surrounding solitary confinement. In Maine's case, advocates were only able to switch from antagonism to cooperation after a change in leadership at the Department of Corrections. Hopefully that will not be necessary in every jurisdiction, but it is a dynamic that advocates would do well to notice, consider, and take advantage of when possible.

Included in SCDC' 4.29.19 letter to LOC

Overcoming Institutional Inertia

Maine State Prison

The first challenge for a solitary reform campaign is overcoming inertia. Using long-term isolation to punish prisoners has been the normal practice in the United States for a very long time—as Commissioner Ponte put it, "It's how we were brought up."[70] And, unfortunately, overcoming that resistance to change is not easy. Despite volumes of evidence, settlements and court decisions, and the experiences of places like Maine and Mississippi, the Director of the Federal Bureau of Prisons nonetheless told a Senate hearing in 2012 that the Bureau hardly uses long-term isolation, and that solitary confinement not really a problem anyway.[71] Since the Federal Bureau of Prisons is the largest prison system in the country, the director's views and lack of concern carry unfortunate weight.

But, by telling prisoners' stories, sharing the medical science in support of reform, reminding people of their moral obligation to treat other human beings with dignity, and applying judicious pressure, inertia can eventually be overcome.

Once that happens, advocates must find ways to overcome the next set of barriers—the predictable counter-arguments in support of the status quo. These, too, can be overcome, but it will be more challenging. Luckily, Maine's experience can help.

Is It Safe?

Safety is the primary objection that sinks every unsuccessful prison reform effort—it was successfully deployed by Maine's former corrections commissioner, Martin Magnusson, to derail proposed legislation, and it was echoed by every unsupportive legislator. Nobody wants to be responsible for needlessly risking the safety of corrections staff or prisoners, and, faced with the specter of that possibility, many decision makers will find it easier to simply do nothing.

But, given the experiences in Maine, the safety excuse is no longer a tenable argument for completely blocking reform. Even after reducing the population of the SMU by more

Included in SCDC' 4.29.19 letter to LOC

than half, Maine has seen no statistically significant rise in incidents of violence. In fact, by some measures, the violence has decreased. Commissioner Ponte requires regular data collection concerning violent incidents, and he reviews that data regularly. He noted in August 2102 that "the violence in the population is a little better than before we made the changes. You could say it is about the same—it hasn't really gone up or gone down, it is about the same."[72] Inevitably, there will be serious violent incidents in prison. But Maine's experience shows that using long-term isolation to punish prisoners does not prevent to such incidents. Prisons can punish prisoners in more humane ways than long-term isolation without risking anyone's safety.

Are There Any Alternatives?

Long-term isolation has been the punishment of choice for so long in so many prisons and jails that it is difficult for corrections officials to imagine any other way of doing things. Solitary, they will insist, is the only tool they have for punishing those prisoners who will not follow the rules.

Unlike the safety argument (which the public may be willing to accept on face value), this excuse should not easily gain traction with the public, judges, or legislators. After all, this is prison—there are an endless number of things that staff can do to enforce rules that do not involve solitary confinement. In Maine, these alternatives include short-term confinement within the general population unit, temporary loss of work privileges, temporary loss of contact visits, and limits on numbers of approved visitors. On top of that, the Maine State Prison has trained its corrections staff to look for ways to defuse situations before there are violations of the rules. Staff are trained to take copious notes on prisoner interactions, so that they are able to anticipate problems. They are also trained in "verbal judo"—a technique for redirecting a prisoner's energy and de-escalating a situation.

Not only are there plenty of disciplinary alternatives to solitary confinement, but the alternatives actually work much better. Prisons do not impose discipline for its own sake (if they do, that is another problem altogether); they impose discipline to correct behavior and keep people safe. But, using solitary confinement as a form of discipline makes it so that prisoners lose the ability to control themselves and their thoughts, which means they are less likely to act rationally and correctly in the future. That, in turn, makes everyone less safe—guards, other prisoners, and the public.

Is Reform Really Worth the Effort?

Unfortunately, it is a widely held view in the national corrections community that reform is not worth the effort. Commissioner Ponte shared that he initially learned about the process of solitary reform from Mississippi's Commissioner Christopher Epps at a national meeting of corrections commissioners. But, he found that few of his colleagues were

Included in SCDC' 4.29.19 letter to LOC

interested in learning more: "there are not a lot of people saying, 'Hey what'd you do and how'd you do that?'"[73] Some people will be persuaded by the moral case against torture, and others will be persuaded by the medical concerns or the public policy arguments. But, for those who are still unpersuaded, there is one important remaining response: money.

It costs two to three times as much money to keep a prisoner in solitary confinement as it does to keep him or her in the general population. In Maine, a prisoner in the SMU was not allowed to go anywhere without full shackles and two guards for escorts. A prisoner in Maine's SMU would have arm and leg shackles placed on for a 10-foot walk to the shower cell, and the two guards that were needed to escort that prisoner were not available for any of the other tasks that needed to be performed at the prison during that shower. Prisoners in Maine's SMU, and in analogous facilities around the country, were not allowed to go to the dining hall for meals, which meant that staff needed to package up the meals, bring the meals to the SMU, and then bring the dirty dishes back to the dining hall. In prison, staff time equals money, and Maine (like most states) spends inordinate amounts of money on solitary confinement that could be better spent elsewhere. After all, under Maine's previous policies, prisoners might be housed in the SMU for all sorts of reasons, very few of which correlated with a tendency towards violence. But, the blanket security practices at the SMU made it an extremely expensive facility to operate, in addition to all the related costs that stem from the long-term effects of solitary confinement.

The money Maine now saves on its SMU can be put towards programing and facilities, which is especially important given the financial crisis that the state has experienced in recent years. New money from the state budget has been extremely hard to come by, and solitary reform provided a way for the MDOC to free up money that was being spent unnecessarily. That process should appeal to decision-makers across the country, no matter how they feel about the moral or medical case for solitary reform.

Do Advocates Really Understand?

The leaders of Maine's solitary reform campaign were doctors, lawyers, clergy, parents, spouses, organizers, and former prisoners. Despite concerted recruitment efforts, though, the campaign did not include any corrections officers. Many of the people involved had spent substantial amounts of time in prisons and jails, and a number of the leaders, like former State Representative Stan Moody, had spent time as chaplains at various facilities. But reform opponents were still enthusiastic about claiming superior knowledge based on personal experience. Advocates were told that if they really knew what it was like in prisons and jails, they would have a different position—maybe they would believe that long-term isolation did not cause health problems, or maybe they would believe that these problems did not matter because prisoners deserve whatever ill treatment they receive. A desire to reform the use of solitary confinement will frequently be portrayed as evidence of a lack of understanding.

Included in SCDC' 4.29.19 letter to LOC

Fortunately, advocates for solitary reform have a growing list of allies with substantial personal experience working in corrections, including Maine's Corrections Commissioner Ponte and Mississippi's Corrections Commissioner Epps. Both of these men and many of their senior staff have gone through the process of reducing and reforming the use of solitary confinement, and they have said on multiple occasions that it is a worthwhile undertaking. Here is Commissioner Epps, who has also served as the President of the American Correctional Association, testifying before the Senate Judiciary Committee:

> *The Mississippi Department of Corrections administrative segregation reforms resulted in a 75.6% reduction in the administrative segregation population from over 1,300 in 2007 to 316 by June 2012. Because Mississippi's total adult inmate population is 21,982 right now, that means that 1.4% are currently in administrative segregation. The administrative segregation population reduction has not resulted in an increase in serious incidents. The administrative segregation reduction along with the implementation of faith-based and other programs has actually led to 50% fewer violent incidents at the penitentiary.*[74]

And here is the testimony of Commissioner Ponte:

> *The MDOC has been able to keep one segregation pod closed for the last year. There has not been an increase in violent incidents as a result. Efforts to improve the unit management approach are still underway as the culture shifts from punitive responses to more positive responses. Shifting thinking among staff is challenging and takes time and education. As positive outcomes are seen and experienced, staff buy-in increases.*[75]

Maine State Prison

Inevitably, advocates for reform will encounter influential decisionmakers who do not want to listen to science, who do not want to listen to doctors, who do not care what clergy have to say, and who are unmoved by the first-person accounts of people who have actually experienced long-term isolation. They may not want to hear from the ACLU either. Maine advocates experienced all those forms of hostility, and the last refuge argument was, "you just don't understand."

To them, you can say that Commissioner Ponte understands and the head of the American Correctional Association understands as well. They understand, and they believe that reforming the use of solitary in prisons and jails is in everyone's best interest. With each passing year, as more and more states undertake reform efforts, there will be more corrections officials available to testify to the possibility of safely and efficiently moving away from a corrections system that depends on locking people in a dark room, alone, to lose their minds.

Included in SCDC' 4.29.19 letter to LOC

The Lessons of The Maine Reform Campaign

It is the great hope of prison reformers in Maine (including this author) that Maine will serve as an example for what is possible in solitary confinement reform. Commissioner Ponte has noted that Mississippi's solitary reform efforts were inspiring to him—once he heard the story of Mississippi Corrections Commissioner Christopher Epps's actions, he felt that "if he can do that in Mississippi I know we can do that in Maine."[76] In turn, Commissioner Ponte hopes that Maine's successes will be inspiring to others.

Lesson One: Bring All the Pieces Together

Advocates, like the MCLU's Alysia Melnick, hope that colleagues around the country recognize how many different pieces there are to a successful solitary reform campaign, and how they can fit together:

> *It's crucial that the benefits of reducing and reforming use of solitary be communicated from all perspectives – meaning, this isn't just about humane treatment of prisoners, or our moral and societal obligation to refrain from torturing those we incarcerate. It's about that – but it's also about good public policy, and about reforming a practice that's proven so costly to our nation not just in terms of ruined lives of the prisoners themselves, but also in terms of increased recidivism, injuries to staff and other inmates, and the tremendous fiscal burden on taxpayers. Overuse and abuse of solitary serves no one.*[77]

Maine's solitary reform campaign was made up of diverse voices and perspectives committed to the same goals: doctors, clergy, lawyers, prisoners, family members, legislators, and volunteers who were simply moved to action. Each of these people had different critical roles to play, personal stories to share, medical information to explain, and moral visions to proclaim. The reform efforts would not have been possible without all of them. Advocates around the country who are embarking on a solitary reform effort should pull together the largest, most diverse coalition that can be successfully organized and managed.

In Maine, the faith community provided important moral leadership and represented a perspective free from partisan influence. Rev. Richard Kilmer of the National Religious Coalition Against Torture ("NRCAT") is a resident of Maine, and he was committed to seeing his home state light the way for other states across the country. As Rev. Kilmer noted,

> *The National Religious Campaign Against Torture advocates for reform because prolonged solitary confinement destroys prisoners' minds, denies the opportunity for community, and violates the inherent, God-given dignity and worth of every person. As people of faith, we are called to speak for those in our community who have no voice, including individuals who are incarcerated.*[78]

Included in SCDC' 4.29.19 letter to LOC

NRCAT's participation led, in turn, to the involvement of the Maine Council of Churches, for whom the campaign as a way of "affirming the inherent worth and dignity of every person, who is made in the image of God."[79] And, once the Maine Council of Churches became involved, its individual member congregations became interested, which led to volunteers writing letters, attending hearings, and visiting prisoners to collect stories.

Lesson Two: The Importance of Leadership

A reform effort will not manage itself, and a shared goal is not the same as a shared plan. Organizations like the ACLU, with experience in legal, legislative, and public advocacy, can provide help getting reform efforts off the ground, but they are not the only ones and they cannot do it alone. The Maine Prisoner Advocacy Coalition that formed around the solitary reform campaign included both professional advocates (including the ACLU) and grassroots volunteers, many of whom had personal connections to the problems associated with the overuse of solitary confinement—either because they themselves had experienced it, or because they had tried to help friends or relatives rebuild their lives after a long stay in solitary. That coalition, in turn, provided leadership to the larger community of concerned individuals who were able to pressure their elected representatives to support reform.

Leadership from the advocacy community is, unfortunately, only one ingredient. Maine's reforms were only possible after leadership in the state correction system made reform a priority. Identifying and encouraging corrections officials who are interested in following in the path set by Commissioner Ponte ought to be a goal of a successful reform effort.

Lesson Three: The Judicious and Timely Application of Pressure

In the end, the MDOC overhauled its use of long-term isolation without being ordered to by a judge or a piece of legislation. But, that end would never have been reached if not for the application of pressure along the way in the form of threatened lawsuits and proposed legislation. Maine's Corrections Commissioner acknowledged this: when asked in an interview about the motivation for change, he noted that he did not come to Maine looking to reform the use of solitary but that the issue was waiting for him in the form of "threats of lawsuits by the ACLU."[80]

Credible legal threats and well-crafted legislation do not appear by magic. Because of the ACLU's long history of litigating complex prisoner rights cases, and its nationwide presence, it can be an important resource in developing a strategy for applying the right types of pressure at the right time. There is a saying from Abraham Maslow that it is tempting, if all you have is a hammer, to treat everything like a nail. One of the great strengths of the ACLU is that it has access to a diverse selection of tools. The problem of

Included in SCDC' 4.29.19 letter to LOC

solitary confinement is one in which different settings, and different moments, will demand the application of different forms of pressure: a lawsuit, a public education campaign, legislation, grassroots pressure, or some combination. In preparing for a solitary reform campaign, advocates should think about how to maximize the efficiency of that pressure.

Conclusion

When the pressure does eventually cause the resistance to change to give way, and when the campaign begins to experience more successes than setbacks, it will be as a result of the combined commitments of every sort of person. No campaign will be identical, but the movement to reform solitary confinement is developing both volume and momentum. As remarkable as the reforms in Maine have been, there is reason to hope that in coming years they will seem insignificant.

Included in SCDC' 4.29.19 letter to LOC

References

1. *An Act to Ensure Humane Treatment For Special Management Prisoner: Hearing on LD 1611 Before the Joint Committee on Criminal Justice and Public Safety,* 124th Legis., 2nd Reg. Sess.(Maine, Feb. 17, 2010) (statement of former prisoner Michael Cole).
2. U.S. Dep't of Justice Bureau of Justice Statistics, "Key Facts At A Glance" (available at http://bjs.ojp.usdoj.gov/content/glance/tables/corr2tab.cfm).
3. Roy Walmsley, *World Prison Population List* (ninth edition), International Centre for Prison Studies, 1 (*available at* http://www.idcr.org.uk/wp-content/uploads/2010/09/WPPL-9-22.pdf).
4. *Id.*
5. ABA Crim. Just. Standards on the Treatment of Prisoners, Standard 23-1.0(r) (2010), *available at* thttp://www.abanet.org/crimjust/policy/midyear2010/102i.pdf.
6. Angela Browne, Alissa Cambier, Suzanne Agha, *Prisons Within Prisons: The Use of Segregation in the United States*, 24 Fed'l Sentencing Reporter 46 (2011).
7. Leena Kurki & Norval Morris, *The Purposes, Practices, and Problems of Supermax Prisons*, 28 Crime and Just. 385, 389 (2001).
8. Kurki & Morris, *supra note* 7, at 411.
9. See, e.g., James Ridgeway & Jean Casella, *Locking Down The Mentally Ill: Solitary Confinement Cells Have Become America's New Asylums*, The Crime Rept., Feb.20, 2010, *available at* http://mostlywater.org/; Mary Beth Pfeiffer, Crazy In America: The Hidden Tragedy Of Our Criminalized Mentally Ill (2007).
10. Chad S. Briggs, et al., T*he Effect of Supermaximum Security Prisons on Aggregate Levels of Institutional Violence*, 41 Criminology 1341, 1341-42 (2006).
11. *In re Medley*, 134 U.S. 160, 168 (1890).
12. Holly Boyer, *Note: Home Sweet Hell: An Analysis of the Eighth Amendment's 'Cruel and Unusual' Clause As Applied to Supermax Prisons*, 32 Sw. U. L. Rev. 317, 326 (2003).
13. Melvin Gutterman, *Prison Objectives and Human Dignity: Reaching a Mutual Accommodation*, 1992 B. Y. U. L. Rev. 857, 862 (1992).
14. Sally Mann Romano, *Comment: If The SHU Fits: Cruel And Unusual Punishment At California's Pelican Bay State Prison*, 45 Emory L. J. 1089, 1094 (1996).
15. Gutterman, *supra note* 13, at 863 (1992).
16. *Id*. at 864.
17. *Id*. at 864-65.
18. Charles Dickens, American Notes 121-22 (1961).
19. See *Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences, Before the Subcomm. on the Constitution, Civil Rights, and Human Rights of the Senate Comm. on the Judiciary*, 112th Cong. (2012) (statement of American Friends Service Committee) (discussing AFSC's solitary reform efforts).
20. David A. Ward & Allen F. Breed, The United States Penitentiary Marion, Illinois: Consultants' Report Submitted to Committee on the Judiciary, H.R. Doc. No. H522-3, 98th Cong., 2d Sess. 1984.
21. *Id.*
22. Terry Kupers, M.D., Prison Madness: The Mental Health Crisis Behind Bars And What We Must Do About It, 56-57 (1999).
23. *Madrid v. Gomez,* 889 F. Supp. 1146, 1265 (N.D. Cal. 1995).
24. Stuart Grassian, M.D., *Psychiatric Effects of Solitary Confinement*, 22 Wash. U. J.L. & Pol'y 325, 331 (2006).
25. *Id.* at 332.
26. Kupers, *supra note* 22, at 55-56.
27. *An Act to Ensure Humane Treatment For Special Management Prisoner: Hearing on LD 1611 Before the Joint Committee on Criminal Justice and Public Safety,* 124th Legis., 2nd Reg. Sess. (Maine, Feb. 17, 2010) (statement of former prisoner Michael Cole).
28. Atul Gawande, Hellhole, THE NEW YORKER, March 30, 2009, at 38.
29. Grassian, *supra note* 24, at 332-33.
30. *An Act to Ensure Humane Treatment For Special Management Prisoner: Hearing on LD 1611 Before the Joint Committee on Criminal Justice and Public Safety, 124th Legis*., 2nd Reg. Sess. (Maine, Feb. 17, 2010) (statement of Terry Kupers, M.D.).
31. Response to public document request, Maine State Prison Deputy Warden Ursula Charlie Charlton, August 2, 2010 (on file with the author).
32. Interview with Joseph Ponte, Commissioner of the MDOC, in Augusta, Me. (July 23, 2012).
33. *An Act to Ensure Humane Treatment For Special Management Prisoner: Hearing on LD 1611 Before the Joint Committee on Criminal Justice and Public Safety, 124th Legis.*, 2nd Reg. Sess. (Maine, Feb. 17, 2010) (anonymous statement of prisoner).
34. Final Report of Review of Due Process Procedures in Special Management Units at the Maine State Prison and the Maine Correctional Center, Mental Health/Substance Abuse Focus Group, Maine Board of Corrections ("Sherrets Report"), 8 (March 2011).
35. 03-201 C.M.R. ch. 15 sec. 15.1.
36. Interview with Joseph Ponte, Commissioner of the MDOC, in Augusta, Me. (July 23, 2012).
37. 03-201 C.M.R. ch. 15 sec. 15.1 attachment F.
38. *Inmates of the Maine State Prison v. Mullaney* (Civil No. 11–187) 2 Prison L. Rptr. 259 (D. Me. 1973).
39. *Id.*
40. *Lovell v. Brennan*, 566 F. Supp. 672 (D. Me. 1983).
41. *Id*. at 677.
42. See Lance Tapley, *Corrections Disobeys Another Federal Court Order,* PORTLAND PHOENIX, Dec. 16, 2009.
43. David Fathi, *The Common Law of Supermax Litigation*, 24 Pace L. Rev. 675, 681 (2004).
44. 03-201 C.M.R. ch. 18 sec. 18.6 procedure G.
45. Interview with Rev. Jill Job Saxby, Executive Director of the Maine Council of Churches, in Portland, Me. (August 23, 2012).
46. Gawande, *supra note* 28.
47. See Edwin James, *37 Years of Solitary Confinement*, The Guardian, March 9, 2010, at http://www.guardian.co.uk/society/2010/mar/10/erwin-james-angola-three.
48. Interview with Emily Posner, in Portland, Me. (October 6, 2012).
49. L.D. 1611, 124th Legls. 2nd Reg. Sess. (Me. 2009).
50. Interview with Alysia Melnick, in Portland, Me. (October 11, 2012).
51. *Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences, Before the Subcomm. on the Constitution, Civil Rights, and Human Rights of the Senate Comm. on the Judiciary*, 112th Cong. (2012) (statement of James Bergen, co-coordinator of the Maine Prisoner Advocacy Coalition).
52. *An Act to Ensure Humane Treatment For Special Management Prisoner: Hearing on LD 1611 Before the Joint Committee on Criminal Justice and Public Safety*, 124th Legis., 2nd Reg. Sess. (Maine, Feb. 17, 2010) (statement of Rep. James Schatz).
53. *An Act to Ensure Humane Treatment For Special Management Prisoner: Hearing on LD 1611 Before the Joint Committee on Criminal Justice and Public Safety*, 124th Legis., 2nd Reg. Sess.(Maine, Feb. 17, 2010) (statement of Reverend Susan M. Murphy).

Included in SCDC' 4.29.19 letter to LOC

54. *An Act to Ensure Humane Treatment For Special Management Prisoner: Hearing on LD 1611 Before the Joint Committee on Criminal Justice and Public Safety*, 124th Legis., 2nd Reg. Sess.(Maine, Feb. 17, 2010) (statement of Eric C. Smith, Assoc. Dir. of Maine Council of Churches).

55. *An Act to Ensure Humane Treatment For Special Management Prisoner: Hearing on LD 1611 Before the Joint Committee on Criminal Justice and Public Safety*, 124th Legis., 2nd Reg. Sess.(Maine, Feb. 17, 2010) (statement of Prof. Craig McEwen and Prof. Richard Maiman).

56. *An Act to Ensure Humane Treatment For Special Management Prisoner: Hearing on LD 1611 Before the Joint Committee on Criminal Justice and Public Safety*, 124th Legis., 2nd Reg. Sess.(Maine, Feb. 17, 2010) (statement of Daureen Stevens).

57. *An Act to Ensure Humane Treatment For Special Management Prisoner: Hearing on LD 1611 Before the Joint Committee on Criminal Justice and Public Safety*, 124th Legis., 2nd Reg. Sess.(Maine, Feb. 17, 2010) (statement of Janis Petzel, M.D., President of Maine Association of Psychiatric Physicians).

58. *An Act to Ensure Humane Treatment For Special Management Prisoner: Hearing on LD 1611 Before the Joint Committee on Criminal Justice and Public Safety*, 124th Legis., 2nd Reg. Sess.(Maine, Feb. 17, 2010) (statement of Stuart Grassian, M.D.).

59. "OPEGA" is the Maine Office of Program Evaluation and Government Accountability.

60. *An Act to Ensure Humane Treatment For Special Management Prisoner: Hearing on LD 1611 Before the Joint Committee on Criminal Justice and Public Safety,* 124th Legis., 2nd Reg. Sess.(Maine, Feb. 17, 2010) (statement of Alysia Melnick, Esq. on behalf of the Maine Civil Liberties Union).

61. *An Act to Ensure Humane Treatment For Special Management Prisoner: Hearing on LD 1611 Before the Joint Committee on Criminal Justice and Public Safety*, 124th Legis., 2nd Reg. Sess.(Maine, Feb. 17, 2010) (statement of MDOC Commissioner Martin Magnusson).

62. RESOLVE Chapter 213, LD 1611, 124th Maine State Legislature, "Resolve, Directing the Department of Corrections To Coordinate Review of Due Process Procedures and To Ensure Transparency in Policies Regarding the Placement of Special Management Prisoners."

63. Sharrets Report, *supra note* 34, at 2.

64. *Id*. at 1.

65. *Id.* at 4-5.

66. *Id*., passim.

67. Interview with Joseph Ponte, Commissioner of the MDOC, in Augusta, Me. (July 23, 2012).

68. *Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences, Before the Subcomm. on the Constitution, Civil Rights, and Human Rights of the Senate Comm. on the Judiciary*, 112th Cong. (2012) (statement of Co-coordinator of Maine Prisoner Advocacy Coalition James Bergen). The stakeholder committee included MDOC Administrative Staff, Commission Joseph Ponte, Maine State Prison Warden Patricia Barnhart, Dr. Steven Sherrets, Maine Board of Visitors Chair Jon Wilson, and two independent advocates, Rachel Talbot-Ross, President of the Maine NAACP-Portland, and Jim Bergin, Co-Coordinator of the Maine Prisoner Advocacy Coalition (M-PAC).

69. *Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences, Before the Subcomm. on the Constitution, Civil Rights, and Human Rights of the Senate Comm. on the Judiciary*, 112th Cong. (2012) (statement of Co-coordinator of Maine Prisoner Advocacy Coalition James Bergen).

70. Interview with Joseph Ponte, Commissioner of the MDOC, in Augusta, Me. (July 23, 2012).

71. *Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences, Before the Subcomm. on the Constitution, Civil Rights, and Human Rights of the Senate Comm. on the Judiciary*, 112th Cong. (2012) (statement of Charles E. Samuels, Jr., Director of the Federal Bureau of Prisons).

72. Interview with Joseph Ponte, Commissioner of the MDOC, in Augusta, Me. (July 23, 2012).

73. *Id*.

74. *Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences, Before the Subcomm. on the Constitution, Civil Rights, and Human Rights of the Senate Comm. on the Judiciary*, 112th Cong. (2012) (statement of Christopher Epps, Commissioner of the Mississippi Department of Corrections and President of the American Correctional Association).

75. *Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences, Before the Subcomm. on the Constitution, Civil Rights, and Human Rights of the Senate Comm. on the Judiciary*, 112th Cong. (2012) (statement of Joseph Ponte, Commissioner of the MDOC).

76. Interview with Joseph Ponte, Commissioner of the MDOC, in Augusta, Me. (July 23, 2012).

77. Interview with Alysia Melnick, in Portland, Me. (October 11, 2012).

78. Interview with Rev. Richard Kilmer, in Portland, Me. (August 29, 2012).

79. Interview with Rev. Jill Saxby, in Portland, Me. (August 23, 2012).

80. See Lance Tapley, *Reducing Solitary Confinement*, PORTLAND PHOENIX, November 2, 2011, at http://portland.thephoenix.com/news/129316-reducing-solitary-confinement/.

Included in SCDC' 4.29.19 letter to LOC

www.aclumaine.org

Included in SCDC' 4.29.19 letter to LOC

Disabled by Solitude: The Convention on the Rights of Persons with Disabilities and Its Impact on the Use of Supermax Solitary Confinement

KATHRYN D. DEMARCO*

I. INTRODUCTION . . . . . 524 R
II. The CRPD . . . . . 529 R
A. *The CRPD and State-Imposed Disabilities.* . . . . . 530 R
B. *Disablement as a Legal Concept* . . . . . 531 R
III. SUPERMAX SOLITARY CONFINEMENT . . . . . 535 R
A. *History of Supermax Solitary Confinement* . . . . . 535 R
B. *Current Description of Solitary Confinement in U.S. Supermax Prisons* . . . 536 R
IV. THE MENTAL EFFECTS OF SENSORY DEPRIVATION FROM SOLITARY CONFINEMENT CONSTITUTE DISABLEMENT UNDER THE CRPD . . . . . 541 R
A. *Mental Effects* . . . . . 541 R
B. *The Effects of Solitary Confinement Meet the Article 1 Disability Definition* . . . . . 544 R
1. "LONG-TERM" . . . . . 544 R
2. "FULL AND EFFECTIVE PARTICIPATION" . . . . . 545 R
3. UNIFORMITY OF RESULT AND FREQUENCY OF "LONG-TERM" PSYCHIATRIC CONSEQUENCES . . . . . 547 R
a. pre-existing mental state . . . . . 547 R
b. the amount of time spent in supermax solitary . . . . . 548 R
V. ARTICLE 15 AS ANOTHER AVENUE FOR A DISABLEMENT CLAIM . . . . . 549 R
A. *Supermax Confinement as Torture or Cruel and Inhuman Treatment* . . . . . 549 R
B. *Disablement and Article 15* . . . . . 551 R
VI. U.S. RATIFICATION AND IMPLEMENTATION OF THE CRPD . . . . . 552 R
A. *The CPRD's Provisions for Implementation and Enforcement* . . . . . 552 R
B. *The Impact on U.S. Law* . . . . . 554 R
1. THE IMPACT OF "CLEAN" RATIFICATION OF THE CRPD . . . . . 554 R
2. THE IMPACT OF CONDITIONS TO THE SENATE'S CONSENT TO RATIFICATION . . . . . 555 R
a. RUDs relating to implementation and enforcement . . . . . 556 R
b. RUDs limiting the substantive scope of the CRPD . . . . . 557 R
VII. CONCLUSION . . . . . 564 R

It's an awful thing, solitary. It crushes your spirit and weakens your resistance more effectively than any other form of mistreatment.
—John McCain[1]

* Articles & Comments Editor, *University of Miami Law Review*; J.D. Candidate 2012, University of Miami School of Law; B.A. 2009, University of Texas. Thank you to Professor Stephen J. Schnably for his insightful feedback and willingness to work with me throughout the writing process, to Professor Susan Stefan for sharing her expertise on disability law, to my family, and to David Fernández.

1. Atul Gawande, *Hellhole: The United States Holds Tens of Thousands of Inmates in Long-*

Included in SCDC' 4.29.19 letter to LOC

I. Introduction

As the first human rights treaty of the twenty-first century, the United Nations Convention on the Rights of Persons with Disabilities (CRPD) aims to protect the "world's largest minority"—some 650 million people in the world living with a disability.[2] It is the most recent and "the most extensive recognition of the human rights of persons with disabilities."[3] The United Nations General Assembly approved the text of the CRPD on December 13, 2006, in order "to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity."[4] On March 30, 2007, the CRPD opened for signatures, and eighty-two countries signed the convention with forty-four signing the Optional Protocol—the largest number of signatories on an opening day in the history of the United Nations.[5] On May 3, 2008, thirty days after the twentieth ratification, the CRPD became legally binding on all state parties.[6] Today, the CRPD has 149 signatures and 103 ratifications.[7] The Optional Protocol for the CRPD has 90 signatures and 62 ratifications.[8] As a result, this convention will have far-reaching implications for those with disabilities around the world and for any nation whose domestic policies violate the precepts of the CRPD.[9]

---

term Solitary Confinement. Is this Torture?, The New Yorker, Mar. 30, 2009, http://www.newyorker.com/reporting/2009/03/30/090330fa_fact_gawande.

2. *See* Secretariat for the Convention on the Rights of Persons with Disabilities, *Fact Sheet on Persons with Disabilities*, U.N. Enable, http://www.un.org/disabilities/default.asp?id=18 (last visited Aug. 16, 2011); *World Report on Disability,* World Health Organization (2011), http://whqlibdoc.who.int/publications/2011/9789240685215_eng.pdf (stating that there are actually more than one billion people living with a disability) [hereinafter *World Report on Disability*]. The *World Health Survey* estimates that 785 to 975 million people over the age of fifteen have disabilities, and the *Global Burden of Disease* estimates that about 190 million individuals suffer from a "severe" disability such as severe depression or blindness. *Id.* at 44. *See also* Arlene S. Kanter, *The Promise and Challenge of the United Nations Convention on the Rights of Persons with Disabilities*, 34 Syracuse J. Int'l L. & Com. 287, 306 (2007); Anna Lawson, *The United Nations Convention on the Rights of Persons with Disabilities: New Era or False Dawn?*, 34 Syracuse J. Int'l L. & Com. 563, 563 (2007).

3. *World Report on Disability, supra* note 2, at 9 (stating that the CRPD "applies human rights to disability, thus making general human rights specific to persons with disabilities").

4. United Nations Convention on the Rights of Persons with Disabilities, art. 1, Dec. 13, 2007, U.N. GAOR, 61st Sess., U.N. Doc. A/RES/61/106 [hereinafter CRPD].

5. Secretariat for the Convention on the Rights of Persons with Disabilities, *Convention on the Rights of Persons with Disabilities and Optional Protocol*, U.N. Enable, http://www.un.org/esa/socdev/enable/conventioninfo.htm (last visited Aug. 10, 2011).

6. Press Release, Department of Public Information, With 20 Ratifications, Landmark Disability Treaty Set to Enter into Force on 3 May, U.N. Press Release HR/4941(Apr. 3, 2008), *available at* http://www.un.org/News/Press/docs/2008/hr4941.doc.htm.

7. U.N. Enable, http://www.un.org/disabilities/ (last visited Aug. 16, 2011).

8. *Id.*

9. *See id.*

Included in SCDC' 4.29.19 letter to LOC

On July 24, 2009, President Obama signed the CRPD, referring to it as a "historic piece of civil rights legislation" that furthers "our global commitment to fundamental human rights for persons with disabilities."[10] While President Obama has not yet submitted the CRPD to the Senate, a requirement for future ratification,[11] the potential implications of this document for domestic policy cannot be ignored. Specifically, this piece will analyze whether the use of supermax solitary confinement is consistent with the CRPD.[12]

Supermax solitary confinement prison facilities are designed for mass and indefinite solitary confinement.[13] They deprive the prisoner of virtually all forms of human interaction and sensory stimulation. Unlike traditional solitary confinement where inmates are placed briefly into cells as a form of punishment, supermax solitary facilities keep inmates in confinement for years on end and use solitary confinement as a "prison management tool."[14] In other words, supermax solitary confinement is a form of long-term confinement as opposed to a brief punishment for a disciplinary infraction.

While supermax solitary confinement units vary in their details, they share certain common features. The cells in supermax solitary units are basically the equivalent of a small "concrete exercise pen"[15] in which prisoners must live for months and possibly years. Deprivation of sensory experience, human interaction, and intellectual stimulation are hallmarks of supermax confinement. In many instances, the cells are designed without color and are furnished with only a stainless steel sink, a toilet, and a concrete bed and writing desk.[16] Inmates are denied access to a clock, television, radio, computer, telephone, and books (except for

10. *Remarks by the President on Signing of the U.N. Convention on the Rights of Persons with Disabilities Proclamation*, WHITEHOUSE (July 24, 2009), http://www.whitehouse.gov/the-press-office/remarks-president-rights-persons-with-disabilities-proclamation-signing.

11. U.S. CONST. art. I, § 2, cl. 2.

12. This article uses the more general term of *supermax prison* when referring to solitary confinement. Different prison systems use different terms to refer to such facilities such as "control unit," "security housing units," or "communications management units." Ken Strutin, *Solitary Confinement*, LLRX (Aug. 10, 2010), http://www.llrx.com/features/solitaryconfinement.htm.

13. *Supermax Prisons: An Overview*, HUMAN RIGHTS WATCH, http://www.hrw.org/legacy/reports/2000/supermax/Sprmx002.htm (last visited Aug. 16, 2011); *see also* Gawande, *supra* note 1.

14. *See* Sharon Shalev, *A Sourcebook on Solitary Confinement*, MANNHEIM CENTER FOR CRIMINOLOGY & LONDON SCHOOL OF ECONOMICS 31 (Oct. 2008), www.solitaryconfinement.org/sourcebook.

15. Laura Sullivan, *In U.S. Prisons, Thousands Spend Years in Isolation*, NPR (July 26, 2006), http://www.npr.org/templates/story/story.php?storyId=5582144; *see also* Terry A. Kupers, *What to Do with the Survivors? Coping with the Long-Term Effects of Isolated Confinement*, 35 CRIM. JUST. & BEHAV. 1005 (2008), http://cjb.sagepub.com/content/35/8/1005.full.pdf+tml.

16. Tracy Hresko, Article, *In the Cellars of the Hollow Men: Use of Solitary Confinement in*

Included in SCDC' 4.29.19 letter to LOC

a religious text).[17] They are subjected to "almost complete idleness" for indefinite periods of time.[18] When there is contact with other people, it is usually brief, routine, and superficial, such as being escorted to the showers by a guard.[19]

Confinement in a supermax facility typically has profound, long-lasting, and adverse effects on the majority of individuals. One description of life at the Pelican Bay State Prison is as follows: "One inmate stands in the middle of his cell, hollering at no one in particular. Another bangs his head against the door. Many of the inmates are naked, some exposing themselves."[20] The monotony and sensory deprivation of everyday life become overwhelming. "There is simply nothing to do. Sit in your bathroom alone with none of your intimate possessions and try to imagine years of it, week after week. Slowly it tears you down, mentally and physically."[21] Tommy Silverstein, who was in solitary confinement for over twenty-five years, described solitary confinement as a "slow constant peeling of the skin, stripping of the flesh."[22]

The criteria for the use of supermax confinement differ by facility, and the length of such confinement is left to the discretion of prison officials.[23] Supporters of supermax confinement in the United States typically offer several justifications for its use. Often supermax facilities claim to house the "worst of the worst"[24]—prisoners who are extremely dangerous to others and utterly incorrigible—though this is quite debatable.[25] Supermax confinement is sometimes used as a way of protecting

U.S. Prisons and Its Implications Under International Laws Against Torture, 18 PACE INT'L L. REV. 1, 10 (2006).

17. Jones 'El v. Berge, 164 F. Supp. 2d 1096, 1098 (W.D. Wis. 2001); Christine Rebman, *The Eighth Amendment and Solitary Confinement: The Gap in Protection from Psychological Consequences*, 49 DEPAUL L. REV. 567, 579 (1999).

18. Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax"Confinement*, 49 CRIME & DELINQ. CONFINEMENT 124, 126 (2003), http://cad.sagepub.com/content/49/1/124.full.pdf+tml [hereinafter *Mental Health Issues*].

19. U.N. Secretary-General, *Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: Note by the Secretary-General*, U.N. DOC. A/63/175 (July 28, 2008) [hereinafter U.N. Secretary-General] (stating that "[t]he reduction in stimuli is not only quantitative but also qualitative").

20. Laura Sullivan, *At Pelican Bay Prison, a Life in Solitary*, NPR (July 26, 2006), http://www.npr.org/templates/story/story.php?storyId=5584254.

21. Shalev, *supra* note 14, at 19.

22. Jules Lobel, *Prolonged Solitary Confinement and the Constitution*, 11 U. PA. J. CONST. L. 115, 116 (2008).

23. Maria A. Luise, *Solitary Confinement: Legal and Psychological Consideration*, 15 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 301, 301 (1989); Gawande, *supra* note 1.

24. Kupers, *supra* note 15, at 1011.

25. *Mental Health Issues*, *supra* note 18, at 129 (stating that there is "no evidence that the rise of supermax prisons was driven by the threat of some new breed of criminal or prisoner"); Colin Dayan, *Barbarous Confinement*, N.Y. TIMES, July 17, 2011, http://www.nytimes.com/2011/07/18/opinion/18dayan.html (stating that the decision to place an inmate in solitary is "haphazard and

Included in SCDC' 4.29.19 letter to LOC

\\jciprod01\productn\M\MIA\66-2\MIA202.txt unknown Seq: 5 16-DEC-11 12:43

certain prisoners from attacks by others,[26] and as a form of punishment for disciplinary infractions—nonviolent as well as violent.[27] Prison officials also place inmates in solitary merely because the inmates are "perceived as troublemakers or simply disliked by correctional officers."[28] Inmates have also been placed in supermax confinement in order to suppress activity that prison officials deem "dissident"—a category that can include helping other inmates with habeas petitions or trying to bring suit against the prison administration.[29] Finally, inmates may be confined to supermax confinement for purely administrative reasons—*e.g.*, prison overcrowding or a lack of more suitable space when they are ill.[30] In general, the criteria behind supermax solitary's use varies from facility to facility, and the term of confinement is entirely dependent on the discretion of prison officials.[31]

Today the use of supermax solitary confinement in the U.S. prison system is on the rise. Conservative estimates report that there are at least 25,000 inmates in supermax solitary confinement in the United States.[32] Nicholas Katzenbach, the former Attorney General of the United States, noted that "the growth rate in the number of prisoners housed in segregation far outpaced the growth rate of the overall prison population."[33] The increase of supermax prisons and solitary confinement has been called "perhaps the most troubling" human rights trend in the United States corrections system.[34] The Commission on Safety and Abuse in America's Prisons stated that after ten days in solitary confinement, there are "practically no benefits" to such confinement, while the "harm

arbitrary" and that while prison officials claim that those imprisoned in the Pelican Bay State Prison are "the worst of the worst . . . often it is the most vulnerable, especially the mentally ill, not the most violent, who end up in indefinite isolation").

26. *See* Sullivan, *supra* note 20.

27. Shalev, *supra* note 14, at 25; *Mental Health Issues*, *supra* note 18, at 126–27.

28. Dayan, *supra* note 25.

29. Bruce A. Arrigo & Jennifer Leslie Bullock, *The Psychological Effects of Solitary Confinement on Prisoners in Supermax Units: Reviewing What We Know and Recommending What Should Change*, 52 INT'L J. OF OFFENDER THERAPY AND COMP. CRIMINOLOGY 622, 626–28 (2008), http://ijo.sagepub.com/content/52/6/622.full.pdf+tml.

30. Craig Haney, *A Culture of Harm: Taming the Dynamics of Cruelty in Supermax Prisons*, 35 CRIM. JUST. & BEHAV. 956, 962, 964–65 (2008), *www.sagepub.com/bartolstudy/articles/Haney.pdf* [*A Culture of Harm*]. *See also* 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, 493–94 (1977); Dayan, *supra* note 25 ("[I]solation, which can last for decades, is often not explicitly disciplinary, and therefore not subject to court oversight. Their treatment is simply a matter of administrative convenience.").

31. Luise, *supra* note 23, at 301.

32. Sullivan, *supra* note 20.

33. COMM'N ON SAFETY AND ABUSE IN AMERICA'S PRISONS, VERA INSTITUTE OF JUSTICE, CONFRONTING CONFINEMENT 53 (2006), *available at* http://www.prisoncommission.org/pdfs/confronting_confinement.pdf.

34. *Mental Health Issues*, *supra* note 18, at 125.

Included in SCDC' 4.29.19 letter to LOC

is clear."[35]

Equally important, there are alternatives to the use of supermax facilities. For example, in the 1980's, Great Britain prison officials began to reduce isolation and to offer inmates access to work and educational opportunities within the prison.[36] The officials also began to allow inmates more free time for exercise and phone calls.[37] This change caused "impressive" results, and now the use of solitary confinement in Great Britain is negligible.[38]

This article argues that the use of supermax facilities is inconsistent with the CRPD. Confining an individual to a supermax facility in essence creates a mental disability. While the major concern of the CRPD is to protect "the rights and development of people with disabilities,"[39] it cannot be consistent with the CRPD for the government to make someone disabled. Accordingly, the use of supermax facilities violates the CRPD.[40]

Because the disability inflicted by supermax facilities is inconsistent with the CRPD, what effect will ratification of the convention have? This article addresses a major policy question heretofore not analyzed in the already significant body of commentary on the CRPD.[41] Specifically, with what reservations, understandings, and declarations might the Senate approve the treaty? The United States has an established pattern of ratification of human rights treaties, the ratification of which is typically accompanied by a standard package of reservations, understandings, and declarations.[42] This package is designed to modify the

35. Gawande, *supra* note 1.

36. *Id.* (analyzing violence levels in state prisons following the opening of new supermaxes in Arizona, Illinois, and Minnesota. Levels of inmate-on-inmate violence remained the same with inmate-on-staff violence fluctuated at random. No steady decrease in violence was found).

37. *Id.*

38. *Id.*

39. Mark Malloch, Deputy U.N. Sec. Gen., Secretary General's Message on the Adoption of the Convention on the Rights of Persons with Disabilities (Dec. 13, 2006), *available at* http://www.un.org/apps/sg/sgstats.asp?nid=2362.

40. While this article is limited to an analysis of supermax solitary confinement, this does not necessarily mean that lesser forms of solitary confinement are consistent with the CRPD. Also beyond the scope of this article is an analysis of the obligations the CRPD places on states with respect to prisoners who have a non-state-imposed disability.

41. *See, e.g.*, Aaron A. Dhir, *Human Rights Treaty Drafting Through the Lens of Mental Disability: The Proposed International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities*, 41 STAN. J. INT'L L. 181 (2005); Kanter, *supra* note 2; Lawson, *supra* note 2; Tina Minkowitz, *The United Nations Convention on the Rights of Persons with Disabilities and the Right to Be Free from Nonconsensual Psychiatric Interventions*, 34 SYRACUSE J. INT'L L. & COM. 405 (2007); Michael L. Perlin, *"A Change Is Gonna Come": The Implications of the United Nations Convention on the Rights of Persons with Disabilities for the Domestic Practice of Constitutional Mental Disability Law*, 29 N. ILL. U. L. REV. 483 (2009).

42. *See* UNITED STATES SENATE FOREIGN RELATIONS COMMITTEE REPORT: INTERNATIONAL

Included in SCDC' 4.29.19 letter to LOC

substantive commitments the United States takes on, bring them into conformity with existing domestic U.S. law, and ensure that U.S. courts lack jurisdiction to enforce the treaty.

Were the Senate to take up the question of ratifying the CRPD, it would likely give serious consideration to exempting supermax facilities from its scope. This article will analyze how it might seek to do so, arguing that it may be extraordinarily difficult to formulate a reservation or understanding that is both politically acceptable and successful in exempting supermax facilities from international scrutiny under the CRPD.

Part II of this article discusses the background of the CRPD and the concept of disablement. Part III presents the history and current use of solitary confinement in the United States. Part IV discusses the medical and psychological effects of supermax solitary confinement and the implications of those effects in reference to the CRPD. Following that, Part V explains an additional avenue of relief for inmates under Article 15 of the CRPD. Lastly, Part VI analyzes possible reservations, understandings, and other procedural mechanisms that the United States might employ in order to limit the effect of a possible ratification of the CRPD.

II. The CRPD

The CRPD aims to protect the civil, political, economic, social, and cultural rights of disabled persons. The rights protected by the CRPD include the right to equality before the law without discrimination,[43] the right to physical and mental integrity,[44] freedom of movement[45] and work,[46] and the right to an adequate standard of living.[47] Article 1 of CRPD defines those who are disabled as those who have "long-term physical, mental, intellectual or sensory impairments."[48] The Secretariat for the CRPD stated that a disability "should be seen as the result of the interaction between a person and his/her environment" and "not something that resides in the individual as the result of some impairment."[49]

Covenant on Civil and Political Rights, S. Exec. Doc. No. 102–123, Cong., 2d Sess. 6–12 (1992), *reprinted in* 31 I.L.M. 645 (1992) [hereinafter US ICCPR Conditions].

43. CRPD, *supra* note 4, art. 5.

44. *Id.* art. 17.

45. *Id.* art. 18.

46. *Id.* art. 27.

47. *Id.* art. 28.

48. *Id.* art. 1; *see also World Report on Disability, supra* note 2, at 21 (defining a disability as a "complex multidimensional experience [that] poses several challenges for measurement. Approaches to measuring disability vary across countries and influence the results.").

49. *See* Secretariat for the Convention on the Rights of Persons with Disabilities, *Focus of the Convention*, U.N. Enable, http://www.un.org/disabilities/default.asp?id=216 (last visited Aug. 16, 2011) [hereinafter *Focus of the Convention*].

Included in SCDC' 4.29.19 letter to LOC

The Secretariat for the CRPD has also made it clear that the CRPD definition of a disabled person is not exhaustive and does not "exclude broader categories of persons . . . with short-term disabilities or persons who had disabilities in the past."[50] In other words, the CRPD does not appear to impose a temporal limitation on disabilities based on the broad language and interpretations of Article 1. For example, one who suffers from a mental disability that is either permanent *or* temporary would be covered by the CRPD.

It is also important to note that both physical and mental impairments are recognized under Article 1 of the CRPD. The Secretariat for the CRPD acknowledged on his official website, U.N. Enable, that the Article 1 definition is not an exhaustive definition for individuals who might be able to claim relief under the CRPD.[51] Therefore, the mental effects produced by supermax solitary would not be excluded under Article 1 of the CRPD.

A. *The CRPD and State-Imposed Disabilities*

As noted, the primary aim of the CRPD is to ensure the full equality and integration into society of people who have disabilities.[52] But there is an equally fundamental right under the CRPD—specifically, the right not to be disabled by government action. Support for this proposition is found in the text and drafting history of the treaty.

Article 4(d) of the CRPD requires states to "refrain from engaging in any act or practice that is inconsistent with the present Convention . . . ."[53] It cannot be consistent with the CRPD for a state to impose a disability on someone. Consider what an alternate interpretation would mean: A state party could deliberately disable an individual, and then would be obligated to take a variety of measures designed to ensure that the disability the state imposed has as little limiting or restrictive effect on that person as possible. To put it another way, by this reading, a state party would be free to take an action, but would then be obligated to undo its effects as much as possible. Any such reading of the CRPD would be inconsistent with the fundamental requirement of international law that a treaty be "interpreted in good faith . . . in light of its object and purpose."[54] In fact, any such reading would be "manifestly absurd" or "unreasonable."[55]

50. *Id.*
51. *Id.*
52. *Id.*
53. CRPD, *supra* note 4, art. 4.
54. Vienna Convention on the Law of Treaties, art. 31(1), May 23, 1969, 1155 U.N.T.S. 331 [hereinafter Vienna Convention].
55. *Id.* art. 32(b).

Included in SCDC' 4.29.19 letter to LOC

The preparatory materials to the CRPD state that "[d]isability often arises from war and inhumane treatment" and that steps must be taken to protect "those who have become disabled as a result of inhumane treatment as well as to promote prevention."[56] Consistent with this admonition, the Secretary-General spoke on the day of the adoption of the CRPD of the "need to enable every person to contribute to the best of their abilities and potential."[57] A state that imposes a disability on an individual is plainly acting contrary to that need.[58] The *World Report on Disability*, meant to facilitate the implementation of the CRPD, also highlights the importance of preventing health conditions that cause disabilities such as nutrition and preventable diseases[59] and the increased risk of disability associated with poverty.[60] The report goes on to mention the "huge effect" environment can have on both the prevalence and extent of a person's disability.[61] For example, environmental changes such as armed conflict and natural disasters can disable individuals.[62]

B. *Disablement as a Legal Concept*

The term "disablement" here refers to state action, intentionally undertaken, that predictably results in the imposition of a disability on the majority of the population subjected to the state action.[63] It is not necessary to show that state officials are motivated by a desire that those

56. Secretariat for the Convention on the Rights of Persons with Disabilities, *Human Rights and Persons with Disabilities*, U.N. ENABLE (2007), http://www.un.org/esa/socdev/enable/rights/humanrights.htm; *see also* U.N. Secretary-General, *Progress in Equalization of Opportunities by, for and with Persons with Disabilities*, (June 27, 2003), http://www.un.org/esa/socdev/enable/rights/a_ac265_2003_3e.htm (stating that "war and conflict, as well as violence in society, are recognized causes of disablement [and] progress in implementing the programme of action would contribute to a reduction of one of the significant causes of disability in populations").

57. Malloch, *supra* note 39.

58. Article 15 of the CRPD states that "[n]o one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment." CRPD, *supra* note 4, art. 15. This provision is analyzed in Part V *infra*.

59. *World Report on Disability, supra* note 2, at 8.

60. *Id.* at 10.

61. *Id.* at 37.

62. *Id.*

63. Some scholars have used the term "disablement" in a broader though related sense, as the social, political, legal, and economic factors by which people who have disabilities are mistreated. Factors such as a lack of medical care and nutrition in prison constitute a form of such disablement. *See* Marta Russell & Jean Stewart, *Disablement, Prison & Historical Segregation*, 53 MONTHLY REV. 3 (2001). Beth Ribet analyzes disablement in the context of prison rape, where a disability is created through external factors and suffering. Beth Ribet, *Naming Prison Rape as Disablement: A Critical Analysis of the Prison Litigation Reform Act, the Americans with Disabilities Act, and the Imperatives of Survivor-Oriented Advocacy*, 17 VA. J. SOC. POL'Y & L. 281, 285 (2010) (referring to disablement as "the process by which some disabilities . . . are produced by violence, inequality, and subordination" in the context of U.S. prisons); *see also* *World Report on Disability*, *supra* note 2, at 169 (stating that "[e]nvironments—physical, social, and attitudinal—can either disable people with impairments or foster their participation and

Included in SCDC' 4.29.19 letter to LOC

subjected to the policy become disabled, but it may be easiest to set out the legal elements of disablement in the context of state action that is so motivated—deliberate physical maiming as punishment.

In 2010, a Saudi Arabian judge asked several hospitals whether they would sever a man's spinal cord as punishment for paralyzing another man during a fight.[64] There is no sign the punishment was ever actually imposed, but it is worth analyzing whether Saudi Arabia would have violated its obligations under the CRPD had the severing been carried out.[65] Additionally, an example of disablement occurred in Iran in 2008, when Iranian authorities amputated the hand of a young man as punishment for stealing.[66] Like Saudi Arabia, Iran is a party to the CRPD.[67]

These examples of governmental action inflicting permanent disabilities would certainly qualify as a violation of the CRPD. "Disablement" has four basic elements, all of which are present here. First, both of these actions were official government actions. In both the Iran and Saudi Arabia examples, a judge imposed a criminal sentence. However, the scope of the CRPD may not necessarily be limited to state action. For instance, the CRPD guarantees protection of disabled people from "all forms of exploitation, violence and abuse,"[68] an obligation which may entail state action to protect people with disabilities from private abuse. But whatever its scope may be, it certainly includes all official state action.

Second, the result of this action is a permanent disability under Article 1 of the CRPD. In the Iran example, the victim would be permanently deprived of the use of his or her hand. In the Saudi Arabia example, were the spine-severing carried out, the victim would permanently

---

inclusion"). The *World Report* also enumerates types of "disabling barriers" such as negative attitudes and inadequate policies and standards. *Id.* at 262.

64. *Saudi Hospitals Are Asked to Maim Man as Punishment*, N.Y. TIMES, Aug. 19, 2010, www.nytimes.com/2010/08/20/world/middleeast/20saudi.html; *see also Saudi Arabia: Authorities Must Not Deliberately Paralyze Man as Punishment*, AMNESTY INT'L, Aug. 20, 2010, www.amnestyusa.org/news/press-releases/saudi-arabia-authorities-must-not-deliberately-paralyze-man-as-punishment.

65. Saudi Arabia ratified both the CRPD and the Optional Protocol in June 2008. *See* Secretariat for the Convention on the Rights of Persons with Disabilities, *Convention and Optional Protocol Signatures and Ratifications*, U.N. ENABLE, http://www.un.org/disabilities/countries.asp?navid=12&pid=166 (last visited Aug. 16, 2011) [hereinafter *Signatures and Ratifications*].

66. *Iran Cuts off Man's Hand for Stealing*, GUARDIAN, Oct. 24, 2010, http://www.guardian.co.uk/world/2010/oct/24/iran-thief-hand-cut-off; *see also Iranian Sentenced to Blinding for Acid Attack Pardoned*, BBC NEWS, July 31, 2011, http://www.bbc.co.uk/news/world-middle-east-14356886 (noting Iranian court's sentencing of a man to blinding for having blinded a woman in an acid attack).

67. Iran ratified the CRPD in 2009. *See Signatures and Ratifications*, *supra* note 65.

68. CRPD, *supra* note 4, art. 16(2).

Included in SCDC' 4.29.19 letter to LOC

lose the ability to walk. Article 1 of the CRPD defines "[p]ersons with disabilities" as those who have "long-term physical, mental, intellectual or sensory impairments . . . [that] may hinder their full and effective participation in society on an equal basis with others."[69] The severing of a spinal cord and the chopping off of a hand undoubtedly meet the Article 1 definition of "long-term," given that these are permanent disabilities for which there is no hope of recovery. It should be emphasized, though, that Article 1 imposes no permanency requirement on a disability, but rather the requirement of "long-term."[70] The second part of Article 1 is also satisfied in these examples. The severing of a spinal cord or hand creates a disability that prevents one's full and effective participation in society on an equal basis with others. These actions do so by depriving someone of the use of his hand or his ability to walk.[71]

Third, in both instances, there is intent to impose a disability. "Intent" for this purpose means intentionally undertaking an action that the state knows or should know will result in disablement. There is nothing unusual in international law about such an understanding of intent. For example, under Article 30(2) of the Rome Statute of the International Criminal Court, an individual has "intent" to cause a consequence when he or she "means to engage in . . . conduct " and "is aware that . . . [the consequence] will occur in the ordinary course of events."[72] Under Article 1 of the Convention Against Torture, moreover, "consent or acquiescence" is sufficient to show that the torture was intentionally inflicted.[73] In the cases of Saudi Arabia and Iran, government authorities took a specific action, which they knew would permanently disable. Thus the disablement would be intentional.

One might argue that there is a lack of intent to inflict a disability on these individuals, as the true reason for purposeful maiming is to uphold religious law. The disability that results is simply a side-product of that true intention. However, this argument confounds the subjective motive of the governmental officials with that of an objective analysis of an overall intent to disable. From an objective standpoint, the requisite intent is present because officials were fully aware of the consequences of deliberately chopping off an individual's hand. There is an intent to

69. *Id.* art. 1.

70. *Id.* Indeed, the Secretariat of the CRPD has suggested that the CRPD can be construed as to cover those with "short-term disabilities or persons who had disabilities in the past." *See Focus of the Convention*, *supra* note 49.

71. CRPD, *supra* note 4, art. 4.

72. Rome Statute of the International Criminal Court, art. 30(2), July 17, 1998, A/CONF.183/9.

73. United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, art. 1(1), Dec. 10, 1984, G.A. Res. 39/46, Annex, 39 U.N. GAOR Supp. No. 51, U.N. Doc. A/39/51 (1984) [hereinafter CAT].

Included in SCDC' 4.29.19 letter to LOC

chop a person's hand off, and the resulting physical disability is the objectively foreseeable consequence of that intent. Any subjective religious or other purpose is irrelevant. In other words, the element of intent can be the knowledge that such an action will logically cause the disability and can exist in conjunction with other motives such as maintaining security.

One additional qualification to the definition of intent is needed. What is *not* covered by an intent standard is strict liability or negligence. Many government actions, legitimate in themselves, might occasionally and unpredictably result in an individual becoming disabled. A police officer using reasonable force to save someone's life might accidentally shoot someone and cause him to be paralyzed. At that point the obligations of the CRPD would become relevant, but the state's action in causing the paralysis would not constitute a violation. Where a state action that is intentionally undertaken predictably causes a disability in the majority of cases, however, it is nonsensical to say that the imposition of the disability was not intended.[74]

Fourth, these two examples present conduct that produces a disability in *all* cases. In other words, there is no chance that an individual will *not* be disabled once his spinal cord is severed or her hand is chopped off. There is, however, no reason why the concept of disablement should

---

74. One might ask whether a state's use of armed force violates the CRPD, especially given that it predictably causes disability on the part of many individuals, civilian and soldier, enemy and national. The answer is no: The CRPD is not the Kellogg-Briand Pact. *See* Treaty Providing for the Renunciation of War as an Instrument of National Policy, Aug. 27, 1928, art. 1, 46 Stat. 2343, TS No. 796, 94 LNTS 57. International law traditionally distinguishes between *jus ad bellum* (the right to engage in war) and *jus in bello* (the law governing the conduct of war). With regard to the former, just as a state party to a treaty that bans capital punishment is not absolutely barred from the use of armed force even though doing so will predictably result in many deaths, so, too, is it reasonable to read the CRPD as having nothing to say about a state's resort to armed force. Similarly, it is clear that whatever application the International Covenant on Civil and Political Rights (ICCPR) may have in time of war, it does not govern a state's decision to resort to armed force—a matter governed by the U.N. Charter. *See* U.N. Charter, arts. 2(4), 51. Confining the CRPD to actions other than the decision to use armed force has no impact on its applicability to all other actions, including the treatment of prisoners, veterans, or the population at large.

With regard to the international law governing the conduct of war, Article 3 of the Geneva Convention bars "mutilation" of civilians, prisoners of war, and the wounded, but not, of course, soldiers taking part in combat. Geneva Convention Relative to the Treatment of Prisoners of War, art. 3, Aug. 12, 1949, 6 U.ST. 3316, 75 U.N.T.S.135. *See also* Theodor Meron, *The Humanization of Humanitarian Law*, 94 AM. J. INT'L L. 239 (2000); Kenneth Watkin, *Controlling the Use of Force: A Role for Human Rights Norms in Contemporary Armed Conflict*, 98 AM. J. INT'L L. 1 (2004). There is controversy over whether international human rights law has any application here, or whether armed conflict is governed solely by international humanitarian law. The CRPD is part of human rights law, and there is no reason to think that the question of its applicability to how war is conducted is any different from that of, say, the ICCPR. It is not necessary for the argument in this article to resolve this larger question. If human rights law applies in some way to the conduct of war, then so would the CRPD; if it does not, then the CRPD would not.

Included in SCDC' 4.29.19 letter to LOC

\\jciprod01\productn\M\MIA\66-2\MIA202.txt unknown Seq: 13 16-DEC-11 12:43

be limited to actions that have one hundred percent efficacy in producing a disability. If a state action results in a disability for a particular individual, it is irrelevant that the imposition of that action on other individuals might not have produced a disability. The affected individual is still disabled. The question of how often the action results in disability can be relevant to intent, as noted, but less than perfect efficacy overall is no defense in an individual case.

In short, physical maiming of the sort that Iran committed and a Saudi judge considered is a clear violation of the CRPD, and so is the use of supermax confinement. First, like the decision to maim, the decision to submit an inmate to supermax confinement is obviously state action.[75] Second, as will be shown in Part IV.B., solitary confinement produces an Article 1 disability because the psychiatric effects of prolonged supermax can be long-term and of a devastating nature.[76] Third, the production of a disability is intentional. Once again, the motive—observance of religious law, a desire to punish or control—is irrelevant. What matters is that a prisoner does not happen into supermax confinement; rather, a prison administrator intentionally authorizes placing the individual into solitary confinement for punishment or for other purposes. Fourth, the disability occurs in a majority of cases. While the devastating effects of solitary confinement do not manifest themselves one hundred percent of the time, as they do in the context of purposeful maiming, intentionally subjecting an inmate to long-term solitary confinement will more often than not result in severe and long-term psychological impairments.[77]

III. Supermax Solitary Confinement

A. *History of Supermax Solitary Confinement*

The rise of supermax prison facilities owes much to prison overcrowding. From 1975 to 2000, the rate of incarceration in the United States quintupled.[78] The size of many state prison systems doubled.[79] Prisoner administrators could no longer manage the large number of inmates or the "inevitable tensions and conflicts that festered behind the

75. The analysis here assumes that the prison is run by the government. Where a prison is run by a private contractor, the article assumes that the state would still be responsible, but an analysis of this issue is beyond the scope of the article.

76. *See* Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 J.L. & Pol'y 325 (2006), *law.wustl.edu/journal/22/p325grassian.pdf.*

77. *See generally id*.

78. *Mental Health Issues*, *supra* note 18, at 127–28 (citing C. Haney & P. Zimbardo, *The Past and Future of U.S. Prison Policy: Twenty-five Years After the Stanford Prison Experiment*, 53 Am. Psychologist 709 (1998)).

79. *Id.* at 128.

Included in SCDC' 4.29.19 letter to LOC

walls."[80] Supermax was the solution. In 1983, the first supermax prison facility in the United States opened in Marion, Illinois, in reaction to inmates killing two of the Marion prison guards.[81] Today, most supermax facilities are modeled after the "Marion Model."[82] In this model of incarceration, solitary confinement is used as a disciplinary measure as opposed to a source of rehabilitation.[83] This "super-maximum security approach" soon spread to other parts of the United States with the Pelican Bay State Prison, which opened in 1989, followed by the ADX Florence supermax-style prison in Colorado in 1994, the federal government's main supermax facility.[84] By 1997, there were fifty-seven supermax prisons in thirty-four states, and by 1998, approximately 20,000 prisoners were held in these facilities.[85] By 2000, over sixty supermax institutions were open in the United States,[86] and in 2004, forty-four states had at least one supermax facility.[87]

B. *Current Description of Solitary Confinement in U.S. Supermax Prisons*

The cells in supermax prisons reflect the purpose of these facilities: "to monitor, to control, to isolate."[88]

> Reflect for a moment on what a small space that is not much larger than a king-sized bed looks, smells, and feels like when someone has lived in it for 23 hours a day, day after day, for years on end. Property is strewn around, stored in whatever makeshift way possible, clothes and bedding soiled from recent use sit in one or another corner or on the floor, the residue of recent meals (that are eaten within a few feet of an open toilet) here and there, on the floor, bunk, or elsewhere in

80. *Id.*

81. Patrick J. Kiger, *History of Solitary Confinement*, NATIONAL GEOGRAPHIC, http://channel.nationalgeographic.com/channel/solitary-confinement-history (last visited Aug. 16, 2011).

82. Haney & Lynch, *supra* note 30, at 495 (stating that "after the notorious federal penitentiary at Marion where the new policy seems to have originated, a number of prison systems (including the Federal Bureau of Prisons) have either begun or completed construction on specialized prisons devoted entirely to long-term punitive segregation and solitary confinement-like conditions and routines") (citations omitted).

83. Rebman, *supra* note 17, at 574–75.

84. Laura Sullivan, *Timeline: Solitary Confinement in U.S. Prisons*, NPR (July 26, 2006), http://www.npr.org/templates/story/story.php?storyId=5579901 (stating that while there are many state-run supermax facilities in states such as Oregon Mississippi, Indiana, Virginia, and Ohio, ADX Florence was the "federal government's first and only Supermax facility"); *see also* Shalev, *supra* note 14, at 2 (stating that at least forty-four States now operate at least one supermax prison).

85. Peter Scharff Smith, *The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature*, 34 CRIME & JUST. 441, 443 (2006).

86. Gawande, *supra* note 1.

87. Arrigo & Bullock, *supra* note 29, at 624.

88. Sullivan, *supra* note 20.

Included in SCDC' 4.29.19 letter to LOC

the cell.[89]

> [The cells] are structured to deprive prisoners of most of the things that all but the most callous commentators would concede are basic necessities of life—minimal freedom of movement, the opportunity to touch another human being in friendship or with affection, the ability to engage in meaningful or productive physical or mental activity, and so on.[90]

With virtually around the clock surveillance and a total lack of human contact and interaction, the effects of supermax solitary confinement are truly experiences of "stark sterility and unremitting monotony."[91] Although the exact conditions of solitary confinement differ by prison, author Leonard Orland gives a basic description of the current physical conditions of supermax solitary confinement:

> I was placed in a 4 x 8 foot steel box with no windows, a bare light bulb, a small peephole (which only the guards could control and which was kept closed most of the time), a sink (occupied by three cockroaches), a toilet, and one steel shelf on which, if the guards so desired, a mattress could be placed for sleeping. It was very much like being forced into a very small stalled elevator.[92]

Generally, the physical layout of supermax facilities is designed to divide and isolate; prisoners in supermax facilities are divided into small and manageable groups of individuals in cell-blocks and then placed in their own individual cells.[93] Each facility has four cell-blocks that are called "pods," each of which has its own shower and recreation areas.[94]

The individual units where inmates are confined are called "secure housing units" (SHUs).[95] These units are usually about eight feet by six feet in size, which means that these cells are equal to the size of a bathroom.[96] As in Orland's description, there is generally a stainless steel sink and toilet, as well as some type of desk and bed.[97] The walls of the cell are bare and white with no windows.[98] Usually the only light is a

---

89. *A Culture of Harm*, *supra* note 30, at 968.

90. *Id.* at 967.

91. Madrid v. Gomez, 889 F. Supp. 1146, 1230 (N.D. Cal. 1995).

92. LEONARD ORLAND, PRISONS: HOUSES OF DARKNESS 72–74 (1975); *see also* Bryan B. Walton, *The Eighth Amendment and Psychological Implications of Solitary Confinement*, 21 LAW & PSYCHOL. REV. 271, 272–73 (1997); Gawande, *supra* note 1 (stating that the average cell is fifty feet long and five feet wide—similar to a "dog kennel").

93. *Cold Storage: Super-Maximum Security Confinement in Indiana*, HUMAN RIGHTS WATCH (Oct. 1997), http://www.hrw.org/legacy/reports/1997/usind/ [hereinafter *Cold Storage*].

94. *Id.*

95. Elizabeth Vasiliades, *Solitary Confinement and International Human Rights: Why the U.S. Prison System Fails Global Standards*, 21 AM. U. INT'L L. REV. 71, 74 (2005).

96. Hresko, *supra* note 16, at 10.

97. *Id.*

98. *Id.*

Included in SCDC' 4.29.19 letter to LOC

bare light bulb, which hangs from the ceiling and remains on twenty-four hours a day.[99] Inmates are unable to control the brightness of their cells and are unable to tell what time of day it is.[100] Prisoners who try to shield the light can be subject to other disciplinary measures.[101] The doors of the SHUs are different from the doors used in cells in other parts of the prison.[102] They are "made of solid steel, interrupted only by a small approximately eye-level clear window and a waist-level food slot."[103] These doors are made of a heavy-gauge metal, which block all light, in order to prevent inmates from throwing objects at guards and other inmates.[104] Moreover, the door is usually outfitted with strips on each side so as to muffle any possible conversations between inmates in adjacent cells.[105] These doors "effectively cut inmates off from the world outside the cell, muffling sound and severely restricting visual stimulus."[106] The doors also have the effect of cutting off ventilation in the units, so that the air becomes "heavy and dank."[107]

There is usually no recreational equipment, and so prisoners generally just pace back and forth. The "the image created is hauntingly similar to that of a caged feline pacing in the zoo."[108] Indeed one inmate in supermax solitary confinement began to think of himself as an animal, stating:

> Look at me. They have reduced me to an animal. I can't take care of myself, I smell, my hair is matted together, I eat all of my meals just a few feet away from the toilet in my cell. I am living like an animal. I am afraid I am becoming one.[109]

The physical exercise facilities are so limited that they are often referred to as "dog runs."[110] Furthermore, when an inmate leaves his cell, he must usually undergo a "visual strip search" in front of the control tower officers.[111] When the prisoners are escorted from their cells to the exercise cage, they are usually placed in restraints and are sometimes

99. *Id.*
100. Arrigo & Bullock, *supra* note 29, at 625.
101. Wilkinson v. Austin, 545 U.S. 209, 214–15 (2005).
102. *Cold Storage*, *supra* note 93.
103. *Id.*
104. Madrid v. Gomez, 889 F. Supp. 1146, 1228 (N.D. Cal. 1995).
105. Jeffrey Kluger, *Are Prisons Driving Prisoners Mad?*, TIME, Jan. 26, 2007, http://www.time.com/time/magazine/article/0,9171,1582304,00.html.
106. *Cold Storage*, *supra* note 93.
107. *A Culture of Harm*, *supra* note 30, at 968.
108. *Madrid*, 889 F. Supp. at 1229.
109. *A Culture of Harm*, *supra* note 30, at 968–69; *see also* Dayan, *supra* note 25 ("If they only touch you when you're at the end of a chain, then they can't see you as anything but a dog. Now I can't see my face in the mirror. I've lost my skin. I can't feel my mind.").
110. *Mental Health Issues*, *supra* note 18, at 126.
111. Rebman, *supra* note 17, at 581–82.

Included in SCDC' 4.29.19 letter to LOC

also attached to a leash that is held by the escorting officer.[112] These protocols have the effect of discouraging many inmates from taking advantage of the recreation time, as leaving the cell is actually more humiliating than remaining in the cell.[113]

In some instances, the food in solitary is a tasteless block called nutra-loaf, which contains "just enough nutrition for survival."[114] Inmates consume all meals within their cells, which deprives the prisoners of an invaluable socializing opportunity with other inmates. Thus even mealtime has become another opportunity for sensory deprivation. Inmates in solitary confinement are also forbidden to have a variety of personal objects and educational materials.[115] However, in the federal supermax facility, ADX-Florence, educational and religious programs are broadcast through the TV channels of the prison.[116]

In general, once a prisoner is placed in a SHU, there is very minimal human contact, and the prisoner could go years without actually seeing another human being.[117] Overall, it is difficult to pinpoint the average length most prisoners are kept in solitary confinement because so much of the statistics depend on the particular supermax facility as well as the type of prisoner.[118] However, once placed in solitary confinement, the prisoner is confined to the SHU for about twenty-two or twenty-three hours a day. The remaining hour or two are for either a brief computer-controlled shower or recreation time.[119]

Throughout solitary confinement, the inmates are not allowed to talk to other inmates by yelling from cell to cell.[120] Interaction with prison guards is also severely limited, as prison officials are able to give

112. *Mental Health Issues*, *supra* note 18, at 126.

113. Rebman, *supra* note 17, at 582 (stating that "to some, time spent outside of the cell is considered more degrading and torturous than remaining in the solitary confinement cells").

114. Gawande, *supra* note 1.

115. Rebman, *supra* note 17, at 579; *Solitary*, THE NEW HUMANIST, Jan. 2011, http://newhumanist.org.uk/2479/solitary (stating that "the personal belongings that prisoners may keep in their cell are extremely limited in number and type"). In the federal supermax facility in Florence, Colorado, an inmate's request for a copy of two books written by Barack Obama was turned down because giving the inmate such literature would be "potentially detrimental to national security." *Id.*

116. *Supermax Prisons and the Psychological Effects of Isolation*, HUMAN RIGHTS WATCH (June 9, 2008), http://www.hrw.org/en/node/62183/section/4#_ftn58.

117. Nan D. Miller, Comment, *International Protection of the Rights of Prisoners: Is Solitary Confinement in the United States a Violation of International Standards?*, 26 CAL. W. INT'L L.J. 139, 159 (1995).

118. *See* Alysia, *Results of the "Solitary Confinement Bill" Bring Moral Victory, New Allies*, MAINE CIV. LIBERTIES UNION (Apr. 8, 2010, 2:28 PM), http://www.mclu.org/node/551 (stating that the average length of supermax solitary confinement for "high risk prisoners" is about 205 days).

119. Hresko, *supra* note 16, at 8.

120. *Id.*

Included in SCDC' 4.29.19 letter to LOC

all instructions through loud speakers.[121] The only form of habitual human contact that a prisoner in solitary has is when his meal is pushed through a slot in the door.[122] The heightened security and technology essentially mean that inmates "may go for months or even years without any meaningful social or physical contact."[123]

For example, many supermax facilities now employ computerized locking and tracking systems, which allow guards to observe an inmate's movement without any human interaction.[124] The inmates are usually watched by camera and speak through intercoms instead of through direct contact with guards.[125] Also, some newer facilities now use videoconferencing equipment for visits so that there is never any direct human interaction.[126] Even more disturbing, some supermax facilities use "tele-medicine" and "tele-psychiatry," which are procedures that allow physicians to "examine" the inmates through the use of television screens located miles away.[127] Sadly, "tele-medicine" seems like a better option than the alternative of "cell front therapy," where inmates are required to shout their medical concerns to a physician on the other side of the door, allowing other inmates to hear.[128] If inmates have a visitor, they are only able to interact with the visitor through a small video screen that is located across the room and has poor sound quality.[129] During the visit, the inmate must remain handcuffed, shackled, and belly chained.[130] To make matters worse, in some facilities, only about ten percent of inmates receive visitors at all.[131]

The fusion of the old practice of solitary confinement and the more modern and sophisticated technology is what really sets these supermax facilities apart from usual solitary confinement and makes supermax solitary an "extraordinary and extreme form of imprisonment unique in the modern history of corrections."[132]

121. *Id.*
122. *Id.*
123. Miller, *supra* note 117, at 156.
124. *Mental Health Issues*, *supra* note 18, at 126.
125. *Id.*
126. *Id.*
127. *Id.*
128. *Id.* at 143.
129. Jones 'El v. Berge, 164 F. Supp. 2d 1096, 1101 (W.D. Wis. 2001) (stating that the audio quality is so poor that "some mentally ill inmates believe that the images on the video screens are manipulated and refuse visitors").
130. *Id.*
131. *Id.*
132. *Mental Health Issues*, *supra* note 18, at 127.

Included in SCDC' 4.29.19 letter to LOC

IV. The Mental Effects of Sensory Deprivation from Solitary Confinement Constitute Disablement Under the CRPD

A. *Mental Effects*

The mental effects caused by prolonged solitary confinement are well documented and widely recognized in extensive historical evidence, clinical research, and empirical data. Solitary confinement has "serious psychological, psychiatric, and sometimes physiological effects on many prison inmates," ranging from insomnia to hallucinations to outright insanity.[133]

The devastating mental effects of solitary confinement were already recognized early in the nineteenth century.[134] The Cherry Hill prison was built in Philadelphia in 1829, representing an approach to imprisonment that aimed to emphasize isolation and self-reflection over whipping and other corporal punishments. Each prisoner was kept entirely isolated, with "absolute silence" imposed on them all.[135] In 1842, after visiting Cherry Hill, Charles Dickens characterized its system as one of "rigid, strict, and hopeless solitary confinement."[136] Though he viewed the prison authorities as well-intentioned, he asserted that "no man has the right to inflict upon his fellow creature" the "dreadful punishment" of prolonged solitary confinement.[137]Alexis de Tocqueville's views on penology were considerably stricter than Dickens'. He believed that prisoners should be kept from communicating with each other to avoid "mutual corruption"[138] and viewed flogging as an appropriate means of discipline.[139] Even so, he was appalled by the approach taken in the Auburn prison in New York when it opened a new wing in 1821. Speaking of the prisoners there, he wrote:

> In order to reform them, they had been submitted to complete isolation; but this absolute solitude, if nothing interrupts it, is beyond the strength of man; it destroys the criminal without intermission and

133. Lobel, *supra* note 22, at 117.

134. Grassian, *supra* note 76, at 341.

135. Lawrence M. Friedman, A History of American Law 220 (3d ed. 2005).

136. Charles Dickens, American Notes for General Circulation 111 (Patricia Ingham ed. 2001).

137. *Id.* at 111, 113 (stating that any prisoner at Cherry Hill was "a man buried alive; to be dug out in the slow round of years; and in the mean time dead to everything but torturing anxieties and horrible despair"). *See also* Friedman, *supra* note 135, at 220.

138. Gustave de Beaumont & Alexis de Tocqueville, On the Penitentiary System in the United States and Its Application to France 44 (Francis Lieber trans. 1964). For accounts of his visits to American prisons and his views on penology, *see* Hugh Brogan, Alexis de Tocqueville: A Life 154–56, 166–67, 189–92 (2006); Leo Damrosch, Tocqueville's Discovery of America 36–40 (2010); Friedman, *supra* note 135, at 220–21.

139. *See* Damrosch, *supra* note 138, at 39.

Included in SCDC' 4.29.19 letter to LOC

\\jciprod01\productn\M\MIA\66-2\MIA202.txt unknown Seq: 20 16-DEC-11 12:43

without pity; it does not reform, it kills.[140]

Sadly, when a former warden of a modern supermax facility wrote in 2004 that "[a]fter long-term confinement and the loss of hope for offenders controlled under [supermax] conditions, mental deterioration is almost assured,"[141] he said nothing that had not been recognized for well over a century and a half. There is now a large body of literature documenting the physical and mental effects of supermax solitary confinement. Overall, the mental effects of solitary confinement, such as post-traumatic stress disorder (PTSD) are similar to the effects seen in torture and trauma victims.[142] And they are long-lasting. Prisoners of war during the Korean war, who were held in conditions similar to those in supermax solitary confinement, displayed "psychosomatic ailments, suspicion, confusion, and depression," and were "detached from social interaction" for as long as forty years after being released.[143]

The mental effects of solitary confinement are so common that psychiatrists now associate a specific psychiatric syndrome known as Reduced Environmental Stimulation (RES) Syndrome or "isolation sickness" with prolonged solitary confinement.[144] The most common symptoms associated with this syndrome include hyperresponsivity to external stimuli, perceptual distortions, illusions and hallucinations, panic attacks, difficulties in thinking, concentration, and memory, "intrusive obsessional thoughts" or "emergence of primitive aggressive ruminations," overt paranoia, and problems with impulse control.[145] These side effects comprise what Dr. Stuart Grassian, a Boston psychiatrist and former member of the Harvard Medical School faculty, has called an "acute organic brain syndrome" or "delirium."[146] This syndrome also results in electroencephalogram (EEG) abnormalities in the brain.[147] More specifically, EEG studies show "diffuse slowing of brain waves" in most prisoners after only a week in solitary confinement.[148]

This overall EEG decline is connected to "a reduction in stimulation seeking behavior."[149] Individuals in supermax solitary become withdrawn and develop a "shut-in" or reclusive personality.[150] Their

140. BEAUMONT & TOCQUEVILLE, *supra* note 138, at 41.
141. *Culture of Harm*, *supra* note 30, at 957 (citing JAMES H. BRUTON, THE BIG HOUSE: LIFE INSIDE A SUPERMAX SECURITY PRISON 38 (2004)).
142. *Mental Health Issues*, *supra* note 18, at 132.
143. Grassian, *supra* note 76, at 383.
144. *Mental Health Issues*, *supra* note 18, at 137.
145. Grassian, *supra* note 76, at 336–37, 372.
146. *Id.* at 337.
147. *Id.* at 338.
148. Gawande, *supra* note 1.
149. Shalev, *supra* note 14, at 20.
150. *Id.* at 18.

Included in SCDC' 4.29.19 letter to LOC

day-to-day mental functioning becomes impaired. There is a "drop in sensory input," which in turn produces a "drop in mental alertness."[151] Concentrating becomes difficult, as prisoners suffer from a decline in motivation.[152] This in turn can cause difficulty in using the speech and motor systems coupled with a "disinclination to learn" and decline in physical activity.[153]

In 1993, in preparation for a class-action lawsuit challenging the use of solitary confinement at the Pelican Bay State Prison, Grassian conducted an in-depth study of forty-nine inmates in that prison.[154] Of those forty-nine inmates, at least seventeen were characterized as "actively psychotic and/or acutely suicidal" and urgently in need of hospital treatment as a result of their confinement.[155] Twenty-three others exhibited "serious psychopathological reactions to solitary confinement," leading Grassian to declare that the sensory deprivation that results from solitary confinement is "toxic to brain functioning."[156] In another study, Grassian studied over two hundred prisoners in solitary confinement and found that about a third suffered from acute psychosis with hallucinations.[157] Grassian also found that the inmates in supermax solitary were hypersensitive to stimuli and suffering from distortions of perception.[158] In some cases inmates developed a "full-blown psychosis and functional disability" while in supermax solitary.[159]

Dr. Craig Haney, a professor of psychology at the University of California, Santa Cruz, has also researched the effects of solitary confinement.[160] His study of one hundred prisoners in the Pelican Bay Security Housing Unit reported that ninety-one percent of the prisoners suffered from anxiety and nervousness; eighty percent suffered from headaches, lethargy, and trouble sleeping; and seventy percent were concerned about having an "impending breakdown."[161] The prisoners also suffered physical effects such as dizziness and heart palpitations.[162]

151. *Id.* at 20.

152. *Id.*

153. *Id.*

154. Grassian, *supra* note 76, at 349. The case was Madrid v. Gomez, 889 F. Supp. 1146 (N.D. Cal. 1995). In *Madrid*, inmates brought suit challenging the use of solitary confinement at the Pelican Bay facility. The court ruled that the supermax confinement did not constitute an Eighth Amendment violation. *See Id.*

155. Grassian, *supra* note 76, at 349.

156. *Id.*

157. Gawande, *supra* note 1.

158. Arrigo & Bullock, *supra* note 29, at 628.

159. Kupers, *supra* note 15, at 1006.

160. Craig Haney, *Hiding from the Death Penalty*, THE HUFFINGTON POST (July 26, 2010, 6:04 PM), http://www.huffingtonpost.com/craig-haney.

161. Shalev, *supra* note 14, at 11.

162. *Id.*

Included in SCDC' 4.29.19 letter to LOC

Haney identified several "social pathologies" that develop in prisoners placed in supermax confinement.[163] For example, because prisoners are unable to organize their lives around a purpose or goal, they begin to suffer from apathy, lethargy, and despair.[164] They lose the ability to concentrate and complete even the most routine of tasks.[165] They lose a sense of self and become "literally at risk of losing their grasp on who they are, of how and whether they are connected to a larger social world."[166] These social pathologies of supermax confinement can "significantly interfere" with post-confinement adjustment upon release.[167]

When analyzing the plethora of mental and physical effects caused by solitary confinement, one must be cognizant of the fact that the side effects are probably worse than we know. In many cases researchers have found that inmates have a tendency to minimize their reaction to solitary confinement and downplay any mental health problems.[168] This was a concern present in both the Haney and Grassian studies.[169]

B. *The Effects of Solitary Confinement Meet the Article 1 Disability Definition*

1. "LONG-TERM"

Article 1 of the CRPD defines people with disabilities as "those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."[170] As previously stated, the vast majority of studies analyzing the mental effects of supermax confinement of more than sixty days show long-lasting and negative mental effects.[171] Such effects include not only "persistent symptoms of post traumatic stress . . . but also lasting personality changes—especially including a continuing pattern of intolerance of social interaction."[172] Examples of personality changes include an inability to tolerate even the most basic social interaction as well as vivid flashbacks and a sense of hopelessness.[173] Many studies also show

163. *Mental Health Issues*, *supra* note 18, at 137.
164. *Id.* at 139.
165. *Id.*
166. *Id.*
167. *Id.* at 144.
168. Shalev, *supra* note 14, at 12.
169. *Id.*
170. CRPD, *supra* note 3, art. 1. The *World Report on Disability*, which is meant to "facilitate" the implementation of the CRPD, defines disability as "complex, dynamic [and] multidimensional." *World Report on Disability*, *supra* note 2, at 3.
171. Lobel, *supra* note 22, at 118.
172. Grassian, *supra* note 76, at 353.
173. *Id.*

Included in SCDC' 4.29.19 letter to LOC

serious and long-term effects such as chronic isolation syndrome.[174] Such prolonged mental effects undoubtedly meet the CRPD definition of "long-term." Moreover, that some of these effects might recede in varying degrees in some individuals after release from solitary confinement does not diminish the fact that solitary confinement still imposes a significant chance that the inmate will indeed "suffer permanent harm as a result of such confinement."[175]

2. "Full and Effective Participation"

The long-term and sometimes permanent effects caused by solitary confinement create an inability for the inmate to participate in society upon release, thereby hindering his or her "full and effective participation in society," as stated in Article 1 of the CRPD. A preliminary question concerns the meaning of "participation in society." Plainly, the term "society" as used in the CRPD includes prison. While a major concern of the use of solitary confinement relates to its impact on prisoners' ability to function effectively after release from prison, the CRPD is also concerned with the prisoners' ability to function effectively *in* prison. Article 14 makes it clear that the CRPD does protect persons in prison.[176] Of course, "full and effective participation in society" is contextual; prisoners, for example, do not have the same freedom of movement as those not in detention. Consequently, "full and effective participation" is implicated not only by impediments to functioning upon release from prison, but also by impediments to functioning effectively as a prisoner upon release from supermax confinement to the general prison facilities.

While in solitary confinement, all parts of the prisoners' daily life are controlled in the solitary unit.[177] As a result, inmates effectively lose any ability to control their behavior or to set limits for themselves.[178] Moreover, prisoners in supermax solitary begin to "lose the ability to initiate behavior of any kind . . . because they have been stripped of any opportunity to do so for such prolonged periods of time."[179]

Human beings rely on social interaction with other people in order

174. Smith, *supra* note 85, at 495.
175. Grassian, *supra* note 76, at 332.
176. Article 14(2) provides:

States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation. CRPD, *supra* note 4, art. 14.

177. *Mental Health Issues*, *supra* note 18, at 139.
178. *Id.*
179. *Id.*; *see also* Arrigo & Bullock, *supra* note 29, at 628.

Included in SCDC' 4.29.19 letter to LOC

to test their understanding of their surroundings.[180] Without this opportunity, inmates in supermax confinement begin to blur the distinction between fantasy and reality.[181] The inmates also become "unnaturally sensitive, and vulnerable to the influence of those who control the environment around them."[182] Inmates then begin to act out in anger as a result of developing intense frustration and rage while in solitary.[183] "[I]rrational anger" and being "consumed with revenge fantasies"[184] are characteristic of maladaptive strategies that inmates use to cope and survive in supermax solitary. Suicide attempts and self-mutilation are also tragic effects that occur with more frequency in solitary confinement.[185] These effects are devastating for those prisoners who might one day be integrated back into the general prison population.

As expected, these psychiatric effects hinder one's "full and effective participation within society" upon release, whether in the context of the general prison environment or the community at large. Grassian has stated that prolonged solitary confinement creates "a handicap . . . which severely impairs the inmate's capacity to reintegrate into the broader community upon release from imprisonment"[186] and leaves the "individual socially impoverished and withdrawn, subtly angry and fearful when forced into social interaction."[187] It is a sad paradox that after yearning for human interaction for so long, individuals released from supermax solitary become unable to tolerate social interaction upon release.[188]

Prisoners become unable to "manage" their conduct when they are released into the world.[189] They are more likely to have clinical depression and long-term impulse-control disorder.[190] Because so much of our personality and identity is socially constructed, the loss of all social contact leads to "a disconnection of experience from meaning" and creates a risk of prisoners "losing their grasp on who they are."[191] It is hard to imagine a set of side effects more problematic for these inmates who one day will be expected to survive and function in the world outside supermax facilities.

180. *Id.* at 627.
181. *Id.*
182. *Id.*
183. *Id.* at 628.
184. Gawande, *supra* note 1.
185. *Id.*; *see also* Kupers, *supra* note 15, at 1009 (stating that about half of the successful suicides in prison occur in the six to eight percent of those inmates in solitary confinement).
186. Grassian, *supra* note 76, at 333.
187. *Id.* at 353.
188. Arrigo & Bullock, *supra* note 29, at 627.
189. *Id.* at 628.
190. *Id.*
191. *Mental Health Issues*, *supra* note 18, at 139.

Included in SCDC' 4.29.19 letter to LOC

3. UNIFORMITY OF RESULT AND FREQUENCY OF "LONG-TERM" PSYCHIATRIC CONSEQUENCES

The consistency with which supermax solitary has devastating mental effects is clear; however, one possible issue with utilizing the framework of the CRPD for a disablement claim is that fewer than one hundred percent of those placed in supermax solitary confinement actually suffer from an Article 1 mental disability as a result.

Variability in mental effects has proved to be legally significant in U.S. law. In 1995, while reviewing the conditions of California's first supermax prison, a California federal court ruled that even though solitary confinement may "hover on the edge of what is humanly tolerable for those with normal resilience," there could be no valid objection to its use because such confinement failed to make *every* inmate go insane.[192] More specifically, the routine use of solitary confinement did not pose "a sufficiently high risk to *all* inmates of incurring a serious mental illness."[193] It is possible that variability in the frequency of mental disabilities might be an obstacle for disablement claims, as this lack of inevitable disability differentiates solitary confinement from physical maiming. Overall, the frequency with which disabilities develop from solitary confinement depends on many factors such as one's pre-existing mental state and the amount of time one spends in solitary.

a. pre-existing mental state

In his 2006 study, Grassian stated that there "is great variability among individuals in regard to their capacity to tolerate a given condition of sensory restriction."[194] He noted that generally, those with a "mature, healthy personality" and average intelligence usually demonstrate fewer psychiatric consequences due to solitary confinement.[195] Human Rights Watch stated that "[h]ow destructive [solitary confinement is] depends on each inmate's prior psychological strengths and weaknesses."[196] The organization went on to say that:

> Although not everyone will manifest negative psychological effects to the same degree, and it is difficult to specify the point in time at which the destructive consequences will manifest themselves, few [long-term supermax inmates] escape unscathed . . . . The psychological consequences of living in these units for long periods of time are predictably destructive, and the potential for these psychic stressors

192. Madrid v. Gomez, 889 F. Supp. 1146, 1280 (N.D. Cal. 1995).
193. *Id.* at 1267.
194. Grassian, *supra* note 76, at 347.
195. *Id.* at 348.
196. *Cold Storage*, *supra* note 93.

Included in SCDC' 4.29.19 letter to LOC

\\jciprod01\productn\M\MIA\66-2\MIA202.txt unknown Seq: 26 16-DEC-11 12:43

to precipitate various forms of psychopathology is clear-cut.[197]

A wide range of psychiatric reactions are possible, as some people suffer all symptoms of RES syndrome, some suffer only a few, and some suffer none at all.[198] However, in another study performed by both Grassian and Dr. Nancy Friedman, results showed that even some prisoners with no previous psychotic tendencies became "grossly psychotic."[199]

b. the amount of time spent in supermax solitary

The amount of time one spends in solitary confinement has some impact on the frequency with which permanently disabling mental effects occur. In this article, "long-term" solitary confinement is the focus of my discussion, but what exactly constitutes "long-term" solitary confinement can be nebulous. How long does one's placement in solitary have to be before negative side effects become disabling in the "long-term" under the CRPD? Many studies analyzing the mental effects of supermax confinement state that more than sixty days in solitary will create long-lasting and negative mental effects.[200] Other studies have said ten days.[201] Dr. Kaufman has studied the effects of solitary confinement in consideration of the amount of time spent in the cell.[202] He found that after only a few hours in solitary confinement, the prisoner's brain waves "shift[ed] toward a pattern characteristic of stupor and delirium."[203] Studies at Montreal McGill University show that with intense sensory deprivation (elimination of sounds, sight, and tactile stimulation), the subject can experience hallucinations within as little as forty-eight hours.[204] The American Correctional Association, on the other hand, has designated thirty days as the time when detrimental mental effects usually appear and when a prisoner must be psychologically evaluated.[205]

While there is some variation in the precise amount of time before these effects occur, it is clear that those prisoners placed in solitary confinement are less likely to be rehabilitated and are much more likely to become violent rather than less so.[206] What is also clear is that despite some variability stemming from individual characteristics or other con-

197. *Id.*
198. Smith, *supra* note 85, at 493.
199. Walton, *supra* note 92, at 279.
200. Lobel, *supra* note 22, at 118.
201. *Mental Health Issues*, *supra* note 18, at 132.
202. Edward Kaufman, *The Violation of Psychiatric Standards of Care in Prisons*, 137 AM. J. PSYCHIATRY 566, 666, 569 (1980).
203. Kluger, *supra* note 105.
204. *Id.*
205. Walton, *supra* note 92, at 282.
206. Kiger, *supra* note 81.

Included in SCDC' 4.29.19 letter to LOC

textual factors, there is "remarkable consistency" in finding negative mental health effects after supermax solitary.[207] To ignore the consistent data and studies on supermax solitary confinement would be ethically and politically irresponsible.

In sum, the mental effects of supermax confinement produce a disability within the meaning of the CRPD. Supermax solitary confinement socially incapacitates inmates while in prison and produces prolonged or permanent psychiatric disabilities including impairments, which "may seriously reduce the inmate's capacity to reintegrate into the broader community upon release from prison."[208]

V. Article 15 as Another Avenue for a Disablement Claim

A. *Supermax Confinement as Torture or Cruel and Inhuman Treatment*

Article 15 is another possible basis for claiming a violation of the CRPD. Article 15 states: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or sci-

207. Shalev, *supra* note 14, at 10. All studies of inmates who have been detained more than ten days involuntarily show negative physical and mental health effects. *Id.* at 21; *see also Mental Health Issues*, *supra* note 18, at 132 (stating that "there is not a single published study of solitary or supermax-like confinement in which non-voluntary confinement lasting for longer than 10 days . . . failed to result in negative psychological effects"); Kupers, *supra* note 15, at 1006 (stating that all prisoners held in supermax confinement for longer than three months have "lasting emotional damage" or "full-blown psychosis and functional disability"). Even federal judges continually recognize the detrimental effects of solitary confinement. *See* Jones 'El v. Berge, 164 F. Supp. 2d 1096 (W.D. Wis. 2001); Ruiz v. Johnson, 37 F. Supp. 2d 855 (S.D. Tex. 1999), *rev'd and remanded for further findings sub. nom.* Ruiz v. United States, 243 F.3d 941 (5th Cir. 2001); Madrid v. Gomez, 889 F. Supp. 1146 (N.D. Cal. 1995). While the consensus is clear, one study by the Colorado Department of Corrections has recently reached a different conclusion, sparking much controversy and dissent. *ACLU and Experts Slam Findings of Doc Report on Solitary Confinement*, ACLU (Nov. 29, 2010), http://aclu-co.org/news/aclu-and-experts-slam-findings-of-doc-report-on-solitary-confinement. The study, entitled "One Year Longitudinal Study of the Psychological Effects of Administrative Segregation," concluded that supermax solitary confinement does not cause the health of mentally ill prisoners to deteriorate. *Id.* The ACLU pointed out that this conclusion contradicts "considerable previous research" and "prevailing expert opinion." *Id.* Dr. Terry Kupers, an expert on the mental effects of prison confinement, stated, "[T]he methodology of the study is so deeply flawed that I would consider the conclusions almost entirely erroneous." *Id.* He also pointed out that the researchers "did not even spend time talking to the subjects about their experience in supermax" and "minimize[d] the emotional pain and suffering because they judge[d] the prisoners to have been already damaged before they arrived at supermax." *Id.* Dr. Kupers then went on to say that the report only included prisoners who volunteered and who were able to read and write, thus excluding two groups of inmates who would be most severely impacted by supermax solitary—"those who refuse to participate in social interaction and those unable to pass time by reading and writing." *Id.*

208. Grassian, *supra* note 76, at 354.

Included in SCDC' 4.29.19 letter to LOC

entific experimentation."[209] It is important to note that an Article 15 claim would be entirely separate from an Article 4 claim under the CRPD. An Article 4 claim in no way depends on an assertion that solitary confinement constitutes torture or cruel or inhuman punishment. Article 15 provides an additional, independent basis for evaluating supermax confinement.

Given its dehumanizing and extreme impact on an individual's mental health, supermax confinement would seem to present a textbook case of torture. The Convention Against Torture is quite relevant to the interpretation of Article 15 of the CRPD. The United States is a party to the Convention Against Torture.[210] When the United States ratified that treaty, it specifically added an understanding defining torture.[211] As shown below, supermax confinement would seem to qualify as torture under this definition.

Even if it were not torture, however, supermax confinement would still be inconsistent with Article 15.[212] Generally, when one of the elements of the definition of torture is not present, certain acts and treatment such as solitary confinement will amount to "cruel, inhuman or degrading treatment or punishment."[213] Manfred Nowak, the Special Rapporteur on Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, stated that prolonged isolation could constitute cruel and inhuman treatment and "in certain instances" even torture.[214] This conclusion finds support in several sources. The United Nations Human Rights Committee (HRC) has stated that the phrase "cruel, inhuman or degrading" in Article 7 of the International Covenant on Civil and Political Rights "should be interpreted so as to extend to the widest possible protection against abuses" in order to protect an individual from the deprivation of the use of "any of his natural senses, such as sight or hearing or of his awareness of place and the passing of time."[215] This broad interpretation could also apply to supermax solitary confinement, given that many cells lack windows and are padded to make them

209. CRPD, *supra* note 4, art 15.

210. U.N. Secretary General, Treaty Collections: Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Sept. 5, 2011), http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-9&chapter=4&lang=en [hereinafter CAT Treaty Collections].

211. *Id.*

212. Vasiliades, *supra* note 95, at 96.

213. Office of the High Commissioner for Human Rights, *Expert Meeting on Freedom from Torture, Cruel, Inhuman or Degrading Treatment or Punishment and Persons with Disabilities; Guide to Discussion for Participants*, (Dec. 11, 2007).

214. U.N. Secretary-General, *supra* note 19.

215. Shalev, *supra* note 14, at 4.

Included in SCDC' 4.29.19 letter to LOC

soundproof.[216] The HRC has also pointed out that solitary confinement for a prolonged amount of time and not under exceptional circumstances may constitute torture and cruel, inhuman or degrading treatment or punishment.[217] The European Court of Human Rights, moreover, has ruled, "[I]nhumane treatment covers at least such treatment as that which deliberately causes severe suffering, mental or physical . . . or treatment that drives [one] to act against his own will or conscience."[218]

B. *Disablement and Article 15*

There is a second way in which supermax confinement could violate Article 15. Unlike the first type of violation,[219] this violation would depend on both Article 15 and Article 4. Torture or cruel and inhuman treatment has long-lasting effects that produce a disability. Thus, supermax solitary confinement would amount to torture or cruel and inhuman treatment under Article 15 of the CRPD, and its effects during and after release from such confinement would amount to disablement under Articles 1 and 4.

The concept of disablement through torture is not new in the world of international human rights. One need only look to the language and purpose of the World Programme of Action Concerning Disabled Persons (World Programme), which recognizes such a concept, stating that:

> With the emergence of "victimology" as a branch of criminology, the true extent of injuries inflicted upon the victims of crime, causing permanent or temporary disablement, is only now becoming generally known. Victims of torture who have been disabled physically or mentally, not by accident of birth or normal activity, but by the deliberate infliction of injury, form another group of disabled persons.[220]

This is highly significant and informs the concept of disablement in the CRPD. This language recognizes that torture can produce a disability and even designates those disabled by torture as a separate, legally distinct group of people. Such language gives credence to a possible disablement claim under Article 15 of the CRPD in that Article 15 can be viewed as a continuation of the World Programme's prohibition of disablement through torture. In other words, the text of Article 15, especially when read in conjunction with the World Programme, can be read as implicitly saying that people in general (those with *and* without disa-

216. Hresko, *supra* note 16, at 10; Kluger, *supra* note 105.
217. Shalev, *supra* note 14, at 33 (citations omitted).
218. Soering v. United Kingdom, 11 Eur. Ct. H.R. 439, 489 (1989).
219. *See supra* Part IV.
220. *See* Secretariat for the Convention on the Rights of Persons with Disabilities, *World Programme of Action Concerning Disabled Persons*, U.N. ENABLE, http://www.un.org/disabilities/default.asp?id=23 (last visited Aug. 16, 2011).

Included in SCDC' 4.29.19 letter to LOC

bilities) have an explicit right to not only be free from torture and "inhuman" treatment, but also to be free from disablement though the use of torture or "inhuman" treatment.

VI. U.S. Ratification and Implementation of the CRPD

If the Obama Administration or some future administration submits the CRPD to the Senate for its advice and consent, ratification of the treaty will make it the "supreme Law of the Land" under the Supremacy Clause of the Constitution.[221] This Part discusses two key questions relating to the impact of ratification. First, what do the CRPD and U.S. law provide with regard to implementation and enforcement? Second, how might the terms on which the Senate gives its consent to ratification affect the implementation and enforcement of the treaty?

A. *The CRPD's Provisions for Implementation and Enforcement*

Article 32 of the CRPD requires states to take "appropriate and effective" steps to implement the CRPD through international cooperation.[222] More importantly, the CRPD obligates states to take a variety of domestic steps to ensure implementation. Parties to the CRPD must adopt "appropriate" legislation and take "other measures" in order to implement the legislation.[223] The state party must implement the Article 4 measures to the "maximum of its available resources."[224] Under Article 4(1)(c), state parties must consider the "protection and promotions of the human rights of persons with disabilities in all policies and programmes."[225] Article 4(1)(d) also imposes a broad obligation on state parties to "refrain from engaging in any act or practice that is inconsistent with the present Convention."[226] In light of its effects on individuals, the CRPD will require state parties to enact legislation against the use of supermax confinement. To the extent that a state continues to use it, prison officials will have to collect statistical information and conduct research to show compliance with the purpose and policies of the CRPD. This might include psychological evaluations of prisoners and in-depth tracking of the frequency and extent of solitary confinement use.[227]

A variety of national and international enforcement mechanisms

221. U.S. Const. art. VI, cl. 2.
222. CRPD, *supra* note 4, art. 32, art. 40(1).
223. *Id.* art. 4(1)(a).
224. *Id.* art. 4(2).
225. *Id.* art. 4(1)(c).
226. *Id.* art. 4(1)(d).
227. Given the effects of supermax solitary confinement, however, it is almost certain that such monitoring would show that the use of supermax confinement is inconsistent with the CRPD, so ultimately compliance would entail ceasing to use it.

Included in SCDC' 4.29.19 letter to LOC

could also be employed once the CRPD is ratified. Article 34 of the CRPD provides for a Committee on the Rights of Persons with Disabilities.[228] Parties to the CRPD are required to submit reports to the Committee every four years concerning the implementation of the goals of the convention.[229] While the Committee has no binding power over state parties, the very process of international examination of U.S. policy could place some pressure on the United States to change practices that are inconsistent with the CRPD.

Domestically, Article 33(2) of the CRPD requires state parties to establish independent mechanisms and organizations that will "promote, protect and monitor the implementation of the present Convention."[230] In particular, states must identify an office within the government that will be responsible for issues relating to the implementation of the CRPD.[231] By requiring not only international but also domestic monitoring, the CRPD has created a second and important layer of enforcement. This requirement has been used before in the 2006 Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), which required that national officials visit detention facilities.[232] These national reporting requirements are significant, as the "struggle for human rights will be won or lost at the national level."[233]

One final implementation mechanism is unlikely to be available in the case of the United States: the individual petition procedure under the Optional Protocol to the CRPD. Under the Optional Protocol, individuals can present complaints to the Committee, and the Committee has the authority to conduct inquiries into the alleged violations of the CRPD.[234] The United States, however, has not signed the Optional Protocol[235] and seems unlikely to submit itself to any type of individual complaint mechanism.

228. CRPD, *supra* note 4, art. 34.
229. *Id.* art. 35(2).
230. *Id.* art. 33(2).
231. *Id.* art. 33(1).
232. Gautheir De Beco, *Article 33(2) of the U.N. Convention on the Rights of Persons with Disabilities: Another Role for National Human Rights Institutions?*, 29 NETH. Q. OF HUM. RTS. 84, 87 (2011).
233. *Id.* at 87 (citing Jack Donnelly, *Post-Cold War Reflections on the Study of International Human Rights*, 8 ETHICS & INT'L AFF., 97, 117 (1994)).
234. CRPD, *supra* note 4, Annex II, arts. 1–7.
235. *Signatures and Ratifications*, *supra* note 65.

Included in SCDC' 4.29.19 letter to LOC

B. *The Impact on U.S. Law*

1. THE IMPACT OF "CLEAN" RATIFICATION OF THE CRPD

If the Senate were simply to ratify the CRPD with no conditions, the treaty might well have a profound impact on the use of supermax confinement. Under Article VI of the Constitution, a ratified treaty is the supreme law of the land.[236] This would make the CRPD superior to all state law and earlier federal statutes.[237] Individuals confined in supermax facilities could therefore seek relief in court under the CRPD, so long as the CRPD were self-executing under U.S. law.[238] As the Supreme Court noted in *Medellín v. Texas*,[239] self-executing treaties "automatically have effect as domestic law," whereas non-self-executing treaties, though they "constitute international law commitments—do not by themselves function as binding federal law."[240]

Under the Restatement, a treaty is "non-self-executing" only if (1) the treaty itself manifests such an intention, (2) the Senate makes it non-self-executing as a condition of ratification, (3) or the constitution requires implementing legislation. Nothing in the United States Constitution would require implementing legislation.[241] As to the first requirement, there does not appear to be any intention in the CRPD to require that it be non-self-executing. On the contrary, Article 4(1)(b) requires states to "take *all* appropriate measures" to bring domestic law into conformity; these measures include legislation, but are not limited to it. One might argue that *Medellín* requires a conclusion that the CRPD is non-self-executing. *Medellín* emphasized the word "undertakes" as a way of showing an intent by state parties that a treaty be non-self-executing.[242] The Court treated the use of that word as indicating something more like a promise to take action, rather than an acceptance of a presently binding obligation. The word "undertake" or some variation appears in the CRPD thirteen times.[243] The context of *Medellín* was, however, quite different. In *Medellín*, there was an underlying concern that finding self-execution in the case before it would deprive the United States of its flexibility in the U.N. Security Council concerning the enforcement of

236. U.S. CONST. art. VI, cl. 2.
237. RESTATEMENT (THIRD) OF THE FOREIGN RELATIONS LAW OF THE UNITED STATES § 115 cmt. e (1987)
238. Restatement § 111 ("Courts in the United States are bound to give effect to . . . international agreements of the United States, except that a 'non-self-executing' agreement will not be given effect as law.").
239. 552 U.S. 491 (2008).
240. *Id.* at 504.
241. Restatement §111.
242. *Medellín,* 552 U.S. at 492.
243. CRPD, *supra* note 4, preamble, art. 4, art. 8, art. 23, art. 29, art. 31, art. 32.

Included in SCDC' 4.29.19 letter to LOC

orders by the International Court of Justice.[244] No such circumstance would be present in a challenge to supermax facilities.

A better approach focuses on the comment in the Restatement that "[s]ome provisions of an international agreement may be self-executing and others non-self-executing."[245] The issue of self-execution should not be determined for the treaty as a whole, but on a case-by-case basis. Some provisions clearly would require implementing legislation or perhaps executive action. Any obligation that could be enforced by traditional injunctive relief, on the other hand, would seem appropriate for self-executing status. The treaty concerns individual rights and obligates state parties to ensure that persons who are disabled have access to justice.[246] An injunction against the use of supermax facilities would be entirely within a court's traditional competence.[247]

As the Restatement notes, however, the Senate does have the power to attach a condition to ratification providing that the treaty should be non-self-executing. Whether the Senate would do so in the case of the CRPD is of great significance because, as shown, without such a condition there would be a very strong basis for a court to enjoin the use of supermax facilities as a violation of the CRPD. Even with such a condition, the treaty would still have some significance in U.S. courts. Courts would consider the CRPD in construing federal and state regulations and statutes and in interpreting the Constitution.[248] Still, the question of the conditions that the Senate might attach to ratification (including regarding self-execution) is an important one and is discussed in the next section.

2. THE IMPACT OF CONDITIONS TO THE SENATE'S CONSENT TO RATIFICATION

The United States has never given a human rights treaty a "clean" ratification—that is, one devoid of qualifying reservations, understand-

244. *Medellín*, 552 U.S. at 492.

245. RESTATEMENT (THIRD) OF THE FOREIGN RELATIONS LAW OF THE UNITED STATES § 111 cmt. h (1987).

246. CRPD, *supra* note 4, art. 13.

247. *Cf.* Brown v. Plata, 131 S. Ct. 1910 (2011) (upholding federal court order to end overcrowding in California prisons).

248. *See* Roper v. Simmons, 543 U.S. 551, 554, 578 (2005) (acknowledging the "overwhelming weight" of international law and of the Convention on the Rights of the Child (CRC) when striking down the juvenile death penalty, despite the United States not having ratified the CRC); *see also* Atkins v. Virginia, 536 U.S. 304 (2002); State v. Romano, 155 P.3d 1102, 1114 n.14 (Haw. 2007) (relying partially on the United Nations Convention for the Suppression of the Traffic in Person and the Exploitation of the Prostitution of Others); *In re* Peggy, 767 N.E.2d 29, 38 (Mass. 2002) (stating that while the CRC is not binding on U.S. courts, the ruling of the court was "completely in accord with principles expressed therein").

Included in SCDC' 4.29.19 letter to LOC

ings, and declarations (RUDs). It is unlikely that any ratification of the CRPD will depart from this pattern. Accordingly, it is important to consider what kinds of RUDs the Senate might adopt in any future ratification of the CRPD and what impact they would have on the United States' use of supermax facilities.

The Senate's use of RUDs will likely fall into two categories: those that affect implementation and enforcement of the CRPD and those that affect the substantive obligations the United States takes on in ratifying the CRPD. As an examination of the likely RUDs makes clear, the conditions the Senate adopts will have a significant impact on domestic implementation and enforcement, but are unlikely to prevent ratification of the CRPD from having important effects on the use of supermax facilities.

a. RUDs relating to implementation and enforcement

Past U.S. practice indicates that the Senate will likely adopt two RUDs that will affect domestic implementation and enforcement. The first is a provision declaring that the entire treaty is non-self-executing. The United States adopted such a declaration in connection with the International Covenant on Civil and Political Rights,[249] the International Covenant on the Elimination of Racial Discrimination,[250] and the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.[251] Such a declaration would deprive federal and state courts of the power to enforce the treaty. Critics have decried the practice and suggested ways to lessen its impact,[252] but inclusion of such a provision appears highly likely if the CRPD is to win ratification.

249. *See* US ICCPR conditions, *supra* note 42; U.N. Secretary-General, Treaty Collections: International Covenant on Civil and Political Rights (Aug. 21, 2011), http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-4&chapter=4&lang=en (stating that the "the United States declares that the provisions of articles 1 through 27 of the Covenant are not self-executing").

250. U.N. Secretary-General, Treaty Collections: International Convention on the Elimination of All Forms of Racial Discrimination (Oct. 21, 1994), http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-2&chapter=4&lang=en#EndDec (stating that "the United States declares that the provisions of the Convention are not self-executing").

251. CAT Treaty Collections, *supra* note 210 (stating that "the United States declares that the provisions of articles 1 through 16 of the Convention are not self-executing").

252. *E.g.*, David Sloss, *The Domestication of International Human Rights: Non-Self-Executing Declarations and Human Rights Treaties*, 24 YALE J. INT'L L. 129 (1999); *see also* Harold Hongju Koh, Commentary, *Is International Law Really State Law?*, 111 HARV. L. REV. 1824 (1998). Even Harold Koh, the current legal advisor at the Department of State, has criticized the United States' pattern of RUDs, stating, "To proceed with such a qualified, 'swiss cheese' ratification in which the legal exceptions would overshadow the core act of ratification would be politically unwise, legally questionable, and practically unnecessary to protect American national interests." Harold Hongju Koh, *Why America Should Ratify the Women's Rights Treaty (CEDAW)*, 34 CASE W. RES. J. INT'L L. 263, 271 (2002).

Included in SCDC' 4.29.19 letter to LOC

\\jciprod01\productn\M\MIA\66-2\MIA202.txt unknown Seq: 35 16-DEC-11 12:43

Ratification even with a non-self-execution declaration would have some impact. Courts are bound to take even a non-self-executing treaty into account in interpreting domestic law. Ratification would formally commit the United States to the basic aims of the CRPD, making clear, for example, that the United States could not reject international criticism of how it handles disability issues as an intrusion on its sovereignty. And it would give a rallying point for domestic advocates for people with disabilities.

A second likely condition concerning implementation and enforcement would be an understanding concerning federalism. In ratifying the International Covenant on Civil and Political Rights (ICCPR), the United States stated that it understood

> that this Covenant shall be implemented by the Federal Government to the extent that it exercises legislative and judicial jurisdiction over the matters covered therein, and otherwise by the state and local governments; to the extent that state and local governments exercise jurisdiction over such matters, the Federal Government shall take measures appropriate to the Federal system to the end that the competent authorities of the state or local governments may take appropriate measures for the fulfillment of the Covenant.[253]

The U.S. government also submitted a similar understanding when it ratified the Convention Against Torture.[254] These federalism understandings have come under severe criticism.[255] While their meaning is not entirely clear, these reservations are plainly intended to create some kind of division of responsibilities between the federal government and the states in implementing the treaty. It seems likely that a similar proviso will be included in any ratification of the CRPD. With the exception of a few federally run supermax prisons such as the ADX Florence and the USP Marion facility, most other supermax facilities are state-run.[256] Such an understanding could complicate application of the CRPD to state supermax facilities.

b. RUDs limiting the substantive scope of the CRPD

Typically, when the United States has ratified human rights treaties, it has made use of reservations and understandings to bring the United States' treaty obligations into conformity with existing domestic law. This approach undercuts much of the domestic benefits of ratification,

253. US ICCPR Conditions, *supra* note 42.

254. CAT Treaty Collections, *supra* note 210.

255. *See* Carlos Manuel Vázquez, Breard*,* Printz*, and the Treaty Power*, 70 U. COLO. L. REV. 1317, 1353–57 (1999). *But see* Edward T. Swaine, *Does Federalism Constrain the Treaty Power?*, 103 COLUM. L. REV. 403, 442–43, 425 n.96 (2003).

256. Arrigo & Bullock, *supra* note 29, at 624.

Included in SCDC' 4.29.19 letter to LOC

\\jciprod01\productn\M\MIA\66-2\MIA202.txt unknown Seq: 36 16-DEC-11 12:43

but it seems likely that the Senate will utilize such conditions in the case of the CRPD. The difference between this kind of RUD and those that relate to implementation and enforcement is important. The latter have no impact on U.S. obligations on the international plane. For example, even if a treaty is non-self-executing, the United States remains obligated as a matter of international law to implement its provisions. In contrast, substantive adjustments to the obligations of the treaty do affect the extent of U.S. obligations on the international plane.

Past examples of the practice of limiting the treaty obligations the United States takes on are numerous. Some of them are quite specific. For example, when the United States ratified the ICCPR, it reserved the right to apply the death penalty to those who were juveniles at the time they committed a crime.[257] At the time, U.S. law permitted such executions,[258] but Article 6 of the ICCPR forbade them.[259] As noted earlier, when the United States ratified the Convention Against Torture, it limited the definition of Torture under Article 1 by adopting an "understanding" that no act inflicting severe mental pain could constitute torture unless the mental suffering was "specifically intended to inflict severe physical or mental pain"; the pain was "prolonged"; and the mental harm resulted from certain specified conditions, including the "administration . . . [of] procedures calculated to disrupt profoundly the senses or personality."[260] According to the Department of Justice, this understanding was so that "mental torture would rise to a severity seen in the context of physical torture."[261]

Other RUDs have been framed more broadly. One example relates to Article 16 of the Convention Against Torture, which prohibits "cruel, inhuman or degrading treatment or punishment."[262] When the United States ratified the Convention Against Torture, it adopted a reservation that it would be bound by Article 16 "only insofar as the term 'cruel, inhuman or degrading treatment or punishment' means the cruel and unusual punishment prohibited" by the Constitution.[263]

As to the RUDs that the Senate might consider in relation to the

257. *See* US ICCPR Conditions, *supra* note 42; *see also* David P. Stewart, *United States Ratification of the Covenant on Civil and Political Rights: The Significance of the Reservations, Understandings, and Declarations*, 42 DEPAUL L. REV. 1183 (1993).

258. *See* Stanford v. Kentucky, 492 U.S. 361 (1989), *overruled by* Roper v. Simmons, 543 U.S. 551 (2005).

259. International Covenant on Civil and Political Rights art. 6, Dec. 16, 1966, S. Treaty Doc. No. 95–20, 6 I.L.M. 368 (1967), 999 U.N.T.S. 171.

260. CAT Treaty Collections, *supra* note 210.

261. Memorandum from Jay C. Bybee, Office of Legal Counsel, U.S. Dep't of Justice, to Alberto Gonzales, Counsel to the President 18 (Aug. 1, 2002).

262. CAT Treaty Collections, *supra* note 210.

263. *Id.*

Included in SCDC' 4.29.19 letter to LOC

CRPD, the most obvious candidate concerns Article 15 of the treaty. The United States might well adopt a declaration concerning the meaning of torture and a reservation regarding cruel, inhuman or degrading treatment or punishment along the lines of the RUDs adopted in connection with the Convention Against Torture. Presumably the intention would be to limit the U.S. obligations under the CRPD to those of current domestic law. If successful, adoption of such RUDs could preclude the Committee from criticizing the United States' use of supermax facilities as a violation of the CRPD.

In gauging whether these RUDs would have their intended effect, two considerations are paramount. First, what substantive impact would they have on the United States' obligations regarding torture and cruel, inhuman or degrading treatment or punishment? Second, would they be valid under international law? With regard to the first point, there is a potential tension between the two RUDs. The declaration on mental suffering as torture would not, by its terms, seem to rule out application of the CRPD to supermax facilities. The reservation regarding cruel and unusual punishment would.

Article 15 of the CRPD does not define torture, but the definition in Article 1(1) of the Convention Against Torture might well give guidance. That Article defines torture as "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person."[264] As previously stated, the U.S. declaration on torture would preclude mental suffering from constituting torture unless the harm was prolonged and rose to the severity of physical pain. This requirement would be satisfied in the case of supermax facilities because loneliness can actually manifest itself as severe physical pain, making solitary confinement a form of "no-touch torture"[265] and causing the mental effects of solitary confinement to fit under the United States' tailored definition of torture.

The U.S. declaration on torture also added requirements that the suffering be intentionally inflicted—the declaration refers to suffering "specifically intended" to inflict severe mental pain, as the result of procedures "calculated" to "profoundly disrupt" the senses or personality.[266] Certainly supermax facilities meet the latter criterion: the whole point is to disrupt the senses. If such a declaration is read, though, to require that officials be driven by evil motives—that is, if they must want to inflict pain and to destroy personality—then it could present a

264. CAT, *supra* note 73, art. 1.
265. Kluger, *supra* note 105.
266. CAT Treaty Collections, *supra* note 211.

Included in SCDC' 4.29.19 letter to LOC

serious obstacle.[267] However, such an extreme reading of the declaration should be avoided.[268]

A U.S. reservation on the meaning of cruel, inhuman or degrading treatment or punishment under Article 15 of the CRPD would likely limit it to whatever constitutes cruel or unusual punishment under the Constitution. This reservation could well be a problem for application of Article 15 to supermax facilities, because as noted earlier, courts have so far rejected challenges to prolonged solitary confinement under the Eighth Amendment.[269] Paradoxically, this could mean that the use of supermax facilities could constitute torture under Article 15, but not cruel, inhuman or degrading treatment under Article 15. How U.S. courts or the Committee might resolve this paradox remains to be seen.

The second question one might raise about the reservations to Article 15 is whether they are valid under international law. Article 46 of the CRPD provides that "[r]eservations incompatible with the object and purpose of the present Convention shall not be permitted."[270] Given the fundamental nature of the ban on torture under international law—it constitutes a peremptory norm[271]—one might wonder how any qualification to or limitation on a treaty provision banning torture could be compatible with its object and purpose. While this question is important—and could have relevance to the potential RUDs discussed below—there is no definitive mechanism for resolving disputes over the validity of reservations. The likely declaration that the treaty is non-self-executing means that U.S. courts would not have the occasion to rule on this question, and while the Committee could express views on the subject, the United States would almost certainly consider such comments to be non-binding. In any event, for the reasons given in the next section, the validity or invalidity of any Article 15 RUD will have little impact on the application of the CRPD to supermax facilities.

Potential RUDs for other parts of the treaty will likely pose more difficult problems for the Senate. Already there is some political sparring over highly controversial issues. For example, U.S. officials have stated in reference to the term "reproductive health" in the CRPD[272] that

267. Michael L. Perlin & Henry A. Dlugacz, *"It's Doom Alone That Counts": Can International Human Rights Law Be an Effective Source of Rights in Correctional Conditions Litigation?*, 27 BEHAV. SCI. & L. 675, 693 (2009).

268. Vienna Convention, *supra* note 54, art. 31(1).

269. *See supra* Part IV.B.3.

270. CRPD, *supra* note 4, art. 46.

271. Restatement § 702 cmt. n (1987).

272. Jeanne E. Head, *U.N. General Assembly Approves Disability Convention; Clear Understanding That the Term "Sexual and Reproductive Health" Does Not Include a Right to Abortion Reaffirmed*, NAT'L RIGHT TO LIFE (Dec. 13, 2006) http://www.nrlc.org/UN/DisabilityConventionApproved.html.

Included in SCDC' 4.29.19 letter to LOC

"the phrase . . . does not include abortion, and its use in that Article does not create any abortion rights, and cannot be interpreted to constitute support, endorsement, or promotion of abortion."[273]

Some of the likely RUDs would have only indirect or limited effect on the question of supermax facilities. For example, one might predict that the Senate will seek to limit the CRPD definition of "disability." Some conservative groups opposed to ratification of the CRPD have already criticized its definition of disability on the ground that it "invites abuse by persons or groups who do not suffer from a recognized medical disability yet seek resources and protection under the authority of the convention."[274] Rather than accept paragraph (e) of the preamble to the CRPD, which states that disability is an "evolving" concept, the Senate might prefer to tie the definition to that under the Americans with Disabilities Act (ADA).[275] One such reservation could be framed as follows: "The United States considers itself bound by the convention only insofar as the term "disability" is understood in the ADA" (or federal law generally). Under the ADA, a disabled person is one who has "a physical or mental impairment that substantially limits one or more . . . major life activities" and "has a record of such an impairment" or has been "regarded as having such an impairment."[276] While any limitation on the definition of disability under the CRPD seems unnecessary, simply using the ADA definition of disability in connection with the CRPD would be unlikely to pose any barrier to the conclusion that the use of supermax facilities is inconsistent with the treaty. It is entirely predictable that the Senate will consider attaching a condition to ratification that aims to exempt supermax confinement from coverage by the convention. What is debatable, however, is whether any such RUD would be both effective and feasible.

What RUDs might be sufficient to remove supermax facilities from scrutiny under the CRPD? While it might be far more desirable to ratify the treaty without seeking to blunt its domestic impact, ratification of the treaty without any RUDs is not a realistic prospect. Therefore, it makes sense to ask what those RUDs might be in relation to the issue of disablement through long-term solitary confinement.

---

273. *Id.*

274. Steven Groves, The Heritage Found., Ratification of the Disabilities Convention Would Erode American Sovereignty 10 (2010), *available at* http://www.heritage.org/research/reports/2010/04/ratification-of-the-disabilities-convention-would-erode-american-sovereignty#_ftn32.

275. CRPD, *supra* note 4, preamble.

276. Americans with Disabilities Act (ADA) of 1990, 42 U.S.C.§ 12102(1) (2006). The ADA then provides further clarification by defining "major life activities" as "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, [and] standing . . . ." *Id.* *§ 12102(2).*

Included in SCDC' 4.29.19 letter to LOC

The most obvious place for the Senate to start is Article 4. As noted earlier, Article 4 provides that States must "refrain from engaging in any act or practice that is inconsistent with the present Convention and to ensure that public authorities and institutions act in conformity with the present Convention."[277] As this article has argued, prolonged solitary confinement is inconsistent with Article 4. What kind of RUD might be formulated that would exempt it from scrutiny under Article 4?

The first point to note here is that exempting supermax facilities from claims under Article 15 (as discussed earlier) would not, by itself, exempt them from scrutiny under Article 4. The claim that prolonged solitary confinement causes disablement in violation of the treaty in no way rests on the distinct assertion that such confinement amounts to torture or cruel, inhuman or degrading treatment. Article 4(d) states that state members must "refrain from engaging in *any* act or practice that is inconsistent with the present Convention."[278] The Article 4 argument would simply not be affected by any conclusion that solitary confinement is not torture or cruel, inhuman or degrading treatment.

Accordingly, a separate RUD would be needed to address Article 4. And this may prove to be a daunting task, for formulating such a RUD in a way that is politically acceptable *and* legally effective may well prove difficult or impossible. Explicitly limiting the scope of Article 4 as it relates to prolonged solitary confinement would be politically unpalatable. It is unclear how the U.S. Government would be able to craft a reservation that would address the implicit violation of disablement without conceding that there is in fact a link between solitary confinement and long-term mental disabilities. Stating, for example, that "nothing in Article 4 will limit the use of solitary confinement" could easily be taken as an admission that solitary confinement does in fact disable people and would be inconsistent with the treaty in the absence of the reservation.

A second strategy would be to adopt a treaty-wide reservation or understanding, stating, for example, that "nothing in this treaty bears on the practice of long-term solitary confinement." This kind of reservation might be more politically palatable, as it could be read to imply not that solitary confinement is disablement but is exempted, but that the CRPD as a whole simply has nothing to say one way or the other as to solitary confinement. The problem with this approach, however, is that it would sweep too broadly, utterly exempting solitary confinement even from Article 15 scrutiny. The United States would be announcing that even if solitary confinement amounts to torture, whether as defined internation-

277. CRPD, *supra* note 4, art. 4.
278. *Id.* (emphasis added).

Included in SCDC' 4.29.19 letter to LOC

ally or as narrowed by a RUD, it would still be acceptable. That is a very different kind of approach from the likely reservation to Article 15 as discussed earlier, which claims to accede to the ban on all forms of torture, though leaving the definition to domestic rather than international law. Nor would it help to modify the reservation to something like the following: "Nothing in this treaty bears on the practice of long-term solitary confinement, except insofar as it may constitute torture under Article 15." This qualification would solve the problem of inadvertently claiming a right to practice torture, but once again at the cost of appearing to concede that prolonged solitary confinement can be torture.

Another conceivable reservation might be one providing that "nothing in this treaty bears on the administration of prisons." A reservation of this sort would almost certainly be too broad to be acceptable politically. Federal law itself protects disabled prisoners.[279] Simply to exempt prisoners from the protection of the CRPD is therefore not a realistic option.

The Senate might, however, consider more limited versions of such a RUD. For example, it might state, "Nothing in this treaty restricts the right of prison administrators to impose on persons under lawful detention conditions of detention that are valid under federal or state law or the U.S. Constitution." This reservation, if valid under Article 46, might achieve the Senate's aims, but once again, at the cost of seeming to exempt the United States even from Article 15 obligations.

Alternatively, the Senate might adopt a declaration that "in the case of persons under lawful detention, the treaty shall be interpreted to provide no more rights than are protected under federal or state law or the U.S. Constitution." This would make the full range of U.S. obligations under the CRPD exactly the same as those under domestic law when it comes to prisoners. In turn, that would give one group of people—prisoners—explicit second-class status under the CRPD, at least in the absence of a general RUD declaring that for all those subject to U.S. jurisdiction, the obligations of the United States under the CRPD are limited to those under U.S. law. Because prisoners are not a politically popular or powerful group, a reservation or declaration of this sort might conceivably be politically possible.

The most extreme reservation would be generally to limit the scope of Article 4 to that of the domestic law of the United States. A reservation of this sort would avoid any drawing of attention to the practice of solitary confinement and the question of whether it violates human rights. But if there were any textbook case for the invalidity of a reserva-

279. 42 U.S.C. §§ 12131, 12132; *see, e.g.*, Pa. Dep't of Corr. v. Yeskey, 524 U.S. 206 (1998).

Included in SCDC' 4.29.19 letter to LOC

tion as "incompatible with the object and purpose" of a treaty,[280] it would be just this. What is the point of ratifying a treaty if its entire substantive content is effectively cancelled in favor of domestic law in the course of ratification—which is what such a reservation would accomplish in practice? Obviously, a reservation that essentially replaced the content of the treaty with current or future domestic law would entirely negate the purpose of the treaty. A reservation of this sort might well be invalid under international law, and more importantly, under the CRPD itself. As previously metioned, Article 46 of the CRPD states, "Reservations incompatible with the object and purpose of the present Convention shall not be permitted."[281] The importance of this observation is not that the reservation would be struck down by a court or international body, but that the Senate would be unlikely to adopt it in the first place.[282]

In short, crafting a reservation or understanding that would effectively remove prolonged solitary confinement from international scrutiny under the CRPD may well prove politically and legally impossible. One possibility is that the Senate, upon drawing such a conclusion, would reject the treaty in its entirety. Doing so would be unfortunate, and it would effectively amount to a concession that prolonged solitary confinement is inconsistent with a major human rights treaty. Alternatively, the Senate might proceed with ratification, accepting as a price of the benefits of ratification the strong possibility that U.S. practice in supermax facilities would now be subject to a new level of international scrutiny. Which path the Senate takes remains to be seen.

VII. Conclusion

Supermax solitary confinement runs counter to international human rights law, undercutting its fundamental aim of "preserving the right to human dignity."[283] The international community has developed a broad understanding and appreciation of the mental effects produced by solitary confinement, and the United States should follow suit.

Even weighted down with qualifying conditions, U.S. ratification of the CRPD has the potential to vindicate the rights of prisoners in

280. CRPD, *supra* note 4, art. 46.

281. *Id.*

282. Adopting such a reservation would put the United States in the company of states that ratified the Convention on the Elimination of All Forms of Discrimination Against Women, but took a general reservation to Article 2 (requiring states to take appropriate measures to implement the Convention) that made compliance subject to Sharia law. *See* Belinda Clark, *The Vienna Convention Reservations Regime and the Convention on Discrimination Against Women*, 85 Am. J. Int'l L. 281, 299–300 (1991).

283. Miller, *supra* note 117, at 167.

Included in SCDC' 4.29.19 letter to LOC

supermax solitary confinement. Even reduced largely to a moral statement rather than a legal instrument, the CRPD might help guide the United States in drafting legislation and forming policy. It could provide the groundwork for the gradual limitation and elimination of supermax solitary confinement. Indeed, even as the treaty awaits ratification, it has some force, given that we have signed it. The Secretariat for the CRPD has stated:

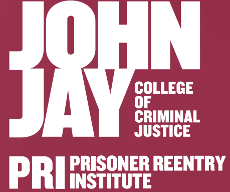
> [B]y signing the Convention or Optional Protocol, States or regional integration organizations indicate their intention to take steps to be bound by the treaty at a later date. Signing also creates an obligation, in the period between signing and ratification or consent to be bound, to refrain from acts that would defeat the object and purpose of the treaty.[284]

The time to begin bringing U.S. practice into conformity with the CRPD is now.

284. *See* Secretariat for the Convention on the Rights of Persons with Disabilities, *Becoming a Party to the Convention and the Optional Protocol*, U.N. ENABLE, http://www.un.org/disabilities/default.asp?id=231 (last visited Aug. 10, 2011). *See also* Vienna Convention, *supra* note 54, art. 18.

Included in SCDC' 4.29.19 letter to LOC

Included in SCDC' 4.29.19 letter to LOC



Solitary Confinement:

Ending the Over-Use of Extreme Isolation in Prison and Jail

A Report on a Colloquium to Further a National Consensus

September 30 – October 1, 2015

Included in SCDC' 4.29.19 letter to LOC

Solitary Confinement:

Report on a Colloquium to Further a National Consensus On Ending the Over-Use of Extreme Isolation in Prisons

Martin Horn, Convener
Ann Jacobs, Co-Convener

September 30 – October 1, 2015

John Jay College of Criminal Justice
New York City

Included in SCDC' 4.29.19 letter to LOC

Acknowledgments

John Jay College wishes to thank the Jacob and Valeria Langeloth Foundation for making this project possible. The Foundation is committed to promoting effective and creative programs, practices, and policies related to healing from illness, accident, physical, social or emotional trauma, and to extending the availability of programs that promote healing to underserved populations. They have taken a leading position in supporting efforts to ameliorate the effects of extreme social isolation and, through their efforts, have moved the conversation forward in important ways. This Colloquium was conceived to further that work.

We are very grateful to the committed corrections executives and the advocates who took three days from their busy schedules to participate in this ambitious effort to find areas of consensus on a very challenging topic. This was a working meeting and no one worked harder than the three facilitators who guided the work groups in addressing a range of difficult questions: Brian Fischer, retired Commissioner, New York State Department of Corrections and Community Supervision; Andie Moss, President of The Moss Group, Inc.; and Professor Michael Mushlin of Pace University Law School. Their leadership was supported and documented by our able team of reporters: Susruta Sudula and Jennifer Peirce of John Jay, Abigail Marion and Nick Reck of Columbia Law School, and Erika Danielsen and Sarah Lusk of Pace University Law School.

This Colloquium was designed and directed by Martin Horn and was made possible through the support of the staff of the Prisoner Reentry Institute (PRI) at John Jay College of Criminal Justice. We particularly wish to thank Daonese Johnson-Colón and Aimée Baker, whose skill and perseverance ensured that the Colloquium would be well managed, and Lila McDowell who was involved in the production of this report. We also thank Cindy Reed, our editor, who sought to make sure that the hard work of the group was presented in a manner that could benefit others wrestling with similar issues.

Finally, the outcome of the Colloquium, these discussions, and our recommendations are the result of the commitment and hard work of our facilitators: Brian Fischer, retired Commissioner, New York State Department of Corrections and Community Supervision; Andie Moss, President of The Moss Group, Inc.; and Professor Michael Mushlin of Pace University Law School. Their leadership was supported and documented by our able team of reporters: Susruta Sudula and Jennifer Peirce of John Jay, Abigail Marion and Nick Reck of Columbia Law School, and Erika Danielsen and Sarah Lusk of Pace University Law School.

Included in SCDC' 4.29.19 letter to LOC

Table of Contents

Acknowledgments i

About The Jacob & Valeria Langeloth Foundation iv

About The John Jay College of Criminal Justice & The Prisoner Reentry Institute v

Participants vi

Executive Summary 1

Introduction 3

Format and Themes 4

Part I | Case Study Presentations 6

A. Reduction in Segregation in Washington State, presented by Bernie Warner, Secretary of Corrections, State of Washington 6

B. Reforms for Youth at Rikers Island in New York City, presented by Joseph Ponte, Commissioner of Correction, City of New York 7

C. Removal of the Seriously Mentally ill from Administrative Segregation in Colorado, presented by Rick Raemisch, Executive Director, Colorado Dept. of Corrections 8

Part II | Work Group Discussions 9

A. Reducing Reliance on Long-Term Segregation/Isolated Confinement as a Corrections Tool (Group 1) 9

1. Criteria for Using Segregation 11

2. Viable Alternatives to Segregation 12

3. The Role of Transparency 12

4. Barriers to Reform 12

B. Managing Prison Gangs and Dangerous, Predatory Individuals Effectively and Safely without the Use of Isolated Confinement (Group 2) 13

1. Behaviors as the Criteria for Segregation 15

2. Defining Types of Segregation 16

3. Maximum Length of Time for Short-Term/Punitive Segregation 17

4. Alternatives to Segregation 18

5. Due Process 18

6. Transparency and Accountability 18

7. Staff Buy-in 19

8. Strategies for Change 19

Included in SCDC' 4.29.19 letter to LOC

C. Managing Vulnerable Individuals, such as individuals with Mental Illness, Youth, and Protective Custody Populations Without the Use of Solitary Confinement (Group 3)....20

1. Defining the Scope: Who are the Vulnerable Populations?....22

2. Housing Vulnerable Persons: Should Vulnerable Individuals be Held in Separate Groups or Can They Live in the General Prison Population and, if so, Under What Conditions?....24

3. Discipline and Isolation for Vulnerable Persons: When, if Ever, Can Isolation Be Imposed on Vulnerable Individuals, and Under What Conditions?....25

4. Should There Be a Classification Appeal for Vulnerable Individuals?....28

5. The Importance of Accountability and Transparency....28

6. The Road Ahead: Barriers to Reaching Goals Related to Vulnerable Populations....29

Part III | Recommendations....30

Part IV | After the Colloquium - Next Steps....34

Appendix A | Biographies....36

Appendix B | Presentation by Bernie Warner, Secretary of Corrections, State of Washington....45

Appendix C | Presentation by Joe Ponte, Commissioner of Correction, State of New York....50

Appendix D | Presentation by Rick Raemisch, Executive Director, Colorado Department of Corrections....53

Included in SCDC' 4.29.19 letter to LOC

About The Jacob & Valeria Langeloth Foundation

The Langeloth Foundation views the field of healing broadly, recognizing that in many cases helping people to heal may also help to prevent future problems. The constitution of the World Health Organization defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. For the Langeloth Foundation, healing is seen as including not only physical recovery from illness, accident or trauma, but also the emotional dimensions of recovery.

The Foundation's grant-making program is centered on the concepts of health and well-being. The Foundation's purpose is to promote and support effective and creative programs, practices and policies related to healing from illness, accident, physical, social or emotional trauma, and to extend the availability of programs that promote healing to underserved populations.

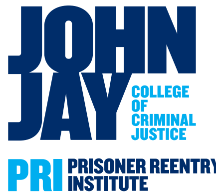
The Foundation is particularly interested in funding programs that address the health of individuals who, because of barriers to accessing care, experience poor and sub-optimal health, including: those with no or severely limited income, cultural differences, lack of English language skills, lack of health insurance or inadequate health insurance, limited access to health care services, mental illness, substance abuse, homelessness, incarceration, and exposure to trauma. More specifically, the Foundation favors proposals that seek to promote healing, healthy lives and healthy communities through:

- Innovative demonstration projects that address a major gap in the field
- Outreach to communities and populations whose health care needs are not being met
- Targeted advocacy efforts for vulnerable populations
- Collaboration among providers and other organizations

The Jacob and Valeria Langeloth Foundation

Scott Moyer, President
Andrea Fionda, Program Officer
New York City
WWW.LANGELOTH.ORG

Included in SCDC' 4.29.19 letter to LOC



About John Jay College Of Criminal Justice

John Jay College of Criminal Justice of The City University of New York is an international leader in educating for justice, offering a rich liberal arts and professional studies curriculum to upwards of 15,000 undergraduate and graduate students from more than 135 nations. In teaching, scholarship, and research, the College approaches justice as an applied art and science in service to society and as an ongoing conversation about fundamental human desires for fairness, equality, and the rule of law.

John Jay is a community of motivated and intellectually committed individuals who explore justice in its many dimensions. The College's liberal arts curriculum equips students to pursue advanced study and meaningful, rewarding careers in the public, private, and non-profit sectors. Its professional programs introduce students to foundational and newly emerging fields and prepare them for advancement within their chosen professions.

Martin F. Horn is the Distinguished Lecturer in Corrections at the John Jay College and serves as Executive Director of the New York State Sentencing Commission by appointment of the Chief Judge of the State of New York. He served as Commissioner of the New York City Department of Probation and simultaneously as Commissioner of the New York City Department of Correction, the City's jail system. For five years, Horn served as Pennsylvania's Secretary of Corrections. Earlier, Horn was executive director and chief operating officer for the New York State Division of Parole and held a variety of positions within the Department of Correctional Services, including Superintendent of Hudson Correctional Facility.

The Prisoner Reentry Institute (PRI), directed by Ann Jacobs, is one of twelve institutes that collectively comprise the Research Consortium of John Jay College of Criminal Justice. The mission of PRI is to spur innovation and improve practice in the field of reentry by advancing knowledge, translating research into effective policy and service delivery, and fostering effective partnerships between criminal justice and non-criminal justice disciplines.

Professor Horn and PRI collaborated on designing and conducting the Colloquium on Solitary Confinement.

John Jay College of Criminal Justice Prisoner Reentry Institute

Jeremy Travis, President, John Jay College of Criminal Justice
Martin Horn, Distinguished Lecturer, John Jay College of Criminal Justice
Ann Jacobs, Director, Prisoner Reentry Institute

New York City
JJAY.CUNY.EDU
JOHNJAYPRI.ORG

Participants

Corrections Officials

John Baldwin
Illinois Department of Corrections

Jeffrey A. Beard
California Department of Corrections and Rehabilitation

Leann K. Bertsch
North Dakota Department of Corrections and Rehabilitation

Marshall Fisher
Mississippi Department of Corrections

Carol Higgins O'Brien
Massachusetts Department of Corrections

Gary M. Lanigan
New Jersey Department of Corrections

Gregg Marcantel
New Mexico Corrections Department

Terri McDonald
Los Angeles County Sheriff's Department

Shirley Moore Smeal
Pennsylvania Department of Corrections

Joseph Ponte
City of New York Department of Correction

Rick Raemisch
Colorado Department of Corrections

Scott Semple
Connecticut Department of Corrections

Bryan P. Stirling
South Carolina Department of Corrections

Bernie Warner
Washington State Department of Corrections

Heidi E. Washington
Michigan Department of Corrections

Advocates

Sarah Baumgartel
Yale Law School
New Haven, Connecticut

Jack Beck
Correctional Association of New York
New York, New York

Brett Dignam
Columbia Law School
New York, New York

Jamie Fellner
Human Rights Watch
New York, New York

Amy Fettig
American Civil Liberties Union
Washington, DC

Robert Fleischner
Center for Public Representation
Northampton, Massachusetts

Stuart Grassian, MD
Chestnut Hill, Massachusetts

Ron Honberg
National Alliance on Mental Illness
Arlington, Virginia

Terry A. Kupers, MD
Institute for Global Communications
Oakland, California

Jules Lobel
Center for Constitutional Rights &
University of Pittsburgh School of Law
Pittsburgh, Pennsylvania

Joe Luppino-Esposito
Right on Crime
Texas Public Policy Foundation
Washington, DC

Rev. Laura Markle Downton
National Religious Campaign Against Torture
Washington, DC

Taylor Pendergrass
New York Civil Liberties Union
New York, New York

Heather Rice-Minus
Prison Fellowship/Justice Fellowship
Landsowne, Pennsylvania

Margo Schlanger
University of Michigan School of Law
Ann Arbor, Michigan

Facilitators

Brian Fischer
Retired NYS Department of Corrections and Community Supervision

Andie Moss
The Moss Group, Inc.
Washington, DC

Michael B. Mushlin
Pace University School of Law
White Plains, New York

Invited Observers

Andre Bethea
U.S. Department of Justice's Bureau of Justice Assistance
Washington, DC

Andrea Fionda
Jacob & Valeria Langeloth Foundation
New York, New York

Marie Garcia
National Institute of Justice
Washington, DC

Lila Kazemian
John Jay College of Criminal Justice
New York, New York

Jeff Mellow
John Jay College of Criminal Justice
New York, New York

Scott Moyer
Jacob & Valeria Langeloth Foundation
New York, New York

Bettina Muenster
John Jay College of Criminal Justice
New York, New York

Fred Patrick
Vera Institute of Justice/Center on Sentencing and Corrections
New York, New York

Sara Sullivan
Vera Institute of Justice/Center on Sentencing and Corrections
New York, New York

Judith Resnik
Yale Law School
New Haven, Connecticut

Included in SCDC' 4.29.19 letter to LOC

Reporters

Erica Danielsen
Pace University School of Law
White Plains, New York

Sarah Lusk
Pace University School of Law
White Plains, New York

Abigail Marion
Columbia Law School
New York, New York

Jennifer Peirce
John Jay College of Criminal Justice
New York, New York

Nick Reck
Columbia Law School
New York, New York

Susruta Sudula
John Jay College of Criminal Justice
New York, New York

Colloquium Staff

John Jay College of Criminal Justice:

Martin F. Horn
Distinguished Lecturer, Department of Law, Political Science and Criminal Justice Administration

Maria Barrera Vilert
Graduate Assistant

John Jay College Prisoner Reentry Institute:

Ann Jacobs
Director

Daonese Johnson-Colón
Chief of Staff

Aimée Baker
Administrative Associate

Report on a Colloquium to Further a National Consensus on Ending the Over-Use of Extreme Isolation in Prisons

Executive Summary

With support from the Jacob and Valeria Langeloth Foundation, on September 30, 2015, John Jay College of Criminal Justice convened a colloquium including 15 corrections agency heads and a like number of attorneys, academics, and experts from the community of those seeking to reform the use of social isolation, often called "solitary confinement," in U.S. prisons and jails.

The purpose of the Colloquium was to determine if consensus might be achievable about ways to reform the use of social isolation by coming to common agreement rather than resorting to litigation. To facilitate discussion, all participating parties agreed to be bound by the "Chatham House Rule," that provides that the outcomes and discussion would be limited to the participants and that the report would not identify discussants by name or affiliation and that in the future the participants would not make reference to statements or admissions by other participants. The result was a remarkable two-day experience that generated a great deal of argument and debate, as well as an equally exciting degree of agreement and consensus. Instead of advocates and corrections officials experiencing an "us versus them" mentality, participants engaged in furthering what one attendee called "a shared mission and goal, but with different intelligences about the pathways to and barriers resisting change."

The gathering provided a first opportunity for many to meet with those they might previously have considered policy adversaries, enabling them to listen to and consider the other side's point of view, forge new friendships and alliances, and establish the basis for constructive conversation. An energized group emerged from the meeting united in the belief that the United States can do better to both limit how it employs extreme social isolation and to ameliorate many of the most damaging results from its overuse.

Included in SCDC' 4.29.19 letter to LOC

As a result of the deliberations, several clear themes and areas of agreement became apparent:

- ***The use of social isolation is greater than it has to be, in large measure because prisons have been called upon to do things they were never intended to do and are inadequately resourced to accomplish.***
- ***Persons with mental illness and other vulnerable populations who do not require imprisonment should be treated elsewhere.***
- ***The only criterion for confining a person to social isolation within prison should be behavior; persons should not be confined based upon their affiliation or status.***
- ***If isolation is used at all, a person should be separated from the general population for the least amount of time necessary and under the least restrictive conditions.***
- ***Separation from general population must always provide for adequate living conditions, meaningful routine, and periodic medical and mental health assessments.***
- ***Transparency and accountability in the use of segregated housing is essential.***
- ***Decisions about the use of social isolation in prison for disciplinary reasons should be made using an appropriate due process procedure.***
- ***The use of isolated confinement should be a last resort, and prison discipline should develop alternatives to isolated confinement as punishment, incorporating a continuum of measures to hold incarcerated persons proportionately accountable for their behavior.***
- ***Multi-disciplinary teams should make decisions about the use of segregation in prison for other reasons, with a view toward improving outcomes.***
- ***Isolated confinement for non-disciplinary reasons should not feel punitive to the affected individual.***
- ***The purpose of isolated confinement must be to improve the outcome for the affected individual and to make the prison and the community safer. To that end, there must be meaningful interventions designed to address the reasons for the confinement and attainable means for the individual to transition back to the general population of the prison.***
- ***Wherever and whenever possible, opportunities to relieve the social isolation of the confined individual should be employed.***
- ***Corrections administrators and advocates for incarcerated persons must work together to obtain political and financial support for needed changes.***
- ***Efforts should be made to educate line corrections staff about the utility of reform.***

These themes are reflected in the 24 specific recommendations contained at the end of this report, which can serve as a roadmap for reform. The road to reforming and reducing the use of extreme social isolation will be long and there remains much to be done. But, as the proverb says, a journey of a thousand miles begins with a single step. These recommendations can serve as the map to the first turn.

Included in SCDC' 4.29.19 letter to LOC

Introduction

Over the last three decades, corrections systems have increasingly relied on isolation and segregation as a prison management tool, even building entire "supermax" prisons where prisoners are held in extreme social isolation, often for years or even decades. The massive increase in the numbers of men, women, and children behind bars has placed extreme stress on existing facilities, corrections systems, and criminal justice budgets, which struggle to accommodate the unprecedented growth in population without the resources or political support necessary to create rehabilitative environments. Prison administrators were left with few tools to keep their prisoners safe and to enforce reasonable prison rules. This fostered an environment where the use of extreme social isolation and segregation became the default approach to addressing many of the complex challenges faced in operating places of detention and incarceration. On an average day in 2011–12, for example, up to 4.4% of the state and federal prison inmates and 2.7% of jail inmates were held in administrative segregation or extreme social isolation. Based on current prisoner populations, this translates into 69,000 state and federal prisoners and 20,100 jail inmates.[1]

Both legal and medical professionals have come to criticize extreme social isolation as unconstitutional and inhumane, pointing to the well-known harms associated with placing people, especially those with mental illness, in such confinement.[2] Research is also emerging which suggests that extreme social isolation can actually have a negative effect on public safety.[3] The results of this questioning of the status quo can be seen in administrative and legislative reform now occurring in jurisdictions around the country.[4] Corrections organizations are engaging on the topic and beginning to develop guidelines for the field.[5] Civil rights and human rights organizations, faith community leaders, lawyers, and mental health organizations all have called for reforms in policy and practice. There is a broad and emerging sense that the use of solitary confinement has gone too far in American correctional facilities. Promising approaches are emerging in some jurisdictions and political space is opening up for reform in numerous states.

While opinions on how to reform the use of isolation differ, common ground exists among corrections practitioners, academics and experts, and prison advocates on the need for change. This consensus provides a unique opportunity to form unlikely partnerships and explore alternative approaches to public engagement on one of the most pressing challenges to the safe, effective, and humane management of our prisons and jails: the over-use of prolonged social isolation.

To leverage this common ground, on September 30, 2015, John Jay College of Criminal Justice, with support from the Langeloth Foundation, convened a two day meeting between 15 corrections leaders, including state corrections directors and leading officials from the major urban jails, and 15 experts, academics, and leaders in the advocacy community working for reform of isolation practice. The goal of the meeting was to bring together these leaders to plan next steps, forge greater connections and collaborations, identify "lessons learned" from efforts to date, and formulate plans to ensure sustainability for a reform effort that still has much to accomplish.

Advocates and administrators emerged from the Colloquium unified in the belief that we must seize the momentum of the day to address and reduce the overuse of extreme social isolation across its myriad incarnations. The Colloquium demonstrated that while different constituents have different priorities, they share the overarching goal of creating a safe, measured, and humane correctional environment. Just as importantly, a reasoned discussion is not only possible, but also essential to progress.

Seizing on the increasingly recognized need for reform, the Colloquium facilitated a candid and productive discussion among key figures of the prison policy community regarding the use of extreme social isolation. From top correctional officials in 15 states to representatives from the ACLU, the Center for Constitutional Rights, the National Alliance for the Mentally Ill, and other organizations, many contrasting perspectives were brought to the table.[6] While disagreements remain, a single thread united the two days of spirited discussion: We have arrived at an extraordinary moment in time where real change is possible.

The outcome of the Colloquium is this document – a written reform agenda bearing the imprimatur of the participants and carrying "weight" in each of their communities of practice. In subsequent reports, John Jay College will document the changes and improvements resulting in the participating jurisdictions and identify the barriers that may have impeded their reform efforts.

Included in SCDC' 4.29.19 letter to LOC

Format and Themes

Case Study Presentations. The first day of the Colloquium began with presentations setting forth three case studies of reform: (i) reduction of segregation in Washington State; (ii) removal of the seriously mentally ill from administrative segregation in Colorado; and (iii) reforms for youth at Rikers Island in New York City. This opening session framed the successes and challenges of these approaches and built in time for lively discussion and comparative analysis among participants.

Small Group Sessions. Following the case studies, participants moved into small working groups designed to confront the core areas where reform is necessary, but hard questions about achieving real and meaningful change remain. These key areas included the following questions:

- *What does meaningful, effective, and humane order maintenance within correctional facilities look like without the use of isolation?*

- *How can correctional institutions respond to prison gangs and dangerous predatory individuals effectively and safely without the use of segregation/isolation housing?*

- *How can vulnerable individuals, such as the seriously mentally ill, pregnant women, and adolescents be protected adequately without the use of isolation?*

Developing a National Reform Roadmap. While the full group had different perspectives and agendas, the goal of the meeting was to establish specific areas of commonality to create a national roadmap for supporting the reduction in the use of long-term isolation. These points of common ground and consensus are outlined in the Recommendations section in Part III of this report.

Post-Colloquium Reporting. Progress towards realizing these principles will be self-reported by participants to Martin F. Horn, John Jay Coordinator, over the course of the next year. John Jay will report on the progress of these reform efforts and lessons learned.

Overarching Themes. This initial discussion raised several themes that would recur throughout the Colloquium, namely, definitional difficulty, goals for reform, and obstacles to reform.

- ***Defining Solitary Confinement.*** *One of the first challenges encountered was the lack of a uniform definition of solitary confinement. Administrative, disciplinary, and protective segregation are defined and treated differently across jurisdictions. Despite these distinctions, a common definition is key to reform, as failure to reach definitional consensus may lead to the continued misuse of extreme social isolation—albeit under a different name. The Colloquium largely settled on the Mandela Rules definition—22 hours of social isolation a day—as the base point for discussion, but was unable to reach consensus on an absolute limit to the duration of that confinement.*[7]

- ***Setting Goals for Reform.*** *The participants also discussed the goals of reform. One primary concern is curbing the negative effects of social isolation on the mental and physical well-being of incarcerated persons. Concurrently, the physical safety and mental health of the correctional staff is of paramount importance and must be a central focus for any reforms on the use of social isolation.*

  One participant suggested that when we talk about "segregated confinement" we need to distinguish between two concepts: ***"Separation"*** *versus* ***"Deprivation."***

  - ***Separation*** *is the need to keep an incarcerated person separated from some or all others because of danger. This would include, for example, isolation for infectious disease, restricted confinement to prevent harm to a suicidal patient, isolation of vulnerable persons from would-be aggressors, and the like.*

  - ***Deprivation*** *is the restriction of meaningful perceptual, social, and occupational stimulation. Deprivation leaves the individual with an inadequate basis upon which to maintain a state of attention and alertness, thus resulting in solitary confinement syndrome marked by stupor and delirium, along with a multiplicity of other burdens, such as loneliness and free-floating anxiety.*

Included in SCDC 4.29.19 letter to LOC

In practice, these two concepts are often not distinguished; an individual who needs to be separated is often exposed without cause to extensive deprivations. Moreover, imposing extensive deprivation, especially over long periods of time, creates problems and danger, rather than reducing them.

Participants frequently noted that social isolation is a form of intervention. Many people agreed that a shift from punitive, isolation-dependent models might well be displaced by positive reinforcement and incentive-based models. Such programs have shown promising outcomes, including decreased institutional violence and improved facility safety.[8] There is no real penological justification to put an individual in segregation for an administrative (as opposed to punitive or investigative) purpose without attempting to enrich his environmental opportunities as much as possible using such mechanisms as conjoint recreation, education, religious worship, books, writing material, letters, phone calls, and visits. Even in the case of punitive confinement, corrections staff must consider whether the deprivations – especially when imposed for more than a short period of time – serve any purpose in keeping the prison safe or in preparing individuals for return to general population or release to the larger community after their prison sentence ends.[9]

- ***Identifying Challenges to Reform.*** *Participants also identified numerous impediments to reform and discussed ways in which these barriers could be overcome:*

  - ***Staff*** *can be resistant to decreasing the use of isolation for fear that prison safety might be compromised if incarcerated persons are placed in less restrictive housing. Prison administrators noted that correctional professionals could be won over by highlighting that, in many instances, reducing the use of social isolation is correlated with lower rates of violence.*

  - ***Political support*** *for reform, though growing, must be expanded significantly.*

  - ***The public*** *is frequently resistant to increased expenditures on prisons. People might be more willing to invest in prison reform if administrators and advocates emphasize that because over 90% of all incarcerated persons will eventually return to the community, prison policy directly affects public safety. The treatment prisoners experience while incarcerated will determine their abilities and behaviors after release.[10] Advocates can be partners in communicating the financial and safety benefits of responsible segregation policy to the general public, relevant interest groups, correctional staff, and affected labor unions.*

  - ***Resource constraints*** *are another significant barrier to change. Even where prison administrators are able to cut costs, state legislatures frequently will not allow correctional officials to reallocate those funds within the correctional system. Instead, legislatures may reclaim the newly freed funds, effectively reducing correctional budgets.[11]*

  - *Current prison* ***architectural infrastructure*** *can be an impediment to reform. Supermax prisons were not designed for any useful purpose beyond detention, and correctional administrators strain to re-purpose them usefully as institutions that facilitate social interaction.*

  - *Lastly, participants noted that correctional facilities were never meant to be* ***mental health*** *care facilities. Yet the 20th century deinstitutionalization of the mentally ill has led too often to correctional re-institutionalization of these individuals.[12] Reform must address the abysmal shortcomings of the patchwork American mental health care system and the counter-therapeutic environment of prisons, neither of which addresses the root causes of these individuals' criminal behavior.*

Included in SCDC' 4.29.19 letter to LOC

Part I

Case Study Presentations

A. Reduction of Segregation in Washington State

*Presented by **Bernie Warner**, Secretary of Corrections, State of Washington, followed by comments from **Jack Beck**, Director, Prison Visiting Project, Correctional Association of New York (presentation available at Appendix A)*

Bernie Warner, Secretary of Corrections for the State of Washington, described the ongoing evolution in the use of restrictive housing in the State of Washington as an effort to move from suppression and containment toward intensive programming, and from punishment to the development of management tools to address the challenge presented by prisoners who cannot be safely managed in the general population of a prison. He identified the most important change as the recognition that one size does not fit all. The agency needs different responses to different people and mission-specific housing to target risk and be responsive to the needs of the prisoner. As he described it, their goal is to change behavior through programming and congregate activity, rather than through the mere service of time in socially isolating situations.

Warner pointed out that since the implementation of their new approach, the number of use of force incidents in the Washington State Penitentiary Intensive Management Unit have decreased and, at the Clallam Bay Corrections Center, where the Intensive Transition Program targets chronic Intensive Management recidivists and includes mixed cognitive-behavioral therapy, they are experiencing an 80% success rate. They have accomplished this by providing staff with more tools, training in motivational interviewing, and by encouraging interaction between prisoners and staff.

Following Warner's presentation and comments from Jack Beck, Director of the Prison Visiting Project of the Correctional Association of New York, Colloquium participants made the following observations:

- *A common definition for isolation or solitary confinement is necessary so that practices can be compared and monitored, but is difficult to pin down given the variation in practices and terminology throughout the prison system;*
- *Uniform definitions are also needed for disciplinary, administrative, and long-term segregation, because without such standardization, some programs purporting to curtail isolation practices might continue severe isolation under euphemistic titles; Trauma suffered by corrections officers is weighty and must be addressed;*
- *Culture change among corrections officers is necessary to effect reforms, but might require significant changes to hiring practices given the reluctance of unions to embrace change where there is perceived risk to their members' safety;*
- *Informing corrections officers that new policies promote officer safety has been effective in reforming facility culture;*

Included in SCDC' 4.29.19 letter to LOC

- *Merit-based approaches to getting out of social isolation/segregation may not properly capture a given individual's level of fault;*

- *Additional research needs to be conducted on the impact of various isolation methods on mental health;*

- *There is danger in releasing individuals directly from segregation into the general prison population or the community; and*

- *One way to monitor practices is to enhance opportunities for additional transparency and access to prisons by outside groups.*

B. Reforms for Youth at Rikers Island in New York City

*Presented by **Joseph Ponte**, Commissioner of Correction, City of New York, followed by comments from **Ron Honberg**, Senior Policy Advisor, Advocacy & Public Policy, National Alliance on Mental Illness (presentation available at Appendix B)*

Joseph Ponte, Commissioner of Correction for the City of New York, described the 14-point program to reduce violence adopted by the New York City jails. New York City's agenda includes efforts to keep weapons and drugs out of the jails, create an integrated classification and housing strategy, design and implement effective inmate educational opportunities and services, and support culture change through expanded training throughout the agency.

As part of this effort, the City is implementing new leadership development training, revamping their internal investigations, improving their recruitment, hiring and staff selection plans, and putting in place a performance management plan that includes operational metrics and analysis. Additionally—and equally importantly—the City is working to improve facility maintenance so that all housing units are in a good state of repair and changing its custody management processes.

Following Ponte's presentation and comments from Ron Honberg, Senior Policy Advisor with the National Alliance on Mental Illness, participants raised the following points for exploration:

- *The importance of corrections officials expressing how the failures of the American mental health system has impacted corrections;*

- *Lack of commitment from elected officials to recognize the problem in the American mental health system and a lack of understanding as to how such reform can be institutionally vital to corrections;*

- *That the "deinstitutionalization [of the American mental health system] led to a different kind of institutionalization";*

- *The importance of understanding different categories of responses to and impacts of isolation, including social, perceptual, and occupational; and*

- *Definitions of isolation are not "black and white."*

Included in SCDC' 4.29.19 letter to LOC

C. Removal of the Seriously Mentally Ill from Administrative Segregation in Colorado

*Presented by **Rick Raemisch**, Executive Director, Colorado Department of Corrections, followed by comments from **The Reverend Laura Markle Downton**, Director, U.S. Prisons Policy and Program, National Religious Campaign Against Torture (presentation available at Appendix C).*

Rick Raemisch, Executive Director of the Colorado Department of Corrections, began his presentation by describing the events surrounding the assassination of Tom Clements, his predecessor at the Colorado DOC, who was murdered by Evan Ebel, a formerly incarcerated person who had spent considerable time in restrictive housing. Raemisch described his approach since taking office as telling staff to "just open the door." The Colorado DOC policy is to establish and provide effective restrictive housing management procedures for offenders who have demonstrated through their behavior that they pose a significant risk to the safety and security of staff and other offenders, as well as to the safe and orderly operation of general population. The use of Restrictive Housing, to include Maximum Security Status, is an offender management process requiring specific action and review for placement and/or progression. The Colorado DOC has taken to heart the United Nations Mandela rule and believes "indefinite solitary confinement should be abolished," and that by opening the door, you open opportunities. From housing 1484 prisoners in administrative segregation in May 2011, the Colorado DOC now has an entirely empty maximum-security prison.

Following Raemisch's presentation and comments from Rev. Laura Markle Downton, Director of U.S. Prisons Policy and Program for the National Religious Campaign Against Torture, participants raised the following concerns and issues for discussion:

- *Prisons must respect an incarcerated person's inherent dignity;*
- *Disparate racial outcomes in the use of social isolation must be addressed;*
  Trauma suffered by corrections officers is weighty and must be addressed;
- *Incentive structures are more effective in reforming problematic behavior, even among people with mental illness, and should be broadly implemented;*
- *Reforms and practice must recognize gender differences, as women very rarely need isolation and rarely respond positively to its use;*
- *It will be difficult to re-purpose supermax prisons for any other housing uses;*
- *Colorado's quick turnaround in results is an example of what energized leadership can accomplish, suggesting that perhaps organizational culture is not as much of a barrier as is often discussed;*
- *Therapy dogs are an example of an effective intervention that can be used as an alternative to isolation; and*
- *More must be done to address mental illness in the prison population. Simply noting the trouble with America's mental health system may serve merely to pass the buck.*

Included in SCDC' 4.29.19 letter to LOC

Part II

Work Group Discussions

Following the three case study presentations, participants were organized into three groups of ten for facilitated small group discussions. Each group focused on one aspect of social isolation:

- *Group 1: Reducing Reliance on Long-Term Segregation/Isolated Confinement as a Corrections Tool*
- *Group 2: Managing Prison Gangs and Dangerous, Predatory Individuals Effectively and Safely Without the Use of Isolated Confinement*
- *Group 3: Managing Vulnerable Individuals, Such as Individuals with Mental Illness, Youth, and Protective Custody Populations Without the Use of Isolated Confinement*

For each key area, the groups addressed the following three questions:

- *What strategies and programs can be used to ameliorate social isolation effectively where segregated housing is necessary for the safety and security of an individual/institution?*
- *What is necessary to effectuate reform?*
- *What are the barriers to reform and how can we overcome them?*

The small work groups were tasked with reaching consensus on as many specific reform recommendations as possible. The discussions of each are laid out in turn below.

A. Reducing Reliance on Long-Term Segregation/Isolated Confinement as a Corrections Tool (Group 1)

Group 1 tackled the key issue of reducing the overall segregation population while creating alternative tools and strategies for the management of correctional institutions without over-reliance on isolation. A central question for this group was: What strategies and tools allow correctional institutions to maintain order and hold prisoners accountable for their behaviors in meaningful, effective, and humane ways without excessive reliance on extreme social isolation?

Included in SCDC' 4.29.19 letter to LOC

Background and Context. Currently, segregation/isolated confinement is too often used as a one-size-fits-all approach to correctional management. It is used for multiple purposes: discipline for rules violations; "protective custody" for vulnerable prisoners; and housing for disruptive or dangerous prisoners. As corrections strategies, such placement of inmates can be unnecessary and even counterproductive for prison and public safety. Using isolated confinement as a default management tool has led to the over-use of this extreme form of housing, incurring unsupportable human and fiscal costs.

Recent research conducted by the Vera Institute of Justice indicates that isolated confinement is too often used to punish minor misbehavior rather than true threats to institutional security. In Illinois, for example, Vera's data analysis found that "more than 85 percent of the people released from disciplinary segregation during a one-year period had been sent there for relatively minor infractions, such as not standing for a count and using abusive language." Similarly, according to Vera, in Pennsylvania, 85% of prisoners found guilty of "failure to obey an order" were placed in isolated confinement, and this charge was the most common violation among prisoners in the isolation units.

Auditing the actual use of isolated confinement to ensure that the population housed there includes only individuals who are guilty of serious misconduct requiring separation is critical for all systems, as is creating alternative tools and practices that better serve safety, security, and rehabilitative purposes. But once isolated confinement populations are so limited, the question remains how to assist prisoners who are justifiably assigned there to expeditiously move out and stay out. Setting up programs that establish privilege levels within isolation units that give inmates clear guidance on the behavior necessary to move to the next level is one step. Ameliorating the conditions of extreme isolation on such units is another goal, including increasing access to group activities; fostering more staff-prisoner interaction; and creating more opportunities for both structured and unstructured out-of-cell time.

A number of correctional systems have implemented such programs. Research on their efficacy is still thin. Some have noted that these programs fail to account for the behavioral problems endemic in isolated confinement—often caused by the psychological stress that confinement induces or exacerbates—and, as a result, fail to create practical mechanisms for allowing inmates to work their way out of segregation. In particular, questions have been raised about programs and strategies that require perfect behavior or penalize minor misbehavior with months and months of additional time in segregation. Preventing long-term stays in isolated confinement both before and after placement must be an objective. But systems continue to grapple with defining what is sufficient compliance with rules to demonstrate that an inmate no longer needs to be placed in isolation housing for safety or security reasons and how to punish misbehavior without resort to isolation.

Questions for Discussion. Group 1's conversation on these issues was guided by the following discussion questions:

- *What behaviors require the use of segregation?*
- *What are the criteria for using segregation?*
  - *For how long?*
  - *What procedures should apply?*
  - *What should be the standard for review?*
    - *Appeal*
    - *Length of stay/reduction in stay/step down*
  - *What should conditions be like for these prisoners?*
    - *Can we humanize conditions in ways that are safe and secure?*

Included in SCDC' 4.29.19 letter to LOC

- *Does staff working in these areas need special skills? What are they?*
  - *Are there structural changes needed? E.g., staffing patterns? Architecture?*

- *How can we do segregation without extreme social isolation?*
- *What resources would be needed to provide the process and conditions recommended?*
- *What oversight and controls are necessary to ensure the limited use of segregation?*

- *For those prisoners whose behavior does not merit segregation, what penalties/ incentives should apply?*
  - *What other alternatives to segregation need to be considered?*
  - *What resources would be needed to make these penalties effective?*
    - *What would a realistic incentive structure look like?*
- *What is the role of transparency and accountability in ensuring the success of these units?*
- *What are the barriers to achieving these reforms?*
  - *How can we overcome them?*
  - *How can we ensure and document continued operationalization of these reforms?*

Conversations and Areas of Consensus. In considering these questions, Group 1 maintained the Colloquium's commitment to voicing a diverse range of opinions while engaging in a robust discussion on the role of segregation as a correctional tool. To narrow its dialogue, the group's discussion was generally limited to disciplinary segregation; participants explicitly did not consider administrative segregation or other forms of isolation. The group focused on four issues: the criteria for using segregation, viable alternatives to segregation, the role of transparency, and the barriers to reform.

***1.* Criteria for Using Segregation.** The group reached consensus on several key points. First, all participants agreed that segregation should be used for the minimum time and in the least restrictive conditions necessary to resolve the issue that led to isolation. Participants further agreed that all isolation should have an incentive component, which would restore certain privileges if the individual is able to reach certain behavioral goals. Ideally, these incentive programs would operate on relatively short timeframes—e.g., two days of good behavior earns a reward—so that the individual would quickly begin to see their good behavior pay off. Participants also agreed that isolation should have a goal of changing specific behavior and an individualized achievable path to reach it.

As to the conditions of social isolation, Group 1 members agreed that segregation must include mental health rounds, health care rounds, and basic adequate living conditions such as physical space, light, and air. Participants also agreed that there should be a minimum amount of family contact allowed while individuals are in segregation, as the loss of family contact can be extremely agitating for both the incarcerated person and the family. Increasing family contact and visits could thus prove to be a strong incentive to produce improved behavior.
Group 1 also reached consensus that there must be due process protections in place. These must include procedural safeguards for placement in segregation, periodic review of an individual's status during segregation, and an exit mechanism. This process should consider the severity of the offense, the length of time spent in segregation, fairness, and the ability of the individual to comply with imposed conditions.

Group 1 did not reach consensus on an acceptable duration for periods of isolation. About half of the participants agreed that disciplinary segregation must be for a determinate length of time and recommended that disciplinary segregation not exceed 15 days, unless extenuating circumstances otherwise dictate. Of those who disagreed with a hard 15-day upper limit, several participants preferred to use the 15-day mark to trigger a procedural review of whether to extend time in isolation, rather than as a hard upper limit. Other participants suggested that the 15-day limit might be used to trigger a different type of segregation with increased access to, for example, television or some type of congregate activity. Others felt that a year in isolation would be an acceptable limit for serious offenses, such as rape or seriously assaulting a staff member.

2. Viable Alternatives to Segregation. Group 1 discussed the use of alternatives to the default use of segregation, agreeing that punishment should be imposed on a continuum, with segregation used as a tool of last resort. Less serious punishments might include loss of commissary privileges or personal property. For more serious infractions or after other punishments have proved ineffective, corrections officials might impose loss of programming, social contact, and/or family contact. Group members agreed that the loss of privileges must be proportionate to the infraction and include a prosocial incentive system for their restoration.

3. The Role of Transparency. Both advocates and administrators were quick to acknowledge the importance of transparency in furthering reform. Transparency increases awareness and trust for the public, prison staff, and incarcerated people. Advocates tended to focus on the importance of granting faith-based, academic, civil rights, and rehabilitation organizations internal access to correctional facilities and data collection. Correctional administrators were particularly interested in internal feedback loops between prison administrators, the staff, and the incarcerated regarding behavior and punishment expectations. The group agreed that such communication between advocates and correctional administrators may avoid needless litigation, assure the responsible stewardship of funds, and help both correctional staff and the public at large to understand reform in public safety terms. In turn, transparency of statistics about the use of segregation and a public safety narrative could serve to educate all interested parties about the benefits of reducing long-term isolation.

4. Barriers to Reform. Group members most easily reached consensus on the multitude of problems both advocates and administrators face in effecting change. Participants agreed that efforts must be made to obtain staff "buy in" on reforms from the outset. Correctional management should find ways to celebrate courage in the service of public safety through small victories, so that when the inevitable tragic but isolated incident occurs, they can resist the impulse to abandon all reform. If staff is invested, change will be collaborative, rather than totalitarian. Absent such involvement, corrections staff will have less incentive to implement reforms, especially if they perceive risk to their personal safety and/or face opposition from unions, victims' rights advocates, and other interest groups.

All Group 1 members were quick to agree that limited resources create a significant barrier to reform. Supermax prisons, for example, cannot easily be transformed into rehabilitative programming spaces. Legislatures have little political cover or incentive to lead reform efforts. In many jurisdictions, correctional staff is grossly underpaid and has little incentive to see themselves as part of the rehabilitative process rather than as "just guards."

Participants acknowledged the importance of clear messaging and outreach to promote the public safety narrative as a means of fighting inertia. That narrative – that the use of isolation actually decreases the safety of the prison, inmates, guards and, ultimately, the community to which these prisoners return – must be communicated to correctional staff, who face considerable mental and emotional trauma in addition to physical danger, as well as to the media, general public, and immediate community around a prison. That message is that the "tough on crime" opposition to reform is ultimately "tough on the community." A partnership between advocates and correctional administrators can play a vital part in fostering reform through a public safety narrative.

Included in SCDC' 4.29.19 letter to LOC

B. Managing Prison Gangs and Dangerous, Predatory Individuals Effectively and Safely Without the Use of Isolated Confinement (Group 2)

Group 2 tackled the serious policy and practice issues involved with managing the population of inmates who do present a legitimate security risk and require some form of segregation. Group 2 considered two central questions:

> **1.** When inmates must be segregated because they are dangerous or disruptive, how can social isolation and environmental deprivation be ameliorated safely and what strategies can be used to return those prisoners to general population and the community?
>
> **2.** Concurrently, how can correctional systems deal effectively with Security Threat Groups (STGs)/prison gangs without reliance on segregation or with limited segregation?

Background and Context. Once correctional facilities reduce their segregation populations to the individuals who need to be there for legitimate safety/security reasons, questions remain about the conditions under which those individuals are housed, as well as the impact of such housing on rehabilitation and ultimately a safe return to the community. Many systems are employing strategies to reduce social isolation for even the most disruptive of prisoners, such as providing access to television, radio, books, MP3 players, and in-cell programming. Increasing social interaction through one-on-one and group programming has also met with success. Allowing increased access to outdoor exercise and recreation, as well as increasing dayroom time and other privileges such as visitation and phone calls, are other areas where systems can enhance social interaction and environmental stimulation to lower the psychological stress of isolated confinement.

Ensuring that conditions in segregation do not damage the physical and mental health of prisoners is central to efforts to make such units more humane and effective. In response, some systems are putting in place policies and practices that rigorously monitor health conditions for prisoners in segregation housing. This is achieved by mandating more frequent and in-depth rounds by health staff; facilitating better communication and coordination between health care and custody staff; allowing prisoners confidential opportunities to seek treatment; and facilitating staff opportunities to observe and talk with prisoners and incorporate such observations into case work and unit management strategies.

Another notable challenge for ameliorating isolation conditions is finding ways to surmount the architectural barriers of some institutions to create more socially stimulating environments while maintaining safe and secure units. A key constraint/challenge for implementing reform and improving outcomes in these units is ensuring that corrections staff have the tools and skills necessary to deal with difficult and potentially dangerous populations without defaulting to the extreme measure of social isolation and lockdown.

Beyond ameliorating the worst features of isolated confinement in corrections, a key challenge remains in the management of prison gangs. Some have pointed to problems of overuse, confining persons not deeply involved in gang culture, in relying on isolation and containment strategies, while others have noted the failure of such strategies to either abate or prevent prison gang activity in most systems. Fresh approaches based on community models may hold out some promise for building alternatives to the segregation model of gang management, but further research and investigation is necessary to build more effective programs and strategies in this critical area.

Included in SCDC' 4.29.19 letter to LOC

Questions for Discussion. Group 2's conversation on these issues was guided by the following questions and topics:

- *What behaviors require the use of segregation?*
  - *Are different responses required for prison gangs than for dangerous predatory prisoners? If so, what are the differences?*
  - *For how long?*
  - *What procedures should apply?*
  - *What should be the standard for review?*
    - *Appeal*
    - *Length of stay/reduction in stay/step down*
  - *What is an effective approach to gang de-briefing/renouncing that would allow inmates previously involved in serious gang activity to move safely back to a general population setting?*
  - *What resources would be needed to make these penalties/incentives effective?*
  - *What oversight and controls are necessary to ensure the limited use of segregation?*
- *What should conditions be like for these prisoners?*
  - *Can we humanize these environments in ways that are safe and secure?*
  - *What resources would be needed to provide the process and conditions recommended?*
  - *What programs/policies are necessary to return these prisoners either to general population or the community in a safe manner?*
- *What alternatives to segregation and isolated confinement can be used to deal with prison gang problems in prisons and jails?*
  - *Are there community models that can be transferred to the correctional setting?*
  - *What does effective gang prevention, as opposed to using a containment model, look like in a correctional setting?*
- *Does staff working in these areas need special skills? What are they?*
- *Are there structural changes needed such as staffing patterns and architecture?*
- *What type of internal and external oversight is necessary to ensure that reforms are successful and lasting?*
- *What is the role of transparency and accountability in ensuring the success of these units?*
- *What are the barriers to achieving these reforms?*
- *How can we overcome them?*
- *How can we ensure and document continued operationalization of these reforms?*

Conversations and Areas of Consensus. Group 2's early conversation demonstrated the range of perspectives on its major themes of discussion, such as who should be put in segregation, for what reasons, under what rules, and with what level of transparency. Group members reached significant agreement on some questions, particularly the categories of people and/or behaviors that should or should not be eligible for segregation, but experienced a divergence of opinion on others, notably as to the appropriate conditions of confinement.

The scope of the questions sparked one participant to begin the conversation with a fundamental baseline inquiry: Is segregation ever necessary? There was a clear division here. Some participants argued that because there is no evidence that segregation deters either the individual or the general population, it does not achieve its intended results in terms of

Included in SCDC' 4.29.19 letter to LOC

behavior change, deterrence, or safety and, therefore, should not be used except for logistical reasons, such as during an investigation. Additionally, several participants said that there is little evidence – research or anecdotal – about what interventions or practices work to change behavior during periods of segregation. Other participants suggested that segregation is an appropriate punishment for egregious transgressions and/or to manage individuals who are seriously dangerous.

Group members did agree that segregation often makes people worse and that reducing the use of segregation creates a safer institution. Further, everyone agreed that since segregation is widely used and can cause harm, it is important to develop rules and guidelines to reduce its use and its harshness as much as possible. Thus, even though some group members preferred to work toward the elimination of segregation entirely as a longer term goal, the group agreed to discuss the various dimensions of segregation in detail, since the most realistic intermediate goal is to reduce its use. The group therefore reached consensus that the prison system's goal should be to get those in segregation out of segregation – or to less restrictive housing – as soon as possible.

Based on this discussion, Group 2 reached consensus on numerous points that were then converted into recommendations. On a few topics, members held strongly divided views and agreement was not reached. The group did not address every topic on its list before time ran out, and so, for a few areas, recommended further discussion. The areas of consensus, compromise, disagreement, and points for additional exploration are outlined below.

***1.* Behaviors as the Criteria for Segregation.** Group 2 first addressed the criteria for employing segregation, agreeing that it should be used for behaviors only, and not for other "status" reasons, such as a person's gang affiliation. The group then moved to the question of which behaviors do merit segregation, reaching consensus only on including the most serious violent behaviors: murder, rape, or assault. After some discussion, participants agreed that "threats of violence" – such as one individual ordering another to commit violence – should also be included in this category.

As for behaviors that should not result in segregation, everyone agreed that it is not appropriate for minor rule infractions. There was less clarity, however, as to what behavior constitutes a "major" versus "minor" infraction, as well as whether segregation is an appropriate response to a major infraction. Some participants argued that major "disturbances" – such as participating in a riot, attempting escape, or trafficking drugs inside prison (not simply possession) – justify segregation, while others argued that these actions merit a disciplinary response, but not necessarily segregation, since the individual does not pose a risk of harm to others.

Members also disagreed as to what constitutes "assault" on a staff member. Most participants agreed that prison staff can abuse their discretion and label a minor slight – such as profanity or spitting toward staff – an "assault," and that segregation is not an appropriate response to such incidents. However, no agreement was reached on the level of serious violence that constitutes the type of assault that would merit segregation. Moreover, some participants noted that prison officials used harsher discipline – including segregation – for lesser levels of violence toward a staff member, while an equivalent level of violence against another person would not result in segregation. Responding to this assertion, other participants contended that an assault against a staff member implies a level of "disturbance" to the prison environment and is thus legitimately considered more serious by corrections staff.

Ultimately, the group did not reach consensus on defining a "serious" assault or distinguishing assaults on staff from assaults against another incarcerated person. Nor did the group agree on how to determine whether a seemingly "minor" altercation or fight could count as a "major" infraction if the staff had reason to believe it would escalate.

2. Defining Types of Segregation. A few of the participants held the view that segregation is almost never justifiable, except in a very few cases of extremely violent or predatory individuals – what was colloquially termed "the Hannibal Lecters."[13] Those who favored the most extreme limits on the use of segregation did, however, support talking about a spectrum of "types" of segregation, since it remains a widely used tactic, with the goal of using the harshest type the least often. All participants agreed that this "spectrum" is a useful concept to reflect the different rationales for segregation, such as punitive versus risk-management.

Since this group was addressing segregation only for predatory or dangerous individuals (i.e., not for protection from others), the participants agreed to consider the types of segregation in this framework:

- *Short-term for investigative purposes;*
- *Short-term for disciplinary reasons;*
- *Short-term for "cooling-off" reasons; and*
- *Longer-term for reasons of risk of violence or harm.*

The group agreed that more austere conditions are acceptable for short-term segregation, but not for longer-term segregation, although there was rigorous debate as to the length of time that should delimit "short-term" segregation, as well as about acceptable minimum conditions of such isolation.

Group 2 generally agreed that too many people are placed in the "longer-term" segregation category than should be. One participant offered the example of prison systems that put condemned persons in long-term segregation because of the conventional view that they are risky due to their "I have nothing to lose" position. Yet, according to this participant, when condemned persons were housed in non-restricted housing, they did not exhibit more violent or risky behavior and, in fact, showed improvements in mental health and social interactions.

a. Conditions for Short-Term Segregation.
The group agreed that setting a specific number of hours of cell confinement per day as a minimum standard was not as important as defining the minimum standards for various conditions of segregation: physical space, food, services, staff interaction, allowable activities, interaction with other people, programming, etc. After some debate, the group reached agreement on a specific phrasing for these basic conditions – which is set out in the recommendations in Part III, below.

The group agreed that in order for short-term segregation to serve a punitive purpose, more restrictions and more austere conditions are necessary than exist in the general population or any separated population. These minimum conditions are meant to represent the floor for what constitutes humane confinement. Some participants mentioned examples of privileges that should not be offered in short-term segregation, including additional recreation, TV, phone calls, and contact visits. Participants explained that in order to create positive incentives, prison officials would need to have the ability to offer privileges that could be earned. Thus, prison officials cannot offer all the privileges as a minimum standard. Other members agreed with this premise, but maintained that this should not mean that persons in segregation are not allowed any of these privileges.

Included in SCDC' 4.29.19 letter to LOC

b. Conditions for Longer-Term Segregation.
The group then considered appropriate conditions for longer-term segregation. They agreed that only people who pose more serious or ongoing risks of violence to others should be in longer-term segregation and that professional clinicians should determine this risk through regular inter-disciplinary assessments. The group also agreed that corrections staff should make a clear decision to transfer a person from short-term to longer-term segregation, documenting the reasons, rather than simply shifting them automatically after a certain period of time.

Some participants argued that the risk of harm posed by longer-term segregation is only justifiable if the facility provides interventions or programs that attempt to address the underlying cause of the risk of violence – that is, if there is an effort to give the individual a path out of the longer-term segregation by changing his or her behavior. The other participants agreed with this view in principle, but expressed concerns about resource requirements for such programs. The group agreed that, in theory, this approach could also involve a graduated program, in which behavior improvements could lead to more time out of the cell. Group members acknowledged that such interventions would not necessarily work for everyone whose behavior merits longer-term segregation, but that it is important to offer such opportunities. All the participants agreed that these interventions should address the behavior we seek to change, and not merely be recreational in nature.

Group 2 frequently mentioned having a minimum standard of 20 hours per week of programming activities for those in longer-term segregation.[14] A few participants noted that some of this programming could occur with some level of restraint, if necessary, rather than denying it completely to those needing restraint.

The group then discussed the sometimes-used "levels system," in which prisoners can earn stepped up privileges through good behavior. Meant to be a path out of segregation, some participants expressed concern that such systems act as a trap for people who have underlying behavioral or mental health problems. Members also generally agreed that the term "step down" could be unhelpful. There was no explicit agreement, however, on whether to recommend eliminating levels systems.

Several participants stressed that the conditions in longer-term segregation needed to be more restrictive than the conditions in the general population, expressing concern that individuals might attempt to get into longer-term segregation on purpose, viewing it as a means to a private cell with nearly equal access to services and privileges. Group members therefore agreed to add the caveat that conditions in longer-term segregation should typically be more restrictive than in general population.

***3.* Maximum Length of Time for Short-Term/Punitive Segregation.** The group agreed that the current length of time used for disciplinary segregation is too long – many years, in some cases – and that those in segregation for "risk" reasons tend to be re-assessed too infrequently.

The group discussed the notion of a 15-day limit on short-term segregation under the most austere of conditions for disciplinary or cooling-off reasons. The 15-day limit provides a clear reference point because it is defined as "prolonged solitary confinement" in the Mandela Rules[15] and recommended by the UN Rapporteur. All conceded, however, that this is a relatively arbitrary number without a clear rationale from social science. Some members strenuously argued that the maximum amount of time allowed in the harshest of segregation should be less than 15 days. Views on an appropriate maximum length of time for the harshest segregation ranged dramatically – from one day to more than a year.

Included in SCDC' 4.29.19 letter to LOC

Some members repeatedly said that imposing an absolute 15-day limit on short-term segregation would be "too much, too fast" for some prison officials, and that having such a number risks causing a backlash. Given this and the fact that other members would not accept a higher number of days, no consensus on a maximum time limit was reached. Ultimately, the group agreed to recommend the "briefest possible period" – a phrase that conveys the urgency of a short time without prescribing a number of days.

The group also considered the issue of "suspending" the crediting of time toward the confinement period when a person misbehaves. Some participants argued that this tactic is not effective as a deterrent and can make a person more angry and violent. Although no explicit recommendation on this issue emerged, the group agreed that "time suspended" is not a helpful or effective practice.

***4.* Alternatives to Segregation.** The group easily agreed to recommend that alternatives to segregation should be used more widely and that segregation should be used as a last resort. One primary alternative to segregation is separation, which can be used, for example, to separately house gang members who are predatory only towards specific individuals with others to whom they do not pose a risk, and with access to a communal space, programs, etc. The main obstacle to this alternative is architectural: many facilities do not have the structure or space for this type of physical separation. Some participants also pointed out that classification systems attempt to accomplish such separation to some extent, but that prison staff and buildings often do not have the resources to build a separation system with enough levels and categories.

Group members suggested other types of separation, including transferring individuals from segregation to the general population of another facility or another state system. Participants noted that in many cases the individual's behavior problems were contextual and thus stopped after the transfer. Members agreed that such transfers should be promoted as another version of separation, providing a further alternative to segregation.

***5.* Due Process.** The group briefly discussed issues of due process in the hearings on incidents of misconduct and disciplinary decisions leading to segregation. Several participants commented that because the administrative systems are overloaded with cases, hearings are often delayed for weeks or months, and sometimes officials do not have time to consider each case in sufficient detail. Participants underlined the dilemma that incarcerated persons face: If they accept a short disciplinary segregation "sentence" without a full hearing, they de facto incriminate themselves. However, if they insist on a hearing, they can be in segregation for several months, waiting for that process to take place. Some members suggested that the hearings are not fair because most of the accused are found guilty. A few people suggested that individuals are pleading guilty – regardless of actual guilt – simply to reduce their time in segregation. Overall, there were many concerns about due process, but all agreed that additional external oversight or interventions might not solve the problem. Due to a lack of time, the group did not reach a consensus or recommendation on this topic, and therefore listed it as requiring further discussion in the future.

***6.* Transparency and Accountability.** The group agreed that there is a clear need to collect and analyze more data related to segregation practices. Some participants noted, however, that states have different capacities for in-house data analysis. Therefore, the group agreed to allow for flexibility in how and by whom data is collected and analyzed, whether via the agency itself or through partnerships with universities. Many participants pushed for more detail as to the type of data that should be made available pertaining specifically to segregation. The group agreed to recommend that agencies should collect and make data available on a specific set of issues related to segregation.

Included in SCDC' 4.29.19 letter to LOC

***7.* Staff Buy-In.** In the initial exercise, several participants listed lack of staff buy-in as an obstacle to change. During the discussion, administrators argued that even if everyone agrees on the end goal in terms of how to reduce the use of segregation, the implementation should be gradual, as staff is often resistant to change. Members suggested that changes in recruiting and hiring of staff – for example, selecting people for their social work skills and orientation – could shift the level of buy-in. A few participants commented several times that even the best-designed policies require consistent understanding and implementation by staff and that, in some facilities, high staff turnover is more of an obstacle than is staff resistance to change. The group did not agree to make a concrete recommendation on this topic, although this resulted more because there was not a clear suggestion made, rather than because of any explicit disagreement.

***8.* Strategies for Change.** Group 2 then identified a variety of strategies to change segregation practices. All participants agreed that sustainable change to segregation policies requires some change in legislation. They also agreed that there should be a concerted effort to focus on this arena.

The group also discussed strategies related to resources. Everyone recognized that reducing the number of people in segregation and the length of segregation may save money, but some members noted that, typically, state governments reabsorb any savings resulting from changes in prison expenditures, rather than reinvesting them in other prison services or expanding buildings or staff. Thus, removing people from isolation may require new resources and incur new costs. The group thus agreed that advocating for the reduced use of segregation on a cost-savings rationale alone is unhelpful, as it contradicts the equally important need for additional resources for more restorative services. Several participants noted that the problem of the over-use of segregation is in some ways self-generated by the under-resourcing of prisons: When incarcerated persons are under pressures due to overcrowding and lack of services, they are more likely to lash out, which leads to discipline and the over-use of segregation, which in turn drains resources away from better conditions and services for the general population.

With regard to how to “sell” changes in segregation policies to the public and to politicians, some members cautioned against advocating that reducing segregation results in reduced recidivism within prison. Given punitive public attitudes, they suggested that the only argument that resonates with the public is that reducing segregation has clear public safety outcomes.

Finally, the group debated the tradeoffs between prescriptive recommendations versus general guidance. Some members suggested that when guidance is too directive, prison officials might balk. Instead, they suggested that general guidance backed up by examples of successful outcomes of new initiatives or changes in policy would be more persuasive.

All participants agreed that this meeting was a unique and crucial opportunity for generating real change – and that if this change process is not done quickly and well, the window for reform will vanish.

Group members frequently noted during the discussion that the key points or conclusions would only apply to prisons and not jails, particularly on topics of clear differentiations of physical space and programs for different categories of individuals, given that there is less space, fewer resources, and more flux in jails, and that different types of infractions and incentives are common in jails versus prisons. The group recommended that separate discussions be held on the topic of the over-use of segregation with specific reference to jails and also, separately, on the use of segregation in the juvenile justice system.

C. Managing Vulnerable Individuals, Such as Individuals with Mental Illness, Youth, and Protective Custody Populations without the Use of Solitary Confinement (Group 3)

Group 3 was charged with discussing the key policy and practice issues involved with managing vulnerable populations without the use of isolated confinement. Central questions for this group to address included how to identify vulnerable groups and, once identified, what alternative programs to isolated confinement should be provided for these individuals with regard to their particular vulnerabilities, such as mental illness. Equally important questions were how to prevent such programs from devolving into isolation units, and how to deal with vulnerable populations that present legitimate safety and security risks to the facility.

Background and Context. Currently, segregation/isolated confinement is too often used as a one-size-fits-all approach to correctional management. It is used for multiple purposes: discipline for rules violations; “protective custody” for vulnerable prisoners; and housing for disruptive or dangerous prisoners. As corrections strategies, such placement of inmates can be unnecessary and even counterproductive for prison and public safety. Using isolated confinement as a default management tool has led to the over-use of this extreme form of housing, incurring unsupportable human and fiscal costs.

Many correctional facilities do nothing to distinguish between populations in segregation for protective versus punitive reasons. As a result, vulnerable prisoners are subject to extremely onerous conditions and denied access to the types of jobs and programming they will need to successfully return to the community. Due to such harsh conditions, vulnerable prisoners can also be discouraged from seeking the protection they need or even reporting legitimate risks. When isolated confinement is the only choice offered a vulnerable prisoner, that prisoner is confronted with a Hobson’s choice: Opt for protection but pay the price of isolation or avoid isolation and risk injury or even death. This choice often means that the facility has undermined its access to the information it needs to operate in a safe and secure manner.

Alternatives to the one-size-fits-all use of segregation are needed. Some jurisdictions have already implemented special units for vulnerable prisoners with custodial conditions similar to general population. These are sometimes called “safekeeping” or “special needs yards.” This is a good start, but is not enough. We need clear principles and practices across corrections to ensure that we deal humanely and effectively with vulnerable prisoners without resorting to isolation settings.

At the outset, we need clear definitions of categories of persons who qualify as vulnerable if held in the general prison population. For corrections facilities everywhere, the vulnerable group that presents the greatest challenges is often those with mental illness. This cohort is a large and ever-growing part of the corrections population. Decades of experience demonstrate that prisoners with mental illness often adapt very poorly to life in prison. They frequently experience social difficulties with other prisoners and staff; they are often vulnerable to attack by other prisoners; and they typically violate rules both large and small due to an inability to conform to the strict constraints of incarcerated life. For all of these reasons, prisoners with mental illness are disproportionately represented in isolated confinement settings.

But decades of research have demonstrated that individuals with mental illness are uniquely vulnerable to isolation and solitary confinement settings. Many deteriorate dramatically and engage in bizarre and extreme acts of self-injury and suicide. As a result, nearly every federal court to consider the question has ruled that placing individuals with serious mental illness in such conditions violates the Eighth Amendment prohibition against cruel and unusual punishment. In systems where lawsuits have been brought on behalf of the seriously mentally ill in isolation housing, new policies and programs have been implemented. Promising practices for

Included in SCDC' 4.29.19 letter to LOC

this population are now emerging and enhanced staff training and collaboration with health care professionals have led to better run, more humane, and safer units for those with mental illness. Yet many systems still house significant populations of seriously mentally ill people in extreme isolation settings.

More recently, reforms have extended to other vulnerable populations, such as youth, pregnant women, and individuals with cognitive impairments and other disabilities. Other groups, such as inmates involved in notorious cases and transgendered inmates, may also be vulnerable. But the programs that have been established in a few locales have yet to become widespread in practice across the country.

A key concern in this area of reform has been the tendency for systems to revert back to the use of isolation once court cases end or public scrutiny relents. Some critics have noted that the exclusion of "special populations" from traditional segregation units has often resulted in a mere relabeling of the units or the prisoners housed there. For example, concerns have been raised that where systems have implemented policies to exclude seriously mentally ill individuals from isolated confinement, there has been a notable trend in re-diagnosing prisoners with long-time mental health diagnoses to lower acuity illnesses so they no longer qualify for alternative housing. In other systems, alternative mental health units—although not labeled as isolation—often look, smell, and feel just like a solitary confinement unit, albeit with a less harsh sounding name.

Another key concern is ensuring that custody and health staff has the skills necessary to deal with difficult populations, such as individuals with mental illness who present serious security concerns. The success of alternatives to segregation is dependent on the ability of staff to do the job intended. Often, this will involve providing substantial, additional training. Line staff is key to the success of new programming and modes of operation that do not rely upon isolation. Just as critical are the significant cultural shifts often necessary within the institutions, including management, line staff, health staff, and the prisoners themselves. Fostering, supporting, and solidifying such culture change is an ongoing challenge for institutions and one that may benefit from outside scrutiny, monitoring, and technical assistance from researchers, advocates, experts, political leaders, and the public.

Questions for Discussion. Group 3 faced the challenge to find consensus on proposals as to how best to reform this system and implement change. To guide its discussions, Group 3 considered the following questions:

- *What groups require special protections?*
    - *Mentally ill? Does the particular diagnosis of mental illness matter in formulating policy?*
    - *Cognitively impaired?*
    - *Informants, former law enforcement, or public officials?*
    - *LGBTQ?*
    - *Other groups? What types are vulnerable?*

- *What procedures should apply to determine the level of protection necessary? For protective custody? For special population housing?*
    - *What does effective screening and classification look like?*
    - *Are there inherent conflicts between medical and mental health care staff and custodial decisions?*
        - *How can those conflicts be resolved?*

- *What procedures should allow appeal by the prisoner of placement or denial in special population units and protective custody?*
    - *How and when should determinations about step down and return to population be made?*

- *Are special population units appropriate? Useful? Counterproductive? In what contexts?*
  - *What tensions does the use of specialty units create in a system? A facility? How can these tensions be avoided or managed?*
  - *What measures must be taken to ensure that special population units maintain their original mission? Do not devolve into isolation housing?*

- *What should the conditions of confinement be like in units for vulnerable individuals?*
  - *What services/programming should be made available?*
  - *What new or specific skills does custodial staff need to work in these settings?*

- *What resources would be needed to make these approaches effective?*
- *What is the role of transparency and accountability in ensuring the success of these units?*
- *What are the barriers to achieving these reforms?*
- *How can we overcome them?*
- *How can we ensure and document continued operationalization of these reforms?*

Conversations and Areas of Consensus. Participants initially disagreed on how to interpret the questions posed by conference organizers. One participant raised a concern about whether to start the discussion by identifying individuals who need protection or those who need services, noting that inadequately treated individuals could potentially be vulnerable and, if those individuals were treated adequately, they would not need protection.

Some members interpreted the questions as asking "Who is vulnerable and who should be placed in a special environment?" Others thought they were being asked "Which categories of individuals should we worry about when removing them from the general population and placing them in a separate unit?"

Given the multiple interpretations of the questions Group 3 was asked to address, the facilitator suggested that there are two conversations to have:

- Whether, if individuals are treated with services and programs, they would still need to be isolated; and
- If those individuals do need to be isolated what conditions of confinement and services should they receive?

The group's conversations and the areas of consensus it reached on these issues are set out below. The group defined vulnerable populations, discussed methods of separating vulnerable individuals from the general population without resorting to isolation, considered when and under what conditions extreme isolation might be used for vulnerable persons and, more generally, considered issues of accountability, transparency, and barriers to reform.

***1.* Defining the Scope: Who are the Vulnerable Populations?** The group contemplated two different vulnerabilities to approach its discussion. The first vulnerability occurs when an individual is vulnerable to the harm associated with isolation. The second vulnerability arises when an individual is vulnerable to other prisoners. When someone in the first category is placed in isolation, the goal should be to work on getting him or her out as soon as possible. When an individual from the second category is placed in isolation based on their status, the system should instead work to find alternative responses to address these vulnerabilities.

Included in SCDC' 4.29.19 letter to LOC

a. Individuals Who are Vulnerable in the General Population.

*Group 3 reached an agreement on the following categories of individuals who are **potentially** vulnerable in the general population:*

- *Serious Mental Illness "SMI"*[16]
- *People with Intellectual Disabilities*
- *Juveniles*
- *Old/Elderly*
- *Infirm*
- *New Admissions*
- *LGBT*[17]
- *Protective Custody*
- *Pregnant*
- *Chronically Ill*
- *Sex Offenders*

After discussion, group members reached consensus quickly on populations that are vulnerable in general population. This category was defined as including the following people:

- *Serious Mental Illness*
- *Intellectual Disabilities/Developmental Disabilities*
- *Juveniles (18 and under/defined by state law)*
- *Elderly/Infirm (without a specific age)*
- *Protective Custody*
- *Chronically Ill*
- *Sex Offenders*

Group members cautioned, however, that corrections officials should not be forced to place these individuals in segregation in order to protect them, but rather that these individuals should be provided opportunities to find ways to live safely within general population.

b. Individuals Who are Vulnerable to the Harms of Segregation.

The above categories relate to those who are vulnerable – either from threat of harm to themselves or others – within the general population. In discussing categories of potentially vulnerable individuals, Group 3 next considered individuals who, if placed in segregation, could become dangerous to themselves and/or who are especially vulnerable to the conditions of isolation.

Participants first addressed the elderly and infirm. The group agreed that the elderly and infirm should be included under the vulnerable to isolated confinement list, but did not specify age ranges. They did not reach consensus as to whether LGBT individuals, those in protective custody, the chronically ill, or sex offenders should be included in this particular list.

The group then considered issues related to pregnant women in isolated confinement. It was argued that women are not provided with the healthcare, exercise, and nutrition necessary to keep their gestating babies healthy while they are in isolation. Some group members pushed back against this notion, contending that women in prison might receive better healthcare than they would otherwise, depending on their circumstances. One corrections official shared a story of a pregnant woman who was jumping and diving off of her prison bed in order to abort her baby, noting that because the state has a moral obligation to protect an unborn child from such attempts to harm it, the woman was placed in isolated confinement to protect her life and the life of her unborn child. Participants acknowledged that if someone is harming herself or others – as in this scenario – then the prison needs to protect her, but she should not be placed in 22-hour isolated confinement for more than 30 days.

Included in SCDC' 4.29.19 letter to LOC

Following this discussion, the group reached consensus that pregnant women are a population that is especially vulnerable to the harms of isolated confinement.
In sum, it was agreed that the following persons are significantly vulnerable to the effects of isolation:

- *Serious Mental Illness*
- *Intellectual Disabilities*
- *Serious Cognitive Limitations/Impairments*
- *Juveniles (18 and under/defined by state law)*
- *Elderly/Infirm (without a specific age)*
- *Pregnant Women*

2. Housing Vulnerable Persons: Should Vulnerable Individuals Be Held in Separate Groups or Can They Live in the General Prison Population and, If So, Under What Conditions?

a. Separate Housing for Vulnerable Populations.
Group 3 addressed how vulnerable individuals should be housed within prison populations and whether, based on their vulnerable status alone, such individuals should be housed separately. Participants suggested that, as a default, all incarcerated persons should be housed in general population irrespective of their classification. Some suggested that corrections officials could create separate units that place vulnerable individuals with others of like status; while others expressed concern that this would merely create a facility segregated by categories, with perhaps some stigmatizing effects.

Several participants agreed that isolation is not a solution to the problem of vulnerable populations and should not be used as a means to protect people: Individuals should not be placed in segregation based solely on their status in a vulnerable category, but rather because their behavior merits it. Instead, such individuals should receive programming to address their unique needs. Ultimately, the question becomes: How do we create living units for vulnerable individuals separate from the general population, yet not isolated or of lesser quality?

One participant suggested that the analysis be as follows:

1. *What is the person's status? Based on status alone, a person should not be placed in isolation.*
2. *What special needs does this individual have and how can corrections officials address them?*
3. *If the individual has a vulnerable status and also has behavioral issues, how do corrections officials respond? If an individual is mentally ill, for example, can therapeutic programs travel with that person if his or her behavior merits a segregated environment?*
4. *How can corrections officials handle people who cannot safely be housed in the general population because of their status?*
5. *What resources do prisons need to create separate housing for vulnerable persons?*

b. The Need for Services and Programs for Vulnerable Populations
The group agreed that vulnerable individuals might require services and programs to help keep them safe and/or address their special needs, but that services available in the general population are often insufficient to accomplish this. Units with vulnerable populations thus need additional services and socialization directed towards a goal. Moreover, progress should not be based on a behavior plan, negative reinforcement, or a punishment-based system, methods that often prove impossible for some vulnerable individuals to meet, such as those with mental disabilities. Rather, a positive incentive-based program should be used.

Included in SCDC' 4.29.19 letter to LOC

The group also discussed the conditions of separation for vulnerable populations. It was suggested that for those individuals who are separated, but not in isolation, separation should not work to deprive them of habilitative, rehabilitative, educational, or similar opportunities.

A participant suggested that vulnerable populations should have as close to the same level of amenities as in the general population, in a setting as similar to the general population as possible, while still being afforded the rights and privileges an individual would otherwise have in the general population. It was even suggested that these populations should receive more amenities than the general population.

Others were concerned that this would result in some individuals seeking to be placed in these separate units in order to be housed in a quiet, single cell while still receiving all the same amenities as the general population. They expressed a need for caution in extending social interactions and services beyond what is offered in general population because, if prison life becomes better in these separate units, individuals may seek placement there in order to obtain these additional privileges.

The question was then posed: "How do you meet the needs of individuals who are in a vulnerable population who want to participate in programs that are only available to the general population, such as congregate religious activities or school?" The following solutions were suggested:

1. *Use escorts to take the individuals to the services or programs;*
2. *Allow the individuals to interact with other incarcerated people they trust and are in the same status; and*
3. *Allow the individuals out-of-cell time with staff and outside personnel who come to fill that individual's day with art conversation, passive recreation, etc.*

Group members agreed that the mere fact an individual is in a vulnerable population should not deprive them of the same services that are provided to the general population.

***3.* Discipline and Isolation for Vulnerable Persons: When, if Ever, Can Isolation Be Imposed on Vulnerable Individuals, and Under What Conditions?** Having defined vulnerable categories of individuals in prison and discussed the preference for separation versus isolation to keep such people, other prisoners, and corrections staff safe, the group moved to considering whether isolation would ever be appropriate for vulnerable individuals. In this discussion, they defined and debated the use of extreme social isolation, focusing on a timeline for initial assessment, its duration and conditions, and step-down procedures.

a. When, if Ever, May Extreme Social Isolation (22 Hour per Day Lockdown) be Imposed on Vulnerable Individuals?

In discussing extreme social isolation, the group considered the question: "To what extent should people in vulnerable categories be held in cells for 22 hours a day because of their status?" The group quickly reached consensus that no one in a vulnerable category should be held in their cell for 22 hours a day solely because of their status, characteristics, or vulnerabilities.

In reaching this consensus, the group discussed the various risks posed by, and the resources available to prison officials to deal with, vulnerable populations. A correctional administrator commented that until he can assess and stabilize an individual who has slashed someone, he knows that the individual is going to present a risk and he struggles with how to allow this person contact with general population while still protecting others.

Included in SCDC' 4.29.19 letter to LOC

An advocate conceded that the current practice is to put these individuals in isolation, but encouraged development of a more flexible system that acknowledges that prolonged confinement is not the answer. The advocate stressed that the risk to the individual needs to be balanced with the risk to others and that even in violent situations, these individuals should not be placed in isolation. An administrator suggested that ignoring the behavior of a vulnerable person who assaults another prisoner is not a realistic option.

The group came back several times to the needs of the seriously mentally ill in isolation – both the behaviors that might cause such a person to be placed in isolation and the special treatment needs they might have in that environment. Participants noted that the services available in prison do not compare to the services of a psychiatric hospital, and that correctional resources might be limited during the time an individual is in isolation. Most prison systems do not have enough psychiatric beds and sometimes there are worse conditions of confinement in psychiatric cells than in isolation. Participants suggested that while in isolation, there should be daily mental health services that involve contact with mental health staff, interaction, programs, treatment, and out-of-cell time. Participants also posited that mentally ill individuals in isolation should receive an immediate evaluation and treatment.

All agreed that the best result is to treat such individuals so that their behavior does not merit isolation in the first place, recognizing, however, that SMI will occasionally run afoul of prison rules and require discipline. The group discussed how best to respond to rule violations by the SMI. When an individual with SMI also has a behavioral issue, that person may need to be separated to keep everyone safe, but that separation should not diminish the level of services that person is provided. Group 3 did not contemplate isolation as being used in any way to punish a vulnerable person.

The group considered the method used in Colorado where, if an individual with SMI commits an act caused by their mental illness, an intervention to address the underlying mental illness is provided instead of punishment. In Colorado, even for discipline, corrections officials use a 10/10 plan[18] and some individuals stay in 10/10 forever. This system does, however, raise the question of determining whether a person's underlying mental illness caused a particular behavior. Participants agreed that this system does not mean that staff can never discipline someone with a mental illness. Rather, SMI as a vulnerable population can be held accountable without the use of social isolation.

b. Is there a Limit to the Number of Days a Vulnerable Person Can Be Placed in Isolation?

Having determined that isolation may sometimes be necessary for individuals in vulnerable populations, the group turned to the duration of such confinement. The group agreed that placing a vulnerable individual in 22-hour a day lockdown for an indefinite period is not the answer. Rather, there should be an initial period of isolation to calm and address the threat. Thereafter, these individuals should be transferred to another unit that will address their needs. Another advocate countered that an individual should be placed in isolation only when all other alternatives to de-escalation of the immediate dangerous situation fail. The restraint needs to end when the emergency ends. There need to be time limits that govern when the individual could be released and these should relate to when the individual is no longer dangerous to themselves or others.

As to a specific time limit on isolation, the group considered whether 15 days was workable for vulnerable people to be held in 22-hour lockdown. One administrator argued that 15 days is not workable, but that 30 days might represent an acceptable upper limit and that 45 days would be excessive. Another commented that any system should allow for flexibility. The group next debated what the alternative to isolation should be, acknowledging that a higher standard or threshold should exist to put vulnerable individuals in isolated confinement in the first place. Most participants suggested 10/10, which averages to about three hours out of cell per day.

Included in SCDC' 4.29.19 letter to LOC

Group 3 considered a recommendation that vulnerable populations should not be placed in isolation for longer than 30 days. Some participants were not willing to come up with an exact time limit, but suggested instead that isolation should be used for the shortest amount of time necessary. Strong opposition was voiced to the 30-day limit for SMI, with reference to the American Psychiatric Association's Position Statement on Segregation of Prisoners with Mental Illness:

> *Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates. If an inmate with serious mental illness is placed in segregation, out-of-cell structured therapeutic activities (i.e., mental health/psychiatric treatment) in appropriate programming space and adequate unstructured out-of-cell time should be permitted. Correctional mental health authorities should work closely with administrative custody staff to maximize access to clinically indicated programming and recreation for these individuals.*[19]

Opinions were that 30 days is punishment; nothing is served by 30 days; and that 30 days should be the limit but less is better. The consensus proposal was that the recommendation should be for a duration of "much less than 30 days."

In discussing duration and time limits, the group also considered the issue of repeated or multiple placements in isolation and the frequency of isolated confinement for the same individual. Group members suggested many ideas, including a limit of only 15 out of 30 days per month depending on the circumstances, and no more than 15 days at a time without at least seven days of non-isolation between being released and before placing the individual back in isolation again. Some in corrections expressed concern about how to then handle disciplinary issues that might arise even immediately after a vulnerable person is released into general population. The group did not reach consensus on this issue.

c. When Should a Vulnerable Person in Isolation Be Assessed?

The group considered the need for prompt assessment of a vulnerable individual placed in isolation, particularly those with SMI needs. As a practical matter, participants noted there might be a lack of available hospital beds, limited resources in smaller or more rural facilities, or lack of other alternatives to remove the individual from isolated confinement. In such circumstances, a suggestion was made to assess the individual within 24 hours of being placed in isolation and to have access to mental health and medical services immediately, if possible, while in isolation.

However, it was recognized that there may not be another facility, unit, or alternative placement available because of a lack of resources, especially in areas that have small prison populations. Expanding on this suggestion, one advocate commented that the individual should be seen by a physician within an hour of being placed in isolated confinement, then must be reassessed a certain number of hours later, followed by a disciplinary team meeting to determine a treatment plan, and a reassessment once out of isolation.

The group considered how fast medical attention or assessment in isolation could occur and how detailed or specific a recommendation to make on this issue. Many seemed to think that it would only take two or three hours after a vulnerable person is placed in isolation to have that person assessed by a medical professional or a corrections official and that a treatment team should meet with the individual on day one. This assumption, however, runs counter to the current standard that provides for 72 hours to assess and formulate a plan. The group's ultimate recommendation adhered to this 72-hour standard.

Included in SCDC' 4.29.19 letter to LOC

d. Step-Down Programs for Vulnerable Populations.
The group considered methods for transitioning vulnerable populations out of isolation and back into less restrictive areas. In particular, participants considered step-down programs, which are incentive-based, multi-step processes that provide those placed in isolation the opportunity to earn enhanced privileges by refraining from participation in Security Threat Group affiliations and behaviors. The ultimate goal of a step-down program is to release the persons from the isolation unit.

Group 3 briefly discussed this issue and commented that a step-down program is a very good idea and should be a goal, but that some prisons with small populations of vulnerable individuals may not have the resources for such programming. One advocate noted that incarcerated persons should never be serving "dead time" – meaning time with no intervention or opportunity to improve one's condition or term of imprisonment – and there should always be a next step where they receive services. This advocate mentioned that the mental health treatment programs function similarly to the step-down programs in some cases.

In the interest of time, group members agreed that they would endorse that step-down programs are a good idea, but that there was not enough time to discuss the details of such programs. Members also reached an understanding that resources or special circumstances might not allow for step-down programs in certain facilities.

4. Should There Be a Classification Appeal for Vulnerable Individuals?
The group disagreed whether the incarcerated person should have a say in his or her classification and placement into a separate unit. One advocate argued that the individual should have input, though not necessarily a vote. A corrections official countered that this might create an expectation that he did not believe was warranted. Others suggested that classifications to place people into separate units are a decision to be made at the facility level by mental health professionals. Ultimately, the group reached consensus that the procedures for determining whether to place a vulnerable person in the general population or in a separate unit should be reached through a multidisciplinary process that includes input from the individual. The group agreed, however, that this procedure need not be a formal process as is the case for an Individual Education Plan or a disciplinary due process hearing.

Group 3 then considered how to handle individuals who disagree with their classification either to be housed in a separate unit or to be placed in general population. Participants discussed liberty interests, due process issues, and the fact that, in many systems, classification is not grounds for a grievance. One of the corrections administrators stated that there may be procedures for an appeal to challenge one's classification. No consensus was reached as to the nature of any such appeals process.

5. The Importance of Accountability and Transparency.
The members of Group 3 were unanimous in their belief that accountability and transparency is essential to reform efforts. Participants suggested that the public should be allowed into the prisons, critical advisory boards should be in place, outside monitoring allowed, and statistics about decisions should be made public. As part of this improved accountability, facilities should collect more data as to the performance of correctional institutions' treatment of vulnerable populations to show the impact of implementing the Colloquium's recommendations.
Group 3 agreed that:

- *Transparency is critically important, because it ensures ethical and moral appropriateness and a commitment to positive performance.*
- *Transparency, external and internal accountability, and robust data that supports measuring outcomes are essential and critical to the success of these units and should be publicly available.*

Included in SCDC' 4.29.19 letter to LOC

The group also agreed on some measures that would help guarantee success, including collecting data on institutional force and violence, suicide attempts, grievances, disciplinary tickets, assaults on staff, and cell extraction.

6. The Road Ahead: Barriers to Reaching Goals Related to Vulnerable Populations. For its final question, Group 3 tackled barriers to reform measures. Everyone agreed that lack of resources is a barrier. Many of those most at risk present an expensive problem for the system, and money and resources need to be reinvested in separation units to address these vulnerable individuals. One participant suggested that it might be that we cannot run our current prison systems the way we want to with currently allocated resources and funding. States must invest in creating new prison environments in locations that will support the needs of vulnerable populations.

To express these thoughts it was agreed that:

- *These are barriers to achieving reform that will be distinct based on the facility and jurisdiction.*
- *Resources will vary by the system and state and each jurisdiction is ultimately going to have to come up with a solution for adequate resources that will work for their system through new funding or redistribution.*

Included in SCDC' 4.29.19 letter to LOC

Part III

Recommendations

What follows is a reconciliation of the recommendations emerging from each of the three groups and reflects the general consensus of the participants of the Colloquium. Not all participants are in agreement with each and every recommendation, but the recommendations that follow have the support of the majority of those in attendance.

1. **Segregation should be used for the minimum time and in the least restrictive conditions necessary to resolve the condition that led to the segregation.**

   1.1. For those in segregation or restricted housing, the goal should be to get them into the least restrictive housing possible. If they are separated from the general population, it should be for the shortest amount of time necessary. We urge correctional officials to consider alternatives to segregation or restricted housing.

2. **Separation is one alternative to segregation or restricted housing. This can be accomplished through moving someone to a different area of a facility, a different facility, or a different prison system.**

3. **Positive incentives should be incorporated into the management of all incarcerated people, including those in segregation or restricted housing.**

   3.1 All isolation should have an incentive component, which would restore certain privileges if the individual were able to reach certain behavioral goals. Ideally, these incentive programs would operate on relatively short timeframes—e.g., two days of good behavior earns a reward—so that incarcerated persons would quickly begin to see their good behavior rewarded. Participants also agreed that isolation should have a goal of changing specific behavior and an individualized achievable path to reach it.

4. **Even for the most restrictive segregation, the conditions should be humane. These conditions should include, at a minimum: access to natural light; control of light in cells; basic sanitary and safe environmental conditions including adequate space, ventilation and temperature; adequate nutrition; adequate medical and mental health services; and reading materials. There should be initial and subsequent periodic mental health evaluations of those in segregation or restricted housing to determine whether changes in conditions of confinement are warranted for mental health reasons.**

   4.1 Segregation must include meaningful mental health rounds, health care rounds, and adequate basic conditions.

   4.2 Apart from the briefest possible initial period, all incarcerated persons in segregation or restricted housing should have some access to out-of-cell time, congregate activity, meaningful social interaction, programming/interventions, phone calls, and visits, recognizing that the extent of these privileges may be more limited than in general population. The most restrictive segregation should be for the shortest amount of time necessary.

Included in SCDC' 4.29.19 letter to LOC

4.3 Segregation or restricted housing for investigation purposes should be brief and may require a brief period of restricted contact with others.

5. **We recognize that there is a small number of people who will require prolonged separation from the general population because they pose a threat of violence to incarcerated persons or staff.**

5.1 Their separation from the general population is not punitive and should not be experienced that way. For these people, the conditions should be humane and as close to general population conditions as possible (in addition to the basic conditions listed in item 4 above).

5.2 These people should be provided with interventions to address their needs and to promote their safe transition back to less restrictive settings.

6. **All people in segregation or restricted housing should be periodically reviewed to determine whether they could be released to a less restrictive environment (e.g., having met treatment goals).**

7. **Responses to disciplinary infractions should be imposed on a continuum, with segregation as the tool of last resort.**

7.1 Segregation or restricted housing for disciplinary or management purposes should be used only for the most serious behavioral offenses, such as violence or threats of violence.

7.2 It should not be used for problems such as gang affiliation, status, or political beliefs, or for minor infractions, except for a brief segregation period for investigation or cooling-off purposes.

8. **There must to be due process protections in place.**

8.1 These must include procedural safeguards for placement in segregation, periodic review during segregation, and an exit mechanism.

8.2 This process should consider the severity of the offense, length of time spent in segregation, fairness, and the ability of the individual to comply with imposed conditions.

9. **The loss of privileges needs to be proportionate to the infraction and must include a pro-social incentive system to restore the privileges.**

10. **There should be family contact allowed while incarcerated people are in segregation, as the loss of family contact can be extremely agitating for both the incarcerated person and the family; increasing family contact and visits for improved behavior can provide a strong incentive.**

11. **Loss of programming, social contact, and family contact should be reserved for more serious infractions or after other punishments have proved ineffective.**

12. **Anyone who is in segregation or restricted housing for more than a brief period of time should be provided with interventions to address their needs and promote their safe transition back to less restrictive settings.**

13. **Incarceration should be avoided whenever possible to prevent bringing vulnerable populations[20] into the prison system in the first place (e.g., juveniles should be in youth systems and should never be in adult prisons; people with mental illness should receive treatment and services elsewhere; elderly and infirm should be released on parole; etc.).**

14. **Where incarceration cannot be avoided, every reasonable effort should be made to manage the vulnerable individual within the general population environment and provide adequate services to meet their needs while in the general population.**

14.1 The determination to place a vulnerable person in the general population or in a separate unit should be made through a multidisciplinary process that includes input from the prisoner, regarding which special unit they should be placed in. The procedure need not be a formal procedure such as an IEP or a disciplinary due process hearing.

15. Where general population placement cannot be effectively managed without posing an unacceptable risk, vulnerable populations should be assigned to separate living units where their needs can be appropriately met with a goal of maximizing congregate activity, habilitative, rehabilitative, and programmatic opportunities.

15.1 The separation accomplished in these living units is separation from the risk posed by general population, not separation or isolation from all other individuals. The conditions of confinement in these separate units should never be punitive.

16. For significantly vulnerable individuals at high risk of harm in extreme isolation, such isolation should be imposed only as a very temporary emergency measure, for no more than 15 days, when absolutely necessary to address immediate serious safety needs. No later than 72 hours following placement in extreme isolation:

16.1 Measures to reduce social isolation, to ameliorate the risks from extreme isolation, and to soften the environment should begin: e.g., for prisoners with serious mental illness, structured therapeutic activities (i.e., mental health/psychiatric treatment) in appropriate programming space and adequate unstructured out-of-cell time; measures to allow pregnant women adequate access to large-muscle exercise; etc.

16.2 Efforts to assess the prisoner's behaviors and the best strategies towards a goal of alternative long-term housing should begin.

17. In extraordinary cases in which a stay of longer than 15 days is essential, any extension must be based on an authorization by medical or mental healthcare professionals in the exercise of their independent professional judgment, with additional review each seven days thereafter, or more often if needed, and in no case shall extreme isolation for significantly vulnerable individuals extend beyond 30 days.

18. There is a consensus on endorsing step-down programs for vulnerable individuals, but no exact procedures for step down were agreed upon.

19. We acknowledge the importance of transparency in furthering reform and believe transparency and accountability further the goals of public safety. Transparency increases awareness and trust for the public, prison staff, and incarcerated persons. Transparency is mission critical and ensures ethical and moral appropriateness and the commitment to positive performance.

20. Every agency should have data on the use of segregation or restricted housing, including:

20.1 Demographics of individuals in segregation/restricted housing;
20.2 The nature of segregation/restricted housing;
20.3 Length of time in segregation/restricted housing; and
20.4 Where individuals were released (internally or to the community).
20.5 Agencies should track the outcomes of those who are released from segregation.

Included in SCDC' 4.29.19 letter to LOC

20.6 It is essential there be robust data collection that measures the outcomes critical to the success of these units. This should be publicly available. Data should include:

20.6.1 Institutional violence
20.6.2 Cell extraction
20.6.3 Suicide attempts
20.6.4 Grievances
20.6.5 Disciplinary tickets
20.6.6 Assaults on staff

20.7 Agencies should also:

20.7.1 Have the capacity to undertake research and data collection.
20.7.2 Make data publicly available on their websites on a regular basis.
20.7.3 To the extent possible, be open to outside research projects for both external and internal accountability.

21. **Communication between advocates and correctional administrators may avoid needless litigation, assure the responsible stewardship of funds, and help both correctional staff and the public at large to understand reform in public safety terms.**

22. **Advocacy should also focus on legislation to ensure sufficient resources, including reallocation of resources saved by reducing segregation or restricted housing. There are barriers to achieving reform that will be distinct based on the facility and jurisdiction. There is consensus that adequate resources will be needed to meet the recommendations set out above either through new funding or reallocation of savings.**

23. **Efforts must be made to get staff "buy in" on reforms from the outset. Correctional management should find ways to celebrate courage in the service of public safety through small victories.**

24. **We call for a separate conversation and set of recommendations on segregation or restricted housing for jails and juvenile justice facilities.**

Part IV

After the Colloquium: Next Steps

Although the Colloquium resulted in the consensus recommendations above, much remains to be done. Areas of disagreement and questions for further exploration remain. For instance, participants recommended continuing discussions specifically directed to the unique challenges facing jails and juvenile corrections institutions.

The first step that should be taken is to publicize and write about the recommendations herein. Jurisdictions that did not participate will require assistance to understand and implement these recommendations. Opportunities to incorporate the ideas emanating from this Colloquium exist in the work of the Vera Institute of Justice's "Safe Alternatives to Segregation" initiative to provide assistance to state and local jurisdictions interested in implementing some of these ideas. We have already discussed and shared these recommendations with the Vera Institute and are exploring opportunities to support its work and incorporate these recommendations into its practice.

As important as the recommendations themselves, what emerged from this Colloquium was the beginning of meaningful and respectful dialogue between parties on both sides of the issue who hold competing views of the problem. This dynamic should be continued by bringing the group together again to hear about progress, learn from the research being done by the Vera Institute and others about what works, advance the discussion of outstanding issues, and narrow the range of disagreement.

Consensus methods have been used productively to solve problems in medicine and health.[21] Their main purpose is to define levels of agreement on controversial subjects. Learning from the medical profession, this Colloquium can serve as the beginning of a "consensus development" effort within corrections to address the use of social isolation. Advocates suggest that, when properly employed, consensus strategies can create structured environments in which experts are given the best available information, allowing their solutions to problems to be more justifiable and credible than otherwise. The challenge moving ahead will be selecting problems, choosing members for consensus panels, specifying acceptable levels of agreement, properly using empirical data, obtaining professional and political support, and disseminating results.

Examples of issues requiring further discussion include the best ways to manage the process of "stepping down" an individual from social isolation in prison, specific time limits on the use of extreme social isolation, and definitions of "serious" disciplinary infractions as distinguished from minor infractions that do not warrant the use of social isolation as punishment. The goal would be to identify common definitions and develop best practices.

Included in SCDC' 4.29.19 letter to LOC

Finally, the strong recommendation from the Colloquium for transparency and accountability requires further work to determine accurately the state of knowledge and available data in each jurisdiction regarding the prevalence and frequency with which different forms of social isolation are being employed, how they are defined, and their outcomes. Efforts have begun, including groundbreaking work by the Liman Center at Yale Law School and the Association of State Correctional Administrators to quantify the use of "Administrative Segregation."[22] A first step would be to survey jurisdictions to determine where their segregation policies meet, exceed, or fall short of these articulated consensus principles, then to assess which policies require rewriting. Subsequent reports could analyze how changes based on these principles have impacted policy and program outcomes. Finally, there may be an opportunity to revisit the principles in a few years to see where greater consensus or new principles have emerged as a result of implementation experiences on the ground.

John Jay College of Criminal Justice, Professor Martin Horn, and the Prisoner Reentry Institute look forward to continuing our efforts to advance these goals.

Included in SCDC' 4.29.19 letter to LOC

APPENDIX A

Participants' Biographies

John Baldwin was named director of the Illinois Department of Corrections on August 14, 2015, by Governor Bruce Rauner. As IDOC director, he is responsible for overseeing the management and operations of more than 35 state prisons, work camps, boot camps and transition centers as well as the supervision of parolees. Baldwin brings more than 35 years of overall experience to the position. He was the director of the Iowa Department of Corrections for eight years, where he oversaw a staff of nearly 4,000 officers and an offender population of 38,000. During his tenure, Baldwin worked with the Pew-MacArthur Results First Initiative to build a state-specific cost-benefit analysis on the state's corrections department. The data was used to make more informed policy and budget decisions in an effort to reduce recidivism. Baldwin began working for the Iowa Department of Corrections in 1983. In addition to his leadership as director, he served as the deputy director of Administration where he oversaw a number of areas including the budget, personnel, and evidence-based practices. Baldwin holds a master's degree in political science from Iowa State University and a bachelor's degree in economics from the University of Iowa.

Sarah Baumgartel, Senior Liman Fellow in Residence, joined the Liman Program at Yale Law School in 2015. From 2008 to 2015, she was an Assistant Federal Defender with the Federal Defenders of New York. She was also a Lecturer in Law at Columbia Law School from 2014 to 2015. Ms. Baumgartel holds degrees from Harvard Law School and Duke University. Prior to her work with Federal Defenders of New York, she worked as an attorney handling civil and criminal litigation.

Jeffrey A. Beard, Ph.D. was appointed as Secretary of the California Department of Corrections and Rehabilitation by Governor Edmund G. Brown, Jr., on December 27, 2012. He also serves as Chairman of the Prison Industry Board. Prior to his appointment as Secretary, Dr. Beard began his criminal justice career in 1972 with the Department of Corrections in Pennsylvania (DCP) as a corrections counselor. During his retirement, Dr. Beard has served as a consultant and/or instructor to the National Institute of Corrections, corrections agencies and various companies on correctional matters, security, performance measures, mental health issues, evidence-based programs and assessment. Dr. Beard holds a B.S. in psychology, and an M.Ed and Ph.D. in counseling, all from the Pennsylvania State University. He is a member of the Pennsylvania Prison Wardens Association (PPWA), American Correctional Association (ACA), Western Association of Correctional Administrators (WACA) and the Association of State Correctional Administrators (ASCA). During his tenure as Secretary in Pennsylvania he served on the National Institute of Justice's Law Enforcement and Corrections Technology Advisory Committee (LECTAC), the last three years of which he served as vice chair for Corrections.

Jack Beck has been the Director of the Prison Visiting Project at the Correctional Association of NY (CA) since 2014. The CA has statutory authority to inspect prisons in NY State and to report its findings to the legislature and public. At the CA, he has focused on monitoring conditions within NY prisons, including confinement in disciplinary housing; safety and violence in the prisons; prison medical and mental health care; and treatment of persons in prison with substance abuse histories. Prior to the CA, he was a Senior Supervising Attorney at the Prisoners' Right Project (PRP) of the Legal Aid Society, where he worked for 23 years. At PRP, he pursued federal class action litigation on behalf of people in state prisons and New York City jails. He specialized in medical care issues, with particular focus on HIV/AIDS and Hepatitis C. He is a member of several statewide coalitions concerned with (1) incarcerated persons placed in isolated confinement, and (2) medical and/or mental health care in prisons that advocate for legislation to improve care of persons inside, particularly those infected with HIV and/or hepatitis C and those who suffer from mental illness and have been placed in isolated confinement.

Included in SCDC' 4.29.19 letter to LOC

Leann K. Bertsch was appointed Director of the North Dakota Department of Corrections and Rehabilitation on July 1, 2005, by Governor John Hoeven. Prior to serving as Director, Bertsch served as the Commissioner of the North Dakota Department of Labor from September 2004 through June 2005. Prior to entering state government, Bertsch served as an Assistant State's Attorney for Burleigh County from August 1996 through August 2004. From 1992 through 1996, Bertsch worked as an attorney for Legal Assistance of North Dakota. Bertsch also served 21 years in the North Dakota National Guard, retiring as a Major in the Judge Advocate General's Corp in 2007. As Corrections Director, Bertsch has worked to implement evidence-based practices throughout the North Dakota Corrections system focusing resources on long-term offender behavior change as opposed to monitoring and compliance. Bertsch has been active on various commissions including the Commission for the Study of Racial and Ethnic Bias in the Courts; the Commission on Alternatives to Incarceration; the Governor's Task Force on Violent and Sexual Offenders; the Interagency Council on Homelessness; and the Stop Violence Against Women Advisory Committee. Bertsch also serves as an officer of the Association of State Correctional Administrators. Bertsch earned a Juris Doctor from the University of North Dakota School of Law and Bachelor of Science degree from North Dakota State University.

Brett Dignam joined the Columbia Law School faculty in 2010. She came to Columbia from Yale Law School, where she led the Prison Legal Services, Complex Federal Litigation and Supreme Court Advocacy clinics. An award-winning teacher, Professor Dignam has supervised students in a broad range of litigation matters and has designed and overseen workshops conducted by students for prisoners at the Federal Correctional Institution in Danbury, Connecticut, on issues including immigration, sexual assault, and exhaustion under the Prison Litigation Reform Act. She has participated in major litigation in over 30 federal and state cases in the area of prisoners' rights. Before entering the legal academy, Professor Dignam served as a law clerk for the Honorable William H. Orrick, U.S. District Court in San Francisco, California, and then developed a prison litigation practice in both federal and state courts. As an associate professor at Yale Law, Dignam taught and supervised students in Prison Legal Services, Poverty/HIV, Landlord/Tenant and Immigration clinics, guiding students through administrative hearings, state and federal trial and appellate courts on issues ranging from state habeas claims to violations of the Voting Rights Act. Dignam received her J.D. from the University of Southern California, where she was student director of the USC Prison Law Project and chair of the Hale Moot Court Honors Program. She has a Master of Arts degree in theater from the University of California at Los Angeles. She received her B.A. from Mount Holyoke College.

Jamie Fellner, Esq., Senior Advisor of the U.S. Program of Human Rights Watch, is engaged in research, documentation and advocacy on US criminal justice issues. Much of her work has focused on human rights abuses in US prisons, and she has written about inadequate treatment and conditions of confinement for inmates with mental illness, prison rape, solitary confinement, abusive use of force, aging prisoners and the lack of compassionate release. In addition, she has engaged in extensive research and advocacy on pretrial policies and practices and on racial disparities in drug law enforcement. She brings to this work decades of national and international professional experience. Ms. Fellner was a commissioner on the National Prison Rape Elimination Commission. She has authored and co-authored numerous published reports and articles addressing human rights problems in the United States. Ms. Fellner received her law degree from the School of Law at the University of California, Berkeley, a M.A. from Stanford University and a B.A. from Smith College.

Amy Fettig serves as Senior Staff Counsel for the ACLU's National Prison Project (NPP). At NPP, she litigates federal class action prison conditions cases. Her practice focuses on claims regarding medical and mental health care in prison, solitary confinement, prison rape and sexual abuse, and comprehensive reform in juvenile facilities. Ms. Fettig is also the Director of the ACLU's nationwide Stop Solitary campaign seeking to end the practice of extreme isolation in our nation's prisons, jails and juvenile detention centers through public policy reform, state and federal legislation, litigation and public education. A leading authority on women prisoners, Ms. Fettig also works with a wide range of ACLU affiliates on both campaigns to end the shackling of pregnant women and their advocacy strategies around women's health in prison. A national expert on prisoner rights law, she provides technical legal assistance and strategic counsel to advocacy groups and lawyers around the country and has served as an Adjunct Professor of Law at Georgetown University. She holds a B.A., with

Included in SCDC' 4.29.19 letter to LOC

distinction, Carleton College; a Master's from Columbia University, School of International and Public Affairs; and a J.D. from Georgetown University. Ms. Fettig is a member of the New York State Bar (2002) and the Bar for the District of Columbia (2006).

Marshall L. Fisher has served as commissioner of the Mississippi Department of Corrections since Jan. 1, 2015. He oversees over 2,600 employees with a $357 million budget for three state prisons, four private prisons, 15 regional facilities, 10 community work centers, three technical violation centers, and four restitution centers. A reputed coalition builder who has worked in local, state and federal law enforcement, Fisher has years of experience in overseeing complex public safety issues. When Gov. Phil Bryant named him commissioner, Fisher was state director for the Mississippi Gulf Coast High Intensity Drug Trafficking Area, where he was a liaison for drug task forces and area law enforcement agencies. Fisher accepted the federal post after spending nearly 10 years as the state's top narcotics enforcer. He was executive director of the Mississippi Bureau of Narcotics from 2005-2014, acting as the senior advisor to the governor and the Mississippi Legislature on drug policy matters. Fisher led MBN after retiring from the Drug Enforcement Administration, where he once served as Agent in Charge of Mississippi DEA operations. During a DEA career that spanned two decades, he was assigned to field offices in Texas, Kansas, and Kentucky and DEA Headquarters in Washington, D.C., where he was section chief in the Office of Domestic Operations to Europe, Asia, Africa and Canada. In 2010, Fisher received the National Impact Award for his anti-methamphetamine efforts. He is also the 2011 recipient of the Jim Ingram Lifetime Achievement Award and the 2015 recipient of the George Phillips Public Service Award. Fisher started his law enforcement career as a police officer in Texas. He is a U.S. Navy veteran and a graduate of the University of Memphis, with a Bachelor of Arts degree in criminal justice.

Robert Fleischner is an attorney and assistant director at the Center for Public Representation, a national public interest law firm in Northampton, Massachusetts. He has represented people with disabilities since 1973, when he graduated from Boston College Law School. He has litigated and argued appeals in prison and juvenile justice reform cases on behalf of adults and youth with mental illness, including those held in segregation. His other litigation includes school-to-prison pipeline, civil commitment, right to treatment, guardianship and community integration cases. He has consulted with dozens of state Protection and Advocacy programs on criminal and juvenile justice issues. He is co-author of *Guardianship and Conservatorship in Massachusetts*, 2d Ed., (Lexis) and has authored numerous law journal articles. Bob has served on the adjunct faculties of Western New England University Law School and Smith College School for Social Work, teaching courses on juvenile justice and disability law.

Dr. Stuart Grassian of Massachusetts is a Board-certified psychiatrist who was on the teaching staff of the Harvard Medical School for almost thirty years. He has had extensive experience in evaluating the psychiatric effects of stringent conditions of confinement and has served as an expert in both individual and class-action lawsuits addressing this issue. Dr. Grassian described a particular psychiatric syndrome resulting from the deprivation of social, perceptual, and occupational stimulation in solitary confinement. His observations and conclusions have been cited in a number of federal court decisions, for example: *Davenport v. DeRobertis*, 844 F.2d 1310 (7th Cir. 1988), and *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995). In his publications, he described the extensive body of literature, including clinical and experimental literature, regarding the effects of decreased environmental and social stimulation in a variety of situations, and specifically, observations concerning the effects of segregated prison confinement.

Ron Honberg, J.D., serves as the national director for policy and legal affairs at NAMI, the National Alliance on Mental Illness. As director of NAMI's policy team, Mr. Honberg oversees NAMI's work on federal and state policy issues and on legal issues. In recent years, he has worked particularly on issues affecting people with mental illnesses involved with criminal justice systems, including jail diversion, correctional treatment, and community reentry. He was also one of the lead authors in NAMI's 2006 "Grading the States" report. During his nearly eighteen years with NAMI, Ron has drafted amicus curiae briefs in precedent-setting litigation impacting people with mental illnesses and has provided technical assistance to attorneys and NAMI affiliates. He has also published a number of articles on policy and

Included in SCDC' 4.29.19 letter to LOC

legal issues affecting people with mental illness and other disabilities. Before coming to NAMI in 1988, Mr. Honberg worked as a Vocational Rehabilitation Counselor for the State of Maryland and in a variety of direct service positions in the mental illness and developmental disabilities fields. A former president of the Maryland Rehabilitation Counseling Association, he served in a voluntary capacity for six years on the board of directors of St. Luke's House, a psychiatric rehabilitation program serving over 400 clients in Montgomery County, Maryland. Mr. Honberg has a Juris Doctor degree from the University of Maryland School of Law and a Master's Degree in Counseling from the University of Maryland.

Terry A. Kupers, M.D., M.S.P., is Institute Professor at The Wright Institute and Distinguished Life Fellow of the American Psychiatric Association. He provides expert testimony in class action litigation regarding the psychological effects of prison conditions, including isolated confinement in supermaximum security units, the quality of correctional mental health care, and the effects of sexual abuse in correctional settings. He is author of *Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It* (1999) and co-editor of *Prison Masculinities* (2002). He is a Contributing Editor of Correctional Mental Health Report. He received the 2005 Exemplary Psychiatrist Award from the National Alliance on Mental Illness (NAMI).

Gary M. Lanigan, who has more than three decades of experience in the criminal justice and financial management realms, was confirmed as Governor Chris Christie's choice as Commissioner of the New Jersey Department of Corrections (NJDOC) in March 2010. As head of the NJDOC, Mr. Lanigan is responsible for a budget of roughly $1 billion, approximately 8,000 employees, 13 correctional institutions and more than 21,000 state-sentenced offenders housed in prisons, county jails and community halfway houses. Mr. Lanigan also was employed by the New York City Department of Correction, serving as the Deputy Commissioner of Administration, followed by a position as First Deputy Commissioner. In addition, Mr. Lanigan served as an Assistant Commissioner with the New York City Police Department and as an analyst with the New York City Office of Management and Budget. The Commissioner, a veteran of the United States Navy, received both a Master of Public Administration degree and a Bachelor of Science degree in business administration from Bernard M. Baruch College. He is also a graduate of the Police Management Institute sponsored by the Columbia University Graduate School of Business. Mr. Lanigan also attended the John F. Kennedy School of Government at Harvard University Leadership Institute.

Jules Lobel is the Bessie McKee Walthour Endowed Chair at the University Of Pittsburgh School of Law. Recently, Lobel co-authored the award winning book *Less Safe, Less Free: Why America is Losing the War on Terror* (2007) with Professor David Cole, which won the first Roy C. Palmer Civil Liberties Prize for exemplary scholarship exploring the tension between civil liberties and national security. He is also the author of *Success without Victory: Lost Legal Battles and the Long Road to Justice in America* (2003) and editor of several books on civil rights litigation as well as the U.S. Constitution. He has authored numerous articles on international and constitutional law in publications including Yale Law Journal, Harvard International Law Journal, Cornell Law Review, University of Pennsylvania Law Review and Virginia Law Review. Lobel is also President of the Center for Constitutional Rights, a national human and constitutional rights organization headquartered in New York City.

Joe Luppino-Esposito is a Policy Analyst for Right on Crime and the Center for Effective Justice at the Texas Public Policy Foundation. Joe serves as the Foundation's liaison in the nation's capital, working with Congress and allied organizations to develop criminal justice reforms. Prior to joining TPPF, Joe was the Editor and General Counsel of State Budget Solutions, focusing on public employee pensions, labor law, and state budget reforms. As the Visiting Legal Fellow at the Heritage Foundation, Joe worked on the over-criminalization project, analyzing federal criminal laws. Joe is a graduate of Seton Hall University School of Law, where he was Editor in Chief of the Circuit Review legal journal. He received a B.A. from the College of William and Mary. Joe is a licensed attorney in Virginia. He is a New Jersey native and currently resides in Virginia.

Included in SCDC' 4.29.19 letter to LOC

Gregg Marcantel, a United States Marine Corps (USMC) veteran, is an experienced law enforcement executive for over three decades. Gregg currently serves the State of New Mexico as Cabinet Secretary for the New Mexico Corrections Department. Before assuming his current post, Gregg served the New Mexico Department of Public Safety as their Deputy Cabinet Secretary following his retirement from the Bernalillo County Sheriff's Department in Albuquerque, New Mexico as a Division Commander. During Gregg's career, he successfully completed the Federal Bureau of Investigation's National Academy and currently serves as the President of the New Mexico FBI National Academy Associates. Gregg also attended the Bramshill Police Staff College in the United Kingdom, where he studied the leadership and management of serious and serial crimes. He possesses a Master of Science Degree in Forensic and Legal Psychology from the University of Leicester and a Bachelor Degree in Criminal Justice from Chaminade University of Honolulu. Throughout his public safety career, Gregg has received numerous awards ranging from the Navy Achievement Medal in the USMC to national recognition by the Department of Justice and the Drug Enforcement Administration, to include receipt of the Nation's Top Cop Award by the National Association of Police Organizations in Washington, D.C. He has presented both nationally and internationally on a host of complex criminal investigation strategies and served in university adjunct faculty roles relating to the delivery of a variety of criminal justice courses to include Criminal Investigations, Behavior-based Rape Investigations, Murder: An Analytical Study, Police Supervision and Management, as well as Forensic Psychology.

Rev. Laura Markle Downton is the Director of U.S. Prisons Policy and Program at the National Religious Campaign Against Torture (NRCAT), an interfaith membership organization working to end torture in U.S. policy, practice and culture. Rev. Markle Downton directs the state and federal advocacy agenda for interfaith leadership in NRCAT's campaign to end torture in U.S. prisons and jails, with a focus on ending long-term solitary confinement. She provides coordination, training, resource development, and technical direction to faith-based organizations nationally. Most recently, she has developed programmatic tools for faith community outreach including supervising the production of a documentary about solitary confinement called "Breaking Down the Box," and coordinated a nationwide tour of a solitary confinement prison cell replica. Prior to joining NRCAT, Rev. Markle Downton was a National Organizer for the General Board of Church and Society of the United Methodist Church, building networks among communities of faith engaged in the promotion of restorative justice. She has worked with diverse religious communities and legal advocates for employment and housing justice in Washington, DC and Philadelphia, PA. She is a Provisional Elder in the Baltimore-Washington Annual Conference of The United Methodist Church. Rev. Markle Downton holds a M.Div. from Princeton Theological Seminary, is a Midwest Academy trained organizer, and holds certification from the Strategies for Trauma Awareness and Resilience (STAR) Program of Eastern Mennonite University.

Terri McDonald, a 24-year veteran of the California Department of Corrections and Rehabilitation (CDCR) was recently appointed to the position of Assistant Sheriff by Sheriff Lee Baca and will oversee the Custody Division of the Los Angeles County Sheriff's Department. Assistant Sheriff McDonald's career in law enforcement began in 1988 as a Correctional Officer with the California Department of Corrections and Rehabilitation. During her tenure with the CDCR, she literally worked her way up through the ranks of the Department, working as an Officer, Sergeant, Lieutenant, Captain, including Captain at Folsom State Prison, Associate Warden, Chief Deputy Warden, Division Chief, Chief Deputy Secretary and Undersecretary. Additionally, she oversaw the Statewide Classification Unit, Statewide Population Management Unit, assisted in revamping the correctional officer academy, and oversaw and activated out-of-state prisons with California inmates. Prior to her employment with the Department, Assistant Sheriff McDonald oversaw California's state prisons, juvenile justice, gang unit, fugitive apprehension unit, victim services, rehabilitative programming and the Ombudsman's office. Assistant Sheriff McDonald holds a Bachelor of Science Degree in Leadership in Law Enforcement, graduating with Honors from the University of San Francisco.

Included in SCDC' 4.29.19 letter to LOC

Shirley Moore Smeal is the Executive Deputy Secretary for the Pennsylvania Department of Corrections. She oversees administrative, programmatic, security and operational areas for the Department. She participated in a correctional system reform effort that resulted in the largest population reduction in the Department's history. Moore Smeal is responsible for enacting all provisions of the Justice Re-Investment initiative within the Department, to include the complete restructuring of our Community Corrections System. Moore Smeal is a member of the Pennsylvania Prison Warden's Association (PPWA) and is a recipient of its lifetime achievement award. She is also a member of the American Correctional Association and Association of Women Executives (AWEC). Moore Smeal holds a bachelor's degree in business administration from Edinboro University.

Carol Higgins O'Brien was appointed Commissioner of the Massachusetts Department of Correction on September 10, 2014, by the Secretary of the Executive Office of Public Safety and Security (EOPSS) Andrea Cabral. Carol's career began as an entry level Corrections Counselor at MCI-Concord in 1984. She remained with the DOC for 15 years, served in three facilities and was promoted from Director of Programs to Director of Treatment to Deputy Superintendent. In 2000, she left the DOC to accept an appointment by Sheriff Frank Cousins to the position of Superintendent of the Essex County Correctional Facility, responsible for care, security and rehabilitation of over 1,100 inmates. In 2002, she was appointed by former Governor Jane Swift to be Undersecretary of Criminal Justice in the EOPSS. Following the transition from the Swift to the Romney Administration, she returned to the Essex County Sheriff's Office, where she managed three community corrections centers and oversaw inmate programs and education. Commissioner Higgins O'Brien holds a Master's Degree in Criminal Justice from UMass-Lowell and is a graduate of the Kennedy School of Government Senior Executive Program at Harvard University. She is also an adjunct professor at UMass-Lowell in the Criminal Justice and Criminology Department, where she teaches courses on violence in America, institutional corrections and community-based corrections and is also a member of the UMass Lowell Criminal Justice Alumni Advisory Board. She is also an active member of the American Correctional Association (ACA) and the Association of State Correctional Administrators (ASCA).

Taylor Pendergrass is a senior staff attorney at the New York Civil Liberties Union (NYCLU), and before that a staff attorney at the ACLU of Colorado. He focuses on litigation and advocacy related to criminal justice reform. He co-authored a human rights report on the use of solitary confinement in New York prisons, filed complaints with international human rights bodies regarding the issue, and is currently lead counsel in the NYCLU's class-action lawsuit challenging those practices. He has been involved in advocating for reforms to solitary confinement practices in the New York City jails on Rikers Island. He was counsel on the NYCLU's class action lawsuit challenging New York's broken indigent criminal defense system, a lawsuit challenging the NYPD's stop-and-frisk practices, and lawsuits challenging inhumane conditions in jails and prisons. He is a graduate of Duke University and the University of Colorado School of Law.

Joseph Ponte has earned a national reputation as a successful reformer in his more than 40-year corrections career. A native of Massachusetts, Ponte has served in jails and prisons around the country, including in Nevada, Florida, Tennessee, New Jersey, Rhode Island and Massachusetts. His broad experience – from frontline correctional officer, to warden, to director and commissioner – gives him a unique perspective and granular understanding of corrections-system management. Before becoming the Commissioner of New York City's Department of Correction in April 2014, Ponte served as Commissioner of the Maine Department of Corrections since 2011, where he instituted substantial reforms, making the system a national leader. He has also served as director of the jail in Shelby County, Tennessee, which includes the city of Memphis – helping transform the violence-prone jail while supporting its staff. Under his leadership, the jail gained accreditation by the American Correctional Association – a certification of merit. Ponte is a Marine Corps veteran (1965-1969) and holds a bachelor's degree in political science from Bridgewater State College.

Included in SCDC' 4.29.19 letter to LOC

Rick Raemisch has been Executive Director of Colorado Department of Corrections since July 2013. Mr. Raemisch's career spans three decades as a Deputy Sheriff, Prosecutor, Elected Sheriff and Head of Wisconsin's Department of Corrections. His professional career started at the Dane County Sheriff's Office in Madison, Wisconsin. He worked from 1976 to 1988 as a deputy sheriff and then as an undercover narcotics detective who also investigated homicides. During the same time, he attended law school and then joined the Dane County District Attorney's Office in Madison as an Assistant District Attorney. He held that job for a year before joining the U.S. Attorney's Office in Madison in 1989 as an Assistant U.S. Attorney. He was appointed sheriff in Dane County in 1990 and elected four more times. In 1997, he entered the private sector until 2002 when he re-entered the public sector as a tax appeals commissioner for the State of Wisconsin's Tax Appeals Commission. He joined the State of Wisconsin's Department of Corrections in 2003 and for the next four years worked as Division Administrator of Community Corrections, in which he had oversight of 68,000 probation and parolees, and then worked as Deputy Secretary. He was named Secretary of the Wisconsin Department of Corrections in 2007. He has received numerous honors throughout his career, including being named the Wisconsin Law Enforcement Executive of the Year by Wisconsin Attorney General Jim Doyle. He earned a bachelor's degree from the University of Wisconsin-Stevens Point and a J.D. with honors from the University of Wisconsin Law School.

Heather Rice-Minus serves as Director of Government Affairs for Justice Fellowship (JF), the advocacy arm of Prison Fellowship. She brings a wealth of experience in policy development and advocacy as a lobbyist on Capitol Hill. As staff lead on JF's federal and state legislative strategy, Rice-Minus works with the faith community, think tanks, and other stakeholders to advance criminal justice reforms, including policies addressing sentencing for drug offenses, prison conditions, victims' rights and services, and reentry programming, among others. Prior to joining JF, Rice-Minus worked as Director of U.S. Prisons Policy for the National Religious Campaign Against Torture and also spent a year in East Africa teaching English and volunteering in orphanages. Rice-Minus was commissioned as a Centurion by the Chuck Colson Center for Christian Worldview in May 2014. She holds a Juris Doctor from George Mason University School of Law and is a member of the Virginia Bar.

Margo Schlanger teaches and writes about constitutional law, civil rights, and prisons at the University of Michigan Law School. In 2010 and 2011, she was the presidentially appointed Officer for Civil Rights and Civil Liberties at the U.S. Department of Homeland Security, the Secretary's lead advisor on civil rights and civil liberties issues, including those relating to immigration detention. She played a key role in DHS's reforms of solitary confinement and sexual abuse prevention. Professor Schlanger earned her J.D. from Yale and served as law clerk for Justice Ruth Bader Ginsburg from 1993 to 1995. Next, she was a trial attorney in the U.S. Department of Justice Civil Rights Division, where she worked to remedy civil rights abuses by prison and police departments. She served on the Vera Institute's Commission on Safety and Abuse in America's Prisons and was the reporter for the American Bar Association's Standards on the Treatment of Prisoners. She founded and runs the Civil Rights Litigation Clearinghouse.

Scott Semple joined the Connecticut Department of Correction as a front line Correction Officer in 1988 at the high security Cheshire Correctional Institution. While working up the ranks, he has held key positions within the agency, including a supervisor at the training academy, the agency's spokesperson, and the Legislative Liaison for the department. In 2004, Commissioner Semple was assigned to the Garner Correctional Institution where he fulfilled a critical role in establishing the agency's first consolidated environment for male offenders with significant mental health needs. He would later serve as the Unit Administrator/Warden at that same facility. In November 2013, then Commissioner James E. Dzurenda appointed Semple as the Deputy Commissioner of Operations and Rehabilitative Services. Less than one year later, with the retirement of Commissioner Dzurenda in August 2014, Semple was chosen to serve as the Interim Commissioner for the agency. On March 10, 2015, a Senate resolution unanimously passed consent on the appointment of Semple as Commissioner for the Connecticut Department of Correction.

Included in SCDC' 4.29.19 letter to LOC

Bryan P. Stirling was appointed by Governor Nikki Haley as Director of the South Carolina Department of Corrections effective October 1, 2013. He is responsible for a staff of over 5,700 employees at SCDC that operates 24 penal institutions across the state incarcerating more than 21,500 inmates. Prior to joining the correctional system, Director Stirling served Governor Nikki Haley as her Chief of Staff from October 2012 to September 2013. As Chief of Staff, he oversaw management of the governor's cabinet and the Office of Executive Policy and Programs. Director Stirling has been an active volunteer in the community, having worked as the Pro Bono CDV Prosecutor during his time with the South Carolina Attorney General's Office. Director Stirling received his Juris Doctor from the University of South Carolina Law School in 1996 and previously received a Bachelor of Arts in Political Science from USC in 1991.

Bernie Warner has over 34 years of experience in both juvenile and adult corrections. In 2011, Mr. Warner was appointed the Secretary of the Washington State Department of Corrections. As Secretary, Mr. Warner leads an agency of 8,000 employees responsible for over 35,000 offenders in 12 prisons, 15 work releases, and 123 community offices. Mr. Warner has held executive corrections positions in Arizona, Florida, and California, where he served as Director of the juvenile justice system. Secretary Warner has focused on comprehensive system reform based on an evidence-based model of risk, need, and responsivity. Secretary Warner is leading innovative initiatives to include the reengineering of community corrections, the first statewide implementation of the HOPE model, blending swift and certain sanctions with community-based cognitive behavioral interventions; a "mission focused" response to offenders in restrictive programs, significantly reducing the number of inmates in segregation; the piloting of a prison based "cease-fire" model as a strategy to manage serious gang behavior; and a gender responsive strategy to ensure appropriate services for incarcerated women.

Heidi E. Washington was appointed Governor Rick Snyder as the director of the Michigan Department of Corrections in May 2015. Her appointment was effective July 1, 2015, and as director, she is responsible for overseeing the administration of Michigan's correctional system, which includes the state's prisons, probation and parole supervision, the Parole Board, and other administrative functions, in addition to managing a $1.9 billion budget. Director Washington is a 17-year veteran of the Department of Corrections and has served in a number of leadership positions during her career with the department. Prior to her appointment as director, she was warden of the Charles E. Egeler Reception and Guidance Center and the Duane L. Waters Health Center. She also held positions as warden of Robert Scott Correctional Facility and administrative assistant to the department's executive bureau and director, where she provided oversight for the Legislative Affairs Office and represented the MDOC before the Legislature. She has additionally served as acting assistant deputy director, overseeing the 19 prison facilities in the southern region of the state, and acting operations administrator for the Correctional Facilities Administration. She joined the MDOC in 1998 as a legislative assistant after working for the legislature for several years. Director Washington holds a Bachelor of Arts degree in political science from Michigan State University and a law degree from Thomas M. Cooley Law School.

Facilitators

Brian Fischer spent over forty-four years in the field of corrections, becoming the Commissioner of the New York State Department of Corrections in 2007, and retiring in 2013. While Commissioner, he consolidated the Division of State Parole and the Department of Corrections into the now existing Department of Corrections and Community Supervision and coordinated the downsizing of the agency by closing prison farms, annexes, camps and several medium security prisons. During his tenure as Commissioner, Mr. Fischer implemented the Sex Offender Management Treatment Act passed into law by former Governor Spitzer and a settlement to a class action lawsuit filed by Disabilities Advocates, Inc., a state-sponsored agency authorized to protect individuals with mental and developmental disorders that required changes in how such persons were treated while in prison. While Commissioner, he also created short-term Parole Violator Treatment Centers in order to reduce the number of technical parole violators being returned to prison for long periods of time. Mr. Fischer currently sits on the board of three non-profit prisoner advocacy agencies; Hudson Link For Higher Education that provides college degree programs in State prisons, the Osborne Association that provides for in-prison and re-entry services to both jail and prison individuals, and Puppies Behind Bars that has prisoners train special service dogs for wounded veterans. Mr. Fischer has been an adjunct professor at both John Jay College of Criminal Justice and Pace University. He was a member of the Standards Committee of the American Correctional Association and the New York State Sentencing Commission. He holds a Bachelor's Degree in Psychology, a Master's Degree in Guidance and Counseling and a Master's Degree in Professional Studies.

Andie Moss is founder and President of The Moss Group, Inc., with over 30 years of experience working on sensitive correctional management issues. She has worked with all levels of state, local and federal officials in management assessment, program development and juvenile and adult operations. Andie serves an as advisor to federal and state policymakers and is a former president of the Association of Women Executives in Corrections. She also provided expertise to the National Prison Rape Review Panel and the National Prison Rape Elimination Commission. She has been recognized for her pioneering work in sexual safety and addressing institutional culture. Andie is a partner with the National PREA Resource Center and the National Resource Center for Justice Involved Women. As best practices are sought amid the national dialogue on restrictive housing, Andie encourages distinguishing the patterns of behavior seen in gender differences and adult and juvenile populations.

Michael B. Mushlin teaches Civil Procedure, Evidence, and Prisoners' Rights at Pace University School of Law. He is the author of book chapters, and articles on a variety of subjects involving evidence, federal jurisdiction, civil procedure, children's rights, and prisoners' rights that have appeared in journals such as the Yale Law and Policy Review, UCLA Law Re- view, Harvard Civil Rights Civil Liberties Law Review, The Journal of Legal Education, Brooklyn Law Review, and the Fordham Urban Law Journal. Professor Mushlin was selected to be a member of the Executive Committee of the New York City Bar, and was elected Secretary of the Executive Committee. He is Vice Chair of the Correctional Association of New York, and was a member of the Task Force on the Legal Status of Prisoners of the American Bar Association. He served as co-chair of the Subcommittee on Implementation of the ABA Resolution on Prison Oversight. He is a member of the New York Advisory Committee on Criminal Law and Procedure of the Office of Court Administration. Professor Mushlin is the former Associate Dean for Academic Affairs, Chair of the Committee on Corrections of the New York City Bar, and former Chair of the Board of the Correctional Association and the Osborne Association. He is a member of the Editorial Board of the Correctional Law Reporter. Professor Mushlin also served on the boards of Children's Rights Inc. and Pace Law School's John Jay Legal Services Inc. Professor Mushlin practiced as a public interest and civil rights lawyer for 15 years as staff attorney with Harlem Assertion of Rights, Inc., as staff attorney and Project Director of the Prisoners' Rights Project of the Legal Aid Society, and as Associate Director of the Children's Rights Project of the American Civil Liberties Union.

Included in SCDC' 4.29.19 letter to LOC

APPENDIX B

Reduction of Segregation in Washington State

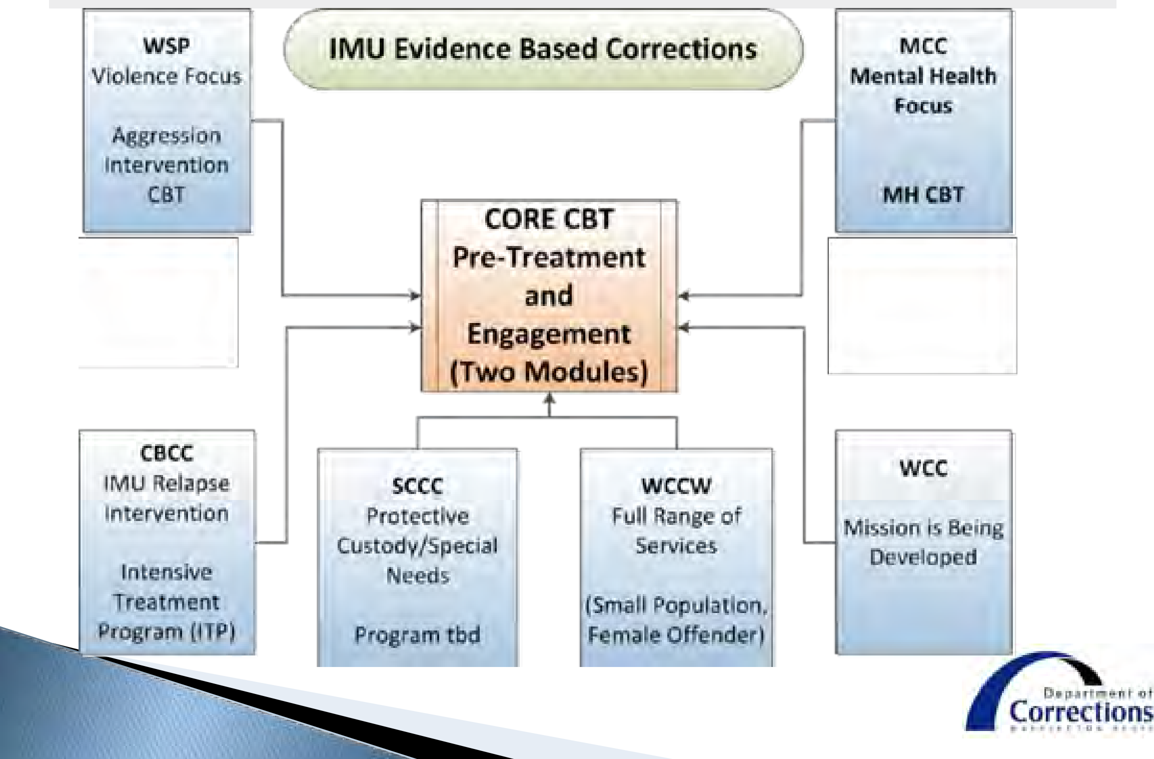
Presented by:
Bernie Warner, Secretary of Corrections, State of Washington

Restricted Housing

Changes to solitary housing

FROM	TO
Suppression and containment	**Intensive programming**
Use as punishment	Use as a **management tool** when they cannot be safely managed in population
Managing different types of prisoners the same	Mission-specific housing to target **risk, need, responsivity**
IMS structured as a time-driven system	Behavior change through programming and **congregate activity**

Missioned Housing



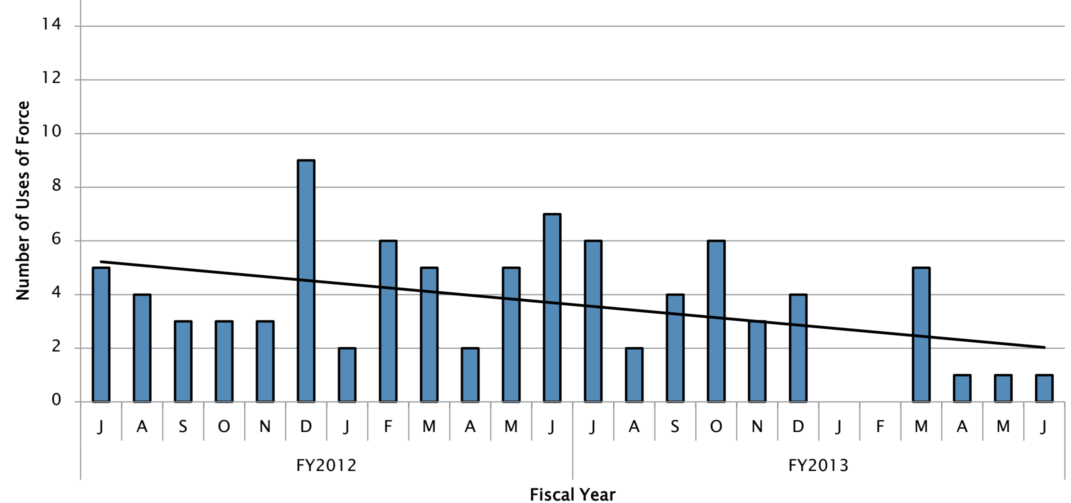
Washington State Penitentiary (WSP)

- **Motivating Offender Change (MOC) Program**
  - Targets Security Threat Group (STG/Gang) prisoners
  - General population STG units co-located at WSP
  - Anger Control Training
  - Four phases of behavior change and development
  - Incremental reinforcers to encourage behavior change

Monroe Correctional Complex (MCC)

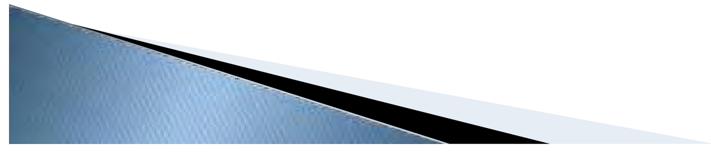
- **Reintegration and Regression Programming (RAPP)**
  - Targets mentally ill prisoners
  - Co-location of Intensive Treatment Unit, mental health facility at MCC
  - Cognitive Behavior Therapy
  - One mental health professional per 50 prisoners
  - Individualized Treatment/ Behavior Management Plan

Use of Force Incidents in WSP – IMU Have Decreased



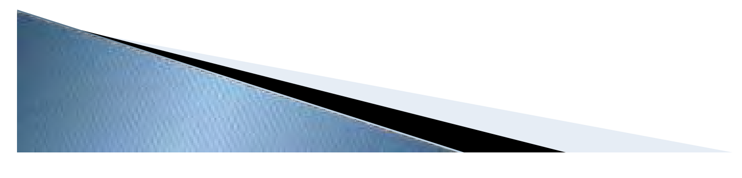
Clallam Bay Corrections Center (CBCC)

- **Intensive Transition Program (ITP)**
  - Targets chronic IMU recidivists
  - Provides prisoners pro-social skills to successfully live in general population
  - Includes mixed cognitive-behavioral therapy curriculum with phases and congregate activity
- **80% success rate**
  - Of the 131 program graduates ITP; 107 have not returned



Organizational culture change

- Give staff professional development tools
  - Core Correctional Practices
  - Motivational interviewing
- Engage staff in the change process
  - Encourage interaction between prisoners and staff through physical setting and interactive tools
  - Having staff build programs, set up classroom, etc.



APPENDIX C

Reforms for Youth at Rikers Island in New York City

Presented by:
Joseph Ponte, Commissioner of Correction, City of New York

The 14 point antiviolence reform agenda will improve DOC

Reducing Violence

- Keep weapons and drugs out of Rikers
- Create an integrated classification and housing strategy
- Comprehensive security camera coverage
- Design effective inmate education opportunities and services
- Redefine First Line Incident Response

Supporting the Culture Change at Rikers

- Improve leadership development and culture
- Redefine Investigations Division
- Design a recruitment, hiring, and staff selection plan
- Design a staff performance management plan
- Implement operational performance metrics and analysis
- Create a well-defined supply distribution process
- Improve custody management processes
- Expand targeted training
- Raise Facilities to a state of good repair

Implement immediate improvements

Improve internal & external communications

Included in SCDC' 4.29.19 letter to LOC

The Ending of Punitive Segregation for 16-17 year-olds

October 1, 2014

- 50 adolescents in Punitive Segregation (25 in RHU + 25 in regular P-Seg)
- 257 in custody
- 1,477 days owed total

December 31, 2014

- 0 adolescents in Punitive Segregation
- 176 in custody

January/February 2015

- 0 days owed

September 29, 2015

- 0 adolescents in Punitive Segregation
- 205 in custody

CAPS - Clinical Alternative to Punitive Segregation

- Specialized mental health treatment of seriously ill inmates who have committed violence.
- DOC established CAPS in 2013 (Opened Oct 17, 2013, CAPS began with 4 inmates at AMKC)
- CAPS has 30 inmates (September 28, 2015)
- The Use of Force in CAPS was 40% lower than the rate on Restricted Housing Unit (RHU) during the first 6 months of 2015

PACE (Program to Accelerate Clinical Effectiveness)

- Non-punitive model
- Created in January 2015 to build on the CAPS.
- 57 inmates (September 28, 2015)
- Designed to encourage adherence to treatment.
- Continuity of care and a team-based approach.

Commissioner Joseph Ponte at the New York City Department of Correction

April 2014
- Commissioner Ponte Appointment

Summer 2014
- CAPS Program Expansion

December 2014
- Punitive Segregation for Adolescent Inmates ends

January / February 2015
- Enhanced Supervision Housing Created
- Elimination of Time Owed

April to July 2015
- PACE Units 1 & 2 Open

September 2015
- DOC Punitive Segregation Population declines 2/3

February 2016
- Punitive Segregation for Young Adult Inmates to End

APPENDIX D

Removal of the Seriously Mentally Ill from Administrative Segregation in Colorado

Presented by:
Rick Raemisch, Executive Director, Colorado Department of Corrections

Rick Raemisch
Executive Director

Residential Treatment Program

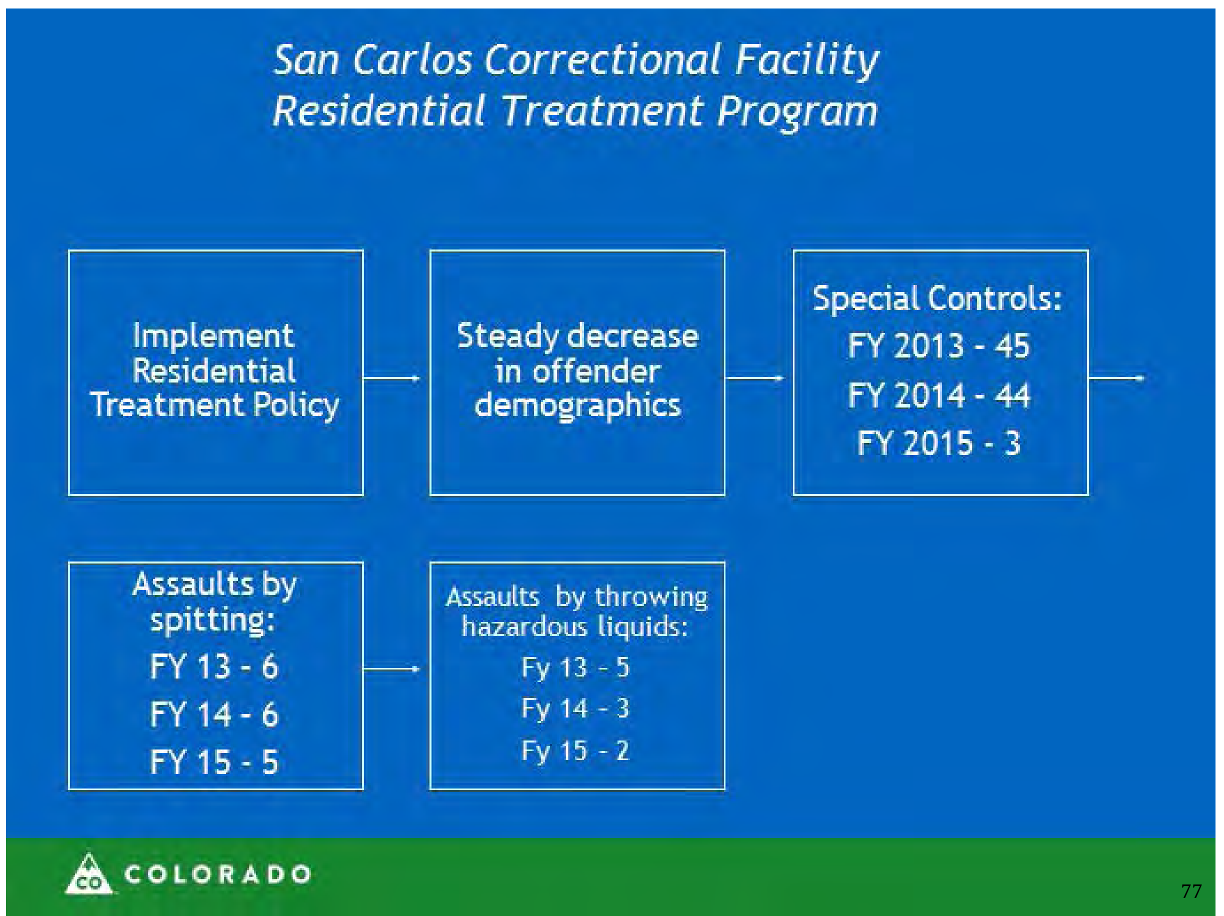
Purpose: To provide a treatment program with incentive level systems for offenders with mental illness and/or intellectual and developmental disabilities, and criteria for movement/transition for RTP offenders.

Deter offenders being placed into Restrictive Housing for behaviors that are directly related to their mental illness.

Residential Treatment Programming

Colorado has 3 Residential Treatment Programs:

255 Bed Acute Needs Facility for males
240 bed Chronic/long term Facility for males
48 bed acute/chronic unit for females



UNITED NATIONS
Rule 82(2).
"Prisoners who suffer from other mental diseases or abnormalities shall be observed and treated in specialized institutions under medical management"

COLORADO DEPARTMENT OF CORRECTIONS
AR 650-04
It is the policy of the Department of Corrections to offer specialized programs to offenders with mental illness and/or intellectual and developmental disabilities.

UNITED NATIONS RECOMMENDATION

"Restrict the criteria in determining whether a person can be sent to isolated confinement or an alternative therapeutic confinement setting to the most serious acts"

"Indefinite solitary confinement should be abolished"

COLORADO DEPARTMENT OF CORRECTIONS

AR 650-03

It is the policy of the Department of Corrections (DOC) to establish and provide effective restrictive housing management procedures for offenders who have demonstrated through their behavior that they pose a significant risk to the safety and security of staff and other offenders, as well as to the safe and orderly operation of general population. The use of Restrictive Housing, to include Maximum Security Status is an offender management process requiring specific action and review for placement and/or progression.

May 2011:

1,484 Administrative Segregation Offenders

BY OPENING THE DOOR... YOU OPEN OPPORTUNITIES

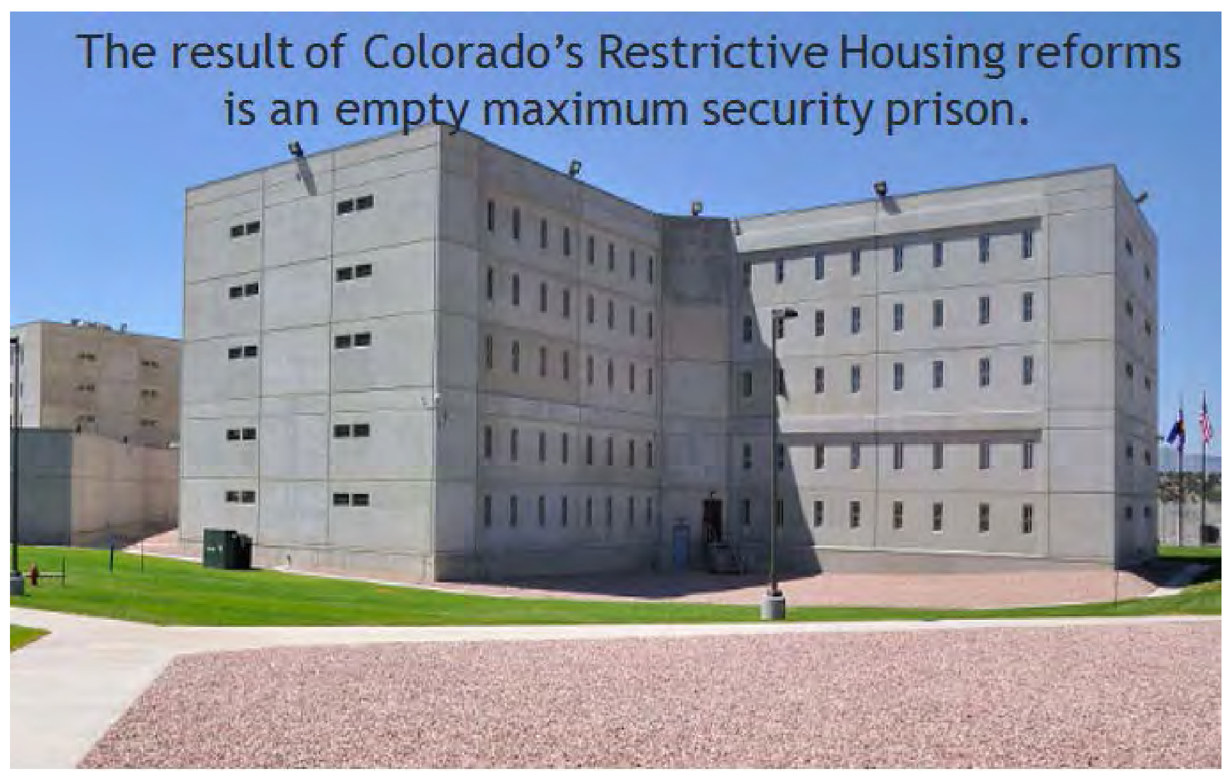
What is next for the Colorado DOC?

2015 -
Colorado is working on evolution of policy to address female sanctions.

Installing restraint tables in restrictive housing for out of cell programming to offenders serving long term sanctions

Development of alternative and immediate sanctions versus referral to Restrictive housing

Visitation technology for those in restrictive housing


The result of Colorado's Restrictive Housing reforms
is an empty maximum security prison.

COLORADO
Department of Corrections

COLORADO
Department of Corrections

ENDNOTES

1. Beck, A.J. Department of Justice. Bureau of Justice Statistics. (Oct. 2015). *Use of Restrictive Housing in U.S. Prisons and Jails, 2011-2012. See also* Carson, E.A. Department of Justice. Bureau of Justice Statistics. (Sept. 2015). *Prisoners In 2014, and* Milton, T. & Zeng, Z. (June 2015). Department of Justice. Bureau of Justice Statistics. *Jail Inmates at Midyear 2014*.

2. *In re Medley*, 134 U.S. 160, 168 (1890) ("[Prisoners subject to solitary confinement] fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community."). See also Editors. (2013). Solitary Confinement is Cruel and Ineffective. *Scientific American* 309(2), available at http://www.scientificamerican.com/article/solitary-confinement-cruel-ineffective-unusual/.

3. *See, e.g.*, Reiter, K. (2010). Parole, snitch, or die: California's supermax prisons and prisoners, 1997-2007. *Punishment & Society* 14(5):530-563. O'Keefe, M. (2005). *Analysis of Colorado's Administrative Segregation*. Colorado Department of Corrections: Office of Planning & Development 25.

4. *See, e.g.*, Hammel, P. (2015, Nov. 7). Prison officials target solitary confinement, mental health treatment in effort to avoid another Nikko Jenkins. *Omaha World-Herald*. Available at http://www.omaha.com/news/legislature/prison-officials-target-solitary-confinement-mental-health-treatment-in-effort/article_361583dd-f22d-5ec6-89b3-d4242b0d7782.html.

5. Mohr, G. & Raemisch, R. (2015). Restrictive housing: Taking the lead. *Corrections Today*, available at http://www.aca.org/ACA_PROD_IMIS/Docs/Corrections%20Today/2015%20Articles/March%202015/Guest%20Editorial.pdf. *See also* Association of State Correctional Administrators. (2013). *Resolution #24 Restrictive Status Housing Policy Guidelines, adopted Sept. 2, 2013.*

6. The meeting was, by agreement of all participants, subject to the "Chatham House Rule," which states, "When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed." *See more* at http://www.chathamhouse.org/about/chatham-house-rule#sthash.NhS71S3u.dpuf.

7. The Mandela Rules state: "For the purpose of these rules, solitary confinement shall refer to the confinement of prisoners for 22 hours or more a day without meaningful human contact. Prolonged solitary confinement shall refer to solitary confinement for a time period in excess of 15 consecutive days." United Nations. Commission on Crime Prevention and Criminal Justice. *Standard Minimum Rules for the Treatment of Prisoners*, proposed rules. Twenty-fourth session Vienna, 18-22 May 2015.

Included in SCDC' 4.29.19 letter to LOC

8. *See, e.g.*, Presentations of Bernie Warner, Joseph Ponte, and Rick Raemisch, at Appendices A-C, *infra*.

9. Labrecque, R.M. (2015). *The Effect of Solitary Confinement on Institutional Misconduct: A Longitudinal Evaluation* (Unpublished doctoral dissertation). University of Cincinnati, Division of Research and Advanced Studies, Cincinnati, OH.

10. Beijersbergen, K., Dirkzwager, A. & Nieuwbeerta, P. (2015). Reoffending after release: Does procedural justice during imprisonment matter? *Criminal Justice and Behavior.* doi: 10.1177/0093854815609643.

11. For example, one participant, a corrections administrator, observed that despite closing 15 administrative segregation and Special Housing Units (SHU) and converting them to general population usage, which will result in a savings of about 250 staff (an average of 16 staff per unit), state budget officials were refusing to allow the corrections department to reinvest the savings into better operations.

12. James, D.J. and Glaze, L.E. (Dec. 2006). Department of Justice. Bureau of Justice Statistics. *Mental Health Problems of Prison and Jail Inmates*.

13. Hannibal Lecter (born 1933) was a serial killer notorious for his habit of consuming his victims, which earned him the nickname "Hannibal the Cannibal." *See* http://hannibal.wikia.com/wiki/Hannibal_Lecter.

14. This programming method is sometimes referred to as "10 and 10," meaning ten hours per week of outside recreation and ten hours per week of therapeutic intervention, averaging about three hours daily.

15. See n.7, *supra*.

16. As to the seriously mentally ill category, some believed that SMI may provide both too broad and too narrow a description. Some SMI may not be vulnerable; still others may not meet specific diagnosis standards, yet require protection. Participants emphasized the importance of personalized and individual treatment plans to manage specific needs rather than focusing on a diagnosis. *The Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association (APA), offers a common language and standard criteria for the classification of mental disorders. The DSM is now in its fifth edition, DSM-5, published on May 18, 2013. The old DSM, AXIS I, and AXIS II diagnoses related to depression, bipolar disorder, and other functional impairments that define serious mental illness is currently in litigation. The latest version of the DSM, however, has moved away from a pure diagnostic approach to a functional approach to mental illness identification and treatment.

17. Although LGBT individuals were included as a potential vulnerable population, Group 3 did not come to a consensus for this group and, ultimately, removed the LGBT category from its list of vulnerable populations.

18, *See* n.14, *supra*.

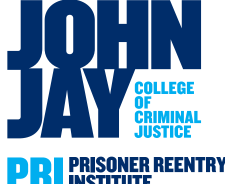
19. American Psychiatric Association. (2012). *Position Statement on Segregation of Prisoners with Mental Illness*.

20. Vulnerable individuals are those people who are so susceptible to the harms of 22-hour lockdown that regardless of their behavior they should have additional limitations on the imposition of solitary confinement. Significantly Vulnerable Individuals who are at high risk of harm in solitary:
    - SMI (serious mental illness)
    - Intellectual disabilities
    - Serious cognitive impairments
    - Juveniles
    - Infirm (elderly without specific age)
    - Pregnant women

21. Institute of Medicine (US) Committee to Improve the National Institutes of Health Consensus Development Program. *Consensus Development at the NIH: Improving the Program*. Washington (DC): National Academies Press (US); 1990. Available from: http://www.ncbi.nlm.nih.gov/books/NBK235517/

22. Baumgartel, S., Guilmette, C., Kalb, J., et al. (2015). *Time in Cell: the ASCA-Liman 2014 National Survey of Administrative Segregation in Prison*. New Haven: Liman Center, Yale Law School, available at http://nicic.gov/library/030161.

Included in SCDC' 4.29.19 letter to LOC



Included in SCDC' 4.29.19 letter to LOC

ENTOMBED

ISOLATION IN THE US FEDERAL PRISON SYSTEM

AMNESTY INTERNATIONAL

Included in SCDC' 4.29.19 letter to LOC

Amnesty International is a global movement of more than 3 million supporters, members and activists in more than 150 countries and territories who campaign to end grave abuses of human rights.

Our vision is for every person to enjoy all the rights enshrined in the Universal Declaration of Human Rights and other international human rights standards.

We are independent of any government, political ideology, economic interest or religion and are funded mainly by our membership and public donations.

AMNESTY INTERNATIONAL

First published in 2014 by
Amnesty International Ltd
Peter Benenson House
1 Easton Street
London WC1X 0DW
United Kingdom

© Amnesty International 2014

Index: AMR 51/040/2014
Original language: English
Printed by Amnesty International,
International Secretariat, United Kingdom

All rights reserved. This publication is copyright, but may be reproduced by any method without fee for advocacy, campaigning and teaching purposes, but not for resale. The copyright holders request that all such use be registered with them for impact assessment purposes. For copying in any other circumstances, or for reuse in other publications, or for translation or adaptation, prior written permission must be obtained from the publishers, and a fee may be payable. To request permission, or for any other inquiries, please contact copyright@amnesty.org

Cover photo: Interior of a SHU cell at ADX © Private

amnesty.org

Included in SCDC' 4.29.19 letter to LOC

TABLE OF CONTENTS

Introduction 2

Restrictions on access to ADX: Lack of transparency regarding BOP use of isolation 5

Long-term isolation in other parts of the federal system 6

Prisoners held in solitary confinement in pre-trial federal detention 7

Further observations on conditions in ADX 8

Conditions in General Population UNITS 8

Exercise 10

In cell activities and programing 13

Contact with staff 16

The Step-Down Program (SDP) 18

Prisoners in ADX more isolated than before 19

Length of time in isolation/access to the SDP 20

Lack of clear criteria or safeguards for progressions to the sdp 21

Special Security Unit (SSU) - H-Unit 24

Control Unit, SHU and Range 13 27

Mentally Ill Prisoners at ADX 31

Overview of US obligations under international law and standards 34

US Law and Standards 36

Recommendations 38

Endnotes 41

Included in SCDC' 4.29.19 letter to LOC

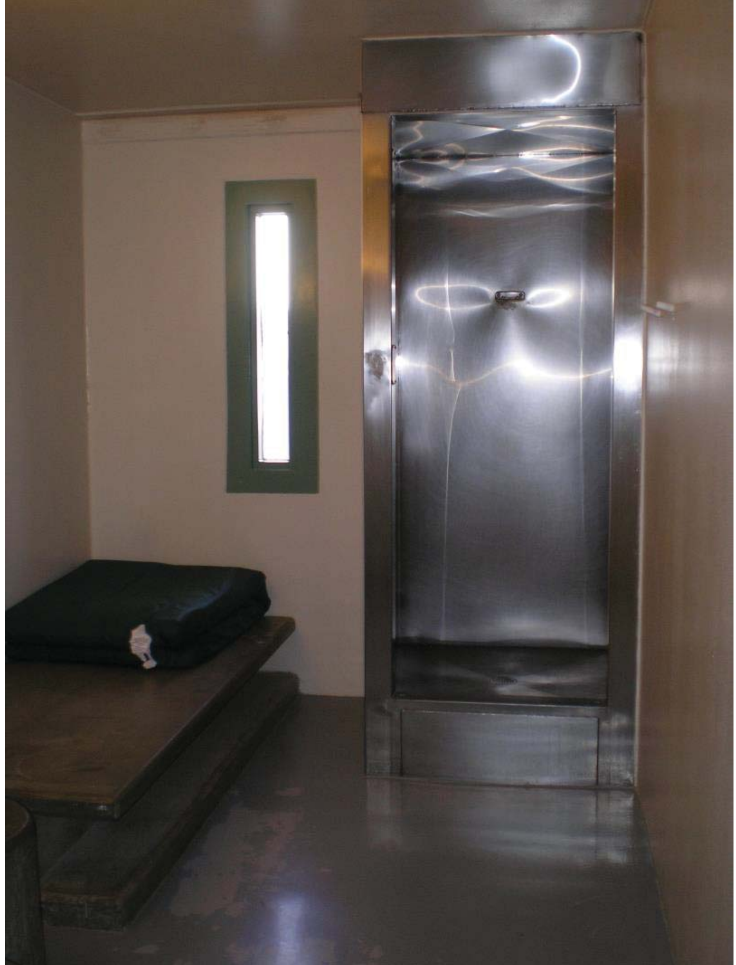
List of abbreviations

- ADX: United States Penitentiary Administrative Maximum facility, super maximum security prison which forms part of the FCC at Florence, Colorado
- BOP: Federal Bureau of Prisons
- CAT: United Nations Committee against Torture
- CU: Control Unit
- ECHR: European Court of Human Rights
- FCC: Federal Correction Complex at Florence, Colorado,
- GAO: General Accounting Office
- GP: General Population Units
- H-Unit, also known as Special Security Unit
- ICCPR: International Covenant on Civil and Political Rights
- IU: Intermediate Unit, first stage of the SDP
- MCC: Metropolitan Correctional Center
- NCCHC: National Commission for Correctional Health Care
- PTU: Pre-Transfer Unit, final stage of the SDP, located at USP Florence
- SAMs: Special Administrative Measures
- SDP: Step Down Program
- SHU: Security Housing Unit
- SMR: United Nations Standard Minimum Rules for Treatment of Prisoners
- SMU: Special Management Unit
- SSU: Special Security Unit, also known as 'H-Unit'
- TU: Transitional Unit, second stage of the SDP, located at USP Florence
- USP Florence, a high security prison which forms part of the FCC at Florence, Colorado

Included in SCDC' 4.29.19 letter to LOC

INTRODUCTION

"Though I know that I want to live and have always been a survivor, I have often wished for death. I know, though, that I don't want to die. What I want is a life in prison that I can fill with some meaning"
Thomas Silverstein, confined for over 30 years in isolation, nine of which have been spent in ADX[1]



An isolation cell in a General Population Unit at United States Penitentiary, Administrative Maximum (ADX) © Private

The USA stands virtually alone in the world in incarcerating thousands of prisoners in long-term or indefinite solitary confinement, defined by the UN Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment as "the physical and social isolation of individuals who are confined to their cells for 22 to 24 hours a day".[2] More than 40 US states are believed to operate "super-maximum security" units or prisons, collectively housing at least 25,000 prisoners.[3] This number does not include the many thousands of other prisoners serving shorter periods in punishment or administrative segregation cells – estimated to be approximately 80,000 on any given day.[4]

Included in SCDC' 4.29.19 letter to LOC

While US authorities have always been able to segregate prisoners for their own protection or as a penalty for disciplinary offences, super-maximum security facilities differ in that they are designed to isolate prisoners long-term as an administrative control measure. It is a management tool that has been criticized by human rights bodies, and is being increasingly challenged by US penal experts and others, as costly, ineffective and inhumane.

The federal government currently operates one super-maximum security prison, the United States Penitentiary, Administrative Maximum (ADX) facility in Colorado. With capacity for 490 male inmates, the vast majority of ADX prisoners are confined to solitary cells for 22-24 hours a day in conditions of severe physical and social isolation. The cells have solid walls preventing prisoners from seeing or having direct contact with those in adjacent cells. Most cells have an interior barred door as well as a solid outer door, compounding the sense of isolation. Prisoners eat all meals inside their cells, and in most units each cell contains a shower and a toilet, minimising the need for the inmate to leave his cell. Visits by prison staff, including routine checks by medical and mental health staff, take place at the cell door and medical and psychiatric consultations are sometimes conducted remotely, through tele-conferencing. All outside visits are non-contact, with prisoners separated from their visitors by a glass screen. Prisoners in the General Population (GP) (the majority of prisoners at ADX) are allowed out-of-cell exercise for up to ten hours a week, in a bare interior room or in small individual yards or cages, with no view of the natural world. Prisoners in some other units receive even less out of cell time.[5]

Most prisoners assigned to ADX have reportedly been convicted of serious offences in prison, such as assault, murder or attempted escape. ADX also houses a number of prisoners convicted of terrorism-related offences; most of these prisoners were sent to the facility based on their committal offence rather than for their conduct during incarceration and some have Special Administrative Measures (SAMs) placed on them by the Department of Justice which restrict their communications with the outside world. In a letter responding to concerns raised by the UN Special Rapporteur on Torture, the US government said that ADX is "designed to meet the exceptional security requirements of its inmates", noting that prisoners are sent there only after it is determined that they would pose a serious risk to themselves or the safety of other inmates, staff, or the public if placed in a less secure setting.[6] The letter asserts that the regime, while restrictive, is humane, pointing out that the cells have windows which allow access to natural light; that most inmates have TVs with multiple channels and access to in-cell educational and other programs; and that they have daily contact with staff. It also states that GP inmates have an opportunity to participate in a Step Down Program (SDP) where they can earn their way to a less restrictive setting and ultimately to another facility.

As discussed in this report, Amnesty International believes that the conditions at ADX are unacceptably harsh and that in-cell programmes cannot compensate for the lack of meaningful social interaction which many prisoners endure for years on end. The poverty of the exercise facilities at ADX is also disturbing, particularly given the long periods in which prisoners are otherwise confined to cells. Failure to provide suitable, daily outdoor exercise falls short of the United Nations (UN) Standard Minimum Rules (SMR) for the Treatment of Prisoners. Amnesty International recognizes that the authorities have an obligation to ensure the safety of staff and inmates and that it may be necessary at times to segregate prisoners. However all measures must be consistent with the USA's obligation to treat all prisoners humanely, without exception.

In recognition of the psychological harm that can result from isolating people even for relatively brief periods, international human rights experts and organizations have called on governments to restrict their use of solitary confinement so that it is applied only in

Included in SCDC' 4.29.19 letter to LOC

exceptional circumstances, for the shortest possible period of time. US professional bodies such as the American Bar Association have made similar recommendations. However, prisoners at ADX must spend a minimum of 12 months in isolation, and often far longer, before becoming eligible for the SDP. There is no detailed public information on the time prisoners spend in each unit at ADX. However, a Federal Bureau of Prisons (BOP) analysis based on a limited survey of 30 inmates in 2011 for a case before the European Court of Human Rights (ECHR) showed prisoners were likely to spend at least three years in the GP (confined to solitary cells 22-24 hours a day) before being admitted to the SDP.[7] Other sources based on a wider sample of prisoners have found that scores of prisoners have spent more than twice as long in solitary confinement.[8] Prisoners in the Control Unit, the most isolated section of the facility, are ineligible for the SDP as they are serving fixed terms in the unit for disciplinary infractions, terms which can extend to six or more years.

While all prisoners now receive a hearing prior to placement at ADX, advocates have criticised the internal review procedures – including those for deciding when a prisoner can access and progress through the SDP – as over-discretionary and lacking clear criteria. According to lawsuits and other sources, this means that some prisoners effectively remain in isolation indefinitely, without being able to change their circumstances.[9] Amnesty International believes that the conditions of isolation at ADX breach international standards for humane treatment and, especially when applied for a prolonged period or indefinitely, amount to cruel, inhuman or degrading treatment or punishment in violation of international law.

Amnesty International is further concerned that prisoners with serious mental illness are detained at ADX and, according to an ongoing lawsuit, have not been adequately screened, treated or monitored.[10] While not in a position to assess the quality of mental health provision currently at ADX, the organization is concerned by the cases cited in the litigation and believes that no prisoner with mental disabilities should be held in solitary confinement. Such practice is against international standards and the recommendations of mental health experts and organizations. US courts have also consistently found that isolating people who are seriously mentally ill in “super-maximum security” facilities is incompatible with the US constitutional prohibition of “cruel and unusual punishment”.

In putting together this report at a time when the BOP is conducting a “comprehensive review” into its restricted housing operations[11], Amnesty International is seeking to ensure that the audit be guided by the organizations’ concerns, including pre-trial isolation, and that its recommendations for best practise reflect those contained within this report.

This report will detail how conditions in ADX breach international standards for the humane treatment of prisoners. By doing so, it seeks to oppose any replication of the ADX regime as currently proposed by the BOP in the newly acquired Thomson facility. The prison, due to open within the next years has been designated as a maximum high security prison with ADX and SMU cells.[12]

This report will also show how in the period of time since ADX was built, conditions have become increasingly restrictive with prisoners held in more severe conditions of isolation for longer periods. As conditions have become more restrictive, so has access to the facility for human rights groups, experts and the press. In detailing how the original purpose of the prison- to provide a route out of isolation within a defined period – has eroded over the years, the organization seeks to underscore the increased need for external scrutiny including access to the facility for the UN Special Rapporteur on Torture.

Included in SCDC' 4.29.19 letter to LOC

RESTRICTIONS ON ACCESS TO ADX: LACK OF TRANSPARENCY REGARDING BOP USE OF ISOLATION

In producing this report, Amnesty International relied on a range of sources including court documents available through lawsuits and other information provided by attorneys representing ADX inmates, as well as policy directives issued by the BOP. However, there is a lack of detailed publicly available information on the facility, including length of time prisoners are held in each unit (see below). In June 2001 an Amnesty International representative was given a tour of ADX and was provided with access to most parts of the facility and an opportunity to speak to the Warden, senior staff and some prisoners. Some of the observations in this report are thus based on first-hand viewing of conditions in the facility and on policies in place at that time. However, the organization's further requests to visit the prison in 2011 and 2012 were turned down by the Bureau. This appears to reflect a more general tightening of access to the facility in recent years, including by members of the media.[13]

While Amnesty International welcomes the review of the use of segregation in federal prisons currently being carried out by outside contractors, it believes that prisons should not be insulated from outside scrutiny by human rights groups and experts. In this regard, the organization has joined with other NGOs in calling on the State Department to extend an invitation repeatedly requested by the UN Special Rapporteur on Torture to visit the USA to examine, among other things, the use of solitary confinement in federal and state facilities, including through on-site visits.[14] Such an invitation would be consistent with the commitment made by the US government to support the work of the Special Rapporteurs and UN human rights mechanisms, and to encourage the full enjoyment of the human rights of persons deprived of their liberty.

External scrutiny is of particular importance in the case of "super-maximum" security facilities where prisoners are isolated within an already closed environment. In ADX there is little publicly available information about the current operation of the facility beyond a few institutional supplements giving a bare outline of the various units and programs. Lack of information on conditions and their impact on individual cases is compounded by the fact that prisoners under Special Administrative Measures (SAMs) often have severe restrictions placed on their communication with the outside world, including through visits and correspondence. A report by the General Accounting Office (GAO) in May 2013 noted more generally that "there is little publicly available information on BOP's use of segregated housing units."[15]

The GAO study also found that, while the BOP had an Internal Review Division which periodically inspected compliance with policies in other federal segregation units (including in Security Housing cells and Special Management Units in other prisons), "BOP does not have requirements in place to monitor similar compliance for ADX-specific policies".[16] Overall, the GAO study found that BOP had not assessed the impact of segregated housing on institutional safety or the impact of long-term segregation on inmates. While the BOP has agreed to develop specific ADX internal monitoring procedures in line with GAO recommendations, Amnesty International believes there should be regular, external reporting and review of conditions at ADX and other isolation facilities.

The need for external scrutiny is heightened by information suggesting that ADX prisoners are held under more isolated conditions than before, including than at the time of Amnesty International's 2001 visit, and that the original purpose of the prison – to allow a clear route out of isolation within a defined period – has been eroded over the years. As described below, there are also conflicting accounts given by prisoners and their attorneys and ADX

Included in SCDC' 4.29.19 letter to LOC

administrators about aspects of the regime, such as the amount of contact prisoners have with staff and the value of programs provided.

LONG-TERM ISOLATION IN OTHER PARTS OF THE FEDERAL SYSTEM

The US Government has pointed out that only 0.25% of the federal prison population is held at ADX. This is less than the national average of around 2% of prisoners in state "super-max" facilities and significantly less than in states such as Arizona or Texas. However, other federal facilities also confine prisoners in prolonged isolation.[17] Several BOP prisons operate Special Management Units (SMUs) in which prisoners are confined – usually with one other inmate -- to small cells for at least 23 hours a day for 18-24 month periods, terms which are frequently extended. According to figures provided by the BOP, the numbers in SMUs had risen from 144 prisoners when the first unit opened in Lewisburg Federal Penitentiary to 1,960 inmates as of February 2013.[18] Conditions in the units are harsh, with prisoners allowed only five hours exercise a week, falling below the SMR. Although having a cell-mate may relieve some of the effects of isolation, confining two people in a small, enclosed space for 23-24 hours a day can lead to severe additional stresses. A lawsuit filed in July 2011 has challenged conditions in the SMU at Lewisburg Penitentiary as amounting to "cruel and unusual punishment", citing, among other things, a series of assaults by prisoners on their cell-mates, including two murders and the punitive use of restraints, often for prolonged periods, for those who refuse a cell mate.[19] Amnesty International believes there should be urgent review of conditions in the SMUs and that the current review of federal segregation policies should include units where prisoners are double-celled in an otherwise isolated environment.

The US government is reported to have reduced the overall number of prisoners in segregated confinement in the past year by nearly 25 percent (such confinement includes SHU cells situated in most prisons) and subsequently closed two of its segregated housing Special Management Units.[20] Despite this reduction, the BOP 2014 budget request to Congress includes a funding proposal to open Thomson Correctional Center, a former state maximum security facility in Illinois, purchased by the BOP in 2012, as a second federal "supermax" prison to "begin activating the facility as an Administrative-Maximum U.S. Penitentiary in Fiscal Year 2014".[21]

The BOP explained the need to expand segregation cells at a time when the use of segregated confinement was declining with the following: "The reduction in our special housing unit population does not lessen the need for these beds…Special Housing refers to units within our prisons where inmates are placed on a temporary basis as a result of misconduct or as a result of circumstances that warrant their separation from the general population". This response suggests that the new facility will house those held in long-term rather than short-term isolation.[22]

While the exact conditions under which prisoners would be held in Thomson remain unclear, Amnesty International is concerned that the facility will replicate the regime at ADX, Florence. Any expansion of the use of long-term solitary confinement as seen at ADX, Florence, would be a retrograde move, contrary to international human rights standards[23]. Such a move would also run counter to growing recognition among mental health, legal and correctional experts, of the harm caused by conditions in isolation units, and trends across states towards reducing the numbers of prisoners in solitary or isolated confinement.

Included in SCDC' 4.29.19 letter to LOC

PRISONERS HELD IN SOLITARY CONFINEMENT IN PRE-TRIAL FEDERAL DETENTION

SYED FAHAD HASHMI

Syed Fahad Hashmi has spent over seven years in conditions of near total isolation. A US citizen who grew up in Queens, New York, he was studying for a post-graduate degree in the UK when he was arrested in 2006 and accused of allowing an acquaintance to use his London apartment to store sock and ponchos intended for al-Qaida in Pakistan. While detained in the UK pending extradition, he was allowed to associate with other detainees without incident. However, on arrival in the USA he was placed in MCC SHU (see below), where he remained for nearly three years in pre-trial detention, confined to a small, solitary cell with no view to the outside and no association with any other inmate or access to outdoor exercise. He was placed under SAMs and had only limited contact with his immediate family (brother and elderly parents). In June 2010 he was sentenced to 15 years in prison after pleading guilty to one charge of providing material support to a terrorist organization. He was transferred to ADX in March 2011, where he remained in isolation, confined to a concrete cell for 22-24 hours a day until June 2014 when he was transferred to a Control Management Unit in USP Terre Haute, Indiana.

Prisoners may also be held in solitary confinement while awaiting trial in the federal courts. There is particular concern about conditions in the Security Housing Unit (SHU) on the 10th floor of the federal Metropolitan Correctional Center (MCC) in New York, where pre-trial detainees are confined for 23-24 hours a day to solitary cells which have little natural light and with no provision for outdoor exercise. Lack of access to natural light and fresh air are in clear breach of international standards for humane treatment. Detainees housed in the unit have included foreign nationals charged with supporting terrorism who have been extradited or subjected to a "rendition" to the USA; in addition to their harsh physical conditions of confinement, some have had only limited contact with their families and few or no social visits. Several prisoners have spent many months or years in the above conditions while awaiting trial.[24]

Amnesty International considers that conditions under which detainees have been confined in the MCC SHU constitute cruel, inhuman or degrading treatment and are incompatible with the presumption of innocence in the case of untried prisoners whose detention should not be a form of punishment.[25] Lawyers who have represented detainees in the unit have described the negative impact of the conditions on their clients' state of mind, raising concern that such conditions may impair a defendant's ability to assist in his or her defence and thus the right to a fair trial.

Included in SCDC' 4.29.19 letter to LOC

FURTHER OBSERVATIONS ON CONDITIONS IN ADX

The United States Penitentiary (USP) Administrative Maximum Facility (ADX), situated in Florence, Colorado, opened in November 1994 as a purpose-built "super-maximum" security facility. It is currently the only level 6 (highest security designation) prison in the federal system.

The prison has eight units consisting of four General Population units (each with capacity to house up to 64 prisoners); the Special Security Unit (H Unit) for prisoners under SAMs; the Control Unit; the SHU (a disciplinary unit); and the Intermediate Unit for prisoners in the Step-Down Program (SDP). There is also an ultra-high security four-cell unit known as Range 13, where prisoners are held in conditions of extreme isolation. Only prisoners in the SDP, and a small number in phase 3 of H Unit, have any group association, which is limited to a few hours a week; the vast majority of the ADX population are held alone, confined to cells for 22-24 hours a day with only limited contact with staff and the outside world.

CONDITIONS IN GENERAL POPULATION UNITS

"Sitting in a small box in a walking distance of eight feet, this little hole becomes my world, my dining room, reading and writing area, sleeping, walking, urinating, and defecating. I am virtually living in a bathroom, and this concept has never left my mind in ten years."

Mahmud Abouhalima, held under SAMS in H Unit, ADX, since 2005.

More than half the population at ADX (up to 256 prisoners) are held in the GP units, where they spend at least 22 hours a day in 87 square foot individual cells. The cells have solid concrete walls and all face the same way, so that prisoners cannot view other cells or have direct contact with inmates in adjacent cells. Each cell also has an interior barred wall with sliding door along the full width of the cell, followed by a small lobby with a solid steel outer door and window looking onto the corridor. As the living space is sited behind the barred interior wall, several feet from the corridor, prisoners are more cut off from human contact than in standard maximum security cells where inmates can stand at the cell door and watch or converse with anyone passing by. The cells have a narrow outside window at the back which allows entry of natural light but provides no view other than buildings and sky. Prisoners can control the lighting by a switch inside the cell. The cell furnishings are sparse, consisting of a fixed bunk, desk and stool made of reinforced concrete. Each cell also has a built-in shower and a metal toilet and sink unit.

Included in SCDC' 4.29.19 letter to LOC

The inside of a cell in a General Population Unit at ADX © Private

The vast majority of prisoners are allowed out of their cells for only a few hours a week, for exercise, occasional visits to a "law library" cell, social or legal visits, or for some medical consultations.[26] All meals are delivered to and eaten inside the cells. As Amnesty International has observed elsewhere, there is concern about the possible health risks from spending so much time in a confined space, and eating all meals in close proximity to the open toilet. Prisoners are placed in full restraints and are accompanied by two guards when being escorted out of their cells. Otherwise nearly all contact with staff takes place either remotely (e.g. through medical teleconferencing) or at the cell front.

Included in SCDC' 4.29.19 letter to LOC

EXERCISE

An outdoor recreation cage for prisoners in the Step Down Program at ADX © Private

GP prisoners are allowed up to ten hours out-of-cell exercise a week, in two hour slots five days a week, alternating between indoor and outdoor exercise. Prisoners always take indoor exercise alone, in a windowless room with only a pull-up bar. Outdoor exercise takes place either in an enclosed solitary yard attached to the unit or in one of five individual cages in a larger yard. The only time a prisoner can communicate directly with another inmate is when conversing with a prisoner in an adjacent cage, an opportunity which takes place, at most, on two or three days a week.

As shown in photographs, the exercise facilities are stark. The outdoor cages are only a little larger than the cells and have no equipment so that prisoners can do nothing other than walk a few paces. Both the individual yards and the larger concrete yard in which the cages are situated have high walls and a chain link roof, giving no view of the natural world other than sky. Lawyers have told Amnesty International that some prisoners decline to take exercise and remain in their cells all day due to depression or other illness (see section on Mental Illness, below).

Included in SCDC' 4.29.19 letter to LOC

An outdoor recreation area in the Control Unit at ADX © Private

According to BOP regulations, prisoners may have their exercise in the larger yards suspended for three months at a time for a single rule violation, with increased suspensions for further offences.[27] It is alleged that prisoners are sometimes punished for minor rule violations, such as in one case for feeding crumbs to birds.[28] The regulations list violations for which the yard exercise can be suspended as including "sexual acts or gestures, suicidal attempts or gestures, smearing or throwing human waste".[29] Amnesty International is concerned that prisoners who have not committed serious violations, or whose behaviour may be indicative of mental health or behavioural problems, should have their outdoor yard exercise -- and thus their only limited association with other inmates -- withdrawn for such extended periods. It urges that this rule be reviewed.

Included in SCDC' 4.29.19 letter to LOC

The SMR state that “every prisoner not employed in outdoor work shall have at least one hour of suitable exercise in the open air daily if the weather permits” (Rule 21 (1)). These are minimum standards applying to all prisoners without exception.

The opportunity to exercise is particularly important for the physical and psychological wellbeing of prisoners who are cut off from normal activities and are confined to cells for prolonged periods. Neither the cages nor the enclosed individual yards in Amnesty International’s view meet the standard of “suitable exercise in the open air” as provided under the SMR, nor, under the present regime at ADX, is outdoor exercise provided to each prisoner daily.

Indoor recreation area in the Control Unit at ADX © Private

Amnesty International is concerned that conditions for prisoners at ADX have become more isolated and restrictive in recent years. When the prison first opened, and at the time of the organization’s visit to ADX in June 2001, GP prisoners were allowed “12 hours or more” out of cell exercise a week which could be taken in small groups of up to 12 prisoners at a time; prisoners were also allowed balls and board games during this period.[30] Unit staff members told Amnesty International’s representative during her visit that one of the measures used to assess prisoners’ progress and suitability for the step down program was how they interacted with others on the recreation yard.

Group recreation was reportedly withdrawn after two prisoners were killed by other inmates in separate incidents in 2005, one occurring in the Transitional (Step Down) Unit, allegedly in full view of ADX staff members.[31] Prison administrators have a clear duty to take all reasonable measures to prevent such deaths. However, the blanket ban on any form of group recreation in the GP, given the length of time prisoners are confined to the unit, is inconsistent with standards for humane treatment. In addition to the potential adverse mental health impact of prolonged confinement to solitary cells, it is difficult to see how a prisoner’s behaviour can be effectively measured in the absence of any meaningful social and

Included in SCDC' 4.29.19 letter to LOC

group interaction. As described below, prisoners in the step-down program also have significantly less association and out of cell time than previously. According to a lawsuit, more could be done to ensure the safety of prisoners in group recreation.[32]

Outdoor recreation cages at ADX © Private

IN CELL ACTIVITIES AND PROGRAMING

Most prisoners in ADX are provided with televisions in their cells with around 60 broadcast channels, including news channels such as CNN and ABC and a range of cable and other network programs. Institutional programs are also provided to each cell through close-circuit channels; these include educational, religious and recreational programs as well as classes on psychology and issues such as anger management. There is no congregate prayer and religious services are conducted through close-circuit TV.

Prisoners also have access to books, newspapers and periodicals, art and hobby-craft materials, and may write and receive correspondence (although limits on the latter may be imposed on prisoners under SAMs, see below). Correspondence courses are also available to some prisoners (not for example, those under SAMS) and prisoners must be able to afford it which limits their reach further. Prisoners are also allowed access to religious materials.

Included in SCDC' 4.29.19 letter to LOC

Outer door of a cell in the Control Unit at ADX, picture take from the corridor © Private

A stipulated court agreement in 2008 provided that an Imam visit ADX four times a month to speak with inmates individually. Prison attorneys have reported that since there is no longer an Imam on site, inmates in the past few years have received far fewer visits from an Imam than the limit set in the court agreement.[33]

The visits take place at the cell door, often, for only a few minutes at a time. It is alleged that most prisoners may confer with the Imam or other religious adviser only when both cell doors are closed with the minister standing in the hall outside, thus requiring inmates to speak at loud volume that renders private consultations impossible.[34] Prison advocates report that in the case of visiting priests or chaplains, they will generally be allowed beyond the solid steel

Included in SCDC' 4.29.19 letter to LOC

door to pray in the sally-port area, right up next to the inmate in the cell, but this does not happen in the case of most Imam visits with Muslim prisoners.

While Amnesty International's delegate recognized that there were a number of in-cell programs available at the time of her 2001 visit, these cannot compensate for the prolonged cellular confinement and social isolation experienced by ADX prisoners for many months or years, or even indefinitely. The value of in-cell programs becomes more questionable the longer a prisoner is held in isolation and unable to interact meaningfully with others. Prisoner advocates have also reported that, apart from some basic educational courses such as GED (which are required by a minority of inmates), there is not much structured educational or rehabilitative programing leading to formal qualifications or defined outcomes or goals.[35]

Inner door of a General Population cell at ADX, picture taken from the corridor © Private

Included in SCDC' 4.29.19 letter to LOC

CONTACT WITH STAFF

The authorities have stressed in court filings that all prisoners have daily contact with unit staff and regular contact with correctional counsellors, medical and mental health and religious staff. However, lawyers representing prisoners report that there is little meaningful contact in practice between staff and inmates, and that prisoners routinely go days with only a few words spoken to them. According to testimony to the ECHR contact could be "as little as one minute per day".[36] Advocates also reported that prisoners would need to call out proactively to seek attention from staff as they walk past cells doing their daily rounds, something many prisoners are reluctant to do. Contact when it does take place is usually at the cell door. A prisoner's isolation is compounded by the fact that psychiatric and medical consultations may also in some cases take place remotely, through teleconferencing.

There is no interaction with the teacher during the classes, all of which are delivered remotely. Although Amnesty International was told during its visit that teachers may visit prisoners at the cell door to discuss their assignments, it was acknowledged that this could in some cases be only be for a few minutes per inmate. A lawyer who has represented a number of prisoners at ADX told the organisation that none of her clients to her knowledge had ever been seen by a teacher at the cell door.

VISITS AND COMMUNICATION WITH THE OUTSIDE WORLD

"We're poor folk," he says of his family, "and coming to visit is too expensive…from what I can tell very few people get visits…this place is too far from anyone's family."

Letter sent to the 'Solitary Watch' website from a prisoner in ADX who has not seen or spoken to his family in the last five years[37]

Prisoners in the GP units may write letters and make two 15-minute non-legal phone calls a month (or, six hours per year in total to speak with their family). All social and legal visits at the facility take place in a non-contact setting, behind a thick plexiglass screen. Other than when being placed in restraints and escorted by guards, prisoners may spend years without touching another human being.

Prisoners are allowed five social visits a month for up to seven hours at a time, with a maximum of three visitors per inmate allowed in the visiting room at any one time. However, it is reported that prisoners at ADX generally do not have many visits, in part because of the remote location of the facility. ADX staff told Amnesty International's representative in 2001 that it was usual for there to be only five or six visitors in total at the week-end. According to a court brief, three prisoners who were transferred to ADX from other prisons after September 2001 had no social visits for the entire time (six and seven years) they were held at the facility; a fourth prisoner named in the lawsuit had received only two visits from family/friends in 13 years.[38]

Prisoners are routinely shackled during non-contact attorney visits which usually take place in booths where the plexiglass barrier has a small slot to allow the passing of documents.[39] Prisoners are placed in three-point restraint during visits, with their wrists and ankles attached to a belly chain and waist belt. The wrist cuffs may be further secured in a black box attached to the front of the belt; this severely restricts hand movement and can cause pain and discomfort, especially when the restraints are worn for an extended period.

One lawyer told Amnesty International that the shackles worn by his client during visits (belly chain and black box) restricted his hand movements and made passing documents difficult. He said the set-up in the visiting room was very uncomfortable, with his client having to sit up on the small table by the glass screen in order to communicate with him.

Included in SCDC' 4.29.19 letter to LOC

Another legal representative told the organization that prisoners may have their ankles shackled during social visits also.

Amnesty International believes the degree of restraint applied routinely during non-contact visits appear to be unnecessarily punitive, especially for prisoners who do not have a history of serious rule violations or acts of institutional violence within the facility, and for prisoners needing to communicate with attorneys. International standards provide that restraints should be applied only when “strictly necessary” as a precaution against escape or to prevent damage or injury.[40]

The inmate side of the social visits compartment © Private

Included in SCDC' 4.29.19 letter to LOC

Recommendations

- Amnesty International recommends that conditions in the ADX General Population be improved so that prisoners are not held in conditions of severe isolation but have more opportunities for interaction with staff, including educational staff, as well as access to meaningful rehabilitation programs. The exercise facilities should be modified to allow more space and equipment; prisoners should be allowed daily outdoor exercise[41].

- Amnesty International recommends that opportunities be reinstated for prisoners to have some social interaction with other inmates, even at the most restrictive levels of confinement, both to aid their rehabilitation and to allow their progress to be measured.

- The use of restraints should be prescribed by law and be restricted by the principles of necessity and proportionality. Prisoners should be placed in restraints only when strictly necessary; restraints should not be applied that cause pain or unnecessary discomfort.[42]

- Facilities should be provided for prisoners to meet with their attorneys in a suitable environment that does not impede communication; when receiving visits from lawyers, prisoners behind barriers should not be restrained in such a way as to restrict their hand movement, making passing documents difficult.

THE STEP-DOWN PROGRAM (SDP)

Prisoners are assigned to ADX if it is determined that they "have demonstrated an inability to function in a less-restrictive environment" and would pose a serious risk to the safety of other inmates or staff or the public if held in a less secure setting.[43] Writing to the UN Special Rapporteur on Torture in 2011, the US Ambassador to the UN gave the primary reasons for referral to the facility as "murder or assault at another facility, escape behaviour or rioting".[44] Prisoners may also be assigned to the facility if the offence for which the person has been convicted or profile prior to arrest is deemed to create a sufficient security risk; thus, some prisoners with particular connections outside prison or who have been convicted of involvement in or support of terrorism have been assigned to the facility without regard to their institutional behaviour.

The ADX mission is described as having a dual purpose: to 1) to maintain the safety of staff and inmates while eliminating the need to increase security in other institutions and 2) confine inmates under close controls while providing them with opportunities to demonstrate progressively responsible behaviour; participate in programs in a safe, secure environment; and establish readiness for transfer to a less secure institution".[45]

Prisoners may move into the SDP only after a minimum of 12 months clear conduct and "positive institutional adjustment" in the ADX GP. The SDP consists of an Intermediate Unit (IU), a Transitional Unit (TU) and a Pre-Transfer Unit (PTU) which is the final phase before a prisoner is ordinarily considered for transfer to an open population institution. Only the IU is currently sited at ADX (see below).

The IU at ADX (with capacity for up to 32 inmates): has standard single occupancy maximum security cells looking onto the unit range, with a narrow outside window providing natural light. The furnishings are the same as in the GP cells except that showers are on the range. The only difference between the GP and IU regime is that prisoners may associate in groups of up to eight prisoners on the range for an hour and a half a day five days a week, in addition to the 10 hours exercise as described above. They are also allowed three 15-minute telephone calls a month. All meals are eaten inside the cells and the same programs are provided as in GP.

Included in SCDC' 4.29.19 letter to LOC

Prisoners in the TU (capacity of up to 32 inmates) are assigned to groups of up to 16 inmates with whom they are allowed to associate on the range for up to three hours a day; they consume meals on the range with their assigned group. The Unit also provides outdoor group recreation and prisoners are allowed an additional 15-minute social phone call a month.

Prisoners in the PTU are usually double-celled, consume meals on the range, are unrestrained when out of their cells and participate in various work assignments.

PRISONERS IN ADX MORE ISOLATED THAN BEFORE

As with the GP (where there is no longer group exercise), conditions in the first two phases of the SDP have become more restrictive than when the prison initially opened. At the time of Amnesty International's 2001 visit to ADX prisoners in the IU were allowed out of their cells onto the ranges for several hours a day, with meals consumed in common areas located on the ranges. Recreation included use of a gymnasium. Prisoners in the TU had religious services and group recreation of up to 35 hours a week.

The TU and the Pre-Transfer Unit were both originally sited at the ADX facility but are now located at USP Florence, a high security prison which, like ADX, forms part of the Federal Correctional Complex (FCC) at Florence. ADX itself has therefore become almost entirely a "lock-down" facility in which prisoners are locked in solitary cells for all but a few hours a week. Amnesty International is concerned that, at a time when there is growing recognition of the damaging effects of isolation and moves to restrict such practice in some states, conditions in ADX have become more restrictive in recent years.

Inside of a cell in the Control unit at ADX © Private

Included in SCDC' 4.29.19 letter to LOC

LENGTH OF TIME IN ISOLATION/ACCESS TO THE SDP

The SDP from GP to the PTU is described as a four-phased program, with prisoners expected to spend at least 12 months in the GP, six months each in the IU and TUs and 12 months in the Pre-Transfer phase before being considered for transfer to an open population institution.

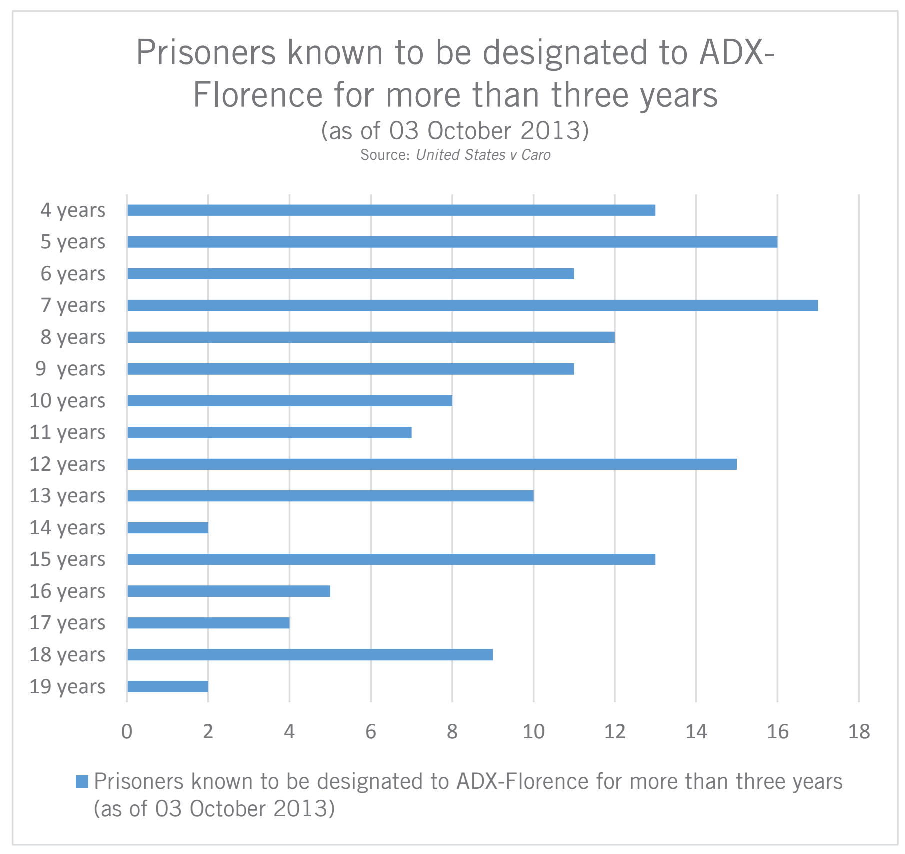
It is clear from BOP policy as set out in the Institutional Supplements on General Population and Step-down Operations that the purpose of the program is to provide inmates with incentives and an opportunity to demonstrate conduct that will enable them to progress from GP through progressively less restrictive units. The Supplements state:

"Every inmate has the opportunity to demonstrate he may be housed in a less restrictive unit".

While the minimum period from placement in the ADX GP to transfer from USP Florence to a less restrictive facility is 36 months, it is reported that, in practice, most prisoners take much longer than this to complete the program. Most disturbing are statistics indicating that most prisoners spend far longer than the minimum 12 months at the base-line level in the GP and thus in conditions of severe social isolation.

There is no publicly available breakdown of the length of time prisoners spend in each stage. However, in October 2011, following a request by the European Court of Human Rights (ECHR) in the Babar Ahmad extradition case, the Bureau of Prisons provided an analysis based on a random sample of 30 prisoners from the ADX GP and SDP, which showed that "an inmate was likely to spend three years at ADX before being admitted to the Step Down or Special Security Programs."[46] Lawyers for the applicants submitted evidence based on a much larger sample of more than 100 ADX prisoners which identified an average solitary confinement length of 8.2 years (see chart below).[47] The US government reported to the ECHR that the numbers of prisoners moving into the SDP had increased since their survey was conducted. However, it appears that few prisoners pass through the system within the minimum period specified. Some prisoners have spent several years in isolation in GP despite reportedly having completing programs necessary to quality for "consideration of" advancement. According to the GAO report on segregation, there were only 15 prisoners in the ADX SDP units located at USP Florence (the TU and PTUs) in February 2013.[48]

Included in SCDC' 4.29.19 letter to LOC



LACK OF CLEAR CRITERIA OR SAFEGUARDS FOR PROGRESSIONS TO THE SDP

"My involvement in my reviews is usually just my presence and the time it takes me to sign the forms. However it is not uncommon for prison staff to slide my prison review form under my door when I am in recreation and expect me to sign them without speaking to me at all".
Thomas Silverstein, confined for over 30 years in isolation, nine of which have been spent in ADX[49]

Following litigation, all prisoners assigned to ADX now receive an administrative hearing prior to their placement at the facility, which provides some minimal procedural safeguards.[50] Prisoners assigned to the ADX GP also have six monthly Program Reviews which, according to BOP regulations, prisoners are expected to attend and can raise question and concerns about his placement in, advancement through, or transfer out of the program. Amnesty International has been told that this rarely happens. Instead, typically the review meetings take place at the cell doors, and the 'program review report' which has already been filled out by prison staff, is slid under the door for prisoners to sign. These routine reviews do not make decisions on whether a prisoner may proceed to the SDP.

The process for allowing a prisoner to move from GP to the SDP appears to be highly discretionary. There is no hearing and determinations on eligibility for, and advancement through, the SDP are carried out by an internal prison SDP Screening Committee in consultation with the unit team, with the Warden having the final decision.[51] If a prisoner is determined to be "eligible" for the SDP (listed criteria for eligibility including, for example, 12 months' clear conduct in GP and active participation and completion of programs), this does not mean that he will necessarily be considered for entry into the SDP.[52] Prisoners take

Included in SCDC' 4.29.19 letter to LOC

no part in the SDP Committee review of placement/advancement determinations and are not present at such reviews. Even if admitted to the SDP, prisoners may be sent back at any time, including, it has been alleged, for minor incidents.

PB, a developmentally disabled and severely depressed inmate, in the phase 2 in of the SDP in USP Florence received an incident report for a "minor rules infraction" and was returned to ADX where he was placed in the SHU. The following month, after he learned of the death of his mother and after pleading for psychiatric help for several hours, he attempted suicide. Guards who witnessed the incident gave him an incident report for "tattooing or self-mutilation". Although this incident report was subsequently expunged after intervention by his lawyer, he remained at ADX having to accrue again a sustained period of clean conduct.

Although decisions may be appealed through an administrative remedy process, this has been described by attorneys as an ineffective remedy in practice, given the discretionary nature of the process and the wide deference afforded to prison administrators in decisions relating to institutional security[53]. The process has been described in court documents as "meaningless because no administrative remedy challenging a Step-Down denial has ever been successful".[54] In reporting on the practice of solitary confinement, the UN Special Rapporteur on Torture has stressed the importance of procedural safeguards when assigning prisoners to segregation, stating inter alia that prisoners "must be provided with a genuine opportunity to challenge both the nature of their confinement and its underlying justification through a process of administrative review".[55]

BOP regulations state that each inmate will receive written notification of the decision to deny entry to, or advancement through, the SDP, which will include "The reason(s) for the denial, *unless it is determined that the release of this information could pose a threat to individual safety or institutional security*" (Amnesty International emphasis). Advocates report that within the past year, prisoners have not been told that they have been considered and rejected for the SDP as they have not received any documentation at all. As a result, there is no actual "decision" that they have access to that they could challenge via the grievance process. It is alleged that some prisoners have been repeatedly denied entry to the SDP for years without being given any specific or detailed explanation, and thus without knowing what they can do to advance through the program. This has included prisoners with no history of serious misconduct, or with clear conduct records, some of whom have remained in isolation at the base-line level of ADX for many years.

- Mohammed Saleh, Ibrahim Elgabrowny and El-Sayyid Nosair were transferred to ADX without a hearing following the September 11th 2001 attacks.[56] While convicted of terrorism-related offences, all three had previously spent six years confined without serious incident at high security open population prisons, where they had jobs, were out of their cells for most of the day and could move freely with other inmates. According to court documents, once in ADX they were held in isolation in the GP and were repeatedly denied access to the SDP without explanation, apart from notices containing formulaic language such as that their "reasons for placement have not been mitigated" and/or that "safety and security" prevented them from being progressed.[57] The prisoners were placed into the SDP (in 2007 and 2009) only after filing lawsuits and following several years of unexplained denials, without any change in their conduct. They were later transferred to other prisons while the case was still in litigation and before completing the SDP. Omar Rezaq, another prisoner named in the lawsuit, spent over 12 years in isolation in the ADX GP before being placed in the SDP.[58]

- While detailed information is lacking on the length of time prisoners currently in ADX have spent in the GP, cases of long-term isolation continue at the prison, with prisoners continuing to be denied access to the SDP despite reportedly having clear conduct

Included in SCDC' 4.29.19 letter to LOC

records.[59] According to a lawsuit filed in 2012, some prisoners with mental illness had spent more than a decade at ADX without adequate treatment or admission to the SDP or, if admitted to the SDP, were returned to the ADX GP for failure to complete the program (see section on Mental Illness, below).

- Norman Matthews, convicted for a number of criminal offences, died last year in ADX after being held for 18 years in the GP unit without being admitted to the SDP.

- John Powers, incarcerated in 1990 after conviction for bank robbery, was sent to ADX in 2001 and suffering from mental health problems spent years being transferred between the special mental health prison facility in Missouri and the Control Unit in ADX. During his 11 years in ADX he was never placed in the SDP.

- Ralph Gambina, serving a life sentence, was transferred to ADX in 1995 from the Control Unit at USP Marion and has spent 21 years in solitary confinement without being entered into the SDP.

- Syed Fahad Hashmi was transferred to ADX in March 2011 after being convicted of one count of providing material support for terrorism after nearly three years in pre-trial solitary confinement (see box) and a further period in isolation in another federal prison. He was initially placed in H-Unit under SAMs but was moved to the ADX GP in January 2012, after his SAMs expired and were not renewed. More than two years on, without being granted access to the SDP, and with no history of any serious institutional misconduct involving physical violence, nor having been convicted of any direct involvement in acts of violence or terrorism he was eventually transferred on 17 June 2014 to the Control Management Unit in Terre Haute, Indiana.

- According to a US government declaration in the Babar Ahmad case, "mitigation of the original reason for placement at ADX" is no longer an explicit factor used to determine entry to the SDP; however, it acknowledged that the SDP Committee could still have regard to the initial reasons for placement at ADX in making its decision.[60] The criteria listed in BOP procedures for placement into or advancement through the SDP are extremely broad and include such vague wording as "the inmate's conduct while housed at the ADX" and "overall institutional adjustment", "the institution's safety and security needs", as well as "The reason(s) the inmate was designated to the ADX" and criminal history. Amnesty International has been told that a number of prisoners remain confined indefinitely to the ADX GP based solely on their committal offence, and without access to the SDP.

- Thomas Silverstein, 62, originally convicted of armed robbery, and serving life without parole for the murder of two inmates and a correctional officer has been confined for 30 years in isolation, nine of which have been spent in ADX. During this time, despite a clean conduct record for 22 years, he has been denied access to the SDP on the basis of the nature of his convictions. On the 10th May, 2014, the US Circuit Court of Appeals ruled that his 30-year confinement in isolation does not violate his rights. The Judges noted that the nature of Silverstein's convictions make it reasonable to keep him in solitary confinement. "In this case," the ruling states, "the risk of death and physical or psychological injury to those exposed to Mr Silverstein must be balanced with the psychological risk he may face if left in administrative segregation."

Some margin of appreciation may be necessary when officials are assessing complex factors relating to behavioural and security needs. However, the organization shares the concerns expressed by advocates about the lack of clear criteria for enabling prisoners to work their

Included in SCDC' 4.29.19 letter to LOC

way through the ADX SDP, and the very broad grounds that can be used to deny progress, including the original reason for assignment. This has meant prisoners spending years – or in some cases being held indefinitely – in conditions of severe isolation.

Recommendations

- Amnesty International recommends that clear criteria be established for SDP placement decisions, with a fair process and meaningful review. Prisoners should be provided with detailed reasons if they are denied advancement through the SDP, with an opportunity to participate in, and challenge, decisions, with clear guidance on how they can progress through the system. No-one should be held continuously in isolation based solely the original reason for placement in ADX. Rehabilitation programs should be meaningful and ensure behaviour can be measured. There should be a presumption that prisoners who are eligible for the SDP will progress at the earliest opportunity.

SPECIAL SECURITY UNIT (SSU) - H-UNIT

"The longer I spent in this period of segregation, the worse it gets on my efforts to survive, to maintain my state of mind and my mental capacity. I lost fifty pounds from being on hunger strike in H-Unit and hunger strikes became a regular occurrence in the unit, with medical staff coming every weekend to weigh each inmate. This was the first time in my life that I experienced the brutality of force feeding."

Mahmud Abouhalima, held under SAMS in H Unit, ADX, since 2005.

ADX prisoners who are under Special Administrative Measures (SAMS) are housed in the SSU, commonly known as H-Unit. SAMs are special restrictions that may be imposed on an inmate under the direction of the Attorney General, when it is determined that such measures are "reasonably necessary" to "prevent disclosure of classified information" or to "protect persons against the risk of death or serious bodily injury" (28 C.F.R. Section 501.3 (a) (2008). The restrictions under SAMs may include housing an individual in administrative segregation and/or limiting privileges such as correspondence and visits. The measures may be renewed annually on the basis of written notification from the DOJ to the BOP that there remains a "substantial risk" that "a prisoner's communications or contacts with persons could result in death or serious bodily injury to persons or substantial damage to property that could entail the risk of death or serious bodily injury to persons".

Prisoners in H-Unit are held in single cells similar to those in the SDP with a narrow window to the outside and solid door with a window looking onto the range. Showers are sited on the range rather than inside the cells. Otherwise the basic regime is identical to that in the GP, with prisoners locked in their cells for 22-24 hours a day with 10 hours out of cell exercise a week, alone or in individual cages with up to five other prisoners. They have access to the same in-cell programs delivered through close-circuit TV as the GP as well as to most books[61] and other TV channels.[62] Most prisoners under SAMs have severe restrictions placed on their communication with the outside world, compounding their isolation. Visits and correspondence are typically limited to approved attorneys and immediate family members only; lawyers may further be prohibited from reporting on their clients' conditions of confinement.[63] Correspondence to or from approved contacts, which is monitored along with the twice-monthly non-legal phone calls allowed, may be limited to only one letter a week.

In February 2014 it was reported that between 8 to 10 prisoners in H Unit were being force fed after initiating a hunger strike in protest against their restrictive conditions of confinement.[64] BOP records, seen by CBS News "60 Minutes," indicate that this is not an isolated incident, according to the program, "there have been as many as 900 of what the Bureau calls 'involuntary feedings' of terrorists in H unit since 2001".[65]

Included in SCDC' 4.29.19 letter to LOC

"I have engaged in two hunger strikes while on H Unit. Both of them were my decision and had nothing to do with other people. No one I corresponded with encouraged me to strike. I did not strike because other prisoners were doing it. I felt like an animal – just eating and sleeping. I decided to stop eating to object to my treatment".
Nidall Ayyad placed under SAMS in 2005 and held in H unit between 2006 and 2012. A few months after his SAMS were removed in 2012 he was transferred to a CMU where he remains today.

Prisoners assigned to H-Unit have no opportunity to enter the GP SDP – the only clear route out of ADX for most prisoners - other than through the lifting of the SAMs which is a decision made by the DOJ rather than the prison administration. However, in May 2008, the prison instituted a separate, internal step-down program for H-Unit. This consists of three "phases" each lasting a minimum of one year. At phase 2, prisoners are allowed certain limited additional privileges, while remaining confined to solitary cells for 22-24 hours a day. Only at phase 3 are H-Unit prisoners allowed some group association, with up to four other prisoners on the range for one and a half hours a day. Decisions on whether a prisoner is eligible for progression through the phases are made by an H Unit Review Committee; decisions are based on criteria relating to safety concerns, the inmate's conduct and participation in programs.

In practice, progression to phase 3 of the H-Unit program is conditional upon modification of the prisoner's SAMs restrictions, a decision which rests with the DOJ and may not depend upon the prisoner's institutional behaviour but on more general security considerations, including the committal offence. Amnesty International does not have a breakdown of the current numbers of prisoners in each phase of H-Unit or the length of time spent at each phase. However, litigation documents describe how some prisoners spent several years in H-Unit without progressing to phase 3 because their SAMs had not been modified, despite clear conduct records. The only way out of H-Unit altogether is generally for the SAMs to be lifted. At least one prisoner remains confined to H-Unit indefinitely, in conditions of severe isolation.

- Ramzi Yousef is serving two life sentences plus 240 years for his role in two terrorist attacks, including the 1993 World Trade Center bombing in New York City in which six people died. He has spent more than 15 years in solitary confinement. He is currently confined in H-Unit under SAMs; he has spent over two years on step 2 of the phased program, and despite a clear conduct record for 5 years, and an orderly appointment which allows him out of cells for few hours a week to clean cells, he continues to be denied access to phase 3. When his SAMS come up for renewal he will have a meeting with his counsellor to discuss, but he is not told when the SAMS will be renewed, nor given the opportunity to refute anything in the decision. According to a lawsuit filed in 2012, his SAMs are renewed every year based on his original conviction, without regard to his institutional behaviour and without a finding that he continues to pose any specific threat behind bars. In May, the Judge is his case ruled that there was no liberty interest under the Constitution in challenging SAMS.

- Mahmud Abouhalima was sentenced to 240 years for his role in the 1993 World Trade Center bombing. Between 1992 and 2001 he was held in GP in USP Lompoc and USP Leavenworth; on September 11 2001 he was placed in segregation and transferred to ADX in 2003 and held in GP unit for two years until his transfer to H Unit in 2005 when he was placed under SAMS. In 2008, Mahmud Abouhalima was placed in the H-Unit step-down program. Despite progress records that reportedly indicate he had positive behaviour and interactions with staff and inmates, as well as participation in education and psychology programs, in June 2011 he received a written denial for phase three of the program and was subsequently returned to phase one. He is now in phase three.

Included in SCDC' 4.29.19 letter to LOC

Amnesty International has joined other human rights advocates in expressing concern about the lack of transparency and fairness in the way in which SAMs have been applied in some cases.[66] Lawyers have reported that prisoners are not always provided with the reasons SAMs are imposed or renewed, and that they do not have adequate opportunity to contest the decision or know what they can do to have them lifted. As shown in Ramzi Yousef's case, SAMs have been imposed and extended on the basis of the original offence, rather than any specific or ongoing threat posed by the prisoner while incarcerated.

Any measure which imposes significant restrictions on an inmate's living conditions and access to the outside world should be subject to a rigorous and accountable review process. All prisoners, regardless of their security classification, must be provided with humane conditions.

International standards provide that prisoners should not be subjected to any hardship beyond that inherent in the deprivation of liberty and maintenance of discipline.[67] In line with this principle, they should be held in the least restrictive conditions practicable, consistent with humane treatment and the aim of rehabilitation.

Recommendations

- Amnesty International recommends that prisoners in H-Unit be afforded more out of cell time, better exercise and recreational provision, and an opportunity for some association with other inmates in the unit at all stages of their confinement rather than, as presently, only after progression to phase 3.

- Prisoners should be provided with a meaningful opportunity to challenge the imposition of SAMs. In any event, consistent with international standards, restrictions should be limited to the minimum necessary and ensure that a prisoner is not subjected to undue hardship. No prisoner should be held in indefinite solitary confinement.

- As a general rule, hunger strikers should not be forcibly fed. Any decision whether to carry out non-consensual feeding of a hunger striker should be made only by qualified health professionals and any such feeding should be done only by medically trained personnel under continuing medical supervision, and only after assessing the individual's health needs and mental competence. The authorities must never require health professionals treating hunger strikers to act in any way contrary to their professional judgment or medical ethics.

Included in SCDC' 4.29.19 letter to LOC

CONTROL UNIT, SHU AND RANGE 13

The SHU range in ADX © Private

The Control Unit (CU), together with the SHU and Range 13, are the most isolated units in ADX as prisoners recreate alone and have no contact with anyone other than staff. Prisoners are assigned to the CU for fixed terms for serious offences, usually committed in other prisons, after a hearing which is similar to a disciplinary hearing. The fixed terms can be as long as six years or more,[68] and may be extended if further offences are committed while the prisoner is in the Unit.

The cells are the same as in the GP, with showers and double-doors cutting off direct contact with anyone on the range or in adjacent cells. CU prisoners have access to TVs and the same

Included in SCDC' 4.29.19 letter to LOC

in-cell programs as GP inmates. However, they are allowed exercise for only seven hours a week, and they do not have even the limited contact that GP inmates may have with prisoners in adjacent cages. Contact with the outside world is more restrictive in that they are allowed only one 15-minute non-legal phone call a month.

Prisoners in the CU have no access to the SDP but they can receive monthly credits for positive behaviour which can reduce their terms; they may also lose credit for disciplinary offences or failure to adjust. ADX regulations require that all prisoners receive monthly reviews by a CU Team attended by a psychologist. An Executive Panel reviews each CU case every 60-90 days to determine an inmate's readiness for release (to another prison or to the ADX GP).[69]

Interior of a SHU cell at ADX © Private

Included in SCDC' 4.29.19 letter to LOC

BOP regulations exclude prisoners with serious mental illness from being housed in the CU, and all inmates are supposed to undergo mental health screening before being assigned to the unit and assessed at the monthly reviews. However, according to an ongoing lawsuit (*Cunningham v Bureau of Prisons*, see below) prisoners with serious mental illness have been held in the CU, sometimes for years, with some prisoners having their terms extended for behaviour caused by their illness, including incidents of extreme self-mutilation. Factors used in awarding good conduct credits, or in evaluating a prisoner's readiness for release from the unit, include "Self-improvement Activities", "Personal Grooming and Cleanliness" and "Quarters Sanitation".[70] Lawyers have described how some prisoners are too ill or depressed to maintain personal hygiene and smear their cell walls with excrement; as they fail to meet positive conduct criteria they too can remain in the unit for extended periods. According to a prison mental health expert, behaviour such as self-harm and smearing excrement is often a symptom of mental health or behavioural disturbance stemming from, or exacerbated by conditions of isolation.[71] While some changes have been instituted as a result of the lawsuit, Amnesty International is concerned that prisoners with mental or behavioural problems may remain in isolation, in the CU or elsewhere at ADX, effectively punished for behaviour they are unable to control, in conditions that are liable to make them worse.

Prisoners in the SHU live in similar conditions of isolation as in the CU, confined to the same double-door cells, with solitary recreation. Many prisoners in the SHU are serving fixed terms for disciplinary offences; some are held there pending investigation of an incident. ADX prisoners usually spend at least a few days in the SHU upon their arrival at the institution. Most inmates in the SHU (those confined for disciplinary reasons) are denied televisions and radios or access to programs. Although prisoners generally spend shorter periods in the SHU than in other units, prisoners' terms can be extended for repeated disciplinary infractions. According to the *Cunningham* lawsuit, seriously mentally ill prisoners have been confined in the SHU for many months, and in some cases for years, due to disturbed behaviour exacerbated by their conditions of confinement.

Range 13

"The outdoor recreation area was a concrete pit surrounded by high, featureless walls on all sides. It felt like being inside of a deep, empty, swimming pool. I couldn't see any of the mountain, even though I knew they had to be close by. I also couldn't see a single tree, a blade of grass, or any sign of nature".

Description of outdoor recreation area on Range 13[72]

The most isolated section of the facility is a small high security unit known as Range 13. The cells have no view of the outside and light comes from a small window at the top of each cell too high to see through. Cameras are positioned on the cells 24 hours a day. Amnesty International was told during its 2001 visit to ADX that very few inmates were ever held there, and for no more than 12-30 days at a time. However, the organization has received information indicating that in recent years prisoners have spent significantly longer periods in Range 13.

- Thomas Silverstein, 62, convicted in 1975 for armed robbery, and implicated in the murder of a guard and two inmates, was held on Range 13 for almost three years between 2005 and 2008. He has had a clean conduct record for over two decades. Held under a "no human contact" order issued by the Director of the BOP in 1983 he was moved to ADX GP in 2008 after he filed his lawsuit. According to court documents, Mr Silverstein, while incarcerated on Range 13, was given no information from prison officials about the 'behavioural standards that were being applied to him and the "program" he would need to follow to have his extreme level of isolation reduced". It was

Included in SCDC' 4.29.19 letter to LOC

'unclear what if any objective or clear standards the BOP applied in making the decision to transfer him out of Range 13 and into D Unit'.[73]Even after the move to GP, he still was, and has been, treated differently from other GP prisoners in the sense that for the majority of the time he has been in GP, he has been forced to recreate alone, not even being able to interact with other prisoners in the outdoor cages.

- Ramzi Yousef, was held for seven years and eight months on Range 13.

Several H-Unit prisoners were also placed there in response to initiating hunger strikes.

Amnesty International has seen documents in which an H-Unit prisoner appealed his placement in Range 13 through the Administrative Remedy procedure, alleging that he was placed there in retaliation for having gone on hunger strike in September 2010. In a letter dated 5 January 2011, the Warden replied to the prisoner denying his appeal, stating that "On October 4, 2010, while you were engaged in the hunger strike, you were removed from H-Unit and placed on Range 13, in SHU, for medical observation and monitoring".[74] The letter goes on to state that "The decision was then made that upon completion of your hunger strike and your monitoring/observation by the Clinical Director, we would continue to house you on Range 13, in the SHU, with other H-Unit inmates". Thus, he was still in Range 13 nearly four months after being placed there, and no longer for observation or monitoring purposes.

Although the Warden states in his letter that H Unit prisoners in Range 13 were afforded "all of the same privileges and restrictions as H-Unit inmates", given the extremely isolated conditions on Range 13 it is hard to see this as other than a punitive measure taken to deter prisoners from going on hunger strike. Amnesty International opposes the imposition of punitive measures against prisoners for going on hunger strike, and is particularly concerned that where a prisoner is on hunger strike in protest against their isolated conditions of confinement, such measures place them in conditions of even more severe isolation.

Recommendations

- Prisoners with mental illness, mental disabilities or severe behavioural disorders should not be housed in ADX but should be treated in an appropriate therapeutic setting. All prisoners in ADX should be regularly monitored by mental health professionals.

- All prisoners, wherever they are housed, should have access to adequate provision for outdoor exercise and recreation and, to the maximum extent possible, opportunities for social contact with other inmates. No prisoner should be confined for prolonged periods in the conditions of severe isolation as exist in the CU or SHU.

- Given the very severe conditions of isolation in Range 13 cells, and the risk of psychological harm that can result from even short periods in isolation, Amnesty International considers that Range 13 should be discontinued for use.

Included in SCDC' 4.29.19 letter to LOC

MENTALLY ILL PRISONERS AT ADX

"The minds of some prisoners are collapsing in on them. I don't know what internal strife lies within them, but it isn't mitigated here. One prisoner subjected to four point restraints (chains, actually) as shock therapy, had been chewing on his own flesh. Why is a prisoner who mutilates himself kept in ADX? Is he supposed to improve his outlook on life while stripped, chained and tormented"

Excerpt from a letter written by Raymond Luc Levasseur a prisoner held in ADX, published on the 'Solitary Watch' website[75]

There is a significant body of evidence that confining individuals in isolated conditions, even for relatively short periods of time, can cause serious psychological and sometimes physiological harm, with symptoms including anxiety and depression, insomnia, hypertension, extreme paranoia, perceptual distortions and psychosis. This damaging effect can be immediate and increases the longer the measure lasts and the more indeterminate it is.[76] Isolation has been found to have negative effects on individuals with no pre-existing illness and to be particularly harmful in the case of those who already suffer from mental illness.[77]

In recognition of such effects, international and regional human rights bodies, mental health organizations and others have called for strict limits on the use of solitary confinement and an absolute prohibition of the practice in the case of prisoners who are mentally ill.[78] In 2012, the American Psychiatric Association approved a policy opposing the prolonged segregation of prisoners with serious mental illness.[79] There is a growing consensus among US courts that housing prisoners who are seriously mentally ill in "super-maximum security" conditions is "cruel and unusual punishment" in violation of the Eighth Amendment to the U.S. Constitution.

BOP policy also prohibits housing prisoners who are seriously mentally ill in ADX. Its written procedures for transferring prisoners to ADX state that prisoners "currently diagnosed as suffering from serious psychiatric illnesses should not be referred for placement at … ADX." (BOP Program Statement 5100.08, "Prisoner Security Designation and Custody Clarification", Chapter 7).

However, in declarations presented to the ECHR asserting that inmates considered seriously mentally ill would not be housed at ADX, the US government stated that "The main mental health disorders such as bipolar affective disorder, depression, post-traumatic stress disorder and schizophrenia would not preclude a designation to ADX and could be managed successfully there".[80] Thus, it appears that, in practice, BOP has taken the position that prisoners with a diagnosis of serious mental illness need not be excluded from assignment to ADX and placement in isolation if they can be managed and are not actively psychotic. This position and definition of when a person is seriously mentally ill has been challenged as contrary to accepted practice in other systems and with recommendations and findings of the US Department of Justice Civil Rights Division investigations into other jurisdictions.[81]

"I heard the head of the BOP in Congress (on radio) saying that they do not have insane inmates housed here...I have not slept in weeks due to these non-existing inmates beating on the walls and hollering all night. And the most "non-insane" smearing feces in their cells"

Letter sent to the website 'Solitary Watch' by an inmate confined in ADX who has spent the last 12 years in solitary confinement[82]

A lawsuit filed in 2012 and still in litigation (*Cunningham v BOP*) has presented evidence that a significant number of inmates suffering from serious mental illness have been confined at ADX without adequate screening, diagnosis or treatment, in violation of BOP's own policies and the Eighth Amendment to the US Constitution.[83]

Included in SCDC' 4.29.19 letter to LOC

While all prisoners are required to be screened upon arrival at the prison, the lawsuit described the process as consisting of "perfunctory interviews that are wholly inadequate as a form of screening or diagnosis".[84] It further stated that, even where prisoners were identified as having a serious mental illness, many were not given appropriate treatment or monitoring.

Because of the particularly severe conditions in the CU, BOP policy provides that, even if referred to ADX, any prisoner with evidence of a serious mental disorder or physical disability for which they require to be medicated should not be placed in the CU. However, cases cited in the lawsuit include several prisoners who had spent years in the CU, despite histories of mental illness and actively psychotic behaviour, including acts of self-mutilation. Some had been taken off their prescribed psychotropic medication in order to be assigned as "eligible" for placement in the unit. The lawsuit claimed that the 30 day evaluations were in practice "rarely performed on inmates in the Control Unit".[85]

JP, a prisoner with a history of mental illness, was transferred to ADX in 2001 and placed in the CU to serve a 60 month sentence imposed after he escaped from a medium security prison.[86] The lawsuit describes how he was repeatedly transferred for brief periods to the federal medical facility at Springfield for psychiatric evaluation after a series of incidents of self-harm, only to be returned to the CU after being "stabilised" with medication. The self-harming incidents included lacerating his scrotum with a piece of plastic (2005); biting off his finger (2007); inserting staples into his forehead (2008); cutting his wrists and being found unconscious in his cell (2009). He finally completed his CU term in 2011, ten years and five months after his original term would have expired had he been able to comply with the behavioural requirements. According to the lawsuit, he continued to be deprived of mental health care after being placed in the ADX GP. In January 2012, he reportedly sliced off his earlobes and in March 2012 sawed through his Achilles tendon with a piece of metal; after he again mutilated his genitals in May 2012 he was placed on the anti-psychotic medication Haldol but had no access to other treatment such as mental health counselling. In August 2013, he left ADX on an emergency mental health transfer to Springfield, Missouri. In October 2013, he was sent to USP Tucson but was transferred back to Springfield in about March 2014 after he rammed his head into an exposed piece of metal in his cell, causing a skull fracture and brain injury, for which he refused most treatment. Since arriving at Springfield he has inserted metal into his brain cavity through the hole that remain in his skull, which BOP says cannot safely be removed.

MW had been treated for mental illness since childhood and was also diagnosed with mental retardation. He was transferred to ADX despite a history of self-harming and attempted suicide at another prison. While in the CU, he twice cut his wrist with a razor blade; he allegedly received no mental health treatment for his behaviour but was punished with seven days loss of TV. He filed an administrative appeal against his placement in the CU which was denied.[87]

According to the lawsuit, many prisoners housed in the SHU also suffer from chronic mental illness and some routinely smear themselves and their cells with their own faeces, howl or shriek continuously or bang their metal showers at all hours of the day or night. Mentally ill prisoners have also been housed in the ADX GP. One prisoner, who had been stabilised with regular psychotropic medication in another federal facility, deteriorated after being transferred to ADX; after cutting a blood vessel in his neck he was treated in hospital then returned to ADX where he was reportedly placed in the same cell and given a pail of water to clean up the blood.[88]

The lawsuit further alleges that, as of the time of filing, there was inadequate mental health staffing at ADX. The prison reportedly had only two mental health professionals – both psychologists – serving around 450 inmates, assisted by a psychiatrist who spent only half a

Included in SCDC' 4.29.19 letter to LOC

day a week at the facility. It was alleged that psychotropic medication was inconsistently or incorrectly administered; that correction officers were not adequately trained to recognize symptoms of serious mental illness crises; and that counselling sessions with mental health staff almost invariably took place at the cell door, in the presence of correctional staff, rather than in an appropriate private setting.

In 2013, two years after the lawsuit was filed, and following rejection by a federal judge of BOP appeals to dismiss the case, both sides entered into a structured settlement process overseen by an assistant federal judge. While at the point of writing no definitive agreement had been reached, prison authorities have reportedly taken steps to address the concerns raised, although, according to the lead attorney in the case, the BOP remains "far from righting chronic treatment gaps".[89]

- In September 2013 a prisoner with a history of serious mental illness hanged himself in his cell in the ADX GP. He had reportedly spent more than a decade at ADX with only intermittent mental health care, having been transferred to a medical facility at least six times to be medicated only to be returned to ADX where each time he deteriorated; he suffered psychotic symptoms which had allegedly been ignored in the days before his death.[90] According to his lawyer, the BOP refused to allow the coroner to interview other prisoners, enter prisoner cells or take witness statements. They also took the reportedly unprecedented step of having three representatives attend the autopsy.

The changes under the above settlement negotiations are reported to include the creation of two new long-term residential programs to treat high security prisoners with serious psychiatric problems: the first in Atlanta, Georgia, opened in September 2013 with capacity for 30 patients –all but one of whom were transferred from ADX. In addition, a number of mentally ill prisoners have been transferred to a federal medical facility in Springfield, Missouri.

Other improvements include a new policy statement on SMI; some improvement in staff training; an increase in the size of mental health staff from two psychologists to four, and a psychiatric nurse; an improved pre-admission evaluation for inmates entering prison; and the employment of an outside consultant to evaluate all prisoners at ADX. Additionally, a change has been made to the policy that previously prohibited the administration of psychotropic drugs to inmates in the CU so that some prisoners in the unit may now receive such medication. While Amnesty International recognizes this latter change as an improvement on withholding medication from mentally ill prisoners, it is deeply concerned that prisoners with SMI should be held at all in the CU given its severe conditions of isolation.

According to information provided to Amnesty International by plaintiff's attorneys, a number of critical objectives are being sought through the settlement process, including better evaluation and diagnostic processes for those being referred to ADX, effective treatment for mentally ill prisoners in an appropriate therapeutic setting, routine monitoring and psychological services for all prisoners at ADX and, for all prisoners, a reduction in extreme isolation time with monitoring and enforcement mechanisms to ensure changes are properly introduced.

International standards, and those set by US professional organizations, require careful monitoring of all prisoners held in isolation due to the negative impact this can have on the psychological health of individuals even without pre-existing illness. The SMR require daily monitoring of prisoners placed in "close confinement" (Rule 32). The National Commission for Correctional Health Care (NCCHC) in the USA has observed that conditions in super-maximum security isolation facilities "Even for the most stable individuals … may precipitate

Included in SCDC' 4.29.19 letter to LOC

mental health or health difficulties" and that "daily contact by medical staff and at least weekly contact with mental health staff is required", noting that such contacts "must be meaningful and allow sufficient interaction for such assessments to take place".[91] Although the standards are not binding on non-accredited facilities, they represent best practice.

Recommendations

- Amnesty International recommends that prisoners who are mentally ill are not housed at ADX; and that all prisoners in isolation have an opportunity for meaningful consultation with mental health staff on at least a weekly basis as recommended under NCCHC and international standards.

- Prisoners with a diagnosis of mental illness, mental disability or severe behavioural disorders should not be housed in ADX and should have access to treatment in an appropriate therapeutic setting.

- All prisoners in ADX should be regularly monitored by mental health professionals.

- Health care staff should report to the prison authorities if a prisoner's health is being put as serious risk by being held in isolation.

- No prisoner with a history or risk of mental illness should be housed in ADX

OVERVIEW OF US OBLIGATIONS UNDER INTERNATIONAL LAW AND STANDARDS

The USA has ratified the United Nations (UN) Convention against Torture and other Cruel, Inhuman or Degrading treatment or Punishment and the International Covenant on Civil and Political Rights (ICCPR) both of which affirm the absolute prohibition of torture and other cruel, inhuman or degrading treatment or punishment (articles 1 and 16 of the Convention against Torture and article 7 of the ICCPR). Additionally, the ICCPR in article 10, requires that "all persons deprived of their liberty shall be treated with humanity and respect for the inherent dignity of the human person", an obligation the UN Human Rights Committee (the treaty monitoring body) has stated is a "fundamental and universally applicable rule"[92].

The Human Rights Committee has further emphasized that the prohibition of torture and other cruel, inhuman or degrading treatment under international law "relates not only to acts that cause physical pain but also that acts that cause mental suffering" and has stated, specifically, that prolonged solitary confinement may breach this prohibition (Human Rights Committee General Comment 20 on article 7).

The Human Rights Committee and the Committee against Torture (CAT) (the monitoring body of the Convention against Torture) have criticised conditions in US "super-maximum" facilities as inconsistent with the USA's obligations under the above treaties. In 2006, the Human Rights Committee reiterated its concern that "conditions in some maximum security prisons are incompatible with the obligation in Article 10(i) to treat detained persons humanely", citing, in particular, prolonged cellular confinement, lack of adequate exercise

Included in SCDC' 4.29.19 letter to LOC

and the "depersonalized environment" found in such units.[93] The Committee also observed that such conditions "cannot be reconciled with the requirement in article 10(3) that the penitentiary system shall comprise treatment the essential aim of which shall be the reformation and social rehabilitation of prisoners".[94] The CAT has urged the USA to review "the regime imposed on detainees in supermaximum prisons, in particular the practice of prolonged isolation", noting the effect of such treatment on prisoners' mental health.[95]

Most recently, the Human Rights Committee issued its Concluding Observations following its consideration of the USA's Fourth Periodic Report in March 2014. It again expressed concern about holding prisoners in prolonged isolation, including in pre-trial detention, and recommended that the USA monitor conditions with a view to ensuring that persons deprived of their liberty be treated in accordance with the requirements of article 7 and 10 of the ICCPR and the SMR. The Committee recommended that the USA "impose strict limits on the use of solitary confinement, both pre-trial and following conviction, in the federal system, as well as nationwide, and abolish the practice in respect of anyone under 18 and prisoners with serious mental illness".[96]

The USA has sought to limit its obligations under article 7 of the ICCPR and Article 16 of the Convention against Torture, by entering reservations upon ratification of the treaties stating that it considers itself bound by the articles 7 and 16 only to the extent that "cruel, inhuman or degrading treatment or punishment" means the "cruel and unusual punishment" prohibited under the US Constitution. Amnesty International has repeatedly called on the USA to withdraw its reservations as defeating the object and purpose of the treaties and therefore incompatible with international law.[97] The Human Rights Committee has also noted with concern the restrictive interpretation made by the USA of its obligations under the Covenant, as has the Committee against Torture. In any event, the USA has made no similar reservation to Article 10 of the ICCPR which requires that all prisoners must be treated humanely, without exception.

As noted above, Amnesty International has found conditions in ADX, and in some other pre-trial or post- conviction federal facilities, to be in specific breach of standards under the SMR. They include standards on access to adequate outdoor exercise and fresh air, conditions essential to health and quality of life. The SMR, although not as such having the legally binding force of a treaty, set out minimum standards which the UN Special Rapporteur on Torture has said are "widely accepted as the universal norm for the humane treatment of prisoners".[98] They have also been cited by the Human Rights Committee in its General Comment on Article 10 and, as shown above, in assessing state parties' reports. Key standards for the treatment of prisoners are also set out in the Basic Principles for the Treatment of Prisoners, adopted by the UN General Assembly (GA) in 1990, and the Body of Principles for the Protection of all Persons under any form of Detention or Imprisonment adopted by the UN GA in 1998.

International norms also provide, as an abiding general principle, that imprisonment should not impose hardship or constraint other than that resulting from the deprivation of liberty or restrictions that are unavoidable in an enclosed environment.[99] While acknowledging the need for heightened security measures for some prisoners, Amnesty International considers that the conditions of prolonged isolation and other deprivations endured by many prisoners in ADX are unnecessarily harsh and breach the above principle.

International and regional human rights treaty bodies and experts have consistently called on states to restrict their use of solitary confinement, in recognition of the physical and mental harm and suffering this can cause even when imposed for limited periods.[100] This was reiterated by the UN Special Rapporteur on Torture in a detailed report issued in August

Included in SCDC' 4.29.19 letter to LOC

2011 in which he called on states to apply solitary confinement "only in exceptional circumstances and for the shortest possible period of time".[101] He defined solitary confinement as "the physical and social isolation of individuals who are confined to cells for 22-24 hours a day". He called for the abolition of solitary confinement in the case of children under 18 and people with mental disabilities on the ground that its imposition in such cases, for any duration, constitutes cruel, inhuman or degrading treatment. He stressed the importance of safeguards for prisoners placed in segregation, including regular monitoring and review of prisoners' mental and physical condition by qualified, independent medical personnel, and a meaningful opportunity for prisoners to challenge their confinement through a process of administrative review and through the courts. In a statement issued on 7 October 2013, the Special Rapporteur urged the US government to take "concrete steps to eliminate the use of prolonged and indefinite solitary confinement in US prisons and detention facilities".[102]

US LAW AND STANDARDS

As outlined in this report, there is concern that the federal system (as well as many state jurisdictions) has failed to put in place the safeguards called for above, including an effective system to enable prisoners to challenge their confinement through administrative review. US courts also provide only a limited remedy for prisoners held in isolation, generally deferring to prison administrators in deciding what restrictions are necessary on security grounds. The US Supreme Court has not ruled that solitary confinement, even when imposed indefinitely, is per se a violation of the Constitution.[103] It has set a high threshold for judging when prison conditions violate the Eighth Amendment prohibition of "cruel and unusual punishment", holding that they must be so severe as to deprive inmates of a "basic necessity of life" – interpreted to mean the physical requirements of food, clothing, shelter, medical care and personal safety – and that the authorities must have shown "deliberate indifference" to a risk of harm.[104] The courts have been less willing to consider mental and psychological pain or suffering as sufficient to render conditions unconstitutional, a situation where US jurisprudence falls short of international human rights law (see Human Rights Committee General Comment 20, above).[105]

While the US courts have generally allowed prison administrators broad leeway in housing prisoners in isolation, other US bodies have been more robust in calling for rigorous standards and safeguards on the use of solitary confinement.

In its 2006 report Confronting Confinement, the Commission on Safety and Abuse in America's Prisons called for an end to conditions of isolation in US prisons.[106] The report stated that "Separating dangerous or vulnerable individuals from the general prison population is part of running safe correctional facility". However, it found that in some systems, the "drive for safety, coupled with public demand for tough punishment, has had some perverse effects", with prisoners who were justifiably separated from the general prison population locked in cells with little opportunity to be productive or to prepare for release, and others who were not a serious threat confined under the same conditions.

The Commission recommended making segregation a last resort, for as brief a period as possible, with tighter admissions criteria and segregated prisoners given an opportunity to engage in productive activities. Noting higher recidivism rates from prisoners released directly from segregation, the Commission also recommended that inmates should spend time in a normal prison setting before being released to the community. The Commission called on US jurisdictions to "End conditions of isolation" and "Ensure that segregated prisoners have regular and meaningful human contact and are free from extreme physical conditions that cause lasting harm".[107]

Included in SCDC' 4.29.19 letter to LOC

In 2010, the American Bar Association (ABA) promulgated standards on the treatment of prisoners which included standards on segregation.[108] These state that segregated housing "should be for the briefest term and under the least restrictive conditions practicable and consistent with the rationale for placement and with the progress achieved by the prisoner" (Standard 23-2.6). The standards state that segregation for more than one year should be imposed only if the prisoner poses a "continuing serious threat" (23-2.7); that "conditions of extreme isolation should not be allowed regardless of the reasons for a prisoner's separation from the general population" (23-3.8 (b)); and that all prisoners in segregated housing should be provided with "meaningful forms of mental, physical and social stimulation", including, where possible, more out-of-cell time and opportunities to exercise in the presence of other prisoners (23-3.8 (c)). The standards also recommend a number of procedural protections for prisoners placed in segregated housing, including a hearing at which the prisoner has a reasonable opportunity to present witnesses and information and to participate in the proceedings, with regular, meaningful review (23-2.9).

Included in SCDC' 4.29.19 letter to LOC

RECOMMENDATIONS

GENERAL RECOMMENDATIONS ON USE OF ISOLATED CONFINEMENT

- In line with international human rights law and standards, all jurisdictions should ensure that solitary or isolated confinement, whether imposed for administrative or disciplinary purposes, is imposed only as a last resort and for the minimum period possible.

- No prisoner should be held in prolonged or indefinite isolation.

- All prisoners in segregated confinement should have access to meaningful therapeutic, educational and rehabilitation programs.

- Conditions in all segregation facilities should provide minimum standards for a humane environment so that prisoners even in the most restrictive settings have adequate facilities for outdoor exercise, access to natural light, and meaningful human contact both within the facility and with the outside world.

- There should be adequate opportunities for some group interaction and association for prisoners at all stages of segregated confinement, both to benefit their mental and physical health and to allow their behaviour to be measured and to encourage their progress to less restrictive custody.

- Children - that is those under 18 - should never be held in solitary confinement. All youthful offenders should receive treatment appropriate to their age and developmental needs with the primary goal of rehabilitation as required under international standards.

- No prisoner with mental illness, mental disabilities or severe behavioural disorders or who is identified as being at risk of developing these conditions should be held in solitary or isolated cellular confinement.

- There should be adequate mental health monitoring of all prisoners in segregation, with frequent opportunities for prisoners to consult with mental healthcare professionals in private.

- Prisoners who have developed serious health care problems as a result of their isolated confinement (whether physical or mental) should be removed and have access to treatment in to an appropriate therapeutic setting.

- Placement in segregated confinement should be made only after an impartial hearing at which the prisoner has a fair and meaningful opportunity to contest the assignment and the right to appeal. Prisoners should be provided with regular, meaningful review of any continued segregation through a similar impartial proceeding, with clear criteria to enable them to move to less restrictive settings within a reasonable time frame.

- There should be regular, external review of conditions in segregation facilities and of the procedures and operation of such facilities.

PRISONERS IN PRE-TRIAL DETENTION

- All detainees in pre-trial detention should be held in conditions consistent with their status as untried prisoners and the presumption of innocence. They should be held in the least restrictive circumstances possible, with regular access to medical care and adequate

Included in SCDC' 4.29.19 letter to LOC

facilities for the preparation of their defence and communication with their lawyers and family members.

- Amnesty International urges that the current review of federal segregation policies include conditions under which prisoners are isolated during pre-trial detention, especially in high security facilities such as those in the MCC SHU.

ADDITIONAL RECOMMENDATIONS SPECIFIC TO ADX

- Conditions for all prisoners in ADX Florence should be improved so that prisoners are not held in conditions of severe isolation and have more opportunities for social interaction with staff and other inmates as well as access to meaningful rehabilitation and recreational programs. The exercise facilities should be modified to allow more space and equipment; prisoners should be allowed daily outdoor exercise[109].

- Opportunities should be reinstated for ADXGP prisoners to have group recreation even at the most restrictive levels of confinement, both to aid their rehabilitation and to allow their progress to be measured.

- Amnesty International recommends that clear criteria be established for SDP placement decisions, with a fair process and meaningful review. Prisoners should be provided with detailed reasons if they are denied advancement through the SDP, with an opportunity to participate in, and challenge, decisions, with clear guidance on how they can progress through the system. No-one should be held continuously in isolation based solely on the original reason for placement in ADX.

- Amnesty International recommends that prisoners in H-Unit be afforded more out of cell time, better exercise provision, and an opportunity for some association with other inmates in the unit at all stages of their confinement rather than, as presently, only after progression to phase 3.

- Prisoners should be provided with a meaningful opportunity to challenge the imposition of SAMs. In any event, consistent with international standards, restrictions should be limited to the minimum necessary and ensure that a prisoner is not subjected to undue hardship. No prisoner should be held in indefinite solitary confinement.

- Amnesty International recommends that prisoners who are mentally ill are not housed at ADX; and that all prisoners in isolation have an opportunity for meaningful consultation with mental health staff on at least a weekly basis as recommended under NCCHC and international standards.

- Prisoners with a diagnosis of mental illness, mental disability or severe behavioural disorders should not be housed in ADX and should have access to treatment in an appropriate therapeutic setting.

- All prisoners in ADX should be regularly monitored by mental health professionals.

- Health care staff should report to the prison authorities if a prisoner's health is being put as serious risk by being held in isolation.

- No prisoner with a history or risk of mental illness should be housed in ADX

- Range 13 cells should be discontinued.

- The BOP should provide publicly accessible information on ADX programs and operating policy. It should also report regularly on the number of prisoners in ADX and in the various

Included in SCDC' 4.29.19 letter to LOC

units and step down programs and the time spent in each program or unit.

RECOMMENDATIONS TO THE FEDERAL GOVERNMENT AND CONGRESS

- Congress should require, and the federal government institute, reforms to the use of solitary and isolated confinement in all BOP facilities so that they meet with the above standards and fully conform to international law and standards for humane treatment.

- The US Government should allow visits by human rights groups and the media and invite the UN Special Rapporteur on Torture to investigate the use of solitary confinement in US prisons, including through on-site visits under the terms requested by the Special Rapporteur.

- A national reporting system to the Bureau of Justice Statistics should be established under which state and local prison and detention facilities, including juvenile facilities, are required to provide data on their use of solitary confinement, including statistics on the numbers of prisoners held in segregated facilities, the length of confinement, the effectiveness of programs instituted, the costs of confinement and the impact on prisoners, on institutional safety and on recidivism.

- The above data and input from experts, including mental health experts and penal reformers, should be studied to provide guidance on best practice and effective measures to reduce the use of solitary or isolated confinement.

- National guidelines should be drawn up to limit the use of solitary and isolated confinement based on international standards, the ABA standards and best practice.

- Amnesty International urges that Thomson Correctional Center not be funded or designated as a super-maximum isolation facility and that the federal government take steps to reduce and provide alternatives to its use of isolated confinement.

Included in SCDC' 4.29.19 letter to LOC

ENDNOTES

[1] Silverstein v. Federal Bureau of Prisons et al, Civil Action No. 07-cv-02471-PAB-KMT, Exhibit 1 (Silverstein v. BOP).

[2] Juan E. Méndez, "Interim report prepared by the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment", A/66/268, 2011, para 26.

[3] No exact current figures are available. However, a survey by the Urban Institute found that, as of 2004, 44 states had "supermax" facilities housing some 25,000 inmates (Daniel P. Mears, *A Critical Look at Supermax Prisons*, Corrections Compendium, 2005). Few US jurisdictions use the term "supermaximum" custody nowadays: maximum custody isolation facilities which fit that description are known by various terms including Special Management Units (SMUs), Security Housing Units (SHUs) or Administrative Segregation Units (ASUs).

[4] A census of state and federal prisons in 2005 conducted by the US Department of Justice's Bureau of Justice Statistics found there were 81,622 prisoners held in some form of "restricted housing" at that time.

[5] Written Testimony of Professor Laura Rovner, University of Denver, Before Senate Judiciary Committee, Subcommittee on the Constitution, Civil Rights and Human Rights, June 15, 2012 available at http://www.law.du.edu/documents/student-law-office-clinical-programs/laura-rovner-university-of-denver-sturm-college-of-law.pdf (accessed 8 July 2014).

[6] Letter from Eileen Chamberlain Donahoe, US Ambassador to the United Nations Human Rights Council, Geneva, 30 November 2011.

[7] The case of Babar Ahmad and Others v The United Kingdom, 10 April 2012 (Babar Ahmad and Others v. UK) before the European Court of Human Rights, an appeal against the extradition from the UK of five individuals to the USA on claims including that they would risk being subjected to cruel, inhuman or degrading treatment if confined in ADX. In a judgment in April 2012, the Court rejected this claim on finding that isolation at the facility was "partial and relative" (noting that while ADX prisoners had no physical contact with others, they could communicate through the air vents in their cells; and during limited exercise); that they had TVs and access to programs in their cells; and that the applicants had a "real possibility" of gaining to the SDP or its equivalent in H-Unit. The ruling was criticized by US human rights lawyers and NGOs as giving too much weight to the evidence submitted by the USG (which they claimed grossly understated the amount of time a prisoner spends at the facility), in the face of other evidence presented on behalf of the applicants on the extent and duration of isolation at the facility. Amnesty International also expressed concern about the reasoning that led to the decision (Amnesty International, *USA must respect rights of individuals extradited from the UK*, 8 October 2010, Index: AMR 51/086/2012). The Court itself stated in its ruling that "solitary confinement, even in cases entailing relative isolation cannot be imposed indefinitely" and that "If an applicant were at real risk of being detained indefinitely at ADX it would be possible to reach the minimum level of severity required for a violation of article 3" and that "Indeed, this may well be the case for those inmates who have spent significant periods of time at ADX". (Babar Ahmad and Others v. UK Judgment, 10 April 2012, para 223).

[8] A survey for the litigants in Babar Ahmad and Others v. UK, found 43 inmates at ADX had spent eight years in isolation (including, in some cases, periods spent in solitary confinement in other prisons before transfer to ADX); similar findings were revealed from a larger sample of 110 ADX prisoners.

[9] Silverstein v. BOP.

[10] Cunningham v BOP, Case 1:12-cv-01570 (formerly Bacote v BOP), filed 06 June 2012. At the time

Included in SCDC' 4.29.19 letter to LOC

of writing the case was pending a decision on a motion to have it certified as a class action. The case is one of a number of lawsuits filed in recent years on behalf of inmates mentally ill in ADX including Jose Martin Vega, who committed suicide by hanging in his ADX cell in 2010 (Cunningham v. BOP).

[11] The BOP awarded the contract for the 'Special Housing Unit Review and Assessment' to CNA Corporation. The review will include an operational assessment of eight BOP special housing units; the Bureau's mental health assessment process; and inmate due process rights. It will not include inmates under SAMS, H Unit, or prisoners held in pre-trial isolation. For further information, see James Ridgeway & Jean Casella, *"Federal Bureau of Prisons details limited audit of solitary confinement practices"*, 'Solitary Watch', http://solitarywatch.com/2013/11/22/federal-bureau-prisons-details-limited-audit-solitary-confinement-practices/ (accessed 08 July 2014).

[12] Lisa Dawson, "Funding Approved for Activation of ADX/USP Thomson, New Federal Supermax Prison", 'Solitary Watch' website, March 2014, http://solitarywatch.com/2014/03/14/funding-approved-for-activation-of-adxusp-thomson-new-federal-supermax/ (accessed 8 July 2014).

[13] According to documents obtained under Freedom of Information Act requests in 2007, from January 2002 through May 2007, officials denied every single media request for face-to-face interviews with ADX prisoners, or tours of the facility (source: Fortress of Solitude, by Alan Pendergast, 16 August 2007. (http://www.westword.com/2007-08-16/news/fortress-of-solitude/full/). Prior to this, some journalists had had regular access to the facility. Following criticism of lack of access, the BOP arranged a restricted tour of the facility in September 2007 for some major media: the Washington Post, the Los Angeles Times, CNN, FOX News, CBS 60 Minutes and two local papers. No similar tours are believed to have been arranged since then.

[14] http://www.aclu.org/files/assets/coalition_letter_to_department_of_state_re_juan_mendez_visit.pdf (accessed 08 July 2014).

[15] GAO report, "Improvements Needed in Bureau of Prisons' Monitoring and Evaluation of Impact of Segregated Housing", May 2013, p. 2. The GAO is the audit, evaluation and investigative arm of the US Congress and examines and reports on the use of public funds and federal programs and policies (GAO report).

[16] GAO report, p 18.

[17] Amnesty International uses the term "solitary confinement" and "isolation" interchangeably to describe circumstances in which prisoners are confined to small, usually single (but sometimes double) cells for 22 hours or more a day, with no group activities and only limited contact.

[18] GAO report, p 15.

[19] Richardson v Kane, filed December 2011 (Richardson v. Kane).

[20] According to the GAO report some 7% of federal prisoners were in some form of segregated confinement as of February 2013; they included prisoners in SMUs as well as in SHUs where prisoners are often confined for fixed terms for rule violations; for their own protection; or while awaiting classification on entry to the prison system. The GAO found this constituted an increase in use of segregation over five years which exceeded the rate of increase in the prison population as a whole, mainly due to the expansion of SMUs. However, a press release issued from Office of Dick Durbin, US Senator for Illinois, *Durbin Statement on Federal Bureau of Prisons Assessment of Its Solitary Confinement Practices*, 4 February 2013, noted the BOP has reduced its segregated population by nearly 25 per cent in the past year. It is unclear how far this reduction is due to closure of some SMU units or relates to short-term isolation (e.g. as short fixed penalties or short periods in administrative detention while awaiting classification or during an investigation) or applies to those held for long periods in administrative or disciplinary segregation.

[21] http://justice.gov/jmd/2014factsheets/prisons-detentions.pdf (accessed 8 July 2014).

Included in SCDC' 4.29.19 letter to LOC

---

[22] Jean Casella & James Ridgeway*, "Feds to Open New Supermax Prison Cells at 'Gitmo North'"*, 'Solitary Watch' website, 8 February 2013, http://solitarywatch.com/2013/02/08/feds-to-open-new-supermax-prison-cells-at-gitmo-north (accessed 8 July 2014)

[23] Basic Principles on Treatment of Prisoners state that "7. Efforts addressed to the abolition of solitary confinement as a punishment, or to the restriction of its use, should be undertaken and encouraged."

[24] They include Syed Hashmi who spent nearly three years in solitary confinement in MCC SHU and Oussama Kassir and Victor Bout who spent 18 months and 15 months respectively in solitary confinement at MCC, all confined to cells 23 or 24 hours a day with only one hour a day exercise in a small inside room not much larger than their cell.

[25] Amnesty International, *Cruel conditions for pre-trial prisoners in US federal custody*, 12 April 2011 (Index: AMR 51/030/2011); *Open Letter to US Attorney General Eric Holder on Special Housing Unit in the Metropolitan Correctional Center, New York*, 16 February 2011 (Index: AMR 51/2011/27).

[26] The only job available is a three-month position as an orderly, cleaning the unit tiers. It is alleged that some prisoners have repeatedly applied for this coveted position and been turned down. Rezaq v Nally, 11-1069, 10th Circuit Court of Appeals (Rezaq v Nalley).

[27] BOP Institutional Supplement, October 8, 2009, 6a-5 (BOP Institutional Supplement 2009). The ruling of the ECHR in the case of Babar Ahmad and Others v UK also noted information in the declarations of General Population Unit Manager Patricia Rengel that "Restrictions on outdoor recreation were in three-month increments (three months for a first offence, six for a second offence and so on"). Babar Ahmad and Others v. UK Judgment, 10 April 2012, para 88.

[28] Lawyers for the plaintiffs in Babar Ahmad and Others v. UK submitted testimony that some ADX prisoners were placed on "single recreation status" for minor violations. In one case, a prisoner was denied outdoor exercise for 60 days for trying to feed crumbs to birds; when he challenged this through the internal grievance process, it was increased to 90 days (Judgment in the case Babar Ahmad and Others v the United Kingdom, ECHR 10 April 2012, para 101).

[29] BOP Institutional Supplement 2009 6a.

[30] Information from Amnesty International's representative Angela Wright. Institutional Supplement No. FLM 5321.1B, May 26, 1995 on General Population and Step-Down Unit Operations: Procedures for General Population Units state inter alia that "These units have multiple and single occupancy exercise areas … Inmates will ordinarily be afforded twelve (12) hours or more out of cell exercise per week." (4.A). (see also Design Meets Mission at New Federal Max Facility, by John M. Vanyur, Corrections Today, July 1995, a detailed description of the operation of the facility at that time, noting, inter alia that General Population inmates "are fed in their cells but are permitted to recreate in small groups of up to 12 inmates for 12 hours per week".

[31] Cunningham v. BOP, p. 14. The lawsuit alleges that two prisoners in K Unit (the Intermediary Unit) "stomped and beat a third prisoner to death over a period of many minutes in full view of ADX staff members, who made no effort to intervene until the victim was lying still…".

[32] Cunningham v. BOP. The lawsuit alleges that, while inmates in the TU are grouped so that they are separated from hostile inmates (e.g. rival gang members) during recreational periods, guards often fail to take adequate precautions, for example, opening cell doors unexpectedly so that hostile inmates have sometimes gained unauthorized access to others in the day room.

[33] As with a number of current privileges as ADX, inmates were provided with access to religious materials only after extensive litigation. According to a Stipulated Agreement dated December 2008 in Saleh et al v BOP, ADX inmates may meet with the prison approved Imam at least weekly, and may communicate with him in Arabic or English at the cell door from within their cells without restraints. The agreement stipulates that if he opens an ADX cell door, the Imam must be accompanied by a BOP

Included in SCDC' 4.29.19 letter to LOC

official.

[34] Nidal Ayyad et al v Nalley, Third Amended Complaint, April 2009, p. 13-14

[35] Examples have been given in litigation documents of programming consisting of shows broadcast on TV, from parenting shows to those on Greek history such as the Peloponnesian wars (Rezaq v Nalley, 11-1069, 10th Circuit Court of Appeals).

[36] Laura Rovner, testimony to ECHR, Babar Ahmad and Others v. UK Judgment para 101.

[37] Sal Rodriguez, *'Profile of an ADX prisoner: "Just half crazy and trying to hold on to the other half"'*, 'Solitary Watch' website, http://solitarywatch.com/2012/12/09/profile-of-an-adx-prisoner-just-half-crazy-and-trying-to-hold-on-to-the-other-half/ (accessed 8 July 2014)

[38] Rezaq v Nalley and Saleh, Nosair et al v Federal Bureau of Prisons, Appellants Brief May 2011.

[39] According to a letter Amnesty International received from the Warden at ADX in 2012, in response to the organization's concerns about the conditions of Syed Fahad Hashmi at ADX, Hashmi was allowed to visit with his attorney unrestrained through a telephone handset, rather than in a room where there was a slot in the barrier and through which correspondence could be exchanged.

[40] UN Standard Minimum Rules for the Treatment of Prisoners (SMR) stipulate that: "Instruments of restraint, such as handcuffs, chains, irons and strait-jackets, shall never be applied as a punishment. They further provide that restraints may only be used when other measures are ineffective and only for so long as is "strictly necessary" (Rules 31, 33 and 34).

[41] International standards require that prisoners not engaged in outdoor work should have at least an hour of suitable exercise in the open air daily (SMR 21 (1)). The SMR further provide that "Young prisoners and others of suitable age and physique shall receive physical and recreational training during the period of exercise" and that, to this end, "space, installations and equipment should be provided" (SMR 21 (2). While the time allowed in the yard meets the above minimum standard, if adhered to daily, Amnesty International does not believe that conditions in the exercise yards at ADX are adequate to qualify as "suitable outdoor exercise", particularly for prisoners otherwise confined to cells for long periods. The need for adequate exercise is particularly important where prisoners are cut off from normal activities and spend long periods in their cells, and in view of the detrimental effects on health of lack of exercise.

[42] The use of restraint techniques and/or instruments may amount to ill-treatment when they are applied unnecessarily or in a degrading manner. See also report of the Special Rapporteur on Torture E/CN.4.2004/56 (2003), para 45.

[43] Inmate Security Designation and Custody Classification, Fed. Bureau of Prisons, 92 (12 September 2006).

[44] Letter from Eileen Chamberlain Donahoe, US Ambassador to the United Nations Human Rights Council, Geneva, 30 November 2011.

[45] This language has been repeated in a number of documents, including letter from Ambassador Eileen Chamberlain Donahoe, US Representative to the Human Rights Council, in her letter to the UN Special Rapporteur on Torture on 30 November 2011, in which she refers to the "penological missions" of ADX. See identical language used also in the Declaration of Mark Collins, Unit Manager for the General Population of ADX on the missions of ADX in Reid v Wiley et al, Civil Action No. 07-cv-01855-PAB-KMT, US District Court for the District of Colorado, November 2009; and Rezaq v Nalley, et al, 10th Circuit Court of Appeals, April 2012.

[46] Judgment in Babar Ahmad and Others v. UK, para. 96. The 30 prisoners in the sample were almost entirely from the GP and SDP but also included two prisoners from the Special Security Unit (housing prisoners held under SAMs) where a separate step down program had been recently instituted.

Included in SCDC' 4.29.19 letter to LOC

[47] Judgment in Babar Ahmad and Others v. UK, para 101, noting a survey by lawyer Mark Donatelli which found that at least 43 inmates of ADX had spent eight years or more in "lock-down" conditions there and at previous institutions. Also included in the defence team's rebuttal evidence was a chart using a sample of 110 ADX prisoners which identified an average solitary confinement length of 8.2 years.

[48] GAO report, p. 13

[49] Silverstein v. BOP.

[50] These safeguards are less than would be required if a prisoner was facing removal to a disciplinary segregation unit. The procedures for transfer to ADX provide that the inmate has at least 24 hours' notice of, and an opportunity to appear before, an administrative hearing at which he can make an oral statement and provide documentary evidence (but without legal representation or an opportunity to present witnesses); is provided with a written summary of the reasons for transfer; has right of administrative appeal of the Regional Director's decision by BOP General Counsel.

[51] While the Institutional Supplement (October 2009) states that the unit team's review of the eligibility of a prisoner to enter into, or advance through, the SDP will "ordinarily" be "conducted in connection with" the regularly scheduled Program Reviews which the inmate can attend and "raise questions and concerns" about his situation, this is not the same as participation in the SDP Committee review itself. Furthermore, as already noted, "eligibility" does not mean that the prisoner will be considered for advancement through the Program. It has also been reported that the regular Program Reviews themselves often consist of nothing more than a visit to the cell door and a few minutes discussion with the prisoner.

[52] The Institutional Supplement setting out the review procedure states, "Eligibility for consideration does not equate to appropriateness for placement into or advancement to the next phase of the Program", FLM 5321.061(1) CN-01, C1(d).

[53] Admission and Orientation Handbook, USP Administrative Maximum Facility Florence, Colorado, November 2008. The first step in the Administrative Remedy procedures is for the inmate to informally resolve his complaint documenting the procedure using an Informal Resolution form. Should this not succeed, the second step is for the inmate to file a formal complaint, an 'Institution Administrative Remedy', which a staff member will review and the decision is then approved by the Warden. Inmates may appeal the decision within 20 calendar days to the Regional Director, FBOP, in Kansas City. The Regional Director will normally respond within 30 days. This decision can then be appealed to the General Counsel who will have a further 30 days to respond.

[54] Saleh v Federal Bureau of Prisons, Objections, ECF No. 352, at 12.

[55] Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment to the United Nations General Assembly, 5 August 2011 (A/66/268).

[56] Following lawsuits, they were given retroactive hearings some years after placement at ADX.

[57] Rezaq v Nalley (Case No. 11-1069) and Mohammed Saleh, Ibrahim Elgabrowny, and El-Sayyid Nosai v Federal Bureau of Prisons (Case No. 11-1072), Appellants' Opening Brief before US Court of Appeals for the Tenth Circuit, 31 May 2011, at p. 13

[58] Rezaq v Nalley et al, Case No. 11-1069.

[59] See Written Testimony of Professor Laura Rovner, University of Denver, Before Senate Judiciary Committee, Subcommittee on the Constitution, Civil Rights and Human Rights, June 15, 2012, pointing to lack of clear guidelines for moving to SDP available at http://www.law.du.edu/documents/student-law-office-clinical-programs/laura-rovner-university-of-denver-sturm-college-of-law.pdf (accessed 8 July 2014).

Included in SCDC' 4.29.19 letter to LOC

[60] Judgment in Babar Ahmad and Others v. UK, para 88.

[61] Staff can reject books if they believe they present a risk; One of the books they rejected for a man under SAMS was President Obama's autobiography. See https://www.prisonlegalnews.org/news/2009/oct/15/news-in-brief/ (accessed 8 July 2014)

[62] Initially H-Unit prisoners had severe restrictions imposed on access to news channels, journals and other materials but these were largely lifted following litigation.

[63] Prisoners under SAMs have their communications, including social calls and visits, monitored; there have reportedly been delays at times in receiving communications due to these needing to be translated.

[64] James Ridgeway & Lisa Dawson, *'ADX H-Unit on Hunger Strike, Prisoners Being Force-Fed'*, 'Solitary Watch' website, 25 February 2014, http://solitarywatch.com/2014/02/25/adx-h-unit-hunger-strike-prisoners-force-fed (accessed 8 July 2014).

[65] CBS News, 60 Minutes, *'Supermax. A Clean Version of Hell'*. 21 June 2009 http://www.cbsnews.com/videos/a-clean-version-of-hell/ (accessed 8 July 2014)

[66] See Center for Constitutional Rights, "*Rights Groups Issue Open Letter on Upcoming Trial of Syed Fahad Hashmi and Severe Special Administrative Measures"*, 23 April 2010, http://ccrjustice.org/newsroom/press-releases/rights-groups-issue-open-letter-upcoming-nyc-trial-syed-fahad-hashmi-and-sev (accessed 8 July 2014)

[67] See section on International Standards and reference inter alia to UN Human Rights Committee General Comments. The SMR also state as a guiding principle that: "Imprisonment and other measures which result in cutting off an offender from the outside world are afflictive by the very fact of taking from the person the right of self-determination by depriving him of his liberty. Therefore the prison system shall not, except as incidental to justifiable segregation or the maintenance of discipline, aggravate the suffering inherent in such a situation." (Article 57)

[68] During her 2001 visit to ADX, Amnesty International's representative was told the longest fixed term assignment on the unit at that time was 104 months; the prisoner in question had his term extended still further after a serious assault on a staff member.

[69] Institution Supplement, Control Unit Programs, May 17, 2010

[70] Institution Supplement, Control Unit Programs, May 17, 2010

[71] Kupers, Terry A, *"How to Create Madness in Prison"*, David Jones, Ed; Humane Prisons, Oxford: Radcliffe Publishing, 2006.

[72] Silverstein v. BOP, Exhibit 1.

[73] Silverstein v. BOP

[74] BP-229 Response, Case Number:614359-F1, attached as Exhibit B to Declaration of Edwin P. Aro, Cunningham v BOP, Plaintiffs' Response to Motion to Dismiss, filed 11/21/12.

[75] Raymond Luc Levasseur, *"Trouble Coming Every Day: ADX–The First Year"*, a letter written by a prisoner held in ADX, republished on the 'Solitary Watch' website, http://solitarywatch.com/solitary-voices/trouble-coming-every-day-adx-the-first-year/ (accessed 8 July 2014).

[76] The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 21st General report, 11 November 2011, para. 53. The European Committee for the Prevention of Torture has also pointed to the higher rate of suicide among prisoners subjected to solitary confinement than that among the general prison population.

[77] Findings of studies published in numerous articles, e.g. Grassian, *Psychiatric Effects of Solitary Confinement*, Wash U.J.L. and Policy (2006) and in court rulings and testimony. See generally Peter

Included in SCDC' 4.29.19 letter to LOC

Scharff Smith, *The Effects of Solitary Confinement on Prison inmates: A Brief History and Review of the Literature*, 34 Crime and Just. 441 (2006).

[78] See for example, Istanbul Statement on the use and effects of solitary confinement, Adopted on 9 December 2007 at the International Psychological Trauma Symposium, Istanbul (Istanbul Statement on the use and effects of solitary confinement); Interim Report by the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 5 August 2011, United Nations General Assembly A/66/268, para 46.

[79] http://www.psych.org/advocacy--newsroom/position-statements (accessed 8 July 2014)

[80] Babar Ahmad and Others v. UK, ECHR Judgment, 10 April 2012, para.90 (citing information from Dr Paul Zohn, psychologist assigned to ADX).

[81] The Federal Bureau of Prison's Abuses of Solitary Confinement, testimony of Deborah M. Golden, Washington Lawyers' Committee, submitted to hearing before the Senate Judiciary Sub-committee on the Constitution, Civil Rights and Human Rights, 25 February 2014 http://www.washlaw.org/pdf/testimony_wlc.pdf (accessed 8 July 2014) (Testimony of Deborah M. Golden).

[82] Jesse Wilson, *"Loneliness Is a Destroyer of Humanity",* article written by an inmate who has spent 12 years in isolation at ADX. Published by Sal Rodriguez as part of the 'Voices from Solitary' series on the 'Solitary Watch' website http://solitarywatch.com/2012/07/07/voices-from-solitary-loneliness-is-a-destroyer-of-humanity/

[83] Cunningham v. BOP.

[84] Cunningham v. BOP p.20.

[85] Cunningham v. BOP p.22.

[86] According to the Cunningham v. BOP lawsuit he had spent time in protective custody after testifying against three inmates he had witnessed murder another prisoner; he reportedly escaped from a medium security prison after learning that he was to be placed back in the prison's general population.

[87] Cunningham v. BOP p. 77.

[88] Cunningham v. BOP p.94.

[89] The Denver Post, *"Lawyer: Supermax inmates moved amid lawsuit",* 9 December 2013, http://www.denverpost.com/news/ci_24689930/lawyer-supermax-inmates-moved-amid-lawsuit (accessed 8 July 2014).

[90] Andrew Cohen, *A Handwritten Letter the Prison System Doesn't Want You to See,* The Atlantic, 18 September 2013, http://www.theatlantic.com/national/archive/2013/09/a-handwritten-letter-the-prison-system-doesnt-want-you-to-see/279751/ (accessed 8 July 2014) describing the case of Robert Gerald Knott, diagnosed with schizophrenia and other severe mental disorders, found hanged on 7 September 2013. See also Testimony of Deborah M. Golden.

[91] 2008 NCCHC Standard for Health Services for Jails and Prisons, Standard E-09

[92] Human Rights Committee General Comment 21

[93] Concluding Observations of the Human Rights Committee on the Second and Third U.S. Reports to the Committee, 2006, (CCPR/C/SR.2395, 27 July 2006), para 36

[94] Concluding Observations of the Human Rights Committee on the Second and Third U.S. Reports to the Committee, 2006, (CCPR/C/SR.2395, 27 July 2006), para 32

[95] Conclusions and recommendations of the Committee against Torture on the second report of the USA,

Included in SCDC' 4.29.19 letter to LOC

para 36, CAT/C/USA/CO/", 18 May 2006.

[96] Concluding Observations, Adopted by the Committee at its 110th Session (10-28 March 2014).

[97] Under treaty-based and customary rules of international treaty law, states may not enter reservations which are incompatible with the object and purpose of a treaty (Vienna Convention on the law of Treaties, adopted 22 May 1969, entered into force 23 May 1980).

[98] Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 5 August 2011, United Nations General Assembly A/66/268/, para 46.

[99] Human Rights Committee General Comment 21; similar provisions are affirmed under the UN Standard Minimum Rules (Article 57) and the Basic Principles for the Treatment of Prisoners (Principle 5).

[100] E.g. the Basic Principles for the Treatment of Prisoners states under Principle 7 that efforts to abolish solitary confinement as a punishment, or to restrict its use, should be undertaken and encouraged. The European Prison Rules, adopted by the Council of Europe in 2006, state that solitary confinement should be imposed as a punishment "only in exceptional cases and for a specified period of time that shall be as short as possible". See also the Istanbul Statement on the use and effects of solitary confinement.

[101] Interim Report by the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 5 August 2011, United Nations General Assembly A/66/268, para 46.

[102] *"US: 'Four decades in solitary confinement can only be described as torture' – UN rights expert"*, 07 October 2013, http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=13832 (date accessed 8 July 2014)

[103] The Court has held only that some due process is required where prisoners are assigned to isolated custody under conditions which impose "an atypical or significant hardship" in relation to the "ordinary incidents of prison life" (Sandin v O'Connor). While courts have found that conditions in some US supermax facilities constitute "atypical or significant hardship", the Tenth Circuit Court of Appeals (the judicial circuit covering Colorado where ADX is situated) has ruled more narrowly than some other jurisdictions in rejecting a claim that conditions at ADX constituted "atypical or significant hardship; this was based in part on the court's finding that confinement at ADX was not indefinite because prisoners had regular reviews, despite its acknowledging that the applicants had spent years at the facility; the court also compared ADX conditions to those in other isolation facilities rather than the general prison population, and it took into account the administration's legitimate penological interest when assessing the harshness of conditions (as opposed only to decisions on assignment) and whether these amounted to atypical hardship, a ruling which has been criticized by human rights lawyers as contrary to constitutional interpretation elsewhere. (US Court of Appeals ruling in Rezaq v Nally et al, April 20, 2012.)

[104] Wilson v Seiter, 501 U.S. (1991) and Farmer v Brennan 511 U.S. (1994)

[105] As noted above, one exception is that US courts have repeatedly ruled in recent years that housing prisoners who are seriously mentally ill in isolation in super-maximum facilities is in violation of the Eighth Amendment of the US Constitution. Some courts have specifically noted that isolation in extreme conditions is likely to inflict some degree of psychological trauma on most inmates, but that this did not under US law bring conditions to the level of constituting deprivation of a "basic necessity of life" (Madrid v Gomez (1995). A further obstacle to prisoners bringing claims on grounds of mental injury or suffering is the Prison Litigation Reform Act (PLRA) passed by Congress in 1995 which provides that "[n]o Federal civil action may be brought by a prisoner confined in a jail, prison, or other correctional facility, for mental or emotional injury suffered while in custody without a prior showing of physical injury." 42.U.S.C. section 1997e (e).

Included in SCDC' 4.29.19 letter to LOC

[106] The Commission on safety and abuse in America's prisons, *"Confronting Confinement",* Vera Institute of Justice, 08 July 2006, http://www.vera.org/content/confronting-confinement (accessed 08 July 2014) (Confronting Confinement). The Commission was established by the Vera Institute of Justice in 2005 and conducted a year-long inquiry which included public hearings. It was co-chaired by former US Attorney General Nicholas B. Katchenbach and the Hon. John Gibbons, former Chief Judge of the US Court of Appeal for the Third Circuit. Its 20 members included prison administrators, prisoner rights advocates, religious representatives and members of both main political parties.

[107] Confronting Confinement p. 57

[108] ABA Criminal Justice Standards on Treatment of Prisoners, approved by the ABA House of Delegates, February 2010. ABA standards are not binding but are "grounded in legal and constitutional principles" and have "guided the development of law and practice in the American criminal justice system" (Statement submitted to Hearing before the Senate Judiciary Committee, 19 June 2012).

[109] International standards require that prisoners not engaged in outdoor work should have at least an hour of suitable exercise in the open air daily (SMR 21 (1)). The SMR further provide that "Young prisoners and others of suitable age and physique shall receive physical and recreational training during the period of exercise" and that, to this end, "space, installations and equipment should be provided" (SMR 21 (2). The need for adequate exercise is particularly important where prisoners are cut off from normal activities and spend long periods in their cells, and in view of the detrimental effects on health of lack of exercise.

Included in SCDC' 4.29.19 letter to LOC

WHETHER IN A HIGH-PROFILE CONFLICT OR A FORGOTTEN CORNER OF THE GLOBE, **AMNESTY INTERNATIONAL** CAMPAIGNS FOR JUSTICE, FREEDOM AND DIGNITY FOR ALL AND SEEKS TO GALVANIZE PUBLIC SUPPORT TO BUILD A BETTER WORLD

I WANT TO HELP

WHAT CAN YOU DO?

Activists around the world have shown that it is possible to resist the dangerous forces that are undermining human rights. Be part of this movement. Combat those who peddle fear and hate.

- Join Amnesty International and become part of a worldwide movement campaigning for an end to human rights violations. Help us make a difference.
- Make a donation to support Amnesty International's work.

Together we can make our voices heard.

☐ I am interested in receiving further information on becoming a member of Amnesty International

name

address

country

email

☐ I wish to make a donation to Amnesty International (donations will be taken in UK£, US$ or €)

amount

please debit my Visa ☐ Mastercard ☐

number

expiry date

signature

Please return this form to the Amnesty International office in your country.

For Amnesty International offices worldwide: www.amnesty.org/en/worldwide-sites
If there is not an Amnesty International office in your country, please return this form to:

Amnesty International, International Secretariat, Peter Benenson House,
1 Easton Street, London WC1X 0DW, United Kingdom

amnesty.org

Included in SCDC' 4.29.19 letter to LOC

ENTOMBED

ISOLATION IN THE US FEDERAL PRISON SYSTEM

The USA incarcerates thousands of prisoners in long-term or indefinite solitary confinement. This report describes Amnesty International's concerns about conditions of severe isolation at the United States Penitentiary, Administrative Maximum (ADX) facility in Colorado, currently the only super-maximum security prison operated by the federal government. It also examines conditions in Special Management Units (SMUs) and Security Housing Units (SHUs) operated at other federal prison facilities.

Since Amnesty International toured ADX prison in 2001 subsequent requests to return to the facility have been denied. The organisation is concerned that as conditions of isolation within federal prisons have become more severe, external oversight of the facilities has declined.

With prisoners held in their cells for 22-24 hours a day in severe physical and social isolation, Amnesty International believes the conditions described in this report breach international standards for the humane treatment of prisoners. Many have been held in isolation for prolonged or indefinite periods - without a means to change their circumstances – amounting to a violation of the prohibition against cruel inhuman or degrading treatment or punishment under international law. The report also details disturbing evidence of prisoners with serious mental illness being detained in harsh isolated conditions without adequate screening, treatment or monitoring.

amnesty.org

Index: AMR 51/040/2014
July 2014

Included in SCDC' 4.29.19 letter to LOC

Solitary Confinement:
Common Misconceptions and Emerging Safe Alternatives

MAY 2015

Alison Shames • Jessa Wilcox • Ram Subramanian

CENTER ON SENTENCING AND CORRECTIONS

THE Robert W. Wilson
CHARITABLE TRUST SERIES

Included in SCDC' 4 29 19 letter to LOC

FROM THE CENTER DIRECTOR

The overuse and misuse of solitary confinement by our prisons and jails is yet another indication of the overly punitive approach that has characterized our nation's sentencing and corrections practices. Not only do we incarcerate too many people and for far too long, we also have a corrections system that employs, all too frequently and—at times, too casually—the most extreme form of confinement as a routine management strategy; this persists despite decades of evidence pointing to the manifold negative impacts of subjecting people to such conditions. Any serious effort to reduce over-incarceration and its harmful consequences must rest on a commitment to human dignity and focus on the treatment of those in jail and prison.

Although this practice goes by many names—isolation, restricted housing, administrative segregation, protective custody, special housing, disciplinary segregation, etc.—the old adage about ducks applies: if it looks like a duck… As this report makes clear, whatever the label, the experience for the person placed in solitary confinement is the same: confinement to an isolated cell for the overwhelming portion of each day, often 23 hours a day, with limited human interaction and minimal, if any, constructive activity; an experience that all too often leads to harmful outcomes for the person's mental and physical health and the well-being of the community to which he or she returns. As U.S. Supreme Court Justice Anthony Kennedy recently opined, "This idea of total incarceration just isn't working, and it's not humane." It's also a significant drain on the budgets of corrections departments.

Solitary confinement need not be corrections' sole first response to incidents of misconduct, nor should it be casually and routinely used to solve custody management challenges that arise in making housing decisions. In the past decade, several jurisdictions, some of which have worked with Vera, have reduced their use of solitary confinement and implemented safe alternatives.

This report shines a bright light on the use/abuse of solitary confinement and pushes us to recognize the critical connection between what happens to people inside penal institutions and the success of their return to community. It is my sincere hope that it fosters both debate and change, which balance respect for human dignity and safety and security concerns, as these are not—nor need not be viewed as—mutually exclusive. Humane and effective management of our nation's prisons and jails requires nothing less.

Fred Patrick

Fred Patrick
Director, Center on Sentencing and Corrections

Included in SCDC' 4.29.19 letter to LOC

Contents

4 Introduction

8 MISCONCEPTION #1
Conditions in segregated housing are stark but not inhumane

12 MISCONCEPTION #2
Segregated housing is reserved only for the most violent

14 MISCONCEPTION #3
Segregated housing is used only as a last resort

15 MISCONCEPTION #4
Segregated housing is used only for brief periods of time

17 MISCONCEPTION #5
The harmful effects of segregated housing are overstated and not well understood

18 MISCONCEPTION #6
Segregated housing helps keep prisons and jails safer

20 MISCONCEPTION #7
Segregated housing deters misbehavior and violence

22 MISCONCEPTION #8
Segregated housing is the only way to protect the vulnerable

24 MISCONCEPTION #9
Safe alternatives to segregated housing are expensive

26 MISCONCEPTION #10
Incarcerated people are rarely released directly to the community from segregated housing

28 Conclusion

Included in SCDC' 4.29.19 letter to LOC

Introduction

What is commonly known as solitary confinement is a practice still widely used by corrections officials in the United States today, largely as a means to fulfill a prison's or jail's top priority: the safety of its staff and the incarcerated people under its care. While it is most often deployed when incarcerated people break rules or engage in violent or disruptive behavior, it is also used as a preventative measure in an effort to protect those at high risk of sexual assault and physical abuse in a prison's or jail's general population (for example, incarcerated people who are transgender or former law enforcement officers). The term solitary confinement, however, is often not used by corrections officials, who prefer labels such as restricted housing, segregated housing, and special or intensive management.

NAMING THE PRACTICE

Corrections officials in the United States refer to solitary confinement by many names, and placement policies also vary by jurisdiction and facility type. The terms in most frequent use today include:

> **Disciplinary or punitive segregation** is used to punish incarcerated people for violating facility rules. As in the larger criminal justice process, charges are written, a hearing is held, evidence is presented, and, if found guilty, a term in segregated housing is imposed.

> **Administrative segregation** is used to remove incarcerated people from the general prison or jail population who are thought to pose a risk to facility safety or security. It may be used for those believed to be members of gangs or active in other restricted activities, even if no violation has been identified. Administrative segregation is not technically a sanction or a punishment, and can be indefinite.

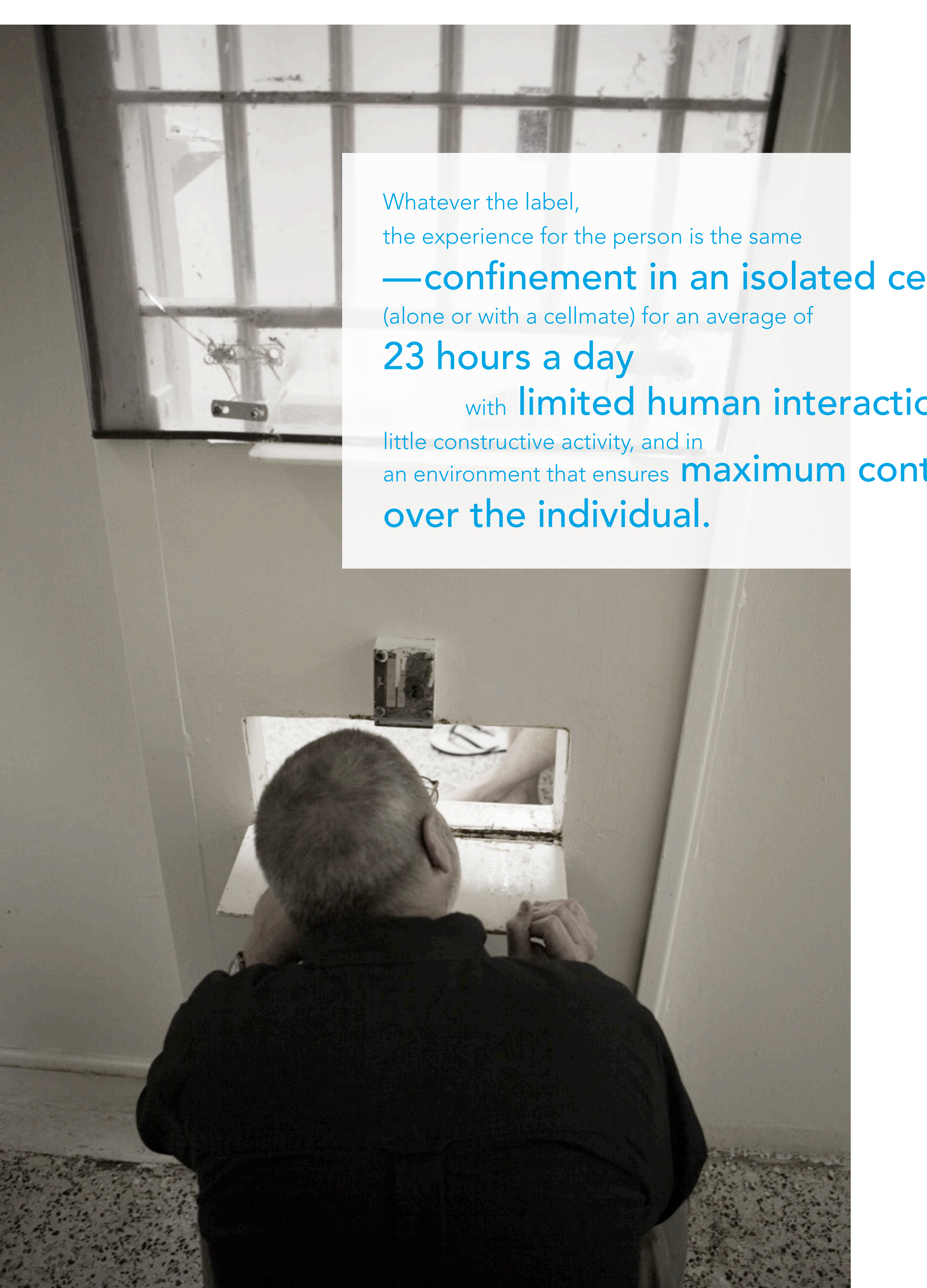
> **Protective custody** is a form of administrative segregation that is used to remove incarcerated people from a facility's general population who are thought be at risk of harm or abuse, such as incarcerated people who are mentally ill, intellectually disabled, gay, transgender, or former law enforcement officers. While some people who fear for their safety in the general population may request protective custody, this status is often conferred involuntarily.

> **Temporary confinement** in segregated housing is used when a reported incident is being investigated or related paperwork is being completed, or when no beds are available for transfers.

Some incarcerated people are held in solitary confinement in prisons or jails, while others are held in disciplinary and administrative segregation in supermax facilities, which are freestanding prisons or distinct units in prisons where the entire incarcerated population is housed in solitary confinement.[a]

All prisons and many jails in the United States use some form of solitary confinement. Whatever the label, the experience for the person is the same—confinement in an isolated cell (alone or

Included in SCDC' 4.29.19 letter to LOC



Whatever the label,
the experience for the person is the same
—confinement in an isolated cell
(alone or with a cellmate) for an average of
23 hours a day
with limited human interaction,
little constructive activity, and in
an environment that ensures maximum control
over the individual.

Included in SCDC' 4.29.19 letter to LOC

with a cellmate) for an average of 23 hours a day with limited human interaction, little constructive activity, and in an environment that ensures maximum control over the individual.[b] When sources cited in this report refer to the practice as solitary confinement, the authors do as well. Otherwise, consistent with American Bar Association standards, "segregated housing" is used as the generic term for the practice.[c]

[a] David C. Fathi, "United States: Turning the Corner on Solitary Confinement," *Canadian Journal of Human Rights*, 4, no. 1 (2015): 168. For the definition of a supermax, see National Institute of Corrections, *Supermax Prisons: Overview and General Consideration* (Washington, DC: US Department of Justice, 1999), 2-3.

[b] In 2013, the Arthur Liman Program at Yale Law School reviewed the policies related to administrative segregation for 46 states and the federal Bureau of Prisons. See Hope Metcalf et al., *Administrative Segregation, Degrees of Isolation, and Incarceration: A National Overview of State and Federal Correction Policies: Public Law Working Paper* (New Haven: Yale Law School, 2013), 2. The states not included in the review—Louisiana, South Carolina, Texas, and Utah—all have forms of segregated housing. For information on Utah, see ibid, p. 24, endnote 7. For information on Louisiana, see Editorial, "Four Decades of Solitary in Louisiana," *New York Times*, November 21, 2014. For information on South Carolina, see Emily Bazelon, "The Shame of Solitary Confinement," *New York Times*, February 19, 2015. For information on Texas, see American Civil Liberties Union of Texas, Texas Civil Rights Project-Houston, *A Solitary Failure: The Waste, Cost and Harm of Solitary Confinement in Texas* (Houston: ACLU of TX, 2015).

[c] The American Bar Association defines "segregated housing" as "housing of a prisoner in conditions characterized by substantial isolation from other prisoners, whether pursuant to disciplinary, administrative, or classification action." See American Bar Association, *ABA Standards for Criminal Justice Treatment of Prisoners* (Washington, DC: ABA, 2010), § 23-1.0.

There are indications that the use of segregated housing has grown substantially in recent years (perhaps as much as by 42 percent between 1995 and 2005), yet the precise number of people held in segregated housing on any given day is not known with any certainty.[1] Estimates range from 25,000 (which includes only those held in supermax facilities) to 80,000 (which includes those held in some form of segregated housing in all state and federal prisons).[2] None of these estimates include people held in segregated housing in jails, military facilities, immigration detention centers, or juvenile justice facilities in the United States. Based on research conducted by the Vera Institute of Justice (Vera) and others, the percentage of a state's prison system's daily population that is held in segregated housing ranges from five to eight percent, while more recent research found that, in November 2013, the Federal Bureau of Prisons—the largest prison system within the United States—held five percent of its prisoners in segregated housing units.[3] Moreover, because these estimates are only one-day snapshots, they most likely underestimate the total number of people subjected to one or more periods in segregated housing over the course of their incarceration.

Against this backdrop, evidence mounts that segregated housing produces many unwanted and harmful outcomes—for the mental and physical health of those placed in isolation, for the public safety of the communities to which most will return, and for the corrections budgets of jurisdictions that rely on the practice for facility safety. As these negative impacts have come to light, concern about its overuse has grown. The severe conditions to which people in segregated housing are subjected are now regularly exposed by mainstream journalists.[4] Incarcerated people who participate in hunger strikes against its use, such as those at Pelican Bay state prison in California in 2013, receive sympathetic national attention.[5] And in response to the shift in public opinion, local,

Included in SCDC' 4.29.19 letter to LOC

RESEARCH AND DATA LIMITATIONS

A full appreciation of the prevalence and impact of segregated housing in the United States is not yet within our grasp because up-to-date and reliable national data on the number of people held in segregated housing do not exist. While many individual jurisdictions can report accurately the number of incarcerated people they hold in segregated housing, comparing and aggregating this information across jurisdictions is highly problematic as the nomenclature used to describe segregated housing varies widely from state to state and there are no national standards for reconciling these differences.[a] For example, the terms "administrative segregation," "supermax," and "administrative separation" are used interchangeably, and housing conditions defined as supermax in some states are classified differently in others. For example, in one state, such conditions are formally termed "high-security control."[b] In addition, differences in the criteria for admission to, and release from, segregated housing further confound efforts to compare the use of segregated housing between jurisdictions. Not only do these vary from state to state, they can change significantly even within jurisdictions from year to year.[c]

The most recent and comprehensive prison census data, published by the Bureau of Justice Statistics (BJS) in 2008, concern people incarcerated in 1,821 state and federal facilities in 2005.[d] However, the number of people reported to be in segregated housing is questionable because the census form used to collect the data did not supply definitions for many of the key terms used by jurisdictions to classify those held in segregated housing. More than 100 facilities indicated that they either did not have people in segregated housing or simply did not answer the question. Moreover, many states failed to match the total number of people in segregated housing with the sum of the segregated sub-types provided (e.g., punitive segregation, death row, protective custody). Researchers encountered similar challenges in a review of supermax custody.[e] For example, they discovered that some jurisdictions changed the way in which they counted supermax prisoners over time with some states inconsistently including or excluding people in administrative segregation and protective custody in their count of supermax prisoners. And even more confusingly, some states reported having supermax prisoners but no supermax housing, and vice versa.

Given these challenges and the prevalence of outdated data systems among corrections departments, it should come as no surprise that nearly 12 percent of the total number of people held in segregated housing reported in the 2005 census is an estimate. Until jurisdictions are compelled to create robust reporting systems, with nationally accepted definitions and measures, accurate data on segregated housing practices in the United States will remain elusive.

[a] For example, such a count was recently done of the federal prison system by the U.S. Government Accountability Office. That count found that from 2008 through 2013, the number of people in restricted housing units in federal prisons grew by 17 percent (almost triple the six percent rise in the total prison population for that same period). See U.S. Government Accountability Office, *Bureau of Prisons: Improvements Needed in Bureau of Prisons' Monitoring and Evaluation of the Impact of Segregated Housing* (Washington, DC: GAO, 2013).
[b] H. Daniel Butler, O. Hayden Griffin III, and W. Wesley Johnson, "What Makes You the 'Worst of the Worst?' An Examination of State Policies Defining Supermax Confinement," *Criminal Justice Policy Review* 24, no. 6 (2012): 676-694; and Alexandra Naday, Joshua D. Freilich, and Jeff Mellow, "The Elusive Data on Supermax Confinement," *The Prison Journal* 88, no. 1 (2008): 69-93.
[c] Jesenia M. Pizarro and Raymund E. Narag, "Supermax Prisons: What We Know, What We Do Not Know, and Where We Are Going," *The Prison Journal* 88, no. 1 (2008): 23-42; Butler and Griffin, 2013, pp. 676-694.
[d] United States Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Census of State and Federal Adult Correctional Facilities, 2005* (Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2010).
[e] Alexandra Naday, Joshua D. Freilich, and Jeff Mellow, 2008, pp. 69-93.

Included in SCDC' 4.29.19 letter to LOC

state, and federal policymakers are turning their attention to the overuse of segregated housing by the nation's prisons and jails. A subcommittee of the U.S. Senate Judiciary Committee held a series of hearings in 2012 and 2014 focused on reassessing the use of solitary confinement.[6] In 2014, 10 states announced or implemented policy changes to reduce the number of adults or juveniles held in segregated housing, improve the conditions in segregation units, or facilitate the return of segregated people to a prison's general population.[7] Some, like Colorado, passed legislation that removed entire classes of people—for example, those with serious mental illnesses—from being housed in long-term segregation.[8] And, most recently, New York City's Department of Correction made the historic decision to ban the use of segregated housing for all those in its custody 21 years old and younger.[9]

Despite increased attention to the issue, many people—policymakers, corrections officials, and members of the public—still hold misconceptions about and misguided justifications for the use of segregated housing. This report aims to dispel the most common of these misconceptions and highlight some of the promising alternatives that are resulting in fewer people in segregated housing.

MISCONCEPTION #1

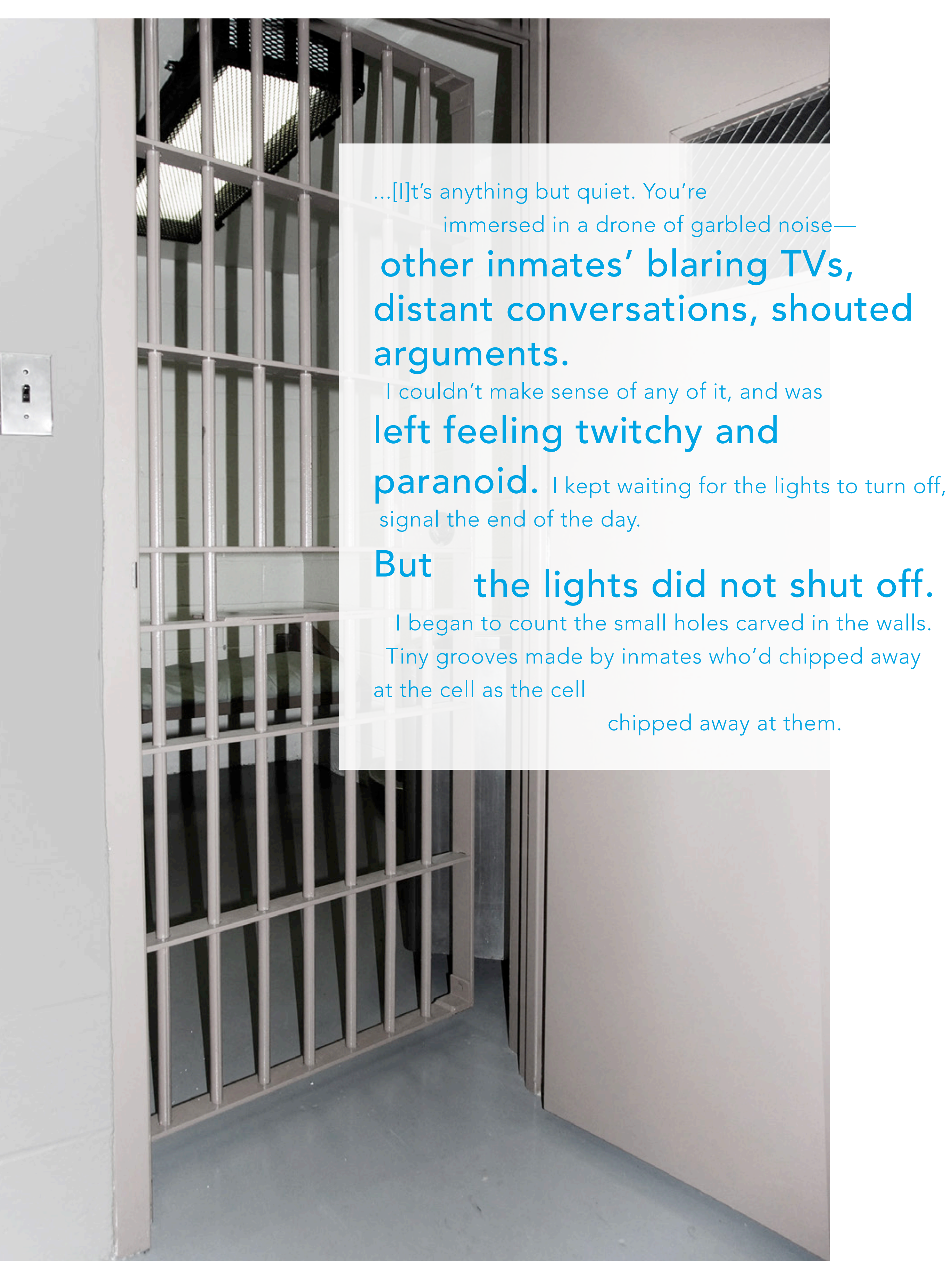
Conditions in segregated housing are stark but not inhumane

"...[I]t'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."[10]

This is solitary confinement, described not by an incarcerated person or an advocate but by Rick Raemisch, director of the Colorado Department of Corrections. Charged by the governor with reforming the use of segregated housing by the state's prison system, Director Raemisch decided he needed to experience it firsthand.

When an incarcerated person is placed in segregated housing, he or she is confined to a cell (either alone or with a cellmate) for 22 to 24 hours a day.[11] The cell is typically six by eight feet, smaller than a standard parking space. It is furnished with a metal toilet, sink, and bed platform. Reading materials are either strictly limited or prohibited altogether. Natural sunlight in the cell is limited to a very small window or does not exist at all, and fluorescent bulbs light the cell, often throughout the night.[12] Recreation is limited to one hour a day, five days per week, which is taken alone in a cage outdoors or an indoor area (sometimes with a barred top).[13] Every time the incarcerated person is taken out of solitary

Included in SCDC' 4.29.19 letter to LOC



...[I]t'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.

Included in SCDC' 4.29.19 letter to LOC

confinement and returned to it, he or she is strip-searched.[14] Interactions with people (other than a cellmate, if double celled) are brief and infrequent. Officers deliver meal trays through a slot in the door; there are only occasional meetings with healthcare practitioners, counselors, or attorneys; and visitation with family may be restricted or prohibited. Any meetings or visits, when they do occur, are almost always conducted through the cell door or conducted by video, speaker, or telephone through a thick glass window.[15] When an in-person visitation is permitted, the incarcerated person is placed in restraints and separated from the visitor by a partition.

Although this is how most incarcerated people experience segregated housing, it need not be this restrictive. Some jurisdictions are experimenting with making conditions more humane and less solitary. For example, Colorado now requires that incarcerated people held in its Management Control Unit receive four hours of time outside their cell each day.[16] New York State, as part of a legal settlement, gives 16- and 17-year-olds in segregated housing at least five hours of exercise and programming outside of their cells five days per week.[17] Maine requires that incarcerated people in segregated housing receive group recreation, counseling sessions, and opportunities to increase privileges through good behavior, as well as greater access to radios, televisions, and reading materials.[18]

Some jurisdictions have developed different levels of segregated housing, including "step-down" incentive programs that are structured in progressive phases that provide increasing privileges—such as more time out of the cell,

IS SOLITARY CONFINEMENT TORTURE?

The Eighth Amendment to the United States Constitution protects individuals from "cruel and unusual punishment."[a] Although the United States Supreme Court has affirmed that solitary confinement is a form of punishment subject to scrutiny under Eighth Amendment standards, most federal courts have been unreceptive to limiting its use.[b] This may be, in part, because in order to demonstrate an Eighth Amendment violation, an incarcerated person must satisfy a particularly onerous two-part test: first, his or her alleged suffering must be reasonably serious; and second, prison officials must have acted with "deliberate indifference to the prisoner's health and safety"—where "deliberate indifference" is only proved if it is shown that prison officials "kn[e]w that inmates face[d] a substantial risk of serious harm," but "fail[ed] to take reasonable measures to abate it."[c] As a result, successful Eighth Amendment claims regarding prison conditions have usually involved the direct action or inaction of prison officials, including medical indifference, failure to protect, and excessive use of force, rather than an overall challenge to general penal practices, such as solitary confinement.[d] Indeed, only a few federal courts have held that certain segregation practices—those narrowly limited to the isolation of incarcerated people with serious pre-existing mental illness or those prone to suffer severe mental injury—violate the Eighth Amendment.[f]

The reluctance by federal courts to outlaw solitary confinement is in direct contrast to international human rights standards. For example, the United Nations General Assembly, through the Basic Principles for the Treatment of Prisoners, adopted in 1990, encourages governments to undertake efforts to abolish or restrict the use of solitary confinement as a punishment. The European Prison

Included in SCDC' 4.29.19 letter to LOC

Rules limit the use of solitary confinement to only exceptional cases and for short periods of time. And the Committee Against Torture, the official body established pursuant to the United Nations' Convention Against Torture, consistently recommends that the practice be abolished altogether.[g]

On an international level, specific reasons are given for why solitary confinement is considered inhumane and degrading. For example, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)—the monitoring body formed out of the European Convention for the Prevention of Torture—has criticized the physical and psychological effects of lengthy solitary confinement on incarcerated people—including increased suicidal thoughts, "fatigue, insomnia, loss of appetite, nausea, headaches, crying fits and bouts of depression becoming more acute in solitary confinement…[as well as] distress upon not being allowed contacts with families and friends…."[h] The CPT has also critiqued procedural weaknesses—such as the lack of laws and regulations governing the use of solitary confinement—and noted the risk of permanent damage to incarcerated people due to the absence of appropriate mental and physical stimulation in prolonged isolation.[i] The European Court of Human Rights too has emphasized that the long-term dangers inherent in social and sensory isolation can make solitary confinement inhuman or degrading and, in certain circumstances, could amount to torture.[j] The Inter-American Court of Human Rights is even more categorical, stating that "prolonged isolation and coercive solitary confinement are, in themselves, cruel and inhuman treatments, damaging to the person's psychic and moral integrity, and.[…]the dignity inherent to the human person."[k]

[a] The Eighth Amendment states, "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." U.S. Constitution, Amendment VIII.

[b] Hutto v. Finney, 437 U.S. 678, 685 (1978); and Estelle v. Gamble, 429 U.S. 97 (1976).

[c] Farmer v. Brennan, 511 U.S. 825, 847 (1994).

[d] Christine Rebman, "The Eighth Amendment and Solitary Confinement: The Gap in Protection from Psychological Consequences," *DePaul Law Review*, 49, no. 2 (1999): 595.

[e] Hutto v. Finney, 437 U.S. 678, 685 (1978).

[f] See Jones 'El v. Berge, 164 F. Supp. 2d 1096 (W.D. Wis. 2001); Ruiz v. Johnson, 37 F. Supp. 2d 855 (S.D. Texas 1999), reversed on other grounds, 243 F.3d 941 (5th Circuit 2001), adhered to on remand, 154 F. Supp. 2d 975 (S.D. Texas 2001); Madrid v. Gomez, 889 F. Supp. 1146 (N.D. Cal. 1995). Notably, in 2013, the Department of Justice notified a governor for the first time ever—the Governor of Pennsylvania—that the manner in which a state uses isolation with prisoners with serious mental illness violates the Eighth Amendment, see Letter from Thomas E. Perez, Assistant Attorney General, United States Department of Justice, Civil Rights Division, to Tom Corbett, Governor of Pennsylvania (May 31, 2013).

[g] Basic Principles for the Treatment of Prisoners, General Assembly Resolution 45/111, U.N. Doc. A/45/49 (1990), Principle 7; Council of Europe Committee of Ministers, Recommendation No. Rec (2006)(2) (January 11, 2006); Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, General Assembly Resolution 46, at 197, U.N. GAOR, 39th Sess., Supp; U.N. Comm. Against Torture, Consideration of Reports Submitted by States Parties Under Article 19 of the Convention: Denmark, ¶ 14, U.N. Doc. CAT/C/DNK/CO/5 (July 16, 2007); U.N. Comm. Against Torture, Consideration of Reports Submitted by States Parties Under Article 19 of the Convention: Luxembourg, ¶ 6, CAT/C/CR/28/2 (June 12, 2002); U.N. Comm. Against Torture, Consideration of Reports Submitted by States Parties Under Article 19 of the Convention: Norway, ¶ 156, U.N. Doc. CAT/A/53/44 (May 6, 1998); and U.N. Comm. Against Torture, Consideration of Reports Submitted by States Parties Under Article 19 of the Convention: Sweden, ¶ 225, U.N. Doc. CAT/A/52/44 (May 6, 1997).

[h] See European Commission for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 2nd General Report on the CPT's Activities Covering the Period 1 January to 31 December 1991, CPT/Inf (92) 3 [EN] (April 13, 1992), ¶ 56; see also European Commission for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), The CPT Standards: "Substantive" Sections of the CPT's General Reports, CPT/Inf/E (2002) 1; Ramirez Sanchez v. France, App. No. 59450/00, 45 Eur. H.R. Rep. 49, ¶ 83 (2007); and CPT Norway Report, CPT/Inf (97) 11 [EN] (September 5, 1997).

[i] See for example, CPT 21st General Report, CPT/Inf (2011) 28 (November 10, 2011).

[j] See for example, Ensslin, Baader, and Raspe v. Federal Republic of Germany, App. No. 7572/76, 14 D.R. 91 (1978); Krocher & Miller v. Switzerland, App. No. 8463/78, 26 Eur. Comm'n H.R. Dec. & Rep 52 (1982); Ocalan v. Turkey, 41 Eur. Ct. H.R. 45 (2005); Ilascu v. Moldova, 40 Eur. Ct. H.R. 46 (2004). See also Iorgov v. Bulgaria, 40 Eur. Ct. H.R. Rep., 7, 22 (2005) (people in isolation with little social contact must be provided with appropriate mental and physical stimulation to prevent their long term deterioration).

[k] Case of the Miguel Castro-Castro Prison v. Peru, Inter-Am. Ct. H.R. (ser. C) No. 160, ¶ 323 (Nov. 25, 2006); see also Velasquez Rodriguez Case, Inter-Am. Ct. H.R. (ser. C) No. 4, 9 ¶ 156 (1988) (finding that "prolonged isolation and deprivation of communication are in themselves cruel and inhuman treatment").

Included in SCDC' 4.29.19 letter to LOC

the opportunity to participate in group activities, television in the cell, and additional reading materials—for sustained compliance to facility rules. Pennsylvania, Washington, and New Mexico have all created step-down programs for gang members held in segregated housing.[19] Washington has an Intensive Transition Program for incarcerated people with chronic behavior problems who are frequently placed in segregated housing, in which they move through a curriculum in stages, progressively learning self-control and gradually engaging in opportunities to socialize until they are ready to return to the prison's general population.[20] Michigan operates an Incentives in Segregation pilot project, in which incarcerated people work through six stages (each stage requiring different tasks and bestowing additional privileges) over several months.[21] The Virginia Department of Corrections has developed a successful step-down program for incarcerated people in administrative segregation that uses evidence-based practices first developed in the community corrections setting. Since 2011, the program has reduced the number of incarcerated people in administrative segregation by 53 percent and the number of prison incidents by 56 percent.[22]

MISCONCEPTION #2

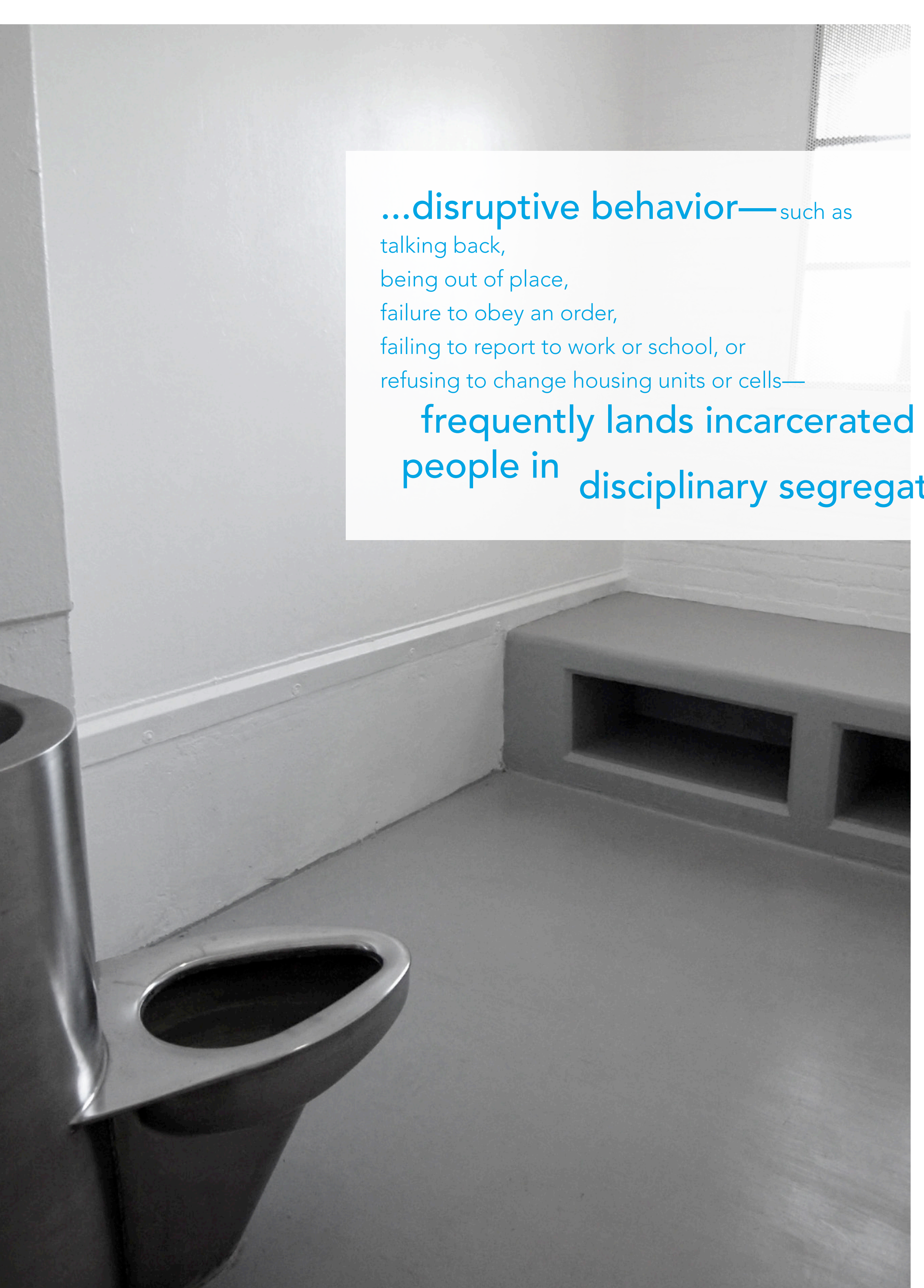
Segregated housing is reserved only for the most violent

It is still widely believed that the incarcerated people who end up in segregated housing are the worst of the worst, the most feared, the incorrigibly dangerous. However, several studies have revealed that a significant proportion of the segregated population is placed there for being neither violent nor dangerous. Many are there not as punishment for actually engaging in violence; rather they are there because they have been categorized as potentially dangerous or violent—often because prison officials have identified them as gang members.[23] This type of segregation, based on identification rather than individual activity, is referred to as administrative segregation.[24]

Segregated housing is not only used to anticipate or react to dangerous or disruptive behavior, it is also used for incarcerated people in protective custody who prison officials believe will be unsafe in the general population. They may be at risk for reasons of mental illness (or other special needs, such as developmental disability), age (such as young people under the age of 18 tried, convicted, and sentenced as adults), former gang or law enforcement affiliation, sexual vulnerability or gender nonconformity, or other reasons, including temporary confinement of someone who has been victimized in general population pending an investigation of the incident.[25] Individuals may even request to be removed from the general population. Although these incarcerated people are separated for their own safety, they are subject to the same restrictive conditions as others in segregation.

The most commonly understood justification for segregation is as punishment for a violation of a prison rule. While this practice, known as disciplinary

Included in SCDC' 4.29.19 letter to LOC



…disruptive behavior—such as
talking back,
being out of place,
failure to obey an order,
failing to report to work or school, or
refusing to change housing units or cells—
frequently lands incarcerated people in disciplinary segregation.

Included in SCDC' 4.29.19 letter to LOC

segregation, is used as a response to behavior that is violent or dangerous, Vera's experience in the field has shown that disruptive behavior—such as talking back, being out of place, failure to obey an order, failing to report to work or school, or refusing to change housing units or cells— frequently lands incarcerated people in disciplinary segregation.[26] In some jurisdictions, these "nuisance prisoners" constitute the majority of the people in disciplinary segregation.[27] Before collaborating with Vera, Illinois found that more than 85 percent of the people released from disciplinary segregation during a one-year period had been sent there for relatively minor infractions, such as not standing for a count and using abusive language.[28] In Pennsylvania, the most common violation associated with a sentence to segregated housing was "failure to obey an order," with 85 percent of those written up for this type of violation sent there.[29] In 2013, an incarcerated person in South Carolina received a penalty of more than 37 years in solitary confinement for posting on Facebook on 38 different days.[30] Piper Kerman, who was incarcerated in a federal prison and is the author of the memoir *Orange is the New Black*, reported to the United States Senate Judiciary Committee in 2014 that she saw many women sent to solitary confinement for at least 30 days for minor infractions such as moving around a housing unit during a count, refusing an order from a corrections officer, and possession of low-level contraband such as small amounts of cash or underwear other than that issued by the prison.[31]

MISCONCEPTION #3

Segregated housing is used only as a last resort

Although many jurisdictions have a list of alternative sanctions that can be used to discipline incarcerated people who are unruly or difficult to manage, the reality is that far too many turn to segregated housing as the first response to bad behavior. This is in stark contrast to the system used in certain European countries, where corrections officers are trained to impose disciplinary measures that are relative and proportionate to the disruptive behavior. Dutch and German prison officials use sanctions such as reprimands, restrictions on money and property, and restrictions on movement or leisure activities. Care is taken to relate the sanction to the alleged infraction.[32] In these countries, solitary confinement is used rarely and only for very brief periods of time. For example, an adult male prison in Germany reported using segregation just two or three times in 2012, and another German prison for young adults had utilized its segregation cell twice between 2008 and 2012, and only for a few hours each time.[33]

One of the most basic measures that a prison can take to ensure that disciplinary segregation is reserved for those who truly pose a risk to the safety of staff and other incarcerated people is to prohibit its use as a punishment for less serious violations. For instance, Pennsylvania no longer sends anyone to

Included in SCDC' 4.29.19 letter to LOC

segregated housing as a sanction for the least serious violations, such as taking unauthorized food from the dining hall and unexcused absences from work, school, or mandatory programs.[34] The Illinois Department of Corrections also prohibits the use of segregated housing as a response to certain disciplinary violations.[35] And corrections officials in Maine use a range of less severe restrictions, such as limiting work opportunities, in response to minor infractions.[36]

Some states use structured sanction grids to provide corrections officers with guidance on the appropriate and proportionate punishment for particular behaviors. The sanction grids articulate when less restrictive sanctions (such as mediation or anger management classes, withholding access to the commissary, removing TV privileges, restricting visitation rights, making the prisoner responsible for the costs of damaged property, and assigning the prisoner to an undesirable work shift) may be used, and when more serious sanctions, such as revocation of good time credit and segregation, are appropriate.[37]

The **sanctions grid** in use by the Washington Department of Corrections can be downloaded at www.vera.org/solitary-confinement-misconceptions-safe-alternatives.

MISCONCEPTION #4

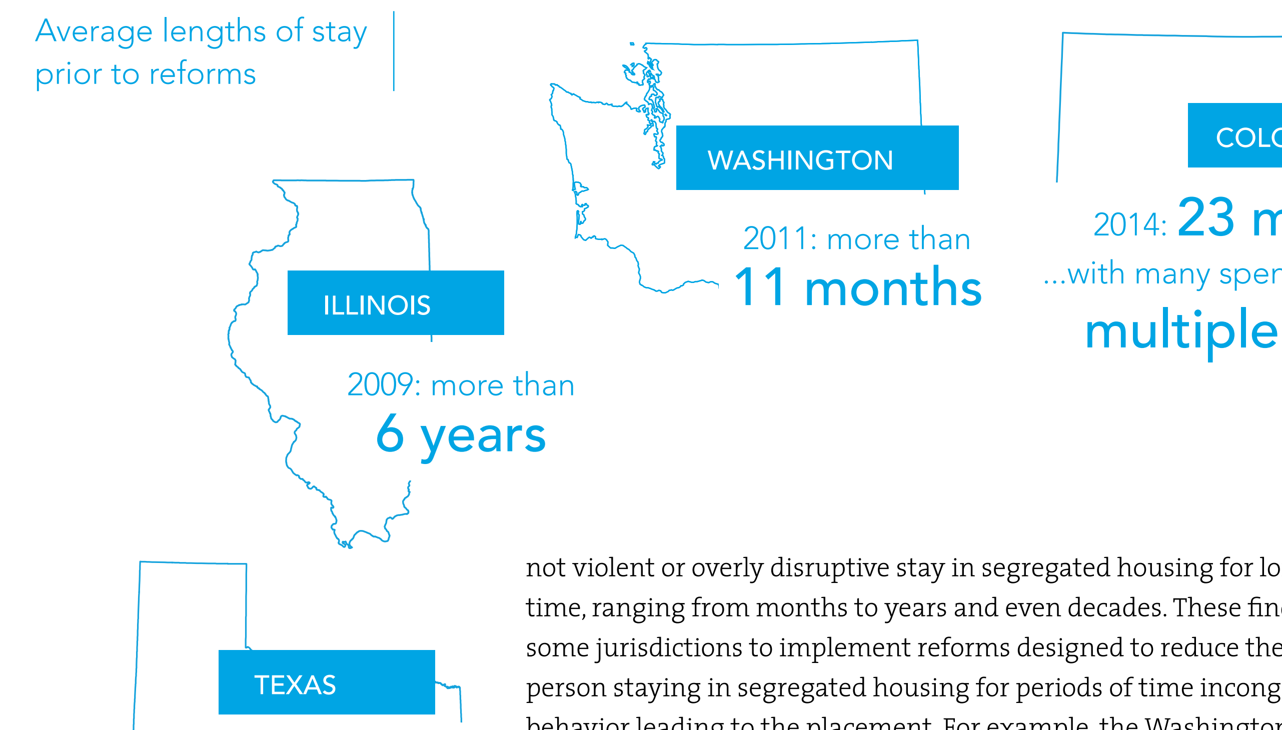
Segregated housing is used only for brief periods of time

As a matter of policy within the federal prison system and in at least 19 states, corrections officials are permitted to hold people in segregated housing indefinitely.[38] While placement in administrative segregation can, with some level of periodic review, be open-ended, a term in disciplinary segregation is almost always a defined period of time.[39] Notably, if a term in disciplinary segregation is thought to be too brief, corrections officials can easily "move" incarcerated people from "short-term" disciplinary segregation to long-term administrative segregation by the simple process of reclassification.[40]

After Colorado Department of Corrections Director Rick Raemisch spent 20 hours in a cell in segregated housing, he reported that it was "practically a blink" in comparison to the experience of incarcerated people in Colorado who, at the time, spent an average of 23 months in segregation, with many spending multiple years.[41] In 2009, the average length of stay at the Illinois supermax facility, since closed, was more than 6 years; in 2011, the average length of stay in Washington's intensive management unit was 11 months; and in Texas, the average amount of time in administrative segregation is almost four years.[42]

Vera begins its work with a jurisdiction by conducting a comprehensive analysis of administrative data in order to understand how the jurisdiction is actually using segregated housing. Vera's inquiry encompasses areas that, due to the data limitations addressed above (see "Research and Data Limitations" on page 7), are not typically examined by corrections systems. The findings from these analyses often surprise corrections officials, who overwhelmingly agree that no one should stay in segregation any longer than necessary to achieve the original safety and disciplinary goals underlying the placement. However, Vera's review of the data regularly shows that incarcerated people who are

Included in SCDC' 4.29.19 letter to LOC



not violent or overly disruptive stay in segregated housing for long periods of time, ranging from months to years and even decades. These findings have led some jurisdictions to implement reforms designed to reduce the likelihood of a person staying in segregated housing for periods of time incongruent with the behavior leading to the placement. For example, the Washington Department of Corrections reduced the amount of time an incarcerated person can be held in administrative segregation from 60 to 47 days, absent direct approval from the Deputy Director.[43]

To ensure that no one remains in segregated housing for indefinite or very long periods of time, some states mandate frequent reviews and assessments.[44] Those who are reclassified or are no longer deemed dangerous can be transferred to less restrictive housing units. In Colorado and Pennsylvania, for example, multi-disciplinary committees review segregated housing placements, making it more likely that they are appropriate and objective.[45] In Pennsylvania, those sentenced to disciplinary segregation may be released upon completion of one-half of the imposed sanction and a review of the Program Review Committee.[46] In California, after changing its segregated housing placement criteria, the state conducted case-by-case reviews of all people held in segregation that resulted in many being transferred to less restricted housing.[47]

Another method of reducing the amount of time someone spends in segregated housing is to implement a system of incentives that allows an incarcerated person to earn his or her way out earlier than the imposed term. This strategy is informed by research that has demonstrated that positive reinforcement of pro-social behavior increases the chances of that behavior being repeated in the future.[48] To this end, several states have devised programs designed to target behavior issues.[49] Some states provide programming for certain incarcerated people, such as gang members with histories of violence, who would otherwise face long-term administrative segregation. Washington instituted the Motivating Offender Change program, which focuses on gang-affiliated people in its maximum custody units. It provides opportunities to learn and practice cognitive-behavioral skills to help reduce violent behavior. Successful graduates

Included in SCDC' 4.29.19 letter to LOC

of the program are transferred to a lower custody environment within the general prison population.[50]

MISCONCEPTION #5

The harmful effects of segregated housing are overstated and not well understood

Despite the long-established consensus among researchers that solitary confinement damages, often irreparably, those who experience it for even brief periods of time, its continued use in prisons and jails in the United States implies that many jurisdictions and correctional officials are unaware of or minimize the importance of this body of evidence. According to one report, "[n]early every scientific inquiry into the effects of solitary confinement over the past 150 years has concluded that subjecting an individual to more than 10 days of involuntary segregation results in a distinct set of emotional, cognitive, social, and physical pathologies."[51] The characteristics that define segregated housing—social isolation, reduced environmental stimulation, and loss of control over all aspects of daily life—create a "potent mix" that produces a litany of negative impacts, including: hypersensitivity to stimuli, distortions and hallucinations, increased anxiety and nervousness, diminished impulse control, severe and chronic depression, appetite loss and weight loss, heart palpitations, talking to oneself, problems sleeping, nightmares, self-mutilation, difficulties with thinking, concentration, and memory, and lower levels of brain function, including a decline in EEG activity after only seven days in segregation.[52] Upon release from segregated housing, these psychological effects have the potential to undermine significantly an incarcerated person's adjustment back in the prison's general population or the community to which he or she returns.[53]

The harmful effects are compounded for people with mental illness, who make up one-third to one-half of all incarcerated people in segregated housing.[54] The conditions of segregated housing can exacerbate a preexisting condition or prompt a reoccurrence. As one psychiatric expert explained, "Prisoners who are prone to depression and have had past depressive episodes will become very depressed in isolated confinement. People who are prone to suicide ideation and attempts will become more suicidal in that setting. People who are prone to disorders of mood...will become that and will have a breakdown in that direction. And people who are psychotic in any way...will have another breakdown."[55]

Suicide rates and incidents of self-harm (such as banging one's head against the cell wall) are much higher for people in segregation than those in the general prison population.[56] For example, in California, where an estimated five

Included in SCDC' 4.29.19 letter to LOC

percent of the prisoners are placed in segregated housing, 69 percent of the suicides in 2006 occurred in those units.[57] In Texas, incarcerated people in segregation are five times more likely to commit suicide than those in the general population.[58] In New York, between 1993 and 2003, suicide rates were five times higher among incarcerated people in segregation than among those in the general prison population.[59]

Several states are revising their segregation policies in light of the harm it poses to vulnerable populations, especially those with mental illness. To settle a lawsuit that charged Pennsylvania with violating the constitutional rights of incarcerated people with serious mental illnesses by keeping them in solitary confinement without access to treatment, the state agreed in January 2015 to keep them out of non-therapeutic segregated housing and to improve their care.[60] In Colorado, a law enacted in 2014 requires the removal from long-term segregated housing of all incarcerated people with serious mental illness.[61] Washington created a Reintegration and Progression Program that targets incarcerated people with mental health issues, especially those who engage in chronic self-injurious behavior. The program addresses maladaptive thought and behavior patterns and teaches enhanced coping skills to gradually integrate them into a lower level of custody.[62]

MISCONCEPTION #6

Segregated housing helps keep prisons and jails safer

The most widely accepted and cited reason for using segregated housing is to ensure safety, order, and control within a prison.[63] Some prison officials believe that the mere existence of segregated housing controls the amount and seriousness of violence within their facilities (both among prisoners and between officers and prisoners).[64] However, there is little evidence to support the claim that segregated housing increases facility safety or that its absence would increase in-prison violence.[65] One study found no relationship between the opening of supermax prisons and the aggregate levels of prisoner-on-prisoner assaults in three prison systems (Illinois, Arizona, and Minnesota).[66] With respect to the impact on the number of prisoner-on-staff assaults after the opening of supermax facilities, although the number of staff assaults dropped in Illinois, staff injuries from prisoner assaults temporarily increased in Arizona, and there was no effect in Minnesota on the incidents of violence directed toward staff.[67]

While corrections administrators and officers remain concerned that a decrease in the use of segregated housing will endanger both incarcerated people and staff, the fear may be unsubstantiated. Colorado has decreased its use of segregated housing by 85 percent and prisoner-on-staff assaults are the lowest they have been since 2006.[68] Colorado decreased its use of segregated housing by narrowing the criteria for placement and reducing the length of stay, which included a step-down program that allows those with compliant behavior to be

Included in SCDC' 4.29.19 letter to LOC

People who are prone to suicide ideation…will become **more suicidal…People who are psychotic** in any way…**will have another breakdown.**

Included in SCDC' 4.29.19 letter to LOC

released to the general population.[69] Other states (for example, Illinois, Maine, New Mexico, and Washington) have also reduced their use of segregated housing and increased the use of alternative strategies.[70] Although it is too soon to fully assess outcomes in these states, evidence to date suggests there has been little or no increase in violence.[71]

MISCONCEPTION #7

Segregated housing deters misbehavior and violence

Many prison officials support the use of segregated housing for managing disruptive and violent behavior because they believe that it has both a general and individual deterrent effect on misbehavior.[72] However, empirical and anecdotal evidence suggests that segregated housing may have little influence on improving the behavior of incarcerated people.

Studies have contrasted "control-oriented" prisons, which rely on formal sanctions like segregated housing, with others that are "responsibility-based," which provide incarcerated people with self-governance opportunities, or "consensual," which incorporate features of both the control-oriented and responsibility-based models of prison management.[73] Researchers tested the relationship between these approaches and prison order and found that prisons that employed a responsibility-based or consensual management model experienced lower levels of minor and serious disorder than prisons that were more control oriented.[74] Moreover, there is no evidence that confinement in a supermax facility produces a deterrent effect on the individual.[75] A recent study found that exposure to short-term disciplinary segregation as a punishment for initial violence did not deter incarcerated people from committing further violence in prison.[76]

Some theoretical models describe the behavior of incarcerated people as a reaction to the strains, frustrations, and pains of imprisonment combined with little access to mitigating factors.[77] Subjecting incarcerated people to the severe conditions of segregated housing and treating them as the "worst of the worst" can lead them to become more, not less, violent.[78]

Rather than rely on segregated housing to deter misbehavior, some prison systems are providing incarcerated people who are most likely to misbehave with special programming. For example, Washington has an Intensive Transition Program for incarcerated people with chronic behavior problems who are frequently placed in segregated housing, in which they move through a curriculum in stages, progressively learning self-control and gradually engaging in opportunities to socialize until they are ready to return to the prison's general population.[79] Pennsylvania is in the process of implementing Behavior Modification Units with a similar focus.[80]

Included in SCDC' 4.29.19 letter to LOC

A recent study found that **exposure to short-term disciplinary segregation as a punishment** for initial violence **did not deter** incarcerated people from committing further violence in prison.

Included in SCDC' 4.29.19 letter to LOC

MISCONCEPTION #8

Segregated housing is the only way to protect the vulnerable

Some people in segregated housing are not violent and do not misbehave but require or request protection from the general population. These include incarcerated people who suffer from mental illness, have developmental or intellectual disabilities, are vulnerable because of their sexuality (e.g., they are lesbian, gay, bisexual, or transgender), may be retaliated against by other prisoners (e.g., they are former gang members or have testified against someone in the facility), committed sex offenses against children, or are former law enforcement officers or public officials. Many prison officials believe these vulnerable incarcerated people can only be kept safe by placing them in segregated housing with conditions as restrictive as those imposed on people who commit the most violent and dangerous acts.

Some jurisdictions are taking a different approach. Rather than isolating those at risk of victimization, they are creating specialized units, which house vulnerable incarcerated people together and provide privileges and programs that are similar to those available in the general population units.[81] In Washington state, for example, the Skill Building Unit houses incarcerated people with developmental and intellectual disabilities in a general population setting that is dedicated to meeting their needs.[82] The unit provides out-of-cell programming, including daily opportunities to interact with each other and staff during meals and recreation in the dayroom. Unit residents also participate in supported work and other activities to help them function more independently while in prison and upon release. Corrections officers assigned to the unit are trained how to respond appropriately to people with special needs and help them live healthy and safe lives.[83] The Washington Department of Corrections reports that the unit has resulted in safer living conditions for these incarcerated people and safer working conditions for corrections staff.[84]

Still other jurisdictions have reformed or are in the process of reforming their use of segregated housing for certain types of vulnerable incarcerated people: Pennsylvania now sends those with significant mental illness, who formerly would have been placed in disciplinary or administrative segregation, to therapeutic units; New York State banned the use of segregated housing to discipline pregnant women or any incarcerated person under the age of 18; in California, a federal judge has ordered the state to find more suitable housing for physically disabled prisoners; and New York City has pledged to eliminate the use of segregated housing for all incarcerated people aged 21 years old and younger.[85] Alaska and Maine have also enacted laws that ban the use of segregated housing for juveniles for punitive reasons.[86]

Included in SCDC' 4.29.19 letter to LOC

Rather than isolating those at risk of victimization, **[some jurisdictions] are creating specialized units,** which house vulnerable incarcerated people together **and provide privileges and programs** that are similar to those available in the general population units.

Included in SCDC' 4.29.19 letter to LOC

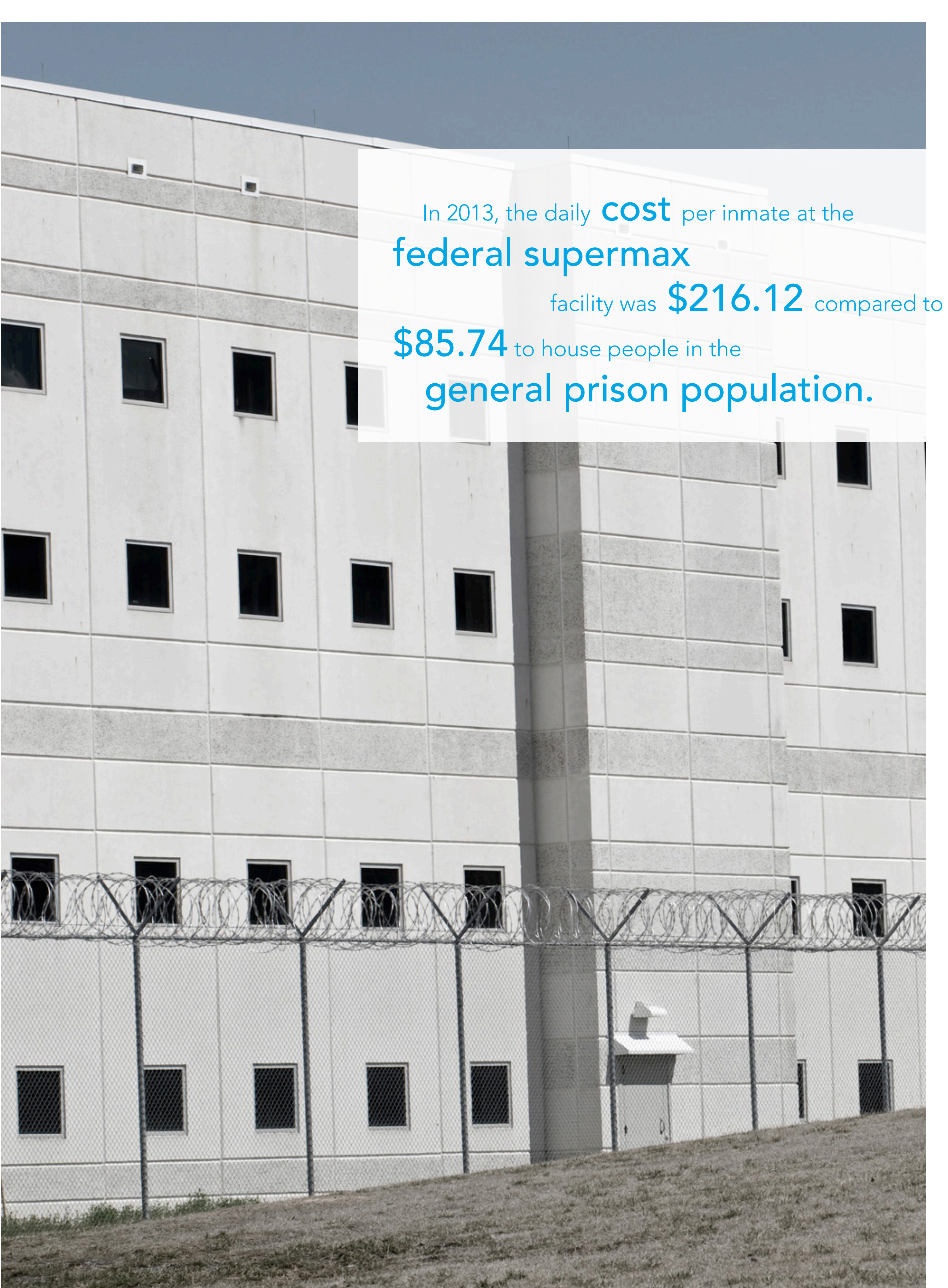
MISCONCEPTION #9

Safe alternatives to segregated housing are expensive

A common objection among corrections officials to reducing the use of segregation is that few safe alternatives exist and they are too costly to implement. However, growing concern among policymakers and the public about over-incarceration in the United States has put the use of segregated housing under particular scrutiny, and for good reason: segregated housing harms those subject to it, produces little, if any, improvement in public and prison safety, and is much more expensive than less restrictive housing. The significant fiscal costs associated with building and operating segregated housing units and facilities are due to the reliance on single-cell confinement, enhanced surveillance and security technology, and the need for more corrections staff (to handle escorts, increased searches, and individualized services).[87] For example, in 2013, the estimated daily cost per inmate at the federal administrative maximum (supermax) facility was $216.12 compared to $85.74 to house people in the general prison population.[88] In 2003, the daily per capita costs of operating a supermax prison in Ohio were estimated at two-to-three times that of regular security units—$149 per day compared to $63 per day, with one corrections officer for every 1.7 prisoners in supermax compared to one for every 2.5 in less restricted housing.[89]

Many of the policy and practice changes undertaken by jurisdictions to reduce their reliance on segregated housing described in this report cost little to implement. Time and patience are required, but not necessarily an enhanced budget. In addition, many of the alternative programs, such as reentry programming and integrated housing units, may only require extending programs that already exist, which would save on start-up costs. Finally, by safely decreasing the number of incarcerated people held in segregated housing, jurisdictions may be able not only to close expensive segregation units and supermax prisons, but free up the staff and other resources needed to pursue evidence-based programming that will help many more incarcerated people return successfully to their communities.

Included in SCDC' 4.29.19 letter to LOC



In 2013, the daily **cost** per inmate at the **federal supermax** facility was **$216.12** compared to **$85.74** to house people in the **general prison population.**

Included in SCDC' 4.29.19 letter to LOC

MISCONCEPTION #10

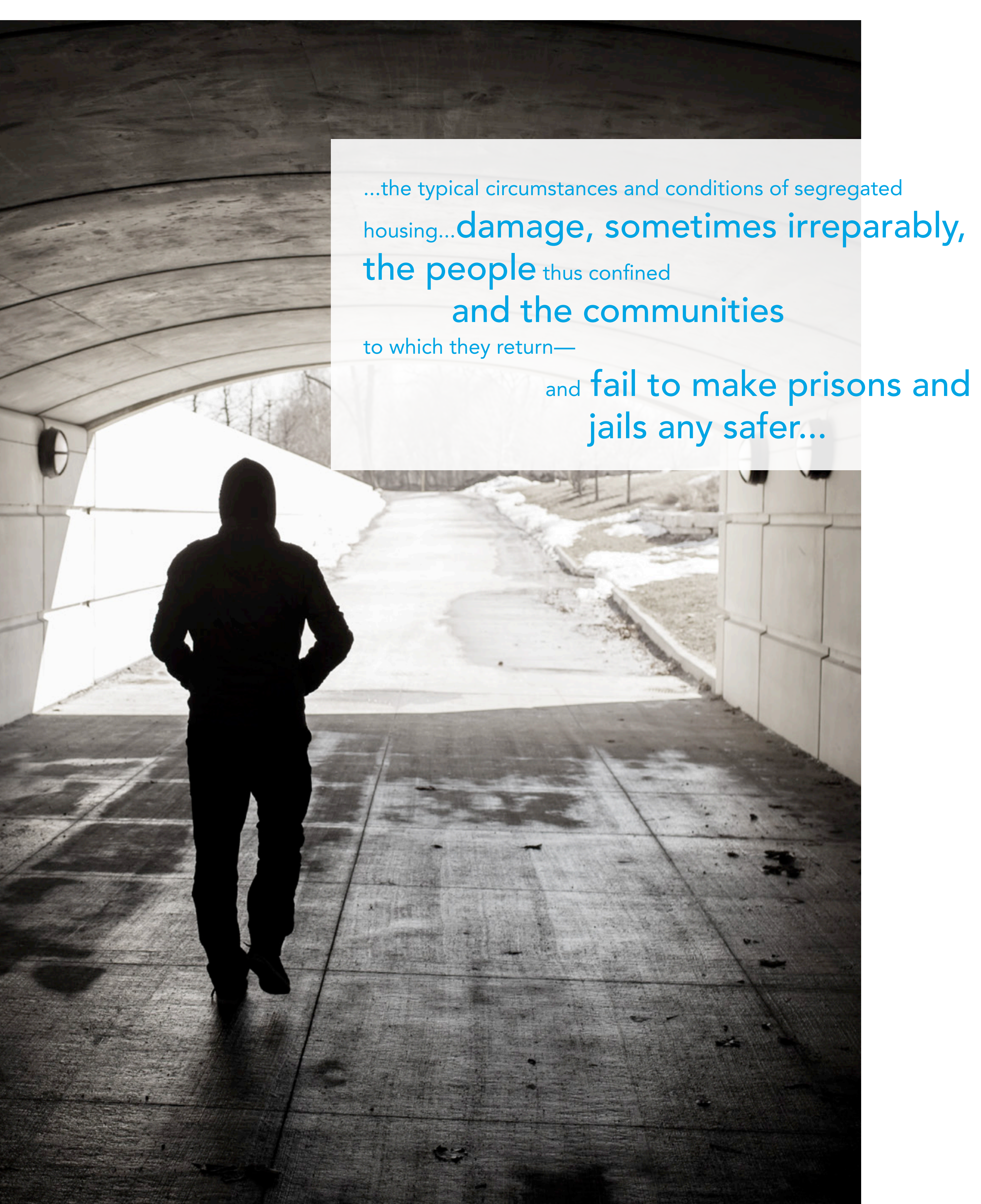
Incarcerated people are rarely released directly to the community from segregated housing

While national data are not available, jurisdictions often hold people in segregated housing until they complete their sentences, releasing them directly to the community. Between 1987 and 2007, California released an estimated 900 incarcerated people each year directly to the community from its secure housing units; in 2013, Texas released more than 1,200 incarcerated people in this way.[90] Releasing people directly from segregated housing into the community sets them up for failure—and endangers the safety and well-being of the communities to which they return—because in segregated housing, people more often than not receive no reentry planning services or rehabilitative programming, such as substance abuse counseling or classes related to life skills or anger management.

Moreover, data from some states suggest that recidivism rates for incarcerated people who have been held in segregated housing, regardless of whether they are released directly to the community, is significantly higher than for those who have not spent time in segregated housing while in prison. A 2001 review of recidivism data in Connecticut found that 92 percent of those who had been held in administrative segregation were rearrested within three years, compared to 66 percent of incarcerated people who had not been held in administrative segregation.[91] Another study found that confinement in supermax housing is associated with an increased risk of violent reoffending.[92] In Colorado, the recidivism rate for those who had been held in administrative segregation was between 60 and 66 percent, while the recidivism rate for those in general population was 50 percent.[93]

While the research is mixed, there is at least one study that shows the likelihood of reoffending by those who have been held in segregated housing may be reduced by returning them to the general prison population for as brief a period as three months before they are released to the community.[94] In Colorado, all people leaving restrictive housing (formerly called administrative segregation) spend up to 180 days in a transition unit where they receive cognitive behavioral programming and spend six hours a day outside of their cell before they return to the general prison population or to their communities.[95] Other jurisdictions have introduced reentry programming to those in segregated housing, primarily aimed at helping them re-socialize and get accustomed to interacting with other people. New Mexico created a Re-Entry and Release Unit for people in segregated housing who are within 180 days of release where

Included in SCDC' 4.29.19 letter to LOC



...the typical circumstances and conditions of segregated housing...**damage, sometimes irreparably, the people** thus confined **and the communities** to which they return—and **fail to make prisons and jails any safer...**

they participate in education and behavioral health programming, are not in restraints during group education activities, and move freely amongst other incarcerated people in recreation areas.[96]

Conclusion

Segregated housing remains a mainstay of prison management and control in U.S. prisons and jails largely because many jurisdictions still subscribe to some or all of the common misconceptions laid out in this report. Few in American corrections would dispute that its use may be unavoidable from time to time and for very brief periods to manage incarcerated people who have committed especially violent or dangerous acts. However, increasingly, policymakers, corrections officials, and the general public are justifiably questioning the human and societal toll of its widespread use. A large body of evidence has now well established that the typical circumstances and conditions of segregated housing—the deprivation of regular social intercourse and interaction, the removal of the rudimentary sights and sounds of life, and the severe restrictions on such basic human activities as eating, showering, or recreating—damage, sometimes irreparably, the people thus confined and the communities to which they return. And they fail to make prisons and jails any safer for those incarcerated or for the people who work in them.

Much of this research affirms the objections expressed by the United States Supreme Court 125 years ago in its landmark case of *In re Medley*. The court declared that solitary confinement is not "a mere unimportant regulation as to the safe-keeping of the prisoner....[A] considerable number of the prisoners... f[a]ll, after even a short confinement, into a semi-fatuous condition...[while] others bec[o]me violently insane; others still, [commit] suicide; while those who st[an]d the ordeal better [are] not generally reformed, and in most cases d[o] not recover sufficient mental activity to be of any subsequent service to the community."[97]

Whether prompted by the public's growing appetite for broad criminal justice reform or compelled by court orders, some jurisdictions are making progress. But much more remains to be done. Every effort must involve the implementation of policies and practices that effectively ban the use of segregated housing as an emergency response to minor rule infractions and as the default placement for those in need of protection—such as incarcerated people with serious mental illness, physical disabilities, or who are at risk of sexual victimization or violent retaliation. Not only will safe alternatives to segregated housing improve overall conditions in prisons and jails, but they will help build the foundation all incarcerated people need to return successfully to their communities.

Included in SCDC' 4.29.19 letter to LOC

Included in SCDC' 4.29.19 letter to LOC

ENDNOTES

1 Percent increase calculation done by Vera Institute of Justice researchers as part of its Segregation Reduction Project, based on data from the 1995 and 2005 *Census of State and Federal Adult Correctional Facilities*. For an estimate of the number of people in segregated housing in 1995, see U.S. Department of Justice, Bureau of Justice Statistics, *Census of State and Federal Adult Correctional Facilities, 1995* [Computer file]. Conducted by the U.S. Department of Commerce, Bureau of the Census. ICPSR ed. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [producer and distributor], 1998. Doi:10.3886/ICPSR06953.v1. For an estimate of the number of people in segregated housing in 2005, see United States Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Census of State and Federal Adult Correctional Facilities, 2005*. ICPSR24642-v2. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2010-10-05. http://doi.org/10.3886/ICPSR24642.v2.

2 For the estimate of 25,000 incarcerated people in segregated housing, see Daniel P. Mears, *Evaluating the Effectiveness of Supermax Prisons* (Washington, DC: Urban Institute, 2006), 4. For the estimate of approximately 80,000 incarcerated people in segregated housing, see United States Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Census of State and Federal Adult Correctional Facilities, 2005*. ICPSR24642-v2. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2010-10-05. http://doi.org/10.3886/ICPSR24642.v2.

3 In 2002, 40 states responded to a National Institute of Corrections survey with respondents having an average of 5 percent of prisoners in administrative and disciplinary custody. See James Austin and Kenneth McGinnis, *Classification of High-Risk and Special Management Prisoners: A National Assessment of Current Practices*, (Washington, DC: US Department of Justice, National Institute of Corrections, 2004), 29-30. https://s3.amazonaws.com/static.nicic.gov/Library/019468.pdf. This mirrors more recent calculations. For example, in 2010, 5.3 percent of Washington state's prison population was in segregated housing. This included 2.1 percent held in administrative or disciplinary segregation and 3.2 percent in the highest custody level of maximum. See Bernie Warner, secretary, Washington Department of Corrections, e-mail exchange with Vera, Washington, DC, March 12, 2015. In 2011, seven percent of Colorado's prison population was held in administrative segregation. See James Austin and Emmitt Sparkman, *Colorado Department of Corrections Administrative Segregation and Classification Review*, (Washington, DC: National Institute of Corrections, 2011, Technical Assistance # 11P1022) https://www.aclu.org/files/assets/final_ad_seg.pdf. In 2014, 5.1 percent of Pennsylvania's prison population was held in segregated housing. See Shirley Moore Smeal, executive deputy secretary, Pennsylvania Department of Corrections, e-mail exchange with Vera, Washington, DC, February 27, 2015. For information on the percentage of incarcerated people in segregation in the custody of the Federal Bureau of Prisons, see CNA, *Federal Bureau of Prisons: Special Housing Unit Review and Assessment* (Washington, DC: CNA, December, 2014). A report from the U.S. Government Accountability Office (GAO) found seven percent of the prison population housed in segregated housing as of February, 2013. U.S. Government Accountability Office (GAO), *Bureau of Prisons: Improvements Needed in Bureau of Prisons' Monitoring and Evaluation of Impact of Segregated Housing* (Washington, DC: GAO, 2013).

4 Ted Conover, "From Gitmo to an American Supermax, the Horrors of Solitary Confinement," *Vanity Fair*, January 16, 2015; Laura Dimon, "How Solitary Confinement Hurts the Teenage Brain," *The Atlantic*, June 30, 2014; and Atul Gawande, "Hellhole," *The New Yorker*, March 30, 2009.

5 See Benjamin Wallace-Wells, "The Plot From Solitary," *New York Magazine*, February 26, 2014.

6 United States Senate Committee on the Judiciary, Subcommittee on the Constitution, Civil Rights and Human Rights, *Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences*, June 19, 2012, http://www.judiciary.senate.gov/imo/media/doc/CHRG-112shrg87630.pdf; United States Senate Committee on the Judiciary, Subcommittee on the Constitution, Civil Rights, and Consequences, *Reassessing Solitary Confinement II: The Human Rights, Fiscal, and Public Safety Consequences*, February 25, 2014, http://www.judiciary.senate.gov/meetings/reassessing-solitary-confinement-ii-the-human-rights-fiscal-and-public-safety-consequences.

7 Eli Hager and Gerald Rich, "Shifting Away from Solitary," *The Marshall Project*, December 23, 2014. Also, South Dakota repealed a law that allowed a county prisoner to be kept in solitary confinement on bread and water for refusal to labor or obey necessary orders, see 2014 S.D. Laws 118 repealed S.D. Codified Laws § 24-11-34 (2014).

8 "The department shall not place a person with serious mental illness in long-term isolated confinement except when exigent circumstances are present," Colorado Revised Statute, 17-1-113.8 (2014).

9 In September 2014, the New York City Department of Correction ordered the end of solitary confinement for 16- and 17-year-olds by the end of the year. See Michael Shwirtz, "Solitary Confinement to End for Youngest at Rikers Island," *New York Times*, September 28, 2014. In January 2015, the New York City Board of Correction adopted rules relating to enhanced supervision housing and punitive segregation, which stated that sufficient resources are made available for staffing and implementing necessary alternative programming; as of January 1, 2016, inmates ages 18 through 21 will no longer be placed in enhanced supervision housing. Rules of the City of New York, Chapter 1, Title 40, §1-16 (c)(1)(ii).

10 Rick Raemisch, "My Night in Solitary," *New York Times*, February 20, 2014, p. A25, http://www.nytimes.com/2014/02/21/opinion/my-night-in-solitary.html. For several personalized accounts of life in segregated housing, see American Civil Liberties Union of Texas, Texas Civil Rights Project-Houston, *A Solitary Failure: The Waste, Cost and Harm of Solitary Confinement in Texas* (Houston: ACLU, 2015).

11 For more information on double celling, see Scarlet Kim, Taylor Pendergrass, and Helen Zelon, *Boxed In: The True Cost of Extreme Isolation in New York's Prisons* (New York: NYCLU, 2012), 34: "Double-celled prisoners experience the same isolation and idleness, withdrawal and anxiety, anger and depression as do prisoners living alone in the SHU. But double-celled, they must also endure the constant, unabating presence of another man in their personal physical and mental space."

12 Caroline Isaacs and Matthew Lowen, *Buried Alive: Solitary Confinement in Arizona's Prisons and Jails* (Arizona: American Friends Service Committee: 2007), 10-11.

13 Craig Haney, "Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement," *Crime & Delinquency* 49, no. 1 (2003): 126.

14 Isaacs and Lowen, 2007, p. 11.

15 Haney, 2003, p. 126; Eric Lanes, "The Association of Administrative Segregation Placement and Other Risk Factors with the Self-Injury-Free Time of Male Prisoners," *Journal of Offender Rehabilitation* 48 (2009): 532; Fred Cohen, "Isolation in Penal Settings: The Isolation-Restraint Paradigm," *Washington University Journal of Law & Policy*, 22 (2006): 297-299.

16 Kellie Wasco, deputy director, Colorado Department of Corrections, e-mail exchange with Vera, Washington, DC, April 17, 2015.

17 Benjamin Weiser, "New York State in Deal to Limit Solitary Confinement," *The New York Times*, February 19, 2014.

18 American Civil Liberties Union of Maine, *Change is Possible: A Case Study of Solitary Confinement Reform in Maine* (Portland, ME: ACLU of ME, 2013), 13. http://www.aclumaine.org/sites/default/files/uploads/users/admin/ACLU_ Solitary_Report_webversion.pdf.

Included in SCDC' 4.29.19 letter to LOC

19 For information on Washington state, see Bernie Warner, secretary, Washington Department of Corrections, e-mail exchange with Vera, Washington, DC, March 12, 2015. For additional information on Washington, see Jonathan Martin, "State Prisons Rethink Solitary Confinement," *Seattle Times* (January 7, 2013). For information on New Mexico, see Gregg Marcantel, secretary, New Mexico Corrections Department, e-mail exchange with Vera, Washington, DC, March 25, 2015. For information on Pennsylvania, see Shirley Moore Smeal, executive deputy secretary, Pennsylvania Department of Corrections, e-mail exchange with Vera, Washington, DC, February 27, 2015; Pennsylvania Department of Corrections, "STGMU Program" (unpublished memorandum, Pennsylvania Department of Corrections, 2014).

20 Carlyne Kujath, manager, Strategic Operations, Washington Department of Corrections, e-mail exchange with Vera, Washington, DC, April 15, 2015.

21 For information on Michigan, see Daniel Heyns, "Incentives in Segregation Program," Director's Office Memorandum (December 23, 2014) http://www.michigan.gov/documents/corrections/DOM_2015-5_478829_7.pdf.

22 "Virginia Step Down Program for Administrative Segregation," *Southern Legislative Conference* (2013), http://www.slcatlanta.org/STAR/2013documents/VA_Step_Down.pdf. Mississippi also uses a step down unit for prisoners with significant mental illness, see Terry A. Kupers et al., "Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs," *Criminal Justice and Behavior* 36 (2009): 1037-50. Maine conducts risk assessments for each prisoner in administrative segregation and uses this information to develop individualized behavioral programs, which can include in cell as well as group counseling. See American Civil Liberties Union of Maine, 2013.

23 Haney, 2003, p. 127. In a survey of supermax admission characteristics, Butler and Griffin found 36 percent of states responded that gang membership or participation in a security threat group was an adequate reason for inmate supermax placement. See H. Daniel Butler, O. Hayden Griffin III, and W. Wesley Johnson, "What Makes You the 'Worst of the Worst?': An Examination of State Policies Defining Supermax Confinement," *Criminal Justice Policy Review* 24, no. 6 (2012): 687.

24 At least 46 states have specific criteria that govern who is placed in long-term administrative segregations. See Hope Metcalf et al., "Administrative Segregation, Degrees of Isolation, and Incarceration: A National Overview of State and Federal Correction Policies," *Public Law Working Paper* (New Haven: Yale Law School, 2013), 2, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2286861; and Haney, 2003, p. 127.

25 For information on incarcerated people in segregation due to mental instability, see Craig Haney, 2003, pp. 124-156. For information on children in segregated housing, see American Civil Liberties Union and Human Rights Watch, *Growing Up Locked Down: Youth in Solitary Confinement in Jails and Prisons Across the United States* (New York: ACLU & HRW, 2012) https://www.aclu.org/files/assets/us1012webwcover.pdf. Additional reasons to place someone in protective custody include advanced age, former affiliation as a law enforcement officer, the crime committed (e.g., a particularly heinous act or sex offenders), owe debts to others in the facility, and testified against someone in the facility.

26 Angela Browne, Alissa Cambier, and Suzanne Agha, "Prisons Within Prisons: The Use of Segregation in the United States," *Federal Sentencing Reporter* 24, no. 1 (2011): 46-49.

27 Leena Kurki and Norval Morris, "The Purposes, Practices, and Problems of Supermax Prisons," *Crime and Justice*, 28 (2001): 385-424, 389; David Lovell, Kristin Cloyes, David Allen, and Lorna Rhodes, "Who Lives in Super-Maximum Custody? A Washington State Study," *Federal Probation Journal* 64, no. 2 (2000): 33-38; and Jean Casella and James Ridgeway, "New York's Black Sites," *The Nation* (July 30-August 6, 2012).

28 Bryan Gleckler, chief of staff, Illinois Department of Corrections, e-mail exchange with Vera, Washington, DC, April 3, 2015.

29 Shirley Moore Smeal, executive deputy secretary, Pennsylvania Department of Corrections, e-mail exchange with Vera, Washington, DC, February 27, 2015.

30 An investigation revealed that South Carolina was sending incarcerated people caught posting on social media sites to segregated housing for an average of 512 days. See Emily Bazelon, "The Shame of Solitary Confinement," *New York Times*, February 19, 2015.

31 Testimony of Piper Kerman, Senate Committee on the Judiciary, Subcommittee on the Constitution, Civil Rights and Human Rights, "Reassessing Solitary Confinement II: The Human Rights, Fiscal, and Public Safety Consequences," (February 24, 2014), http://www.judiciary.senate.gov/imo/media/doc/02-25-14KermanTestimony.pdf.

32 Ram Subramanian and Alison Shames, *Sentencing and Prison Practices in Germany and the Netherlands: Implications for the United States* (New York: Vera Institute of Justice, 2013), 13. The corrections systems in Germany and the Netherlands embrace two principles that the National Research Council finds particularly missing from current criminal justice policies and practices in the United States: proportionality—i.e., offenses should be punished in proportion to their seriousness—and parsimony—i.e., the period of confinement should be sufficient but not greater than necessary to achieve the goals of the disciplinary policy. See National Research Council, Committee on Causes and Consequences of High Rates of Incarceration, Jeremy Travis, Bruce Western, and Steve Redburn, eds., *The Growth of Incarceration in the United States: Exploring Causes and Consequences* (Washington, DC: The National Academies Press, 2014).

33 Subramanian and Shames, 2013, p. 13.

34 These violations are eligible for informal resolution, which does not permit segregated housing as a sanction. Should these violations be referred for formal resolution, the only sanctions levied are those sanctions other than segregated housing.

35 Bryan Gleckler, chief of staff, Illinois Department of Corrections, e-mail exchange with Vera, Washington, DC, April 3, 2015.

36 American Civil Liberties Union of Maine, 2013, p. 15.

37 Washington Department of Corrections, *Prison Sanctioning Guidelines* (DOC 320.150 Attachment 2), on file with Vera.

38 Ryan Jacobs and Jaeah Lee, "Maps: Solitary Confinement, State by State," *Mother Jones,* November/December 2012.

39 See American Correctional Association, Standards for Adult Correctional Institutions (4th edition, 2003), § 4-4249. For information on review while in administrative segregation, see Hope Metcalf et al., 2013, pp. 15-17, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2286861.

40 Cohen, 2006, p. 300.

41 Raemisch, 2014, p. A25.

42 For information on length of stay in Illinois, see Illinois Department of Corrections, *Tamms Closed Maximum Security Unit: Overview and Ten-Point Plan* (Springfield, IL: Illinois Department of Corrections, September 3, 2009), p. 39, Table 4; in Washington, Carlyne Kujath, manager of strategic operations, Washington Department of Corrections, e-mail exchange with Vera, Washington, DC, April 17, 2015; and in Texas, see American Civil Liberties Union of Texas, 2015, 2. This report does not specify the year(s) for which data was analyzed. According to the report's author, the average length of stay in Texas

Included in SCDC' 4.29.19 letter to LOC

was calculated using data available as of August 13, 2013. Burke Butler, Arthur Liman Fellow, the Texas Civil Rights Project, e-mail exchange with Vera, Washington, DC, April 18, 2015.

43 Bernie Warner, secretary, Washington Department of Corrections, e-mail exchange with Vera, Washington, DC, March 12, 2015.

44 In a review of the policies of 47 jurisdictions, Metcalf et al. found that every jurisdiction required some form of review of prisoners in administrative segregation. The majority of jurisdictions required an initial review within seven days with subsequent reviews ranging from weekly to yearly. The decision makers for the review can include facility staff, warden, a specially designated committee, and high-level administrators. Additional research is needed on whether and how the frequency of reviews correlates with the length of time spent in segregation. Metcalf et al., 2013, pp. 15-16.

45 Shirley Moore Smeal, executive deputy secretary, Pennsylvania Department of Corrections, e-mail exchange with Vera, Washington, DC, February 27, 2015. Kellie Wasco, deputy director, Colorado Department of Corrections, e-mail exchange with Vera, Washington, DC, April 17, 2015.

46 Shirley Moore Smeal, executive deputy secretary, Pennsylvania Department of Corrections, e-mail exchange with Vera, Washington, DC, February 27, 2015.

47 Data obtained from the California Department of Corrections and Rehabilitation reveals that 69 percent of Security Housing Unit case reviews led to release to a step down program or a general population setting and 63 percent of administrative segregation unit case reviews led to a return to the general population. See Sal Rodriguez, "In California Prisons, Hundreds Have Been Removed from Solitary Confinement—and Thousands Remain," *Solitary Watch*, January 27, 2015.

48 Paul Gendreau, Sheila A. French, and Angela Gionet, "What Works (What Doesn't Work): The Principles of Effective Correctional Treatment," *Journal of Community Corrections* 13 (Spring 2004): 5.

49 Metcalf et al. specify Connecticut, Massachusetts, Mississippi, New Jersey, New Mexico, and Virginia as states that have structured programs that target behavior issues. Metcalf et al., 2013, p. 18.

50 Bernie Warner, secretary, Washington Department of Corrections, e-mail exchange with Vera, Washington, DC, March 12, 2015. The Washington State Department of Corrections uses the Risk-Need-Responsivity Model as a foundation of the Washington State Department of Corrections Offender Change Model. For more information on the Risk-Need-Responsivity model, see James Bonta and D. A. Andrews, *Risk-Need-Responsivity Model for Offender Assessment and Rehabilitation* (Ottawa: Public Safety Canada, 2007), http://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/rsk-nd-rspnsvty/index-eng.aspx.

51 David H. Cloud, Ernest Drucker, Angela Browne, and Jim Parsons, "Public Health and Solitary Confinement in the United States," *American Journal of Public Health*, 105, no.1 (2015): 18-26. For a comprehensive summary of the published studies documenting this statement see Haney, 2003, pp. 124-156. On historical research on the "sizable and impressively sophisticated literature, now largely forgotten," that documented significant damage to incarcerated people held in segregated housing, see Peter Scharff Smith, "The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature," *Crime and Justice*, 34, no. 1 (2006): 441. One contrasting study of incarcerated people in administrative segregated housing in Colorado found no mental deterioration while in segregation, see Maureen L. O'Keefe et al., "One Year Longitudinal Study of the Psychological Effects of Administrative Segregation." (National Institute of Justice Document 232973, October 2010). However, experts with long professional track records in correctional mental health have taken issue with the design of that study and caution not to draw any conclusions from the study. See Kirsten Weir, "Alone in the Hole: Psychologists Probe the Mental Health Effects of Solitary Confinement," *American Psychological Association* 43, no. 5 (May 2012): 54, http://www.apa.org/monitor/2012/05/solitary.aspx; and Stuart Grassian and Terry Kupers, "The Colorado Study vs. the Reality of Supermax Confinement," *Correctional Mental Health Report*, 13, no.1 (May/June 2011): 1-4.

52 For information on the "potent mix," see Sharon Shalev, *A Sourcebook on Solitary Confinement* (London: Mannheim Centre for Criminology, London School of Economics, 2008). For information on negative effects of solitary confinement, see Haney, 2003, pp. 130-136; Paul Gendreau, et al. "Changes in EEG Alpha Frequency and Evoked Response Latency During Solitary Confinement," *Journal of Abnormal Psychology* 79 (1972), 57-58; Stuart Grassian, "Psychiatric Effects of Solitary Confinement," *Washington University Journal of Law & Policy*, 22 (January 2006): 325-383; Stuart Grassian, "Psychopathological Effects of Solitary Confinement," *American Journal of Psychiatry* 140, no.11 (1983): 1450-1454.

53 See Craig Haney and Mona Lynch, "Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement," *New York University Review of Law and Social Change* 23 (1997): 568.

54 While precise estimates are difficult, Professor Haney writes that the number of prisoners in segregated housing with mental illness may be twice as high as in the general prison population. See Haney, 2003, pp. 124-156; Sasha Abramsky and Jamie Fellner *Ill-Equipped: US Prisons and Offenders With Mental Illness* (New York: Human Rights Watch, 2003); David Lovell, "Patterns of Disturbed Behavior in a Supermax Prison," *Criminal Justice and Behavior* 3, no. 8 (2008): 985-1004.

55 Abramsky and Fellner, 2003, available at http://www.hrw.org/reports/2003/usa1003/18.htm, citing an e-mail from Dr. Terry A. Kupers, who testified in *Jones 'El v. Berge*, 164 F. Supp 2d 1096 (W.D. Wisconsin, 2001), which challenged the conditions in a Wisconsin supermax.

56 Fatos Kaba et al., "Solitary Confinement and Risk of Self-Harm Among Jail Inmates," *American Journal of Public Health* 104, no. 3, (2014): 442-447; Eric Charles Lanes, "Are the 'Worst of the Worst' Self-Injurious Prisoners More Likely to End Up in Long-Term Maximum-Security Administrative Segregation?" *International Journal of Offender Therapy and Comparative Criminology* 55, no. 7 (2011): 1034-1050.

57 Kevin Johnson, "Inmate Suicides Linked to Solitary," *USA Today*, December 27, 2006.

58 American Civil Liberties Union of Texas, 2015, p. 10. Rates for suicide and self-harm calculated using data from fiscal year 2013 per Burke Butler, Arthur Limas Fellow, Texas Civil Rights Project, email exchange with Vera, Washington, DC, April 18, 2015.

59 For an examination of suicides from 1993-2003, see Bruce Way et al., "Inmate Suicide and Time Spent in Special Disciplinary Housing in New York State Prison," *Psychiatric Services* 58, no. 4 (2007): 558-560.

60 Samantha Melamed, "Deal Aims to End Solitary Confinement For Seriously Mentally Ill Prisoners in Pa." *Philadelphia Inquirer*, January 8, 2015.

61 Colorado Revised Statute, 17-1-113.8 (2014).

62 Bernie Warner, secretary, Washington Department of Corrections, e-mail exchange with Vera, Washington, DC, March 12, 2015.

63 See Mears, 2006, p. 41; Chad S. Briggs, Jody L. Sundt, and Thomas C. Castellano, "The Effect of Supermaximum Security Prisons on Aggregate Levels of Institutional Violence," Criminology 41, issue 4 (2003): 1342.

64 Mears, 2006, p. 42. Interestingly, the physical conditions of a prison—some of which are present in segregated housing units—have been found to relate to misconduct, with worse levels of noise, clutter, dilapidation, and lack of privacy predicting higher levels of violence. D.M. Bierie, "Is Tougher Better? The Impact of Physical Prison

Included in SCDC' 4.29.19 letter to LOC

Conditions on Inmate Violence," *International Journal of Offender Therapy and Comparative Criminology* 56, no. 3 (2012): 338-355.

65 There are few, if any, credible studies on the impact of administrative segregation on facility safety, see Daniel P. Mears, "Supermax Prisons: The Policy and the Evidence," *Criminology & Public Policy* 12, no. 4 (2013): 681-720. The authors of a report on the use of segregated housing in federal prisons said that the literature does not make it "clear if there is a causal relationship between segregation policies and institutional safety," see CNA, 2014. Moreover, the federal Bureau of Prison's has never assessed whether the use of segregated housing has any effect on prison safety, see U.S Government Accountability Office (GAO), 2013, p. 33.

66 Briggs, Sundt, and Castellano, 2003, p. 1367.

67 Ibid, pp. 1365-1367.

68 In October 2009, Colorado Department of Corrections housed 1,166 incarcerated people in long-term administrative segregation. In April 2014, 215 incarcerated people were housed in long-term administrative segregation. Office of Planning and Analysis Prison Operations, Colorado Department of Corrections (CDOC), *SB 11-176 Annual Report: Administrative Segregation For Colorado Inmates* (Colorado: CDOC, 2015), 3; Rick Raemisch, director, Colorado Department of Corrections, e-mail exchange with Vera, Washington, DC, February 27, 2015.

69 CNA, 2014, p. 48; and Office of Planning and Analysis Prison Operations, Colorado Department of Corrections (CDOC), 2015, pp. 3-4.

70 Colorado, Kansas, Maine, Mississippi, and Ohio greatly reduced their use of segregated housing and officials reported little or no adverse impact on facility safety, see U.S. Government Accountability Office (GAO), 2013, 34. Washington has reduced the number of prisoners assigned to maximum custody by 47 percent from January 2011 to December 2014, see Bernie Warner, secretary, Washington Department of Corrections, e-mail exchange with Vera, Washington, DC, March 12, 2015; Gregg Marcantel, secretary, New Mexico Corrections Department, e-mail exchange with Vera, Washington DC, March 25, 2015.

71 When Maine cut its population in segregated housing, incidents of prison violence dropped. See American Civil Liberties Union of Maine, 2013, pp. 30-31.

72 Jesenia M. Pizarro and Raymund E. Narag, "Supermax Prisons: What We Know, What We Do Not Know, and Where We Are Going," *The Prison Journal* 88, no. 1 (2008): 29; Mears, 2006.

73 John J. DiIulio, *Governing Prisons: A Comparative Study of Correctional Management* (New York: Free Press, 1987); and Michael D. Reisig, "Rates of Disorder in Higher-Custody State Prisons: A Comparative Analysis of Managerial Practices," *Crime and Delinquency*, 44, no. 2 (1998), 230.

74 Michael D. Reisig, 1998, p. 239.

75 Chad S. Briggs, Jody L. Sundt, and Thomas C. Castellano, 2003, p. 1370.

76 Robert G. Morris, "Exploring the Effect of Exposure to Short-Term Solitary Confinement Among Violent Prison Inmates," *Journal of Quantitative Criminology* DOI 10.1007/s10940-015-9250-0 (2015): 1-24.

77 See Kristie R. Blevins et al., "A General Strain Theory of Prison Violence and Misconduct: An Integrated Model of Inmate Behavior," *Journal of Contemporary Criminal Justice* 26, no. 2 (2010): 148-166; Gresham M. Sykes, *The Society of Captives* (Princeton, New Jersey: Princeton University Press, 1958); Hans Toch, *Living in Prison: The Ecology of Survival* (New York: Free Press,1977); and Burt Useem and Anne Piehl, "Prison Buildup and Disorder," *Punishment and Society* 8, no. 1 (2006): 87-115.

78 Kate King, Benjamin Steiner, and Stephanie Ritchie Breach, "Violence in the Supermax: A Self-Fulfilling Prophecy," *The Prison Journal*, 88, no. 1 (2008): 161-62.

79 Carlyne Kujath, manager, Strategic Operations, Washington Department of Corrections, e-mail exchange with Vera, Washington, DC, April 15, 2015.

80 See Shirley Moore Smeal, executive deputy secretary, Pennsylvania Department of Corrections, e-mail exchange with Vera, Washington, DC, April 10, 2015.

81 Pennsylvania houses prisoners with special needs in a specialized unit, which provides privileges and programming similar to those offered in the general population. See Shirley Moore Smeal, executive deputy secretary, Pennsylvania Department of Corrections, e-mail exchange with Vera, Washington, DC, April 10, 2015.

82 Bernie Warner, secretary, Washington Department of Corrections, e-mail exchange with Vera, Washington, DC, March 12, 2015; Washington State Department of Corrections, "Skill Building Unit – Cedar Hall, WCC for Offenders with Cognitive Disabilities," (unpublished memorandum, Washington State Department of Corrections) on file with Vera. More information is available at http://www.doc.wa.gov/facilities/prison/wcc/.

83 Ibid.

84 Bernie Warner, secretary, Washington Department of Corrections, e-mail exchange with Vera, Washington, DC, March 12, 2015.

85 For information on Pennsylvania, see Samantha Melamed, January 8, 2015, http://articles.philly.com/2015-01-08/news/57797425_1_solitary-confinement-illness-inmates. For information on New York State, see Benjamin Weiser, February 19, 2014, http://www.nytimes.com/2014/02/20/nyregion/new-york-state-agrees-to-big-changes-in-how-prisons-discipline-inmates.html?ref=solitaryconfinement. Despite California's agreement in 2012, the state continues to house disabled prisoners in segregation units. A federal judge ordered the state to suspend this practice in February 2015. Paige St. John, "Federal Judge Orders California to Stop Isolation Housing of Disabled Inmates," *Los Angeles Times*, February 3, 2015. For New York City's new policy, see endnote 9.

86 Alaska Delinquency Rule 13 (Oct. 15, 2012); Me. Rev. Stat. tit. 34-A § 3032 (5) (2006).

87 Daniel P. Mears and William D. Bales, "Supermax Incarceration and Recidivism," *Criminology* 47, no. 4, 2009: 1135.

88 U.S. Government Accountability Office (GAO), 2013, p. 32.

89 Calculating costs from 2003, see Mears, 2006, p. 26.

90 For information on California, see Keramet A. Reiter, "Parole, Snitch, or Die: California's Supermax Prisons & Prisoners, 1987 – 2007," *Punishment and Society*, 14 (2012): 552-553. For information on Texas, see American Civil Liberties Union of Texas, 2015, p. 2.

91 Legislative Program Review and Investigations Committee, *Recidivism in Connecticut* (2001), http://www.ct.gov/opm/lib/opm/cjppd/cjresearch/recidivismstudy/2001recidivisminconnecticut.pdf.

92 Mears and Bales, 2009, p. 1151. The study found no effect of supermax incarceration on recidivism in general, but did find that supermax incarceration was associated with an increase in violent recidivism. Ibid, p. 1154.

93 Maureen L. O'Keefe, *Analysis of Colorado's Administrative Segregation* (Colorado Springs, Colorado: Colorado Department of Corrections, 2005), iii, 25. This study of incarcerated people held in segregated

Included in SCDC' 4.29.19 letter to LOC

housing between 1995 and 2003 did not match incarcerated people (for example on past offending record, current offense, behavior while incarcerated) held in segregated housing with incarcerated people held in the general population.

94 One study shows that incarcerated people who are released from segregated housing directly to the community reoffend more quickly and at higher rates than those who spent at least three months back in the general prison population before their return to the community. See David Lovell, L. Clark Johnson, and Kevin C. Cain, "Recidivism of Supermax Prisoners in Washington State," *Crime and Delinquency* 53 no. 4 (2007): 649-650. However, a different study found no evidence that the timing of the supermax experience influenced recidivism, see Mears and Bales, 2009, p. 1154.

95 Kellie Wasco, deputy director, Colorado Department of Corrections, e-mail exchange with Vera, Washington, DC, April 17, 2015. Colorado Department of Corrections has not released any incarcerated person from administrative segregation or restrictive housing maximum security status directly to the community since May 2014. See Office of Planning and Analysis Prison Operations, Colorado Department of Corrections (CDOC), 2015, p. 8.

96 Gregg Marcantel, secretary, New Mexico Corrections Department, e-mail exchange with Vera, Washington, DC, March 25, 2015.

97 See *In re Medley*, 134 US 160, 168 (1890), per Mr. Justice Miller.

Included in SCDC' 4.29.19 letter to LOC

Acknowledgments

The authors would like to thank Christine Herrman and Fred Patrick for their insight and guidance throughout the drafting of this report. We would like to thank Sara Sullivan for her review and comments and Angela Browne, Léon Digard, and Ari Agha for their assistance in understanding and explaining the research data. A special thank you to Patricia Connelly for her help and expertise in the planning and editing of this report; Paragini Amin for designing the report; and, finally, Mary Crowley for her generous assistance.

This publication is the first in a series about solitary confinement, its use and misuse, and how to safely reduce it in our prisons and jails. This series was made possible in part by the Robert W. Wilson Charitable Trust. Both during his lifetime and currently through his charitable trust, Mr. Wilson supported Vera's work with government partners around the country to reduce our nation's reliance on solitary confinement and improve conditions of confinement. We are honored to name this series of publications in his memory.

About Safe Alternatives to Segregation Initiative

In March 2015, the Vera Institute of Justice (Vera) launched the Safe Alternatives to Segregation (SAS) Initiative—a two-year national campaign aimed at reducing the number of incarcerated people held in segregated housing while simultaneously improving safety in prisons and jails. In addition to providing technical assistance to state and local jurisdictions selected through a competitive bidding process, SAS features a series of publications and an online resource center (to be launched in June 2015) that highlight the latest research and policy analysis by leaders in the field. For more information about SAS, contact Christine Herrman, project director, Center on Sentencing and Corrections, at cherrman@vera.org.

© Vera Institute of Justice 2015. All rights reserved. An electronic version of this report is posted on Vera's website at www.vera.org/solitary-confinement-misconceptions-safe-alternatives.

Image credits: Cover, RIRF Stock/Shutterstock; Page 5, Ed Kashi/VII; Page 9, Frances A. Miller/Shutterstock; Page 13, trekandshoot/Shutterstock; Page 19, Alexander Chaikin/Shutterstock; Page 21, schafar/Shutterstock; Page 23, Ed Kashi/VII; Page 25, Eddies Images/Shutterstock; Page 27, photoiva/Shutterstock.

The Vera Institute of Justice is an independent nonprofit organization that combines expertise in research, demonstration projects, and technical assistance to help leaders in government and civil society improve the systems people rely on for justice and safety. For more information, visit www.vera.org.

For more information about this report, contact Ram Subramanian, director of publications, Center on Sentencing and Corrections, at rsubramanian@vera.org.

Included in SCDC' 4.29.19 letter to LOC

Suggested Citation

Alison Shames et al. *Solitary Confinement: Common Misconceptions and Emerging Safe Alternatives.* New York, NY: Vera Institute of Justice, 2015.

Vera Institute of Justice
233 Broadway, 12th Floor
New York, NY 10279
Tel: (212) 334-1300
Fax: (212) 941-9407

Washington DC Office
1100 First St. NE, Suite 950
Washington, DC 20002
Tel: (202) 465-8900
Fax: (202) 408-1972

New Orleans Office
546 Carondelet St.
New Orleans, LA 70130
Tel: (504) 593-0937
Fax: (212) 941-9407

Los Angeles Office
707 Wilshire Blvd., Suite 3850
Los Angeles, CA 90017
Tel: (213) 223-2442
Fax: (213) 955-9250

Included in SCDC' 4.29.19 letter to LOC

ASSOCIATION OF STATE CORRECTIONAL ADMINISTRATORS

Executive Officers

President **Leann Bertsch** | *Vice President* **Brad Livingston**

Treasurer **John Wetzel** | *Past President* **Ashbel T. Wall, II**

Regional Representatives

Midwest **Ed Wall** | *Northeast* **Andy Pallito**

Southern **Derrick Schofield** | *Western* **Bernie Warner**

Embargoed until Wednesday, September 2, 2015 at Noon EDT

Contact: George or Camille Camp
Phone: 301.791.2722

New Report on Prisoners in Administrative Segregation Prepared by the Association of State Correctional Administrators and the Arthur Liman Public Interest Program at Yale Law School

Prolonged isolation of individuals in jails and prisons is a grave problem in the United States. The insistence on change comes not only from legislators across the political spectrum, judges, and a host of private sector voices, but also from the directors of correctional systems at both state and federal levels.

Even as a national outcry has arisen about isolation, relatively little information exists about the actual number of people held in restrictive housing, the policies determining their placement, and whether and how conditions vary in different jurisdictions. Indeed, the figures cited on the number of people held in isolation vary from 25,000 to more than 80,000. But that information comes from a decade and more ago.

To rectify the absence of data and to pave the way for changes, the Association of State Correctional Administrators (ASCA) joined with the Arthur Liman Public Interest Program at Yale Law School to develop a national database of the policies and practices on what correctional officials call "restricted housing" and is frequently referred in the media as "solitary confinement." ASCA is the only national organization of persons directly responsible for the administration of correctional systems and includes the heads of each state's corrections agencies, as well as the Federal Bureau of Prisons, the District of Columbia, New York City, Philadelphia and Los Angeles County.

The result is the new report *Time-in-Cell: The Liman-ASCA 2014 National Survey of Administrative Segregation in Prison*, which is the first to provide updated information, as of the fall of 2014, on both the numbers and the conditions in restrictive housing nationwide. This Report represents the commitments of correctional leaders to make such changes. But without a baseline, it is not possible to know the impact of the many efforts underway. *Time-in-Cell* provides one way to measure and to learn whether the hoped-for changes are taking place, to reduce and to eliminate the isolation of prisoners, so as to enable prisoners and staff to live and work in safe environments, respectful of human dignity.

Getting the numbers is a piece of the news; the other is that changes are underway at both the state and federal levels. Correctional leaders across the country are committed to reducing the number of people in restrictive housing and altering what it means to be there. Thus, prison system directors insist that the 2014 figures are or will soon be out-of-date because they are placing new limits on putting prisoners into restrictive housing and developing activities to change what restricted housing means. In a few jurisdictions, for example, new programs mandate out-of-cell time (of up to 20 hours) for subpopulations, such as those with significant mental illness.

Thirty-four jurisdictions -- housing about 73% of the more than 1.5 million people incarcerated in U.S. prisons - provided data on all the people in restricted housing, whether termed "administrative segregation," "disciplinary segregation," or "protective custody." In that subset, more than 66,000 prisoners were in restricted housing. If that number is illustrative of the whole, some 80,000 to 100,000 people were, in 2014, in restrictive housing settings in prisons (and these numbers do not include jails, juvenile facilities, or immigration and military detention).

The 2015 *Time-In-Cell* Report analyzes the results of a survey of more than 130 questions, again sent to the directors of all the prison systems. Forty-six jurisdictions responded with details on a subset of restricted housing, the 31,500 male prisoners reported held in administrative segregation. Across the country, in many jurisdictions, prisoners are required to spend 23 hours in their cells on weekdays, and in many, 24 hours in their cells on weekends. The permitted hours out-of-cell ranged from 3 to 7 a week in many jurisdictions. Phone calls and social visits ranged from one per month in several jurisdictions; in others, more opportunities existed. In virtually all jurisdictions, the possessions that prisoners can keep in their cells, the programs, visits, and telephone calls they might be able to have access to could be cut back or stopped as sanctions for misbehavior.

Most jurisdictions had no fixed time limits on administrative segregation; only one state imposed a one-year limit. Several jurisdictions did not track the numbers of continuous days a person has been held. In the 24 jurisdictions that did, the time spent varied widely. In a substantial number, people remained in segregation for more than three years. For those released, the 30 jurisdictions tracking information estimated that, in 2013, 4,400 prisoners were directly released from administrative segregation to the community.

Prison directors also described the challenges of staffing administrative segregation, and the need for additional training, flexible schedules, rotating staff, or more benefits. Many directors reported on the many incentives for changing the current policies – citing prisoner and staff well-being, litigation, and the costs and, as a few put it, because it "is the right thing to do."

By facilitating cross-jurisdictional comparisons of the rules and practices that surround administrative segregation, the two Report both reflect and support ongoing efforts to limit or end extended isolation. In some states, new legislation limits administrative segregation for subpopulations, such as the mentally ill, juveniles, and individuals with disabilities; many more proposals are pending at the state and national level. Litigation has addressed segregation in specific state, and some advocates call for abolition. The 2015 "Mandela Rules," shaped with input from leaders of ASCA and promulgated two months ago by the Committee on Crime Prevention and Criminal Justice of the United Nations, have called confinement of prisoners for 22 hours or more for longer than 15 days a form of "cruel, inhuman or degrading treatment."

By way of background, the 2015 Report is the second in a series. In 2012, the Liman Program and ASCA asked the directors of state and federal corrections systems to provide their policies governing administrative segregation, defined as removing a prisoner from general population to spend 22-23 hours a day in a cell for 30 days or more. Thus, *Administrative Segregation, Degrees of Isolation, and Incarceration: A National Overview of State and Federal Correctional Policies (2013)* is based on responses from 47 jurisdictions.

That report details how broad the criteria for being put into administrative segregation were – staff has wide discretion to do so if perceiving that the prisoner posed "a threat" to institutional safety or was a danger to "self, staff, or other inmates." The kind of notice and what constituted a "hearing" varied substantially, as did the level of staff with the authority to make the decision. In short, at the formal level, getting into segregation was relatively easy, and few policies focused on how people got out.

For additional information, please contact George and Camille Camp, Co-Executive Directors of ASCA at 301-791-2722 and, at Yale Law School, please contact Judith Resnik, Arthur Liman Professor of Law 203-436-1447; Judith.Resnik@yale.edu; Johanna Kalb, Visiting Professor and Director of the Liman Program, 203-436-3520; Johanna.Kalb@yale.edu; and Sarah Baumgartel, Senior Liman Fellow-in-Residence, 203-436-3532, sarah.baumgartel@yale.edu. The full Report may be downloaded, free of charge at www.asca.net or at www.law.yale.edu/intellectuallife, at the Yale Law School. This project has been generously supported by the Yale Law School, the Liman Program, the Oscar M. Ruebhausen Fund at Yale Law School, and the Vital Projects Fund.

Included in SCDC' 4.29.19 letter to LOC

Prisons Within Prisons: The Use of Segregation in the United States
Author(s): Angela Browne, Alissa Cambier and Suzanne Agha
Source: *Federal Sentencing Reporter*, Vol. 24, No. 1, Sentencing Within Sentencing (October 2011), pp. 46-49
Published by: University of California Press on behalf of the Vera Institute of Justice
Stable URL: http://www.jstor.org/stable/10.1525/fsr.2011.24.1.46
Accessed: 04/04/2013 12:03

Your use of the JSTOR archive indicates your acceptance of the Terms & Conditions of Use, available at
http://www.jstor.org/page/info/about/policies/terms.jsp

JSTOR is a not-for-profit service that helps scholars, researchers, and students discover, use, and build upon a wide range of content in a trusted digital archive. We use information technology and tools to increase productivity and facilitate new forms of scholarship. For more information about JSTOR, please contact support@jstor.org.

University of California Press and *Vera Institute of Justice* are collaborating with JSTOR to digitize, preserve and extend access to *Federal Sentencing Reporter.*

http://www.jstor.org

Included in SCDC' 4.29.19 letter to LOC

This content downloaded from 149.101.37.2 on Thu, 4 Apr 2013 12:03:32 PM
All use subject to JSTOR Terms and Conditions

Prisons Within Prisons: The Use of Segregation in the United States

ANGELA BROWNE

Senior Policy Researcher, Vera Institute of Justice

ALISSA CAMBIER

Program Associate, Vera Institute of Justice

SUZANNE AGHA

Senior Research Associate, Vera Institute of Justice

I. Prisons Within Prisons

Since the 1980s, departments of corrections have sharply increased the use of segregation as a discipline and management tool. For example, according to the U.S. Bureau of Justice Statistics, in just the five years between 1995 and 2000, the number of prisoners held in segregation beds increased 40 percent nationally.[1] By 2004, more than forty U.S. states reported having some form of supermax housing.[2] Based on the most recent data available from the Bureau of Justice Statistics census, in 2005 U.S. prisons held 81,622 people in restricted housing.[3]

Segregation is used for a variety of reasons, most commonly as a form of punishment for rule violations, as a way to remove prisoners from the general prison population who are thought to pose a risk to security or safety, and as a way to provide safety to prisoners believed to be at risk in the general prison population. Prisoners placed in segregation are moved to special housing units with high levels of restrictions and control. Prisoners may stay in segregated housing for years without the opportunity to engage in the types of interactions, treatment, and education experiences that would help them adjust when reentering either the general prison population or society. In effect, segregation is a secondary sentence imposed by the correctional facility—one that follows long after and usually is unrelated to the conviction for which the person is incarcerated.

The consequences of holding an individual in these conditions over time may include new or exacerbated mental health disturbances, assaultive and other antisocial behaviors, and chronic and acute health disorders. People who have been housed in segregation for long periods of time may also find it difficult to be in the company of others, whether in the general prison population or later in the community. In fact, studies show that prisoners who are released from segregation directly to the community reoffend at higher rates than general-population prisoners.[4]

Also, significant fiscal costs are associated with housing people in segregation. In the Ohio State Prison in 2003, it cost $149 a day to house a supermax prisoner, compared with $101 per day for maximum-security and $63 per day for an average general-population prisoner.[5] The majority of these higher costs come from the need for additional staff to monitor segregation units. In the Ohio State Prison, the supermax facility required one corrections officer for every 1.7 prisoners; maximum-security housing required one officer for every 2.5 prisoners.[6]

A. The Emergence of Segregation in U.S. Prisons

The use of solitary confinement in the United States dates back to Pennsylvania in the late 1770s. At that time, the philosophy was that prisoners who were isolated would have time to repent and rehabilitate themselves. Although this system spread to other jurisdictions and survived for nearly a century, its use was reduced when the psychological and physical damage caused by this seclusion became apparent.[7] In 1890, a prisoner on death row in Colorado filed a writ of habeas corpus in the Supreme Court challenging his imprisonment under an ex post facto law that required all death row prisoners be held in solitary confinement. In a landmark decision, the Court noted some severe effects of this isolation, stating,

> A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition . . . and others became violently insane; others still committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community.[8]

Following these observations, the Court found that this prisoner's placement in solitary confinement "was an additional punishment of the most important and painful character," and thus the application of the new law to his situation violated the Constitution.[9]

This shift away from segregation was short lived, however, and reversed when the federal government opened Alcatraz Prison in 1934 and the United States Penitentiary in Marion, Illinois, in 1963. Both prisons were built to house the nation's worst criminals; they relied primarily on isolating prisoners who posed the greatest behavioral and management concerns in order to maintain control. States followed suit and began to add segregation units to house those they deemed dangerous

Federal Sentencing Reporter, Vol. 24, No. 1, pp. 46–49, ISSN 1053-9867 electronic ISSN 1533-8363.
©2011 Vera Institute of Justice. All rights reserved. Please direct requests for permission to photocopy or reproduce article content through the University of California Press's Rights and Permissions website, http://www.ucpressjournals.com/reprintInfo.asp. DOI: 10.1525/fsr.2011.24.1.46.

FSR2401_15.indd 46 9/14/11 12:03:46 PM

Included in SCDC' 4.29.19 letter to LOC

This content downloaded from 149.101.37.2 on Thu, 4 Apr 2013 12:03:32 PM
All use subject to JSTOR Terms and Conditions

and threatening. The first supermax prison, built solely to house prisoners in segregation, was Pelican Bay State Prison, opened in California in 1989.

B. Types of Segregation in U.S. Prisons

Segregation is used in minimum-, medium-, and maximum-security facilities and may have varying conditions and restrictions. Generally, prisoners in segregation are confined to a special housing unit—essentially prisons within prisons—unless they are sent to a supermax facility, which houses only prisoners in segregation. The following are the main types of segregation in the United States:

1. **Disciplinary segregation** is a form of punishment for rule violations occurring within the prison setting. For example, a prisoner may be sentenced to a year in segregation for assault or possession of contraband, or for a period of months for violation of a direct order.
2. **Administrative segregation** typically is used to remove prisoners from the general prison population who are thought to pose a threat to safety or security, or for prisoners who are believed to have information about an incident under investigation; this type of segregation is not a form of punishment for a specific violation. For example, a gang leader believed to be responsible for coordinating gang activities within the prison may be placed in administrative segregation even if that individual has not been found in violation of any rules. Administrative segregation usually lasts for an indeterminate period of time and, for those considered a threat to safety and security, may be of long duration. In some systems, prisoners are not told the reason for their transfer to administrative segregation, and options for reevaluation or release back to the general prison population may be few.
3. **Protective custody** is the use of segregation to provide safety for prisoners believed to be at risk in the general prison population, such as a prisoner who provides information to correctional staff about violations committed by others, or someone who is considered at risk due to physical characteristics or other individual factors. Although segregated for their own protection, restrictions on human contact and programming for prisoners in protective custody can be as severe as for prisoners in disciplinary or administrative segregation.
4. **Temporary confinement** is the use of segregation while a reported incident is being investigated; it usually lasts for a short period of time and begins immediately after a rule violation is identified but before a hearing is conducted.
5. **Supermax (or closed maximum-security) prisons** may hold both administrative and disciplinary segregation prisoners. All prisoners in supermax facilities are held in high levels of confinement, often for long periods of time. Architecturally, supermax prisons are built to restrict visual and tactile stimulation for prisoners, as well as contact with others. Educational and programmatic activities are greatly restricted in these environments.

C. Conditions of Confinement in Segregation

The use of segregation that began in the mid-1980s was accompanied by increasingly severe conditions of confinement, both in supermax facilities and in prison segregation units throughout the country. Conditions in segregation typically include intense isolation and control.

Prisoners usually spend at least twenty-three hours a day in their cells. The federal district court in 1995 in *Madrid v. Gomez* described a segregation cell at Pelican Bay State Prison in California in these words:

> Each cell is 80 square feet and comes equipped with two built-in bunks and a toilet-sink unit. Cell doors are made of heavy gauge perforated metal; this design prevents objects from being thrown through the door but also significantly blocks vision and light. . . . [The] interior is designed to reduce visual stimulation. . . . The cells are windowless; the walls are white concrete. When inside the cell, all one can see through the perforated metal door is another white wall.[10]

Prisoners in segregation are generally taken out of their cells for only one hour out of every twenty-four hours, either for recreation or a shower. However, in some systems, prisoners are released only one day a week for a total of five hours. Before being taken to showers, recreation, or appointments, prisoners are cuffed and also may be shackled at the waist and placed in leg irons. Recreation times may occur anytime from 7:00 a.m. until 3:00 a.m. Typically, recreation takes place in either an open cage outdoors (called a yard) or an indoor area with an open barred top. Because exercise areas usually are exposed to the weather, prisoners must choose whether to use them during extreme weather conditions or remain in their cells. Periods of extreme weather may greatly reduce the amount of time prisoners are out of the cell, particularly when recreation periods are offered in five-hour blocks.

Except when overcrowding requires double celling, face-to-face human contact—except with corrections officers—is virtually eliminated in segregation. Meal trays are delivered through a slot in the door, visits with counselors and mental health staff also are usually conducted through the cell door, and exercise is taken alone. Segregation prisoners typically are not allowed contact with other prisoners, and visits with family members are curtailed or may be completely prohibited for a year or more. When family visits are allowed, they usually are conducted by speaker or telephone through a thick glass window, precluding the opportunity for human touch. Mental health and medical services are often extremely limited for prisoners in segregation as well, further reducing human contact.

FSR2401_15.indd 47 9/14/11 12:03:46 PM

Included in SCDC' 4.29.19 letter to LOC
This content downloaded from 149.101.37.2 on Thu, 4 Apr 2013 12:03:32 PM
All use subject to JSTOR Terms and Conditions

II. A New Way Forward

Even with high fiscal costs and exposure to litigation related to conditions of confinement, prison officials fear that moving prisoners out of segregation will lead to violence and other serious violations. Two states—Ohio and Mississippi—have tested that concern. In the mid-2000s, Ohio and Mississippi reduced their supermax populations by 89 percent and 85 percent, respectively, while apparently decreasing violence and disruption. Mississippi went from 1,000 to 150 prisoners in segregation;[11] Ohio went from 800 to 90 prisoners.

Mississippi provides a particularly vivid example of multifaceted reform. In the early 1990s, reports on conditions in the Mississippi Department of Corrections' (MDOC) Parchman Unit 32 indicated that prisoners were severely isolated. The unit was filthy with excrement, and prisoners with mental illness created constant disturbances by starting fires, flooding the cells, and screaming all night.[12] Officers in the unit often responded to these disturbances with force. The unit also became infested with mosquitoes in the summer, forcing prisoners to keep cell windows closed, thereby exacerbating the poor conditions. In 2005, the American Civil Liberties Union filed suit against the MDOC related to conditions in Unit 32. In response, the MDOC convened a task force to address the issues identified, in particular the assignment of prisoners to segregation.

In 2007, the MDOC voluntarily implemented the task force's recommendations. Within a year, the department successfully reclassified and moved more than three quarters of its supermax prisoners to the general prison population. Prisoners remaining in Unit 32 were allowed to eat meals together and spend several more hours out of their cells each day. The MDOC also physically transformed Unit 32 by building program and recreation areas and providing access to educational programming and mental health treatment.

Mississippi successfully implemented these changes by dramatically revising its classification system and creating more restrictive criteria for placement in administrative segregation. Specifically, the new objective classification system allowed placement in Unit 32 only for prisoners who had committed a serious infraction, were active, high-level gang members, or had prior escapes or escape attempts from a secure facility. Only the commissioner had the authority to place an individual in segregation without these criteria. In addition, the MDOC implemented a step-down program so that prisoners with mental illness could transition out of segregation; participants received intensive mental health treatment and rewards for success in the program, and special training was provided to assist officers in dealing with mentally ill prisoners. These changes not only reduced the number of people held in segregation but also were associated with an almost 70 percent decrease in prisoner-on-prisoner and prisoner-on-staff violence, and use of force by officers in the unit plummeted.[13]

III. Vera's Segregation Reduction Project

Inspired by the success of Ohio and Mississippi, and informed by the *Confronting Confinement* report issued by the Commission on Safety and Abuse in America's Prisons, the Vera Institute of Justice launched its Segregation Reduction Project (SRP) in 2010. The SRP seeks to safely reduce the number of prisoners held in segregation by facilitating policy changes that reassess violations qualifying a prisoner for segregation and that redefine prisoners' length of stay in segregation (especially for minor violations). The project also focuses on improving conditions of confinement in segregation and enhancing programming and support for transitions back to the general prison population. The overall goal of the SRP is to develop a national model that can be adapted for use in many jurisdictions.

To that end, Vera is currently collaborating with Illinois, Maryland, and Washington to implement the SRP in those states. Although the exact process varies depending on the specific challenges and concerns of each state corrections system, Vera staff do the following:

- conduct intensive site visits to supermax facilities and segregation units
- review policies and practices related to the use of segregation
- complete comprehensive analyses of segregated populations, violations resulting in segregation time, and new violations by prisoners moved to other levels of security
- provide data-based presentations to corrections officials about patterns in and outcomes of their use of segregation
- in consultation with corrections staff, recommend strategies to safely reduce segregation and improve conditions of confinement
- in close partnership with corrections staff, help pilot changes and track the outcomes of those changes on institutional safety and new violations over time.

IV. Making a Positive Change in Segregation in U.S. Prisons

Given the current fiscal crisis, many jurisdictions now are looking for new and effective paths forward, away from reliance on this expensive form of incarceration. Especially with the current U.S. recession, states can no longer afford these unsustainable costs. Illinois—with approximately 46,000 men and women in state prisons in February 2010—provides one example of why it is important to reassess the use of segregation in the nation's prisons. Although only about 5 percent of the prison population was in segregation on any given day, more than half (56 percent) had spent some time in segregation during that prison stay. Reducing the use of segregation and improving conditions of confinement in segregation nationally will affect thousands of individuals.

FSR2401_15.indd 48 9/14/11 12:03:46 PM

Included in SCDC' 4.29.19 letter to LOC
This content downloaded from 149.101.37.2 on Thu, 4 Apr 2013 12:03:32 PM
All use subject to JSTOR Terms and Conditions

With this project, Vera hopes to demonstrate that it is possible for states to reduce the numbers of prisoners they hold in segregation without jeopardizing institutional or public safety, as well as create a replicable model that can be adapted for use in other jurisdictions. Based on observations and analyses so far, it seems clear that segregated populations in U.S. prisons *can* be dramatically reduced in a safe way. A substantial number of prisoners are being sent to segregation for relatively nonserious types of behavior, such as unauthorized movement, failure to report to work or school, insolence or talking back, and disobeying a direct order. Confinement to segregation is often out of scale for these violations, especially when alternative sanctions (e.g., restricted movement in their current housing and reduction of other privileges) are available. Policy changes that will reduce the use and long-term impact of segregation include the following:

- using alternative sanctions for minor violations
- reducing segregation time for certain categories of violations
- employing standardized incentivized reductions in segregation time for sustained good behavior
- providing opportunities for gradual resocialization to the general prison population

Changes in Mississippi and Ohio segregation practices suggest that this change can be made safely, without loss of staff positions, and with cost savings. Enhancing the programming available to individuals held in segregation also has the potential to decrease violence and disturbances and increase prisoners' positive adjustment. The provision of safe and healthy conditions in segregation will benefit not only the staff and prisoners in these units but also ultimately the well-being of facilities, systems, and the community.

Notes

1 John J. Gibbons & Nicholas de B. Katzenbach, Confronting Confinement: A Report of the Commission on Safety and Abuse in America's Prisons (Vera Institute of Justice, 2006); Jennifer C. Karberg & James J. Stephan, Census of State and Federal Correctional Facilities, 2000 (Bureau of Justice Statistics, U.S. Department of Justice, August 2003).

2 Daniel P. Mears, *A Critical Look at Supermax Prisons*, 30 Corrections Compendium 6–7, 45–49 (2005).

3 James J. Stephan, Census of State and Federal Adult Correctional Facilities, 2005 (Bureau of Justice Statistics, U.S. Department of Justice, October 2008).

4 *See* David Lovell, L. Clark Johnson, & Kevin C. Cain, *Recidivism of Supermax Prisoners in Washington State*, 53 Crime Delinquency 633–56 (2007); David Lovell & Clark Johnson, Felony and Violent Recidivism Among Supermax Prison Inmates in Washington State: A Pilot Study (University of Washington, 2004), *available at* http://www.son.washington.edu/faculty/fac-page-files/Lovell-SupermaxRecidivism-4-19-04.pdf.

5 Daniel P. Mears, Evaluating the Effectiveness of Supermax Prisons (Urban Institute Justice Policy Center, 2005), *available at* http://www.urban.org/publications/411326.html.

6 *Id.*

7 Bruce A. Arrigo & Jennifer L. Bullock, *The Psychological Effects of Solitary Confinement on Prisoners in Supermax Units: Reviewing What We Know and Recommending What Should Change*, 52 Int'l J. Offender Therapy & Comp. Criminology 622–40 (2007).

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

9 *In re* Medley, 134 U.S. at 171.

10 Madrid v. Gomez, 889 F. Supp. 1146, 1228 (N.D.Cal. 1995).

11 Terry Kupers et al., *Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs*, 36 Crim. Just. & Behav. 1037–50 (2009).

12 *Id.*

13 *Id.*

FSR2401_15.indd 49 9/14/11 12:03:46 PM

Included in SCDC' 4.29.19 letter to LOC
This content downloaded from 149.101.37.2 on Thu, 4 Apr 2013 12:03:32 PM
All use subject to JSTOR Terms and Conditions

The effects of solitary confinement: Commentary on O*ne Year Longitudinal Study of the Psychological Effects of Administrative Segregation*

By Peter Scharff Smith

Abstract

Solitary confinement is a common practice in many prisons, but it has sparked debates and research on its effects on prisoners. This article examines a recent study on administrative segregation in Colorado in the context of relevant European research on the effects of solitary confinement

Key words: administrative segregation, solitary confinement

The use of large scale solitary confinement became common with the rise of the modern penitentiary during the first half of the 19th century and has remained a feature of Western prison systems. A debate about the effects of solitary confinement was largely settled early in the 20th century, when both experts and practitioners tended to agree that solitary confinement was harmful. Discussions on the effects of solitary confinement resurfaced in the 1950s and the following two decades when sensory deprivation studies were carried out in reaction to, among other things, stories of the brainwashing of U.S. prisoners of war during the Korean War. During the 1980s, solitary confinement regained topicality in the wake of the creation of supermax prisons in the United States. But solitary confinement has also been used, debated, and researched extensively elsewhere, As one example, solitary confinement has been an integral part of Scandinavian pre-trial prison practice for many years (Smith 2006). In 2010, the Colorado Department of Corrections and the Department of Psychology at the University of Colorado issued a new study on solitary confinement. In this article, I will discuss research on the effects of solitary confinement and make some comments on the Colorado study. (*Editor's note: All references to, or quotes from, the Colorado study are from O'Keefe et al., 2010.*)

Included in SCDC' 4.29.19 letter to LOC

Colorado Study

The Colorado study is longitudinal and mainly based on self-reported data. The battery of tests used in this study looks impressive and covers the various symptoms and health issues described in the earlier solitary confinement literature, such as anxiety, depression, and suicidal thinking. However, it is clearly important that all these tests were used without in-depth interviews being conducted, and that the self-reported data was not collected by a psychiatrist, a psychologist, or an experienced prison researcher. The main conclusion in the Colorado study was that the results "were largely inconsistent with (…) the bulk of literature that indicates AS is extremely detrimental to inmates." and that "there was initial improvement in psychological well-being across all study groups, with the bulk of the improvements occurring between the first and second testing periods." However "all of the study groups, with the exception of the GP NMI (general population, non-mentally ill) group, showed symptoms that were associated with the SHU (special housing unit) syndrome" (i.e. high degrees of psychological disturbance). In this article, I will discuss a number of issues that will help explain the apparent discrepancy between the Colorado study conclusions and the results gathered in other available research.

Why not use the available research?

The Colorado report begins with the claims that the debate on the use of long-term administrative segregation "has suffered from a lack of empirical research" and that "the scant empirical research conducted to date suffers from research bias and serious methodological flaws." This is a seriously misleading statement. The problem is not that relevant and rigorous empirical research does not exist, but that the authors of the Colorado report haven't used it. Much of this research is European, but it has been presented and reviewed in international journals, including U.S.-based journals (Smith, 2006 and Haney, 2009).

European studies on the effects of solitary confinement

A growing body of American research is clearly relevant to a discussion of solitary confinement and segregation regimes (see, for example, Lovell, 2008; Cloyes, Lovell, Allen, and Rhodes, 2006; Rhodes, 2004; and Haney, 2008). In the following, I will briefly review some of the European research, which seems to be less known to American readers. This research has not been carried out in supermax prisons in the U.S. (for European supermax research, see King, 2005 and Shalev, 2009) but it is, in fact, research on how prisoners react to being subjected to 22-23 hours of solitary confinement in their cell each day, so it is most certainly relevant. According to the Colorado study, the "defining feature" of administrative segregation in Colorado is single-cell confinement for 23 hours per day.

For various reasons, the use of pre-trial solitary confinement has historically been extensive in Sweden, Norway, and Denmark and has sparked intense debates and also research on the effects of solitary confinement, especially in Denmark and Norway (Smith 2006). In Norway, a 1993 longitudinal study of 63 isolated remand prisoners found widespread health problems after four weeks of solitary confinement, including depression, anxiety, stomach and muscle pains, and an inability to concentrate. The study excluded inmates with obvious withdrawal symptoms and those deemed at risk of suffering from a psychosis (Gamman 2001). A longitudinal follow-up in 1995 with a sample of 54 remand prisoners

Included in SCDC' 4.29.19 letter to LOC

included a control group and reported significantly more physical and psychological suffering, including sleeplessness, concentration problems, anxiety, and depression, among the prisoners in solitary confinement, who were also given much more medication than the control group (Gamman, 1995, 2001). The author of this study found that several of the isolated prisoners developed symptoms of a hallucinatory nature, that there were “important differences” between the health of those isolated and those not, and concluded that “the isolated had more symptoms of both psychological and somatic nature” (Gamman, 1995, p. 2245).

In terms of the prevalence of symptoms, 94 percent of those in pre-trial solitary confinement suffered from adverse symptoms after four weeks. More than half suffered from serious symptoms like depression and anxiety, and 13 percent had mutilated themselves (Gamman, 2001). In a third Norwegian study on disciplinary segregation, more than 43 percent of the isolated prisoners suffered adverse symptoms after only an average of 39.7 hours in solitary confinement (Stang et al., 2003).

In Denmark during the 1980’s and 90’s, extensive research on the effects of solitary confinement was carried out in the form of a number of interview-based studies as well as a so-called “isolation-study,” which was a large-scale longitudinal study consisting of a comprehensive psychiatric and psychological study (1994) and a follow-up study (1997), both with control groups. The Colorado report authors are not aware of some of the most important articles and results from these studies (Sestoft et al., 1998; Andersen, 2004; see also Smith, 2006), and furthermore do not fully incorporate the findings of the two related studies they actually list in their references. The Danish 1994 study involved 367 remand prisoners and reported a significantly higher rate of psychiatric problems among prisoners in isolation. A higher incidence of psychiatric morbidity – mainly adjustment disorders - was found among those in solitary confinement (28 percent) compared to those not in isolation (15 percent). The rate of psychiatric morbidity was highest (43 percent) among a third group of remand prisoners who had been in solitary confinement for more than two months (Andersen et al., 1994). A number of standardized instruments were used to measure health quantitatively. The scores for those in solitary (as a group) were unchanged throughout the isolation period, while those not in isolation “had a gradual improvement on most quantitative mental health scores during this early phase of imprisonment (Andersen, 2004, p. 39)” Those in solitary confinement experienced an improvement in health scores when the solitary confinement conditions were relieved (Andersen 2004). The researchers concluded that the differences between the isolated remand prisoners and the control group were caused “mainly by different conditions of SC and non-SC” (Andersen 2004, p. 39), and that pre-trial detention in isolation compared with pre-trial detention without isolation involved strain and risk of damaging the mental health of the imprisoned individuals (Andersen et al. 1994, 2000).

The 1994 study was longitudinal, incorporated both quantitative and qualitative elements, used standardized instruments to measure health, incorporated in-depth interviews, used highly-skilled researchers, included control groups and a very large number of prisoners in solitary confinement, produced statistically significant results, and verified their results through other objective data regarding the hospitalization of remand prisoners.

Still, the thoroughness of the study caused the research itself to constitute a significant intrusion into the lives of the study’s participants (Andersen, 2004). During the first three weeks of imprisonment those in solitary confinement were typically subjected to four or five days of intense interviews and testing (2–4

Included in SCDC' 4.29.19 letter to LOC

hours each day, not counting filling out questionnaires, having blood samples taken etc.). These remand prisoners were, in other words, effectively *not* in solitary confinement during those four or five days. This constituted around 20 to 25 percent of the period between the first test and the end of the second test round after approximately three weeks. This must have downgraded the measured differences between the isolated prisoners and the control group significantly, especially since the interviews constituted meaningful social contact in which the well-being and innermost thoughts of the imprisoned individual was in focus (Smith, 2006).

Given this issue, it is not surprising that the second part of the 1994 study - a survey of hospitalization among remand prisoners – gave even more clear-cut results. A sample of 124 remand prisoners who had been transferred to prison hospital revealed that, if "a person remained in SC [solitary confinement] for four weeks the likelihood of being admitted to the prison hospital for a psychiatric reason was about twenty times as high as for a person remanded in NSC [non-solitary confinement] for the same period of time" (Sestoft et al., 1998, p. 103).

A 1997 follow-up study was based on reports (questionnaires) from former participants in the original study, and illustrated how former remand prisoners in solitary confinement found their incarceration significantly more straining than did remand prisoners not in isolation. Thirty-eight percent of those in solitary confinement and 36 percent of those in long-term solitary found their remand imprisonment extraordinarily straining, as opposed to 12 percent of those not in solitary (Andersen et al., 1997). Furthermore, 23 percent of those in solitary confinement and 27 percent of those in long-term solitary reported that they experienced severe psychological reactions after their remand imprisonment, as opposed to nine percent of those not in solitary (Andersen et al.,1997). The authors concluded that from a medical and psychological perspective the practice of pre-trial solitary confinement should be abandoned (Andersen et al., 1997).

A Swiss study on the effects of solitary confinement documented a similar problem surrounding hospitalization of inmates in solitary confinement. The study sample consisted of 203 male patients in a psychiatric clinic in Zurich, of whom 102 were committed from a prison (76 percent of these came directly from solitary confinement). The study concluded that remand prisoners in solitary confinement were much more often hospitalized for psychiatric reasons than were prisoners who came from communal prison conditions (Volkart, Rothenfluth, et al., 1983).

Volkart and colleges also compared 30 prisoners in solitary confinement with a control group of 28 prisoners in communal imprisonment. The study was cross-sectional and incorporated no longitudinal data. Isolated inmates had spent an average of ninety-one days in solitary confinement while the control group had spent on average 326 days imprisoned. All participants had normal intelligence and their health and personalities were assessed through psychiatric questionnaires. The group of isolated inmates "showed considerably more psychopathological symptoms than the control group [and these] effects were mainly caused by solitary confinement; age, schooling, duration of detention and personality turned out to be of subordinate importance." (Volkart, Dittrich, et al. 1983, p. 44)

Included in SCDC' 4.29.19 letter to LOC

Social contact and contamination across groups

The available research, including the above-mentioned studies, demonstrates that solitary confinement "causes serious health problems for a significant number of inmates. The central harmful feature is that it reduces meaningful social contact to an absolute minimum: a level of social and psychological stimulus that many individuals will experience as insufficient to remain reasonably healthy and relatively well-functioning." (Smith, 2006, p.503)

This should be a starting point for further research on solitary confinement. Previous research does not show, for example, that the availability of television, radio, or newspapers, or even good material conditions of confinement, will offset the negative impact of solitary confinement on many prisoners, although access to such items and conditions can ameliorate any prison experience to a certain extent. But as the Colorado report concludes, the availability of modern technology, such as videoconferencing, is not always positive for the prisoners since "it also increases the degree of isolation experienced by inmates."

Therefore, it is unfortunate that the Colorado study does not explore this issue convincingly, i.e., measuring the relative level of psychologically meaningful social contact in administrative segregation (AS), punitive segregation, and general population (GP). If we look closer at the Colorado study it describes basic AS conditions as single-cell confinement for around 23 hours per day. In AS, prisoners are given five 1-hour recreation spells each week, as well as three 15-minute showers (although apparently inmates use less time for showers). Prisoners are escorted to recreation in "full-restraints." Depending on custody level, inmates are allowed either two 2-hour noncontact visits per month (Level 2) or four 3-hour visits per month (Level 3). Phone calls for those in the Colorado State Penitentiary apparently amounted to only a few minutes daily. If we look at both recreation, visits, and showers, an inmate on level 2 will apparently (assuming he receives visitors) stay at least around 23 hours in his cell on a daily basis, while those on level 3 get two more hours out of their cell on a weekly basis (once again assuming that they receive visits) – i.e. less than 20 minutes less cell time on a daily basis.

In addition to the above, there is some contact with mental health clinicians who do monthly rounds and occasional "mental health sessions" for one to two hours per week. Furthermore inmates in AS go through a "Quality of Life Program," which includes cognitive classes, but as far as I can see this does not result in increased social contact since these classes, along with some recreational activities, take place over the television.

Punitive segregation, where many inmates stayed prior to AS, is single-cell confinement for 23-24 hours per day, during which inmates only come out for recreation and showers in the living unit. So most inmates stay inside the segregation unit during their entire stay and are "placed in full-restraints" if escorted out of the cell. Inmates in punitive segregation are not allowed to work or participate in any programs or education, and do not have a television.

Descriptions of these conditions indicate that the amount of psychologically meaningful social contact is extremely scarce in both AS and punitive segregation, with the latter regime apparently allowing even less out-of-cell time and social contact. There is, however, one unclear factor. According to the Colorado

report, the inmates in AS can communicate with sign language and they can also yell to each other. Exactly how much and what kind of contact this results in is not described. Furthermore, GP conditions are not described along with the amount of social contact allowed under that regime.

Basically, it is somewhat unclear in the Colorado study how much meaningful social contact inmates in AS had access to during the study. AS conditions suggest that they had very limited access to such contact, although it is not entirely clear what level of communication was allowed through yelling and sign language, where especially the former might potentially yield some level of meaningful contact. Furthermore, it is unclear how much staff contact inmates have, although it is seemingly not a lot.

To confuse matters even more, there was "contamination across groups" meaning that "all offenders in AS were not confined in segregation for their entire period of participation in the study" and inmates in GP may "at some time during their study participation [have] been placed in punitive segregation or even AS." In fact, when looking at "pure cases" of continuous AS, there were only 26 among the mentally ill and 39 among the non mentally ill, and even more alarming, there were only 13 "pure cases" of continuous GP prison time among the mentally ill GP control group (GP-MI) and 11 "pure cases" of continuous GP prison time among the non mentally ill GP control group (GP-NMI). This means that out of the 33 GP-MI and 43 GP-NMI who participated in the study (some of which later dropped out) only 13 GP-MI and 11 GP-NMI spent their entire study time in GP conditions. So the GP control group was not really a GP control group at all since the majority of these experienced either AS or punitive segregation during their participation in the study, and in addition most – perhaps all – experienced AS immediately prior to their AS hearing, after which they went into GP.

The Colorado researchers looked at their "pure cases" and found no major differences between these and other GP inmates. Then, they disregarded the problem, although such a finding questions the validity of their self-reported data and the setup of the entire study. Under all circumstances, the Colorado study is in fact *not* a study comparing segregation/solitary confinement with non-segregation/solitary confinement, since most of the GP inmates experienced solitary confinement during the study.

Equally important are uncertainties surrounding the levels of meaningful contact the study participants had prior to the start of the study. It is unclear how many participants came from solitary confinement when they entered AS or how much time they spent under such conditions before their initial tests. If some came directly from GP conditions to AS, then it is a problem that we do not know what that means in terms of a change in the level of available, meaningful social contact. We do know that some inmates – although not how many - came directly from punitive segregation and given the way these conditions are described in the Colorado study it seems likely that these inmates experienced better conditions with more meaningful contact when they entered AS. In that case, it is hardly surprising that the study found positive developments between the first and second testing of the inmates.

Were the study participants harmed by solitary confinement prior to the study?

The mental health of the Colorado inmates when they entered AS is very important, as are the conditions they arrived from prior to the start of the study. Needless to say, it puts the Colorado study in different light if many participants were actually in segregation prior to the start of the study. Unfortunately, the Colorado study is somewhat unclear about this.

Included in SCDC' 4.29.19 letter to LOC

The Colorado report states that “all study participants classified to AS were waitlisted for and placed in CSP,” which as far as I understand means that they were living in AS conditions when waiting for their AS hearing. The introduction to the report says something slightly different, however, when it states that “in the time leading up to and during their AS hearing, inmates have typically been in segregation.” So some prisoners were apparently not in segregation? The Colorado authors “recognized that significant changes could occur while inmates were held in segregation at their originating facility.” Therefore, they collected a pre-baseline measure “as close to the AS hearing as possible.”

In order to use the study to discuss the effects of solitary confinement, we need to know exactly how many were in segregation prior to the study and, even more importantly, we need to know for how long those subjected to a pre-baseline measure had been in segregation before they were subjected to the pre-baseline measure. This information is crucial and seems lacking in the report. All we are told is that pre-baseline measures were collected “as close to the AS hearing as possible.” But what does this mean in practice? The question, of course, involves the extent to which participants were possibly affected by solitary confinement prior to the start of the study. This is important since we know from other research that reactions to solitary confinement vary from one individual to another, but they “often set in very quickly.” (Thelle & Traeholt, 2003, p.769)

The Colorado report concludes that “all of the study groups, with the exception of the GP-NMI group, showed symptoms that were associated with the SHU syndrome. These elevations were present from the start and were more serious for the mentally ill than non-mentally ill.” So if many study participants had been subjected to segregation prior to the study that would likely explain their symptoms. In other words, the study participants were already damaged by solitary confinement when the study began, and the Colorado study shows us that these prisoners continued to show “symptoms that were associated with the SHU syndrome” during their time in AS.

Furthermore, positive developments between the first and second test could be explained by the transfer from punitive segregation conditions to apparently better AS conditions, which include a more meaningful form of social contact (visits). Seen in this light, the results of the Colorado study are in line with previous research. The AS inmates in Colorado got slightly better when they had access to slightly more meaningful social contact, but they remained in a very bad condition, and continued to show symptoms, as they stayed in solitary confinement.

How was the self-reported data obtained?

According to the Colorado study, all the self-reported data were collected by one field researcher who was a female university employee with CDOC training and badge that allowed her unescorted access to the prison facilities. The field researcher had an undergraduate degree and is not the responsible author. This is a very big difference in contrast to Danish and Norwegian studies, where the actual researchers who designed the studies and wrote the reports were trained psychiatrists and psychologists and also operated as field researchers. They accessed the health of the study participants themselves and did the in-depth interviews. In my opinion, this is the only serious and professional way to design and conduct a study about health in prison, which includes obtaining data directly from prisoners. Sending a “researcher” who is neither a health practitioner nor a PhD-level researcher with experience doing prison research, into a prison in order to access the health of prisoners by collecting self-reported data simply means that the

data are likely to be unreliable. That the field researcher had to report to an employee of the prison system studied (the leading author of the report) is also problematic.

The Colorado report itself describes instances in which the self-reported data appeared questionable. When this occurred, the field researcher apparently asked prisoners to retake the test if they admitted to "not being truthful." If study participants said they were being honest and the researcher still did not believe them, she "marked the test as questionable." This validation process seems outright naive. On what grounds did the university's inexperienced field researcher assess whether or not the prisoners were "being truthful" about their psychological problems and mental health? This obviously requires education, experience, and psychological or medical knowledge. Seen in this light, it is interesting to note that when the Colorado study authors removed persons "with questionable or inconsistent responses" it "did not change the overall effects and results" so they used all the responses in their analysis. This raises serious questions about the field researcher's capacity to assess whether or not the prisoners were 'truthful' and, once again, raises questions about the reliability of all of the self-reported data.

Professional researchers report that it can be difficult to learn about symptoms suffered by isolated inmates since many (male prisoners in particular) try to hide their condition (Smith, 2006). Researchers also explain that it is often extremely difficult, traumatic, and painful for formerly isolated individuals to talk about their experience of solitary confinement: "A few studies seem to explain the fact that some inmates do not complain and seem to adapt more or less peacefully to solitary confinement as a sign of a healthy coping strategy, while others explain this as an unhealthy sign of social withdrawal typically accompanied by severe psychological problems. Such problems often will be discovered only by personal in-depth interviews in a positive (therapeutic) atmosphere." (Smith, 2006, p. 474; see also Koch, 1982; Toch, 1992; Jackson, 1983)

King, who has interviewed many supermax prisoners, observes that a significant number of these prisoners "found it extremely difficult to bring themselves to talk about their experience" and only after "considerable persistence some prisoners came to regard a researcher from another culture, who treated them with respect and clearly wanted to learn, as an acceptable proxy and began to open up." (King, 2005, p.130)

Furthermore, the study authors made a mistake by advising inmates that "the purpose of the study was to learn about their adjustment to prison." It is well known that within a prison community it is important for prisoners to seem capable of adjusting to prison, and those who do not manage to do this are typically placed at the bottom of the prison hierarchy. Approaching study participants with an overall question regarding "their adjustment to prison" in other words makes it likely that they will try to hide possible weaknesses and try to convey the impression that they cope and adjust relatively well. In a prison context, it is not an "open" but a "leading" question.

Included in SCDC' 4.29.19 letter to LOC

Crisis events, hospitalization, and objective data

The Colorado researchers describe initial attempts to include “crisis events” such as self-mutilation or suicide attempts recorded by prison clinicians in their study, but they decided not to, because the number of participants who experienced these events allegedly was too small and because crisis events could occur without staff’s knowledge. The authors conclude that the available data “raise more questions than they provide answers.” If we look carefully at these data, however, they certainly raise some questions.

If we compare the number of crisis events among the mentally ill in GP and in AS, we find that throughout the study two persons had two crisis events in the former group, while 10 persons had 26 crisis events in the latter group (one suicide attempt, 14 cases of suicidal/self harm ideation, and 11 cases of self harming behavior). This seems a significant difference with respect to important behaviors that have been identified in past research as among the adverse effects of solitary confinement. The numbers are small, but, still, five times as many prisoners in the AS-MI group had crisis events compared to the GP-MI group, and 13 times as many crisis events occurred in the AS-MI group compared to the GP-MI group. Furthermore, 11 crisis events in the AS-MI group were associated with psychotic symptoms compared to one such crisis event in the GP-MI group.

These data are important in two ways. They suggest that solitary confinement had a negative impact on the health of the mentally ill, but also, even more importantly, they seriously question the reliability of the study’s self-reported data. These crisis event data raise questions about why the difference among the AS-MI and GP-MI groups was not found through the self-reported data. After all, a significant number of participants in the AS-MI group had crisis events and the prevalence of these events were much higher than in the GP-MI group. Furthermore, such crisis events would normally be considered “the tip of the iceberg.” A likely hypothesis would be that a prison environment producing significantly more self-harm and suicidal thoughts than other prison regimes would also reveal many more “lesser” psychological problems. One cannot help asking how and why the Colorado researchers chose to ignore this data, which in fact questions the entire setup of their study?

Conclusion

The Colorado study suffers from several major problems. First, some of the most relevant research available was not used and it was wrongfully claimed that previous research was biased and flawed. Secondly, the way the self-reported data was collected very likely made these data unreliable. Thirdly, the study authors ignored that their crisis data seriously questioned the validity of their self-reported data and in fact suggested that AS might have serious ill effects. Fourth, the majority of the study participants apparently came directly from segregation, and were thus likely to be harmed from solitary confinement before the study started. Finally, the Colorado study in fact did not compare segregation/solitary confinement with non-segregation/solitary confinement since most of the GP participants also went into solitary confinement during the study. Imagine a similar situation with, for example, medical research on the effects of a new type of medicine where it turns out that most of the control group participants also received the new medicine being tested both during the study and prior to study start. It does not make sense. It is therefore extremely difficult to gain any valuable information about the effects of AS and solitary confinement from the Colorado Study.

Included in SCDC' 4.29.19 letter to LOC

Author note: *Peter Scharff Smith, Ph.D., has studied the history, practice, and effects of solitary confinement for more than a decade, Currently a Senior Research Fellow at the Danish Institute of Human Rights, his published articles on solitary confinement have appeared in, for example,* ***Crime and Justice****,* ***Criminal Justice & Behavior****,* ***Torture****, and* ***Punishment & Society****. Email: pss@humanrights.dk.*

References

Andersen, H.S. 2004. "Mental Health in Prison Populations: A Review – with Special Emphasis on a Study of Danish Prisoners on Remand." *Acta Psychiatrica Scandinavica Supplementum* 110(424):5-59.

Andersen, Henrik Steen, Dorte Sestoft, Tommy Lillebæk, Gorm Gabrielsen, and R. Hemmingsen. 2003. "A Longitudinal Study of Prisoners on Remand: Repeated Measures of Psychopathology in the Initial Phase of Solitary versus Nonsolitary Confinement." *International Journal of Law and Psychiatry,* 26, 165–77.

Andersen, Henrik Steen, Dorte Sestoft, Tommy Lillebæk, Gorm Gabrielsen, R. Hemmingsen, and P. Kramp. 2000. "A Longitudinal Study of Prisoners on Remand: Psychiatric Prevalence, Incidence and Psychopathology in Solitary versus Non-solitary Confinement." *Acta Psychiatrica Scandinavica,* 102(1):19–25.

Andersen, Henrik Steen, Tommy Lillebæk, and Dorte Sestoft. 1997. *Efterundersøgelsen - en opfølgningsundersøgelse af danske varetoegtsarrestanter*. Copenhagen: Schultz.

Andersen, Henrik Steen, Tommy Lillebæk, Dorte Sestoft, and Gorm Gabrielsen. 1994. *Isolationsundersøgelsen: Varetoegtsfængsling og psykisk helbred.* Vols. 1–2. Copenhagen: Schultz.

Cloyes, K., Lovell, D., Allen, D., and Rhodes, L. 2006. "Assessment of Psychosocial Impairment in a Supermaximum Security Unit Sample." *Criminal Justice and Behavior,* 33, 760.

Gamman, Tor. 2001. "Om bruk av isolasjon under varetektsfengsling." *Nordisk Tidsskrift for Kriminalvidenskab* 88:42–50.

Gamman, Tor. 1995. "Uheldige helsemessige effekter av isolasjon. En klinisk studie av to grupper av varetektsinnsatte." *Tidsskrift for den norske Loegeforening,* 115:2243–46.

Haney, C.. 2009. "The Social Psychology of Isolation: Why Solitary Confinement is Psychologically Harmful." *Prison Service Journal*, 181, 12-20.

Haney, C.. 2008. "A Culture of Harm: Taming the Dynamics of Cruelty in Supermax Prisons." *Criminal Justice and Behavior*, *35*, 956-984.

Included in SCDC' 4.29.19 letter to LOC

Jackson, Michael. 1983. *Prisoners of Isolation: Solitary Confinement in Canada*. Toronto: University of Toronto Press.

King, Roy D. 2005. “The Effects of Supermax Custody.” In Liebling and Maruna, eds. *The Effects of Imprisonment.* Portland, OR: Willan Publishing.

Koch, Ida E. 1982. “Isolationens psykiske og sociale følgevirkninger.” *Månedsskrift for Praktisk Lægegerning* 60(June):369–32.

Lovell, David. 2008. “Patterns of Disturbed Behavior in a Supermax Population.” *Criminal Justice and Behavior,* 35, 985.

O’Keefe, M.L., K.J. Klebe, A. Stucker, K. Strum, and W. Leggett. 2010. *One Year Longitudinal Study of the Psychological Effects of Administrative Segregation*. Colorado Springs, CO: Colorado Department of Corrections.

Sestoft, Dorte Maria, Henrik Steen Andersen, Tommy Lillebæk, and Gorm Gabrielsen 1998. “Impact of Solitary Confinement on Hospitalization among Danish Prisoners in Custody.” *International Journal of Law and Psychiatry* 21:99-108.

Shalev, Sharon. 2009. *Supermax: Controlling Risk through Solitary Confinement*, Portland, OR: Willan Publishing.

Smith, Peter S. 2006. “The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature.” In Michael Tonry, ed. *Crime and Justice*, 34, 441-528.

Stang, Jan, Jens Moe, Inge Arne Teigset, Bjørn Østberg, and Tron Anders Moger. 2003. “Fanger i sikkerhetscelle - en utfordring.” *Tidsskrift for Den norske Lægeforening.* 123(13–14):1844–46.

Thelle, Hatla, and Anne-Marie Traeholt. 2003. “Protection of Suspects’ Rights versus Investigation Needs: The Use of Solitary Confinement in Denmark.” In *How to Eradicate Torture: A Sino-Danish Joint Research on the Prevention of Torture*, edited by Morten Kjærum, Xia Yong, Hatla Thelle, and Bixiaoqing. Beijing: Social Sciences Documentation Publishing House.

Toch, Hans. 1992. *Mosaic of Despair: Human Breakdowns in Prison*. Princeton, NJ: Princeton University Press.

Volkart, Reto, A. Dittrich, T. Rothenfluth, and W. Paul. 1983. “Eine kontrollierte Untersuchung über psychopathologische Effekte der Einzelhaft.” *Schweizerische Zeitschrift fu¨ r Psychologie und ihre Anwendungen,* 42:25–46.

Volkart, Reto, Thomas Rothenfluth, Erner Kobelt, Adolf Dittrich, and Klaus Ernst. 1983. “Einzelhaft als Risikofaktor für psychiatrische Hospitalisierung.” *Psychiatrica Clinica,* 16:365–77.

Included in SCDC' 4.29.19 letter to LOC

ASSOCIATION OF STATE CORRECTIONAL ADMINISTRATORS

Executive Committee
President, John Wetzel
Vice President, Colette Peters
Treasurer, Anne Precythe
Past President, Leann Bertsch

Regional Representatives
Northeast, Scott Semple
Southern, Jefferson Dunn
Midwest, Heidi Washington
Western, Rick Raemisch

Embargoed until October 10, 2018 at 9 am

Reforming Restrictive Housing 2018: Prison Systems Trying to Reduce Numbers in 'Solitary Confinement'

Two new reports by the Association of State Correctional Administrators (ASCA) and the Liman Center at Yale Law School find that prison directors around the country are aiming to limit the use of what they call "restrictive housing" and what is generally known as solitary confinement. Once, prison administrators viewed isolating individuals as the solution to prison security. Now, they see it as a problem to be solved.

The 2018 Reports provide the only comprehensive, current national data on the number of prisoners in restrictive housing and the length of time they spend there. Because ASCA-Liman has done a series of these surveys, the impact of changing policies can be seen through the new numbers. The 2014 ASCA-Liman survey estimated that 80,000 to 100,000 prisoners were in segregation. The 2016 Report pegged the number at about 68,000 people. As of the fall of 2017, about 61,000 prisoners were in isolation across the country.

In the aggregate, from the 43 prison systems providing data on 1,087,671 prisoners, we totaled 49,197 individuals—or 4.5%—that were confined in cells 22 hours per day for 15 continuous days or more. But in one state, almost no prisoners were in those conditions. In contrast, in other states, more than a tenth of their prisoners were in segregation.

How are some prison directors getting the numbers down? Several systems no longer put prisoners in restrictive housing for minor rule violations. Prison administrators have also increased oversight, so that decisions to keep prisoners in isolation require high-level approval. And many states are implementing new standards from the American Correctional Association that prohibit putting juveniles into restrictive housing and limit its use for pregnant women and seriously mentally ill prisoners.

In *Reforming Restrictive Housing: The 2018 ASCA-Liman Nationwide Survey of Time-in-Cell* and the related report, *Working to Limit Restrictive Housing: Efforts in Four Jurisdictions to Make Changes*, the directors of prison systems in Colorado, Idaho, Ohio, and North Dakota detail how they are making changes to or abolishing solitary confinement. But the picture is not uniform. In more than two dozen states, the numbers of prisoners in restrictive housing decreased from 2016 to 2018, but in eleven states, the numbers went up.

Two areas of special concern are the impact of mental illness and the length of time individuals spend in restrictive housing. States have a variety of definitions for serious mental illness. Using their own descriptions, jurisdictions counted more than 4,000 prisoners identified as seriously mentally ill and in restrictive housing. Not all correctional systems track how long prisoners remain in restrictive housing. Thirty-six jurisdictions reported on 41,000 prisoners in segregation; 80% were held for a year or less. At the other end of the spectrum, almost 2,000 were held for more than six years.

To learn more about these two reports read *Reforming Restrictive Housing* and *Working to Limit Restrictive Housing* or contact Kevin Kempf, kkempf@asca.net; Wayne Choinski, wchoinski@asca.net; Judith Resnik, judith.resnik@yale.edu; Anna Van Cleave, anna.van.cleave@yale.edu; Ali Harrington, alexandra.harrington@yale.edu.

Included in SCDC' 4.29.19 letter to LOC

Rethinking Death Row:
Variations in the Housing of Individuals Sentenced to Death

The Arthur Liman Public Interest Program
Yale Law School

July 2016

Included in SCDC' 4.29.19 letter to LOC

Rethinking "Death Row":

Variations in the Housing of Individuals Sentenced to Death

The Arthur Liman Public Interest Program
Yale Law School

July 2016

Included in SCDC' 4.29.19 letter to LOC

The Arthur Liman Public Interest Program, Yale Law School, New Haven, CT

The Arthur Liman Public Interest Program was endowed to honor one of Yale Law School's most accomplished graduates, Arthur Liman, who graduated in 1957 and who personified the ideal of commitment to the public interest. Throughout his distinguished career, he demonstrated how dedicated lawyers, in both private practice and public life, can serve the needs of people and causes that might otherwise go unrepresented. The Liman Program was created in 1997 to forward the commitments of Arthur Liman as an exemplary lawyer dedicated to public service in the furtherance of justice.

Inquiries:
Judith.Resnik@yale.edu
Yale Law School
PO Box 208215,
New Haven, CT 06520-8215
Courier: 127 Wall Street
New Haven, CT 06511

Acknowledgements

The primary authors of this Report are Celina Aldape, Ryan Cooper, Katie Haas, April Hu, Jessica Hunter, and Shelle Shimizu, Yale Law School students participating in this Liman Project from 2014 to 2016 and working under the supervision of Johanna Kalb, Visiting Associate Professor of Law and Director, Arthur Liman Public Interest Program, and Judith Resnik, Arthur Liman Professor of Law. This project has been generously supported by Yale Law School, the Liman Program, the Vital Projects Fund, and the Oscar M. Ruebhausen Fund at Yale Law School.

To download copies of this Report, please visit the website of the Liman Program at https://www.law.yale.edu/centers-workshops/arthur-liman-public-interest-program/liman-publications. This Report may be downloaded and reproduced free of charge and without the need for additional permission. All rights reserved, 2016.

Included in SCDC' 4.29.19 letter to LOC

Rethinking "Death Row":

Variations in the Housing of Individuals Sentenced to Death[1]

In 2015, individuals sentenced to death in the United States were housed in varying degrees of isolation. Many people were kept apart from others in profoundly isolating conditions, while others were housed with each other or with the general prison population. Given the growing awareness of the debilitating effects of long-term isolation, the placement of death-sentenced prisoners on what is colloquially known as "death row" has become the subject of discussion, controversy, and litigation.

This Report, written under the auspices of the Arthur Liman Public Interest Program at Yale Law School, examines the legal parameters of death row housing to learn whether correctional administrators have discretion in deciding how to house death-sentenced individuals and to document the choices made in three jurisdictions where death-sentenced prisoners are not kept in isolation. Part I details the statutes, regulations, and policies that govern the housing of those sentenced to death and reviews prior research on the housing conditions of death-sentenced prisoners. Part II presents an overview of decisions in three states, North Carolina, Missouri, and Colorado, where correctional administrators enable death-sentenced prisoners to have meaningful opportunities to interact with others. Given the discretion that correctional officials have over housing arrangements, these states provide models to house capital-sentenced prisoners without placing them in solitary confinement.

Included in SCDC' 4.29.19 letter to LOC

Table of Contents

I. A Nationwide Look at Discretion in "Death Row" Housing 3

A. Laws Governing Isolation of Death-Sentenced Prisoners 4

1. Placement in Isolation or Segregation 4

2. Visiting and Time Out-of-Cell 5

B. Policies Governing Isolation of Death-Sentenced Prisoners 6

C. Prior Research Regarding Death-Sentenced Prisoner Housing 7

II. Housing Arrangements for Death-Sentenced Prisoners in North Carolina, Missouri, and Colorado 8

A. North Carolina 9

B. Missouri 11

C. Colorado 14

III. Looking Forward 17

Appendix A: Table of Statutes, Administrative Regulations and Case Law by Jurisdiction

Included in SCDC' 4.29.19 letter to LOC

In 2015, nearly 3,000 death-sentenced prisoners were incarcerated in state and federal facilities in the United States.[2] Most were housed in some form of isolation. A growing body of research documents the harms of long-term isolation on prisoners' mental and physical health, and correlates isolation with increased violence in prison.[3] Further, prison administrators report the challenges and costs of staffing isolation units.[4] Proposals for reducing the use of isolating conditions in prison have been put forth by the executive branch of the federal government,[5] by state correctional leaders,[6] and by the legislative branches of the federal[7] and state governments.[8] Detention of juveniles in solitary has been a specific source of concern. In 2016, both the Colorado legislature and the Los Angeles County Board of Supervisors enacted provisions banning the use of isolation for juveniles, defined in Colorado as individuals under the age of 21,[9] and in Los Angeles as individuals younger than 18.[10] Lawsuits have successfully challenged isolating conditions – resulting in consent decrees to limit the use of isolation either for all prisoners[11] or for subpopulations, such as the seriously mentally ill and juveniles.[12] Reports and articles document the harms of such isolating confinement and analyze its legal parameters.[13]

These concerns raise questions – in terms of both practices and as a matter of law – about the use of long-term isolation for a specific set of prisoners, those serving capital sentences and often housed on what is colloquially known as "death row." A few prior reports have surveyed conditions; for example, in 2013, the American Civil Liberties Union (ACLU) detailed the severity of isolation experienced by death-sentenced prisoners and criticized the practice of imposing long-term isolation as an automatic consequence of death sentences.[14]

Lawsuits challenging the practice have also been filed. In 2012, Alfred Prieto, a death-row prisoner in Virginia, argued that automatic segregation violated his constitutional right to an individualized decision about the need for placement in isolation. A trial-level judge agreed[15] but on appeal, the Fourth Circuit reversed. The court held (over a dissent) that because all death-sentenced prisoners in Virginia were subjected to the same treatment, Mr. Prieto's isolation was not "atypical" and therefore he had no liberty interest protected by the Due Process Clause in avoiding such confinement.[16] Although U.S. Supreme Court review was sought, after Mr. Prieto was executed[17] his petition for certiorari was dismissed as moot.[18]

More generally, members of the U.S. Supreme Court have questioned the constitutionality of profound isolation.[19] In June 2015, Justice Kennedy raised the issue when concurring in the reversal of a grant of habeas corpus relief obtained by Hector Ayala, who had been sentenced to death. Justice Kennedy wrote that in all likelihood, Mr. Ayala would have spent "the great majority of his more than 25 years in custody in 'administrative segregation' or, as it is better known, solitary confinement."[20] Justice Kennedy explained that, if following "the usual pattern," the prisoner had likely been held "in a windowless cell no larger than a typical parking spot for 23 hours a day; and in the one hour when he leaves it, he likely is allowed little or no opportunity for conversation or interaction with anyone."[21] Justice Kennedy drew attention to the "human toll wrought by extended terms of isolation," and called for change through more "public inquiry;" through judicial discussion of the harms; and, in an appropriate case, through decisions by judges about "whether workable alternative systems for long-term confinement exist, and, if so, whether a correctional system should be required to adopt them."[22]

Included in SCDC' 4.29.19 letter to LOC

The isolation of prisoners is also the subject of case law in many jurisdictions and of international concern. The European Court of Human Rights has concluded that the Convention on Human Rights imposes limits on isolating conditions,[23] and research in Great Britain detailed the injuries of what it termed "deep custody."[24] International standards also address isolation. In 2015, the United Nations Commission on Crime Prevention and Criminal Justice met to revise its standards for the treatment of prisoners. The result are the Standard Minimum Rules for the Treatment of Prisoners (known as the "Nelson Mandela Rules"), which were adopted by the U.N. General Assembly in 2015.[25]

These rules define "solitary confinement" to be "confinement of prisoners for 22 hours or more a day without meaningful human contact;" "[p]rolonged solitary confinement" is "solitary confinement for a time period in excess of 15 consecutive days."[26] The Mandela Rules state that, "[i]n no circumstances may restrictions or disciplinary sanctions amount to torture or other cruel, inhuman or degrading treatment or punishment." The Mandela Rules provide specific "practices, in particular" that "shall be prohibited;" included are "[i]ndefinite solitary confinement;" and "[p]rolonged solitary confinement."[27] Moreover, the Rules state that "[s]olitary confinement shall be used only in exceptional cases as a last resort, for as short a time as possible and subject to independent review, and only pursuant to the authorization by a competent authority," and "shall not be imposed by virtue of a prisoner's sentence."[28] In addition, "solitary confinement should be prohibited in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures" as well as for "women and children."[29]

This Liman Report contributes to this discussion by providing an analysis of the statutory, administrative, and procedural rules governing the housing of death-sentenced prisoners in the United States; by summarizing past research on conditions for death-sentenced prisoners; and by offering a detailed account from correctional administrators in three states who have chosen to use their discretion not to put individuals sentenced to death in isolation. Part I provides both an overview of the legal parameters governing the housing of death-sentenced individuals in the thirty-five jurisdictions that had such prisoners in 2015,[30] and a review of prior research on housing conditions of death-sentenced individuals. After examining statutes, administrative codes, and available department of correction policies in those jurisdictions, we learned that correctional officials have substantial discretion to decide how to house death-sentenced prisoners. An appendix provides the legal rules and policies of each jurisdiction.

Part II summarizes interviews conducted in the spring of 2015 with correctional administrators in three jurisdictions – North Carolina, Missouri, and Colorado – that permitted death-sentenced prisoners some degree of direct contact with each other or the general prison population. Specifically, as of 2015:

> **North Carolina** housed 156 death-sentenced prisoners, separated them from the general population, but afforded them similar access to resources and programs as other prisoners. Death-sentenced prisoners were able to spend sixteen hours each day in a common room and were permitted to exercise and dine in groups.

Included in SCDC' 4.29.19 letter to LOC

> **Missouri** housed 28 death-sentenced prisoners, integrated them into the general population of a maximum-security prison. Death-sentenced prisoners shared cells with other prisoners and had all the same privileges and opportunities as those who had not been sentenced to death.
>
> **Colorado**, which confined 3 death-sentenced prisoners, placed them in a designated unit together with other prisoners classified as in need of increased supervision. All prisoners housed in the unit had access to a common room in small groups for at least four hours each day; death-sentenced individuals had most of the opportunities available to other prisoners in the unit.

A central finding of this Report is that prison officials have many options when determining the housing of individuals sentenced to death. Our hope is that this Report will provide models for lessening the isolation of death-sentenced individuals and invite innovations in the housing arrangements for all prisoners.

I. A Nationwide Look at Discretion in "Death Row" Housing

As of 2015, thirty-five jurisdictions (thirty-four states and the federal government) housed death-sentenced prisoners. These thirty-five jurisdictions varied widely in the number of death-sentenced prisoners in custody. As of the fall of 2015, California had the largest number – 745. Both Wyoming and New Hampshire each housed one person sentenced to death.[31]

We searched the statutes and administrative codes of these jurisdictions to identify materials governing death-sentenced prisoners.[32] Such provisions may be found in a jurisdiction's criminal laws, capital sentencing provisions, or rules governing the execution of death sentences. We also reviewed case law discussing housing for death-sentenced prisoners.

We sought to learn about whether laws addressed single-celling; hours in cell; participation in groups for meals, recreation, and programming; contact with other death-sentenced prisoners, the general population, visitors, or prison staff; access to books, television, or other media; and opportunities, if any, for periodic reviews of and changes in housing. As we detail below, many of these topics were not the subject of statutes, regulations, and administrative policies. A summary of this research is compiled in Appendix A.

We also researched policies adopted by state and federal corrections departments to govern the housing of death-sentenced prisoners. We consulted the publicly available policy and procedure manuals for each jurisdiction's department of corrections, and supplemented our findings with secondary sources, such as law review articles and newspaper reports.

Further, we sought to learn about prior resources on the housing of people serving capital sentences. Below, we summarize four surveys that included information on housing practices for death-sentenced prisoners: a 2013 survey by the ACLU; a 2014 survey by the Association of State Correctional Administrators (ASCA) and the Liman Program at Yale Law School; a 2013 survey by ASCA; and a 2008 survey that was prepared by Professor Sandra Babcock for the

Included in SCDC' 4.29.19 letter to LOC

Death Penalty Information Center. The surveys all reported high degrees of isolation for death-sentenced prisoners.

To preview what follows, this review of statutes and regulations documents that most jurisdictions do not require isolation of death-sentenced prisoners and leave correctional officials substantial discretion to determine housing conditions. Many correctional departments' policies impose isolation; the four surveys further document how profoundly isolating the conditions have been for many prisoners. In contrast, in a few jurisdictions, correctional officials have published policies describing the placement of death-sentenced prisoners in less restrictive housing conditions.

A. Laws Governing Isolation of Death-Sentenced Prisoners

1. Placement in Isolation or Segregation

In nineteen of the thirty-five jurisdictions with death-sentenced prisoners, statutes and regulations specifically address death-sentenced prisoner housing. Seventeen states do so by statute,[33] and four of those seventeen also address housing in regulations.[34] Two (Florida and Ohio) do so by regulation.[35] A compilation of relevant statutes, regulations and policies is included in Appendix A.

In three states – Idaho, Pennsylvania and Wyoming – statutes require, but do not define, "solitary confinement" for death-sentenced prisoners.[36] Idaho's statute states, "Whenever a person is under death warrant, execution of which has not been stayed, the warden of the prison in which the person is incarcerated shall keep the condemned person in solitary confinement until execution."[37] Pennsylvania's statute provides, "Upon receipt of the warrant, the secretary shall, until infliction of the death penalty or until lawful discharge from custody, keep the inmate in solitary confinement."[38] The Wyoming statute states that a death-sentenced prisoner shall be kept "in solitary confinement until execution of the death penalty . . . ."[39]

Three state statutes – Washington, Texas and Florida – reference single cells. Washington's statute provides that a death-sentenced prisoner "shall be confined in the segregation unit, where the defendant may be confined with other prisoners not under sentence of death, but prisoners under sentence of death shall be assigned to single-person cells."[40] Texas's governing statute calls for prisoners confined in "death row segregation" to be held "in single occupancy cells."[41] Florida's administrative regulations require "single-cell special housing . . . of an inmate who, upon conviction or adjudication of guilt of a capital felony, has been sentenced to death . . . ."[42]

Florida, South Dakota, and Texas call for death-sentenced prisoners to be segregated from the general prison population, although not necessarily from each other. The governing regulation in Florida provides, "Death row housing shall be separate from general population housing."[43] South Dakota's statute directs that death-sentenced individuals "shall be segregated from other inmates at the penitentiary."[44] In a general provision not limited to death-sentenced prisoners, Texas states that institutions "may not house inmates with different custody classifications in the same cellblock or dormitory unless the structure of the cellblock or dormitory allows the physical separation of the different classifications of inmates."[45]

Included in SCDC' 4.29.19 letter to LOC

Administrative regulations in Oregon and Ohio reference “death row.” Oregon regulations state: “It is the policy of the Department of Corrections to assign inmates with a sentence of death to the Death Row Housing Unit or to a Death Row status cell.”[46] Ohio’s regulations provide both that prisoners sentenced to death “may be assigned to an area of the institution . . . which area shall be known as ‘death row’” (and that “absent significant extenuating circumstances, no inmate shall be assigned to or housed in death row unless that inmate has been sentenced to death . . .”),[47] as well as that correctional officials “may assign or reassign an inmate who has been sentenced to death to a security classification or special management status other than that which is normally used for such inmates, based on the security or medical and mental health requirements for the inmate.”[48]

Connecticut has legislation crafted in 2012 when the state legislature abolished the death penalty. In lieu of the death penalty, the statute created a new category, “murder with special circumstances,” and specified certain conditions of confinement for individuals convicted under the statute.[49] The Connecticut statute states that the Commissioner of Correction place “special circumstances” inmates in administrative segregation until reclassification.[50]

In Alabama, California, Colorado, and New Hampshire, statutes name specific institutions at which death-sentenced individuals are to be housed.[51] Alabama directs death-sentenced prisoners to the “William C. Holman unit of the prison system at Atmore”;[52] California references San Quentin State Prison;[53] Colorado directs prisoners to the “correctional facilities at Canon City” after a death warrant is delivered;[54] and New Hampshire names the “state prison at Concord.”[55]

In a few jurisdictions, statutes expressly state that corrections officials have discretion when making decisions on housing death-sentenced prisoners. For example, Louisiana’s statute directs the Department of Public Safety and Corrections “to incarcerate the offender in a manner affording maximum protection to the general public, the employees of the department, and the security of the institution.”[56]

In sum, most jurisdictions do not have statutes mandating segregation, isolation, or other particulars related to the housing conditions provided to death-sentenced prisoners.

2. Visiting and Time Out-of-Cell

Some jurisdictions discuss visiting and out-of-cell time for death-sentenced prisoners. Colorado, Idaho, South Dakota, and Wyoming all state that a death-sentenced prisoner should be permitted visits with his lawyer, spiritual adviser, and family.[57] Under Colorado’s statute, prison “rules shall provide, at a minimum, for the inmate’s attendants, counsel, and physician, a spiritual adviser selected by the inmate, and members of the inmate’s family” to have “access” to the inmate.[58] Idaho permits “access” to “the attorney of record, attending physicians, a spiritual adviser of the condemned’s choosing, and members of the immediate family of the condemned.”[59] South Dakota, which requires segregation of death-sentenced prisoners, mandates that “[n]o other person may be allowed access to the defendant without an order of the trial court except penitentiary staff, Department of Corrections staff, the defendant’s counsel, members of the clergy if requested by the defendant, and members of the defendant’s family.”[60] Wyoming

Included in SCDC' 4.29.19 letter to LOC

authorizes access by "physician and lawyers [and] . . . [r]elatives and spiritual advisers of the prisoner."[61]

The laws of Alabama, Indiana, and Pennsylvania address visiting and describe categories of individuals who may do so.[62] Under Alabama's statute, "while so confined, all persons outside the said prison shall be denied access to [a death-sentenced prisoner], except his physician and lawyer . . . , and the relatives, friends and spiritual advisors of the condemned person, who shall be admitted to see and converse with him at all proper times, under such reasonable rules and regulations as may be made by the Board of Corrections."[63] In Indiana, the death-sentenced prisoner's "(1) attorney; (2) physician; (3) relatives; (4) friends; and (5) spiritual advisor may visit the convicted person while the convicted person is confined."[64] If a death warrant has been issued, Pennsylvania requires that death-sentenced prisoners be housed in solitary confinement and that, other than correctional staff, "no person shall be allowed to have access to the inmate without an order of the sentencing court," other than "counsel of record or other attorney requested by the inmate" and "a spiritual adviser selected by the inmate or the members of the immediate family of the inmate."[65]

Most jurisdictions' laws do not address in-cell conditions or the number of hours that death-sentenced prisoners must spend in cell each day. A few – including Florida, Ohio and Oregon – discuss out-of-cell time and certain other conditions.[66] For example, Florida's regulations provide for a minimum of six hours per week of outdoor exercise.[67] Ohio's regulations specify "[f]ive hours of recreation per week."[68]

B. Policies Governing Isolation of Death-Sentenced Prisoners

Eighteen states had published policies addressing death-sentenced prisoners.[69] Further, in jurisdictions where we could locate no official policy, we supplemented our knowledge by reviewing the Department of Corrections' websites or handbooks, as well as secondary sources such as reports in periodicals and law review articles.

Policies varied widely in terms of specificity and topics. For example, Ohio's policies do not require automatic assignment of death-sentenced prisoners to the highest security classification, which carries the most restrictive housing conditions.[70] In Idaho, death-sentenced prisoners are initially placed in restrictive housing (also known as administrative segregation), and corrections officials must then conduct a hearing to determine if the prisoner can be moved to the less restrictive "close-restrictive custody."[71] If remaining in segregation, the death-sentenced prisoner's placement must be reviewed "at least once a year" to decide if a shift to close-restrictive custody is appropriate.[72] In contrast, as of the fall of 2015, in Virginia, death-sentenced prisoners were required under Department of Corrections' policy to be held in single-person cells and confined for 23 hours per day. According to news reports, when the *Prieto* litigation was pending, policy shifts occurred to allow death-sentenced prisoners some access to each other and to visitors.[73] Jurisdiction-by-jurisdiction policies are included in Appendix A.

Included in SCDC' 4.29.19 letter to LOC

C. Prior Research Regarding Death-Sentenced Prisoner Housing

This Report is not the first to consider death-sentenced prisoner housing, which has been the subject of research focused specifically on the topic, as well as on solitary confinement more generally. Four such surveys, based on different information sources, are detailed below. The reports consistently portray corrections officials as housing death-sentenced prisoners in very restrictive and isolating conditions. In addition, some commentators have also raised questions about the necessity and the legality of isolation on death row.

In 2013, the ACLU published a report, *A Death Before Dying: Solitary Confinement on Death Row*, which was drawn from a survey of "advocates for death row prisoners and others knowledgeable about death row conditions."[74] Based on responses about housing conditions in twenty-six states,[75] the Report concluded that ninety-three percent of those states held death-sentenced prisoners in their cells for twenty-two hours or more per day.[76] The cells ranged in size from thirty-six to one hundred square feet; most were "the size of an average bathroom."[77] Meals and medication often came through slots in the cell door,[78] and death-sentenced prisoners were allotted an hour or less of exercise a day, alone in a small pen.[79]

As the ACLU survey put it: "Many prisoners will go years without access to fresh air or sunshine."[80] Policies on visits were highly restrictive.[81] In most of these states, death-sentenced prisoners were not permitted to have physical contact with their visitors[82] and, in some, prisoners were required to remain in arm and leg restraints during visits.[83] In general, the ACLU found that prisoners were forced to live in a state of "extreme social isolation" and "enforced idleness," as the "overwhelming majority of states" did not provide access to work opportunities, educational programming or vocational training.[84]

In 2014, ASCA joined with the Liman Program to gather information on the numbers of people in isolation and the conditions in "administrative segregation," one form of restrictive housing. The resulting Report, *Time-in-Cell*, was based on survey responses from forty-six jurisdictions. Thirty-four of those jurisdictions – housing about 73% of the more than 1.5 million people incarcerated in U.S. prisons – provided data on all the people in restricted housing, whether termed "administrative segregation," "disciplinary segregation," or "protective custody." In that subset, more than 66,000 prisoners were in restricted housing. Given that number, ASCA and Liman estimated that some 80,000 to 100,000 people were, in 2014, in restrictive housing settings in prisons. *Time-in-Cell* focused on conditions in administrative segregation across the country; demographic information regarding these prisoners; the length of prisoners' stay in administrative segregation; their weekly time in-cell; conditions within these cells; and segregated prisoners' access to recreation, programming, visits, and social contact.[85] One subset of the survey's questions, answered by some of the responding jurisdictions, addressed the housing conditions of death-sentenced prisoners. Twenty-eight jurisdictions reported that death-sentenced prisoners were housed in administrative segregation or some other form of separation from the general population.[86]

A third source of information comes from a 2013 ASCA survey, asking correctional directors about housing policies; officials in twenty-nine states responded, providing jurisdiction-specific information.[87] Two states, Maryland (which has since abolished the death penalty) and Missouri, reported holding death-sentenced individuals in the general population.[88] Correctional

Included in SCDC' 4.29.19 letter to LOC

departments in the other twenty-seven jurisdictions all indicated that death-sentenced prisoners were held in some form of "segregated" or "other" housing.[89] Of these twenty-seven jurisdictions, fourteen reported that segregated death-sentenced prisoners could engage in some form of congregate activity.[90] In addition, eleven states indicated that death-sentenced individuals were permitted some movement without restraints.[91] Twenty-five jurisdictions reportedly provided programming for death-sentenced prisoners.[92]

Another survey, for the Death Penalty Information Center, conducted in 2008 by Professor Sandra Babcock working with a group of her students, compiled a state-by-state comparison of thirty-one jurisdictions based on interviews with capital defense attorneys and through materials published by various departments of corrections.[93] This research identified twenty jurisdictions that held death-sentenced prisoners in cells for twenty-two hours or more per day.[94] Eleven permitted death-sentenced prisoners to participate in group recreation,[95] and nine provided some educational opportunities, occupational training, or work opportunities.[96] Ten jurisdictions allowed contact visits with the prisoner's family,[97] and seventeen permitted contact visits with the prisoner's lawyer.[98]

As noted, other commentators have also raised concerns about death-row housing. For example, in 2005, Andrea Lyon and Mark Cunningham reviewed analysis of the "mainstreaming" of death-sentenced prisoners in Missouri and argued that evidence of the success of that practice raised questions about the constitutionality of imposing profound isolation.[99] More recently, Marah Stith McLeod also relied on the Missouri data as well as on other literature to argue that prison administrators ought not have the discretion to impose the isolation of death row; given the severity of conditions on most death-rows, she argued that the democratic processes of legislatures ought to decide whether that form of punishment is necessary and just.[100]

II. Housing Arrangements for Death-Sentenced Prisoners in North Carolina, Missouri, and Colorado

We identified at least six states – California, Colorado, Missouri, Montana, North Carolina, and Ohio – that did not impose confinement of 20 hours or more in cells each day for death-sentenced prisoners. To learn more about the policies and their implementation, we chose North Carolina, Missouri and Colorado, three states that varied in the size of their death-sentenced prisoner populations and in the degree of these prisoners' integration with the general prison population. We then reviewed their statutes, administrative regulations, and prison policies, as well as scholarly research, surveys, and media reports, and we interviewed administrators from each state's corrections department. Like many states, neither North Carolina nor Missouri have a specific statute or regulation governing the housing of death-sentenced prisoners. As noted, Colorado's statute leaves correctional administrators significant discretion by providing for incarceration at the correctional facilities at Canon City and for visiting by the prisoner's "attendants, counsel, . . . physician, a spiritual adviser . . . and members of the inmate's family."[101]

Included in SCDC' 4.29.19 letter to LOC

Below, we begin with North Carolina, the state with the largest death-sentenced prisoner population – 156 people – of the three. We interviewed Kenneth Lassiter, Deputy Director of Operations for the North Carolina Department of Public Safety (NCDPS); he served as the warden at Central Prison, the facility holding male prisoners sentenced to death. In April of 2015, at the time of the interview, North Carolina's death-sentenced housing arrangement had been in place for over a decade.

We then turn to Missouri, and the materials provided by George Lombardi, Director of the Missouri Department of Corrections (MDOC), who was the Director of Adult Institutions in 1989, when MDOC changed its policies on death-sentenced prisoners; Director Lombardi also co-authored a report on the transition. As noted, others have also done research on the Missouri "mainstreaming" practices; we had the benefit of a study by Mark D. Cunningham, Thomas J. Reidy, and Jonathan R. Sorensen, who compared the rate between 1991 to 2002 of violent misconduct by integrated death-sentenced prisoners to that of non-death sentenced prisoners,[102] as well as a follow-up study published in 2016 and reviewing twenty-five years of data.[103]

To learn about Colorado, we interviewed Rick Raemisch, Executive Director, and Kellie Wasko, Deputy Executive Director, of the Colorado Department of Corrections (CDOC).[104] Director Raemisch, who was appointed in 2013, instituted a series of changes in the housing of death-sentenced prisoners and for the general prisoner population.

As is detailed below, in each state, correctional officials praised their own systems, each of which enabled death-sentenced individuals to live with other prisoners. In each interview, the Directors explained the reasons for and the process of transition, and why they understood the reforms to be a success in terms of improving the lives of those in prison, lowering rates of violence, and reducing the challenges faced by staff.

A. North Carolina

North Carolina has one of the largest death-sentenced populations in the country, with 156 death-sentenced prisoners as of 2015.[105] Since 1984, the state has executed forty-three people.[106] As of the spring of 2016, the last execution was in 2006.[107]

According to Deputy Director Lassiter, North Carolina's death row policies have been in place for more than a decade.[108] Deputy Director Lassiter recalled having looked into the history of death row during his time as warden of Central Prison; he reported finding no information suggesting that the prisoners had previously been held in a greater degree of isolation.[109]

Deputy Director Lassiter explained that, as of 2015, the NCDPS housed 153 male and three female death-sentenced prisoners.[110] The men were incarcerated in Central Prison,[111] and the women at the North Carolina Correctional Institution for Women, both in Raleigh.[112] Men sentenced to death were placed in what was known as Unit III of Central Prison.[113] Though they were housed separately from the general population, they were afforded roughly the same privileges as other serious offenders held in Central Prison.[114]

Deputy Director Lassiter described Unit III as including eight cell pods.[115] In each pod, twenty-four single cells opened onto a central dayroom.[116] Each cell measured approximately

Included in SCDC' 4.29.19 letter to LOC

eleven-by-seven feet and was equipped with a bed, a sink, a toilet, a small writing table, a narrow window, and a radio.[117] The dayrooms were outfitted with a television, several stainless steel tables, and showers.[118] Death row prisoners could spend time and watch television in the dayroom together from 7 a.m. until 11 p.m.[119]

Death-sentenced prisoners ate their meals as a group in a common dining hall, at a different time than other prisoners.[120] Individuals sentenced to death were permitted at least one hour per day to exercise in groups and to shower.[121] Deputy Director Lassiter estimated that, depending on which unit activities were scheduled, the prisoners typically spent more than one hour a day in their recreation yard.[122] Death-sentenced prisoners were also permitted to work jobs within Unit III, including as a barber, janitor, recreation clerk, and in the library, canteen, or clothes house.[123]

North Carolina permitted two noncontact visitors each week.[124] Access to religious services was within the unit.[125] The religious services consisted of a one-hour Christian worship service every Sunday; a one-hour Islamic worship service every Friday, and a ninety-minute Bible study class every Tuesday morning.[126] Programming, such as working towards a GED, was not regularly available to death-sentenced prisoners, but Director Lassiter indicated that case managers would try to find volunteers to fulfill individual requests.[127] In the case of a disciplinary infraction, a death-sentenced prisoner would be sent to what was called Unit I, the restricted housing unit, where he would eat meals, exercise, and shower apart from other prisoners.[128]

Deputy Director Lassiter also explained that, if an execution date were set, both male and female death-sentenced prisoners would be moved three to seven days prior to the scheduled execution to the "death watch" area of Central Prison.[129] The single cells in the death watch area each had a bed, lavatory, commode, and writing table. The prisoner, who spent the entire day in the cell except fifteen minutes for a shower, had no contact with other prisoners.[130] Visits from attorneys, religious advisers, psychologists, and family were permitted; contact visits were at the warden's discretion.[131]

Housing policies for death-sentenced prisoners had not been a subject of significant political debate.[132] One brief flurry took place after a death-sentenced prisoner wrote a letter in 2012 to a newspaper and claimed that he enjoyed a luxurious life on death row.[133] In response, legislators introduced a bill that would have banned television on death row.[134] Deputy Director Lassiter, then the warden of Central Prison, testified that television served the Department as a management tool.[135] Although the bill came out of committee, it was not enacted.

Deputy Director Lassiter expressed unequivocal support for NCDPS's death row policies.[136] He explained that prisoner-on-officer violence was nearly non-existent on death row, and prisoner-on-prisoner violence was extremely rare.[137] Death row had fewer disciplinary infractions, fewer fights, and fewer assaults than any of the other units at Central Prison.[138] According to Lassiter, death row prisoners who subsequently had their death sentences commuted had better behavioral records in the general population than other prisoners.[139]

Included in SCDC' 4.29.19 letter to LOC

Deputy Director Lassiter explained that "giving inmates an opportunity to create social connections with other inmates and providing some sense of normalcy is an important part of why our policies are successful."[140] He acknowledged that some corrections officials believed that death-sentenced prisoners were inherently more dangerous, but said that North Carolina had a "totally opposite mentality."[141] "Our inmates police themselves within their own community," he continued, "Part of the reason that works is that they are not isolated twenty-three hours each day." The mental health consequences of isolating death row prisoners were, from his point of view, likely to lead to more problems with violence and discipline than isolation solved.[142]

Deputy Director Lassiter also believed that the relatively safe conditions on North Carolina's death row were in part because most of the prisoners no longer viewed death row as the place where they were going to die. "The majority of inmates sentenced to death ultimately don't end up being executed. The list of people removed from death row is a lot longer than the list of executions," he explained.[143] Accordingly, death row prisoners had a strong incentive to behave well. Moreover, he noted that many death row prisoners were of a different profile than other prisoners at Central Prison.[144] They were generally not habitual offenders, but tended to have been convicted of a single, serious crime. Deputy Director Lassiter speculated that this difference in background helped explain the success of North Carolina's policies.[145]

Deputy Director Lassiter noted that when he was the warden of Central Prison, he dined on a regular basis with the death row prisoners on Unit III, in part because they were his "favorite prisoners to interact with." He added that death row prisoners tended to be "extremely remorseful and take responsibility for what they have done and wish they could go back and change it. Generally, prisoners with a death sentence have a totally different view of life than another inmate."[146] When asked whether he had ever considered changing North Carolina's approach to housing death-sentenced prisoners, Deputy Director Lassiter responded emphatically: "Our system is proven to work and we have no desire to tweak it."[147]

B. Missouri

As of January 2016, Missouri had 28 death-sentenced prisoners, all of whom were housed at the Potosi Correctional Center (PCC) in Mineral Point. Since 1989 and as of the spring of 2016, the state had executed 86 people.[148] The state's last execution occurred in May 2016.

The housing system for death-sentenced prisoners in Missouri was designed in response to protest and litigation challenging the use of isolation and poor conditions. Before 1989, death-sentenced prisoners in Missouri were housed in a separate, below-ground unit at the now-closed Missouri State Penitentiary (MSP).[149] Death-sentenced prisoners did not leave the housing unit for services, programming, or recreation; the limited program opportunities available were brought to the unit.[150] Prisoners were allowed to exercise an hour each day in a separate area,[151] and were kept in six-by-ten foot cells for the other twenty-three hours of the day.[152] Director George Lombardi characterized conditions on death row in MSP as "marginal."[153]

In August 1985, a class of death-sentenced prisoners at the Missouri State Penitentiary filed a lawsuit pursuant to 42 U.S.C. § 1983.[154] The prisoners alleged that defendants, administrators in the MDOC, had violated their First, Sixth, Eighth, and Fourteenth Amendment rights.[155] According to Director Lombardi, opposing this lawsuit seemed "futile."[156]

Included in SCDC' 4.29.19 letter to LOC

On May 22, 1986, the parties initially entered into a consent decree intended to eliminate conditions that "may" have denied death-sentenced prisoners their constitutional rights.[157] The consent decree included provisions to protect prisoners' access to legal mail, religious services, telephones, medical and mental health services, visitation, and recreation.[158] The decree provided for specialized training for corrections staff, including administrative segregation training for custody staff and mental health care training for caseworkers.[159] The consent decree also described a multi-tiered classification system for death-sentenced prisoners, with different custody or security levels, in which death-sentenced prisoners with good behavior could receive greater privileges.[160] MDOC was also permitted, with court approval, to transfer death-sentenced prisoners to a new location.[161] In 1989, with court approval, the MDOC moved all death-sentenced prisoners to PCC, a recently opened maximum security prison.[162]

When death-sentenced prisoners were first moved to PCC, they were housed in a separate unit, with death-sentenced prisoners classified as minimum custody in one wing, and all other death-sentenced prisoners in another wing.[163] Director Lombardi described PCC as better and cleaner than MSP, but noted that staff still had to arrange for services to be brought separately to death-sentenced prisoners.[164] Following the transfer, death-sentenced prisoners filed a motion for contempt to challenge conditions at PCC and their segregation from other prisoners.[165]

While the renewed challenge was pending, administrators and staff in the MDOC began to consider better ways to manage death-sentenced prisoners and to provide them with a similar level of services as provided to the general population.[166] The process of bringing meals and medical services to death-sentenced prisoners, as well as locking down the prison whenever these prisoners left their cells, was cumbersome.[167] Director Lombardi stated that the idea that capital offenders were inherently more dangerous than other long-term prisoners did not make sense to corrections staff.[168] The conversation developed into a discussion of the feasibility of integrating death-sentenced prisoners into the general population at PCC.[169]

The full integration of PCC took place incrementally.[170] Prison officials started calling death-sentenced prisoners "capital punishment inmates," and began to escort minimum custody death-sentenced prisoners to the dining room to eat with the general population.[171] Death-sentenced prisoners were then given permission to visit the law library and to work in the laundry. For the first time, these individuals were classified using the Adult Internal Management System (AIMS).[172] Prisoners were able to play softball together, and did so without incident.[173] By January of 1991, all individuals with capital sentences were mainstreamed into the general population.[174] At the time, corrections staff "expressed surprise at the ease with which the transition occurred."[175]

The transition was completed before the district court ruled on the plaintiffs' motion for contempt, and the defendants moved thereafter to vacate the consent decree.[176] The District Court of the Eastern District of Missouri (to which jurisdiction had been transferred following the transfer of the prisoners to PCC) found that the defendants had complied with the requirements of the consent decree and that no unconstitutional conditions existed. The court vacated the decree and terminated its continuing jurisdiction over the matter.[177] The prisoners appealed, but the Eighth Circuit affirmed the lower court decision.[178]

Included in SCDC' 4.29.19 letter to LOC

As of the winter of 2015, all of Missouri's death-sentenced prisoners were housed at PCC.[179] PCC houses death-sentenced prisoners, life-sentenced prisoners, and parole-eligible prisoners.[180] As of 2015, the procedure for receiving and housing prisoners was that death-sentenced prisoners were transferred directly from courts and jails to PCC, a maximum security facility (Custody Level 5);[181] non-death sentenced prisoners were first sent to one of three diagnostic centers in the state to determine their custody level before being assigned to a facility.[182] Once death-sentenced prisoners arrived at PCC, they were treated no differently than other prisoners in the institution.[183]

Upon arrival at PCC, all prisoners were initially assigned to one of the administrative segregation units during their reception and orientation,[184] and could then be moved to a double cell in the transitional administrative segregation unit.[185] PCC then used its AIMS classification system to categorize all prisoners into one of thirteen housing units.[186]

Prisoners could be promoted from the transitional unit to one of two "baseline" general population units, where they ate meals with the rest of the prisoners and could attend religious and educational services.[187] If approved, prisoners could advance to one of the two general population units, where they had access to recreation and programming in large groups and could purchase a television and radio.[188] Prisoners who were conduct-violation free for a certain period of time could be moved to the "honor dorm,"[189] where they were "out of their cells most of the day."[190] Death-sentenced individuals could be double-celled with other general population prisoners, regardless of sentence.[191]

Like the rest of the prison population, death-sentenced prisoners could be assigned to the protective custody unit, where they ate and participated in recreation as a group.[192] Prisoners could be placed in the special needs unit, where they exercised and attended mental health programming separately but took meals with the general population.[193] Correctional administrators assigned some death-sentenced prisoners who were not special needs to this unit for the purpose of ensuring a permanent single cell.[194] Prisoners who had "difficulty in adjusting to institutional life" were placed in the partial treatment unit.[195]

Death-sentenced prisoners had the same privileges and could access the same services afforded to all prisoners in their housing unit. For example, death-sentenced prisoners in general population were allowed eight hours of recreation each day and permitted to do crafts for six of those hours.[196] PCC offered Narcotics Anonymous and Alcoholics Anonymous programs and vocational education programs.[197] Prisoners at PCC could also participate in a dog adoption program that enabled prisoners to train dogs that had been held in shelters and could be adopted by people in the community.[198] Death-sentenced prisoners could apply for jobs, access the commissary, enjoy equal access to visitation and phones, and visit the law library.[199] Visitation hours were three days a week for eight hours each day.[200]

Unique to death-sentenced prisoners was their housing prior to execution: after an execution date was set, a death-sentenced prisoner was moved into protective custody. The prisoner was subsequently taken to a segregated holding cell two to three days prior to the scheduled execution.[201]

Included in SCDC' 4.29.19 letter to LOC

Director Lombardi stated that mainstreaming death-sentenced prisoners eliminated the burdensome costs of maintaining separate death row facilities.[202] PCC no longer had to assign staff to escort death-sentenced prisoners around the facility.[203] There was no longer a need to arrange for death-sentenced prisoners to have access to health care and medications, psychological counseling, and the law library.[204] Commissary hours, visitation days, and medical services access were expanded after the transition because separate time windows for death-sentenced prisoners were no longer required.[205] Jobs in the laundry also became available for administrative segregation prisoners when death-sentenced prisoners gained access to all employment.[206] Director Lombardi thought that the MDOC would incur less in legal expenses arising from prisoners' litigation about death row conditions.[207]

Director Lombardi noted that in the prison as a whole, disciplinary infractions and violence had decreased after the integration of death-sentenced prisoners.[208] He stated that while there was some initial skepticism, staff encountered no problems with the gradual process of integration, and that he had generally found no difference between death-sentenced prisoners and other long-term prisoners.[209] Additionally, Director Lombardi believed that because death-sentenced prisoners were no longer subject to automatic long-term administrative segregation, there were fewer mental health problems following integration.[210]

Director Lombardi stated that it seemed that death-sentenced prisoners at PCC have slightly lower rates of assaultive behavior than other prisoners.[211] Director Lombardi credited the incentive structure: just like any other prisoner, a death-sentenced prisoner could be sent to administrative segregation for harming someone but could earn the highest level of privileges available with a good disciplinary record.[212] Furthermore, most prisoners facing execution were still engaged in appeals or collateral attacks on their convictions, motivating them to avoid sanctions.[213] Lombardi believed that such a system, in conjunction with services such as counseling and the dog adoption program, motivated death-sentenced prisoners to behave well.[214]

Lombardi considered the integration of death-sentenced prisoners into the general population a success. He stated that integration is "so ingrained in the system now that it's no big deal. We don't even think about it."[215] According to him, "We did the right thing, and it's proven time and again that it is the right thing."[216]

C. Colorado

As of 2015, the Colorado Department of Corrections (CDOC) had a total of three death-sentenced prisoners, all male, who were housed at Sterling Correctional Facility in Sterling, Colorado, which was overseen by Warden James Falk. As of 2016, the last execution in Colorado was in 1997.[217]

The question of solitary confinement has been an issue for the Colorado prison system for several years. Relatively few individuals were sentenced to death, but a significant number of other prisoners were held in isolation until 2011, when Tom Clements became the Director of Corrections. Under his leadership, Colorado reduced that population from more than 1,400 to about 700.[218] After Director Clements was murdered by a former prisoner in 2013, Rick

Included in SCDC' 4.29.19 letter to LOC

Raemisch, who had been the head of the Wisconsin Department of Corrections, was appointed;[219] he continued Director Clements's efforts to lower the number of individuals in isolation.

Until 2014, Colorado housed death-sentenced prisoners in administrative segregation at Sterling Correctional Facility;[220] no separate facility was provided for those with death sentences.[221] At the time, administrative segregation was the most secure custody level in the CDOC.[222] Prisoners were locked in their cells twenty-three hours a day, with one hour out for exercise and showering. Prisoners could not leave their cells unless they were in full restraints and escorted by at least two correctional officers. Meals, pharmaceutical, educational, and library services were delivered to the cells. Prisoners were permitted to have a television and two and a half hours of non-contact visitation time per week.[223]

Colorado reformed its housing policies for death-sentenced prisoners in 2014 as part of its more general effort to reduce reliance on administrative segregation.[224] According to Director Raemisch, a long period of isolation is psychologically damaging and has the effect of "taking someone who has committed a very violent act and possibly making them more violent."[225] Director Raemisch noted during our interview that, prior to reform:

> Colorado had failed in its mission . . . . Its mission is not to run a more efficient institution, which is what segregation is for. Running an efficient institution is a noble goal, but the mission really is to protect the community. You don't do that by sending someone out worse than they came in.[226]

By March 2014, CDOC had decreased the population held in solitary confinement to 577[227] and, as of the spring of 2016, to some 160 prisoners.[228]

CDOC extended its reform efforts to death-sentenced prisoners. On March 4, 2014, Deputy Executive Director Kellie Wasko sent an email to all CDOC employees announcing the planned introduction of a policy eliminating administrative segregation for death-sentenced prisoners.[229] Director Raemisch noted that part of the impetus for this change was the long period that death-sentenced prisoners would likely spend living in Colorado prisons.[230] While death-sentenced prisoners might never re-enter the larger community, Director Raemisch viewed reform of those prisoners' conditions as an issue for the well-being of the prison community and its safety.[231]

As a first reform, CDOC permitted the three male death-sentenced prisoners[232] to be with each other; this change evolved into the current policy under which death-sentenced prisoners are housed with non-death-sentenced prisoners in a "close custody management control unit" (MCU), first housed at Sterling Correctional Facility in Sterling, Colorado[233] and, by 2016, at the Colorado State Penitentiary (CSP).[234]

The discussion about reforming housing for death-sentenced prisoners originated in the upper level of CDOC, and administrators then sought feedback on the reforms from corrections officers. Director Raemisch called his staff's handling of segregation reform "amazing." He noted that they had achieved "a complete change in culture" in a short amount of time. Deputy Executive Director Wasko said that the biggest part of training staff on these reforms was to

Included in SCDC' 4.29.19 letter to LOC

point out that death-sentenced prisoners were functionally the same as many others in the prison; staff were "already walking around with that type of offender [convicted of serious crimes of violence]. The only difference is the sentence. Several hundred inmates have life without possibility of parole."[235]

As of the spring of 2015, death-sentenced prisoners were classified as "close custody" prisoners.[236] Within the "close custody" classification, prisoners were placed into various status designations based on their management needs.[237] Death-sentenced prisoners were designated to and housed in a close custody MCU.[238] Prisoners in the MCU each had their own cell, measuring about seven-by-thirteen feet. Each MCU had about sixteen prisoners, and both death-sentenced and non-death-sentenced prisoners could be housed together within the same MCU. Death-sentenced prisoners generally had the same living conditions and privileges as other close custody prisoners in the MCU. According to Wasko, "they are not identified as death-sentenced offenders. You couldn't pick them out. They are treated like all other prisoners in the management control unit."[239]

As of 2015, MCU prisoners were permitted to leave their cells for a minimum of four hours a day, seven days a week; prisoners spent two hours in the morning and two hours in the afternoon in groups of about eight prisoners, some of which was spent together in a dayroom. During such times, corrections officers, who were not physically in the dayroom, maintained visual contact at all times.[240] Prisoners were permitted four hours of indoor or outdoor recreation per week.[241]

In terms of the backdrop before the reforms under Director Raemisch, the Colorado prison system had also faced litigation (as had Missouri) about conditions for death-sentenced prisoners. In 2009, three individuals claimed that they had been subjected to cruel and unusual punishment because they were denied the opportunity for outdoor exercise for an extended period of time.[242] The case was settled by the joint request of the parties under an agreement in which Colorado moved death-sentenced prisoners to Sterling so they could have access to outdoor recreation.[243] At the time, Sterling Correctional Facility did not have outdoor areas for groups; recreation was available on an individual basis.[244] As noted above, death-sentenced individuals were part of the MCU, and those prisoners were later moved to another facility, the Colorado State Penitentiary (CSP). That prison was the subject of another case, brought by a non-death sentenced prisoner about its lack of outdoor recreational space.[245] As of the spring of 2016, Colorado was building an outdoor recreation area for CSP; the expected completion date is in December 2016.[246]

Returning to the rules for the MCU prisoners in general, Colorado permits six non-contact visits a month, each lasting two hours. After thirty days, MCU prisoners become eligible for no more than two contact visits (of no more than ninety minutes) per month.[247] In addition to legal telephone calls, death-sentenced and other MCU prisoners could make eight twenty-minute telephone calls per month.[248]

MCU prisoners received meals in their cells. They were eligible for in-unit work opportunities.[249] They were also eligible for in-cell programming through a television or self-service kiosk.[250] While MCU prisoners were given access to religious guidance and publications

Included in SCDC' 4.29.19 letter to LOC

from the prison Chaplain's Office, they were not authorized to attend group religious services or group programming.[251] Director Raemisch expected that CDOC MCUs will continue to evolve and that more programming, such as cognitive-behavioral therapy and anger management, will be added.[252]

These reforms have encountered some political resistance. In 2014, in *The Complete Colorado*, an online political blog, a CDOC employee, a district attorney, and a relative of a victim of a Colorado death row prisoner all expressed opposition to the proposed reforms.[253] Bob Beauprez, the 2014 Republican candidate for governor, also opposed the change and referenced it in advertisements criticizing the incumbent, John Hickenlooper,[254] who was thereafter reelected, and the reforms continued.

Director Raemisch views the revised policies on housing of death-sentenced prisoners and the larger project of reforming segregation in Colorado as a success. In his view, the changes have had a positive effect on the demeanor and personalities of prisoners. Director Raemisch and his top administrative staff "believe that in the long run this policy will lead to a safer facility . . . . [A]ll the evidence is pointing in that direction." Director Raemisch reported that prisoner-on-prisoner violence had stayed the same since the segregation reforms began and that prisoner-on-staff assaults were at their lowest since 2006.[255]

When asked about the popular perception of death-sentenced prisoners as more dangerous because they have nothing left to lose, Director Raemisch explained that the CDOC "believes just the opposite." They "have no evidence to show that [death-sentenced prisoners] are more violent in the facility." Director Raemisch's sense was that, while "there may be a few inmates who are very dangerous," those inmates can be managed accordingly; their presence does not mean that isolation reform cannot be done safely. He and his administrative staff "all believe that people can change."[256]

III. Looking Forward

This review of the laws and policies governing death-sentenced individuals makes plain that many correctional systems have a range of options when deciding on the conditions of confinement for death-sentenced prisoners. The correctional leaders in North Carolina, Missouri, and Colorado report the success of their systems. In addition, as discussed below, empirical work has been done on the Missouri system and, in Colorado, studies of the impact of reforms of solitary confinement are underway.

Specifically, the assessment by Director Lombardi that death-sentenced prisoners in Missouri were not more likely to commit disciplinary infractions than their fellow prisoners was confirmed in an analysis by Mark Cunningham, Thomas Reidy, and Jon Sorenson. The researchers reviewed incidents of violent misconduct by prisoners at PCC between 1991 and 2002, a period after the integration of death-sentenced prisoners.

That study compared the rate of misconduct by prisoners sentenced to death to that of prisoners sentenced to life without parole or to shorter prison terms.[257] The researchers found

Included in SCDC' 4.29.19 letter to LOC

that death-sentenced prisoners committed violent misconduct at roughly the same low rate as prisoners sentenced to life without parole.[258] Both groups were also significantly less likely than parole-eligible prisoners to commit violent misconduct: their rate was "about one-fifth of the rate of violent misconduct among parole eligible inmates."[259] In addition, from 1991 to 2002, there were no homicides or attempted homicides committed by the death-sentenced prisoners.[260] The authors concluded that the "practice of integrating death-sentenced inmates in the general population of a maximum-security prison is strongly supported by these findings" and that the findings undermined "[c]onventional assumptions that death-sentenced inmates require super-maximum security protocols."[261] The authors concluded that this demonstrated death-sentenced prisoners could be integrated safely into the general prison population.[262]

In 2016, the authors published a follow up report that relied on twenty-five years of data on the Missouri "mainstreaming" policy.[263] The researchers evaluated eighty-five prisoners with capital sentences who were housed in the general population, and 702 prisoners serving life-without-parole sentences, as well as 3,000 prisoners serving term sentences.[264] The study concluded that those prisoners with capital sentences had "equivalent or lower rates of violent misconduct" than did either of the other sets of prisoners. In addition, the study found that "rates of violence among Missouri [death-sentenced] inmates were markedly lower after being mainstreamed than they had been under the prior era of heightened security conditions on 'death row.'"[265] The researchers argued that the "failure of assumptions of high violence risk undergirding death row has important public policy and correctional implications."[266] As the title, *Wasted Resources and Gratuitous Suffering: The Failure of a Security Rationale for Death Row* reflected, the authors viewed their data as supporting a national change in policies to reduce the isolation of individuals serving capital sentences.[267]

In sum, the mix of empirical work and reports of experiences of North Carolina, Missouri, and Colorado demonstrates that less restrictive, less isolating housing policies on death row have, in the judgment of correctional officials, contributed to the safety and security of prisoners and correctional staff alike.

Included in SCDC' 4.29.19 letter to LOC

[1] All rights reserved; Arthur Liman Public Interest Program, 2016. For additional information, contact Judith.Resnik@yale.edu. The primary authors of this Report are Celina Aldape, Ryan Cooper, Katie Haas, April Hu, Jessica Hunter, and Shelle Shimizu, Yale Law School students participating in this Liman Project from 2014 to 2016, and working under the supervision of Johanna Kalb, Visiting Associate Professor of Law and Director, Arthur Liman Public Interest Program, and Judith Resnik, Arthur Liman Professor of Law.

We thank Kenneth Lassiter, Deputy Director for Operations, North Carolina Department of Public Safety; George Lombardi, Director, Missouri Department of Corrections; Rick Raemisch, Executive Director, Colorado Department of Corrections; and Kellie Wasko, Deputy Executive Director, Colorado Department of Corrections, all of whom shared their experiences and then reviewed the descriptions of their work prior to this Report's publication. Thanks are also due to the many colleagues who helped us shape the Report and who provided advice on research: Burke Butler, Staff Attorney, Texas Defender Service; George Camp, Co-Executive Director, Association of State Correctional Administrators; Mark D. Cunningham, Ph.D., ABPP; David Fathi, Director of the American Civil Liberties Union's National Prison Project; Amy Fettig, Senior Staff Counsel for the American Civil Liberties Union's National Prison Project; Meredith Martin Rountree, Visiting Assistant Professor, Northwestern School of Law; Brian W. Stull, Senior Staff Attorney, American Civil Liberties Union, Capital Defense Project; and Sandra Babcock, Clinical Professor of Law, Cornell Law School. Yet more thanks are due to Sarah Baumgartel, Senior Liman Fellow in Residence, and Yale Law School staff, Bonnie Posick and Christine Donahue Mullen, who have thoughtfully helped in bringing this project to fruition.

[2] Deborah Fins, *Death Row U.S.A.*, NAACP Legal Defense and Educational Fund, Inc. 1 (Fall 2015), *available at* http://www.naacpldf.org/files/our-work/DRUSA_Fall_2015.pdf (identifying total number of death-sentenced prisoners as 2,959 as of October 1, 2015).

[3] *See*, *e.g.*, Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 WASH. U. J. L. & POL'Y 325 (2006) (describing evidence of severe psychiatric harm resulting from solitary confinement); Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax" Confinement*, 49 CRIME & DELINQ. 124 (2003) (reviewing literature on negative psychological effects caused by isolation and the high percentage of mentally ill prisoners confined in isolation); Fatos Kaba, Andrea Lewis, Sarah Glowa-Kollisch, James Hadler, David Lee, Howard Alper, Daniel Selling, Ross MacDonald, Angela Solimo, Amanda Parsons & Homer Venters, *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 AM. J. PUBLIC HEALTH 442 (2014) (concluding acts of self-harm are significantly associated with having been in solitary confinement); Jeffrey L. Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, 38 J. AM. ACAD. PSYCHIATRY & L. 104 (2010) (describing effects of solitary confinement on prisoners with preexisting serious mental illness); John J. Gibbons & Nicholas de B. Katzenbach, *Confronting Confinement: A Report of the Commission on Safety and Abuse in America's Prisons*, VERA INST. OF JUSTICE 54-55 (2006), *available at* http://www.vera.org/sites/default/files/resources/downloads/Confronting_Confinement.pdf (noting research efforts suggesting that the increasing use of expensive segregated housing units can cause violence inside facilities and increase recidivism); *A Solitary Failure: The Waste, Cost and Harm of Solitary Confinement in Texas*, AM. CIVIL LIBERTIES UNION OF TEX. (Feb. 2015) [hereinafter *A Solitary Failure*], *available at* https://www.aclutx.org/sites/default/files/field_documents/SolitaryReport_2015.pdf; *see also* Cyrus Ahalt and Brie Williams, *Reforming Solitary-Confinement Policy – Heeding a Presidential Call to Action*, 374 N. ENG. J. MED. 1704 (2016) (calling for new research on the health consequences of solitary confinement).

[4] Sarah Baumgartel, Corey Guilmette, Johanna Kalb, Diana Li, Josh Nuni, Devon Porter & Judith Resnik, *Time-In-Cell: The ASCA-Liman 2014 National Survey of Administrative Segregation in Prison*, THE LIMAN PROGRAM, YALE LAW SCHOOL 58 (2015) [hereinafter ASCA-Liman, *Time-in-Cell*] (reporting that incentives for making changes to administrative segregation policies according to members of the Association of State Correctional Administrators included, *inter alia*: concerns about prisoner and staff well-being, concerns about prisoner and staff safety, space/facility constraints, and possible cost savings), *available at* https://www.law.yale.edu/system/files /documents/asca-liman_administrativesegregationreport.pdf; *see also A Solitary Failure*, *supra* note 3, at 9 (estimating that Texas taxpayers spend $46 million or more per year to house prisoners in solitary confinement rather than in the general population).

Included in SCDC' 4.29.19 letter to LOC

[5] President Barack Obama ordered a Justice Department review of solitary confinement in 2015, and expressed concerns about the effects of long-term solitary confinement on safety and prisoner reentry. Peter Baker & Erica Goode, *Critics of Solitary Confinement Are Buoyed as Obama Embraces Their Cause*, N.Y. TIMES (July 21, 2015), *available at* http://www.nytimes.com/ 2015/07/22/us/politics/critics-of-solitary-confinement-buoyed-as-obama-embraces-cause.html?rref=collection%2Ftimestopic%2FSolitary%20Confinement. The Department of Justice released a final Report in January 2016, setting out best practices for correctional facilities and policy recommendations for the Federal Bureau of Prisons and related agencies. *Report and Recommendations Concerning the Use of Restrictive Housing*, U.S. DEP'T OF JUSTICE (Jan. 2016), *available at* https://www.justice.gov/dag/file/815551/download. President Obama published a presidential memorandum ordering implementation of the DOJ Report in March. *Presidential Memorandum – Limiting the Use of Restrictive Housing by the Federal Government,* THE WHITE HOUSE, OFFICE OF THE PRESS SEC'Y (Mar. 1, 2016), *available at* https://www.whitehouse.gov/the-press-office/2016/03/01/presidential-memorandum-limiting-use-restrictive-housing-federal.

[6] In 2013, the Association of State Correctional Administrators (ASCA) adopted new restrictive housing guidelines, calling for individual jurisdictions to develop policies to "manag[e] inmates in the least restrictive way necessary." *Restrictive Status Housing Policy Guidelines*, ASS'N OF STATE CORR. ADMINS. (Aug. 9, 2013), *available at* http://www.asca.net/system/assets/attachments/6145/B.%20ASCA%20Restrictive%20Status%20Housing%20Policy%20Guidelines-Final%2008092013.pdf?1375723019. ASCA uses the term "restrictive status housing" to encompass restrictive forms of housing for prisoners who "would pose a serious threat" in the general prison population. *Id.* at 1.

When the ASCA-Liman *Time-in-Cell* Report was released in the fall of 2015, ASCA's press release introducing the Report explained that it provided "one way to measure and to learn whether the hoped-for changes are taking place, to reduce and eliminate the isolation of prisoners, so as to enable prisoners and staff to live and work in safe environments, respectful of human dignity." *New Report on Prisoners in Administrative Segregation Prepared by the Association of State Correctional Administrators and the Arthur Liman Public Interest Program at Yale Law School*, ASS'N OF STATE CORR. ADMINS. 1 (Sept. 2, 2015), http://www.asca.net/system/assets/attachments/8895/ASCA%20LIMAN%20Press%20Release%208-28-15.pdf?1441222595.

[7] The Senate Judiciary Committee's Subcommittee on the Constitution, Civil Rights and Human Rights held hearings in 2012 and 2014 on the topic of isolation in prisons. *Reassessing Solitary Confinement: The Human Rights, Fiscal and Public Safety Consequences*, U.S. SENATE COMM. ON THE JUDICIARY (June 19, 2012), *available at* http://www.judiciary.senate.gov/meetings/reassessing-solitary-confinement-the-human-rights-fiscal-and-public-safety-consequences; *Reassessing Solitary Confinement II: The Human Rights, Fiscal and Public Safety Consequences*, U.S. SENATE COMM. ON THE JUDICIARY (Feb. 25, 2014), *available at* http://www.judiciary.senate.gov/meetings/reassessing-solitary-confinement-ii-the-human-rights-fiscal-and-public-safety-consequences.

Senator Richard Durbin, who presided over the hearings, expressed serious concerns about the psychological impact of solitary confinement, noting that half of prison suicides occur among isolated prisoners. Erica Goode, *Senators Start a Review of Solitary Confinement*, N.Y. TIMES (June 19, 2012), *available at* http://www.nytimes.com/2012/06/20/us/senators-start-a-review-of-solitary-confinement.html. Senator Durbin requested an independent review of the Federal Bureau of Prisons' use of restrictive housing, which was completed in 2014. Kenneth McGinnis, James Austin, Karl Becker, Larry Fields, Michael Lane, Mike Maloney, Mary Marcial, Robert May, Jon Ozmint, Tom Roth, Emmitt Sparkman, Roberta Stellman, Pablo Stewart, George Vose & Tammy Felix, *Federal Bureau of Prisons: Special Housing Unit Review and Assessment*, CNA ANALYSIS & SOLUTIONS (Dec. 2014), *available at* https://www.bop.gov/resources/news/pdfs/CNA-SHUReportFinal_123014_2.pdf. Senator Durbin noted that, while the BOP had successfully reduced the number of prisoners in solitary confinement, further work remained to be done to reform its segregation policies. *Durbin: First-Of-Its-Kind Report on Solitary Confinement Shows Need for More Improvement*, DICK DURBIN, U.S. SENATOR, ILL. (Feb. 27, 2015), *available at* http://www.durbin.senate.gov/newsroom/press-releases/durbin-first-of-its-kind-report-on-solitary-confinement-shows-need-for-more-improvement.

[8] Several state legislatures have introduced bills that would place limits on the extent and duration of solitary confinement. For example, in Illinois, a pending bill would limit the permissible uses of solitary confinement, prohibit the use of solitary confinement for members of vulnerable populations in most circumstances, and prohibit

Included in SCDC' 4.29.19 letter to LOC

holding anyone in solitary confinement for more than five consecutive days in most situations. H.B. 5417, 99th Gen. Assemb. (Ill. 2016). In Massachusetts, several pending bills would limit the use of segregation. HB 3451 would limit the use and extent of segregation for prisoners under 21, and limit isolation for any prisoner over 21 to fifteen days for one offense. H.B. 3451, 189th Gen. Court (Mass. 2015). HB 1475 would limit disciplinary segregation to fifteen days, and prohibit segregation for certain classes of prisoners. H.B. 1475, 189th Gen. Ct. (Mass. 2015). In New Jersey, a pending bill would limit the purposes for which solitary confinement may be used, prohibit its use for more than fifteen consecutive days under most circumstances, and limit the use of solitary confinement for members of vulnerable populations. S51, 217th Leg. (N.J. 2016). In New York, a bill in committee would limit the use and length of time of segregated confinement, prohibit segregation for certain classes of prisoners, and create alternative therapeutic and rehabilitative confinement options. A8588A, 2013-2014 Legis. Sess. (N.Y. 2014).

[9] *See* H.B. 1328, 70th Gen. Assemb. (Co. 2016) (defining "youth" to mean "an individual who is less than twenty-one years of age" and forbidding holding youth "in seclusion under any circumstances for more than eight total hours in two consecutive calendar days without a written court order"); and http://aclu-co.org/colorado-legislature-passes-bill-protect-children-solitary-confinement.

[10] Motion by Chair Hilda L. Solis and Supervisor Sheila Kuehl, *Ending Juvenile Solitary Confinement in Los Angeles County*, BD. OF SUPERVISORS, CNTY. OF LOS ANGELES (May 3, 2016), *available at* http://supervisorkuehl.com/wp-content/uploads/2016/05/5.3.16-Solitary-Confinement-Motion-REVISED.pdf (providing that "[i]n very rare situations, after all other interventions have been exhausted, a juvenile may be separated from others as a temporary response" and that "[e]ven in such cases, the placement should be brief, designed as a 'cool down' period, and done only in consultation with a mental health professional"); *see also* Adam Nagourney & Timothy Williams, *Los Angeles County Restricts Solitary for Juveniles*, N.Y. TIMES (May 3, 2016), *available at* http://www.nytimes.com/2016/05/04/us/los-angeles-county-restricts-solitary-for-juveniles.html?_r=0.

[11] In 2015, a class of California prisoners reached a settlement agreement with the state of California, in which the California Department of Corrections and Rehabilitation agreed to limit the amount of time a prisoner could be held in a segregated housing unit, to cease placing prisoners in segregation solely on the basis of gang affiliation, and to speed up the rate at which segregated prisoners are reintegrated to the general population. *See* Ashker v. Governor, Case No: 4:09-cv-05796-CW (Oct. 6, 2015), *available at* http://documents.latimes.com/californias-solitary-settlement/; *see also* Ian Lovett, *California Agrees to Overhaul Use of Solitary Confinement*, N.Y. TIMES (Sep. 1, 2015), *available at* http://www.nytimes.com/2015/09/02/us/solitary-confinement-california-prisons.html. The United States District Court for the Northern District of California granted final approval of the settlement agreement. Ashker v. Governor, Case No: 4:09:-cv-05796-CW (N.D. Cal. Jan. 26, 2016), *available at* http://www.clearinghouse.net/chDocs/public/PC-CA-0054-9001.pdf.

In 2016, the United States District Court for the Southern District of New York approved a settlement between a class of New York prisoners and the New York State Department of Corrections and Community Supervision that would limit the circumstances in which disciplinary solitary confinement can be imposed, implement a step-down program for prisoners leaving solitary confinement, and create alternatives to solitary confinement for juveniles and special needs prisoners. Peoples v. Annucci, Case No: 1:11-cv-02694-SAS (S.D.N.Y. Mar. 31, 2016), *available at* http://www.nyclu.org/files/releases/3_31_Solitary_Confine_settlement_approval.pdf.

[12] Several agreements illustrate the role played by such challenges. The Disability Rights Network of Pennsylvania reached a settlement agreement with the Pennsylvania Department of Corrections in 2013 to stop housing prisoners with serious mental illness in solitary confinement in the Restricted Housing Units and to establish new treatment units that provide significant out-of-cell time. Disability Rights Network of Pennsylvania v. Wetzel, Case No: 1:13-CV-00635 (M.D. Pa. Jan. 5, 2015), *available at* https://www.aclupa.org/download_file/view_inline/2714/677/. The United States District Court for the Middle District of Pennsylvania ordered the matter dismissed without prejudice in accordance with the terms of the settlement agreement. Disability Rights Network of Pennsylvania v. Wetzel, Case No: 1:13-CV-00635 (M.D. Pa. Jan. 15, 2015), *available at* http://www.clearinghouse.net/chDocs/public/PC-PA-0031-0004.pdf.

The Illinois Department of Corrections entered a settlement agreement under which prisoners with mental illness in solitary confinement must be allowed a certain minimum number of hours per week out of the cell, receive periodic reviews of placement, and continue to receive mental health treatment while in segregation. Rasho v. Baldwin, Case No. 1:07-CV-1298-MMM-JEH (C.D. Ill. Jan. 21, 2016), *available at* http://www.clearinghouse.net/chDocs/public/PC-IL-0031-0009.pdf. The settlement was approved by the United States District Court for the

Included in SCDC' 4.29.19 letter to LOC

Central District of Illinois in May, 2016. *See* Rasho v. Walker, 07-CV-1298-MMM-JEH (C.D. Ill. May 13, 2016) (finding agreement "fair and reasonable").

The Arizona Department of Corrections entered a stipulation in 2014 to increase access to health care, increase time spent out-of-cell, and restrict the use of chemical agents for seriously mentally ill prisoners in solitary confinement. Parsons v. Ryan, No. CV 12-00601-PHX-DJH (D. Ariz. Oct. 14, 2014), *available at* http://www.clearinghouse.net/chDocs/public/PC-AZ-0018-0028.pdf.

[13] *See*, *e.g.*, *A Solitary Failure*, *supra* note 3; *Boxed In: The True Cost of Extreme Isolation in New York's Prisons*, N.Y. CIVIL LIBERTIES UNION (2012), *available at* http://www.nyclu.org/publications/report-boxed-true-cost-of-extreme-isolation-new-yorks-prisons-2012; *Ending Torture in U.S. Prisons,* NAT'L RELIGIOUS CAMPAIGN AGAINST TORTURE, *available at* http://www.nrcat.org/torture-in-us-prisons; Margo Schlanger, *Regulating Segregation: The Contribution of the ABA Criminal Justice Standards on the Treatment of Prisoners*, 47 AM. CRIM. L. REV. 1421 (2010); Alison Shames, Jessa Wilcox & Ram Subramanian, *Solitary Confinement: Common Misconceptions and Emerging Safe Alternatives*, VERA INST. OF JUSTICE (May 2015), *available at* http://www.vera.org/pubs/solitary-confinement-misconceptions-safe-alternatives; Keramet Ann Reiter, *The Most Restrictive Alternative: A Litigation History of Solitary Confinement in U.S. Prisons, 1960-2006*, 57 STUD. IN L., POL, & SOC'Y 71 (2012); *see also* ASCA-Liman, *Time-In-Cell*, *supra* note 4.

[14] *A Death Before Dying: Solitary Confinement on Death Row*, AM. CIVIL LIBERTIES UNION (July 2013), *available at* https://www.aclu.org/sites/default/files/field_document/deathbeforedying-report.pdf [hereinafter *A Death Before Dying*].

[15] Prieto v. Clarke, No. 1:12CV1199 LMB/IDD, 2013 WL 6019215, at *11 (E.D. Va. 2013).

[16] Prieto v. Clarke, 780 F.3d 245 (4th Cir. 2015), *cert. dismissed as moot*, 136 S. Ct. 319 (2015).

[17] Associated Press, *Appeals Exhausted, Alfred Prieto, Serial Killer, Is Executed*, N.Y. TIMES (Oct. 1, 2015), *available at* http://www.nytimes.com/2015/10/02/us/appeals-exhausted-alfredo-prieto-serial-killer-is-executed.html.

[18] *See* Petition for Writ of Certiorari, Prieto v. Clarke, 2015 WL 4100302 (2015) (No. 15-31), *cert. dismissed as moot*, 136 S. Ct. 319 (2015). In June of 2016, the Court granted review in a death penalty case regarding the standards that should be used to determine intellectual disability; the Court declined to consider a second question in the case – whether the death-sentenced prisoner's more than three decades of incarceration awaiting execution (spent in solitary confinement) violated the Eighth Amendment. *See* Ex Parte Moore, 470 S.W.3d 481 (Tex. Crim. App. 2015), *cert. granted in part*, Moore v. Texas, No. 15-797, 2016 WL 3128994, at *1 (U.S. June 6, 2016); *see also* Adam Liptak, *Supreme Court to Hear Death Penalty Cases*, N.Y. TIMES (Jun. 1, 2016), *available at* http://www.nytimes.com/2016/06/07/us/politics/supreme-court-to-hear-two-major-death-penalty-cases.html?_r=0.

[19] *See* Glossip v. Gross, 135 S. Ct. 2726, 2765 (2015) (Breyer, J., dissenting, joined by Ginsburg, J.) (stating that "nearly all death penalty States keep death row inmates in isolation for 22 or more hours per day" and discussing the "dehumanizing effect of solitary confinement."); Davis v. Ayala, 135 S. Ct. 2187, 2208-10 (2015) (Kennedy, J., concurring).

[20] *Ayala*, 135 S.Ct. at 2208 (2015) (Kennedy, J., concurring).

[21] *Id.*

[22] *Id.* at 2209-10.

[23] Courts review the length and nature of conditions when considering whether the confinement violates rights against degrading treatment and rights to family life. *See, e.g.*, Ramirez-Sanchez v. France, App. No. 59450/00, 2006 Eur. Ct. H.R. 685; Öcalan v. Turkey (No. 2), App. Nos. 24069/03, 197/04, 6201/06, 10464/07, 2014 Eur. Ct. H.R. 286; *see also* Breivik v. Ministry of Justice and Public Security, Case No. 15-107496TVI-OTIR/02 (Oslo District Court, 2016).

[24] *See* Sharon Shalev & Kimmett Edgar, *Deep Custody: Segregation Units and Close Supervision Centres in England and Wales*, PRISON REFORM TRUST (2015*), available at* http://www.prisonreformtrust.org.uk/Portals/0/Documents/deep_custody_111215.pdf. A comprehensive review of practices can be found in Sharon

Included in SCDC' 4.29.19 letter to LOC

Shalev, *A Sourcebook on Solitary Confinement,* MANNHEIM CENTRE FOR CRIMINOLOGY, LONDON SCH. OF ECON. (2008), *available at* http://solitaryconfinement.org/uploads/sourcebook_web.pdf.

[25] U.N. Standard Minimum Rules for the Treatment of Prisoners (the "Nelson Mandela Rules"), G.A. Res. 11745, U.N. Doc. E/CN.15/2015/L.6/Rev.1 (May 22, 2015), *available at* http://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6_Rev1/ECN152015_L6Rev1_e_V1503585.pdf; *see also General Assembly Adopts 64 Third Committee Texts Covering Issues Including Migrants, Children's Rights, Human Rights Defenders* (Dec. 17, 2015), *available at* http://www.un.org/press/en/2015/ga11745.doc.htm.

[26] *Id.* at 18 (Rule 44).

[27] *Id.* (Rule 43(1)).

[28] *Id.* (Rule 45(1)).

[29] *Id.* (Rule 45(2)).

[30] *Fins*, *supra* note 2, at 36 (listing the number of prisoners on death row in each jurisdiction as of October 1, 2015). These thirty-five jurisdictions included: thirty-two jurisdictions, including thirty-one states and the federal system (including the federal government and the U.S. military – counted as one jurisdiction), with a death penalty statute in effect for all of 2015; one state (New Mexico) that repealed the death penalty prospectively prior to 2016, but continued to hold prisoners whose death sentences may or may not be carried out; one state (Nebraska) in which the status of the death penalty was the subject of a pending referendum; and one state (Connecticut) in which, at the time, the retroactive application of the death penalty after a prospective legislative repeal was an issue pending before the state supreme court.

[31] *Fins, supra* note 2*,* at 1.

[32] In doing this research, at least two law students reviewed each jurisdiction's statutes and administrative codes on LexisNexis or WestLaw, consulted each jurisdiction's Department of Corrections policies, where publicly available, and ran a Google search for relevant news articles and reports. Specifically, the following search strings were used: "death w/3 sentence," "death AND row," "solitary AND confin*," and "execut*." In addition, the students individually read all death penalty-related sections of each jurisdiction's statute or administrative code. This functioned as an additional accuracy check to ensure that the search strings did not omit important information.

[33] The jurisdictions are Alabama, California, Colorado, Connecticut, Georgia, Idaho, Indiana, Kentucky, Louisiana, Nebraska, New Hampshire, Oregon, Pennsylvania, South Dakota, Texas, Washington and Wyoming. *See* Appendix A.

[34] These jurisdictions are Alabama, California, Oregon, and New Hampshire. *See* Appendix A.

[35] *See* Appendix A.

[36] *See* Appendix A.

[37] IDAHO CODE ANN. § 19-2705 (2016).

[38] 61 PA. CONS. STAT. ANN. § 4303 (West 2016).

[39] WYO. STAT. ANN. §7-13-907 (2015).

[40] WASH. REV. CODE § 10.95.170 (2015).

[41] TEX. GOV'T CODE ANN. § 501.113(b)(1) (West 2015).

[42] FLA. ADMIN. CODE ANN. r. 33-601.830 (2015).

[43] *Id*.

[44] S.D. CODIFIED LAWS § 23A-27A-31.1 (2015).

[45] TEX. GOV'T CODE ANN. § 501.112 (2015).

[46] OR. ADMIN. r. 291-093-0005 (2015).

[47] OHIO ADMIN. CODE r. 5120-9-12 (2016).

Included in SCDC' 4.29.19 letter to LOC

[48] *Id.*

[49] CONN. GEN. STAT. § 18-10b (2015).

[50] *Id.* In the spring of 2016, the Connecticut Supreme Court reaffirmed that the death penalty abolition statute applied to those individuals who had been sentenced to death before the statute was enacted. *See* State v. Peeler, 321 Conn. 375 (2016).

[51] *See* Appendix A.

[52] ALA. CODE § 15-18-80(a) (2016).

[53] CAL. PENAL CODE § 3600(b)(1) (2015).

[54] COLO. REV. STAT. ANN. § 18-1.3-1205 (West 2016).

[55] N.H. REV. STAT. ANN. § 630:5 (West 2016).

[56] LA. REV. STAT. ANN. § 15:568 (West 2016).

[57] *See* COLO. REV. STAT. ANN. § 18-1.3-1205 (West 2016); IDAHO CODE ANN. §19-2705 (2015); S.D. CODIFIED LAWS § 23A-27A-31.1 (2015); WYO. STAT. ANN. §7-13-907 (2015). Colorado and Wyoming affirmatively protect prisoners' access to specified visitors, while Idaho and South Dakota assume the availability of such visits, but indicate that they are subject to the rules of the facility.

[58] COLO. REV. STAT. ANN. § 18-1.3-1205 (West 2016).

[59] IDAHO CODE ANN. § 19-2705 (2016).

[60] S.D. CODIFIED LAWS § 23A-27A-31.1 (2016).

[61] WYO. STAT. ANN. §7-13-907 (2015).

[62] *See* Ala. Code § 15-18-81 (2016); Ind. Code Ann. § 35-38-6-4 (2016).

[63] ALA. CODE § 15-18-81 (2016).

[64] IND. CODE ANN. § 35-38-6-4 (West 2016).

[65] 61 PA. CONS. STAT. ANN. § 4303 (West 2016).

[66] *See* Appendix A; FLA. ADMIN. CODE r. 33-601.830 (2015) (allotting minimum of six hours); OHIO ADMIN. CODE r. 5120-9-12 (2016) (permitting five hours); OR. ADMIN. R. 291-093-0015 (2016) (specifying minimum hours for exercise). A few jurisdictions' laws also provide for particular security classifications for death-sentenced prisoners, at least initially, which may impact out-of-cell time and other cell privileges. These jurisdictions include California, which considers a death sentence to be an "administrative determinant" that overrides other classification factors, *see* CAL. CODE REGS. tit. 15 § 3375.2(b)(5) (2015); Connecticut, *see* CONN. GEN. STAT. § 18-10b (2015); New Hampshire, *see* N.H. CODE ADMIN. R. ANN. COR 402.04 (2015); and Oregon, *see* OR. ADMIN. R. 291-104-0111 (2015).

[67] FLA. ADMIN. CODE r. 33-601.830 (2015).

[68] OHIO ADMIN. CODE r. 5120-9-12 (2016).

[69] The eighteen states with published policies were: Arizona, California, Colorado, Idaho, Indiana, Kansas, Kentucky, Montana, Nebraska, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Virginia, and Washington. In determining which states had published policies, we considered only states in which the state's Department of Corrections had made available online a formal statement of policy or procedure regarding the housing of death-sentenced prisoners – whether referred to as a "policy," "regulation," or by some other name – to have a published policy. States for which information regarding housing procedures for death-sentenced prisoners could be inferred from descriptions of death row conditions on Department of Corrections websites, in handbooks intended for use by prisoners and their families, or from media reports were not considered to have published policies. These states included Alabama, Arkansas, Delaware, Georgia, Mississippi, Missouri, Nevada, and Utah.

Included in SCDC' 4.29.19 letter to LOC

[70] *See Inmate Security Classification Levels 1 Through 4*, OHIO DEP'T. OF CORR. POLICIES, No. 53-CLS-01 (Aug. 4, 2015), *available at* http://www.drc.ohio.gov/web/drc_policies/documents/53-CLS-01.pdf.

[71] *Restrictive Housing*, IDAHO DEP'T OF CORR., No. 319.02.01.002 (Sep. 6, 2011), *available at* https://www.idoc.idaho.gov/content/policy/720.

[72] *Id.*

[73] *See* Alanna Durkin, *Virginia Quietly Grants Death Row Inmates New Privileges*, AP: THE BIG STORY (Oct. 16, 2015), *available at* http://bigstory.ap.org/article/24129250f1b74fefb1c4d4921f3aa199/virginia-quietly-grants-death-row-inmates-new-privileges. *See also* Brief in Opp'n to Cert., *Prieto v. Clarke*, 2015 WL 5312503, at *7-9, No. 15-31 (Sept. 9, 2015) (describing modifications to conditions for death-sentenced prisoners).

[74] *A Death Before Dying*, *supra* note 14, at 4.

[75] *Id.* at 4.

[76] *Id.* at 5.

[77] *Id.* at 4.

[78] *Id.* ("The majority of death row prisoners eat alone in their cells, fed on trays inserted through a slot in the door. They also receive the majority of their medical and mental health care through these slots.").

[79] *Id.* at 5 ("In fact, 81 percent of states allow only one hour or less of exercise daily for death row prisoners. And nearly half provide only a cage, pen, or cell in which to exercise."); *accord Inmates Sentenced to Death Housing Policy*, ASS'N OF STATE CORR. ADMINS. (Feb. 2013), *available at* http://www.asca.net/system/assets/attachments/5520/WA%20-%20Death%20Penalty%20Housing.pdf?1362689706 [hereinafter 2013 ASCA Survey] (showing a majority of responding states do not allow group recreation).

[80] *A Death Before Dying*, *supra* note 14, at 5.

[81] *Id.* at 5.

[82] *Id.* at 5.

[83] *Id.* ("Most death row prisoners will never be able to touch or hug family members or loved ones, as 67 percent of states mandate no-contact visitation for death row prisoners. This means that all human interactions during family visits occur while the prisoner is behind some sort of barrier. Frequently, prisoners will also be in arm and leg restraints during visits."); *accord* 2013 ASCA Survey, *supra* note 79.

[84] *A Death Before Dying*, *supra* note 14, at 5 ("An overwhelming majority of states do not allow death row prisoners to have access to work or employment opportunities, or provide access to educational or vocational programming of any kind."); *accord* 2013 ASCA Survey, *supra* note 79 (providing qualitative responses indicating the sorts of programming available in each responding state).

[85] *See* ASCA-Liman, *Time-in-Cell*, *supra* note 4.

[86] *Id.* at 52-53.

[87] ASCA received responses from the following states reporting that they housed death-sentenced prisoners at the time of the survey: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Idaho, Kentucky, Louisiana, Maryland, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, and Wyoming. 2013 ASCA Survey, *supra* note 79. This survey is also discussed in Marah Stith McLeod, *Does the Death Penalty Require Death Row? The Harm of Legislative Silence*, 77 OHIO STATE L.J. 2016 (forthcoming 2016), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2589716 (last visited June 6, 2016).

[88] 2013 ASCA Survey, *supra* note 79, at 3-4. The 2013 ASCA survey was from February 2013. Maryland abolished the death penalty later that year. *See* Ian Simpson, *Maryland Becomes Latest U.S. State to Abolish Death Penalty*, REUTERS (May 2, 2013), *available at* http://www.reuters.com/article/us-usa-maryland-deathpenalty-idUSBRE9410TQ20130502.

Included in SCDC' 4.29.19 letter to LOC

[89] 2013 ASCA Survey, *supra* note 79, at 1-8.

[90] *Id.* at 9-16. These states were Alabama, Arizona, Arkansas, California, Florida, Kentucky, Nebraska, Nevada, New Hampshire, North Carolina, Ohio, Oregon, Tennessee and Utah.

[91] *Id.* These states were Alabama, Delaware, Kentucky, Nebraska, Nevada, New Hampshire, North Carolina, Ohio, Oregon, South Carolina and Utah.

[92] *Id.* at 25-32. The states reporting programming opportunities were Alabama, Arkansas, Arizona, California, Delaware, Florida, Kentucky, Louisiana, Maryland, Mississippi, Missouri, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Washington, Wyoming, Tennessee, Texas and Utah. The states permitting contact visitation opportunities were Alabama, Arkansas, California, Connecticut, Florida, Idaho, Kentucky, Louisiana, Missouri, Nebraska, Nevada, Ohio and Tennessee.

[93] *See* Sandra Babcock, *Survey of Death Row Conditions*, DEATH PENALTY INFO. CTR. (2008), *available at* http://www.deathpenaltyinfo.org/death-row.

[94] *Id.*

[95] *Id.* These jurisdictions were Alabama, California, Illinois, Indiana, Missouri, Nevada, North Carolina, Ohio, Oregon, South Carolina and Utah.

[96] *Id.* These jurisdictions were Connecticut, Missouri, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Virginia and Washington.

[97] *Id.* These jurisdictions were Alabama, Arkansas, California, Georgia, Indiana, Louisiana, Missouri, Nevada, Virginia and Washington.

[98] *Id.* These jurisdictions were Alabama, California, Colorado, Connecticut, Georgia, Idaho, Indiana, Missouri, Nevada, New Jersey, Ohio, Oklahoma, South Carolina, Tennessee, Virginia, Washington and Wyoming.

[99] Andrea D. Lyon & Mark D. Cunningham, *"Reason Not the Need": Does the Lack of Compelling State Interest in Maintaining a Separate Death Row Make It Unlawful?*, 33 AM. J. CRIM. L. 1, 4-5 (2005); *see also* Mark D. Cunningham, Thomas J. Reidy,& Jon R. Sorensen, *Wasted Resources and Gratuitous Suffering: The Failure of a Security Rationale for Death Row*, 22 PSYCHOL. PUB. POL'Y & L. 185 (2016) [hereinafter Cunningham, Reidy & Sorenson, *Wasted Resources*].

[100] *See* McLeod, *supra* note 87.

[101] COLO. REV. STAT. ANN. § 18-1.3-1205 (West 2016).

[102] Mark D. Cunningham, Thomas J. Reidy & Jonathan R. Sorensen, *Is Death Row Obsolete? A Decade of Mainstreaming Death-Sentenced Inmates in Missouri*, 23 BEHAV. SCI. & L. 307 (2005) [hereinafter Cunningham, Reidy & Sorenson, *Is Death Row Obsolete?*].

[103] *See* Cunningham, Reidy, & Sorenson, *Wasted Resources*, *supra* note 99.

[104] Director Raemisch and Deputy Director Wasko were interviewed together.

[105] *Fins*, *supra* note 2, at 35.

[106] *Executions Carried Out Under Current Death Penalty Statute*, N.C. DEP'T OF PUB. SAFETY (2016), *available at* https://ox.dps.prod.nc.gov/Adult-Corrections/Prisons/Death-Penalty/List-of-persons-executed/Executions-1984-2006.

[107] *Id.*

[108] Telephone Interview with Kenneth Lassiter, Deputy Dir. for Operations, N.C. Dep't of Pub. Safety (April 2, 2015). Although death-sentenced prisoners were moved within Central Prison in 2000, the relocation did not entail a change of conditions.

[109] *Id.*

[110] *Fins*, *supra* note 2, at 52.

Included in SCDC' 4.29.19 letter to LOC

[111] A description of the conditions on North Carolina's death row for men at Central Prison can be found on the NCDPS website. *See Death Row and Death Row Watch*, N.C. DEP'T OF PUB. SAFETY [hereinafter *Death Row and Death Row Watch*], *available at* https://www.ncdps.gov/index2.cfm?a=000003,002240,002327. The policies on conditions of confinement are available online. *See* Division of Prisons, *Policies and Procedures: Conditions of Confinement*, N.C. DEP'T OF CORR. (Nov. 1, 2011), *available at* http://www.doc.state.nc.us/dop/policy_procedure_manual/C1200.pdf. In addition, a number of media accounts have reported on Unit III. *See* Steve Daniels, *I-Team: Inside the Walls of Raleigh's Central Prison*, ABC NEWS (Feb. 24, 2014), *available at* http://abc11.com/archive/9443918/; *Life on Death Row: 'Am I Going to Be Next?*',' WRAL (Feb. 27, 2013), *available at* http://www.wral.com/life-on-death-row-am-i-going-to-be-next-/12160383/; *WRAL Visits NC's Death Row*, WRAL (Feb. 27, 2013), *available at* http://www.wral.com/news/local/video/12161641/; *Inside NC's Death Row*, WRAL (Feb. 27, 2013), *available at* http://www.wral.com/news/local/image_gallery/12155529/; *On Death Row...a Rare Look Inside the Chambers*, WFMY NEWS (May 17, 2012), *available at* http://archive.digtriad.com/news/article/229062/1/On-Death-RowA-Rare-Look-Inside-The-Chambers.

[112] *Death Row and Death Row Watch*, *supra* note 111. This Report focuses on Central Prison, which houses male prisoners. However, NCDPS reported that the conditions for women were similar, consisting of a single cell with a bed, lavatory, and commode, in a cellblock with a dayroom that had a television and table and chairs for meals. Women were given at least an hour per day for exercise and showers and had access to religious services.

[113] Interview with Lassiter, *supra* note 108; *Death Row and Death Row Watch*, *supra* note 111.

[114] Interview with Lassiter, *supra* note 108; *Death Row and Death Row Watch*, *supra* note 111.

[115] Interview with Lassiter, *supra* note 108.

[116] *Death Row and Death Row Watch*, *supra* note 111.

[117] Interview with Lassiter, *supra* note 108; *Death Row and Death Row Watch*, *supra* note 111.

[118] *Death Row and Death Row Watch*, *supra* note 111.

[119] Prisoners watching television listened to the audio through portable headsets. The television channel was determined by a committee of prisoners. Interview with Lassiter, *supra* note 108.

[120] *Id.*

[121] *Id.*; *Death Row and Death Row Watch*, *supra* note 111.

[122] Interview with Lassiter, *supra* note 108.

[123] *Id.*; *Death Row and Death Row Watch*, *supra* note 111.

[124] Interview with Lassiter, *supra* note 108; *Death Row and Death Row Watch*, *supra* note 111.

[125] Interview with Lassiter, *supra* note108.

[126] *Death Row and Death Row Watch*, *supra* note 111.

[127] Interview with Lassiter, *supra* note 108.

[128] *Id.*; *Death Row and Death Row Watch*, *supra* note 111.

[129] *Death Row and Death Row Watch*, *supra* note 111.

[130] *Id.*

[131] *Id.*

[132] Interview with Lassiter, *supra* note 108. Lassiter stated that the only time he could remember North Carolina's death row policies being subject to political criticism was the incident discussed here.

[133] Gary D. Robertson, *North Carolina House Committee Votes to Remove TVs for Death Row Inmates*, FAYETTEVILLE OBSERVER (Jun. 7, 2012), *available at* http://www.fayobserver.com/ news/crime_courts/north-carolina-house-committee-votes-to-remove-tvs-for-death/article_1a20530c-7991-59f8-921f-ca722192d168.html.

[134] H.B. 1008, 2011-2012 Leg. Sess. (N.C. 2011).

Included in SCDC' 4.29.19 letter to LOC

[135] Interview with Lassiter, *supra* note 108.

[136] *Id.*

[137] *Id.*

[138] *Id.*

[139] *Id.*

[140] *Id.*

[141] *Id.*

[142] *Id.*

[143] *Id.*

[144] *Id.*

[145] *Id.*

[146] *Id.*

[147] *Id.*

[148] *See Execution List 2016*, DEATH PENALTY INFO. CTR. (2016), *available at* http://www.deathpenaltyinfo.org/execution-list-2016.

[149] George Lombardi, Richard D. Sluder & Donald Wallace, *Mainstreaming Death Sentenced Inmates: The Missouri Experience and Its Legal Significance*, 61 FED. PROBATION 3 (1997).

[150] *Id.*

[151] *Id.*

[152] Lyon & Cunningham, *supra* note 99, at 4.

[153] Telephone Interview with George Lombardi, Dir., Mo. Dep't of Corr. (April 16, 2015).

[154] McDonald v. Armontrout, Case No. 85-4422-CV-C-5 (W.D. Mo. Aug. 19, 1985), *available at* http://www.clearinghouse.net/chDocs/public/PC-MO-0001-0005.pdf.

[155] *Id.* at 1.

[156] Interview with Lombardi, *supra* note 153.

[157] Consent Decree, McDonald v. Armontrout, No. 85-4422-CV-C-5 (W.D. Mo. May 22, 1986), *available at* http://www.clearinghouse.net/chDocs/public/PC-MO-0001-0001.pdf.

[158] *Id.* at 4–15.

[159] *Id.* at 8, 10.

[160] *Id.* at 9.

[161] *Id.* at 19.

[162] *See* McDonald v. Armontrout, No. 85-4422CVC5, 1989 WL 1128973, at *1 (W.D. Mo. May 10, 1989). The physical structure and security measures at PCC were "quite similar" to most other maximum-security facilities in the nation. Lyon & Cunningham, *supra* note 99, at 7.

[163] Lombardi, Sluder, & Wallace, *supra* note 149, at 9.

[164] Interview with Lombardi, *supra* note 153.

[165] McDonald v. Bowersox, 1995 WL 17013058, at *1 (E.D. Mo. Sep. 18, 1995) (describing history of litigation).

[166] Lombardi, Sluder, & Wallace, *supra* note 149, at 9.

Included in SCDC' 4.29.19 letter to LOC

[167] Interview with Lombardi, *supra* note 153.

[168] *Id.*

[169] *Id.*

[170] *Id.*

[171] Lombardi, Sluder, & Wallace, *supra* note 149, at 10.

[172] *Id.* at 13.

[173] Interview with Lombardi, *supra* note 153.

[174] *Id.*; *see also* McDonald v. Bowersox, No. 89-1086 C (2), 1995 WL 17013058, at *1 (E.D. Mo. Sep. 18, 1995) (noting that officials at the PCC altered the conditions of class members' confinement by "mainstreaming" them with other prisoners at the PCC and that by 1995 death-sentenced prisoners at the PCC were treated the same as other maximum security prisoners incarcerated there).

[175] Lombardi, Sluder, & Wallace, *supra* note 149, at 13.

[176] McDonald v. Bowersox, No. 89-1086 C (2), 1995 WL 17013058, at *1-2 (E.D. Mo. Sep. 18, 1995) ("By their motion to vacate, defendants seek an order dissolving the decree adopted by the May 10, 1989, ruling and terminating the Court's jurisdiction over this case . . . . Defendants urge the purposes of the decree have been fulfilled because the changes in conditions meet or supersede the requirements of the May 10, 1989, decree. Because the purposes and goals of that decree are achieved by the present conditions of plaintiffs' confinement, movants argue, it is proper to vacate the decree.")

[177] *Id.* at *3-27.

[178] McDonald v. Carnahan, 109 F.3d 1319 (8th Cir. 1997).

[179] Lombardi, Sluder, & Wallace, *supra* note 149, at 8-9.

[180] Interview with Lombardi, *supra* note 153.

[181] Cunningham, Reidy & Sorenson, *Is Death Row Obsolete?*, *supra* note 102, at 311.

[182] *Id.*

[183] *Id.*

[184] Interview with Lombardi, *supra* note 153.

[185] Cunningham, Reidy & Sorenson, *Is Death Row Obsolete?*, *supra* note 102, at 311.

[186] *Id.* These units included: four administrative segregation units; one transitional administrative segregation unit; two levels of "baseline" general population units; two levels of general population units; one "positive action community" or "honor dorm;" one protective custody unit; one special needs unit; and one partial treatment unit.

[187] *Id.*

[188] *Id.*

[189] Interview with Lombardi, *supra* note 153.

[190] Cunningham, Reidy & Sorenson, *Is Death Row Obsolete?*, *supra* note 102, at 311.

[191] Interview with Lombardi, *supra* note 153.

[192] Cunningham, Reidy & Sorenson, *Is Death Row Obsolete?*, *supra* note 102, at 311.

[193] *Id.*

[194] *Id.*

[195] *Id.*

[196] Lombardi, Sluder, & Wallace, *supra* note 149, at 11.

Included in SCDC' 4.29.19 letter to LOC

[197] *Joint Committee on Corrections: Information for Legislative Institutional Visits,* MO. GEN. ASSEMBLY JOINT COMM'N 1, at 3 (2012), *available at* http://www.moga.mo.gov/corrections/Potosi.pdf.

[198] Interview with Lombardi, *supra* note 153.

[199] Lombardi, Sluder, & Wallace, *supra* note 149, at 11–12.

[200] *Visiting Hours by Institution,* MO. DEP'T OF CORR. (2010), *available at* http://doc.mo.gov/DAI/Visiting_Hours.php.

[201] *Id.* at 311–12.

[202] Interview with Lombardi, *supra* note 153.

[203] Lombardi, Sluder, & Wallace, *supra* note 149, at 11–12.

[204] Interview with Lombardi, *supra* note 153.

[205] Lombardi, Sluder, & Wallace, *supra* note 149, at 12.

[206] *Id.* at 10.

[207] *Id.* at 11–12.

[208] *Id.* at 7.

[209] Interview with Lombardi, *supra* note 153.

[210] Director Lombardi notes that at MSP, where capital punishment prisoners were locked down in segregation day after day, he saw more prisoners acting out. *Id.*

[211] *Id.*

[212] *Id.*

[213] Cunningham, Reidy & Sorenson, *Is Death Row Obsolete?*, *supra* note 102, at 311.

[214] Interview with Lombardi, *supra* note 153.

[215] *Id.*

[216] *Id.*

[217] *See Execution List by State*, DEATH PENALTY INFO. CTR. (2016), *available at* http://www.deathpenaltyinfo.org/node/5741#CO.

[218] *See* Erica Goode, *After 20 Hours in Solitary, Colorado's Prisons Chief Wins Praise*, N.Y. TIMES (Mar. 15, 2014), *available at* http://www.nytimes.com/2014/03/16/us/after-20-hours-in-solitary-colorados-prisons-chief-wins-praise.html. Tom Clements's brief two-year tenure as the head of CDOC came to an end in March 2013 when a former CDOC prisoner murdered him at his home. *See* Keith Coffman, *Prosecutors Say Neo-Nazi Killed Colorado Prison Chief, Pizza Delivery Man*, REUTERS (Feb. 10, 2014), *available at* http://www.reuters.com/article/us-usa-colorado-shooting-idUSBREA1A03C20140211. The prisoner, Evan Ebel, had spent much of his eight-year prison sentence housed in administrative segregation and had been released directly from isolation to the community. *Id.*

[219] *Rick Raemisch*, COLO. OFFICIAL STATE WEB PORTAL, https://www.colorado.gov/governor/rick-raemisch; Press Release, Colo. Office of the Governor, Gov. Hickenlooper Names New Department of Corrections Executive Director (June 14, 2013), *available at* https://www.colorado.gov/governor/news/gov-hickenlooper-names-new-department-corrections-executive-director.

[220] *Death Row FAQ*, COLO. DEP'T OF CORR., *available at* http://www.doc.state.co.us/death-row-faq. This is an archived website that is no longer active.

[221] *Id*.

[222] *Id*. The most secure custody level in Colorado today was "Restrictive Housing Maximum Security Status." *Offender Classification*, COLO. DEP'T OF CORR., Administrative Regulation 600-01, at 3 (effective Jan. 1, 2015), *available at* http://www.doc.state.co.us/sites/default/files/ar/0600_01_010115_3.pdf. For information on conditions,

Included in SCDC' 4.29.19 letter to LOC

see *Restrictive Housing*, COLO. DEP'T OF CORR., Administrative Regulation 650-03, (effective Jan. 15, 2015), *available at* http://www.doc.state.co.us/sites/default/files/ar/0650_03_011515_1.pdf.

[223] *Death Row Daily Routine*, COLO. DEP'T OF CORR., *available at* http://www.doc.state.co.us/daily-routine (on file with authors).

[224] Telephone Interview with Rick Raemisch, Dir., and Kellie Wasko, Deputy Dir., Colo. Dep't of Corr. (Mar. 30, 2015).

[225] *Id.*

[226] *Id.*

[227] Goode, *supra* note 218.

[228] E-mail from Rick Raemisch, Dir., Colo. Dep't of Corr. (May 5, 2016) (on file with authors).

[229] E-mail from Kellie Wasko, Deputy Exec. Dir., Colo. Dep't of Corr., to staff (Mar. 4, 2014, 14:57 MST), *available at* http://www.scribd.com/doc/244050829/Death-Row-Ad-Seg-Colorado-DOC.

[230] Telephone Interview with Raemisch and Wasko, *supra* note 224. Colorado Governor John Hickenlooper granted prisoner Nathan Dunlap a temporary reprieve from his 2013 execution date and announced that it is "highly unlikely" that he will reconsider allowing the execution to go forward during his time in office. Karen Augé & Lynn Bartels, *Nathan Dunlap Granted 'Temporary Reprieve' By Governor,* THE DENVER POST (May 22, 2013), *available at* http://www.denverpost.com/breakingnews/ci_23299865/nathan-dunlap-temporary-reprieve-from-governor; Karen Augé & Adrian Garcia, *Judge: Nathan Dunlap to Face Execution on Week of Aug. 18*, THE DENVER POST (May 1, 2013), *available at* http://www.denverpost.com/ci_23147555/nathan-dunlap-execution-date-august-18-24-2013. Hickenlooper won a second term in November 2014.

[231] Telephone Interview with Raemisch and Wasko, *supra* note 224.

[232] *Death Row*, COLO. DEP'T OF CORR., *available at* http://www.doc.state.co.us/death-row (last visited May 2015) (on file with authors). There are currently no female death-sentenced prisoners in Colorado. *Id*.

[233] Telephone Interview with Raemisch and Wasko, *supra* note 224.

[234] E-mail from Kellie Wasko, Deputy Dir., Colo. Dep't of Corr. (May 5, 2016) (on file with authors).

[235] Telephone Interview with Raemisch and Wasko, *supra* note 224.

[236] *Management of Close Custody Offenders*, COLO. DEP'T OF CORR., Administrative Regulation 600-09, at 3 (effective June 30, 2014). CDOC defined close custody as "[a] general population offender classification level which requires an increased level of housing, supervision, controlled movement, and monitored programming. Close custody offenders may have an additional designation based on their management needs." *Id*. at 2.

[237] The designations were: Close Custody General Population; Close Custody Management Unit; Close Custody Management Unit / Protective Custody; Close Custody Management Unit / High Risk; Close Custody Transition Unit. *Id*. at 1-2.

[238] *Id*. at 3.

[239] Telephone Interview with Raemisch and Wasko, *supra* note 224.

[240] *Id.*

[241] *Management of Close Custody Offenders*, *supra* note 236, at 3; *see also* Telephone Interview with Raemisch and Wasko, *supra* note 224.

[242] *See* Dunlap v. Zavaras, No. CIV.A 09CV01196BNB, 2009 WL 2006848, at *2 (D. Colo. Jul. 9, 2009).

[243] *See* Dunlap v. Clements, No. 09-CV-01196-WJM-MEH, (D. Colo. Aug. 4, 2011); *see also* Kirk Mitchell, *Colorado Moves Death-Row Inmates So They Can Exercise Outdoors*, THE DENVER POST (Jul. 28, 2011), *available at* http://www.denverpost.com/ci_18564471.

[244] Telephone Interview with Raemisch and Wasko, *supra* note 224.

Included in SCDC' 4.29.19 letter to LOC

[245] Troy Anderson challenged the conditions of confinement in administrative segregation at Colorado State Penitentiary (CSP). *See* Anderson v. Colorado, Dep't of Corr., 848 F. Supp. 2d 1291, 1294 (D. Colo. 2012). Mr. Anderson alleged that he had been denied appropriate diagnosis and treatment for serious mental health issues; that the Colorado State Penitentiary provided no facility for outdoor exercise and therefore caused physical and mental harm; and that an arbitrary system prevented him from earning his way out of administrative segregation and effectively punished his improperly treated mental illness. *Id.*

The district court held that the long-term lack of access to outdoor exercise, coupled with the problems in conditions, violated the Eight Amendment. *See* Anderson v. Colorado, 887 F. Supp. 2d 1133, 1140-42 (D. Colo. 2012). The court ordered the CDOC to develop and present a plan that "ensures that Troy Anderson has access for at least one hour, at least three times per week, to outdoor exercise in an area that is fully outside and that includes overhead access to the elements, e.g., to sunlight, rain, snow and wind." *Id.* at 1157. Colorado initially transferred Mr. Anderson to Sterling. *See* Anderson v. Colorado, 10 Cv. 1005 (RBJ/KMT), at 3 (D. Col. Apr. 7, 2015). Subsequently, Colorado agreed to build an outdoor recreation area at CSP. *See* Alan Pendergrast, *Colorado Supermax Will Build Rec Yards to Settle Prisoners' Lawsuit*, WESTWARD (Dec. 7, 2015), *available at* http://www.westword.com/news/colorado-supermax-will-build-rec-yards-to-settle-prisoners-lawsuit-7402391.

[246] E-mail from Kellie Wasko, Deputy Exec. Dir., Colo. Dep't of Corr. (May 5, 2016) (on file with authors).

[247] *Management of Close Custody Offenders*, *supra* note 236, at 5-6.

[248] *Id.* at 8-9.

[249] Telephone Interview with Raemisch and Wasko, *supra* note 224.

[250] *See Management of Close Custody Offenders*, *supra* note 236, at 9.

[251] *Id.* at 7.

[252] Telephone Interview with Raemisch and Wasko, *supra* note 224.

[253] Todd Shepherd, *Dept of Corrections Wants Less Solitary, More 'Leisure Time' for Death Row Inmates*, THE COMPLETE COLORADO: PAGE TWO (Oct. 22, 2014), *available at* http://completecolorado.com/pagetwo/2014/10/22/dept-of-corrections-wants-less-solitary-more-leisure-time-for-death-row-inmates/.

[254] Joey Bunch, *Tom Clements' Widow Tells Bob Beauprez to Stop Using Prison Chief's Death*, THE DENVER POST: THE SPOT (Oct. 23, 2014, 3:39 pm), *available at* http://blogs.denverpost.com/thespot/2014/10/23/tom-clements-widow-tells-bob-beauprez-stop-using-prison-chiefs-death/114478.

[255] Telephone Interview with Raemisch and Wasko, *supra* note 224.

[256] Telephone Interview with Raemisch and Wasko, *supra* note 224.

[257] Cunningham, Reidy & Sorenson, *Is Death Row Obsolete?*, *supra* note 102, at 310.

[258] *Id.* at 313-314.

[259] *Id.* at 316.

[260] *Id.*

[261] *Id.*

[262] *Id.* at 316.

[263] *See generally* Cunningham, Reidy, & Sorenson, *Wasted Resources*, *supra* note 99.

[264] *Id.* at 191.

[265] *Id.* at 195.

[266] *Id.* at 185.

[267] "From a violence risk-management standpoint, widespread adoption of mainstreaming [capital punishment] inmates is fiscally sound, promotes the most efficient use of limited staffing resources, reflects a scientifically

Included in SCDC' 4.29.19 letter to LOC

informed approach to classification, and reduces the substantial psychological costs of death row. The closing of death row is efficient, enlightened, and humane. To do otherwise is to perpetuate a legacy of wasted resources and gratuitous suffering." *Id.* at 197.

Included in SCDC' 4.29.19 letter to LOC

Appendix A: Statutes, Administrative Regulations and Case Law by Jurisdiction

Jurisdiction	Statute	Administrative Regulation	Case Law	Other Sources
Alabama	**Ala. Code § 15-18-80 (2016):** "(a) Whenever any person is sentenced to death, the clerk of the court in which the sentence is pronounced shall, within 10 days after sentence has been pronounced, issue a warrant under the seal of the court for the execution of the sentence of death, . . . which shall be directed to the warden of the William C. Holman unit of the prison system at Atmore, commanding him to proceed, at the time and place named in the sentence, to carry the same into execution, as provided in Section 15-18-82, and the clerk shall deliver such warrant to the sheriff of the county in which such judgment of conviction was had, to be by him delivered to the said warden, together with the condemned person as provided in subsection (b) of this section; provided, however, that in case of appeal to the Supreme Court of Alabama by the defendant and the suspension of execution of sentence by the trial court, said condemned person shall remain in the county jail of the county in which the conviction was had	**Ala. Admin. Code r. 240-X-1-.01 (2016):** "(2) The Commissioner is vested with the authority to carry out and enforce the provisions of Title 14, Code of Ala. 1975, and to promulgate rules and regulations not inconsistent with Title 14 [Criminal Correctional and Detention Facilities]."	**Laube v. Haley, 234 F. Supp. 2d 1227, 1238 n. 5 (M.D. Ala. 2002):** "Disciplinary segregation is different from other types of segregation. Inmates may be housed in segregation [at Tutwiler] for a variety of reasons; for example, they are in protective custody, are on death row, or their security classification calls for constant segregation." **McCray v. Bennet, 467 F. Supp. 187, 190 (M.D. Ala. 1978):** "The segregation unit is located on the west side of Holman prison; it consists of 244 individual cells, including 48 cells in the old death row unit. Not all of these cells are in operation at the present time. Inmates who are housed in the segregation unit are restricted to single cells. They are not allowed to work. They receive a maximum of thirty	**Alabama Department of Corrections Male Inmate Handbook:** Level VII, the highest security level, "is the security level for Death Row housing."[1] **Alabama Department of Corrections website**: "As planned in response to Kilby Prison's continued deterioration, the Main Office moved . . . [in] November 1968. To accommodate the inmates, during November of 1969, Holman Prison was completed. . . . [T]he maximum security unit housed all death row inmates and was designated by statute to be the location for all electrocutions."[2] "The Holman Correctional Facility houses Death Row inmates and is the only facility in the state that carries out executions. Additional housing of Death Row inmates is located at the William C. Donaldson Correctional Facility in Bessemer, Alabama. The present population of Holman C.F. consists of minimum through closed custody inmates, including life without parole and

Included in SCDC' 4.29.19 letter to LOC

Included in SCDC' 4.29.19 letter to LOC

	unless the court in which the case is tried orders otherwise, in which case, upon the affirmation of the appeal by the Supreme Court, said warrant for the execution of the death sentence, under seal of the court, together with the person of the condemned shall be delivered within 10 days after such affirmation to the warden of Holman prison as provided above." **Ala. Code § 15-18-81 (2016):** "Upon the receipt of a condemned person by the warden of Holman prison, he shall be confined therein until the time for his execution arrives; and, while so confined, all persons outside the said prison shall be denied access to him, except his physician and lawyer, who shall be admitted to see him when necessary to his health or for the transaction of business, and the relatives, friends and spiritual advisors of the condemned person, who shall be admitted to see and converse with him at all proper times, under such reasonable rules and regulations as may be made by the Board of Corrections."		minutes of exercise per day. They have no access to the general population of the prison. They are allowed to have visitors, but even on these occasions they are kept isolated from the rest of the prisoners. Normally, a prisoner is released from his segregation cell only when he is accompanied by two guards." **Mitchell v. Fuqua, 2000 WL 362040, at *3 (S.D. Ala. Mar. 20, 2000):** "First, plaintiff has provided this Court with no evidence whatsoever that the defendant knew that housing a segregation inmate on the death row side of the segregation unit would increase the likelihood of an attack on that inmate's person particularly since death row inmates are housed in single cells almost the entire day." **Eaton v. Capps, 348 F. Supp. 237, 242 (M.D. Ala. 1972), aff'd, 480 F.2d 1020 (5th Cir.**	Death Row inmates. . . . There are 200 segregation unit beds and Death Row has a capacity of 194 for a total of 1031 beds."[3] **Alabama Department of Corrections Administrative Regulations:** Does not contain a section on housing death row inmates.

Included in SCDC' 4.29.19 letter to LOC

			1973): “Petitioner is not being confined on death row for purposes of reasonable maintenance of prison discipline . . . nor for “administrative” purposes, . . . rather, Petitioner is being held on death row segregated from the general prison population solely because of a now invalid sentence which was imposed upon him. . . . [C]ontinued segregation solely because of this invalid sentence cannot be sanctioned. It is, therefore, the Order, judgment and decree of this Court that . . . Petitioner be removed from death row and placed in general population in the prison system of Alabama . . .”	
Arizona				**Arizona Department of Corrections website**: “Arizona’s Death Row for men is located in the Browning Unit at Arizona State Prison Complex-Eyman which is located just outside the city of Florence Arizona. Female inmates on Death Row are housed at the Lumley Unit at the Arizona State Prison Complex-Perryville, near

Included in SCDC' 4.29.19 letter to LOC

				Goodyear Arizona. All executions are performed in Central Unit at the Arizona State Prison Complex-Florence in Florence Arizona. The Browning Unit at ASPC-Eyman has 720 single-man cells. In addition to confining Condemned Death Row male inmates, Browning Unit also houses 230 validated gang members of eight certified Security Threat Groups. In addition Browning Unit has a Violence Control unit where inmates requiring exceptional management are housed. All male and female inmates on Death Row are classified as maximum custody. All inmates are in single cells which are equipped with a toilet, sink, bed and mattress. Each Death Row inmate has no contact with any other inmate. Out-of-cell time is limited to outdoor exercise in a secured area, two hours a day, three times a week, and a shower, three times a week. All meals are delivered by correction officers at the cell front. Limited non-contact visitation is available. Death Row inmates may place two ten minute telephone calls per week. Personal property is limited to hygiene items, two appliances, two books and writing materials, which can be purchased from the inmate

Included in SCDC' 4.29.19 letter to LOC

				commissary. Health care is provided at the Health Unit; medication is passed out at the cell front. Clergy contacts are provided at the cell."[4] **Arizona Department of Corrections Orders, Chapter 800, Sec. 801.09, 1.1.1 (2010):** Classifying death-sentenced inmates as maximum custody prisoners.[5] **Arizona Department of Corrections Orders, Chapter 800, Sec. 801.03, 1.3 (2010):** "Non-discretionary overrides – The following criteria requires the inmate to be classified no lower than the highest custody level associated with the criteria as applicable to the inmate. . . . 1.3.1 Death Sentence – maximum custody."[6] **Arizona Department of Corrections Orders, Chapter 700, Sec. 704.08, 1.5.11.1 (2013):** "Neither inmate placed together in a double cell environment shall have: . . . A sentence to condemned row or an active court appeal pending the death sentence."[7] **Arizona Department of Corrections Orders, Chapter 100, Sec. 101.02, 1.4 (2010):**

Included in SCDC' 4.29.19 letter to LOC

				Provides that all orders must be approved by the Director of the Arizona DOC.[8]
Arkansas				**Department of Corrections Inmate Handbook (2016):** “Special Status/Assignment . . . Death Row visits are held in accordance with the appropriate administrative directive.”[9] **News Sources:** An account from a released former death row prisoner describes his experience at the super maximum security facility in Grady, Arkansas. He described being in a single cell in solitary confinement; being able to communicate orally with other death-sentenced prisoners held in single cells; being transported in shackles to an exercise yard; having no-contact visitation with a non-spouse and chaperoned visitation with a spouse.[10]
California	**Cal. Penal Code § 3600 (2016):** “(a) Every male person, upon whom has been imposed the judgment of death, shall be delivered to the warden of the California state prison designated by the department for the execution of the death penalty, there to be kept until the execution of the judgment, except as	**15 Cal. Code Regs., tit. 15 § 3375.2 (2016):** “(b) [A]dministrative determinants . . . may be imposed by Departmental officials to override the placement of an inmate at a facility according to his/her placement score. (5) DEA. Inmate was		**CA Department of Corrections Operation Manual:** Section 61010.11.5 (Placement): “Apply Mandatory Minimum Score Factor Code A to inmates sentenced to Death.” Code A is a Mandatory Minimum Score of 52, the highest minimum possible. The Mandatory Minimum Score determines the minimum Placement Score. “The

Included in SCDC' 4.29.19 letter to LOC

	provided in subdivision (b). (b) Notwithstanding any other provision of law: (1) A condemned inmate who, while in prison, commits any of the following offenses, or who, as a member of a gang or disruptive group, orders others to commit any of these offenses, may, following disciplinary sanctions and classification actions at San Quentin State Prison, pursuant to regulations established by the Department of Corrections, be housed in secure condemned housing designated by the Director of Corrections, at the California State Prison, Sacramento: (A) Homicide. (B) Assault with a weapon or with physical force capable of causing serious or mortal injury. (C) Escape with force or attempted escape with force. (D) Repeated serious rules violations that substantially threaten safety or security. (2) The condemned housing program at California State Prison, Sacramento, shall be fully operational prior to the transfer of any condemned inmate. (3) Specialized training protocols for supervising condemned inmates shall be provided to those line staff and supervisors at the	formerly or is currently sentenced to death."		Placement Score is one of the factors used to determine the security level to which the inmate is assigned."[11] Section 62050.6 (Inmates with Death Sentences): San Quentin "is the reception center for all male inmates with a death sentence unless the Director has designated another institution as the place of reception. Death sentence inmates shall not be transferred to any other institution without the prior approval of the DRB and the Director. Exceptions may be made for temporary transfer to CMF for urgent or emergency medical treatment with prior approval . . ." The California Institution for Women "is the reception center for all female inmates with a death sentence. Upon exhaustion of her appeal and by order of the Deputy Director, Institutions, a female inmate sentenced to death shall be transferred to [San Quentin] within three days of her execution date."[12] **News Sources:** According to an article in 2015, eath row at San Quentin was a five-tiered unit, housing over 500 prisoners in 6-by-9 foot single cells. California had a 40-inmate psychiatric unit to treat death-sentenced prisoners suffering from mental illness, and

Included in SCDC' 4.29.19 letter to LOC

	California State Prison, Sacramento, who supervise condemned inmates on a regular basis. (4) An inmate whose medical or mental health needs are so critical as to endanger the inmate or others may, pursuant to regulations established by the Department of Corrections, be housed at the California Medical Facility or other appropriate institution for medical or mental health treatment. The inmate shall be returned to the institution from which the inmate was transferred when the condition has been adequately treated or is in remission. (c) When housed pursuant to subdivision (b) the following shall apply: (1) Those local procedures relating to privileges and classification procedures provided to Grade B condemned inmates at San Quentin State Prison shall be similarly instituted at California State Prison, Sacramento, for condemned inmates housed pursuant to paragraph (1) of subdivision (b) of Section 3600. Those classification procedures shall include the right to the review of a classification no less than every 90 days and the			was about to open a 100-inmate wing to shift some death-sentenced prisoners. 68 death-sentenced prisoners are held in the "North Block," which houses prisoners with good behavior.[13] According to an article in 2014, all female death-sentenced prisoners were housed at the Central California Women's Facility, and all male death-sentenced prisoners were housed in three units at San Quentin. Those three units included: the Adjustment Center, where death-sentenced prisoners were initially housed, and to which they were returned "if they behave badly;" North Segregation, for prisoners "who have behaved well for years;" and East Block, which housed "everyone else." Prisoners housed in the Adjustment Center were in single cells for 23 ½ hours of the day. In North Segregation, prisoners were released from their cells from 7AM to 1:30PM and permitted to walk freely in a contained environment.[14]

	opportunity to petition for a return to San Quentin State Prison. (2) Similar attorney-client access procedures that are afforded to condemned inmates housed at San Quentin State Prison shall be afforded to condemned inmates housed in secure condemned housing designated by the Director of Corrections, at the California State Prison, Sacramento. Attorney-client access for condemned inmates housed at an institution for medical or mental health treatment shall be commensurate with the institution's visiting procedures and appropriate treatment protocols. (3) A condemned inmate housed in secure condemned housing pursuant to subdivision (b) shall be returned to San Quentin State Prison at least 60 days prior to his scheduled date of execution. (4) No more than 15 condemned inmates may be rehoused pursuant to paragraph (1) of subdivision (b). (d) Prior to any relocation of condemned row from San Quentin State Prison, whether proposed through legislation or any other means, all maximum security Level IV, 180-degree housing unit facilities with an electrified perimeter shall be evaluated by the			

Included in SCDC' 4.29.19 letter to LOC

	Department of Corrections for suitability for the secure housing and execution of condemned inmates.”			
Colorado	**Colo. Rev. Stat. Ann. § 18-1.3-1205 (West 2016):** “When a person is convicted of a class 1 felony, the punishment for which is death, and the convicted person is sentenced to suffer the penalty of death, the judge passing such sentence shall appoint and designate in the warrant of conviction a week of time within which the sentence must be executed; the end of such week so appointed shall be not fewer than ninety-one days nor more than one hundred twenty-six days from the day of passing the sentence. Said warrant shall be directed to the executive director of the department of corrections . . . and shall be delivered to the sheriff of the county in which such conviction is had, who, within three days thereafter, shall proceed to the correctional facilities at Canon City and deliver the convicted person, together with the warrant, to said executive director or designee, who shall keep the convict in confinement until execution of the death penalty. Persons shall be permitted access		**Dunlap v. Clements, No. 09-CV-01196-WJM-MEH, (D. Colo. Aug. 4, 2011)**: Order granting parties’ request to administratively close § 1983 suit based on parties’ entry of settlement agreement. The agreement provided that death-sentenced inmates would be moved to Sterling Correctional Facility to give them the opportunity for outdoor exercise, which was not available at the Colorado State Penitentiary at Canon City.[15]	**Colorado Department of Corrections Policies, Regulation Number 600-01, (IV)(D)(6)(b) (2016):** “All offenders received with a death penalty sentence will be reviewed for Close Custody Management Control Units, in accordance with AR 600-09, *Close Custody Offenders*. All male offenders will be initially assigned to the Sterling Correctional Facility (SCF) or the Colorado State penitentiary (CSP) and all female offenders will initially be assigned to the Denver Women’s Correctional Facility (DWCF).”[16] **Colorado Department of Corrections Policies, Regulation Number 600-09, (2014):** “(III)(C) Close Custody Management Control Unit (MCU): A close custody designation that provides an increased level of housing, supervision and control to maintain the safety of the public, volunteers, staff and offenders. . . . (IV)(A)(6) Offenders with death penalty sentences may initially be assigned to Restrictive Housing

Included in SCDC' 4.29.19 letter to LOC

Included in SCDC' 4.29.19 letter to LOC

	to the inmate pursuant to prison rules. Such rules shall provide, at a minimum, for the inmate's attendants, counsel, and physician, a spiritual adviser selected by the inmate, and members of the inmate's family to have access to the inmate.”			Maximum Security Status in accordance with AR 650-03, (Restrictive Housing), prior to transitioning to Close Custody Management Control Units. The Director of Prisons/designee will be consulted and shall approve all initial placements and transition plans for these offenders. (IV)(C)(6) Telephone Access: Offenders designated as Close Custody shall be allowed limited telephone privileges unless phone restrictions have been invoked by the Warden or designee. . . . (IV)(C)(7) Access to Services: Offenders designated as Close Custody shall have access to Programs and services that include, but are not limited to the following; educational services, commissary services, library services, social services, counseling services, religious guidance and recreational programs. . . . (IV)(C)(9) Visiting Privileges: Offenders designated as Close Custody shall have opportunities for contact, non-contact and attorney visiting, unless there are documented substantial reasons for withholding such privileges. . . .

Included in SCDC' 4.29.19 letter to LOC

				(IV)(C)(11) Recreational Opportunities: Offenders designated as Close Custody shall receive a minimum of one hour of exercise per day outside their cells, a minimum of five days per week, unless security or safety considerations dictate otherwise. . . . (IV)(C)(19) Offender Work Assignments: Offenders designated as Close Custody shall be given consideration for facility, unit, and/or pod employment opportunities in accordance with AR 300-23 . . ." (IV)(G)(1)(b); (IV)(G)(2)(b); and (IV)(G)(3)(c): states that offenders in Management Control Unit (MCU), MCU/High Risk, or MCU/Protective Custody "will be afforded a minimum of 4 hours of out of cell time per day (7 days per week) to participate in pod/day hall, recreational, and programming activities. Out of cell time includes 3 hours of indoor or outside recreation per week. (1) A maximum of 8 offenders designated as Close Custody Management Control (MCU) may be allowed out of their cells at a time to participate in pod/day hall, recreational, and programming activities in the day hall or outside

Included in SCDC' 4.29.19 letter to LOC

				recreation areas. . . ."[17]
Connecticut	**Conn. Gen. Stat. § 18-10b (2016):** "(a) The Commissioner of Correction shall place an inmate on special circumstances high security status and house the inmate in administrative segregation until a reclassification process is completed under subsection (b) of this section, if . . . (2) the inmate is in the custody of the Commissioner of Correction for a capital felony committed prior to April 25, 2012, . . . for which a sentence of death is imposed . . . and such inmate's sentence is (A) reduced to a sentence of life imprisonment without the possibility of release by a court of competent jurisdiction . . . . (c)(1) The commissioner shall place such inmate in a housing unit for the maximum security population if, after completion of such reclassification process, the commissioner determines such placement is appropriate, provided the commissioner (A) maintains the inmate on special circumstances high security status, (B) houses the inmate separate from inmates who are not on			**Chief Attorney Report on Prison Conditions:** Written in 2011, the report states that inmates sentenced to death were housed at Northern Correctional Institution, where DOC directives set out the conditions of confinement. Death-sentenced prisoners were held in single cells, had "two hours of recreation outside of their cells six days a week and [were] always by themselves," "[ate] meals alone in their cells," were "allowed up to three non-contact visits per week that [were] limited to one hour," needed to be "escorted by at least one staff person" and "placed in restraints when moving outside their cell," and "may have work assignments that are restricted to the death row housing unit."[18] **News Sources:** Since the Connecticut Supreme Court has ruled the death penalty unconstitutional, with another case pending, there remain questions about whether the inmates will continue to be held in death row or in similar conditions to those sentenced to life in prison without parole.[19]

Included in SCDC' 4.29.19 letter to LOC

	special circumstances high security status, and (C) imposes conditions of confinement on such inmate which shall include, but not be limited to, conditions that require (i) that the inmate's movements be escorted or monitored, (ii) movement of the inmate to a new cell at least every ninety days, (iii) at least two searches of the inmate's cell each week, (iv) that no contact be permitted during the inmate's social visits, (v) that the inmate be assigned to work assignments that are within the assigned housing unit, and (vi) that the inmate be allowed no more than two hours of recreational activity per day."			
Delaware				**Delaware Department of Corrections Website:** "All inmates currently sentenced to the death penalty are housed in maximum security at James T. Vaughn Correctional Center (JTVCC). The inmates may be housed in any of the available maximum housing units and may be assigned to any program available to other maximum security classified inmates. The cells are approximately 13 feet long, 7 feet wide and 8 feet high. They may be housed in single cells or in cells with another inmate in some maximum security units.

Included in SCDC' 4.29.19 letter to LOC

				Their housing assignment, program assignment, and privilege level are reviewed every 90 days. Meals: All inmates sentenced to the death penalty are served the same meals as the general population . . . In more restrictive units, they are served meals in their cells; those assigned to less restrictive units eat in a dining hall in a group setting. . . . Showers and Exercise: Inmates sentenced to the death penalty receive opportunities to shower and exercise up to seven days each week depending on their maximum security unit assignment. The weekly time permitted for [showers] and recreation can range from as few as three hours each week and can reach up to 21 hours each week." Death-sentenced prisoners, depending on their security control level, may be allowed to participate in group recreation, join available programs, and move without restraints.[20]
Florida		**Fla. Admin. Code r. 33-601.830 (2016):** "(1)(a) Death Row – The single-cell special housing status of an inmate who, upon		

Included in SCDC' 4.29.19 letter to LOC

		conviction or adjudication of guilt of a capital felony, has been sentenced to death. Death row housing shall be separate from general population housing. . . . (5)(a) Prior to opening a death row cell for any reason, staff members shall restrain the inmate. . . . (7)(j) Exercise – An exercise schedule shall be implemented to ensure a minimum of six hours per week of exercise out-of-doors. . . . (7)(l) Visitation – Death row visits shall be contact visits unless security concerns indicate that a non-contact visit is necessary . . . (15) Death Warrants – Upon receipt of a death warrant signed by the Governor authorizing execution, the warden or designee will determine the housing location of the inmate. Inmates housed at Union		

		Correctional Institution will be immediately transferred to Florida State Prison. . . . If the inmate is housed at Lowell Correctional Institution, the inmate shall not be transferred to Florida State Prison until Phase II. . . . (2) The inmate's visiting list shall be frozen once an execution date is set. . . . All visits shall be non-contact, except that the inmate may receive a one-hour contact visit on the day of execution."		
Georgia	**Ga. Code Ann. § 17-10-33 (West 2016):** "Upon a judgment of death made by a judge, it shall be the duty of the judge to sentence the defendant to death and to indicate the sentence in writing, ... In all cases it shall be the duty of the sheriff of the county in which the defendant is sentenced, . . . to convey the defendant to the appropriate state correctional institution, not more than 20 days nor less than two days prior to the time fixed in the judgment for the execution of the defendant, unless otherwise directed by the			**Georgia Department of Corrections Facility Descriptions:** Indicates men under death sentence were housed at Georgia Diagnostic and Classification Prison.[21] **News Sources:** Prison Legal News reported in 2010 that the Georgia DOC had decided to revoke contact family visits and cap the number of non-family visitors. Although the rules required that prisoners be allowed one hour of yard recreation a day, the prisoners told reporters that they were receiving 2.5 hours a week instead.[22] These Rules and Regulations are not

Included in SCDC' 4.29.19 letter to LOC

Included in SCDC' 4.29.19 letter to LOC

	Governor or unless a stay of execution has been caused by an appeal, granting of a new trial, or other order of a court of competent jurisdiction."			publicly available.
Idaho	**Idaho Code Ann. § 19-2705 (West 2016):** "(1) Whenever a person is sentenced to death, the judge passing sentence shall . . . sign and file a death warrant fixing a date of execution not more than thirty (30) days thereafter. . . . (3) Whenever a person is under death warrant, execution of which has not been stayed, the warden of the prison in which the person is incarcerated shall keep the condemned person in solitary confinement until execution. No person shall be allowed access to the condemned person except law enforcement personnel investigating matters within the scope of their duties, the attorney of record, attending physicians, a spiritual adviser of the condemned's choosing, and members of the immediate family of the condemned, and then only in accordance with prison rules. Persons under death warrant will be allowed contact visits with their attorneys of record and the agents			**Idaho Department of Corrections Directive 303.02.01.001, Sec. 5 (2014):** "Inmates under the sentence of death . . . will be housed in either the Idaho Maximum Security Institution (IMSI) for males or the Pocatello Women's Correctional Center (PWCC) for females."[23] **Idaho Department of Corrections Directive 319.02.01.002, Sec. 07.02.00–07.10.00 (2016):** "Newly committed offenders under sentence of death will be placed directly into restrictive housing . . . . Investigation staff will have fifteen (15) days to . . . complete a referral file . . . . The restrictive housing committee for offenders under sentence of death has two (2) weeks to review the file submitted by the investigation staff . . . . Within seventy-two (72) hours following the two (2) week review period, the chairperson will schedule a restrictive housing hearing." After this hearing, the "director will review all the information and make

Included in SCDC' 4.29.19 letter to LOC

	of their attorneys of record. Such visits will take place subject to prison rules. No other contact visits shall be permitted. Prison officials have authority to suspend or deny visits when the safe, secure and orderly operation of the facility or public safety could be compromised. . . . (11) When a person has been sentenced to death, but the death warrant has been stayed, the warden is not required to hold such person in solitary confinement or to restrict access to him until the stay of the death warrant is lifted or a new death warrant is issued by the sentencing court; provided however, no condemned person shall be housed in less than maximum security confinement, and provided further that nothing in this section shall be construed to limit the warden's discretion to house such person under conditions more restrictive if necessary to ensure public safety or the safe, secure and orderly operation of the facility . . ."			a decision regarding the offender's housing placement . . . . If the release to close-restricted custody is not approved, the offender will remain unclassified in administrative segregation. If the release is approved, the offender will be classified as close-restricted custody and released from administrative segregation." The restrictive housing committee will review the housing status of death-sentenced prisoners at least once a year to determine if they may be released into close-restricted housing with the rest of the general prison population that has been classified into close-restricted housing. Inmates in close-restricted housing are permitted to work.[24]
Indiana	**Ind. Code Ann. § 35-38-6-3 (West 2016):** "Sec. 3. A sheriff who receives a warrant under section 2 [death warrant] or section 7 of this			**Indiana Department of Corrections, Policy and Administrative Procedures 02-03-115, (IV), (IX) (2007):** Stating that death-sentenced

Included in SCDC' 4.29.19 letter to LOC

	chapter shall immediately: (1) transport the person to the state prison; . . . ." **Ind. Code Ann. § 35-38-6-4 (West 2016):** "Sec. 4. (a) The convicted person shall be confined in the state prison until the date of the convicted person's execution. The convicted person may temporarily be held in a maximum security facility for security purposes or during renovation of the state prison. A convicted female shall be confined in a maximum security women's prison until not more than thirty (30) days before the date of her execution. A convicted female shall be segregated from male prisoners after her transfer from the women's prison. (b) The convicted person's: (1) attorney; (2) physician; (3) relatives; (4) friends; and (5) spiritual advisor; may visit the convicted person while the convicted person is confined. The department of correction shall adopt rules, under IC 4-22-2, governing such visits."			prisoners are flagged as 'Potential High Risk Offenders,' who may upon further review be categorized as 'High Risk Offenders' depending on other factors; 'High Risk Offenders' may be placed in administrative segregation if they present a threat to safety or security.[25] **Indiana Department of Corrections Website:** "Offenders sentenced to death in Indiana are housed at the Indiana State Prison in Michigan City, IN. . . . All offenders on Death Row are classified as maximum security and housed in single cells."[26]
Kansas				**Kansas Department of Corrections, Internal Management Policy and Procedure 20-104**

Included in SCDC' 4.29.19 letter to LOC

				(2004): "(I)(A) Inmates may be confined in administrative segregation for any of the reasons or conditions articulated under procedure I.B. of this IMPP. . . . (II)(B)(16) An inmate may be placed in administrative segregation if the inmate has been sentenced to death subsequent to his or her conviction of a capital offense, and such inmates shall not be subject to the [periodic reviews] . . . unless there is some departure from their capital status due to any substantive action taken by the courts."[27]
Kentucky	**Ky. Rev. Stat. Ann. § 532.100 (West 2016):** "(3) When a sentence of death is imposed, the court shall commit the defendant to the custody of the Department of Corrections with directions that the sentence be carried out according to law."			**Kentucky Corrections Policies and Procedures, Policy No. 10.2, Special Management Inmates:** "'Death row' means a maximum security housing situation to control the inmate serving a sentence of death."[28] "An inmate may be placed in administrative segregation for one (1) or more of the following: . . . f. Pending orientation and classification of an inmate received under sentence of death, if necessary."[29]
Louisiana	**La. Rev. Stat. Ann. § 15:568 (West 2016):** "Until the time of his execution,		**Ball v. Leblanc, 792 F.3d 584, 589-90 (5th Cir. 2015):**	

Included in SCDC' 4.29.19 letter to LOC

	the Department of Public Safety and Corrections shall incarcerate the offender in a manner affording maximum protection to the general public, the employees of the department, and the security of the institution."		Stating that Louisiana's death row facility, Angola, houses death row inmates in cells for 23 hours.	
Mississippi				**Mississippi Department of Corrections, Inmate Handbook Chapter 1, (II)(D) (2015):** "Death Row Inmates committed to the MDOC under a sentence of death and are housed in a facility/unit deemed appropriate by the MDOC Commissioner. Death Row status requires the highest level of custody supervision available. Inmates in this status are precluded from assignment to a principal custody designation." Identifies Central Mississippi Correctional Facility and Mississippi State Penitentiary as the facilities that house Death Row custody assignments.[30] **Mississippi Department of Corrections Website:** "All male Death Row offenders are housed at MSP [Mississippi State Penitentiary], Unit 29, and all female offenders sentenced to Death are housed at Central Mississippi

Included in SCDC' 4.29.19 letter to LOC

				Correctional Facility in Rankin County."[31]
Missouri				**Missouri Department of Corrections Website:** Paper detailing Missouri's mainstreaming of death row inmates into the general prison population after January 8, 1991.[32]
Montana				**Department of Corrections, Montana State Prison Operational Procedure 4.2.1, Inmate Classification System:** "Maximum custody: is the third highest custody level as determined by the prison's objective classification system. Inmates classified to this level require the highest degree of control and supervision because of extreme misconduct or the nature of their sentence (death sentence). Inmates classified to this level must be housed in a locked housing unit."[33] "Inmates within the following categories will be separated from the general population, to the extent possible: . . . Maximum custody, administrative segregation, and restricted administrative segregation cases."[34]
Nebraska	**Neb. Rev. Stat. Ann. § 29-2543 (West 2016):**			**Department of Correctional Services Administrative**

Included in SCDC' 4.29.19 letter to LOC

	"(1) Whenever any person has been tried and convicted before any district court in this state, has been sentenced to death, and has had his or her sentence of death affirmed by the Supreme Court on mandatory direct review, it shall be the duty of the Supreme Court to issue a warrant, . . . establishing a date for the enforcement of the sentence directed to the Director of Correctional Services, commanding him or her to proceed at the time named in the warrant." **Neb. Rev. Stat. Ann. § 29-2546 (West 2016):** "Whenever the Supreme Court reverses the judgment of conviction in accordance with which any convicted person has been sentenced to death and is confined in a Department of Correctional Services adult correctional facility as herein provided, it shall be the duty of the Director of Correctional Services, upon receipt of a copy of such judgment of reversal, duly certified by the clerk of the court and under the seal thereof, to forthwith deliver such convicted person into the custody of the sheriff of the county in which the conviction was had to be held in the jail of the county awaiting the further			**Regulation 210.01:** Provides a table that shows how Death Row prisoner conditions of confinement differ from other differently classified individuals. For instance, death-sentenced prisoners may not receive meals in their cells, but can shave and shower once per day, have contact visits, can exercise outside their cell for two hours, once per day, and have work assignments.[35] **Department of Correctional Services Administrative Regulation 201.02:** "All male inmates committed to the NDCS [Nebraska Department of Correctional Services], with the exception of males sentenced to death, shall be received at the Diagnostic & Evaluation Center . . . . Males sentenced to death shall be received at, or immediately transferred to the NDCS institution designated by the Director."[36] Uses the term "death row."[37] **Department of Correctional Services Administrative Regulation 201.05**: "The Director shall designate Restrictive Housing units to house special management inmates. . . . SPECIAL MANAGEMENT

Included in SCDC' 4.29.19 letter to LOC

	judgment and order of the court in the case."			INMATES INCLUDE, BUT ARE NOT LIMITED TO, INMATES IN ONE OR MORE OF THE FOLLOWING CATEGORIES: . . . B. Death Row – The confinement of inmates sentenced to the death penalty."[38]
Nevada				**Department of Corrections Website:** Ely State Prison contains a "Condemned Men's Unit" with visiting hours posted online.[39] **News Sources:** Death-sentenced male prisoners were housed in single cells at Ely State Prison, and many spent 23 hours per day in their cells.[40]
New Hampshire	**N.H. Rev. Stat. Ann. § 630:5 (West 2016):** "XIII. When the penalty of death is imposed, the sentence shall be that the defendant be imprisoned in the state prison at Concord until the day appointed for his execution, which shall not be within one year from the day sentence is passed."	**N.H. Code Admin. R. Ann., Cor 402.04 (2016):** "(e) Death sentence inmates shall: (1) Not be assigned a classification score lower than C-5 [maximum custody] at initial classification; (2) Not be eligible for re-classification lower than C-5 and thus not be subject to re-classification hearings; and (3) Be afforded all the same access to		**Department of Corrections "Time in Prison" Handbook (2001):** The C-5 custody level "provides the highest degree of supervision and control. Inmates are locked in their cells approximately 22 hours daily with limited time for exercise within the living quarters."[41]

		programs, recreation and other services as afforded to other C-5 inmates."		
New Mexico				**Corrections Department, Policies and Procedures, CD-143000:** "Involuntary Placement into Custody Levels V and VI: Separation from the general population of an inmate whose continued presence in the general population represents a threat to the security of the institution or the inmate is in danger of bodily harm or other violent acts from himself/herself or other inmates, if the inmate remains in the general population. This category includes all pre-trial detainees (county jail holds) and death-sentenced inmates."[42] **Corrections Department, Policies and Procedures, CD-143003:** "Inmates Sentenced to Death: . . 2. Inmates in this status shall be subject to conditions of confinement as per the Table of Services, Step 4, with the exception of congregate activity, which must be approved by the Warden."[43]
North Carolina				**North Carolina Department of Public Safety Policy & Procedure Manual, C.1201:** "Death Row is the classification status established for inmates sentenced to Prisons under a death

Included in SCDC' 4.29.19 letter to LOC

Included in SCDC' 4.29.19 letter to LOC

				order commitment. Only Central Prison and the North Carolina Correctional Institution for Women are authorized to establish a death row housing unit. Death Row classification inmates shall be housed in a secure area of the facility and segregated from the general inmate population in so far as feasible."[44] Death-sentenced prisoners are "permitted to receive meals outside the cell if control can be maintained in the protective and death row facility."[45] Death-sentenced prisoners also "have the opportunity to shave twice a week and shower at least three times per week . . . limited to a maximum of ten (10) minutes per day." Furthermore, "Unless specifically restricted under the provisions of this policy, inmates assigned to death row . . . shall be provided one hour per day to exercise outside the cell."[46] "If approved by the Director, television privileges may be authorized by the facility head for death row . . . inmates depending upon programmatic needs of the offender and physical plant characteristics."[47] When receiving

Included in SCDC' 4.29.19 letter to LOC

				visitors, "death row offenders will normally visit only in the noncontact visiting area."[48]
Ohio		**Ohio Admin. Code § 5120-9-12 (2016):** "(A) All inmates sentenced to death under Ohio law shall be confined in one or more institutions designated by the director of the department of rehabilitation and correction. Such inmates may be assigned to an area of the institution to be designated by the managing officer, which area shall be known as 'death row.' (B) Absent significant extenuating circumstances, no inmate shall be assigned to or housed in death row unless that inmate has been sentenced to death. . . . (C) The director or his designee may assign or reassign an inmate who has been sentenced to death to a security		**Ohio Department of Rehabilitation and Correction Policies, 53-CLS-01:** "1. . . . Death row is not a security classification, and inmates assigned to this status are not subject to security classification procedures as long as they remain in this status. 2. An inmate assigned to death row status who presents a threat to security may be subject to assignment to a security classification that is appropriate for the security risk. In the event of a potential security classification assignment for a death row inmate, the security classification procedures for the proposed security level shall be followed. Once the inmate no longer poses a threat to security in death row, he may be returned to that status."[49]

Included in SCDC' 4.29.19 letter to LOC

		classification or special management status other than that which is normally used for such inmates, based on the security or medical and mental health requirements for the inmate. The inmate so assigned shall receive the privileges and programming that are appropriate for the other security or management status, notwithstanding paragraph (D) of this rule. (D) Inmates who are sentenced to death and who have not been reassigned to some other status shall receive cell privileges which at a minimum, shall include: (1) Personal hygiene articles; (2) Mail and kite privileges; (3) Access to legal materials and services, including legal kit; (4) Access to cleaning articles for cell sanitation as approved by the warden or his designee; (5) Visits by department		

Included in SCDC' 4.29.19 letter to LOC

		staff; (6) Adequate food; (7) Access to current rules of the Ohio administrative code, also known as 'ARs,' 5120-9 series; (8) Cell furnishings to include toilet, wash basin, running water, mattress, sheets, blanket (depending on weather conditions); (9) Access to medical services as required by their medical condition; (10) Regular assessment of their mental health condition by the bureau of behavioral health services and access to such services as required by their mental health condition; (11) Institution coveralls or clothing, underwear, and footwear; (12) Adequate lighting for reading; (13) Five hours of recreation per week; (14) Opportunity to shower and shave five times per week; (15) One non-contact visit per visitor, per		

Included in SCDC' 4.29.19 letter to LOC

		month; and (16) Limited commissary purchases."		
Oklahoma			**Hooks v. State, 22 P.3d 231, 233 (Okla. 2001):** "Oklahoma's prison system has one Death Row and one place of execution, both housed in the McAlester prison."	**Oklahoma Department of Department of Corrections Policy & Operations Manual, OP-060107:** "Offenders assigned to death row who are not employable due to lockdown status or other justifiable reasons may promote to Level 3 [a less restrictive custody level] if all other level criteria is met."[50]
Oregon	**Or. Rev. Stat. Ann. § 137.463 (West 2016):** "(1) When a sentence of death is pronounced, the clerk of the court shall deliver a copy of the judgment of conviction and sentence of death to the sheriff of the county. The sheriff shall deliver the defendant within 20 days from the date the judgment is entered to the correctional institution designated by the Director of the Department of Corrections pending the determination of the automatic and direct review by the Supreme Court under ORS 138.012."	**Death Row Housing Unit, Or. Admin. R. 291-093 *et seq.* (2016)** **Or. Admin. R. 291-093-0005:** "(3) Policy: It is the policy of the Department of Corrections to assign inmates with a sentence of death to the Death Row Housing Unit or to a Death Row status cell." **OAR § 291-093-0015:** Detailing death row inmates' access to canteen services, clothing, exercise, mail, telephone, visiting, religious services,		

Included in SCDC' 4.29.19 letter to LOC

		education and other materials. Inmates on death row "may be provided an opportunity for inside exercise a minimum of 40 minutes per day (which may include shaving and showering), seven days per week" and "an opportunity for outside exercise for one hour per day a minimum of five days per week, if they choose to participate." **Or. Admin. R. 291-104-0111 (2016):** "(9) Custody Classification Level: One of five levels of supervision assigned to an inmate through initial and classification review procedures. (a) Level 5: An inmate assigned at this custody classification level meets one of the following criteria: . . . (B) Has a sentence of death or is pending retrial in a case in which a sentence of death may be re-imposed. (C) Has a pending trial		

Included in SCDC' 4.29.19 letter to LOC

		for a case in which a sentence of death may be imposed. . . ."		
Pennsylvania	**61 Pa. C.S.A. § 4303 (West 2016):** "Upon receipt of the warrant, the secretary shall, until infliction of the death penalty or until lawful discharge from custody, keep the inmate in solitary confinement. During the confinement, no person shall be allowed to have access to the inmate without an order of the sentencing court, except the following: (1) The staff of the department. (2) The inmate's counsel of record or other attorney requested by the inmate. (3) A spiritual adviser selected by the inmate or the members of the immediate family of the inmate."		**Jones v. Sec'y Pennsylvania Dep't of Corr., 549 F.Appx 108 (3d Cir. 2013) cert. denied sub nom. *Jones v. Wetzel*, 135 S. Ct. 94, 190 L. Ed. 2d 77 (2014):** Court ruled that former death row prisoner's Eighth Amendment rights were not violated by his confinement in solitary while awaiting resentencing to LWOP. State statute 61 Pa. Cons.Stat. Ann. § 4303 requires solitary confinement of death row prisoners, and prison policy requires that any death row prisoners who may still be subject to death after resentencing must reside in the CCU. Prisoner challenged that prison policy; Third Circuit held that the prison was reasonably exercising the power given to it by the legislature to house and classify prisoners, and that prisoner could not	

Included in SCDC' 4.29.19 letter to LOC

			demonstrate that the administrative-segregation-like conditions of death row infringed on his constitutional rights.	
South Carolina				**South Carolina Department of Corrections (SCDC) Policy and Procures OP-22.16 (2014): Policy Statement** To promote safety and security, inmates assigned to the Death Row Unit at Lieber Correctional Institution will be housed in an area that is separate and independent from all other areas where other SCDC inmates are assigned. . . . NOTE: THESE PROCEDURES APPLY ONLY TO MALE INMATES ON DEATH ROW AT LIEBER CORRECTIONAL INSTITUTION. FEMALE DEATH ROW INMATES WILL BE ASSIGNED TO A HOUSING AREA WITHIN THE SPECIAL MANAGEMENT UNIT AT CAMILLE GRIFFIN GRAHAM CORRECTIONAL INSTITUTION (CGGCI). IF A FEMALE IS ASSIGNED TO DEATH ROW AT CAMILLE GRIFFIN GRAHAM CORRECTIONAL INSTITUTION, INSTITUTIONAL SPECIFIC PROCEDURES FOR THIS INMATE WILL BE DEVELOPED… [AND] WILL BE PUBLISHED AS A SUPPLEMENT

				TO THIS POLICY/PROCEDURE. (2) ASSIGNMENT OF INMATES TO LEVELS: Death Row inmates will be assigned to Level I, II, or III based upon their behavior/classification status. Most inmates on Death Row will be assigned to Levels II or III. (2.2) .. The following will be applicable for all Death Row inmates who are placed on execution status: (2.2.1) The inmate placed on execution status will be housed in a specific location of the B-Wing on the Death Row Unit. (2.2.2) The inmate placed on execution status will not be allowed to associate with other inmates at anytime while in execution status. Separate visiting hours will be established for those inmates. (2.2.3) Inmates placed on execution status will not be allowed out of the cell at the same time as other Death Row inmates. (3) DEATH ROW UNIT: The U-1 housing unit will be utilized for Death Row inmates at Lieber. Death sentenced inmates will be separated from those in Security Detention as well as from inmates in the general population for the purpose of maintaining the safety, security, and

Included in SCDC' 4.29.19 letter to LOC

Included in SCDC' 4.29.19 letter to LOC

				order of the facility. (7) INSTITUTIONAL CLASSIFICATION COMMITTEE (ICC) (7.3.1) … New arrivals will be classified as Level I. (7.3.3) Level I – Inmates assigned to Level I will be reviewed every 30 days for behavior change and as needed for status change. (7.3.4) Level II – Inmates assigned to Level II will be reviewed for a possible change in level status every 90 days following their initial placement in Level II. (7.3.5) Level III – Inmates assigned to Level III will have an annual status review once per year, unless a change occurs (i.e., disciplinary, court decision, or another event) that would affect status. (9) RECREATION (9.1) Schedule: Death Row inmates in any category of segregation will be allowed out-of-cell recreation privileges (indoor/outdoor) five (5) days a week, to exclude weekends and holidays, at least one (1) hour per day, weather permitting, unless safety and security reasons dictate otherwise. (9.1.1) Level I: Level I Death Row inmates will retain their restraints while they are secured within the

Included in SCDC' 4.29.19 letter to LOC

				individualized recreation area. (Only one [1] inmate at a time may be recreated in these areas.) (9.1.2) Level II: Inmates will have general recreation with other Level II and Level III inmates. Only one (1) inmate will be allowed in recreation area. (28) DEATH ROW SECURITY STAFF DUTIES: (28.2) Death Row Escort Procedures: Death Row inmates will be strip-searched and placed in restraints before exiting the cell block. (28.3.1) . . . Inmates in Level I will be housed in a separate physical location. Inmates in Level II and III may be housed in the same physical location; however, an empty cell will be maintained between the two (2) levels. (28.3.2) Inmates on Death Row will be single-celled.[51]
South Dakota	**S.D. Codified Laws § 23A-27A-31.1 (2016):** "Segregation of defendant from other inmates—Access to defendant by others limited. From the time of delivery to the penitentiary until the infliction of the punishment of death upon the defendant, unless lawfully discharged from such imprisonment, the defendant shall			**DOC Policy 1.3.D.2 (2015):** (3)(B)(1) Capital punishment inmates will be housed one (1) inmate to a cell. 3)(B)(2) Unless extenuating circumstances exist, capital punishment inmates will not be allowed to have personal contact with inmates in general population. (3)(B)(3)Capital punishment inmates will have meals brought to them by

Included in SCDC' 4.29.19 letter to LOC

	be segregated from other inmates at the penitentiary. No other person may be allowed access to the defendant without an order of the trial court except penitentiary staff, Department of Corrections staff, the defendant's counsel, members of the clergy if requested by the defendant, and members of the defendant's family. Members of the clergy and members of the defendant's family are subject to approval by the warden before being allowed access to the defendant."			staff. They will eat their meals in their assigned cell. (3)(C)(1) Transportation of a capital punishment inmate throughout the facility (e.g. to Health Services, to meet with an attorney, etc.) will be scheduled when there is the least amount of potential for the capital punishment inmate to have contact with general population inmates. (4)(B) Capital punishment inmates will normally receive forty-five (45) minutes out of cell recreation each weekday.[52] **DOC Website:** Male inmates sentenced to death are housed in a separate wing of the Jameson Annex of the South Dakota State Penitentiary in Sioux Falls. The Jameson Annex is the maximum-security area of the Penitentiary. Female inmates sentenced to death are housed at the South Dakota Women's Prison in Pierre.[53]
Tennessee				**Administrative Policy 404.11 (2011)(IV)(A) Mandatory Segregation:** "Mandatory Segregation: Assignment to maximum security housing of those inmates committed to the Department under the sentence of death or in the physical custody of the Department by court order for safekeeping. . . .

Included in SCDC' 4.29.19 letter to LOC

				(V) POLICY: Inmates who are sentenced to death or housed in the TDOC for the purpose of safekeeping shall be assigned to mandatory segregation… (VI) PROCEDURES: (A) Inmates with a sentence of death shall be: (A)(2) Designated as maximum custody and assigned to mandatory segregation on LIBD. (A)(7) Reviewed annually thereafter in compliance with Policy #401.05.[54] **Administrative Policy 506.14 (2014):** "(IV)(D) Maximum Security Administrative Segregation (MSAS): The purposeful separation of inmates which are a threat to the safety and security of an institution, the welfare of staff, inmates, or public due to past or current acts of violence and/or escape or are committed to the Department under sentence of death. (VI)(B)(2) Inmates who are under a sentence of death shall be single-celled and housed in a Maximum Security Administrative Segregation (MSAS) unit separate from the general population.

Included in SCDC' 4.29.19 letter to LOC

				(VI)(B)(3) Inmates placed in MSAS shall be single-celled and confined within a maximum security unit separate from the general population."[55]
Texas	**Tex. Gov't Code Ann. § 501.113 (West 2015):** "(b) The institutional division shall house the following classes of inmates in single occupancy cells:(1) inmates confined in death row segregation; (2) inmates confined in administrative segregation; . . . ." **Tex. Gov't Code Ann. § 501.112 (West 2015):** "(a) Except as provided by Subsection (b), the institutional division may not house inmates with different custody classifications in the same cellblock or dormitory unless the structure of the cellblock or dormitory allows the physical separation of the different classifications of inmates. (b) If an appropriate justification is provided by the unit classification committee or the state classification committee, the board may permit the institutional division to house inmates with different custody classifications in the same cellblock or dormitory,		**Trottie v. Thaler, 2013 U.S. Dist. LEXIS 19373 (E.D. Tex. 2013):** Resolving a case where an inmate complained that automatic administrative segregation for death row inmates violated his due process rights. **Young v. Stephens, 2014 U.S. Dist. LEXIS 16007 (W.D. Tex. 2014):** Noting that a Texas DOC Warden testified that only death row inmates remain in administrative segregation permanently. **Allen v. State, 2006 Tex. Crim. App. LEXIS 2545 (Tex. 2006)**: Noting that a correctional official testified that death row is basically identical to administrative segregation.	

Included in SCDC' 4.29.19 letter to LOC

	but only until sufficient beds become available in the division to allow the division to house the inmates in the manner required by Subsection (a) and in no event for more than 30 days."			
Utah				**DOC website:** "The Uintas . . . include the Maximum Security facilities at the Utah State Prison. . . . The Uintas also house high-profile inmates, death-row inmates, and inmates who pose severe management problems such as active gang members. . . . Uinta 1 is the highest-security building in the State's prison system. The building is capable of housing 96 inmates. Inmates are 'single-celled,' meaning they do not have cellmates. Unlike traditional depictions of 'solitary confinement,' inmates housed in this area can communicate with one another through the doors of their cells. Each cell has a window that provides natural light, and inmates have the opportunity to recreate either indoors in a common area, or outdoors on a concrete pad confined by side walls and chain-link fencing overhead. Like inmates in other facilities, privilege levels vary based on behavior. Nearly all inmates in this section have the ability to earn

Included in SCDC' 4.29.19 letter to LOC

				greater privileges and transition to other areas over time by demonstrating positive behavior. Generally, death-row inmates are the only exception, requiring a sentence to be overturned or commuted to life. Utah currently has nine men on death row."[56]
US Govt./ Military				**Army Regulation 190-47: The Army Corrections System (last updated in 2006)** 3-2. Authorized place of confinement: "Except in time of war, the USDB [United State Disciplinary Barracks] is the only ACS facility authorized to incarcerate prisoners under the sentence of death." 11-1. Custody procedures: "ACS facilities will place prisoners under sentence of death into administrative segregation until they are prepared for transfer to the USDB." 12-6. Segregation: "Prisoners who have been adjudged a sentence of death will be segregated from the remainder of the prison population at all times. These prisoners will not be commingled with other than death sentence prisoners in billets, recreation, employment, or subsistence that is separate from general population."[57]

Included in SCDC' 4.29.19 letter to LOC

Virginia				**Virginia Department of Corrections, Operating Procedure 830.2, (IV)(D)(7) (2015):** "Any offender sentenced to death will be assigned directly to Death Row. . . . No reclassification will be completed."[58] **News Sources:** Following Prieto, news sources have reported that the Virginia DOC relaxed some of the policies to now allow death row prisoners to interact with one another in groups of up to four, see their family on a weekly basis, and access showers and recreational opportunities more often.[59]
Washington	**Wash. Rev. Code § 10.95.170 (2015):** "The defendant shall be imprisoned in the state penitentiary within ten days after the trial court enters a judgment and sentence imposing the death penalty and shall be imprisoned both prior to and subsequent to the issuance of the death warrant as provided in RCW 10.95.160. During such period of imprisonment, the defendant shall be confined in the segregation unit, where the defendant may be confined with other prisoners not under sentence of death, but prisoners under		**In re Gentry, 170 Wash. 2d 711, 716, 245 P.3d 766, 768 (2010):** "In contrast to Colorado statutes, Washington statutes and DOC regulations in effect at the time of Gentry's crime and sentence provide that death row inmates are initially placed in the IMU and remain there for at least one year. Ford Decl., Ex. 1A. Subsequent transfer to SHU, with its attendant privileges, is dependent upon inmate	**DOC Policy 320.250 and 300.380 (2015):** "(II)(C)(2) Inmates Sentenced to the Death Penalty (ISDPs) will be housed in the IMU at the Washington State Penitentiary (WSP) or Washington Corrections Center for Women, as applicable."[60]

	sentence of death shall be assigned to single-person cells." **Wash. Rev. Code § 72.02.250 (2015):** "Female persons sentenced to death shall be committed to the Washington correctional institution for women, notwithstanding the provisions of RCW 10.95.170, except that the death warrant shall provide for the execution of such death sentence at the Washington state penitentiary as provided by RCW 10.95.160, and the secretary of corrections shall transfer to the Washington state penitentiary any female offender sentenced to death not later than seventy-two hours prior to the date fixed in the death warrant for the execution of the death sentence."		conduct." **Jeffries v. Reed, 631 F. Supp. 1212, 1214–15 (E.D. Wash. 1986)**: "Plaintiff initially claims that defendants violated his rights by transferring him to IMU solely because he is subject to the death penalty. Death Row inmates are the only prisoners incarcerated in IMU for reasons other than institutional misconduct. " "…[S]tate law requires that all Death Row inmates be confined in a segregation unit. R.C.W. 10.95.170. Accordingly, this court finds that Washington law does not create a protected liberty interest regarding the location of plaintiff's confinement."	
Wyoming	**Wyo. Stat. Ann. §7-13-907 (West 2015):** "(a) The administrator of the state penal institution shall keep a person sentenced to death in solitary confinement until execution of the death penalty,			

Included in SCDC' 4.29.19 letter to LOC

Included in SCDC' 4.29.19 letter to LOC

	except the following persons shall be allowed reasonable access to the prisoner: (i) The prisoner's physician and lawyers; (ii) Relatives and spiritual advisers of the prisoner; and (iii) Persons involved in examining a prisoner believed to be pregnant or mentally unfit to proceed with the execution of the sentence."			

[1] Alabama Department of Corrections, *Male Inmate Handbook* 8 (Aug. 1, 2013), http://www.doc.state.al.us/docs/PublicMaleInmateHandbook.pdf.
[2] *History of the ADOC*, Alabama Department of Corrections, http://www.doc.state.al.us/History.aspx (last visited May 26, 2016).
[3] *Holman Correctional Facility*, Alabama Department of Corrections, http://www.doc.state.al.us/facility.aspx?loc=33 (last visited May 26, 2016).
[4] *Death Row Information and Frequently Asked Questions*, Arizona Department of Corrections, https://corrections.az.gov/public-resources/death-row/death-row-information-and-frequently-asked-questions (last visited May 26, 2016).
[5] Arizona Department of Corrections, Department Order: 801, Inmate Classification at 12, effective Feb. 25, 2010, revised Nov. 5, 2011, https://corrections.az.gov/sites/default/files/policies/800/0801.pdf.
[6] *Id.* at 5.
[7] Arizona Department of Corrections, Department Order: 801, Inmate Classification at 13–14, effective July 6, 2013, revised Sept. 19, 2015, https://corrections.az.gov/sites/default/files/policies/700/0704_effective_9-19-15.pdf.
[8] Arizona Department of Corrections, Department Order: 101, System of Written Instructions at 5, effective Sept. 28, 2010, revised April 6, 2011, https://corrections.az.gov/sites/default/files/policies/100/0101.pdf.
[9] Arkansas Department of Correction, *Inmate Handbook* 30 (July 2015), http://adc.arkansas.gov/images/uploads/Inmate_Handbook_edited_March_25_2016.pdf.
[10] Emma John, *Damien Echols: How I Survived Death Row*, THE GUARDIAN (May 25, 2013), *available at* http://www.theguardian.com/society/2013/may/26/damien-echols-i-survived-death-row.
[11] California Department of Corrections and Rehabilitation, *Operations Manual*, Policy 61010.11.5 Placement at 515 (Jan. 31, 2016), http://www.cdcr.ca.gov/Regulations/Adult_Operations/docs/DOM/DOM%202016/2016_DOM.PDF.
[12] *Id.* at Policy 62050.6 Inmates with Death Sentences, 561.
[13] Howard Mintz, *San Quentin: Inside California's Death Row*, THE MERCURY NEWS (Dec. 30, 2015), *available at* http://www.mercurynews.com/crime-courts/ci_29323310/inside-californias-death-row.
[14] Nancy Mullane, *One Reporter on California's Death Row*, LIFE OF THE LAW (July 17, 2014), *available at* http://www.lifeofthelaw.org/2014/07/reporter-on-death-row-2/.
[15] *See also* Kieran Nicholson, *Colorado Death Sentence Inmates Moved to State Penitentiary*, THE DENVER POST (Nov. 2, 2015), *available at* http://www.denverpost.com/search/ci_18564471.

Included in SCDC' 4.29.19 letter to LOC

[16] Colorado Department of Corrections, Regulation Number 600-01, Offender Classification at 6, effective Jan. 1, 2015, http://www.doc.state.co.us/sites/default/files/ar/0600_01_010115.pdf.
[17] Colorado Department of Corrections, Regulation Number 600-09, Management of Close Custody Offenders at 9–11, effective June 30, 2014, revised April 1, 2014, http://www.doc.state.co.us/sites/default/files/ar/600_09_063014%20(COMPLETE%20REWRITE)_0.pdf.
[18] Christopher Reinhart, *Prison Conditions for Death Row and Life Without Parole Inmates*, OLR RESEARCH REPORT (April 4, 2011), *available at* https://www.cga.ct.gov/2011/rpt/2011-R-0178.htm.
[19] Pat Eaton-Robb, *Weeks After Court Ruling, Connecticut Inmates Still Living on Death Row*, NEW HAVEN REGISTER (Sept. 19, 2015), *available at* http://www.nhregister.com/article/NH/20150919/NEWS/150919458.
[20] *Death Row: General Facts*, State of Delaware Department of Correction, http://www.doc.delaware.gov/deathrow/factsheet.shtml#General Facts (last visited May 26, 2016).
[21] *Facility Descriptions*, Georgia Department of Corrections (May 3, 2016), http://www.dcor.state.ga.us/sites/default/files/Facilities%20Descriptions%20_0.pdf.
[22] David M. Reutter, *Georgia Ends Contact Visits for Death Row Prisoners*, PRISON LEGAL NEWS (Oct. 2010), *available at* https://www.prisonlegalnews.org/news/2010/oct/15/georgia-ends-contact-visits-for-death-row-prisoners/.
[23] Idaho Department of Correction, Standard Operating Procedure 303.02.01.001, Classification: Inmate at 7, effective Sept. 15, 2014, https://www.idoc.idaho.gov/content/policy/822.
[24] Idaho Department of Correction, Directive 319.02.01.002, Offenders Under Sentence of Death at 5–10, revised Feb. 25, 2016, https://www.idoc.idaho.gov/content/policy/904.
[25] Indiana Department of Correction, Policy 02-03-115, High Risk Offenders at 3, effective Dec. 15, 2007, http://www.in.gov/idoc/files/02-03-115_High_Risk_Offenders_12-15-07.pdf.
[26] *Death Penalty in Indiana*, Indiana Department of Correction, http://www.in.gov/idoc/3349.htm (last visited May 26, 2016).
[27] http://www.doc.ks.gov/kdoc-policies/AdultIMPP/chapter-20/20104.pdf.
[28] Kentucky Corrections Policies and Procedures, Policy 10.2, Special Management Inmates at 1, effective Aug. 20, 2013, http://corrections.ky.gov/communityinfo/Policies%20and%20Procedures/Documents/CH10/CPP%2010-2%20SMU.pdf.
[29] *Id*. at 3.
[30] Mississippi Department of Corrections, *Inmate Handbook: Chapter I, Admission, Orientation and Classification* 5, http://www.mdoc.ms.gov/Inmate-Info/Documents/CHAPTER%20I.pdf (last visited May 26, 2016).
[31] *State Prisons*, Mississippi Department of Corrections, http://www.mdoc.ms.gov/Institutions/Pages/State-Prisons.aspx (last visited May 26, 2016).
[32] George Lombardi, Richard D. Sluder & Donald Wallace, *The Management of Death-Sentenced Inmates: Issues, Realities, and Innovative Strategies*, 8-9 (1996), *available at* https://doc.mo.gov/Documents/DeathSentencedInmates.pdf.
[33] Department of Corrections, Montana State Prison Operational Procedure 4.2.1, Inmate Classification System at 5, effective Sept. 1, 1998, revised Nov. 12, 2013, http://cor.mt.gov/Portals/104/Resources/Policy/MSPprocedures/4-2-1InmateClassificationSystem.pdf.
[34] *Id*. at 6.
[35] Department of Correctional Services, State of Nebraska, Administrative Regulation 210.01, Conditions of Confinement – Special Management Inmates at 4–8, effective March 1, 1980, revised June 30, 2015, http://www.corrections.nebraska.gov/pdf/ar/classification/AR%20210.01.pdf.
[36] Department of Correctional Services, State of Nebraska, Administrative Regulation 201.02, Inmate Classification and Assignment – Initial Classification, Reception and Orientation at 2, effective March 1, 1980, revised July 31, 2015, http://www.corrections.nebraska.gov/pdf/ar/classification/AR%20201.02.pdf
[37] *Id*. at 4.
[38] Department of Correctional Services , State of Nebraska, Administrative Regulation 201.05, Inmate Classification and Assignment – Special Management Inmates at 2, effective March 1, 1980, revised July 31, 2015, http://www.corrections.nebraska.gov/pdf/ar/classification/AR%20201.05.pdf.

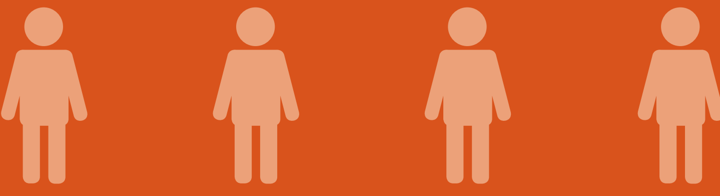
Included in SCDC' 4.29.19 letter to LOC

[39] *Ely State Prison (ESP)*, State of Nevada Department of Corrections, http://doc.nv.gov/Inmates/Visiting/ESP_Visiting/ (last visited May 26, 2016).
[40] Ana Ley, *A Look Inside Nevada's Death Row with a Federal Defense Attorney*, LAS VEGAS SUN (Aug. 22, 2014), http://lasvegassun.com/news/2014/aug/22/q-look-inside-nevadas-death-row-federal-defense-at/.
[41] State of New Hampshire Department of Corrections, *Time In Prison* 9 (2001), https://www.nh.gov/nhdoc/divisions/victim/documents/timeinprison.pdf.
[42] New Mexico Corrections Department, CD-143000, Prison Security Levels V and VI at 3, effective Apr. 30, 2002, revised, June 24, 2014, http://cd.nm.gov/policies/docs/CD-143000.pdf.
[43] New Mexico Corrections Department, CD-143003, Level V and VI Admission, Orientation and Conditions of Confinement at 3, effective Apr. 30, 2002, revised June 24, 2014, http://cd.nm.gov/policies/docs/CD-143000.pdf.
[44] State of North Carolina Department of Public Safety, C.1200, Conditions of Confinement at 1-2, issued Mar. 2, 2015, https://ncdps.s3.amazonaws.com/s3fs-public/div/Prisons/Policy_Procedure_Manual/C_1200_03_02_15.pdf.
[45] *Id*. at 6.
[46] *Id*. at 8.
[47] *Id*. at 13–14.
[48] *Id*. at 16.
[49] State of Ohio Department of Rehabilitation and Correction, 53-CLS-01, Inmate Security Classification Levels 1 Through 4 at 14, effective Aug. 4, 2015, http://www.drc.ohio.gov/web/drc_policies/documents/53-CLS-01.pdf.
[50] Oklahoma Department of Corrections, Policy & Operations Manual, OP-0601017, Systems of Incarceration at 5, effective July 27, 2015, revised Sept. 2, 2015, https://www.ok.gov/doc/documents/op060107.pdf.
[51] South Carolina Department of Corrections Policy/Procedure, OP-22.16, Death Row at 24, issued June 26, 2014, http://www.doc.sc.gov/pubweb/policy/OP-22-16.htm1464300036105.pdf.
[52] South Dakota Department of Corrections, 1.3.D.2, Capital Punishment Housing at 2-5, effective Sept. 21, 2015, http://doc.sd.gov/documents/about/policies/Capital%20Punishment%20Housing.pdf.
[53] *Frequent Questions: Capital Punishment*, South Dakota Department of Corrections, http://doc.sd.gov/about/faq/capitolpunishment.aspx (last viewed May 26, 2016).
[54] State of Tennessee Department of Correction, Administrative Policies and Procedure, 404.11, Mandatory Segregation at 1–2, effective Feb. 1, 2011, https://www.tn.gov/assets/entities/correction/attachments/404-11.pdf. Policy #401.05, governing annual reviews of death row inmate's custody, does not appear to be publicly available.
[55] State of Tennessee Department of Correction, Administrative Policies and Procedure, 506.14, Housing Assignments at 1–3, effective June 1, 2014, https://www.tn.gov/assets/entities/correction/attachments/506-14.pdf.
[56] *Special Services Dormitory*, Utah Department of Corrections, http://corrections.utah.gov/index.php?option=com_content&view=category&id=18&Itemid=138 (last visited May 26, 2016).
[57] U.S. Department of the Army, AR 190-47, The Army Corrections System at 3, 48, 58, revised June 15, 2015, http://armypubs.army.mil/epubs/pdf/r190_47.pdf.
[58] Virginia Department of Corrections, OP 830.2, Security Level Classification at 5, effective Jan. 1, 2015, https://vadoc.virginia.gov/about/procedures/documents/800/830-2.pdf.
[59] Matt Zapotosky, *Virginia Relaxes Restrictions on Death Row Inmates*, THE WASHINGTON POST (Aug. 29, 2015), *available at* https://www.washingtonpost.com/local/crime/virginia-relaxes-restrictions-on-death-row-inmates/2015/08/29/614b4d9e-4ce3-11e5-902f-39e9219e574b_story.html.

[60] State of Washington Department of Corrections, DOC 320.250, Intensive Management/Treatment Status Placement/Transfer/Release at 3, revised Feb. 1, 2015, http://www.doc.wa.gov/policies/showFile.aspx?name=320250.

Included in SCDC' 4.29.19 letter to LOC

Included in SCDC' 4.29.19 letter to LOC



A sourcebook on solitary confinement

Sharon Shalev

Included in SCDC' 4.29.19 letter to LOC

Copyright © Sharon Shalev 2008

Copyright notice
The right of Sharon Shalev to be identified as the author of this work has been asserted in accordance with the Copyright, Designs and Patents Act 1988. As we wish to encourage the widespread use of the Sourcebook, users are permitted to copy and distribute the material without having to seek formal permission or to pay a fee, provided that:

- The material is reproduced accurately and not in a misleading context
- The material is correctly acknowledged and the author's name appears on the work or the excerpt
- A copy of the publication containing the material is sent to the author
- No charge shall be made for the copy containing the work or the excerpt

No translation of the material may be produced without the expressed permission of the author.

Electronic copies of this report can be downloaded from the Solitary Confinement website, www.solitaryconfinement.org

ISBN 978-0-85328-314-0
October 2008

Included in SCDC' 4.29.19 letter to LOC

A sourcebook on solitary confinement

Sharon Shalev

Mannheim Centre for Criminology
London School of Economics and Political Science
Houghton Street, London WC2A 2AE, UK

With the support of the Nuffield Foundation

Email: sharon.shalev@solitaryconfinement.org

Included in SCDC' 4.29.19 letter to LOC

Acknowledgments

This project would not have been possible without the assistance of the Nuffield Foundation. Their support has been generous and unstinting.

Particular thanks are due to Jonathan Beynon and Monica Lloyd, who helped shape the Sourcebook from its early stages to its final form and contributed to the drafting of particular sections. Hernan Reyes and Camille Giffard also deserve a special mention for their extensive and perceptive comments on later drafts.

Many others have given generously of their time during the preparation of this Sourcebook by sharing their expertise, providing practical and professional insight and by commenting on whole or part of drafts. Thanks are due to: Henrik Steen Andersen, Helen Bamber, Jamie Bennett, Francesca Cooney, Andrew Coyle, Kimmett Edgar, Neil Frazer, John Gale, Dougie Graham, Andy Flynn and the Mental Health Team at Woodhill CSC, Stuart Grassian, Adrian Grounds, Craig Haney, Alison Hannah, Morit Heitzler, Lucy Kralj, Juliet Lyon, Clive Meux, Marlies Morsink, Lars Moller, Mary Murphy, Patrick Owen, Paul Rock, Peter Scharff-Smith, Julian Sheather and Ann Somerville.

Views expressed in the Sourcebook and any errors made in it are my own.

Sharon Shalev
October 2008

Included in SCDC' 4.29.19 letter to LOC

Preface

The wide use of solitary confinement in prisons and other places of detention has long been a source of grave concern to those involved with the international protection of human rights. Never more so than in recent years, which have seen a marked increase in the use of strict and often prolonged solitary confinement across the world: in the context of the 'war on terror'; as disciplinary punishment; with pre-trial detainees, the mentally ill and former death-row prisoners; and, in the so-called 'supermax' prisons.

As this sourcebook clearly demonstrates, solitary confinement has a well documented negative impact on mental health and wellbeing and may amount to cruel, inhuman or degrading treatment or punishment, particularly when used for a prolonged time. The use of solitary confinement should therefore be strictly limited to exceptional cases or where it is absolutely necessary for criminal investigation purposes. The severe suffering caused by solitary confinement means that in all cases it should only be used as a last resort, and then for the shortest possible period of time. When used for interrogation purposes, either in combination with other methods or on its own, solitary confinement can amount not only to cruel, inhuman or degrading treatment but even to torture.

This comprehensive sourcebook brings together the accumulated knowledge and standards relating to solitary confinement and its harmful consequences. It identifies how solitary confinement may be misused and the protections that should be put in place. It is a valuable resource for prison staff and policy makers in the effort to promote the respect and protection of the rights and wellbeing of prisoners and detainees. Let us not forget that persons deprived of liberty are among the most vulnerable human beings in every society.

Solitary confinement has not received the attention it merits in international standards. There is a need to further develop protections aimed specifically at reducing its use and mitigating the harm it causes. The Sourcebook on Solitary Confinement is thus an important contribution in a shared endeavour that seeks the universal protection of human rights in all places of deprivation of liberty. I commend it to a wide readership.

Univ. Prof. Dr. Manfred Nowak, LL.M.
Professor for International Human Rights Protection, University of Vienna
Director, Ludwig Boltzmann Institute of Human Rights
UN Special Rapporteur on Torture

Included in SCDC' 4.29.19 letter to LOC

Contents

1	**Introduction**	**1**
1.1	What is the Sourcebook about?	1
1.2	How is the Sourcebook structured?	1
1.3	Definition: what constitutes solitary confinement?	2
1.4	Brief historic context	2
1.5	Legal and regulatory framework	3
2	**The health effects of solitary confinement**	**9**
2.1	Introduction	9
2.2	The health effects of solitary confinement: a brief review of the literature and prisoners' accounts	10
2.3	The negative health effects of solitary confinement: reported symptoms	15
2.4	What makes solitary confinement harmful?	17
2.5	The duration of solitary confinement	21
2.6	Sequelae of isolation: the lasting effects of solitary confinement	22
2.7	Concluding remarks about the effects of solitary confinement	23
3	**The decision to place prisoners and detainees in solitary confinement**	**25**
3.1	When and why are prisoners and detainees placed in solitary confinement?	25
3.2	Placement in solitary confinement: procedural safeguards, and special provisions and recommendations regarding the isolation of specific categories of prisoners	28
3.3	The human rights position and case law regarding the placement of prisoners in solitary confinement	33

Included in SCDC' 4.29.19 letter to LOC

4 **Design, physical conditions and regime in solitary confinement units** **39**

4.1 Introduction 39

4.2 International standards regarding prison conditions and regime 40

4.3 Research findings and recommendations regarding prison design and environmental factors 49

4.4 Human rights case law regarding regime and physical conditions in segregation units 51

4.5 Concluding remarks on regime and conditions of confinement in segregation and high security units 53

5 **The role of health professionals in segregation units: ethical, human rights and professional guidelines** **57**

5.1 Introduction: ethics as applied to prison medicine 57

5.2 Issues regarding prison medicine in solitary confinement units 58

5.3 Case law regarding the provision of medical care in prison 65

6 **Monitoring and inspecting solitary confinement units** **69**

7 **Summary of recommendations** **73**

Appendix 1 **75**
Selected texts

Appendix 2 **78**
The Istanbul statement on the use and effects of solitary confinement

Acronyms and abbreviations **83**

Links & Resources **84**

Bibliography **85**

Included in SCDC' 4.29.19 letter to LOC

Included in SCDC' 4.29.19 letter to LOC

1 | Introduction

1.1 What is the Sourcebook about?

Isolation, segregation, separation, cellular or solitary confinement are some of the terms used to describe a form of confinement where prisoners are held alone in their cell for up to 24 hours a day, and are only allowed to leave it, if at all, for an hour or so of outdoor exercise. Solitary confinement may be imposed on prisoners as short-term punishment for prison offences, or indefinitely for the prisoner's own protection, either at his request or at the discretion of the prison authorities. In other cases prisoners may be isolated from others for months and even years on administrative grounds: as a long-term strategy for managing challenging prisoners or where prisoners are deemed to be a threat to national security. Finally, pre-charge and pre-trial detainees may be isolated from others whilst their interrogation or the investigation into their case is ongoing.

This Sourcebook provides a single reference point for those concerned with the practice of solitary confinement, particularly when it is imposed for prolonged periods of time. Its purpose is to a) inform prison operational staff, health professionals, and policy makers of the human rights position regarding solitary confinement, of ethical and professional standards and codes of practice relating to prisoner isolation, and of research findings on the health effects of solitary confinement, and b) propose safeguards and best practice in light of the above. More broadly, it aims to raise awareness of the potential consequences of prolonged solitary confinement.

The basic premise in compiling this Sourcebook is that prolonged solitary confinement is inherently damaging and is not good practice. It should only be used as a last resort and be reserved for a handful of the most extreme cases. In the few cases where solitary confinement may be exceptionally and absolutely necessary, it should only be used for the shortest possible time, and be managed within established guidelines and strict safeguards. By extension, prison regimes which are entirely constructed around a solitary confinement model cannot but be damaging to prisoners and run contrary to principles of rehabilitation and social reintegration. While prison authorities may sometimes need to resort to short term disciplinary segregation, it must, again, only be as a last resort and managed within strict safeguards. The use of solitary confinement as a means of coercing a 'confession' or as means of 'softening up' detainees for interrogation must be prohibited under all circumstances.

1.2 How is the Sourcebook structured?

The rest of this chapter addresses issues of definition, provides the historic context for the use of solitary confinement, and sets out the legal and regulatory framework for the operation of prisons and the treatment of prisoners. Chapter Two examines the documented health effects of solitary confinement, both physical and psychological, and attempts to understand what makes solitary confinement damaging. Chapter Three examines the different roles of solitary confinement in

Included in SCDC' 4.29.19 letter to LOC

contemporary prison systems – as punishment, for the prisoner's own protection, as a tool for managing difficult prisoners and as part of the investigation or interrogation process – and some of the standards, safeguards and recommendations relating to the placement of prisoners and detainees in solitary confinement. Chapter Four examines international standards, research findings and recommendations regarding the design, physical conditions and regime in isolation units. Chapter Five addresses some of the ethical issues and dilemmas facing health professionals working in solitary confinement units, and Chapter Six briefly examines international, regional and national mechanisms for inspecting and monitoring solitary confinement units. Chapter Seven recaps some of the main issues and themes discussed throughout the Sourcebook.

1.3 Definition: what constitutes solitary confinement?

For the purpose of the Sourcebook, solitary confinement is defined as a form of confinement where prisoners spend 22 to 24 hours a day alone in their cell in separation from each other[1]. Notwithstanding the different meanings attached to each of these terms in different jurisdictions, the term 'solitary confinement' will be used interchangeably with the terms 'isolation' and 'segregation' when describing regimes where prisoners do not have contact with one another, other than, as is the case in some jurisdictions, during an outdoor exercise period[2].

1.4 Brief historic context

Solitary confinement is one of the oldest and most enduring prison practices. Bar the death penalty, it is also the most extreme penalty which can legally be imposed on prisoners. Solitary confinement was first widely and systematically used on both sides of the Atlantic in the 'separate' and 'silent' penitentiaries of the 19th century, with the aim of reforming convicts. It was believed that once left alone with their conscience and the Bible, prisoners would engage in inner reflection, see the error of their ways and be reformed into law abiding citizens. It soon transpired, however, that rather than being reformed, many prisoners became mentally ill, and there was little evidence that the newly built, expensive prisons were more successful than their predecessors in reducing offending. Such criticisms, combined with growing prison populations and pressures for additional prison spaces, led to the dismantling of the isolation system in most countries by the late 19th century[3]. By then, however, solitary confinement had become a permanent feature of prison systems world-wide, used mainly as a form of short term punishment for prison offences, for holding political prisoners, for protective custody, and as a technique for 'softening-up' detainees, particularly those suspected of crimes against the State, before and between interrogation sessions.

In addition to these 'traditional' uses, towards the end of the 20th century and at the beginning of the 21st, the use of long term, large scale solitary confinement returned in the form of 'supermax' (short for super-maximum security) and 'special security' prisons. These are large, high tech prisons, designed for long term and strict isolation of prisoners classified as high risk and/or difficult to control. This phenomenon is particularly evident in the United States, where the Federal Government and some 44 States operate at least one such prison, but similar units can now also

Included in SCDC' 4.29.19 letter to LOC

be found in other countries. The use of prolonged solitary confinement has also increased in recent years in the context of the 'war on terror', not least at Guantanamo Bay where detainees have been held in supermax-like facilities for years, for the most part without any charge and without trial, and in secret detention centres where isolation is used as an integral part of interrogation practices[4]. Another form of solitary confinement, favoured in a number of European countries, is 'small group isolation' wherein prisoners who are classified as dangerous or high risk are held in solitary confinement in small high security units, and allowed limited association with one to five others at designated times, typically during the one-hour long outdoor exercise period required under international law. Paradoxically, although prison overcrowding is a major issue in many jurisdictions, the use of various forms of solitary confinement has increased in the last two decades.

1.5 Legal and regulatory framework

The operation of prisons and other places of detention, and the treatment of those held in them, are regulated by national laws, standards and directives, which vary from State to State. Such national instruments must also, however, be compatible with both international and regional human rights standards and laws[5] as established by the United Nations and regional standard setting bodies (such as the Council of Europe, the Organisation of American States, the African Union etc.).

The Sourcebook draws on international and regional human rights instruments and their interpretation by the courts and monitoring bodies. It also draws on standards set by professional bodies to guide those working with prisoners. The Sourcebook does not, however, aim to provide a comprehensive review of human rights law and practice, but rather to address some of the most pertinent issues relating to solitary confinement[6]. Some of the key human rights instruments and bodies which are referred to throughout the Sourcebook are briefly introduced below, and Appendix 1 contains selected texts with which readers are encouraged to familiarise themselves. These resources are 'living instruments' which evolve over time, and the Sourcebook reflects current views and directives.

Human rights instruments and bodies

International human rights law includes both instruments designed for the universal protection of all human beings, and those designed specifically for the protection of prisoners and detainees. The basic premise of these instruments is that, other than limitations inherent in the deprivation of liberty, prisoners retain their human rights whilst incarcerated. These rights include, for example, the right to a free and fair trial; the right to freedom of thought, conscience and religion; the right to a private and family life; the right to adequate food, shelter and clothing; the right to health; and, the right to education.

The right of prisoners to be treated in a manner respectful of their human dignity and the prohibition against all forms of torture, inhuman or degrading treatment or punishment are reaffirmed in a large number of human rights instruments, including two international treaties, the International Covenant on Civil and Political Rights (ICCPR) and the UN Convention Against Torture (CAT) which are legally binding on all signatory parties to them, and parallel regional instruments. Additional instruments lay out rules of conduct for prison officers, health and other

Included in SCDC' 4.29.19 letter to LOC

personnel, and set acceptable minimum standards for prison design, provisions and conditions. These include the UN Standard Minimum Rules for the Treatment of Prisoners (SMR), discussed below, and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment[7].

A. International human rights instruments and bodies

The International Covenant on Civil and Political rights (ICCPR)

The ICCPR came into force in 1976. Its provisions are interpreted and its implementation monitored by the **UN Human Rights Committee (HRC).** Under Article 40 of the ICCPR, all State parties to it are required to submit a report on their compliance with the ICCPR initially upon ratification, and periodically thereafter. In addition, under the Covenant's Optional Protocol, the Human Rights Committee may consider individual communications from nationals of signatory states to the Protocol.

Two articles of the ICCPR relate directly to the treatment of prisoners and prison conditions, including solitary confinement. Article 7 of the ICCPR proclaims that "*No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment...* ".

The Human Rights Committee has interpreted Article 7 to mean[8]:

> *[2] The aim of the provisions of Article 7 is to protect both the dignity and the physical and mental integrity of the individual... [3] The text allows no limitation, even in time of public emergency...no justification or extenuating circumstances may be invoked to excuse a violation of Article 7 for any reason. [4] [The Committee] does not consider it necessary to draw up a list of prohibited acts, or to establish sharp distinction between the different kinds of punishment or treatment; the distinction depends on the nature, purpose and severity of the treatment applied.*

The terms cruel, inhuman or degrading treatment or punishment, *"should be interpreted so as to extend the widest possible protection against abuses, whether physical or mental, including the holding of a detained or imprisoned person in conditions which deprive him, temporarily or permanently, of the use of any of his natural senses, such as sight or hearing, or of his awareness of place and the passing of time"* (Note to Principle 6, Body of Principles). This interpretation would apply to some uses of solitary confinement, for example in dark, windowless or soundproofed cells. In such cases, solitary confinement may amount to inhuman or degrading treatment and sometimes even to torture[9].

Article 7 is closely linked to Article 10 of the ICCPR, which proclaims that *"All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person … the penitentiary system shall comprise treatment of prisoners the essential aim of which shall be their reformation and social rehabilitation".* Solitary confinement, by definition, deprives the individual from human contact and social interaction, and therefore clearly runs contrary to this principle.

Together, articles 7 and 10 of the ICCPR set out a blanket protection of detainees from any form of ill-treatment. The Human Rights Committee stipulated that:

Included in SCDC' 4.29.19 letter to LOC

Article 10(1) imposes on state parties a positive obligation ... thus, not only may persons deprived of their liberty not be subjected to treatment that is contrary to Article 7...but neither may they be subjected to any hardship or constraint other than that resulting from the deprivation of liberty; respect for the dignity of such persons must be guaranteed under the same conditions as that of free persons. Persons deprived of their liberty enjoy all the rights set forth, subject to the restrictions that are unavoidable in a closed environment. [4] treating all persons deprived of their liberty with humanity and respect for their dignity is a fundamental and universally applicable rule... this rule must be applied without distinction of any kind, such as race, colour, sex, language, religion, political opinion, national or social origin, property, birth or other status…[10].

The UN Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment

The Convention Against Torture was adopted by the UN General Assembly in 1984 and came into force in 1987. Article 1 of the Convention stipulates that:

For the purpose of this Convention, the term "torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person....

The implementation of the Convention by State parties is monitored by a body of independent experts, the **Committee Against Torture (CAT)**. All State parties to the Convention are required to submit a report within a year of ratification, and periodically thereafter. The Committee considers these reports and publishes its findings. In 2006 the **Optional Protocol to the CAT (OPCAT)** came into force with the aim of preventing torture and other ill-treatment through a system of regular inspection visits to all places of deprivation of liberty. The OPCAT establishes both an international inspection body (the Sub-Committee for the Prevention of Torture) and a permanent national inspecting body (known as the National Preventative Mechanism).

UN Standard Minimum Rules for the Treatment of Prisoners (SMR)

The SMR were adopted by the UN Economic and Social Council in 1957[11], and set out principles and guidelines as to *"what is generally accepted as being good principle and practice in the treatment of prisoners and the management of institutions"* (SMR preamble). The SMR list a very specific set of guidelines for the treatment of offenders, ranging from basic food, shelter and exercise requirements to guidelines on prisoner classification and the provision of educational and vocational training. The SMR also clearly set out general principles, including Rule 60 which reaffirms that prisoners are entitled to respect due to their dignity as human beings, Rules 64 & 65 which reaffirm that prisoners should be imprisoned as punishment, not for punishment, and Rule 27 which affirms that prisons should operate with *"no more restriction than is necessary for safe custody and well ordered community life"*. Rule 31 addresses solitary confinement directly in prohibiting placement in a dark cell and all cruel, inhuman or degrading punishments for disciplinary offences. Although the SMR are not strictly legally binding on States, they set out minimum standards and recommendations for the operation of prisons which are now widely accepted as the main universal guidance for the treatment of prisoners. This is evidenced by the fact that in some countries they have been enacted into law or form the basis for national prison regulations.

Included in SCDC' 4.29.19 letter to LOC

The UN Special Rapporteur on Torture

An independent expert appointed by the UN Commission on Human Rights (now replaced by the Human Rights Council), who is mandated to report on the situation of torture anywhere in the world, regardless of whether or not the country is a signatory of the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment. Successive Rapporteurs have addressed the use of various forms of solitary confinement around the world, and have identified situations where its use constitutes cruel, inhuman or degrading treatment or punishment and sometimes even torture.

B. Regional human rights instruments and bodies[12]

European Convention on Human Rights (ECHR)

The European Convention on Human Rights was adopted by the Council of Europe in Rome in 1950 and came into force in 1953. The **European Court of Human Rights (ECtHR)** monitors compliance with the Convention by Member States.

The ECHR proclaims in its Article 3 that "*No one shall be subjected to torture or to inhuman or degrading treatment or punishment.*" The prohibition of torture and ill treatment is absolute. States cannot derogate from it in times of war or other public emergency, and it is expressed in unqualified terms. The threshold which ill treatment has to attain in order to fall within the scope of Article 3 of the ECHR is a relative one; *"It depends on all the circumstances of the case, such as the duration of the treatment, its physical or mental effects and, in some cases, the sex, age and state of health of the victim"*[13]. Inhuman treatment *"covers at least such treatment as deliberately causes severe suffering, mental or physical, which, in the particular situation, is unjustifiable"*[14]. Prison conditions, and therefore the use of solitary confinement, may also fall within the scope of Article 3. When assessing any one case the Court will take account of the cumulative effects of those conditions, as well as the specific allegations made by the applicant[15].

The European Prison Rules (EPR)

The EPR[16] contain 108 Rules, affirming that prisoners retain their human rights and setting detailed standards to guide the administration of prisons, prison conditions, the provision of health care in prisons, prison discipline, and the conduct of prison management and staff. Like the UN SMR, the EPR are not legally binding but they do set out minimum standards below which prison conditions must not fall.

The Committee for the Prevention of Torture (CPT)

The European Committee for the Prevention of Torture was created under Article 2 of the European Convention for the prevention of torture and inhuman or degrading treatment or punishment (1987), with a view to providing a non-judicial machinery of a preventive character and strengthening the protection of prisoners and detainees from torture or degrading treatment prohibited by Article 3 of the ECHR, through a system of visits. The CPT may visit any place where people are deprived of liberty within the jurisdiction of State parties. Through developing a set of standards which it applies when carrying-out visits to places of detention, the CPT also plays an important standard-setting role.

Included in SCDC' 4.29.19 letter to LOC

Notes

1 Prison segregation should be distinguished from isolation or seclusion for medical purposes or in psychiatric settings, which are not discussed in this publication. The Sourcebook focuses mainly on adult, male prisoners and does not address issues relating specifically to other groups, such as women or young offenders.

2 The exercise period usually lasts for one hour, which is the minimum required by international law, but in some jurisdictions it may last up to two hours.

3 For an excellent account of the thinking behind the isolation prisons of the 19th Century see Evans, R. (1982) *The Fabrication of Virtue: English prison Architecture 1750-1840*. Cambridge: Cambridge University Press. See also: Morris, N. and Rothman, D., eds. (1998) *The Oxford History of the Prison: The Practice of Punishment in Western Society*. Oxford: Oxford University Press; Rothman, D.J. (1980) *Conscience and Convenience: The Asylum and its Alternatives in Progressive America*. Boston: Little, Brown and Company.

4 See Human Rights Watch report: Locked Up Alone: Detention Conditions and Mental Health at Guantanamo, June 2008.

5 Human rights laws include: treaty law (treaties, conventions, covenants), which is legally binding on States which are parties to it and on State agents, including prison officials; customary law, which reflects long established practices that are accepted as unwritten laws, and; human rights declarations, recommendations, principles, codes of conduct and guidelines, which are not in themselves legally binding but nonetheless reflect international norms and customs.

6 For a more general discussion of human rights and prisons see: Andrew Coyle (2002) A Human Rights Approach to Prison Management, International Centre for Prison Studies, London; Office of the United Nations High Commissioner for Human Rights (2005) Human Rights and Prisons, Professional Training Series No.11, available online at: www.ohchr.org

7 The Body of Principles was adopted the UN General Assembly in December 1988. It contains 39 principles reaffirming that prisoners and detainees retain their human rights when detained, and lists some of the procedural and substantial principles which should direct the operation of all places of detention universally. Other relevant human rights instruments include the Basic Principles for the Treatment of Prisoners (adopted in 1990, affirming that prisoners retain their fundamental human rights); UN Code of Conduct for Law Enforcement Officials; Principles of Medical Ethics; and, in situations of armed conflict, the Geneva Conventions of 1949 and their Additional Protocols of 1977.

8 General comment 20/44 of 3 April 1992.

9 See Reyes, H. The worst scars are in the mind: psychological torture, International Review of the Red Cross, Volume 89 No. 867 September 2007 pp 591-617.

10 United Nations Human Rights Committee General comment 21/44 of 6 April 1992, para. [3].

11 Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held in Geneva in 1955, and approved by the Economic and Social Council by its resolutions 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977.

12 The brief discussion in this chapter is based on European instruments and bodies, but similar provisions are made in other regional instruments including the American Convention on Human Rights (ACHR) which proclaims in its Article 5 that "(1) Every person has the right to have his physical, mental and moral integrity respected. (2)No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. All persons deprived of their liberty shall be treated with respect for the inherent dignity of the human person".

13 *Ireland v UK* A25 (1978) at par. 162

14 *The Greek Case*, 5.11.69, Yearbook of the European Convention on Human Rights, Vol. 12,1969, p186.

15 *Dougoz v. Greece*, no. 40907/98, 46, ECHR 2001-II

16 Council of Europe, Recommendation No R(87)3, revised and replaced by recommendation (2006)2.

Included in SCDC' 4.29.19 letter to LOC

Included in SCDC' 4.29.19 letter to LOC

2 | The health effects of solitary confinement[17]

2.1 Introduction

Being held in solitary confinement is, for most prisoners, a stressful experience with potentially harmful health effects. The prisoner is socially isolated from others, his human contacts reduced to superficial transactions with staff and infrequent contact with family and friends. He is almost completely dependent on prison staff – even more than is usual in the prison setting – for the provision of all his basic needs, and his few movements are tightly controlled and closely observed. Confined to a small sparsely furnished cell with little or no view of the outside world and with limited access to fresh air and natural light, he lives in an environment with little stimulation and few opportunities to occupy himself.

Throughout the long history of its use in prisons – from the 'silent' and 'separate' penitentiaries of the 19th century through to modern-day segregation units and 'supermax' prisons – practitioners and researchers have observed the adverse effects of solitary confinement on prisoners' health. In the context of coercive interrogation, international experts have identified solitary confinement as psychological torture[18]. The potentially damaging effects of solitary confinement are also recognised by national and international instruments and by monitoring bodies, which view it as an extreme prison practice which should only be used as a last resort and then only for short periods of time. Indeed, expressing strong concern about the use of solitary confinement as punishment, in 1990 the United Nations went as far as to call for its abolition[19].

This chapter examines some of the research findings on the health effects of solitary confinement dating back to the 19th century, and attempts to explain how and why solitary confinement adversely affects physical, mental and social wellbeing[20]. Although negative health effects may emerge after a very short period of time in solitary confinement, this chapter is mostly concerned with the more serious health effects that are associated with longer periods of solitary confinement.

Included in SCDC' 4.29.19 letter to LOC

2.2 The health effects of solitary confinement: a brief review of the literature and prisoners' accounts

General observations

There is unequivocal evidence that solitary confinement has a profound impact on health and wellbeing, particularly for those with pre-existing mental health disorders, and that it may also actively cause mental illness. The extent of psychological damage varies and will depend on individual factors (e.g. personal background and pre-existing health problems), environmental factors (e.g. physical conditions and provisions), regime (e.g. time out of cell, degree of human contact), the context of isolation (e.g. punishment, own protection, voluntary/ non voluntary, political/criminal) and its duration.

Notwithstanding variations in individual tolerance and environmental and contextual factors, there is remarkable consistency in research findings on the health effects of solitary confinement throughout the decades. These have mostly demonstrated negative health effects, with studies reporting no negative effects being few and far between, and virtually no study reporting positive effects[21].

Historic accounts

The extensive use of solitary confinement in prisons of the early 19th century was well documented, and its effects on prisoners reported in medical journals of the time. Grassian and Friedman (1986) cite thirty seven reports and articles published in Germany alone between 1854 and 1909, identifying solitary confinement as the single central factor in the development of psychotic illness among prisoners. Examples include an 1854 report by the chief physician of Halle prison, Germany, who observed what he termed Prison Psychosis among isolated prisoners and concluded that *"prolonged absolute isolation has a very injurious effect on the body and mind and seems to predispose to hallucinations"* and should therefore be immediately terminated (Nitsche & Williams, 1913). A report from 1863 describes vivid hallucinations, delusions, apprehension and psychomotor excitation experienced by 84 prisoners suffering from what its authors termed the Psychosis of Solitary Confinement. In 1881, a summary of diagnostic assessments of 186 prisoners held at the 'insane department' at Waldheim prison, also in Germany, concluded that over half of the prisoners suffered reactive manifestations to solitary confinement (Grassian & Friedman, 1986).

Similar observations were made in England, where in 1850 for example, 32 out of every 1000 prisoners had to be removed from their solitary cells in Pentonville prison on grounds of insanity, compared to 5.8 prisoners per 1000 in prisons not practising solitary confinement (McConville, 1981:208-9). In the US, the Boston Prison Discipline Society, which helped devise the 'Separate' or 'Pennsylvania' system of solitary confinement, reported from as early as 1839 serious mental problems amongst isolated prisoners, including hallucinations and dementia (cited in Scharff-Smith, 2004). Referring to similar reports several years later, the US Supreme Court noted that the effects of solitary confinement were such that *"a considerable number of prisoners.... fell into a semi- foetus condition... and others became violently insane"* (*Re Medley*, 1890:167-8). Indeed, the understanding that instead of its intended role of helping to 'cure the disease of crime', solitary confinement was creating mental illness in prisoners, played a central role in the dismantling of the isolation prisons on both sides of the Atlantic by the late 19th century.

Included in SCDC' 4.29.19 letter to LOC

Yet, although the use of solitary confinement on a large scale ceased, it remained an integral part of prison systems and, as previously noted, in the last decade its use has increased in many jurisdictions. Throughout the decades researchers have continued to report negative effects associated with solitary confinement, and their findings are strikingly similar to those made by their historic counterparts.

Contemporary findings

More recent studies have mostly reaffirmed that solitary confinement adversely affects those subjected to it, and have identified "confinement psychosis" as a medical condition typified by *"psychotic reaction characterised frequently by hallucinations and delusions, produced by prolonged physical isolation and inactivity in completely segregated areas"* (Scott & Gendreau, 1969:338).

A 1975 inquiry into the use of isolation in Canadian prisons concluded that administrative isolation over long periods of time represented a *"serious danger for prisoners"*[22]. Two years later a Council of Europe (1977) study suggested that prolonged close-confinement of long-term prisoners led to what was termed 'separation syndrome' that included emotional, cognitive, social and physical problems[23]. Benjamin & Lux (1977:262) stated that *"evidence overwhelmingly [indicates] that solitary confinement alone, even in the absence of physical brutality or unhygienic conditions, can produce emotional damage, decline in mental functioning and even the most extreme forms of psychopathology such as depersonalization, hallucinations and delusions"*. Ruling in a case involving prisoners held in strict isolation in Germany, the European Human Rights Commission (1978:97) similarly noted that *"isolation can be sufficient in itself to gravely impair physical and mental health"*.

Grassian's (1983) psychiatric evaluation of 14 prisoners held in the solitary confinement block at the Massachusetts Correctional Institution at Walpole reported perceptual changes, affective disturbances, difficulty with thinking, concentration and memory, disturbances of thought content, and problems with impulse control. Korn's study (1988) of the women's High Security Unit at Lexington, Kentucky, found that women held there suffered claustrophobia, rage, severe depression, hallucinations, withdrawal, blunting of affect and apathy. He also reported appetite loss, weight loss, visual disturbances and heart palpitations. Brodsky & Scogin's (1988) study of 45 prisoners held in protective custody similarly reported a high prevalence of negative physiological and psychological symptoms including nervousness, talking to oneself, hallucinations and delusions, confusion, irrational anger, headaches and problems sleeping. Hodgins & Cote (1991) found severe mental disorders amongst 29 per cent of a sample of 41 segregated prisoners held in Quebec's Special Handling Unit (SHU), and in 31 per cent of a sample of 32 prisoners segregated in the Long-Term Segregation Unit (LTSU)[24].

Haney's (1993) study of 100 randomly selected prisoners in one of California's supermax prisons, Pelican Bay Security Housing Unit, reported a very high prevalence of symptoms of psychological trauma with 91% of the prisoners sampled suffering from anxiety and nervousness, more than 80% suffering from headaches, lethargy and trouble sleeping and 70% fearing impending breakdown. More than half of the prisoners suffered from nightmares, dizziness and heart palpitations and other mental-health problems caused by isolation, which included ruminations, irrational anger and confused thought processes (more than 80% of prisoners sampled), chronic depression (77%), hallucinations (41%) and overall deterioration.

Included in SCDC' 4.29.19 letter to LOC

Miller's (1994:48) study of 30 prisoners in a Kentucky prison similarly found that "*inmates housed in the most restrictive environment [punitive segregation] reported significantly higher levels of psychological distress symptoms such as anxiety and hostility, than inmates in the general population*". A follow-up study (Miller & Young, 1997:92) reported withdrawal, hostility, aggression, rage and irresistible impulses among those held in disciplinary segregation and concluded that these findings indicate that *"there may be a level of restriction that, instead of solving administrative problems, becomes both a mental health issue and a further problem for the prison administration"*. Sestoft et al. (1998:105) concluded their study of the impact of solitary confinement on subsequent hospitalisation among Danish detainees by stating that "*individuals in solitary confinement are forced into an environment that increases their risk of hospitalisation ... for psychiatric reasons".*

In his extensive study on the effects of imprisonment on more than 900 prisoners, including those held in segregation units, Hans Toch coined the term "'Isolation Panic'" to describe the experiences of isolated prisoners. Symptoms of this syndrome included

> *A feeling of abandonment … dead-end desperation… helplessness, tension. It is a physical reaction, a demand for release or a need to escape at all costs… [Isolated prisoners] feel caged rather than confined, abandoned rather than alone, suffocated rather than isolated. They react to solitary confinement with surges of panic or rage. They lose control, break down, regress...* (Toch 1992:49).

Harvard psychiatrist Stuart Grassian, who has been studying the effects of solitary confinement for over two decades, similarly suggested that the symptoms experienced by isolated prisoners form a distinct syndrome, closely akin to 'delirium',

> *That is, a constellation of symptoms occurring together and with a characteristic course over time, thus suggestive of a discrete illness… while this syndrome is strikingly atypical for the functional psychiatric illnesses, it is quite characteristic of an acute organic brain syndrome: delirium, characterised by a decreased level of alertness, EEG abnormalities ... perceptual and cognitive disturbances, fearfulness, paranoia, and agitation; and random, impulsive and self-destructive behavior …* (Grassian, 2006:338).

Finally, the growing body of research into the health effects of confinement in 'supermax' prisons in the United States (for example: Cloyes et al. (2006); Haney (2003); Kupers (1999); Miller (1994); Miller & Young (1997); Rhodes (2004); Grassian, (2006).) largely confirms findings reported in earlier studies, namely, that *"this experience 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"* (Haney& Lynch, 1997:500).

The accounts of prisoners

Researchers have found that prisoners in solitary confinement often have little insight into their own mental state and tend to minimise their reaction to solitary confinement and play down any mental health problems (Grassian, 1983; Haney, 2003). Segregated prisoners also appear to have a more negative view of psychiatric treatment in prison and tend to avoid seeking such help (Coid et al. 2003-1:315). Mental health problems are particularly stigmatised amongst Muslim prisoners who are reluctant to seek help (Robbins et al. 2005). A report of the inspection of a small unit for Muslim prisoners detained under immigration law on the grounds of national security in the UK, for

Included in SCDC' 4.29.19 letter to LOC

example, identified that five of the eight had significant mental health problems but that there was very little take up of the mental health service provided (An Inspection of the Category A Detainee Unit at Long Lartin, HMCIP, 2007). Nonetheless, accounts from prisoners themselves illustrate a range of severe adverse health effects. What follows is what has emerged from interviews with prisoners in isolation, or after the event, and from writings by formerly isolated prisoners.

One of the problems most commonly reported by prisoners who were isolated is that they found it hard to distinguish between reality and their own thoughts, or found reality so painful that they created their own fantasy world. Researchers link such incidents to the absence of external stimuli which results in the brain starting to create its own stimulation, manifesting in fantasy and hallucinations. One study of prisoners who were isolated for periods ranging from 11 days to 10 months reported both auditory and visual hallucinations. One interviewee described how: *"the cell walls start wavering... everything in the cell starts moving; you feel that you are losing your vision".* Others reported auditory hallucinations: *"I overhear guards talking. Did they say that? Yes? No? It gets confusing. Am I losing my mind?"* Prisoners also reported high sensitivity to noise and smells: *"you get sensitive to noise. The plumbing system... the water rushes through the pipes- it's too loud, gets on your nerves. I can't stand it. Meals- I can't stand the smells....the only thing I can stand is the bread"* (Grassian, 1983).

Other studies have reported similar experiences, ranging from hypersensitivity to sound and smell, to paranoid episodes and self-injury. One former female prisoner described extreme sensitivity to sounds "*Your vision was highly restricted, so you live by sound… you could hear every creaking of the place, you know, the building. It was almost amplified… not that our hearing was better, it was just that we paid more attention because sound had to do with… with life*" (Cited in Shalev, forthcoming). Another former prisoner who was isolated in a dark punitive isolation cell 'saw faces' and 'held conversations' with people who were not there:

> *Sometimes I felt like I was losing my mind, or that I have lost it already, you know… Holding conversations with myself… I had conversations with people. I mean dialogues, long dialogues with people. Some of them I knew, and some of them I didn't know. There were times when the darkness wasn't dark. I could see faces… I think that I found out that I may be hallucinating when I touched my eyes and my eyes were open so I kind of knew I wasn't dreaming. After a while I thought that maybe I will die there. I really thought I would* [Former prisoner, USA, cited in Shalev, forthcoming].

Similar findings were reported by Siegel's (1984) study of 31 people who were subjected to isolation, visual deprivation and restraint on physical movement as hostages, prisoners of war or convicted prisoners over varying periods. All interviewees reported visual and auditory hallucinations that appeared within hours of being isolated and became more and more elaborate as time went by. Prisoners participating in Toch's (1992) large-scale study of the psychological effects of incarceration reported similar experiences in solitary confinement. Interviewee 'M', for example, described panic and paranoid thoughts during his first days in isolation:

> *…and then I lay on the mattress, and then after I sit there I feel the walls coming in around me. And then when the guards come in and I am screaming, they say: 'what the fuck is going on here?' and I say 'the walls are closing in on me' and they say 'that's tough, you're going to die anyway. We'll strangle you'… I was thinking that if I don't get the hell out of there, they're going to kill me. And I don't feel like fighting them* (Toch 1992:150).

Included in SCDC' 4.29.19 letter to LOC

Another former prisoner who spent two years in a supermax prison in California chose to refer to 'seeing others lose it' and described similar scenarios[25]:

> *I have seen inmates lose their mind completely because of the sound of a light where they are yelling at the light, cursing at the light, believing that for some reason the [authorities] planted some kind of noise inside the light purposely…and so the inmates that ain't strong minded, don't have something to hang on to, the light, the sound of the door, can make them lose their mind… I found it strange, you know, how can a grown man, a very big, grown man, break down to a light. But that's what [that place] can do. And once you lose your mind, you don't know right from wrong. You don't know that you're breaking a rule. You don't know what to do exactly* [Former prisoner, USA, cited in Shalev forthcoming].

Seeing and hearing other prisoners break down is a stressful experience in itself, as Henry Charriere ('Papillon') found during his time in isolation on 'Devil's Island', a French penal colony in Guyana: *"A great many suicides and men going raving mad around me… it's depressing to hear men shouting, weeping or moaning for hours or even days on end"*. He himself survived eight years in solitary confinement through fantasy: *"thanks to my wandering amongst the stars it was very rare that I ever had a lasting despair. I got over them pretty fast and quickly invented a real or imaginary voyage that would dispel the black ideas"* (1970:354-356). One of the problems with such techniques is that the boundaries between fantasy and reality can become dangerously blurred, as was the case for one former female prisoner, who regularly 'left her body' to 'travel' in the outside world. These were not daydreams, but out-of-body experiences from which at times, according to her, it was "really hard to come back":

> *The first four years of prison was such a fantasy world… I was in segregation. I could be in my cell and shut everyone out and I would go travelling. I would go up and out of prison and fly over the beaches and mountains of Okinawa, where I used to live. Sometimes it was really, really hard to come back* [Former prisoner, USA, cited in Shalev, forthcoming].

As her time in isolation grew longer, so did the intensity and frequency of her 'travels', until one day the prison chaplain saw her lying on her cell-floor in a near catatonic state and took her under his wing. British prisoner Doug Wakefield had somewhat less pleasant hallucinations after a period in isolation, *"usually in the form of spiders and insects crawling over the floor, the bed and walls, and at such times it is common to hear voices and strange noises"* (Wakefield 1980:28). Describing himself as a 'graduate of 1000 days in segregation', he wrote: *"fantasising and day-dreaming become prevalent pastimes and the obvious danger here is that this activity could become a permanent feature of the mind with the consequent disadvantage of not knowing at times whether you are in reality or fantasy"* (Ibid at p. 30).

The similarities between these accounts of time in isolation in different contexts, geographical locations, and for varying periods of time are striking and cannot be easily discounted. Further, the personal accounts cited above are consistent with research findings on the health effects of solitary confinement reviewed previously. Some of the reported health effects of solitary confinement, both physiological and psychological, are listed in the following section.

Included in SCDC' 4.29.19 letter to LOC

2.3 The negative health effects of solitary confinement: reported symptoms

Physiological effects

Although psychological effects are most common and usually dominant, physiological effects are nevertheless commonly reported. Some of these may be physical manifestations of psychological stress, but the lack of access to fresh air and sunlight and long periods of inactivity are likely also to have physical consequences. Grassian and Friedman (1986) list gastro-intestinal, cardiovascular and genito-urinary problems, migraine headaches and profound fatigue. Other signs and symptoms recorded by the some of the studies reviewed above are

- Heart palpitations (awareness of strong and/or rapid heartbeat while at rest)
- Diaphoresis (sudden excessive sweating)
- Insomnia
- Back and other joint pains
- Deterioration of eyesight
- Poor appetite, weight loss and sometimes diarrhoea
- Lethargy, weakness
- Tremulousness (shaking)
- Feeling cold
- Aggravation of pre-existing medical problems.

Psychological effects

The most widely reported effects of solitary confinement are its psychological effects[26]. These will vary with the pre-morbid adjustment of the individual and the context, length and conditions of confinement. The experience of previous trauma will render the individual more vulnerable, as will the involuntary nature of confinement as punishment, and confinement that persists over a sustained period of time. Initial acute reactions may be followed by more chronic symptoms if the confinement persists. While the majority of those held in solitary confinement will report some form of disturbance, there may be a small number of prisoners who show few signs and symptoms and may be more resilient to the negative effects of solitary confinement. Symptoms occur in the following areas and range from acute to chronic.

Anxiety, ranging from feelings of tension to full blown panic attacks

- Persistent low level of stress
- Irritability or anxiousness
- Fear of impending death
- Panic attacks

Depression, varying from low mood to clinical depression

- Emotional flatness/blunting – loss of ability to have any 'feelings'
- Emotional lability (mood swings)
- Hopelessness
- Social withdrawal; loss of initiation of activity or ideas; apathy; lethargy
- Major depression

Anger, ranging from irritability to full blown rage

- Irritability and hostility,
- Poor impulse control
- Outbursts of physical and verbal violence against others, self and objects
- Unprovoked anger, sometimes manifesting as rage

Cognitive disturbances, ranging from lack of concentration to confusional states

- Short attention span
- Poor concentration
- Poor memory
- Confused thought processes; disorientation.

Perceptual distortions, ranging from hypersensitivity to hallucinations

- Hypersensitivity to noises and smells
- Distortions of sensation (e.g. walls closing in)
- Disorientation in time and space
- Depersonalisation/derealisation
- Hallucinations affecting all five senses, visual, auditory, tactile, olfactory and gustatory (e.g. hallucinations of objects or people appearing in the cell, or hearing voices when no-one is actually speaking).

Paranoia and Psychosis, ranging from obsessional thoughts to full blown psychosis

- Recurrent and persistent thoughts (ruminations) often of a violent and vengeful character (e.g. directed against prison staff)
- Paranoid ideas – often persecutory
- Psychotic episodes or states: psychotic depression, schizophrenia.

Included in SCDC' 4.29.19 letter to LOC

Self-harm and suicide

Historical reports of 19th Century isolation prisons repeatedly describe acts of auto-aggression, self-mutilation, and suicide. Contemporary studies have also shown that self-harm (including banging one's head against the cell wall) and suicides are more common in isolation units than in the general prison population (Haney & Lynch 1997:525). In California, for example, a reported 69% of prison suicides in 2005 occurred in segregated housing units (USA Today, 27/12/2006), and in England and Wales in 2004/5 a fifth of prison suicides took place in segregation units (National Offender Management Service, Safer Custody Group. Self inflicted deaths Annual Report, 2004/5).

Other forms of self-harm are also prevalent in solitary confinement. Researchers have noted that self-mutilation or cutting is often *"a result of sudden frustration from situational stress with no permissible physical outlet... Self-addressed aggression forms the only activity outlet"* (Scott & Gendreau, 1969:341). Another study found that self-mutilation was a means to *"liberate the self from unbearable tension- the physical pain becomes a compensatory substitute for psychic pain or shame"* (Dabrowski (1937), cited in McCleery, 1961:303). Former prisoners have testified that self harm played another role for them when they were held in segregation – it asserted that they were still alive.

> *I was totally frustrated… I started smashing up the cell. I refused to eat. I started refusing water. I was totally paranoid. I started sipping my own urine because I thought they were trying to poison me. I resorted to self-injury, was put in a body belt. You become so angry. It's an outlet, but you have to vent it out. Even your own blood is something real* [Former prisoner, UK, cited in Shalev, forthcoming].
>
> *I found myself curled up in a foetal position rocking myself back and forth and banging my head against the wall. In the absence of sensation, it's hard sometimes to convince yourself that you're really there* [Former prisoner, US, cited ibid.].

It is difficult to obtain figures for forms of self-harm that do not result in death. Nonetheless, there is compelling anecdotal evidence that the prevalence of such incidents in segregation and isolation units is particularly high.

2.4 What makes solitary confinement harmful?

Each of the three main factors inherent in solitary confinement- social isolation, reduced environmental stimulation and loss of control over almost all aspects of daily life- is potentially distressing. Together they create a potent mix. Moreover, psychiatric morbidity studies of prisoners indicate that they are a particularly vulnerable population, even when not in solitary confinement. In England and Wales, a morbidity survey of prisoners carried out by the Office for National Statistics in 1998 found that only 10% were without any history of neurotic disorder, psychotic disorder, personality disorder or substance misuse, and many experienced some or all of these in combination (ONS psychiatric morbidity survey, 1998). It is also known that about 7% of prisoners have a severe learning disability, with an IQ of 70 or below[27], and that those with learning disabilities find it particularly difficult to cope with isolation. About 12% will also be receiving psychiatric treatment while in prison for severe and enduring mental illness (HMCIP, The mental health of Prisoners, 2007). One cause of these high levels of disturbance is the experience of early life trauma

Included in SCDC' 4.29.19 letter to LOC

and the resulting poor personal and social adjustment. All these features conspire to render prisoners particularly vulnerable to the effects of isolation, reduced activity, under-stimulation and loss of control over their lives.

Conversely, anecdotal evidence suggests that some prisoners are protected from the worst impact of solitary confinement by the meaning they are able to make of the experience. Some political prisoners, for example, have demonstrated remarkable resilience during prolonged periods of confinement. That does not mean that the experience was not a difficult one. Describing his time in Robben Island, Nelson Mandela writes: *"I found solitary confinement the most forbidding aspect of prison life. There is no end and no beginning; there is only one's mind, which can begin to play tricks. Was that a dream or did it really happen? One begins to question everything."* (Nelson Mandela, The Long Walk to Freedom, 1995). Leaders of the Tupamaro movement in Uruguay, who were imprisoned in strict solitary confinement (they were not allowed to communicate with anyone, meals were delivered to them through a hatch in the cell-door by guards who were instructed not to exchange a word with them) for several years during the 1970's, reported that solitary confinement was the worst form of torture; one prisoner said that *"electricity [torture] is mere child's play in comparison to prolonged solitude"* (cited in Reyes, 2007:607).

Social isolation

Social well-being is seen by the World Health Organisation as integral to its definition of 'health'[28]. Solitary confinement removes the individual from the company of others and deprives him or her of most forms of meaningful[29] and sympathetic social interaction, as well as physical contact. In most cases the isolated individual is deprived of any form of interaction with fellow prisoners, and sometimes with family and friends through restrictions on visits. Where visits do take place they can be closed, with a barrier separating the prisoner from his visitors, preventing any physical contact between them.

Social learning theories highlight the importance of social contact with others not just for pleasure and play but for the individual's very sense of 'self' which is shaped and maintained through social interactions. Social contact is crucial for forming perceptions, concepts, interpreting reality and providing support[30].

> *The self… is essentially a social structure and it arises in social experience. After a self has arisen, it in a certain sense provides for itself its social experiences, and so we can conceive of an absolutely solitary self. But it is impossible to conceive of a self arising outside social experience. When it has arisen we can think of a person in solitary confinement for the rest of his life, but who still has himself as a companion, and is able to think and to converse with himself as he had communicated with others….* ***This process of abstraction cannot be carried on indefinitely***. (Mead, 1934, emphasis added).

Paradoxically, social isolation can lead to further withdrawal. One study found support for the hypothesis that the "*shut-in*" or *"seclusive"* personality, *"generally considered to be the basis of schizophrenia, may be the result of an extended period of 'cultural isolation', that is, separation from intimate and sympathetic social contact"* (Faris, 1962:155). Faris adds that *"seclusiveness is frequently the last stage of a process that began with exclusion or isolation which was not the choice of the patient"* (Ibid. at p. 159).

Included in SCDC' 4.29.19 letter to LOC

Deprived of meaningful and sympathetic social contact and interaction with others, the prisoner in solitary confinement may withdraw and regress. Even when isolated prisoners do not show any obvious symptoms, upon release from isolation they can become uncomfortable in social situations and avoid them, with negative consequences for subsequent social functioning in both the prison community and the outside community, again undermining the likelihood of successful resettlement.

Reduced activity and stimulation

Monotony and reduced sensory stimulation are part and parcel of the experience of isolation. In the isolation prisons of the 19th century, where prisoners had access to work, great care was taken to ensure that they were given intentionally tedious and dull jobs usually performed in silence. In 'modern' isolation sections of prisons, work, education or other diversion such as reading material, radio or television, can be withheld or restricted as part of a system of punishment. When work is allocated, it is often conducted inside the cell and, as in the 19th century, can be simple and monotonous, for example stuffing envelopes. Prisoners can be detained in sparsely furnished cells for up to 23 hours a day with little sensory or mental stimulation.

Prisoners' accounts illustrate the effects of monotony and boredom on their mental state during a period of isolation:

> *Boredom is a major enemy. Sensory deprivation is a way of life. There is simply nothing to do. Sit in your bathroom alone with none of your intimate possessions and try to imagine years of it, week after week. Slowly it tears you down, mentally and physically*[31].
>
> *The utter and monstrous boredom that becomes so obvious after a short period of isolation is an all-powering one… in order to fight off the tendency to complete idleness and to retain a hold on the senses, it is necessary to make great exertions… Yet no matter how successful a prisoner may be in staving off the effects of... isolation, it is only a matter of time before it catches up with him* (Wakefield 1980:28).
>
> *…you sit in solitary confinement stewing in nothingness, not merely your own nothingness but the nothingness of society, others, the world. The lethargy of months that add up to years in a cell, alone, entwines itself about every 'physical' activity of the living body and strangles it slowly to death, the horrible decay of the truly living death. You no longer do push-ups or other physical exercise in your small cell; you no longer pace the four steps back and forth across you cell. You no longer masturbate; you can call forth no vision of eroticism in any form…time descends in your cell like the lid of a coffin in which you lie and watch it as it slowly closes over you… solitary confinement in prison can alter the ontological makeup of a stone* (Abbott 1982:44-45).

These personal accounts are supported by studies which indicate that reduced sensory input may lead to reduced brain activity. Building on the input-output theory, one study suggested that sensory input and motor-mental output work in parallel:

> *A drop in sensory input through sensory restriction produces a drop in mental alertness, an inability to concentrate, a drop in planning and motivation, together with a drop in physical activity in the speech and motor systems… In prison life boredom generates boredom. A drop in stimulus input results in mental sluggishness, a disinclination to learn and a correlated drop in planning, motivation and physical activity* (Scott & Gendreau, 1969:338).

To evaluate this hypothesis, the brain activity of isolated prisoners was measured daily. Researchers found that following seven days in isolation there was a decline in brain activity. This decline *"was correlated with apathetic, lethargic behaviour… and with a reduction in stimulation seeking behaviour. Up to seven days the EEG decline is reversible, but if deprived over a long period this may not be the case"* (Scott & Gendreau, ibid.).

Lack of control

A third aspect of segregated confinement is the rigid regime and exceptionally high level of control over all aspects of prisoners' lives, or what has been termed "an authoritarian system of social control" (McCleery, 1961:272), or the "totality of control" (Haney, 1993).

While undergoing any special control or disciplinary measure, some degree of increased control and watchfulness from the authorities is inevitable. However, in the case of solitary confinement, this control is extreme and prisoners have few avenues or areas where they can exercise personal autonomy, and are completely dependent on staff for the provision of all their basic needs. When this degree of control is exercised over long periods of time, the psychological impact is proportionally greater.

Various studies have examined the socio-psychological aspects of long-term imprisonment in highly controlled environments and have identified some common psychological reactions[32]. These typically range from apathy to aggression: "*either reaction to the system of rigid discipline tends to become something very much like insanity – apathy, listlessness, vagaries, or else irritability, hatred and nervous instability"* (Sutherland & Cressey, 1955:473). Another study similarly noted that over time, symptoms experienced by isolated prisoners are *"likely to mature into either homicidal or suicidal behaviour"* (McCleery, 1961:265).

Thus, contrary to the aims of enforcing calm and control on a prisoner, solitary confinement can produce further irritability and even violent outbursts, often unprovoked. Such violent outbursts may be directed against staff, but may also be turned upon the prisoner himself in the form of self-harm or suicide. Where the prisoner does become more docile and apparently conforming to the rules, it may in fact be a pathological reaction in the form of withdrawal, emotional numbing and apathy. Further, the 'totality of control' means that some prisoners become so reliant on the prison to organise their lives and daily routines that they lose the capacity to exercise personal autonomy. This, again, may render them dysfunctional in society upon their release and some will seek to return to prison.

Included in SCDC' 4.29.19 letter to LOC

2.5 The duration of solitary confinement

All studies of prisoners who have been detained involuntarily in solitary confinement in regular prison settings for longer than ten days have demonstrated some negative health effects (Haney, 2003), and even apologists of the practice agree that prolonged punitive solitary confinement "*presents considerable risk to the inmates"* (Gendreau and Bonta, 1984:475).

A study comparing subsequent admission to psychiatric hospitals in Denmark for prisoners held in solitary confinement compared to those held with other prisoners, found that hospitalisation rates diverged significantly after four weeks. The *"probability of being admitted... for psychiatric reasons was about 20 times as high as for a person remanded in non-solitary confinement for the same period of time"* (Sestoft et al. 1998:105). Siegel's (1984) study of 31 people who were subjected to isolation, visual deprivation and restraint on physical movement in different situations (hostages, POWs, prisoners) and for varying times reported visual and auditory hallucinations within hours of being isolated, becoming more severe with time.

Studies with volunteer prisoners isolated for periods of up to ten days have commonly reported minimal negative effects. Walters et al (1963:772) noted that for 20 long-term prisoners in a Canadian Federal Penitentiary who volunteered to stay in solitary cells for four days *"while social isolation may produce some change in subjective feelings, it does not result in mental or psychomotor deterioration or increased susceptibility to social influence."* Similarly Ecclestone, Gendreau and Knox in 1974 reported that for eight volunteers over a period of 10 days *"solitary confinement was not more stressful than normal institutional life."* But these outcomes may be accounted for by the short duration of stay in isolation and by the fact that prisoners who participated in these studies welcomed the opportunity to spend time away from the general prison population

Experimental studies with volunteers have reported relatively short-lived tolerances for isolation. Although such studies are not equivalent to enforced isolation in the prison context where prisoners are not free to end the experiment at any time, the findings serve to illustrate the powerful impact of isolation on human subjects. In a study aimed at measuring levels of tolerance to isolation, approximately two-thirds of the volunteers were able to remain in an isolated room for periods ranging from three to fourteen days (Zuckerman, 1964:255-276). In another, twenty volunteers were placed separately in a silent room, and asked to remain in it for as long as they could. The average quitting times were 29.24 hours for men and 48.70 hours for women. None of the participants endured the 'silent room' for longer than four days (Smith & Lewty, 1959:342-345). Where the duration of isolation was unspecified, two hours were sufficient to generate confusion and the fear of becoming insane (Solomon et al, 1961).

Other studies have also demonstrated that an important element in the level of endurance of solitary confinement is prior knowledge of its duration. Uncertainty as to its duration *"promotes a sense of helplessness. Finite sentences imposed for acknowledged acts seem less prone to inspire panic"* (Toch, 1992:250). Another study concluded that uncertainty is a critical factor relating to the outcome of hostility and aggression (McCleery 1961:303). Knowing how long the experience is to last is therefore a clear mitigating factor available to those responsible for placing a prisoner in segregation.

Included in SCDC' 4.29.19 letter to LOC

2.6 Sequelae of isolation: the lasting effects of solitary confinement

There are few longitudinal studies of the effects of solitary confinement and no follow-up studies of formerly isolated prisoners following their release from prison. Again, any long term effects are likely to be dependent on the individual, the type of confinement and its duration. One study of detainees held on remand in solitary confinement at the Western prison in Copenhagen, which examined them on the second to fourth day of their isolation and thereafter at monthly intervals, found a decrease in symptoms soon after transfer to the general population, indicating that *"solitary confinement conditions are distressing and probably temporary, at least partially"* (Andersen et al. 2003:174). The authors note, however, that *"the finding that mental health condition improved when prisoners were moved from solitary confinement to non-solitary confinement indicates that solitary confinement imposes a condition that arguably could be avoided by abolishing it"* (Ibid. at page 175).

Similarly, Grassian's (1983) study of prisoners held in solitary confinement at Walpole prison in Massachusetts, where the legal statute required that isolated prisoners be relieved from their status for at least 24 hours every 15 days, reported rapid diminution of symptoms during breaks in confinement.

However, other studies report sleep disturbances, nightmares, depression, anxiety, phobias, emotional dependence, confusion, impaired memory and concentration (Hocking, 1970) long after release from isolated environments. These symptoms are similar to those experienced by prisoners in isolation and may imply a degree of irreversibility. But the lasting effects of solitary confinement are perhaps most evident in social settings and with interpersonal relationships:

> *Although many of the acute symptoms suffered by inmates are likely to subside upon termination of solitary confinement many [prisoners], including some who did not become overtly psychiatrically ill during their confinement in solitary, will likely suffer permanent harm… this harm is most commonly manifested by a continued intolerance to social interaction, a handicap which often prevents the inmate from successfully readjusting to … general population prison and often severely impairs the inmate's capacity to reintegrate into the broader society upon release from imprisonment* (Grassian, 2006:332).

Former prisoners who have spent prolonged periods in solitary confinement have testified to experiencing difficulties in social situations long after their release:

> *I mean there are still times where I may go to the walk-in and after the movie's over and, you know, it's like I've been in the dark and all of the sudden the light comes on and boom all these millions of people around me, I'm like, you know, looking around like, okay, okay, who's gonna hit me, what's gonna happen ... I mean, you feel real uncomfortable and then all of the sudden you start shaking, you know, you feel your heart beat and then you realise, wait a minute, I'm at a theatre, what am I tripping on? There ain't nobody out here all crazy. I'm not in prison. It gets real uncomfortable when I'm around a big crowd. Like sometimes even going to the grocery store I feel uncomfortable, you know, when people look at me, and I'm wondering, you know, wow, what are they looking at? [Former prisoner, US. Cited in Shalev, forthcoming].*

> *My character and personality have undergone many negative changes and I am now a very paranoid and suspicious person. The paranoia has become so extensive that I find it impossible to trust anyone anymore and I have developed a tendency to hate people for no apparent reason* (Wakefield, 1980:30).

Included in SCDC' 4.29.19 letter to LOC

Unable to regain the necessary social skills for leading a 'normal' life, some may continue to live in relative social isolation after their release. In this sense, solitary confinement operates against one of the main purposes of the prison which is to rehabilitate offenders and facilitate their reintegration into society.

2.7 Concluding remarks about the effects of solitary confinement

There are problems in drawing general conclusions from studies of particular prisoners and from experimental research with volunteers. Studies carried out with prisoners in the context of lawsuits being brought by the prisoner against the authorities raise questions about the partiality of the findings, as do studies carried out by medical professionals employed by the authorities responsible for the confinement. Getting access to prisoners in real life segregation for research purposes raises both practical difficulties and ethical concerns. There is also a clear lack of equivalence between the experience of solitary confinement in real life prisons and within the context of time-bounded experiments. The role of pre-existing mental health problems is also a significant compounding variable.

Nevertheless, there is a large and growing body of literature that demonstrates the harmful impact of isolation, particularly when used punitively, without clear time limits, for periods that are longer than four weeks and for people with prior mental health problems and poor social adjustment.

Key points

- **There is unequivocal evidence, dating back to the 19th century, demonstrating the negative health effects of solitary confinement.**

- **The extent of psychological and physiological damage of solitary confinement will depend on the individual prisoner, his background, the context of placement in isolation, its duration, conditions of confinement and degree of mitigation.**

- **Uncertainty about the expected duration of solitary confinement is likely to increase its adverse effects.**

- **While some of the health effects of solitary confinement will subside upon its termination, others may persist.**

- **For these reasons, the use of solitary confinement should be reserved for extreme cases, for as short time as possible, but usually no more than a matter of days.**

- **The misuse of the psychological and physiological effects of solitary confinement as part of an interrogation process may amount to cruel, inhuman or degrading treatment or punishment and even to torture, and should be prohibited in all circumstances.**

Included in SCDC' 4.29.19 letter to LOC

Notes

17 This chapter was co-authored with Monica Lloyd, Forensic Psychologist, formerly of the Chief Inspector of Prisons (HMCIP) office, and Jonathan Beynon, MD, Medical Co-ordinator for Health in Detention, International Committee of the Red Cross. The points of view expressed here represent the personal opinions of the authors, and do not necessarily represent the position of their organisations.

18 Reyes, H. The worst scars are in the mind: psychological torture, *International Review of the Red Cross*, Volume 89 No. 867, September 2007 pp 591-617. See also: Human Rights Watch report: *Locked Up Alone: Detention Conditions and Mental Health at Guantanamo*, June 2008; Physicians for Human Rights (PHR): *Break them down: systematic use of psychological torture by US forces*. Physicians for Human Rights, USA, 2005.

19 Principle 7 United Nations Basic Principles for the Treatment of Prisoners, adopted and proclaimed by General Assembly resolution 45/111 of 14 December 1990

20 This chapter is only intended as a brief and selective review of the literature. The studies examined in this review vary greatly in scope, location, context, factors examined and methodology. For a comprehensive review of the literature on the health effects of solitary confinement and a discussion of methodological issues see Scharff-Smith (2006).

21 With the exception of Suedfeld & Roy (1975) who suggested that short-term, non-punitive solitary confinement of volunteer participants may have beneficial effects (though these are not elaborated).

22 Reported in the Canadian Medical Journal 1977:408-416

23 Researchers reported emotional disturbances, disturbances in comprehension and ability to think, infantile regressive changes and difficulty in making social contacts, as well as sleep disturbances, headaches and severe digestive problems (cited in Amnesty International, 1980).

24 The authors note that many of the prisoners in both samples suffered prior mental health problems.

25 As Toch (1992:152) noted *"personal breakdown in isolation does not square with manly self-images and reputations",* so prisoners may find it easier to refer to others 'losing it'.

26 The symptoms listed in this section have been consistently reported by the studies discussed above. For a more detailed review of research findings see, Grassian & Friedman (1986); Grassian (2006); Haney & Lynch (1997); Haney (2003); Scharff-Smith (2006).

27 Mottram, P. 2007. *HMP Liverpool, Styal and Hindley Study Report*, University of Liverpool

28 "Health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right ..." World Health Organisation, Declaration of Alma-Ata, 1978.

29 '*Meaningful*' is emphasised because it cannot be argued that regular contact with custodial staff whilst being fed, restrained and escorted constitutes meaningful contact.

30 See Mead (1934). For a review of social learning theories and their application in situations of social isolation see Haney & Lynch 1997:503-506

31 A prisoner in Florida's Supermax, cited in the Campaign to Stop Control Units Report, 1997

32 See Sutherland & Cressey (1955); Sykes (1958); Goffman (1961); McCleery (1961). See also Cohen & Taylor's ([1972] 1981) study of prisoners in Durham prison's maximum-security wing in the late 1960s and Toch's (1992) study of prisoners' reactions to the "psychological strain of imprisonment".

Included in SCDC' 4.29.19 letter to LOC

3 | The decision to place prisoners and detainees in solitary confinement

The extreme nature of solitary confinement and its potentially harmful effects on prisoners' physical and mental wellbeing require prison authorities to be particularly cautious in imposing it, even for short periods of time. By extension, long-term prison regimes based entirely on solitary confinement run contrary to two of the primary goals of imprisonment, namely rehabilitation and social reintegration. This chapter examines the different uses of solitary confinement and some of the human rights provisions and recommendations that apply to them. Where current human rights standards and provisions are lacking, it seeks to explore how they may be developed and strengthened.

3.1 When and why are prisoners and detainees placed in solitary confinement?

Where prisoners and detainees are held in solitary confinement, whether in an especially designed free-standing isolation unit or in a designated segregation wing in a general population prison, this is typically on one of the following official grounds:

Punishment: punitive segregation is used as a form of punishment for prisoners' misconduct whilst in custody, and is typically imposed for a set, limited period of time, following some form of a disciplinary hearing within the prison. Segregation is considered as the most severe form of punishment for the most serious prison offences. Cell fittings in punitive segregation units are often minimal, and prisoners are allowed fewer provisions and personal belongings than those afforded to prisoners in 'normal location'. Prisoners held in punitive isolation typically only leave their cell for a one-hour period of solitary exercise a day, but in some jurisdictions, exercise as well as access to family visits, are restricted even further. Legislation in some jurisdictions also permits courts to impose periods of solitary confinement as a part of the sentence for certain crimes. In Peru, for example, under the rule of its former president, Alberto Fujimori, those convicted of crimes against the State were automatically placed in solitary confinement for the first year of their imprisonment. In Pakistan, the Penal Code allows for convicted prisoners to be sentenced by the court for up to three months in solitary confinement at the beginning of their sentence (Pakistan Penal Code, Act XLV of 1860).

Protection: protective segregation is used for holding vulnerable prisoners separately from the general prison population for their own protection, either at the prisoner's request or at the discretion of staff. Vulnerable prisoners may include, for example, sex offenders, police informants,

Included in SCDC' 4.29.19 letter to LOC

former police or prison officers, debtors, prisoners at risk of self harm and those who might be harmed by other prisoners. In some jurisdictions these prisoners are allowed to associate with each other, whilst in others they are held in regimes of strict solitary confinement, identical to those in punitive segregation, for the duration of their prison sentence.

Prison management: managerial or administrative segregation is used as an internal tool for isolating prisoners variously defined as potentially dangerous, disruptive or otherwise posing a management problem, for example gang members. The rationale is that isolating such prisoners will reduce incidents of violence across the prison system and maintain prison order and discipline. This form of solitary confinement is usually imposed through an internal process governed by administrative rules. In some jurisdictions, prisoners are offered structured regimes starting with strict solitary confinement followed by gradually improved provisions and opportunities to engage with other prisoners, whilst in others, prisoners will be held in strict separation for the duration of their sentence. Where small group isolation is used, prisoners are held in single cells but allowed to associate with one to five other prisoners at designated times, usually during exercise periods.

National security: protecting the public and/or national security is, and has historically been, used as a justification for placing those suspected or convicted of politically motivated crimes and of senior membership of major organised criminal gangs in solitary confinement. The rationale is to prevent the prisoner from contact with 'terrorist' or 'subversive' groups or organised crime gangs outside the prison, or to prevent the dissemination of State secrets. Convicted prisoners isolated on grounds of national security will typically spend their prison sentence in strict solitary confinement.

Pre-charge and pre-trial investigation: suspects may be held in isolation without being charged whilst their interrogation is ongoing. In most jurisdictions such pre-charge detention is limited by law to a few hours or a few days, but some jurisdictions now have provisions for lengthier periods. In the UK, for example, terror suspects may be detained without any charge being brought against them for up to 28 days and, subject to a Bill introduced by the Government being enacted in its present form, this period may be extended to 42 days. Noting that the current provision of 28 days is already controversial, critics have called for this proposal to be scrapped. Pre-trial detainees, particularly those charged with crimes against the State, are also often isolated during the investigation or interrogation process. In some countries, most notably in Scandinavia, criminal suspects are also sometimes isolated pending investigation. The rationale in such cases is to prevent the detainee from compromising the investigation. In some cases detainees are isolated without access to legal counsel. This form of detention, called 'incommunicado', may be illegal under international law and is subject to special provisions[33].

Lack of other institutional solutions: prisoners are also sometimes held in solitary confinement because there are no appropriate alternatives available for housing them. For example, mentally ill prisoners may be isolated because there are no available secure hospital beds for them. These prisoners may not necessarily pose a danger to others or to themselves, but they are vulnerable to abuse and their behaviour may disturb or unsettle other prisoners and prison staff. Prisoners may also be segregated due to prison overcrowding whilst waiting for space to become available in a setting appropriate to their security classification.

Included in SCDC' 4.29.19 letter to LOC

In countries which still use the death penalty, and in those where it was only recently abolished, Death Row prisoners are also typically held in strict solitary confinement. Finally, prisoners may also be held in de-facto solitary confinement – sometimes remaining locked up in single occupancy cells due, for example, to staff shortages. To illustrate, in a recent report from the Chief Inspector of Prisons in England and Wales, 30% of prisoners surveyed in local prisons in 2006/7 (some of whom were held in single cells) claimed that they were unlocked for less than two hours a day (HMCIP Thematic Report, Time out of Cell, 6 June 2008).

Case study: Solitary confinement in England & Wales

Prisoners may be held in solitary confinement for periods of 22-24 hours a day in the following circumstances:

- In police custody, where they will invariably be held in a single cell. Most police detainees are released within less than 24 hours, but some may be held longer for questioning. Authority for this has to be granted from a senior police officer at nine hourly intervals up to 72 hours, at which point authority for continued detention has to be sought from a court. Those suspected of terrorism may be held in police custody for up to 28 days.
- If they are placed in segregation overnight for adjudication the following day (in which case their confinement may not exceed 24 hours).
- If they are awarded cellular confinement as a punishment, in which case this will last no more than 14 days in the case of young prisoners or 28 days in the case of adult prisoners.
- If they are placed in segregation to preserve good order or discipline (GOOD) or for their own protection (OP), in which case the period of time is open-ended. In these circumstances prisoners are subject to a local review of their confinement after the first 72 hours and weekly thereafter.
- If they are placed in the Close Supervision System (CSC) within a restricted regime, in which case they are provided with in-cell activities and a high level of staff engagement, and are subject to local monitoring and ongoing case management from the CSC selection committee within the High Security Directorate.
- When a CSC prisoner is transferred to a segregation unit in a high security prison and held in a designated CSC cell or high control cell* for a period of time-out, in which case they are subject to ongoing case management by the CSC selection committee within the High Security Directorate, but in practice to little local monitoring.
- When a prisoner with mental health problems is held in a single cell within the prison hospital under the care of health care staff.

*A high control cells are equipped with a feeding hatch in the cell door which allow for food and other provisions to be delivered without unlocking the prisoner at all.

Included in SCDC' 4.29.19 letter to LOC

3.2 Placement in solitary confinement: procedural safeguards, and special provisions and recommendations regarding the isolation of specific categories of prisoners

As solitary confinement is a harsh measure with potentially harmful consequences for the prisoner involved, the decision to isolate a prisoner, be it as short-term punishment, for longer term management or for his own protection, must not be taken lightly or in an arbitrary manner. Good practice dictates that it must always be taken by a competent body, in accordance with the law and in adherence with the requirements of due process. The authority making the decision must justify its decision in writing, and be accountable for it. This authority should not the prison doctor, nor should the doctor certify the prisoner 'fit for isolation' (this issue is discussed further in some detail in Chapter Five). Another important safeguard where solitary confinement is imposed is to ensure that the decision to segregate a prisoner, or to continue his segregation, is substantially and regularly reviewed by an independent body, and that the prisoner has a right to appeal against the decision.

> *Such reviews should always be based on the continuous assessment of the individual prisoner by staff specially trained to carry out such assessment. Moreover, prisoners should as far as possible be kept fully informed of the reasons for their placement and, if necessary, its renewal; this will inter alia enable them to make effective use of avenues for challenging that measure* (CPT 11th General Report, CPT/Inf (2001) 16, section 32).

Review hearings: good practice example

At Woodhill prison's (UK) Close Supervision Centre, where some of those considered to be amongst the most challenging prisoners in the prison system are held in solitary confinement, prisoners' placement is reviewed monthly, and prisoners' legal representatives are invited to attend their clients' review hearings.

The general procedural requirements and guarantees outlined above apply to the decision to place a prisoner in solitary confinement, regardless of the reason for his placement. In addition, some specific issues arise in relation to detainees and particular categories of prisoners who are placed in solitary confinement.

Punitive segregation

Punitive or disciplinary segregation is the most serious punishment which can be imposed on prisoners, and as such should be reserved for the most serious prison offences and be proportional to them. It must only be imposed as last resort and for as short a time as possible, lasting days rather than weeks or months.

Rule 30 of the UN Standard Minimum Rules for the Treatment of Prisoners (SMR) stipulates that:

Included in SCDC' 4.29.19 letter to LOC

(2) No prisoner shall be punished unless he has been informed of the offence alleged against him and given a proper opportunity of presenting his defence. The competent authority shall conduct a thorough examination of the case.

Article 6 of the ECHR, which guarantees the right to a fair trial, also elaborates on some of the necessary safeguards:

1. In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law ...

3. Everyone charged with a criminal offence has the following minimum rights:

- to be informed promptly, in a language which he understands and in detail, of the nature and cause of the accusations against him;
- to have adequate time and facilities for the preparation of his defence;
- to defend himself in person or through legal assistance ... ;
- to examine ... witnesses against him ... ;
- to have the free assistance of an interpreter if he cannot understand or speak the language used in court.

It has been established that these protections also apply to prison adjudication proceedings, particularly when a harsh penalty is imposed on the prisoner[34].

Pre-trial and pre-charge detainees

The isolation of those who have not yet been convicted of any crime is particularly problematic, as it inflicts punitive and potentially harmful conditions on people who are innocent until proven guilty, and serves to coerce them.

Typically, in addition to being held in isolation from others, pre-trial detainees are subjected to further restrictions on visits and communications with the outside world. In Denmark and Norway, for example, remanded detainees may be held in solitary confinement for up to three months (or indefinitely, if the crime they are charged with will result in a prison term of more than six years if they are found guilty), allowed only supervised weekly visits lasting 30 minutes, prohibited from making telephone calls and may have their communications restricted or withheld. Such practices have been the subject of ongoing concern and criticism by international and regional monitoring bodies. The UN Human Rights Committee, for example, called on the government of Denmark to "*reconsider the practice of solitary confinement so as to ensure that it was imposed only in cases of urgent need… except in exceptional circumstances, solitary confinement should be abolished, especially for pre-trial detainees…* "[35].

Included in SCDC' 4.29.19 letter to LOC

Over time, through its visits to places of detention in Europe, the Committee for the Prevention of Torture has developed the following safeguards concerning the isolation of pre-trial detainees[36]:

- Solitary confinement of pre-trial detainees should only be resorted to in exceptional circumstances, should be strictly limited to the requirements of the case, and should be proportional to the needs of the investigation;
- Restrictions should be authorised by a court;
- Detainees should have an effective right of appeal to a court or another independent body;
- Detainees should have access to a doctor whose written report should be forwarded to the competent authorities;
- Detainees should be offered purposeful activities in addition to outside exercise and guaranteed appropriate human contact.

These safeguards should be followed as a minimum in all cases. Isolating pre-trial detainees may also pressurise them to provide confessions in order to ease their conditions of confinement. The CPT has reported that in Denmark, for example, it was 'not unusual' for confessions to be immediately followed by a discontinuation of solitary confinement regimes[37]. This amounts to a form of coercion which, as stated in the introduction, should be prohibited.

The use of solitary confinement for those who have not yet been charged with any offence must be strictly limited by law and must only be used in exceptional circumstances, with judicial oversight, for as short a time as possible, and never for more than a matter of days. The misuse of solitary confinement in secret detention centres, particularly those linked with the so-called 'war on terror' as a means of coercing or 'softening up' detainees for the purpose of interrogation should be prohibited, as the deliberate infliction of mental and physical suffering for such purposes amounts to cruel, inhuman or degrading treatment and even torture.

The mentally ill

There is consensus amongst observers, experts and, increasingly, the courts, that the mentally ill and those at risk of self harm should not be held in solitary confinement – *"The 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 ... For these inmates, placing them in [isolation] is the mental equivalent of putting an asthmatic in a place with little air to breath"* (*Madrid v. Gomez* judgement, 1995). Yet, reports indicate that segregation is widely used to manage mentally ill prisoners, and that mentally ill prisoners are overrepresented in segregation units[38].

The particular vulnerability of mentally ill prisoners means that prison authorities must be especially vigilant in their treatment. The Inter-American Court on Human Rights has stated that *"... when the person kept in isolation in a penitentiary institution has a mental disability, this could involve an even more serious violation of the State's obligation to protect the physical, mental and moral integrity of persons held under its custody"*[39]. Thus, those suffering from mental illness must not be placed in solitary confinement and under no circumstances should the use of solitary confinement serve as a substitute for appropriate mental health care.

Included in SCDC' 4.29.19 letter to LOC

Challenging, dangerous, or disruptive prisoners

As noted above, in some jurisdictions prisoners who are classified as dangerous or chronically disruptive are placed in prolonged solitary confinement as a prison management tool. The practice of "isolating risk", as one commentator termed it (Riveland 1999), is widely criticised. Supermax prisons in the United States, for example, have been criticised by the courts, the UN Human Rights Committee, the Committee Against Torture and the UN Special Rapporteur on Torture. All have stated that conditions of confinement in these prisons may amount to cruel, inhuman or degrading treatment in violation of international human rights law. Both the European Court of Human Rights and the Committee for the Prevention of Torture have expressed similar concerns about the 'special security' regimes imposed on prisoners in a number of European states. Referring to isolation at the Extra Security Institution (EBI) in the Netherlands, the CPT has stated that *"to subject prisoners classified as dangerous to such measures could well render them more dangerous still"* (CPT re Netherlands, 1998, para.69), and the ECtHR has stated on a number of occasions that it shares these concerns (for example, *Mathew v. the Netherlands, 2005*).

Addressing the use of 'reinforced security' units for holding dangerous prisoners, the Council of Europe's Committee of Ministers called on the Governments of Member States[40]:

1. To apply, as far as possible, ordinary prison regulations to dangerous prisoners;
2. To apply security measures only to the extent to which they are necessarily required;
3. To apply security measures in a way respectful of human dignity and rights;
4. To ensure that security measures take into account the varying requirements of different kinds of dangerousness;
5. To counteract, to the extent feasible, the possible adverse effects of reinforced security conditions;
6. To devote all necessary attention to the health problems which might result from reinforced security;
7. To provide education, vocational training, work and leisure time occupations and other activities to the extent that security permits;
8. To have a system for regular review to ensure that time spent in reinforced security custody and the level of security applied do not exceed what is required;
9. To ensure, when they exist, that reinforced security units have the appropriate number of places, staff and all necessary facilities;
10. To provide suitable training and information for all staff concerned with the custody and treatment of dangerous prisoners.

Included in SCDC' 4.29.19 letter to LOC

It is also worth noting that studies suggest that solitary confinement is not an effective tool for managing those defined as 'problem' or 'difficult' prisoners and may even be counter-productive. A study of the 'incorrigible units' in North Carolina in the late 1950s, where prisoners were subjected to a regime of strict and prolonged solitary confinement, concluded that *"the over-all impact of the incorrigible unit in penal practice probably is one that intensifies tendencies to criminal attitudes and behavior"* (McCleery, 1961:306). Other studies identified isolation regimes as central factors leading to prison riots. One study of events leading to the 1980 riot in the New Mexico Penitentiary (USA), for example, attributed the riot directly to the strategy of isolating prisoner leaders, which led to the fragmentation of prisoner solidarity and in turn led to growing violence. A study of 'order and discipline' in prisons in England and Wales concluded that *"to impose additional physical restrictions, especially of a severe character, will almost certainly lead to a legitimacy deficit; and that deficit may well in the end play itself out in enhanced violence"* (Bottoms, 1999:263).

Similar findings emerge with regard to the isolation of gang members. One study found that the policy of placing gang members in solitary confinement in special security units in California led to an increase in gang activity, as *"prison authorities' efforts to contain the spread of gangs led, unintentionally, to a vacuum within the prison population within which new prison groupings developed"* (Hunt et al. 1993:403). Leadership struggles among these new groupings then resulted in gang related murders in general population prisons (Parenti, 1999:209). Data on prison violence before and after the introduction of special security (or 'supermax') units, similarly indicates that the isolation of prisoners classified as dangerous or disruptive did not result in a reduction of prison violence in general population prisons[41].

In short, though solitary confinement may be a convenient tool for managing challenging prisoners in the short term, in the long term it is not effective, and may prove to be counter-productive. Further, as Chapter Two illustrated, prolonged solitary confinement may have very serious health consequences for the individual concerned and may also affect his chances of successful reintegration into society. Every effort should therefore be made to reverse the trend towards supermax prisons and similar regimes which are wholly based on solitary confinement. Where it is absolutely necessary to hold a handful of extremely dangerous prisoners in separation from others, there should be ongoing assessment of the need to keep them isolated, and they should be afforded increased in-cell provisions, access to programmes, opportunities for meaningful human contact and so on.

Included in SCDC' 4.29.19 letter to LOC

3.3 The human rights position and case law regarding the placement of prisoners in solitary confinement

The potentially harmful effects of solitary confinement are recognised by human rights bodies, who view it as an undesirable prison practice which can only be justified in extreme cases[42], must only be used for the shortest time possible[43], and which, in certain circumstances, may be in violation of international law.

The Human Rights Committee has expressed the view that

> *"solitary confinement is a harsh penalty with serious psychological consequences and is justifiable only in case of urgent need; the use of solitary confinement other than in exceptional circumstances and for limited periods is inconsistent with article 10, paragraph 1, of the Covenant"*[44] and may amount to acts prohibited by Article 7 (torture and cruel, inhuman or degrading treatment or punishment)[45].

The UN Committee Against Torture (CAT) has been critical of practices involving prolonged solitary confinement and has stated that these may amount to treatment in violation of the prohibition against torture or inhuman treatment. For example, the CAT has expressed grave concerns regarding the strict and prolonged solitary confinement in supermax prisons in the United States (CAT, 2000); lack of time limits on placement in solitary confinement and the number of detainees isolated for more than ten years in Japan (CAT, 2007); and, the isolation of pre-trial detainees in Denmark and Norway (CAT, 2002).

A joint report issued by UN Rapporteurs on the situation of detainees held by US forces at Guantanamo Bay stated that *"the general conditions of detention, in particular the uncertainty about the length of detention and prolonged solitary confinement, amount to inhuman treatment and to a violation of the right to health as well as a violation of the right of detainees under article 10 (1) of ICCPR to be treated with humanity and with respect for the inherent dignity of the human person"* (Report to the UN Commission on Human Rights, 62 Session, 15/2/06, UN DOC E/CN.4/2006/120).

The European Committee for the Prevention of Torture (CPT) has taken the view that solitary confinement, for whichever reason, requires particular attention. In assessing any one case,

> *"the principle of proportionality requires that a balance be struck between the requirements of the case and the application of a solitary confinement-type regime, which is a step that can have very harmful consequences for the person concerned"*[46].

Included in SCDC' 4.29.19 letter to LOC

Grounds which were accepted by the European Court of Human Rights (ECtHR) as justifying solitary confinement include: the prisoner's extremely dangerous behaviour[47], the prisoner's *"ability to manipulate situations and encourage other prisoners to acts of non-discipline"*[48] and the prisoner's safety[49]. The *"general situation regarding terrorist climate at the time"* was also found to justify severe security measures, including solitary confinement[50]. Ten years later, in 1992, the Court somewhat narrowed this view when it stated that *"the undeniable difficulties inherent in the fight against crime, particularly with regard to terrorism, cannot result in limits placed on the protection to be afforded in respect of the physical integrity of individuals"*[51]. These protections are not dependent on the individual's conduct: *"The Court is well aware of the immense difficulties faced by States in modern times in protecting their communities from terrorist violence. However, even in these circumstances, the Convention prohibits in absolute terms torture or inhuman or degrading treatment or punishment, irrespective of the victim's conduct"*[52]. In a more recent case, whilst the Court reaffirmed that the absolute prohibition against torture, inhuman or degrading treatment extends even to the *"most difficult circumstances, including the fight against terrorism and organised crime",* and that solitary confinement must never be imposed on prisoners indefinitely, it ruled that holding a man who, at the time, was *"considered to be the most dangerous terrorist in the world"* in solitary confinement for 8 years and two months did not constitute a breach of Article 3 of the ECHR[53].

But the Court's willingness to accept that prolonged solitary confinement may be justified in exceptional cases, particularly those involving offences against the State, does not extend more generally. The placement of a prisoner in solitary confinement because he could not adapt to an ordinary prison setting was not accepted as sufficient grounds, and was found to constitute inhuman treatment in breach of Article 3[54]. A breach of Article 3 was also found where a regime of strict solitary confinement was imposed for more than three years on a former Death Row prisoner yet *"the government have not invoked any particular security reasons ... and have not mentioned why it was not possible to revise the regime*[55]*".*

Hence, while it is generally accepted that in the prison setting short-term solitary confinement may sometimes be necessary, its use is subjected to close scrutiny to ascertain whether it serves a legitimate purpose, and is absolutely necessary in any given case. Once it is established that the placement of a prisoner in solitary confinement has been undertaken in accordance with due process requirements and serves a legitimate purpose, the physical conditions and regime afforded to isolated prisoners are addressed. These are the subject of the following chapter.

Included in SCDC' 4.29.19 letter to LOC

Key points

- **The decision to place a prisoner in solitary confinement, for whatever reason, must always be made by a competent body and in accordance with due process requirements, including the right to appeal against the decision.**
- **When used as punishment for prison offences, solitary confinement must only be used as a last resort, and then for the shortest time possible, no more than a matter of days.**
- **Ensuring that the process through which prisoners are isolated is transparent and adheres to due process requirements not only ensures that the decision is carried out legally and professionally, but may also contribute to prisoners' perception of their placement as being legitimate and fair and, in turn, positively affect their behaviour.**
- **The use of prolonged solitary confinement for managing prisoners is rarely justified, and then only in the most extreme of cases.**
- **Solitary confinement is an undesirable tool for the long term management of challenging prisoners, and may be counter-productive.**
- **Those suffering from mental illness must not be placed in solitary confinement and under no circumstances should the use of solitary confinement serve as a substitute for appropriate mental health care.**
- **The use of solitary confinement for pre-charge and pre-trial detainees must be strictly limited by law, must only be used in exceptional circumstances, with judicial oversight, and for as short a time as possible, never for more than a matter of days.**
- **The use of solitary confinement as a means of coercing or 'softening up' detainees for the purpose of interrogation should be prohibited.**
- **Solitary confinement should never be imposed indefinitely and prisoners should know in advance its duration.**

Included in SCDC' 4.29.19 letter to LOC

Notes

33 Incommunicado detention involves the detainee being held without access to a lawyer, doctor and family members. The UN Special Rapporteur on Torture has proposed that this form of detention be declared illegal, as it is *"the most important determining factor as to whether an individual is at risk of torture"* and called on States to release all persons held incommunicado without delay (Report by the Special Rapporteur on the question of torture and other cruel, inhuman or degrading treatment or punishment (1999) UN doc. A/54/426, par. 42; Same, 1995 Report UN doc. E/CN.4/1995/34, par. 926). Successive resolutions of the UN Commission on Human Rights have reiterated this stance and stated that prolonged incommunicado detention can in itself constitute a form of cruel, inhuman or degrading treatment (see for example Commission on Human Rights resolutions 1997/38, 1998/37 and 1999/32). The UN Human Rights Committee called on States to make provisions against incommunicado detention (General Comment 20), and in considering individual cases involving incommunicado detention for varying periods of time found a violation of Articles 10 and/or 7 of the ICCPR (in many cases the applicant's incommunicado detention was accompanied by other deprivations. See, for example: *de Polay v. Peru* (1997) Communication 577/1994; *Mukong v. Cameroon* (1994) Communication 458/1991; *Gilboa v. Uruguay* (1985) Communication 147/1983). The European Court of Human Rights (ECtHR) found a breach of Article 6 protections where detainees were held incommunicado for 24 hours in one case and 48 hours in another (*Averil v. UK*, ECHR 212, [2001] 31 EHRR 36; *John Murray v. UK*, ECHR 3, [1996] 22 EHRR 29). The Inter-American Court of Human Rights found a violation of the prohibition against torture, inhuman or degrading treatment where a detainee was held incommunicado for 36 days, and declared that this form of detention, in itself, may constitute a violation of human rights law (*Castillo Petruzzi et al. v. Peru*, Judgement of 30 May, 1999.).

34 *Ezeh and Connors v. UK*, Judgement of 9/10/2003, (violation of Article 6(3)); *Whitfield and others v. UK.*, Judgement of 12/7/2005 (violation of Article 6(1) and 6(3)c .)

35 UN Human Rights Committee (2001) A/56/156, Session of 3/11/2000.

36 See CPT reports, particularly report re Denmark (1991 para.29; 1997; 2001); Norway (1994; 1996; 2006); Sweden (1995 paras.19-27).

37 CPT/Inf (2002) 18, at para.39.

38 In the UK, for example, see: Dora Rickford and Kimmett Edgar, *Troubled Inside: Responding the Mental Health Needs of Men in Prison*, Prison Reform Trust, 2005, in particular chapter 5, and HMCIP report, *The Mental Health of Prisoners, A thematic review of the care and support of prisoners with mental health needs*, October 2007.; In the US, see: The Commission on Safety and Abuse in America's Prisons: *Confronting Confinement*, June 2006. See also Prison Reform International (2003) Training Manual no. 1: *Human Rights and Vulnerable Prisoners*.

39 *Victor Rosario Congo v. Ecuador*, Case 11.427, Report No. 63/99, Inter-Am. C.H.R., OEA/Ser.L/V/II.95 Doc. 7 rev. at 475 (1998). April 13, 1999 para.58; See also ECtHR cases cited below

40 Recommendation concerning Custody and Treatment of Dangerous Prisoners (No. R (82) 17)

41 Shalev, S. (2007). 'The power to classify: avenues into a supermax prison' in: Downes, D., Rock, P., Chinkin, C. and Gearty, C. (Eds.) *Crime, Social Control and Human Rights: From moral panics to states of denial*, Devon: Willan Publishing, pp. 107-119. See also Briggs et al. (2003) 'The effects of supermaximum security prisons on aggregate levels of institutional violence', *Criminology*, Vol.41 (4) pp 1341-1376.

42 See for example the ECtHR judgements in *Ensslin, Badder and Raspe v FRG* , DR 14 (1978); *X v FRG*, Application 6038/73 Coll. 44 (1973).

43 *Mathew v the Netherlands*, Judgement of 29/9/2005 at Para. 199. See also CPT 2nd General Report CPT/Inf (92)3 par. 56

44 Human Rights Committee, Concluding Remarks on Denmark. 31/10/2000. CCPR/CO/70/DNK

45 General Comment 21/44, of 6 April, 1992.

46 CPT, 2nd General Report, 1992 par. 56.

47 *M v UK*, application 9907/82 DR 35 (1983)

Included in SCDC' 4.29.19 letter to LOC

48 *X v UK,* application 8324/78 unpublished

49 *X v UK,* application 8241/78 unpublished

50 *Krocher and Moller v Switzerland*, DR 34 (1982) p 54.

51 *Tomasi v France* A 241-A,1992

52 *Chahl v. The UK*, Judgement of 15/11/96, para.79

53 *Ramirez Sanchez v. France*, application no. 59450/00, Judgment of 27.1.05. The *Ramirez* case is quite unusual. Not only was he a very 'high profile' prisoner, but his conditions of confinement were relatively comfortable, he had frequent contact with people from outside the prison, and was in apparent good physical and mental health. In reaching it decision, the Court relied heavily on these factors and on the fact that he was later removed from solitary confinement and placed in an ordinary prison wing.

54 *Mathew v the Netherlands*, Judgement of 29.9.2005

55 *Iorgov v. Bulgaria* (2004) ECHR 113 (2005) 40 EHRR 7, ECtHR 185 par. 84

Included in SCDC' 4.29.19 letter to LOC

Included in SCDC' 4.29.19 letter to LOC

4 | Design, physical conditions and regime in solitary confinement units

4.1 Introduction

The design layout and 'hardware' of a prison building- including building materials, colour schemes and surveillance mechanisms- have a great impact on the way in which the prison is managed, on its regime, on the daily experiences of prisoners and staff and on the relationship between them. The specific design features of any prison are determined by many factors including its age, size, construction and operating budgets, its mission statement and the prevailing penal policies and attitudes and managerial theories at the time. By extension, the design of segregation units varies greatly, not only between one State and another, but also within the same jurisdiction, affording prisoners different levels of interactions, sensory stimulation, comfort, privacy, and so on.

Although the architectural design of isolation units and cells varies between prisons and jurisdictions, they typically share some common features including: location in a separate or remote part of the prison; the absence of, small, or partially covered windows; sealed air quality; stark appearance and dull colours; toughened cardboard or other tamper proof furniture bolted to the floor; and, small and barren exercise cages or yards. These features constitute a claustrophobic and monotonous environment, which has health implications for both prisoners and, to some extent, staff who work in these units. Such health implications are made worse by the lack of opportunities for social, vocational and recreational activities which also characterise these units.

Newly built isolation units tend to adopt the 'small pod' design where cells are grouped together in small clusters (or 'pods') of 6-8 single cells, arranged around a centralised control room from which prisoners are supervised. These units are designed to increase surveillance and to enable prolonged solitary confinement and minimise contact between prisoners and staff. Cells are self contained with a toilet and a wash-basin. Other measures, such as feeding-slots built into cell-doors, are taken to ensure that most services can be provided to prisoners inside their cells, reducing prisoner movement in and outside the unit. Typically, physical conditions in the new, purpose built isolation units are better than those in segregation units in older prisons, which were not designed for prolonged solitary confinement. Conversely, since in the newer purpose-built units most prisoner services can be provided in the cell or at the cell-front, prisoners enjoy even less stimulation and opportunities for interaction than in older segregation units. In some of the newly built isolation units, cells are also soundproofed and/or do not have windows, further reducing sensory stimulation.

Included in SCDC' 4.29.19 letter to LOC

The design of the prison is closely linked to its regime. Together they have great impact on prisoners' experience of the prison and their wellbeing. The section which follows examines international standards regarding prison conditions and regime, with a special emphasis on solitary confinement units.

4.2 International standards regarding prison conditions and regime

Human rights instruments form the guiding principles and minimum standards for the humane treatment of prisoners. The daily running of prisons is governed by national laws and prison rules which include detailed practical provisions, but they must in all cases conform to the overarching international human rights standards ensuring that prisoners are held in a humane manner in a sanitary and healthy environment. Indeed, monitoring bodies and the courts pay particular attention to the physical conditions in which prisoners are held and will be more inclined to find a violation of human rights law where these fall below the required minimum standards.

Having regard to the diversity in resources, laws and cultures of states, Article 2 of the UN Standard Minimum Rules (SMR) stipulates that standards should "*serve to stimulate a constant endeavour to overcome practical difficulties in the way of their application, in the knowledge that they represent, as a whole, the minimum conditions which are accepted as suitable by the United Nations*". In its General Comment 21, on the interpretation of what is meant by treating all persons deprived of liberty with "*humanity and with respect for their inherent dignity*" (ICCPR, Article 10), the UN Human Rights Committee made clear that such treatment is fundamental, and "*cannot be dependent on the material resources available in the State party*" (Human Rights Committee General Comment 21, Article 10 of the International Covenant on Civil and Political Rights (44th Session 1992)). In other words, these minimum requirements must be observed, "*even if economic or budgetary considerations may make compliance with these obligations difficult*"[56].

As their title implies, the Standard Minimum Rules (and other similar instruments) set out the base-level minimum requirements for the operation of prisons globally. The standards examined below are generic and apply to all prisons and to all sections of the prison, but they take on a particular importance in solitary confinement units. Conditions which fall below these minimum standards may constitute cruel, inhuman or degrading treatment or punishment. Adherence to, or even improvement on, the standards discussed below still does not mean that solitary confinement necessarily becomes any less damaging. But ensuring humane conditions and access to meaningful human contact may help mitigate some of its harmful effects.

A. Physical conditions

As noted above, instruments such as the UN Standard Minimum Rules (SMR) and European Prison Rules (EPR) prescribe minimum standards of physical conditions in all places of confinement. These include:

Included in SCDC' 4.29.19 letter to LOC

Cells

Rule 10 of the UN SMR stipulates that:

> All accommodation provided for the use of prisoners and in particular all sleeping accommodation shall meet all requirements of health, due regard being paid to climatic conditions and particularly to cubic content of air, minimum floor space, lighting, heating and ventilation.

The European Prison Rules (2006 revisions) use similar language, adding the importance of privacy (Article 18.1). Article 18.3 of the EPR stipulates that specific minimum requirements shall be set in national law.

Cell size and fixtures are of particular importance where prisoners spend most of their day inside the cell in solitary confinement. While international instruments do not specify a minimum size for cells intended for solitary confinement, one can infer from judgements and reports what constitutes an acceptable standard. The European Committee for the Prevention of Torture (CPT) found that solitary confinement cells measuring 8 sq. m. (CPT re Germany, 1993) and 9 sq. m. (CPT re the Netherlands, 1993) to be of a 'reasonable size' for single occupancy, and cells measuring 11 sq. m. to be of a 'good size' (CPT re Netherlands, 1998). The European Court of Human Rights judged a cell measuring 6.84 sq. m. to be 'sufficiently large' for single occupancy (*Ramirez v. France*, Judgement of 27/1/2005). Clearly, any cell should be large enough to allow sufficient area for sleeping, eating and studying, whilst keeping the lavatory area separate.

Windows and light

The use of dark cells as punishment is prohibited under international human rights law (SMR 31; EPR 62.3). International standards also require that in all places where prisoners live or work:

> (a) The windows shall be large enough to enable the prisoners to read or work by natural light, and shall be so constructed that they can allow the entrance of fresh air whether or not there is artificial ventilation (SMR Rule 11a).

Windows are particularly important where prisoners spend most of their day alone in the cell. The existence of windows, or lack thereof, as well as access to natural light for prisoners held in solitary confinement, have been important factors in the assessment of prison conditions by human rights bodies and the courts, and can tip the balance between acceptable conditions and inhuman treatment. In addition to natural light, international instruments also require that:

> Artificial light shall be provided sufficient for the prisoners to read or work without injury to eyesight (SMR Rule 11b)

Cell fittings should enable prisoners to control artificial light inside their cells. In no case should cell lights be left on continuously.

Included in SCDC' 4.29.19 letter to LOC

Sanitary fixtures and personal hygiene

Articles 12 and 13 of the UN SMR stipulate that

> 12. The sanitary installations shall be adequate to enable every prisoner to comply with the needs of nature when necessary and in a clean and decent manner.
>
> 13. Adequate bathing and shower installations shall be provided so that every prisoner may be enabled and required to have a bath or shower, at a temperature suitable to the climate, as frequently as necessary for general hygiene according to season and geographical region, but at least once a week in a temperate climate.

The standard set by European Prison Rules is for prisoners to be allowed to shower daily if possible, and at least twice a week (EPR Rule 19.4). Cells used for solitary confinement should, at a minimum, have an in-cell lavatory and wash-basin installed, and where possible, also a shower. These should be situated in a far corner of the cell and screened-off to afford the prisoner privacy. Prisoners should be provided with water and the necessary toiletries to maintain personal cleanliness (SMR Rule 15; EPR Rule 19.6), and with cleaning materials to maintain the cleanliness of their cells. More generally, all areas used by prisoners including showers, exercise areas and corridors should be clean and well maintained.

Other environmental features

The monotonous and claustrophobic environment of segregation units can be improved by some additional design features including[57]:

- Good ventilation and comfortable temperatures, ideally controlled by the prisoner
- Low noise levels
- 'Soft materials' for cell furnishings
- Colourful environment
- Privacy
- Alarm button

Physical design and conditions: country examples

The importance of good prison design and adequate physical provisions is perhaps best illustrated by examples of segregation units which fail to meet international standards. The selection below is drawn from reports on physical conditions in segregation units in various countries.

Included in SCDC' 4.29.19 letter to LOC

Physical conditions in segregation units: case studies

The 'S' security cells in Staubing prison (Germany)

Once inside the cell with all the doors closed, prisoners could not hear any of the usual prison sounds. The cells were located at the intersection of the wings of a building and were reached through a door opening onto a corridor, which served as a form of antechamber and where the showers were also situated. Each corridor contained two cells. In principle, there were no guards in the corridors and the occupants of the cells had no opportunities for visual or other forms of sensory contact with other prisoners or prison officers [CPT report 1993, par. 74-75.]

The isolation cells in Komotini prison (Greece)

Were also not in a fit condition to hold prisoners… [cells were] hot and filthy, with a putrid smell; there was poor ventilation, no bed (only a dirty mattress on the ground), no wash basin (hands were washed in the toilet) and minimal access to natural light [CPT report 2006, par. 41].

The disciplinary cells at Sremska Mitrovica prison (Serbia)

Were equipped with only a wooden platform (with a mattress and bedding), a box for personal belongings, a sink and an Asian-type toilet … access to natural light and artificial lighting were at best mediocre [CPT report 2006, par.133].

Cells in Section 209 of Evin prison (Iran)

Were placed in the basement ... Cells measured about one meter by two meters, with a ceiling height of about four meters. A light at the top of the cell is on twenty-four hours a day. Cells had a toilet and a sink. The floor was made of... chalk [and] the walls were all white. Some prisoners were granted twenty minutes per day in a caged outdoor area, but others never saw the open air... [Human Rights Watch, "Like the Dead in Their Coffins" Torture, Detention and the Crushing of Dissent in Iran; June 2004, Vol. 16, No.2 (E)

B. Prison regime

While it is generally accepted by human rights and monitoring bodies that certain restrictions may be unavoidable in segregation units where solitary confinement is imposed as a short-term disciplinary punishment, prison authorities are nonetheless required to provide prisoners with minimal regime provisions, as prescribed in international instruments. Where prisoners are held in longer term solitary confinement, international bodies make it clear that they must be afforded access to prison programmes and meaningful human contact. The minimal regime provisions prescribed by international instruments include some of the following:

Access to outdoor exercise

> 27.1 Every prisoner shall be provided with the opportunity of at least one hour of exercise every day in the open air, if the weather permits.
>
> 27.2 When the weather is inclement alternative arrangements shall be made to allow prisoners to exercise. (European Prison Rules (2006 rev.); SMR Rule 21(1))

Included in SCDC' 4.29.19 letter to LOC

The requirement for prisoners to have at least one hour of open-air exercise daily is generally accepted as an absolute minimum (CPT/Inf(93)15 at para.95). Where possible, prisoners should be allowed to associate with each other during recreation time (see also EPR 27.7). For prisoners held in solitary confinement, the exercise period is the only opportunity they have to get fresh air and a glimpse of the world outside their cells. This requirement is therefore of particular importance and should be strictly adhered to with a view to extending recreation times and enabling prisoners to exercise together. The lack of opportunity for outdoor exercise combined with the lack of access to natural light was found by the European Court of Human Rights to amount to degrading treatment in violation of Article 3 of the ECHR[58].

Designated exercise yards in segregation and special high security units often comprise a small and barren concrete enclosure (see various CPT Country Reports). In some jurisdictions the area is covered with metal mesh obstructing the view of the sky. This should be avoided. Exercise yards should be of sufficient size to enable prisoners to exert themselves and, so far as possible, should be equipped with appropriate equipment. Efforts should also be made to modify the bleakness of exercise yards through, for example, painting the area or planting greenery.

Exercise yards: good practice example

Exercise yards at the Extra Security Unit (EBI) in Vught prison (the Netherlands) were *"large enough for prisoners to exert themselves physically"* and had a 'running strip' for prisoners who "*wished to engage in more strenuous physical activities"*. Exercise could take place with between one to three other prisoners. Prisoners also had access to a large and well equipped gymnasium. [CPT Report, 1998, CPT/Inf(98)15.]

Access to programmes

> Provisions shall be made for the further education of all prisoners capable of profiting thereby ... the education of illiterates and young prisoners shall be compulsory and special attention shall be paid to it by the administration (SMR Rule 77; EPR (2006 Rev) Rule 28)
>
> Recreational and cultural activities shall be provided in all institutions for the benefit of the mental and physical health of prisoners (SMR Rule 78)
>
> All prisoners shall have the right to take part in cultural activities and education aimed at the full development of the human personality (Basic Principles for the Treatment of Prisoners, Principle 6)

Programme provision in prisons has many obvious advantages for prisoners' wellbeing and personal development as well as for their prospects of successful reintegration upon release. Research also strongly suggests that access to programmes in prison positively affects behaviour, whereas the lack of things to do may result in increased violent behaviour. A literature review of over ninety studies of the impact of prison programmes concluded that:

Included in SCDC' 4.29.19 letter to LOC

> *"Research shows a fair amount of support for the hypothesis that adult academic and vocational correctional education programs lead to fewer disciplinary violations during incarceration, reductions in recidivism, increases in employment opportunities, and to an increase in participation in education upon release"* (Gaes et al. 1999:411).

Prisoners held in disciplinary segregation for a short period of time may excluded, as part of their punishment, from participation in prison programmes. However, programme provision is crucial for prisoners who are isolated for longer periods of time, as they enjoy little or no social contact, experience substantially reduced sensory stimulation, and have very few means to occupy themselves inside their solitary cells. As Chapter Two demonstrated, these factors have negative health effects and may also lead to behavioural problems. To counteract such effects, research suggests that it is crucial for prisoners to have access to an adequate programme of activities in custody, particularly in high security prisons: *"the greater the security of an institution, the more intense must be its activity program. Maximum prison lock-up without an appropriate activity program is detrimental to the inmate's health and his rehabilitative prognosis"* (Scott & Gendreau, 1969:341). CPT Standards elaborate:

> *"The existence of a satisfactory programme of activities is just as important – if not more so – in a high security unit than on normal location. It can do much to counter the deleterious effects upon a prisoner's personality of living in the bubble-like atmosphere of such a unit. The activities provided should be as diverse as possible (education, sport, work of vocational value, etc.). As regards, in particular, work activities, it is clear that security considerations may preclude many types of work which are found on normal prison location. Nevertheless, this should not mean that only work of a tedious nature is provided for prisoners"* (CPT Standards, CPT/Inf/E(2002)1 Rev. 2006, par.32).

Ideally, programmes should be provided outside the cell and in association with others. Where this is not feasible, prisoners should, as a minimum, be provided with in-cell or at-cell-door programme delivery.

Access to activities: good practice example

The Close Supervision Centre (CSC) at Whitemoor prison (UK) has a communal area with table tennis and pool tables, a classroom equipped with a computer, a trolley of books and a stock of board games, and a workshop. It also has a well equipped fitness suite with free weights and an outside exercise yard which contained a greenhouse and a secure garden. [HMCIP, Extreme Custody, June 2006]

Access to meaningful human contact within the prison

It is crucial for isolated prisoners, particularly those isolated for longer periods, to have regular and meaningful human contact. The potential health effects of social isolation have been discussed in detail in Chapter Two but here it should be noted that every effort should be made to ensure that the prisoner has some degree of interaction with other human beings. This may mean, for example, allowing some association between prisoners during meal or recreation times, encouraging contact between the prisoner and educational, health and religious staff, allowing visits by 'prison visitors'

Included in SCDC' 4.29.19 letter to LOC

and so on. Informal interactions with custodial staff should also be encouraged. Monitoring bodies and the courts pay particular attention to the level and quality of human contact afforded to isolated prisoners and will be more inclined to find a violation of human rights law where these are lacking.

Contact with the outside world

Human rights law emphasises the importance of enabling prisoners to maintain contact with the outside world. This requirement covers visits by family and friends, access to written and broadcast media and various forms of communication including letters and the telephone. Where prisoners are held in solitary confinement and enjoy little human interaction and few social contacts, these requirements become all the more important. Contacts with family, friends, and the community are not only important factors for prisoners' wellbeing, but have also been shown to be important factors in positively influencing prisoners' behaviour and improving their chances of successful reintegration upon release from prison[59.]

Family contacts

Article 17 of the International Covenant on Civil and Political Rights (ICCPR) stipulates that

> No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence...

The right to family life is also protected under Article 11 of the American Convention on Human Rights and Article 8 of the European Convention on Human Rights. It has been established that, notwithstanding limitations inherent in prison life, prisoners retain the right to family life and prison authorities have a duty to assist them in maintaining close family contacts (*Messina (No.2) v. Italy*, 2000).

Prisoners' right to respect for their family life through visits and communications is further established in several international instruments:

> Prisoners shall be allowed under necessary supervision to communicate with their family and reputable friends at regular intervals, both by correspondence and by receiving visits (SMR Rule 37. See also: SMR Rule 79; Principle 19 of the Body of Principles for the Protection of All Persons Under any Form of Detention or Imprisonment; EPR (2006 Rev) Rule 24).

To encourage family ties, where possible, prisoners should be housed in a prison close to their home (Body of Principles, Principle 20). Visits should take place in specially designated areas which should be appropriately furnished, clean and well maintained. It is good practice to allow for contact visits (i.e. not held through a glass partition) between the prisoner and their visitor(s), particularly when the visitor is a child. Visitors should be treated with respect and must not be subjected to unnecessary security procedures.

Included in SCDC' 4.29.19 letter to LOC

Access to written and broadcast media

> Prisoners shall be kept informed regularly of ... items of news by reading newspapers... by hearing wireless transmissions ... or by any similar means (SMR Rule 39)

This requirement, again, is particularly important when the prisoner is held in prolonged solitary confinement with little access to the outside world. Knowledge of, and interest in, current and community affairs will not only assist the prisoner's eventual transition back to life as a free member of society, but may also have a positive effect on his mental wellbeing during his time in isolation. For these reasons, it is also recommended that, so far as possible, prisoners held in solitary confinement, particularly for prolonged periods, have television sets and radios in their cells.

Impoverished regimes: country examples

The main component of solitary confinement regimes, of course, is that the detainee or prisoner is held alone in their cell for up to 24 hours a day. The specific provisions which prisoners are entitled to whilst in segregation, and the degree and level of contact that they have with the outside world, however, varies from one jurisdiction to another. As noted earlier, in addition to 'regular' segregation units, some jurisdictions now also operate regimes specifically designed to place further restrictions on certain categories of prisoners who are in solitary confinement. Some examples of such regimes are set out below.

Impoverished solitary confinement regimes: case studies

Italy

Prisoners may be placed in solitary confinement for the duration of their sentence under a 'special regime' for reasons of public order and security, in particular offences relating to Mafia activities. They are held in single cells and allowed to mingle with between three to five others during exercise period. Some of the additional measures which may be applied under this regime, at the discretion of prison staff, include:

- A ban on visits by persons other than family members, a cohabitant or a lawyer;
- A maximum of one family visit lasting one hour each month;
- No access to a telephone or a maximum of one telephone call per month;
- Censorship of all correspondence except for privileged correspondence;
- No more than two hours per day to be spent outdoors;
- No extra visits allowed for good conduct;
- No more than two parcels per month;
- No sums of money to be received from outside prison or sent out;
- No handicrafts;
- No conversation or correspondence with other prisoners.

Included in SCDC' 4.29.19 letter to LOC

The Netherlands

Prisoners who are considered extremely likely to attempt to escape from prison and who, if they succeed, pose an unacceptable risk to society in terms of committing further serious violent crimes or in terms of severe disturbance of public order, may be placed at the extra-security units (EBI and (T)EBI) at Vaught prison, which have a total capacity of 35 cells. The regime and security arrangements at the units include some of the following:

- Two screened telephone calls of up to 10 minutes a week and screening of all non-privileged correspondence;
- Closed, pre-arranged visits with approved visitors (one weekly visit of up to an hour);
- One monthly contact visit with immediate family/spouse lasting an hour (physical contact is limited to a handshake upon arrival and departure; guards remain in close proximity throughout the visit; visitors are subjected to a search ('frisking') prior to visit)
- No educational activities and limited in-cell work opportunities;
- Staff are separated from prisoners by a glass partition; only one prisoner at a time may come into contact with staff, and at least two staff members must be present; on such occasions the prisoner must be handcuffed;
- One hour a day of outdoor exercise with between one and three other prisoners;
- Up to six hours weekly of 'group activities' with no more than three others;
- Weekly cell searches;
- Weekly strip searches.

United States

Prisoners who are classified as gang members or have been found guilty of a 'serious rule violation' in prison may be held in solitary confinement in the Security Housing Unit (SHU) at Pelican Bay State Prison (California) for periods ranging from two to five years in the case of rule violators and indefinitely in the case of gang members. Once at the SHU, which has capacity of 1056 cells, they spend 23 to 24 hours a day inside their cell and have access to the following:

- Solitary exercise in a small and barren exercise yard for one hour four times weekly;
- A 15 minute long shower in a single shower-cell three times weekly;
- One quarter of the monthly canteen allowance;
- No access to recreational or vocational activities;
- Telephone calls on an emergency basis only, as determined by staff;
- Two 2 hour long no-contact family visits on weekends once a month;
- One annual package, not exceeding 30 pounds in weight;
- One-off special purchase of one television or one radio/television unit;
- Up to ten items of reading materials (magazines and books);
- No hobby or craft materials.

Included in SCDC' 4.29.19 letter to LOC

As these examples demonstrate, although provisions for prisoners who are held in solitary confinement regimes vary between States, such regimes typically involve further restrictions and security measures in addition to the physical segregation of prisoners from the general prison population. It is difficult to see what legitimate penal purpose is served by restricting prisoners' access to craft and hobby materials and other in-cell activities, or subjecting them to routine strip searches even when the prisoner had no physical contact with others, and how such practices are conducive to rehabilitation and reintegration purposes or, indeed, to prison security. Such regimes are contrary to international standards and good practice and, in some cases, can be in violation of international law. Moreover, they result in boredom and frustration which may in turn lead to mental health and behavioural problems.

4.3 Research findings and recommendations regarding prison design and environmental factors

There are few studies of the relationship between the prison environment and prisoner behaviour in general, and no studies which focus on segregation units. The sparse literature and few empirical studies reaffirm the fairly obvious: *"the design of the prison environment is crucial to its operation and to the impact it has on the achievement of correctional goals for inmates, staff and public users"* (Fairweather, 2000:47). Environmental conditions in prison also affect prisoners' health and can *"easily exacerbate the symptoms of mental illness for some people. In fact, the prison environment itself can contribute to increased suicide and the inability of inmates with serious mental illness to adjust. Environmental factors can also elicit significant adjustment reactions from inmates who may not have had a previous diagnosis but who become ill while incarcerated"* (Hills at al. 2004:15). Further, design and environmental factors can influence the frequency and severity of violent incidents[60].

The design of a prison is closely linked to its regime, as the layout of the prison dictates, to a large degree, the activities and human interaction that can take place within it. Studies of the effects of specific prison design features on prisoners and staff indicate that these can have 'negative' or 'positive' effects. Positive design features are those that reduce the institutionalised atmosphere in prisons, lessen stress, aggression and violence, and generally increase prisoners' wellbeing. Negative features are those that foster and increase the above. Some of the design features that are cited as positively influencing behaviour and wellbeing are those which:

Increase opportunities for social interaction between prisoners and between prisoners and staff

Clearly, segregation units are not designed for continuous prisoner association. Yet, even in units or prisons designed for solitary confinement the design should allow for some degree of social interaction. This can be done through the inclusion of communal areas for recreational, sports and games facilities and so on.

Included in SCDC' 4.29.19 letter to LOC

Enable direct supervision of prisoners

The prison's supervision style is determined by both its management approach and its architectural layout, and is cited by researchers as one of the most important factors in affecting behaviour. There are two basic layouts: direct supervision and indirect supervision. In prisons with indirect supervision, staff and prisoners occupy separate territories. Supervision and control are remote and characterised by reliance on distant visual surveillance from secure staff stations, and on patrolling corridors and landings. Indirect supervision is reactive in nature, and tends to alienate prisoners and staff. With direct supervision prisons, staff areas are located inside the unit, so that staff have greater face to face contact with prisoners. These prisons are proactive rather than reactive, as their layout and the presence of staff lessen opportunities for misconduct. Research suggests that direct supervision allows more effective surveillance and better security, and results in a dramatic reduction in prison violence[61]. Direct supervision has also been endorsed by professional bodies, as well as the United Nations, as the best method for managing prisoners, including those classified as dangerous or disruptive.

Allow flexibility/ adaptability in the use of the unit

Positive architecture allows adaptability to future change. Planning can anticipate, and the design should include, the possibility of future alteration of internal spatial divisions, external additions or subtractions, and 'functional flexibility'. New prefabricated technologies make it possible to design prison units so that they can serve different functions according to actual needs. So, for example, the division of space and design of a unit designated for long-term solitary confinement should not be so inflexible as to preclude the possibility of prisoner association areas or the provision of programmes, should there be a change in policies regarding the prisoners held in the unit or in their individual needs.

Communicate a positive message

The appearance of the prison communicates to prisoners how they are expected to behave (Wener, 2000:52). If the design and security arrangements in segregation and high security units communicate to prisoners that they are highly dangerous and not fit for human contact, they are more likely to start perceiving themselves as such and behave accordingly. Security arrangements should therefore be as limited and un-intrusive as possible and reflect the fact that segregated prisoners are already secured, individually, in their cells. It is also important to break the monotony of segregation units to allow a degree of sensory stimulation. This can be achieved easily and inexpensively by, for example, colourful wall paint, good lighting, and so on.

Included in SCDC' 4.29.19 letter to LOC

4.4 Human rights case law regarding regime and physical conditions in segregation units

States have a duty to ensure that prisoners are *"detained in conditions which are compatible with respect for his human dignity, that the manner and method of the execution of the measure do not subject him to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, his health and well-being are adequately secured*[62]". Where these fall below acceptable standards, prison conditions may amount to inhuman or degrading treatment, in violation of international law.

Human rights bodies pay particular attention to the use of solitary confinement which, as the previous chapter noted, is viewed as an extreme prison practice, which should only be used in exceptional cases and then for the shortest duration possible. The ECtHR has stated that "*complete sensory isolation coupled with complete social isolation can no doubt destroy the personality*[63]" and would constitute treatment in violation of the absolute prohibition on torture, inhuman or degrading treatment enshrined in Article 3 of the European Convention on Human Rights. The Inter American Court of Human Rights has similarly stated in several cases that prolonged solitary confinement, in itself, may violate Article 5 of the American Convention on Human Rights: "*prolonged isolation and deprivation of communication are in themselves cruel and inhuman treatment, harmful to the psychological and moral integrity of the person, and a violation of the right of any detainee to respect for his inherent dignity as a human being. Such treatment, therefore, violates Article 5 of the Convention...*"[64]. Finally, the UN Human Rights Committee criticised "*... the practice of solitary confinement which affected the physical and mental health of persons deprived of freedom and which amounted to a cruel, inhuman and degrading treatment*"[65].

In two separate cases brought against Uruguay, the Human Rights Committee found that holding a detainee for one month in a cell where "*rainwater filtered in and one lives in the midst of human excrement*" violated Article 10(1) of the ICCPR but not Article 7, whilst holding a detainee for one month in a small windowless cell where artificial light is left on 24 hours a day violated both Articles 10(1) and 7 of the ICCPR (UN Human Rights Committee, 1990, CCPR/C/OP/2). The UN Committee Against Torture (CAT) has found a violation of the prohibition against inhuman or degrading treatment or punishment in several cases involving the use of solitary confinement. For example, it found that isolation in cold and damp punishment cells measuring 1.5x2 metres without proper bedding or sanitation in Bolivia was "*tantamount to torture*", and the strict isolation in sound-proof cells of political prisoners in high security prisons in Peru amounted to torture[66].

But solitary confinement may also constitute inhuman and degrading treatment when physical conditions are not so clearly below internationally established standards. When considering whether solitary confinement constitutes inhuman or degrading treatment in any one case, the courts and monitoring bodies will assess the surrounding circumstances, including: the particular conditions of confinement, the stringency of the measure, its duration, and whether the prisoner had minimal possibilities for human contact[67]. The objective pursued by the measure and its effects on the individual concerned will also be assessed[68]. As some of the cases below, drawn from judgements made by the ECtHR, demonstrate, both the physical conditions in which the

Included in SCDC' 4.29.19 letter to LOC

prisoner is held and the degree of human contact he is afforded whilst in solitary confinement will be subjected to particularly close scrutiny. Where, in the Court's view, there are compelling reasons to hold a prisoner in separation from other prisoners, and the physical conditions of confinement are relatively comfortable, provisions are good and the extent of human contact is such that it is arguable whether the prisoner is really isolated, then case law suggests the Court is less likely to find a breach of the Convention[69].

- The placement of a pre-trial detainee in solitary confinement for just under a year was found not to constitute inhuman or degrading treatment because although *"a period of such a length may give rise to concern because of the risk of harmful effects upon mental health"* the Court considered that the extent of social isolation to which he was subjected did not reach the necessary threshold and while *"he was totally excluded from association with other inmates ... during the day he had regular contact with prison staff, [and] in addition, every week he received lessons in English and French from the prison teacher and he visited the prison chaplain. Also, every week he received a visit from his counsel. Furthermore, during the segregation period in solitary confinement the applicant had contact twelve times with a welfare worker; and he was attended to thirty-two times by a physiotherapist, twenty-seven times by a doctor; and forty-three times by a nurse. Visits from the applicant's family and friends were allowed under supervision".* The Court also noted that the physical conditions of detention were adequate as the detainee was held in a cell measuring eight square meters equipped with a television set, and had access to newspapers (*Rhode v. Denmark,* Judgement of 21/7/2005, pars. 97-98).
- The Court found that a regime of strict solitary confinement (the prisoner was held alone in his cell for 23 hours a day and was only allowed to mingle with other prisoners for one hour during a daily walk) imposed on a former death row prisoner for over three years, and the material conditions in which he was held (cell measuring 2 by 3 metres with a small window which did not allow sufficient light or fresh air, a heating system which was covered by a layer of bricks and illumination by only one 60-Watt electric bulb which was insufficient for reading) must have *"caused him suffering exceeding the unavoidable level inherent in detention"* and constituted inhuman and degrading treatment in breach of Article 3 of the ECHR (*Iorgov v. Bulgaria*, Judgement of 11/3/2004).

In sum, the extreme nature of solitary confinement and its potential health effects give rise to special human rights concerns, and its use is subjected to close scrutiny by the courts and monitoring bodies. In particular, the physical conditions in which prisoners are held, the regime provisions they enjoy and the degree of human contact they have whilst isolated will be assessed.

Although the human rights view is that solitary confinement is an undesirable prison practice, its use is not prohibited per se. Rather, the practice will be assessed on a case by case basis to determine whether it has violated the prohibition against torture, inhuman or degrading treatment or punishment.

Included in SCDC' 4.29.19 letter to LOC

4.5 Concluding remarks on regime and conditions of confinement in segregation and high security units

Isolated prisoners spend up to 24 hours a day inside their cells. They have limited human contact, little or no physical contact with others, few personal possessions, and few ways to occupy themselves inside their cells. Prolonged confinement in these conditions is physically and mentally taxing. We discussed some of the potential health effects of solitary confinement in Chapter Two. These effects can be mitigated, to some degree, by ensuring that isolated prisoners:

- are accommodated in cells which are sufficiently large to enable them to conduct all their daily activities in a clean and humane environment, respectful of their human dignity;
- have daily access to fresh air and exercise;
- have access to meaningful human contact and purposeful activities; and,
- have contact visits with family members.

The deprivations inherent in segregation units should not be made worse by further restrictions on in-cell provisions such as reading materials, craft and hobby materials, personal radios and so on. Wherever possible, prisoners should be allowed to conduct daily activities in association with other prisoners. Where there are compelling reasons not to allow prisoner association, increased contact with staff, particularly non-custodial (religious, educational, health) staff should be encouraged. Custodial staff should also be encouraged to engage informally with prisoners and maintain good relationships and a good atmosphere in the unit. It is thus crucial that staff working in segregation units are carefully selected, well supported and properly trained. In particular, staff should receive training in mental health and de-escalation techniques. Well trained, experienced staff can make a huge difference in segregation units.

In short, every effort should be made to ensure that the harmful aspects of solitary confinement are mitigated through the provision of decent facilities, sensible regimes and purposeful activities. Adherence to the standards discussed in this chapter is not only legally required, but it also makes good managerial sense. Even when all these mitigating factors are in place, solitary confinement should not, as discussed in Chapter Three, be used for a prolonged time other than in a handful of cases where it may be exceptionally and absolutely necessary.

Included in SCDC' 4.29.19 letter to LOC

Key points

- Isolated prisoners spend most of their time inside their cell. Cells should therefore be designed to accommodate this regime and, as a minimum, contain a toilet and a wash-basin.
- Allow segregated prisoners to exercise some degree of autonomy and control over their immediate environment.
- Encourage visits by family and friends and ensure that visiting areas are clean and in good decorative order.
- Ensure that isolated prisoners have as much human contact as possible with people from outside the prison and with custodial, educational, religious and medical staff.
- Allow for as many activities as possible, for example meals, to take place in association with other prisoners.
- Where this is not possible, creative solutions should be sought to ease the restrictive monotonous environment and impoverished regime in segregation units.
- Small concessions go a long way. Be flexible and think creatively.
- One size does not fit all. Additional restrictions may be unavoidable for certain prisoners at certain times, but should not be applied as a matter of course.
- The recommendations discussed in this chapter set out ***minimum*** standards which prison administrations should strive to improve on.
- Further standards and safeguards need to be developed to ensure that prisoners are protected against the harm that solitary confinement causes.

Included in SCDC' 4.29.19 letter to LOC

Notes

56 U.N. Doc. CCPR/C/51/D/458/1991; *Mukong v. Cameroon* (August 10, 1994).

57 Royal College of Psychiatrists, 1998; Buchanan et al. 1988; Fairweather, 2000.

58 *Poltrotsky v Ukraine*, 146 ECHR 2003-V; See also judgements in the cases of *Kuznetsov; Nazarenko; Dankevich; Aliev; Kokhlich v Ukraine*, judgments of 29 April 2003, ECHR 2003-V.

59 Moyer, 1975:58-60; Fairweather 2000:34. The Royal College of Psychiatrists' Clinical Practice Guidelines propose that staff working with the mentally ill should "Encourage and provide privacy for visits from friends and relatives" as good practice in preventing violence (1998:59).

60 Management of imminent violence, Royal College of Psychiatrists OP41 (1998).

61 Fairweather, 2000; Bottoms, 1999:243-245; Buchanan et al., 1988:51-54

62 *Kudła v. Poland* [GC], no. 30210/96, 92, ECHR 2000-XI

63 *Ensslin, Baader and Raspe v. FRG*, DR14 (1978) at Para. 109.

64 *Velasquez Rodriguez v. Honduras*, Judgement of 29 July 1988, Series C No.4 at par. 156

65 UN Human Rights Committee (2001) A/56/156. November 3rd, 2000, session.

66 UN Committee Against Torture (2001) paragraphs 95(g) and 186 respectively.

67 *Ensslin, Baader and Raspe v FRG* 14 DR 64 (1978).

68 *McFeeley and Others v. the UK*, no. 8317/78, Commission decision of 15 May 1980, DR 20

69 The placement of a prisoner, Ilich Ramirez ('Carlos the Jackal'), who, at the time, *"was considered to be the most dangerous terrorist in the world"*, in solitary confinement for more than eight years was found not to violate Article 3. In reaching its decision, the Court took account of the relatively comfortable conditions of his detention (his cell measured 6.84 sq. meters, was equipped with a toilet and washing facilities and had a window which provided natural light. He also had access to a television, newspapers and books), the fact that he was allowed out of his cell two hours daily for outdoor exercise and one hour in a gym, had frequent contact with people from outside the prison (he was visited by a doctor twice a week, by a cleric once a month, and frequently by his 58 lawyers, including 640 times in a period of five years by one of his lawyers, whom he later married), and, by his own testament, was in good physical and mental health. The Court also noted that he was later removed to a normal prison location, whilst reaffirming that in any case, solitary confinement should not be imposed on the prisoner indefinitely (*Ramirez v. France*, Judgement of 27/1/2005).

Included in SCDC' 4.29.19 letter to LOC

Included in SCDC' 4.29.19 letter to LOC

5 | The role of health professionals in segregation units: ethical, human rights and professional guidelines[70]

5.1 Introduction: ethics as applied to prison medicine

Health professionals working in prisons and other places of detention face some particular challenges which stem from the inherent tension between the role of the prison as a place of punishment through deprivation of liberty, and their role as protectors and promoters of health (physical, mental and social). Firstly, they need to provide care in an environment which is geared towards security and all the physical arrangements – and institutional culture – that this entails. Their patients are held involuntarily in conditions which severely limit not only their freedom of movement, but the degree of control they have over most other aspects of their daily lives and activities. Other challenges include a high workload, often coupled with limited resources; work with populations with special needs and high prevalence of mental illness; dual obligations towards their patients and the prison's authorities; the competing demands of each and potential mistrust by both; poor training and, where they are employed exclusively by the prison, a degree of isolation from other members of their profession[71].

The ethical challenges are especially acute when the question of the involvement of health personnel in disciplinary measures arises, and nowhere is this more contentious than in their role, if any, in segregation units[72].

By asking a number of pertinent questions, the following section outlines the ethical and legal framework that guides the role of health personnel when confronted with the use of solitary confinement. Some of the potential dilemmas and conflicts identified below are not always easy to resolve in practice. Nonetheless, health professionals must always ensure that their conduct is not compromised by external and possibly spurious considerations. When faced with such dilemmas, advice and guidance should always be sought from senior health colleagues and from professional bodies.

Included in SCDC' 4.29.19 letter to LOC

5.2 Issues regarding prison medicine in solitary confinement units

What are 'dual loyalties' and where can health professionals seek support and advice?

> A physician shall owe his/her patients complete loyalty and all the scientific resources available to him/her (WMA International Code of Medical Ethics, 1949).

A situation of dual loyalty arises when health professionals face *"simultaneous obligations, expressed or implied, to a patient and a third party"*[73]. Health professionals working in prisons will almost inevitably face situations where they are asked or expected to suspend their clinical judgement in favour of other considerations or to contribute to processes and procedures that are not driven by therapeutic purposes. Codes of ethics make it clear that the duty owed to the patient takes precedence over any other obligation, and that health professionals must act in the best interest of their patients at all times. Many of the issues outlined in the following sections, such as whether to certify someone fit for punishment, or the right to access healthcare, are examples of such dual loyalties.

Clearly, as in any medical practice, there will be situations in which health professionals will have to judge whether their primary obligation to the care of the individual patient might have to be overridden in order to protect that individual, other prisoners, or staff. Again, their actions should be guided primarily by their function as health professionals, above that of their status as employees of a prison, police force or the military, but therein lies the very essence of "dual loyalties". Health professionals should strive to retain a professional independence, and thereby to retain the trust and confidence of their prisoner-patient.

Physicians seeking advice on ethical dilemmas can approach both their national medical association and the World Medical Association[74] (www.wma.net). Nursing professionals can approach their national nursing association as well as the International Council of Nurses, the body which provides ethical guidance to nurses (International Council of Nurses www.icn.ch).

Do health professionals have any role in certifying a prisoner 'fit' to undergo disciplinary measures, including solitary confinement?

In exactly the same manner as any health professional working in the community, the primary duty of the health professional working inside a prison is to protect, promote and improve the health of their patients. Naturally, when working in an environment whose over-arching aim is security, the health professional must follow the rules and procedures necessary for the safe and lawful running of the institution, but their role as health professionals must not be subordinated to this purpose. Their ethical duties remain the same as if they were working in the community but, as we shall see below, with the various constraints that working in a place of deprivation of liberty brings.

Included in SCDC' 4.29.19 letter to LOC

"Act only in the patient's interest when providing medical care which might have the effect of weakening the physical and mental condition of the patient" (World Medical Association International Code of Medical Ethics 1949, amended 1983).

It is clear that for health staff to participate in any manner in disciplinary measures within a prison would, in the first place, be in direct contradiction with their fundamental role as healthcare providers. The primary duty of the physician and the nurse, wherever they work, is to the health of their patient (World Medical Association Declaration of Geneva 1949, amended 1994, and International Council of Nurses Code of Ethics for Nurses, adopted 1953 and revised 2005). Moreover, in order to establish and to maintain the professional relationship and confidence and trust with the prisoner-patient, the prison health staff cannot be seen to have any role in the prison administration, and in particular in disciplinary matters. Health care must be provided with *"full technical and moral independence"* and be based purely upon medical needs (World Medical Association International Code of Medical Ethics 1949, amended 1983, and International Council of Nurses Position Statement on Nurses' Role in the Care of Prisoners and Detainees 1998, revised 2006).

"It is a contravention of medical ethics for health personnel, particularly physicians…to certify, or to participate in the certification of, the fitness of prisoners or detainees for any form of treatment or punishment that may adversely affect their physical or mental health and which is not in accordance with the relevant international instruments, or to participate in any way in the infliction of any such treatment or punishment which is not in accordance with the relevant international instruments" (Principle 4 (b), United Nations Principles of Medical Ethics[75]).

International standards of medical ethics thus clearly state that health professionals, particularly physicians, must neither certify someone "fit for punishment", nor participate in any way in the administering of such punishment. When isolation is used for any purpose that is not purely medical (e.g. isolating a potentially infectious patient), health staff can have no part in the process of deciding on its application or its administration.

It has often been argued that the physician can have a protective role by examining the fitness of individuals to undergo certain punishments. Indeed, the UN Standard Minimum Rules, which date from the 1950s and from a more 'paternalistic' view of medical ethics state that *"Punishment by close confinement or reduction of diet shall never be inflicted unless the medical officer has examined the prisoner and certified in writing that he is fit to sustain it"* (Rule 32. (1)). Standards evolve over time, however, and this rule is now clearly at odds with contemporary standards of medical ethics (see above) as well as current standards of prison administration and treatment of prisoners which, obviously, would not allow a reduction in the basic nutrition of any prisoner as a punishment. Looking at the issue from another perspective, were the physician to decide that certain prisoners are not fit to undergo solitary confinement, those people may well be spared the punishment. But this also means that in other cases the physician is effectively authorising the punishment of placing another prisoner in solitary confinement. Not only are they certifying someone fit for punishment, but they are acquiescing in a punishment that is known to adversely affect mental and physical health.

Included in SCDC' 4.29.19 letter to LOC

But there is a more decisive argument. The Sourcebook has set out the substantial body of research that shows the deleterious effects of solitary confinement on the mental and physical health of individuals, even if only inflicted for relatively short periods. The fact that in several international prison standard instruments and in many national prison regulations particular attention is given to solitary confinement and to attempts to mitigate its negative effects by involving health staff in its application, is a clear indication that the potentially harmful consequences are known to those writing them. Put more simply, if solitary confinement is safe, why must a physician check that someone can withstand it, and why must they be required to monitor their physical and mental health on a daily basis? No other legal disciplinary measure requires so much medical oversight.

For these reasons, the World Health Organisation (WHO) recommends that *"doctors should not collude in moves to segregate or restrict the movement of prisoners except on purely medical grounds, and they should not certify a prisoner as being fit for disciplinary isolation or any other form of punishment"* (Health in Prisons, A WHO Guide to the essentials in prison health 2007:36). The official commentary on the revised European Prison Rules (EPR) similarly states that "*medical practitioners or qualified nurses should not be obliged to pronounce prisoners fit for punishment but may advise prison authorities of the risks that certain measures may pose to the health of prisoners*"[76].

Do health professionals have any role in monitoring the effects of a disciplinary punishment once it has started?

From the previous paragraphs it is clear that health staff have no role in prison discipline, and that this includes monitoring the health effects of a sanction once it is being carried out. If the health professional, of their own volition and following their medical judgement rather than as 'standard procedure', was to chart the appearance of negative health effects, and at a given point intervene to end a disciplinary sanction, then effectively they are acting as arbiter of how long particular individuals can withstand the punishment. Inevitably, they will then have to decide that some individuals must be removed from isolation, while others must remain isolated (while knowing that the latter may sooner or later develop psychological, psychiatric or physical disorders linked to the isolation).

Monitoring the potential health consequences must, however, be distinguished from the right of all prisoners, irrespective of their status, location, or behaviour, to access healthcare (this will be discussed in more detail in the following section). Again, herein lies one of the key tensions of dual loyalty, since there is clearly a fine line between monitoring the punishment and providing needed clinical attention and care.

The revised version of the European Prison Rules (2006) states that solitary confinement should be an exceptional measure, and that even then it should only be applied for the shortest possible time (Rule 60.5). The Rules then require that medical staff should monitor prisoners in solitary confinement on a daily basis, and emphasise that if their mental or physical health is "seriously at risk", this must be reported to the director[77]. Similarly, the CPT in its early general reports foresaw a monitoring role for physicians (CPT 2nd General Report, CPT/Inf (92) 3 Para. 56).

Included in SCDC' 4.29.19 letter to LOC

However, in an often overlooked footnote contained in the revised European Prison Rules the government of Denmark objected to the proposed role of physicians in monitoring those in solitary confinement, on the basis that this could constitute certifying that the person is fit to continue the punishment of solitary confinement, which would be unethical. The objection could also have been made on the basis that this particular treatment may amount to a form of ill-treatment and not only would the participation of health staff be unethical, it would also be a contravention of international law. Addressing this ethical issue, the official commentary on the revised Rules stipulates that daily visits to isolated prisoners "*can in no way be considered as condoning or legitimising a decision to put or to keep a prisoner in solitary confinement*".

What if the disciplinary measure actually or potentially inflicts injury?

It is self-evident that if acts of torture or other cruel, inhuman or degrading treatment are prohibited by international law, health professionals are also bound by such laws. Furthermore, their conduct is also constrained by international ethical standards which clearly prohibit not only active participation in interrogation, but also any other acts such as devising or planning methods of interrogation, particularly when the use of medical knowledge is solicited or when confidential medical information is misused against the patient [78]. The World Medical Association's Declaration of Tokyo states in its paragraph 3:

> "When providing medical assistance to detainees or prisoners who are, or who could later be, under interrogation, physicians should be particularly careful to ensure the confidentiality of all personal medical information. A breach of the Geneva Conventions shall in any case be reported by the physician to relevant authorities. The physician shall not use nor allow to be used, as far as he or she can, medical knowledge or skills, or health information specific to individuals, to facilitate or otherwise aid any interrogation, legal or illegal, of those individuals".

Ethical standards also clearly dictate that if health professionals are aware or suspect that a criminal or other illegal act is planned or has taken place in a prison or other place of detention, they are obliged to report this act through the appropriate channels, and it is these authorities who will decide if there is criminal liability and what action is to be taken. Understandably, acting to report or denounce actions of colleagues (sometimes known as "whistle blowing") is a very delicate issue, and in some States may even endanger the life of the person reporting such cases. In countries where there is a degree of impunity for particular authorities, then there may be separate channels established to allow confidential reporting of incidents. The World Medical Association has specifically stated that fellow professionals should provide support and protection to physicians who are either pressured to participate in acts of torture or other ill-treatment, as well as to those physicians who report and denounce such acts (WMA Declaration of Hamburg[79]).

Thus, if the use of solitary confinement is considered to be inhuman or degrading treatment, and in some cases torture, then it would be contrary both to international law and to international standards of medical ethics for physicians and other health professionals to participate in the practice in any way, or to condone or acquiesce to its use. In those instances where the negative health effects of solitary confinement are deliberately used as a tool for interrogation purposes,

Included in SCDC' 4.29.19 letter to LOC

either to mentally or physically weaken the individual, or to instil disorientation, dependence, fear and so on, then this may amount to torture or to cruel, inhuman or degrading treatment, contrary to international law and standards of medical ethics. Health professionals involved in such acts will be culpable to the same degree that the prison or security forces are culpable. Similarly if a physician or any other health staff divulge confidential medical information on a patient primarily to serve the purposes of the interrogation, this would be unethical, and in those cases where the interrogation amounts to torture or other ill-treatment, this would amount to complicity in those acts or omissions.

Does a prisoner in solitary confinement lose the right to access healthcare?

No. It is a matter of international law that every person, including all prisoners (regardless of their location within a prison, and regardless of any disciplinary infraction they may have committed), retain the right to access and receive appropriate health care[80]. This right places a positive duty on prison authorities and governments to provide prisoners with a level of healthcare equivalent to that provided in the community, and this obligation should be reflected in national legislation and national prison rules and regulations. In England and Wales, the principle of equivalence of care has been endorsed by Parliament and incorporated into the Prison Service's standards and guidelines[81.]. This requirement excludes the right to choose one's own doctor (BMA 1992:177).

The ethical obligation to provide healthcare to prisoners on an equivalent level to that available in the local community is also clearly stated in several international instruments:

> Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained (Principle 1 of the UN Principles of Medical Ethics relevant to the Role of Health Personnel, 1982)

Thus anyone placed in solitary confinement, for however long, does not forfeit the right to request medical attention, to be seen without delay, and to receive treatment appropriate to the nature and gravity of the problem.

As in any other section of the prison, prison staff may alert the health staff to potential or actual health problems that the prisoner himself may not have noticed. In the first instance this should be done with the consent of the prisoner, who may not wish to see a member of the health staff, but if the staff consider that the condition may be a risk to the individual then they should alert the health staff. It is also recommended that, where they have concerns about a particular prisoner in solitary confinement, doctors visit that prisoner at their own initiative, even if the prisoner did not request this (WHO Health in Prisons, 2007:36). This is good practice, which is in line with principles of assertive community treatment outside the prison.

Finally, prisoners' right to health has been recognised as an integral part of wider public health promotion and protection in the community, because prisoners are a part of society, with the vast majority passing through prison for relatively short periods before returning to the community.

Included in SCDC' 4.29.19 letter to LOC

Health issues within prisons usually mirror and amplify health issues in the community, so ignoring prison health effectively means that community public health is not fully attended to. This is best summarised by the WHO, who have stated that "*prison health is public health*"[82].

Do prisoners in segregation have the right to confidential medical examinations and confidentiality of their medical files?

Again, the health staff must at all times distinguish themselves from custodial staff and, while it is accepted that in a very few cases the health staff may need to take precautions against a potentially violent prisoner, medical examinations should be carried out in a manner which is respectful of the patient's right to privacy and allows for confidentiality to be maintained. If a relationship of trust and confidence has been established between health staff and the prisoner from the outset, then excessive security measures are rarely warranted.

Particular challenges to the principle of medical confidentiality may arise in high security and segregation units because of their security arrangements, and because they house prisoners who are regarded as high risk. This may mean, for example, that all areas of the unit are covered by CCTV, limiting the availability of private spaces in which to conduct the examination. In some situations the custodial staff may insist that medical interviews with prisoners are conducted through a glass partition, or that the prisoner is handcuffed or otherwise physically restrained, or they may insist on remaining in close proximity whilst the medical examination takes place. The previous discussion on the duties of health staff to provide an equivalent level of healthcare within prisons and to follow the same ethical practice as they must outside the prison makes it clear that such security measures would interfere with the doctor-patient relationship. It should also be noted, however, that such security measures also interfere with proper clinical care. It is obvious that conducting any kind of medical interview or intervention through either a glass partition or through the viewing slot of a cell door is unacceptable clinical practice. There will of course be instances where an individual has a proven history of violence or threats, and consideration must naturally be given to the safety of health staff. But this must be done on a case by case basis, and not form a blanket policy for all consultations with the prison population.

Thus, a prisoner in solitary confinement should be seen in the prison health centre just like any other patient. The use of restraints during a medical consultation not only interferes with the clinical procedure but can damage the relationship between the prisoner-patient and the health staff, since the latter are seen as just another facet of the security system. The need for any extra security for a specific prisoner must be assessed, and periodically reassessed, on an individual basis, preferably by an interdisciplinary group comprising of health professionals, custodial staff and management, and using established risk assessment protocols. Where a serious threat of violence does exist, health and custodial staff should attempt de-escalation techniques first, and any additional security measures deemed necessary by custodial staff should be taken on the basis of proportionality and using the minimum means necessary. Further, more attention should be given to making the examination room safe and secure than to the ultimate measure of restraining the patient[83]. If there is thought to be a significant risk, then some form of 'panic button' should be available in the room, and if prison staff insist on remaining close to the patient, they may remain in sight, but must be out of hearing distance of the consultation.

Included in SCDC' 4.29.19 letter to LOC

The General Medical Council's (UK) Good Medical Practice Guidelines (2006) require doctors to respect the patient's right to dignity and confidentiality and the expectation is that prisoners will be examined without restraints and without the presence of prison officers unless there is a high risk of violence. Where such high risk is present, the patient's privacy, dignity and confidentiality should be maintained as much as possible (British Medical Association (BMA) Ethical Guidance, 2004). Practice shows that the circumstances in which doctors need to compromise on privacy and confidentiality are very few, and this should be a guiding principle when accepting restrictions on clinical practice. Ultimately doctors operate professional judgement and have to balance the needs of their patients against the needs for security and safety. Experience shows that the latter rarely needs to override the former.

Once a medical examination is conducted and medical notes are made, health professionals have a duty to hold information on their patients in confidence.

> A physician shall respect a patient's right to confidentiality. It is ethical to disclose confidential information when the patient consents to it or when there is a real and imminent threat of harm to the patient or to others and this threat can be only removed by a breach of confidentiality (World Medical Association International Code of Medical Ethics, 1949).

This requirement is central to the doctor-patient relationship, and without the assurance of confidentiality, patients may be reluctant to give information to their health-care providers. Establishing trust and a good doctor-patient relationship in the prison setting is potentially even more difficult than it is outside the prison, as medical staff may be identified by prisoners as being part of the prison's authorities. Further, medical staff may face pressures to disclose information to non-medical prison staff who mistakenly feel that they have a right to know such information for their own protection. Good practice guidelines make it clear that any disclosure of confidential information must adhere to established principles of medical ethics, and doctors making such disclosure must always be prepared to justify their decision in accordance with these principles[84.] As stated in the International Code of Ethics, there will of course be situations in which the health professional may judge that a real and imminent threat exists, either to the patient himself or to other prisoners or staff, and which may necessitate disclosing limited medical information to assist in protecting the patient or others. This would be the case, for example, if a patient is judged to have suicidal ideas which they could act upon. The doctor may then judge that they must disclose some information for the patient to be put on "suicide watch". In cases where the health professional feels that a prisoner threatened harm against another prisoner or staff, in a way which suggested a very real risk of the threat being carried out, then they must consider reporting such a threat in order to protect the potential victim.

Included in SCDC' 4.29.19 letter to LOC

5.3 Case law regarding the provision of medical care in prison

Failure to provide adequate medical care in prisons not only raises ethical issues, but may also breach prisoners' human rights under international law. In examining the question of access to appropriate medical care in prisons and detention centres, some of the following principles have been established.

- Prison authorities have an obligation to protect the health of persons deprived of liberty (*Hurtado v Switzerland* 1994 Series A. No. 280 par. 79) and are required to provide medical assistance and treatment to those held in their custody (*Aers v Belgium* 1998, Reports 1998-V).
- This obligation is not dependent on the prisoner's behaviour: *"It must be stressed in this respect that the applicant's alleged rude behaviour towards medical staff and, indeed, any violation of prison rules and discipline by a detainee, can in no circumstances warrant a refusal to provide medical assistance"* (*Iorgov v. Bulgaria*, 2004 par. 85).
- Failure to provide appropriate medical care to a prisoner who clearly needs it may amount to inhuman or degrading treatment in breach of Article 3 of the ECHR (*Beceiev and Sorban v. Moldova*, 2005; *McGlinchey v. UK*, Application 50390/99 ECHR 2003-V).
- An increased standard of vigilance is required where a vulnerable person, for example a mentally ill prisoner, is involved, taking into account their vulnerability and their inability, in some cases, to complain coherently or at all about how they are being affected by their conditions of detention (*Herczegfalvy v. Austria*, 1993 15 EHRR 437).

Case study: the death of Mark Keenan[85]

Mark Keenan was 28 years old when he died from asphyxia caused by hanging in his cell at Exeter prison. His medical history included symptoms of paranoia, aggression, violence and deliberate self-harm. He was previously diagnosed as suffering from paranoid schizophrenia and, from the age of 21, was intermittently treated with anti-psychotic medication.

Facts of the case

On April 1st 1993 Mark Keenan was convicted of an assault on his girlfriend and sentenced to four months imprisonment. He was admitted to Exeter prison where he was initially placed at the prison's health centre for observation and assessment. When it was suggested on April 14th that he could be moved to an ordinary location at the prison, he barricaded himself at the health centre in protest. On April 16th he was discharged to ordinary location but was returned to the health centre the following evening after his cell-mate reported that he had made a noose from his bed sheet. He was placed in an unfurnished cell and placed on a 15 minute watch. On April 26th there was another attempt to return him to ordinary location, but he was again returned to the medical centre the following day. On April 29th he was assessed by the prison's visiting psychiatrist who prescribed a change in his medication, and recommended that he should not associate with other prisoners until his panic subsided. The following day the possibility of movement to ordinary location was raised again. Mark Keenan said that he did not feel fit for the move. In the course of the day his mental state deteriorated, with evidence of aggression and paranoia. The doctor, who

Included in SCDC' 4.29.19 letter to LOC

had no psychiatric training, considered that this might be because of the change in his medication, and prescribed a return to his previous medication. At 6 pm that day Mark Keenan assaulted two hospital officers and was placed in an unfurnished cell and put on a 15 minute watch. On May 1st the prison's senior medical officer, who had six months training in psychiatry, certified him fit for adjudication in respect of the assault, and fit for segregation. Whilst in the segregation wing, Mark Keenan appeared agitated and distressed and was threatening to harm himself. He was transferred again to an unfurnished cell in the hospital wing where he continued to appear agitated and was aggressive towards staff.

On May 3rd his medical notes recorded that Mark Keenan's attitude was 'very much better', and that he had requested to be returned to the segregation unit. Back at the segregation unit, it was noted that he seemed better but still needed watching. It was further noted that he stated that he felt that he was about to 'go off on one'. The medical notes from that evening recorded that he was being troublesome and given extra medication. There were no further entries in his medical notes until his suicide on May 15th, although entries in the segregation unit's log indicated that he was 'acting very strangely'. On May 14th, nine days before his expected release date and two weeks following the event, adjudication in respect of his assault on the officers took place and he was awarded 28 additional days in prison, and seven days in punitive segregation. The following morning he was seen by the chaplain, the doctor, and visited by a friend. They all later recalled that he seemed calm if unhappy about his punishment. At 18:35 that evening Mark Keenan was found dead in his cell. There was indication that sometime prior to hanging himself he pressed the panic button in his cell.

The court's findings

Assessing whether Mark Keenan's treatment violated Article 3 of the ECHR, the Court found that it had, and was particularly critical of the level and standard of medical care he received: *"the Court is struck by the lack of medical notes concerning Mark Keenan, who was an identifiable suicide risk and undergoing the additional stresses that could be foreseen from segregation ... the lack of effective monitoring of Mark Keenan's condition and the lack of informed psychiatric input into his assessment and treatment disclose significant defects in the medical care provided to a mentally ill person known to be a suicide risk. The belated imposition on him ... of a serious disciplinary punishment... which may well have threatened his physical and moral resistance, is not compatible with the standard of treatment required in respect of a mentally ill person"*(at pars. 113-115).

Included in SCDC' 4.29.19 letter to LOC

Key points

- **Health staff must not participate in disciplinary procedures in any way, particularly in certifying prisoners fit to withstand procedures, including solitary confinement.**
- **Where the use of solitary confinement is abusive and may amount to torture or other forms of ill-treatment, health staff have a duty to report and denounce such acts to the appropriate authorities and professional bodies.**
- **Prisoners in solitary confinement, just like other prisoners, have the right to an equivalent level of medical care to that available outside the prison**
- **The providers of medical care in prison are bound by the usual established principles of medical ethics, in particular the confidentiality of medical information.**
- **It is the duty of medical personnel to familiarise themselves with these principles**

Included in SCDC' 4.29.19 letter to LOC

Notes

70 This chapter was co-authored with Jonathan Beynon, MD, Medical Co-ordinator for Health in Detention, International Committee of the Red Cross. Thanks are also due to Julian Sheather of the Medical Ethics Department of the British Medical Association for his insightful comments on a draft of this chapter. The points of view expressed here represent the personal opinions of the authors, and do not necessarily represent the position of their organizations

71 For further discussion see: British Medical Association (2001) *The Medical Professions & Human Rights: Handbook for a changing Agenda*, Zed Books, London & New York, particularly chapter 5.

72 This chapter does not aim to address the range of issues of medical ethics as applied in places of deprivation of liberty, but focuses on the conflicts and issues related to the use of solitary confinement.

73 *Dual Loyalty & Human Rights in Health Profession Practice*, Physicians for Human Rights and the School of Public Health and Primary Health Care, University of Cape Town, 2002:I

74 The World Medical Association (WMA) formed in 1948 in direct response to the horrors perpetrated by the Nazi regime, and in particular by the direct participation of Nazi doctors in many of the atrocities, has as one of its principal aims the adoption and promotion of international standards of medical ethics. The WMA Declaration of Geneva is a modern version of the Hippocratic Oath, the pledge of service to mankind implicit in the work of all physicians.

75 Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture, and other cruel, inhuman or degrading treatment or punishment. Adopted by General Assembly resolution 37/194, 18 December 1982.

76 Commentary to Recommendation REC(2006)2 of the Committee of Ministers to Member States on the European Prison Rules, Commentary on Rule 43.

77 European Prison Rules. Council of Europe Committee of Ministers Recommendation Rec (2006)2. Rule 43.2: *The medical practitioner or a qualified nurse reporting to such a medical practitioner shall pay particular attention to the health of prisoners held under conditions of solitary confinement, shall visit such prisoners daily, and shall provide them with prompt medical assistance and treatment at the request of such prisoners or the prison staff.* And Rule 43.3: *The medical practitioner shall report to the director whenever it is considered that a prisoner's physical or mental health is being put seriously at risk by continued imprisonment or by any condition of imprisonment, including conditions of solitary confinement.*

78 World Medical Association, Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment, Adopted by the 29th World Medical Assembly Tokyo, Japan, October 1975 and revised 2006 (Known in abbreviated form as the Declaration of Tokyo). Article 1: "*The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures…* ". Also: International Council of Nurses, Position Statement on Torture, Death Penalty and Participation by Nurses in Executions, 1998

79 Declaration of Hamburg. World Medical Association. Concerning Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman or Degrading Treatment Adopted by the 49th WMA General Assembly Hamburg, Germany, November 1997

80 The right to health in international human rights law is stipulated in the International Covenant on Economic, Social and Cultural Rights, and detailed in General Comment No.14 of the Committee on Economic Social and Cultural Rights ('The right to the highest attainable standard of health' (11 August 2000) UN Doc E/C.12/2000/4 par. 1). See also Rule 22 of the UN Standard Minimum Rules and Rule 40 of the European Prison Rules.

81 Prison Service Order 3200; PSI 5/2003. See also: Joint Parliamentary Committee on Human Rights (2004), Third Report Session 2004-05, HL 15/I/HC 137-I; All Parliamentary Group on Prison Health (2006), The Mental Health Problem in UK HM Prisons.

82 World Health Organization Europe, The Moscow Declaration: Prison Health as part of Public Health, 24 March 2003

83 The use of restraints for medical purposes, for example with an acutely psychotically disturbed patient, is governed more by clinical judgement for protecting the individual patient or others than purely on the grounds of security or prison management.

84 For further guidance see: General Medical Council, Good Practice Guidance on Confidentiality: Protecting and Providing Information, April 2004; British Medical Association Medical Ethics Today, 2004; Royal College of Psychiatrists, Good Psychiatric Practice: Confidentiality and Information Sharing, CR 133, 2006

85 *Keenan v. The United Kingdom*, Application No. 27229/95, ECtHR Judgement of 3 April, 2001.

Included in SCDC' 4.29.19 letter to LOC

6 | Monitoring and inspecting solitary confinement units

All the aspects of solitary confinement discussed in this Sourcebook – placement, conditions of confinement, regime, contact with the outside world, and the provision of medical care – should be subject to close scrutiny and review by national and international inspecting bodies.

The importance of installing mechanisms for inspection and scrutiny of all prisons and other places of detention is emphasised in international and regional instruments:

> There shall be a regular inspection of penal institutions and services by qualified and experienced inspectors appointed by a competent authority. Their task shall be in particular to ensure that these institutions are administered in accordance with existing laws and regulations and with a view to bringing about the objectives of penal and correctional services (SMR Rule 55; Body of Principles Principle 29(1); EPR Rules 9, 92, 93).

In addition to physically inspecting places of detention, the inspecting body should have full and free access to those held within:

> A detained or imprisoned person shall have the right to communicate freely and in full confidentiality with the persons who visit the places of detention or imprisonment in accordance with paragraph I of the present principle, subject to reasonable conditions to ensure security and good order in such places (UN Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment, Principle 29(2)).

Inspections are particularly important in segregation units, as they are closed units within closed establishments, shut off not only to the outside world, but also to other sections of the prison and to the prison society at large. As the principles cited above make clear, the inspecting body should have unhindered access to both the physical facilities at the unit, and to prisoners held in them. The inspecting body should also have access to relevant documentation, for example records of placement and review hearings, the unit log and records, CCTV footage and so on. Health staff on the visiting team must have full access to the medical registers and records. Inspectors should ensure that segregated prisoners have the opportunity to talk about their treatment privately and confidentially.

Under Article 14 of the Optional Protocol to the UN Convention against Torture (OPCAT), State Parties undertake to grant the Sub-committee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment:

Included in SCDC' 4.29.19 letter to LOC

1 (a) Unrestricted access to all information concerning the number of persons deprived of their liberty in places of detention as defined in article 4, as well as the number of places and their location;

(b) Unrestricted access to all information referring to the treatment of those persons as well as their conditions of detention;

(c) Subject to paragraph 2 below, unrestricted access to all places of detention and their installations and facilities;

(d) The opportunity to have private interviews with the persons deprived of their liberty without witnesses, either personally or with a translator if deemed necessary, as well as with any other person who the Subcommittee on Prevention believes may supply relevant information;

(e) The liberty to choose the places it wants to visit and the persons it wants to interview.

2. Objection to a visit to a particular place of detention may be made only on urgent and compelling grounds of national defence, public safety, natural disaster or serious disorder in the place to be visited that temporarily prevent the carrying out of such a visit. The existence of a declared state of emergency as such shall not be invoked by a State Party as a reason to object to a visit.

The inspecting body will examine some of the following[86]:

- Was the decision to place the prisoner in segregation taken in accordance with the law?
- What were the reasons for placing the prisoner in the unit, is the prisoner aware of these reasons and was he given an opportunity to appeal against his placement?
- Is the placement decision reviewed on a regular basis?
- Do physical conditions of detention (cells, shower area, exercise yards) comply with the required standards?
- Do prisoners have access to adequate medical care?
- Are medical records being kept in good order in a secure place?
- Do prisoners have access to an appropriate regime?
- Do prisoners have regular access to an outside area?
- Do prisoners have contact with the outside world?

Nationally inspections are usually carried out by a body appointed by the ministry in charge of prisons, and report to it. They may also appoint a local watchdog body to provide regular monitoring of individual prisoners between inspections. These bodies will pay particular attention to segregation units and to the use of force and restraints.

Included in SCDC' 4.29.19 letter to LOC

Case study: Extreme Custody: a report by HM Chief Inspector of Prisons for England & Wales.

In 2006 HMCIP carried out a thematic review of all the segregation units in the High Security Estate (HSE) and of the Close Supervision System (CSC) designed to manage disruptive prisoners. These were the units where prisoners were held in isolation in the most restricted and controlled environments with the most potential for prisoner damage. The thematic review followed previous criticisms of the approach of staff in high security segregation units from coroners and others.

The report charted the progress that had been made – some of it innovative, particularly in integrating mental health approaches with custodial care – but also pointed out the distance still to travel. The inspection exposed a hard core of long stay prisoners in segregation units who had complex needs and who could not be managed safely elsewhere. Though there was some psychiatric and therapeutic support in the units, it was not enough, and many prisoners were deteriorating further in lengthy solitary confinement. HMCIP recommended individual, multidisciplinary and properly resourced care plans to ensure that prisoners' health was supported and that opportunities for mental and social stimulation and time out of cell were provided.

The inspection team examined records and interviewed both prisoners and staff. It made 17 recommendations for improvements in the CSC and 21 in the HSE segregation units, and identified 17 areas of good practice. Only one recommendation was rejected.

This review illustrates the constructive role that an independent inspectorate can have, opening up to scrutiny an otherwise hidden part of a closed prison system where the potential for over-control by staff and of consequent prisoner deterioration is high. Where the prison system is also a mature user of inspection and makes good use of the findings, the process can result in positive outcomes for prisoners.

Prison inspections may also be carried out by regional bodies. In Europe, for example, the Committee for the Prevention of Torture (CPT), whose reports we have referred to throughout the Sourcebook, may visit any place of detention within the jurisdiction of Member States. International bodies charged with inspecting and monitoring places of detention include the International Committee of the Red Cross (ICRC), which is mandated to visit any place of detention in situations of armed conflict, and the UN Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment. The Optional Protocol to the UN Conventions Against Torture (OPCAT) establishes both an international body of experts to conduct preventative visits to any place of deprivation of liberty in State parties (see above), and a National Preventative Mechanism, which is an independent body tasked with regular and ongoing preventative visits to any place of deprivation of liberty in that country.

Included in SCDC' 4.29.19 letter to LOC

Notes

86 See: Association for the prevention of torture (APT), *Monitoring Places of Detention: A Practical Guide*. Geneva, April 2004; HM Chief Inspectorate of Prisons, Expectations: criteria for assessing the condition in prisons and the treatment of prisoners (updated regularly).

Included in SCDC' 4.29.19 letter to LOC

7 | Summary of recommendations

A number of common themes emerge from the various sources examined in the Sourcebook: a) Solitary confinement is an extreme and potentially harmful measure; b) Its use should be reserved for a handful of exceptional cases; c) Periods in solitary confinement should be as short as possible, and; d) Where prisoners are isolated they must be held in decent conditions and offered access to **meaningful** human contact and to **purposeful** activities. The deprivations inherent in solitary confinement should not be made worse by further restrictions on family visits and in-cell provisions such as books and magazines, craft and hobby materials, personal radios and so on. These may help to mitigate the harmful aspects of solitary confinement.

It is also clear that there are currently lacunae in international safeguards and protections against the misuse of solitary confinement and its negative health effects. Further development of international human rights standards is thus necessary, building on the United Nations' call from 1990 to abolish the use of solitary confinement (Principle 7 of the UN Basic Principles for the Treatment of Prisoners). To this end, on December 9th 2007, a working group of 24 international experts adopted the Istanbul Expert Statement on the Use and Effects of Solitary Confinement, calling on States to limit the use of solitary confinement to very exceptional cases, for as short a time as possible and only as a last resort (see Appendix 2). Other such efforts should be initiated by experts, international bodies, and States

Specific recommendations that this Sourcebook makes include:

Procedural safeguards

- Inform prisoners, in writing, of the reason for their segregation and its duration.
- Allow prisoners to make representations on their case at a formal hearing.
- Undertake regular reviews of placement – substantive and at short intervals.

These safeguards apply to all forms of solitary confinement.

Placement in solitary confinement

- When used as punishment for prison offences, solitary confinement must only be used as a last resort, and then for the shortest time possible, lasting days rather than weeks or months.
- The use of prolonged solitary confinement for managing prisoners is rarely justified, and then only in the most extreme of cases.

Included in SCDC' 4.29.19 letter to LOC

- Those suffering from mental illness must not be placed in solitary confinement and under no circumstances should the use of solitary confinement serve as a substitute for appropriate mental health care.
- The use of solitary confinement for pre-charge and pre-trial detainees must be strictly limited by law and must only be used in exceptional circumstances, with judicial oversight, for as short a time as possible, and never for more than a matter of days.
- Solitary confinement must not be imposed indefinitely, and prisoners should know in advance its duration.
- The use of solitary confinement as a means of coercing or 'softening up' detainees for the purpose of interrogation should be prohibited.

Physical conditions and regime:

- Provide decent accommodation (as per established standards discussed in chapter 4), reflecting the fact that prisoners will spend most of their day in their cell.
- Provide educational, recreational and vocational programmes.
- Provide these activities, wherever possible, in association with others.
- Allow in-cell reading, hobbies and craft materials.
- Ensure that prisoners have regular human contact; encourage informal communication with staff.
- Allow regular and open family visits.
- Enable prisoners a degree of control of their daily lives and physical environment.
- Include a progressive element.

Health

- Health staff must maintain the same standards of care and ethical behaviour as those which apply outside the prison, in particular the right to health care and to privacy and confidentiality.
- Health staff must not participate in the decision to impose or the enforcement of any disciplinary measure.
- Provide mental health training for custodial staff

Included in SCDC' 4.29.19 letter to LOC

Appendix 1

Selected texts

European Prison Rules, Council of Europe Committee of Ministers Recommendation Rec (2006)2

43.2 The medical practitioner or a qualified nurse reporting to such a medical practitioner shall pay particular attention to the health of prisoners held under conditions of solitary confinement, shall visit such prisoners daily, and shall provide them with prompt medical assistance and treatment at the request of such prisoners or the prison staff.

43.3 The medical practitioner shall report to the director whenever it is considered that a prisoner's physical or mental health is being put seriously at risk by continued imprisonment or by any condition of imprisonment, including conditions of solitary confinement.

…

60.5 Solitary confinement shall be imposed as a punishment only in exceptional cases and for a specified period of time, which shall be as short as possible.

Note 1 When this recommendation was adopted, and in application of Article 10.2c of the Rules of Procedure for the meetings of the Ministers' Deputies, the Representative of Denmark reserved the right of his government to comply or not with Rule 43, paragraph 2, of the appendix to the recommendation because it is of the opinion that the requirement that prisoners held under solitary confinement be visited by medical staff on a daily basis raises serious ethical concerns regarding the possible role of such staff in effectively pronouncing prisoners fit for further solitary confinement.

UN Standard Minimum Rules

31. Corporal punishment, punishment by placing in a dark cell, and all cruel, inhuman or degrading punishments shall be completely prohibited as punishments for disciplinary offences.

32. (1) Punishment by close confinement or reduction of diet shall never be inflicted unless the medical officer has examined the prisoner and certified in writing that he is fit to sustain it.

(2) The same shall apply to any other punishment that may be prejudicial to the physical or mental health of a prisoner. In no case may such punishment be contrary to or depart from the principle stated in rule 31.

(3) The medical officer shall visit daily prisoners undergoing such punishments and shall advise the director if he considers the termination or alteration of the punishment necessary on grounds of physical or mental health.

Included in SCDC' 4.29.19 letter to LOC

The Oath of Athens (International Council of Prison Medical Services, 1979)

We, the health professionals who are working in prison settings, meeting in Athens on September 10, 1979, hereby pledge, in keeping with the spirit of the Oath of Hippocrates, that we shall endeavour to provide the best possible health care for those who are incarcerated in prisons for whatever reasons, without prejudice and within our respective professional ethics.

We recognize the right of the incarcerated individuals to receive the best possible health care.

We undertake:

1. To abstain from authorizing or approving any physical punishment.
2. To abstain from participating in any form of torture.
3. Not to engage in any form of human experimentation amongst incarcerated individuals without their informed consent.
4. To respect the confidentiality of any information obtained in the course of our professional relationships with incarcerated patients.
5. That our medical judgements be based on the needs of our patients and take priority

Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Adopted by General Assembly resolution 37/194 of 18 December 1982

Principle 1

Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

Principle 2

It is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment. [1]

Principle 3

It is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health.

Included in SCDC' 4.29.19 letter to LOC

Principle 4

It is a contravention of medical ethics for health personnel, particularly physicians:

(a) To apply their knowledge and skills in order to assist in the interrogation of prisoners and detainees in a manner that may adversely affect the physical or mental health or condition of such prisoners or detainees and which is not in accordance with the relevant international instruments; [2]

(b) To certify, or to participate in the certification of, the fitness of prisoners or detainees for any form of treatment or punishment that may adversely affect their physical or mental health and which is not in accordance with the relevant international instruments, or to participate in any way in the infliction of any such treatment or punishment which is not in accordance with the relevant international instruments.

Principle 5

It is a contravention of medical ethics for health personnel, particularly physicians, to participate in any procedure for restraining a prisoner or detainee unless such a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of the prisoner or detainee himself, of his fellow prisoners or detainees, or of his guardians, and presents no hazard to his physical or mental health.

Principle 6

There may be no derogation from the foregoing principles on any ground whatsoever, including public emergency.

Notes

1 See the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel. Inhuman or Degrading Treatment or Punishment (resolution 3452 (XXX), annex).

2 Particularly the Universal Declaration of Human Rights (resolution 217 A (III)), the International Covenants on Human Rights (resolution 2200 A (XXI). annex), the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (resolution 3452 (XXX), annex) and the Standard Minimum Rules for the Treatment of Prisoners (First United Nations Congress on the Prevention of Crime and the Treatment of Offenders: report by the Secretariat (United Nations publication, Sales No. E.1956.IV.4, annex I.A)).

Included in SCDC' 4.29.19 letter to LOC

Appendix 2

The Istanbul statement on the use and effects of solitary confinement

Adopted on 9 December 2007 at the International Psychological Trauma Symposium, Istanbul.

The purpose of the statement

Recent years have seen an increase in the use of strict and often prolonged solitary confinement practices in prison systems in various jurisdictions across the world. This may take the form of a disproportionate disciplinary measure, or increasingly, the creation of whole prisons based upon a model of strict isolation of prisoners (1). While acknowledging that in exceptional cases the use of solitary confinement may be necessary, we consider this a very problematic and worrying development. We therefore consider it timely to address this issue with an expert statement on the use and effects of solitary confinement.

Definition

Solitary confinement is the physical isolation of individuals who are confined to their cells for twenty-two to twenty-four hours a day. In many jurisdictions prisoners are allowed out of their cells for one hour of solitary exercise. Meaningful contact with other people is typically reduced to a minimum. The reduction in stimuli is not only quantitative but also qualitative. The available stimuli and the occasional social contacts are seldom freely chosen, are generally monotonous, and are often not empathetic.

Common practices of solitary confinement

Solitary confinement is applied in broadly four circumstances in various criminal justice systems around the world; as either a disciplinary punishment for sentenced prisoners; for the isolation of individuals during an ongoing criminal investigation; increasingly as an administrative tool for managing specific groups of prisoners; and as a judicial sentencing. In many jurisdictions solitary confinement is also used as a substitute for proper medical or psychiatric care for mentally disordered individuals. Additionally, solitary confinement is increasingly used as a part of coercive interrogation, and is often an integral part of enforced disappearance (2) or incommunicado detention.

Included in SCDC' 4.29.19 letter to LOC

The effects of solitary confinement

It has been convincingly documented on numerous occasions that solitary confinement may cause serious psychological and sometimes physiological ill effects (3). Research suggests that between one third and as many as 90 per cent of prisoners experience adverse symptoms in solitary confinement. A long list of symptoms ranging from insomnia and confusion to hallucinations and psychosis has been documented. Negative health effects can occur after only a few days in solitary confinement, and the health risks rise with each additional day spent in such conditions. Individuals may react to solitary confinement differently. Still, a significant number of individuals will experience serious health problems regardless of the specific conditions, regardless of time and place, and regardless of pre-existing personal factors. The central harmful feature of solitary confinement is that it reduces meaningful social contact to a level of social and psychological stimulus that many will experience as insufficient to sustain health and well being.

The use of solitary confinement in remand prisons carries with it another harmful dimension since the detrimental effects will often create a de facto situation of psychological pressure which can influence the pre-trial detainees to plead guilty.

When the element of psychological pressure is used on purpose as part of isolation regimes such practices become coercive and can amount to torture.

Finally solitary confinement places individuals very far out of sight of justice. This can cause problems even in societies traditionally based on the rule of law. The history of solitary confinement is rich in examples of abusive practices evolving in such settings. Safeguarding prisoner rights therefore becomes especially challenging and extraordinarily important where solitary confinement regimes exist.

Human rights and solitary confinement

The use of torture, cruel, inhuman or degrading treatment or punishment is absolutely prohibited under international law (Article 7 of the UN convention on Civil and Political Rights (ICCPR) and the UN convention against Torture (CAT), for example). The UN Human Rights Committee has stipulated that use of prolonged solitary confinement may amount to a breach of Article 7 of the ICCPR (General comment 20/44, 3. April 1992). The UN Committee against Torture has made similar statements, with particular reference to the use of solitary confinement during pre-trial detention. The UN committee on the Rights of the Child has furthermore recommended that solitary confinement should not be used against children (4). Principle 7 of the UN Basic Principles for the Treatment of Prisoners states that 'Efforts addressed to the abolition of solitary confinement as a punishment, or to the restriction of its use, should be undertaken and encouraged'. Jurisprudence of the UN Human Rights Committee has previously found a specific isolation regime to violate both article 7 and article 10 of the ICCPR (Campos v. Peru 9. January 1998).

Included in SCDC' 4.29.19 letter to LOC

On a regional level, the European Court and former Commission on Human Rights, as well as the European Committee for the Prevention of Torture (CPT), have made it clear that the use of solitary confinement can amount to a violation of Article 3 of the ECHR (i.e. constitute torture, inhuman or degrading treatment), depending on the specific circumstances of the case, and the conditions and duration of detention. It has been recognised that "…complete sensory isolation coupled with total isolation, can destroy the personality and constitutes a form of inhuman treatment which cannot be justified by the requirements of security or any other reason" (5). The CPT has also stated that solitary confinement "can amount to inhuman and degrading treatment" and has on several occasions criticized such practices and recommended reform – i.e. either abandoning specific regimes, limiting the use of solitary confinement to exceptional circumstances, and/or securing inmates a higher level of social contact (6). The importance of developing communal activities for prisoners subjected to various forms of isolation regimes has for example been stressed (CPT, visit report Turkey, 2006, para. 43). Furthermore, the revised European Prison Rules of 2006 have clearly stated that solitary confinement should be an exceptional measure and, when used, should be for as short a time as possible(7).

The Inter-American Court of Human Rights has also stated that prolonged solitary confinement constitutes a form of cruel, inhuman or degrading treatment prohibited under Article 5 of the American Convention on Human Rights (Castillo Petruzzi et al., Judgment of May 30, 1999).

Policy implications

Solitary confinement harms prisoners who were not previously mentally ill and tends to worsen the mental health of those who are. The use of solitary confinement in prisons should therefore be kept to a minimum. In all prison systems there is some use of solitary confinement – in special units or prisons for those seen as threats to security and prison order. But regardless of the specific circumstances, and whether solitary confinement is used in connection with disciplinary or administrative segregation or to prevent collusion in remand prisons, effort is required to raise the level of meaningful social contacts for prisoners.

This can be done in a number of ways, such as raising the level of prison staff-prisoner contact, allowing access to social activities with other prisoners, allowing more visits, and allowing and arranging in-depth talks with psychologists, psychiatrists, religious prison personnel, and volunteers from the local community. Especially important are the possibilities for both maintaining and developing relations with the outside world, including spouses, partners, children, other family and friends. It is also very important to provide prisoners in solitary confinement with meaningful in cell and out of cell activities. Research indicates that small group isolation in some circumstances may have similar effects to solitary confinement and such regimes should not be considered an appropriate alternative.

Included in SCDC' 4.29.19 letter to LOC

The use of solitary confinement should be absolutely prohibited in the following circumstances:

- For death row and life-sentenced prisoners by virtue of their sentence.
- For mentally ill prisoners.
- For children under the age of 18.

Furthermore, when isolation regimes are intentionally used to apply psychological pressure on prisoners, such practices become coercive and should be absolutely prohibited.

As a general principle solitary confinement should only be used in very exceptional cases, for as short a time as possible and only as a last resort.

Notes

(1) For the purpose of this document we use the term prisoner as a broad category covering persons under any form of detention and imprisonment.

(2) The International Convention for the Protection of All Persons from Enforced Disappearance of December 2006 defines enforced disappearance as "…the arrest, detention, abduction or any other form of deprivation of liberty by agents of the State or by persons acting with the authorization, support or acquiescence of the State, followed by a refusal to acknowledge the deprivation of liberty or by concealment of the fate or whereabouts of the disappeared person, which place such a person outside the protection of the law."

(3) For studies on the 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" in *Crime and Justice* vol. 34, 2006 (pp. 441-528); Craig Haney "Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement" in *Crime & Delinquency* 49(1), 2003 (pp. 124-56); Stuart Grassian "Psychopathological Effects of Solitary Confinement" in *American Journal of Psychiatry* 140, 1983 (pp. 1450-4).

(4) CRC/C/15/Add.273, "Denmark", 30 September 2005, para. 58 a.

(5) Ramirez Sanchez v. France, Grand Chamber, 4. July 2006, para. 123.

(6) Rod Morgan and Malcolm Evans "Combating torture in Europe", 2001, p. 118. See also Recommendation Rec(2003)23 Committee of Ministers under the European Council, para.7, 20, and 22.

(7) Committee of Ministers – Rec(2006)2E (Adopted by the Committee of Ministers on 11 January 2006 at the 952nd meeting of the Ministers' Deputies), article 60.5. See also CPT, GR2, §56.

Included in SCDC' 4.29.19 letter to LOC

Task group participants

Alp Ayan, psychiatrist, Human Rights Foundation of Turkey

Türkcan Baykal, M.D., Human Rights Foundation of Turkey

Jonathan Beynon, M.D., Coordinator of health in detention, ICRC, Switzerland*

Carole Dromer, Médecins du Monde

Şebnem Korur Fincancı, Professor, Specialist on Forensic Medicine, Istanbul University, Turkey

Andre Gautier, Psychologist and psychoanalyst, ITEI-Bolivia

Inge Genefke, MD, DMSc hc mult, IRCT Ambassador, Founder of RCT and IRCT

Bernard Granjon, Médecins du Monde

Bertrand Guery, Médecins du Monde

Melek Göregenli, Professor in psychology, Psychology Dept., Ege University, Turkey

Cem Kaptanoğlu, Professor, psychiatrist, Osmangazi University, Turkey

Monica Lloyd, the Chief Inspector of Prisons office, United Kingdom*

Leanh Nguyen, Clinical Psychologist, Bellevue/NYU Program for Survivors of Torture

Manfred Nowak, Special Rapporteur on Torture, UN and Director of the Ludwig Boltzmann Institute of Human Rights

Carol Prendergast, Director of Operations, Bellevue/NYU Program for Survivors of Torture

Christian Pross, M.D., Center for the Treatment of Torture Victims, Berlin, Germany

Sidsel Rogde, MD, PhD, Professor of Forensic Medicine, University of Oslo, Norway

Doğan Şahin, Ass. Professor, psychiatrist, Istanbul University, Turkey

Sharon Shalev, Mannheim Centre for Criminology, London School of Economics

Peter Scharff Smith, Senior Researcher, the Danish Institute for Human Rights

Alper Tecer, psychiatrist, Human Rights Foundation of Turkey

Hülya Üçpınar, legal expert, Human Rights Foundation of Turkey

Veysi Ülgen, M.D., TOHAV

Miriam Wernicke, Legal Adviser, IRCT

* The points of view expressed are the personal opinions of the individuals, and do not necessarily represent the position of their organizations.

Included in SCDC' 4.29.19 letter to LOC

Acronyms and abbreviations

BMA	British Medical Association
CAT	Committee against Torture
CPT	Committee for the Prevention of Torture
CSC	Close Supervision Centre
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
EPR	European Prison Rules
HMCIP	Her Majesty's Chief Inspector of Prisons for England and Wales
ICN	International Council of Nurses
OPCAT	Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
SMR	Standard Minimum Rules for the Treatment of Prisoners
UN	United Nations
WHO	World Health Organisation
WMA	World Medical Association

Included in SCDC' 4.29.19 letter to LOC

Links & Resources

Human rights bodies and legal instruments

Office of the UN High Commissioner on Human Rights (OHCHR) www.ohchr.org
(Contains international law texts and materials and links to other UN bodies)

Committee for the Prevention of Torture (CPT) www.cpt.coe.int
(Contains country reports and CPT Standards)

European Court of Human Rights (ECtHR) www.echr.coe.int/echr
(Contains case law of the Court)

Non-governmental organisations

Amnesty International (AI) www.amnesty.org

Association for the Prevention of Torture (APT) www.apt.ch

Human Rights Watch (HRW) www.hrw.org

Prison Reform International (PRI) www.penalreform.org

Professional Associations

British Medical Association (BMA) www.bma.org.uk

British Psychological Association (BPS) www.bps.org.uk

International Council of Nurses (ICN) www.icn.ch

Royal College of Psychiatrists www.rcpsych.ac.uk

World Health Organisation (WHO) www.who.int

World Medical Association (WMA) www.wma.net

England and Wales

Her Majesty's Inspectorate of Prisons (HMCIP) http://inspectorates.homeoffice.gov.uk/hmciprisons

Prisons and Probation Ombudsman www.ppo.gov.uk

Prison Reform Trust (PRT) www.prisonreformtrust.org.uk

International Centre for Prison Studies www.kcl.ac.uk/schools/law/research/icps

Electronic copies of the Sourcebook on solitary confinement and additional links and resources can be found on the Solitary Confinement website: www.solitaryconfinement.org

Included in SCDC' 4.29.19 letter to LOC

Bibliography

Abbott, J.H., (1982) In the Belly of the Beast: Letters from Prison. New York: Vintage Books.

Adams, R., (1994) Prison Riots in Britain and the USA. 2nd ed. London: Macmillan Press

All Parliamentary Group on Prison Health (2006) The Mental Health Problem in UK HM Prisons.

Amnesty International, (1980) Prison Conditions of Persons Suspected or Convicted of Politically Motivated Crimes in the FRG: Isolation and Solitary Confinement. AI Index: EUR 32/01/80.

Andersen, H.S., Sestoft, D., Lillebaek, T., Gabrielsen, G., Hemmingsen, R. (2003) A longitudinal study of prisoners on remand. Repeated measures of psychopathology in the initial phase of solitary versus non-solitary confinement. International Journal of Law and Psychiatry, 26:165-177.

Association for the prevention of torture (APT), Monitoring Places of Detention: A Practical Guide. Geneva, April 2004

Benjamin, T.B. and Lux, K., (1977) Solitary Confinement as Psychological Punishment. California Western Law Review, 13:265-296.

Binda, H., (1975) Effects of Increased Security on Prison Violence. Journal of Criminal Justice, 3:33-46.

Bottoms, A.E., (1999) Interpersonal Violence and Social Order in Prisons. IN: Tonry, M. and Petersilia, J., eds. Crime and Justice: a review of research. Vol. 26, Prisons. Chicago and London: University of Chicago Press.

Briggs et al. (2003). 'The effects of supermaximum security prisons on aggregate levels of institutional violence', Criminology, Vol.41 (4) pp 1341-1376.

British Medical Association Ethics Department, (2004) Medical Ethics Today.

British Medical Association (2001) The Medical Profession and Human Rights, London and New York: Zed Books.

Brodsky, S.L., and Scogin, F.R., (1988) Inmates in Protective Custody: First Data on Emotional Effects. Forensic Reports 1:267-280

Buchanan, R.A., Unger, C.A. and Whitlow, K.L., (1988) Disruptive Maximum Security Inmate Management Guide. Washington DC: US Department of Justice, National Institute of Corrections.

Campaign to Stop Control Units Report, 1997

Charriere, H., (1970) Papillon. London: Panther Books.

Cloyes, K.G., Lovell, D., Allen, D.G., Rhodes, L.A. (2006) Assessment of psychological impairment in a supermaxium security sample. Criminal Justice and Behavior, Vol. 33(6):760-781.

Cohen, S. and Taylor, L., ([1972]1981) Psychological Survival: The Experience of Long-Term Imprisonment. 2nd ed. Harmondsworth, Penguin Books.

Included in SCDC' 4.29.19 letter to LOC

Coid, J., Petruckevitch, A., Bebbington, P., Jenkins, R., Brugha, T., Lewis, G., Farrell, M., Singleton, N. (2003). Psychiatric morbidity in prisoners and solitary cellular confinement, I: disciplinary segregation. Journal of Forensic Psychiatry & Psychology, Vol. 14 No. 2:298-319, September.

Coid, J., Petruckevitch, A., Bebbington, P., Jenkins, R., Brugha, T., Lewis, G., Farrell, M., Singleton, N. (2003). Psychiatric morbidity in prisoners and solitary cellular confinement, II: special ('strip') cells. Journal of Forensic Psychiatry & Psychology, Vol. 14 No. 2:320-340, September.

Colvin, M., (1992) The Penitentiary in Crisis- From Accommodation to Riot in New Mexico. Albany: State University of New-York Press.

Commission on Safety and Abuse in America's Prisons: Confronting Confinement, June 2006.

Coyle, A. (2002), A Human Rights Approach to Prison Management, International Centre for Prison Studies, London.

Evans, R. (1982) The Fabrication of Virtue: English prison Architecture 1750-1840. Cambridge: Cambridge University Press.

Ecclestone, C., Gendreau, P. and Knox, C., (1974) Solitary confinement of prisoners: an assessment of its effects on inmates' personal constructs and adrenocortical activity. Canadian Journal of Behavioural Science Review, 6(2):178-191.

Fairweather, L. (2000) Psychological effects of the prison environment. IN: Fairweather, L. and McCnoville, S., eds. (2000) Prison Architecture: Policy, Design and Experience. London: Architectural Press.

Faris, R.E., (1934) Cultural Isolation and the Schizophrenic Personality. American Journal of Sociology, September, 40(2):155-164.

Gendreau, P. and Bonta, J., (1984) Solitary confinement is not Cruel and Unusual Punishment: People Sometimes Are! Canadian Journal of Criminology, 26:467-478.

General Medical Council, Good Practice Guidance on Confidentiality: Protecting and Providing Information, April 2004.

Goffman, E. (1961) Asylums: Essays on the social situation of mental patients and other Inmates. Garden City, New York: Anchor Books.

Grassian, S., (1983) Psychopathological Effects of Solitary Confinement. American Journal of Psychiatry, 140(11):1450-1454.

Grassian, S. and Friedman N., (1986) Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement. International Journal of Law & Psychiatry, 8:49-65.

Grassian, S. (2006) Psychiatric Effects of Solitary Confinement, Journal of Law and Policy, Vol.22:325-383.

Haney (2003) Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement. Crime & Delinquency, 49(1):124-156.

Haney, C. and Lynch, M., (1997) Regulating Prisons of the Future: Psychological Analysis of Supermax and Solitary Confinement. New York University Review of Law & Social Change, XXIII (4):477-570.

Included in SCDC' 4.29.19 letter to LOC

Hills, H., Siegfried, C., Ickowitz, A. (2004) Effective Prison Mental Health Services: guidelines to expand and improve treatment. U.S. Department of Justice National Institute of Corrections.

Hocking, F., (1970) Extreme environmental stress and its significance for psychopathology, American Journal of Psychiatry, 24:4-26.

Hodgins, S. and Cote, G., (1991) The Mental health of penitentiary inmates in isolation. Canadian Journal of Criminology, April 1991:175-182.

Hunt, G. et al., (1999) Changes in Prison Culture: Prison Gangs and the Case of the Pepsi Generation. Soc. Prob. Issue 40.

HM Chief Inspectorate of Prisons for England and Wales, Expectations: criteria for assessing the condition in prisons and the treatment of prisoners (updated regularly).

Human Rights Watch, "Like the Dead in Their Coffins" Torture, Detention and the Crushing of Dissent in Iran; June 2004, Vol. 16, No.2 (E)

Human Rights Watch, Locked Up Alone: Detention Conditions and Mental Health at Guantanamo, June 2008.

Joint Parliamentary Committee on Human Rights (2004) Third Report Session 2004-05, HL 15/I/HC 137-I.

Korn, R. (1988) The effects of confinement in the High Security Unit at Lexington. Social Justice, 15(1):8-19

Kupers, T. (1999) Prison Madness: The Mental Health Crisis Behind Bars and What we Must do about it. San Francisco: Jossey-Bass.

McCleery, R., (1961) Authoritarianism and the Belief System of the Incorrigibles. IN: Cressey, D., (ed.) The Prison. New York: Holt, Rinehart and Winston, pp.260-306.

McConville, S., (1981) A History of English Prison Administration. London: Routledge and Kegan.

Mead, G. H., (1934) Mind, Self and Society. Chicago: University of Chicago Press.

Miller, H. (1994) Reexamining Psychological Distress in the Current Conditions of Segregation. Journal of Correctional Health Care, Vol. 1:39-53

Miller, H. and Young, G. (1997) Prison segregation: administrative detention remedy of mental health problem? Criminal Behaviour and Mental Health, Vol. 7:85-94

Morgan, R. and Evans, M. (2001) Combating torture in Europe. Strasburg: Council of Europe Publishing.

Morris, N. and Rothman, D., eds. (1998) The Oxford History of the Prison: The Practice of Punishment in Western Society. Oxford: Oxford University Press

Mottram, P. (2007) HMP Liverpool, Styal and Hindley Study Report, University of Liverpool

Moyer, F., (1975) The Architecture of closed institutions. IN: United Nations Social Defence Research Institute (UNSDRI) Prison Architecture: An International Survey of Representative and Closed Institutions and Analysis of Current Trends in Prison Design (prepared by G.D. Gennarro). London: The Architectural Press, pp.53-66.

Murdoch, J. (2006) The treatment of prisoners: European Standards. Strasburg: Council of Europe Publishing.

Included in SCDC' 4.29.19 letter to LOC

National Offender Management Service, Safer Custody Group. Self Inflicted Deaths Annual Report 2004/5.

Nitsche, P., and Williams, K., (1913) The History of the Prison Psychosis. Nervous and Mental Disease Monograph Series, No.13. New York: Nervous and Mental Disease Publishing Company.

Office of the United Nations High Commissioner for Human Rights (2005) Human Rights and Prisons, Professional Training Series No.11, available online at: www.ohchr.org

Parenti, C. (1999) Lockdown America: Police and Prisons in the Age of Crisis. London: Verso.

Physicians for Human Rights and the School of Public Health and Primary Health Care University of Cape Town (2002) Dual Loyalty & Human Rights in Health Profession Practice. A Project of the International Dual Loyalty Working Group

Physicians for Human Rights (PHR) (2005) Break them down: systematic use of psychological torture by US forces Physicians for Human Rights, USA.

Prison Reform International (2003) Training Manual no. 1: Human Rights and Vulnerable Prisoners

Rasmussen, J. (Ed.) (1973) Man in Isolation & Confinement, Chicago: Aldine Publishing Company

Reyes, H. The worst scars are in the mind: psychological torture, International Review of the Red Cross, Volume 89 No. 867 September 2007 pp 591-617.

Rickford, D. and Edgar, K. Troubled Inside: Responding the Mental Health Needs of Men in Prison, Prison Reform Trust, 2005

Riveland, C., (1999) Supermax prisons: Overview and General Considerations. Washington DC: US Department of Justice, National Institute of Corrections

Rhodes, L.A. (2004) Total confinement: madness and reason in the maximum security prison. Berkley and Los Angeles: University of California Press.

Robbins et al. (2005), Psychiatric problems of detainees under the Anti-Terrorism Crime and Security Act 2001. Royal College of Psychiatrists, Psychiatric Bulletin 29:407-409

Rothman, D.J. (1980) Conscience and Convenience: The Asylum and its Alternatives in Progressive America. Boston: Little, Brown and Company.

Royal College of Psychiatrists (2006) Good Psychiatric Practice: Confidentiality and Information Sharing, CR 133.

Royal College of Psychiatrists (1998) Management of imminent violence, OP 41.

Scharff-Smith, P., (2004) A Religious Technology of the Self: rationality and religion in the rise of the modern penitentiary. Punishment and Society, 6(2):195-220.

Scharff-Smith, P., (2006) "The Effects of Solitary Confinement on Prison Inmates. A Brief History and Review of the Literature" Crime and Justice Vol. 34: 441-528

Scott, G.D. and Gendreau, P., (1969) Psychiatric Implications of Sensory Deprivation in a Maximum Security Prison. Canadian Psychiatric Association Journal, 14(1):337-341.

Included in SCDC' 4.29.19 letter to LOC

Shalev, S (2009) Supermax: controlling risk through solitary confinement. Devon: Willan Publishing

Shalev, S. (2007) "The power to classify: avenues into a supermax prison" in: Downes, D., Rock, P., Chinkin, C. and Gearty, C. (Eds.) Crime, Social Control and Human Rights: From moral panics to states of denial, Devon: Willan Publishing, pp. 107-119.

Sestfot, D.M., Andersen, H.S., Lillebaek. T. and Gabrielsen, G., (1998) Impact of solitary confinement on hospitalisation among Danish prisoners in custody. International Journal of Law and Psychiatry, 21(1):99-108.

Siegel, R., (1984) Hostage Hallucinations: Visual Imagery Induced by Isolation and Life-Threatening Stress. Journal of Nervous and Mental Disease, 17(5):264-272.

Smith, S. and Lewty, W., (1959) Perceptual isolation using a silent room. Lancet, 2:342-345.

Solomon, P. et al., eds. Sensory Deprivation. Cambridge, Mass: Harvard University Press.

Suedfeld, P., (1975) The Benefits of Boredom: Sensory Deprivation Reconsidered. American Scientist, Jan-Feb, 63:60-69.

Suedfeld, P. and Roy, C., (1975) Using Social Isolation to Change the Behaviour of Disruptive Inmates. International Journal of Offender Therapy and Comparative Criminology, 19:90-99.

Suedfeld, P., Ramirez, C., Deaton, J. and Baker-Brown, G., (1982) Reactions and Attributes of Prisoners in Solitary Confinement. Criminal Justice and Behaviour, 9(3):303-340.

Sutherland, E.H., and Cressey, D.R., (1955) Principles of criminology, 5th Ed. New York: J.B. Lippincott Company.

Sykes, G., (1958) The Society of Captives: A Study of Maximum Security Prison. Princeton: Princeton University Press

Toch, H (1992) Mosaic of Despair: Human Breakdown in Prison. Washington DC: American Psychological Association.

UN Human Rights Committee (2001) A/56/156.

UN Human Rights Committee, Concluding Remarks on Denmark. 31/10/2000. CCPR/CO/70/DNK

UN Special Rapporteur on the question of torture and other cruel, inhuman or degrading treatment or punishment Report (1999) UN doc. A/54/426

UN Special Rapporteur on the question of torture and other cruel, inhuman or degrading treatment or punishment Report (1995) UN doc. E/CN.4/1995/34

Wakefield, D., (1980) A Thousand Days of Solitary. London: National Prisoners' Movement (PROP).

Walters, R.H., Callagan, J.E. and Newman, A.F., (1962) The effects of solitary confinement on prisoners. American Journal of Psychiatry, 119(5):771-773.

World Health Organisation (WHO) Health in Prisons: a WHO Guide to the essentials in prison health. 2007

Zuckerman, M., (1964) Perceptual isolation as a stress situation. Archives of General Psychiatry, pp.255-276.

Included in SCDC' 4.29.19 letter to LOC

Mannheim Centre for Criminology
London School of Economics
and Political Science
Houghton Street
London WC2A 2AE
UK

Produced with the assistance of the
Nuffield Foundation

ISBN 978-0-85328-314-0
October 2008

Included in SCDC' 4.29.19 letter to LOC

A SOLITARY FAILURE

The Waste, Cost and Harm of Solitary Confinement in Texas

February 2015

Included in SCDC 4.29.19 letter to

A Solitary Failure:
The Waste, Cost and Harm of Solitary Confinement in Texas

February 2015

American Civil Liberties Union of Texas
P.O. Box 8306
Houston, TX 77288
www.aclutx.org

Texas Civil Rights Project - Houston
2006 Wheeler Ave.
Houston, TX 77004
www.texascivilrightsproject.org

Cover photo © Roberto A Sanchez

Included in SCDC' 4.29.19 letter to LOC

TABLE OF CONTENTS

EXECUTIVE SUMMARY 2
Findings 6
Recommendations 11

BACKGROUND 16
The Early Failure of Solitary Confinement 16
The Misguided Return of Solitary Confinement in the Late Twentieth Century 17
The Renewed Consensus: Solitary is a Dangerous and Expensive Correctional Practice 22

SOLITARY CONFINEMENT INCREASES CRIME 24
Solitary Permanently Damages People Who Will One Day Return to Texas Communities 24
Solitary Confinement Causes Permanent Mental Deterioration 24
Isolation Erodes People's Capacity to Interact with Others 31
Solitary Confinement Severs Family Bonds 33
TDCJ Deprives People in Solitary of All Opportunities for Self-Improvement 36
The Consequence of Overusing Solitary is More Crime in Texas Communities 37

TEXAS OVERUSES SOLITARY CONFINEMENT AT TREMENDOUS COST TO TAXPAYERS 39
Solitary Confinement Costs Texas Taxpayers at Least $46 Million a Year 39
Texas Overuses Solitary Confinement 40

TDCJ INCREASES PRISON VIOLENCE BY OVERUSING SOLITARY CONFINEMENT 44
Solitary Confinement Makes Texas Prisons Less Safe 44
Solitary Confinement Deprives Officers of the Option to Incentivize Good Behavior 45
Violence Escalates When Officers Deny People in Solitary Basic Necessities 46
Other States Improved Prison Safety by Reducing Solitary Confinement 46

MENTALLY ILL PEOPLE DETERIORATE IN SOLITARY CONFINEMENT 48
The Universal Consensus: Never Place the Seriously Mentally Ill in Solitary 48
Texas Sends Thousands of People with Mental Illness to Solitary Confinement 49
TDCJ Inadequately Monitors and Treats People with Mental Illness in Solitary 51

CONCLUSION: OUR VALUES AND COMMITMENTS AS TEXANS 55

METHODOLOGY 56

Included in SCDC' 4.29.19 letter to LOC

EXECUTIVE SUMMARY

The Texas Department of Criminal Justice (TDCJ) confines 4.4 percent of its prison population in solitary confinement.[1] Texas locks more people in solitary-confinement cells than twelve states house in their entire prison system.[2] On average, prisoners remain in solitary confinement for almost four years[3]; over one hundred Texas prisoners have spent more than twenty years in solitary confinement.[4] The conditions in which these people live impose such severe deprivations that they leave prison mentally damaged; as a group, people released from solitary are more likely to commit more new crimes than people released from the rest of the prison system. Yet in 2013, TDCJ released 1,243 people directly from solitary-confinement cells into Texas communities.[5] These prisoners return to society after living for years or decades in a tiny cell for twenty-two hours a day, with no contact with other human beings or access to educational or rehabilitative programs.[6] As documented in this report, this dangerous and expensive practice is making our state less safe.

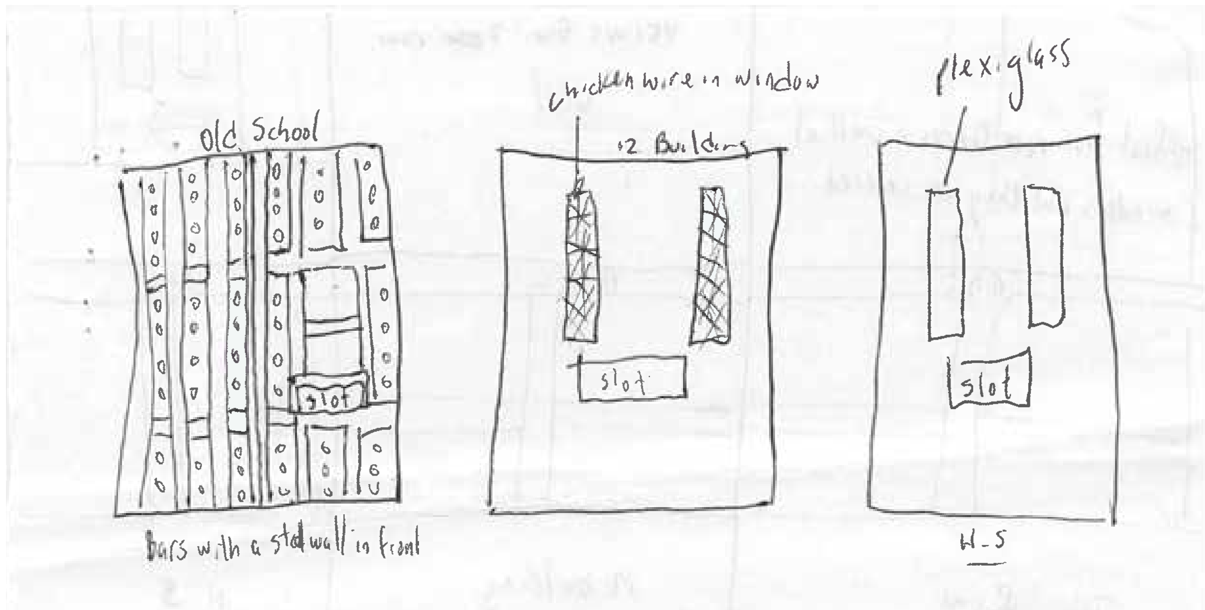
Alex is one of 6,564 Texas prisoners[7] who live in a solitary-confinement cell.[8] It is sixty square feet in size[9]; he can cross its length in six paces.[10] If he lifts his arms to their full wingspan, his fingertips almost graze the walls.[11] The cell is completely bare; just a concrete floor and four concrete walls.[12] Alex is not allowed to place anything on his walls, not even a calendar.[13] The door is made of solid metal with a slot for a food tray, and two thin Plexiglas rectangles to allow officers to see in.[14]

---

1 Texas Department of Criminal Justice (TDCJ) Administrative Segregation Information Sheet, at 6 (Sept. 2014) (obtained from Jeff Baldwin, Chief of Staff, TDCJ, and on file with ACLU of Texas and TCRP). TDCJ's technical term for solitary confinement is administrative segregation. Solitary confinement is the commonly accepted term, used nationwide, to describe the practice of housing prisoners alone in a cell for at least twenty-two hours a day. Therefore, we use the term solitary confinement throughout this report.
2 E. Ann Carson & Daniela Golinelli, Bureau of Justice Statistics, Prisoners in 2012: Trends in Admissions and Releases, at 23-24 (Sept. 2, 2014), *available at* http://www.bjs.gov/content/pub/pdf/p12tar9112.pdf.
3 TDCJ Administrative Segregation Information Sheet, *supra* note 1, at 6.
4 Spreadsheet from TDCJ in response to Open Records Request (ORR) (Nov. 20, 2012) (on file with ACLU of Texas and TCRP).
5 Letter from TDCJ to authors in response to open records request (July 9, 2014) (on file with ACLU of Texas and TCRP).
6 TDCJ Administrative Segregation Information Sheet, *supra* note 1, at 6.
7 Letter from TDCJ to authors, *supra* note 5.
8 We have changed the names of people we interviewed or corresponded with in order to protect confidentiality.
9 The average size of a solitary-confinement cell in Texas is sixty square feet; some are as small as forty-five square feet. Letter from TDCJ to authors in response to open records request (Feb. 27, 2014) (on file with ACLU of Texas and TCRP).
10 Letter from Alex to authors (Sept. 17, 2014) (on file with ACLU of Texas and TCRP).
11 *Id.*
12 *Id.*
13 *Id.*
14 *Id.*

Included in SCDC' 4.29.19 letter to LOC

Alex's drawing of the door to his solitary cell



Alex calls this cell his "house";[15] and for the past ten years, it has been the only home he has known.[16]

Alex's entire life is confined within the four corners of his "house." He eats sitting on the floor or on his bed. He sleeps on a steel bunk along one wall, covered in a thin plastic mattress.[17] He goes to the bathroom in the toilet in the corner. The cell smells "[l]ike mold and urine and feces and filth," Alex writes. "Like a downtown subway restroom. Like a locker room that's never been cleaned."[18]

Most days, Alex's only contact with another human being is the hand that slides his food tray through a slit in his cell door. Weeks pass in which Alex never sees another person's face, or looks another person in the eyes. He can only talk to people by shouting to other prisoners through the concrete walls. He cannot practice his Christian faith with a community of others who share his beliefs.[19] He cannot play sports or games with other people.[20] When his niece comes to visit, he cannot hug her goodbye; he must talk to her through a pane of glass.[21]

15 Interview with Alex, individual incarcerated in TDCJ (May 28, 2014).
16 *Id.*
17 Letter from Alex to authors, *supra* note 10.
18 *Id.*
19 TDCJ Administrative Segregation Plan, at att. A (Mar. 2012) (unpublished) (on file with ACLU of Texas and TCRP).
20 *Id.*
21 *Id.*

Included in SCDC' 4.29.19 letter to LOC

There is no window in Alex's cell.[22] His field of vision is limited to peering through the Plexiglas slit in his cell door to the door of the cell opposite him.[23] Alex has not seen the stars in a decade.[24] "I miss that so much," he writes. "One time I was going to the hospital, down to Galveston and we were riding the ferry and the sun was coming up and it was the only one I'd seen in years. I'm a pretty tough guy, but it brought tears to my eyes."[25]

Alex struggles to fall asleep at night. Usually, he can only sleep for four hours.[26] The fluorescent light hanging from his ceiling remains on all night.[27] The cell block constantly echoes with screams because some of the men confined in neighboring cells have gone insane, cutting themselves or eating their own feces.[28] Alex is overwhelmed by the noise: "Constant banging, clanking, rage, anger," he writes. "Like a jammed packed area for a boxing match with everyone screaming murder. The night sounds are the worst. More personal and filled with sadness. It sounds like hell."[29]

Prison regulations require that officers take Alex outside his cell for one hour several times a week to exercise in a recreation yard. Often, he is deprived of even this minimal reprieve. Officers go for weeks without letting people on his block leave their cell for recreation.[30] But even in the recreation space—a caged outdoor box not much larger than his cell, covered in bird feces[31]—Alex is alone.

Solitary confinement forces Alex into a life of idleness. Alex wants to educate himself before returning to society. He wants to get counseling to help him deal with the abuse from his childhood.[32] But he is not allowed to take group classes to get his associate's degree.[33] He cannot take classes to help him manage his anger, or join Alcoholics Anonymous to manage the addictions that led him to prison.[34] He cannot purchase a television to watch in his cell.[35]

"I want something meaningful, not meaningless in my life," Alex says. "I do everything I can to make my time mean something. To take responsibility for my day."[36]

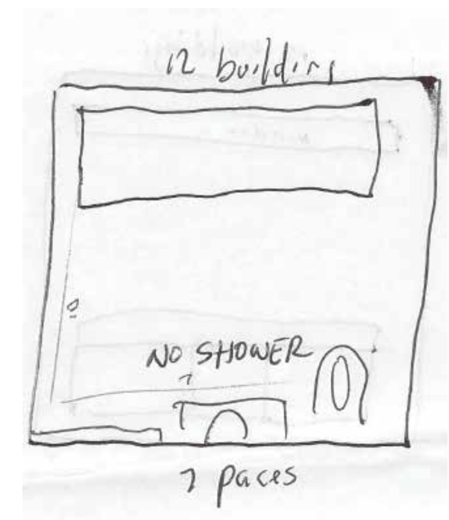
22 Letter from Alex to authors, *supra* note 10.
23 *Id.*
24 *Id.*
25 *Id.*
26 Alex's Journal (entries eated June 12 & 19, 2014) (on file with ACLU of Texas and TCRP).
27 Interview with Alex, *supra* note 15.
28 Alex's Journal, *supra* note 26 (entry dated July 7, 2014).
29 Letter from Alex (Sept. 17, 2014), *supra* note 10.
30 Interview with Alex to authors, *supra* note 15.
31 Alex's Journal, *supra* note 26 (entry dated June 17, 2014).
32 *Id.*
33 TDCJ Administrative Segregation Plan, *supra* note 19, at att. A.
34 *Id.*
35 *Id.*
36 Alex's Journal, *supra* note 26 (entry dated June 19, 2014).

Included in SCDC' 4.29.19 letter to LOC

Alex keeps a journal; he calls it "Wilson," the name Tom Hanks gave a volleyball—his only companion and confidant while abandoned on a desert island—in the movie *Castaway*.[37] Every morning, Alex picks a new word out of the dictionary to learn. He reads inspiring quotations. He reads books on self-improvement from the prison library; the most recent one was *The Power of Habit*, which "is basically about replacing bad habits with good ones. . . . This is the kind of stuff we need to be addressing if we have any hope of giving ourselves a chance."[38] He keeps a strict workout schedule of pushups and crunches.[39] On Saturdays, he cleans his cell.[40] On Sundays, he listens to Lakewood Church on the radio.[41] Each morning he makes his bed; then he lays out a towel on his cell floor, sits on it, and meditates for twenty minutes.[42] He had to train himself to meditate over time, though; it used "to be so hard because the last thing your nerves or body wants to do is relax when your neighbor is 'cell warring' and kicking his door, or when the whole wing is in complete chaos."[43] When someone walks by his cell, he comes up to his cell door to say "hello"; he says, "It keeps the free world present and keeps my social skills from completely wasting away."[44] He feeds the lizards that crawl in his cell to keep him company.[45] He has a "*mantra*": "I am stronger than this place, I am stronger than these circumstances."[46]

But the cries from his neighbors' cells shake his confidence that he will be able to withstand the isolation. Sometimes, he wonders if he will go insane before returning to the outside world.[47]

"I have to be honest," he wrote. "[W]hen your[48] back here and the guy next to you is so crazy he's cutting on his face or eating his feces. It makes things even worse because you don't know if they came into [solitary] this way, or the walls, this place, has caused it. So you begin to wonder, am I next?"[49]



Floor plan of Alex's cell (drawn by Alex).

37 *Id.* (entry dated June 7, 2014).
38 *Id.*
39 *Id.*
40 *Id.*
41 *Id.*
42 *Id.* (entry dated June 12, 2014).
43 *Id.*
44 *Id.* (entry dated June 12, 2014).
45 *Id.*
46 *Id.* (entry dated June 25, 2014).
47 *Id.* (entry dated June 7, 2014).
48 Throughout this report, we represented people's words as they wrote them to us, without edits to grammar or punctuation.
49 Alex's Journal, *supra* note 26 (entry dated July 7, 2014).

Included in SCDC' 4.29.19 letter to LOC

Findings

At stake in TDCJ's use of solitary confinement is whether thousands of people like Alex will successfully rejoin their families and society upon their release, or whether they will return to their communities irreversibly damaged by years of isolation and sensory deprivation. Solitary confinement permanently damages people. Rather than prepare prisoners for their eventual return to Texas communities, solitary confinement breaks down their ability to interact with other human beings; erodes their family relationships; deprives them of educational, rehabilitative, and religious programming; causes mentally healthy people to descend into mental illness; and severely exacerbates symptoms for people with pre-existing mental illness.

Because it so damages Texas prisoners by confining them in severe conditions, TDCJ ultimately increases crime in Texas communities. Ninety-five percent of incarcerated people return to our communities one day.[50] TDCJ recognizes in its mission statement that one of its most important duties is to improve public safety: "The mission of the Texas Department of Criminal Justice is to provide public safety, promote positive change in offender behavior, reintegrate offenders into society, and assist victims of crime."[51] Yet years of social isolation, enforced idleness, lack of programming, and sensory deprivation make people released from solitary confinement, as a group, more dangerous within prison walls and ultimately to society. All of us pay the price.

In 2014, the American Civil Liberties Union of Texas (ACLU of Texas) and the Texas Civil Rights Project (TCRP) studied Texas's use of solitary confinement. We conducted a written survey of 147 people in solitary confinement, collected data from public-information requests to TDCJ, interviewed and corresponded with people in solitary confinement, reviewed other states' practices, researched the financial impacts of solitary, consulted with security and psychiatric experts, and interviewed correctional officers.

We discovered that TDCJ overuses solitary confinement compared to other states, houses many people in solitary confinement who could be safely confined in a lower security setting, and keeps people in solitary confinement for years and decades, long after they cease to pose a threat. By overusing solitary confinement, TDCJ increases crime, wastes taxpayer money, increases violence in prison, and causes thousands of mentally ill people to further deteriorate before returning to Texas communities.

50 *See* Timothy Hughes & Doris James Wilson, *Reentry Trends in the United States*, Bureau of Justice Statistics, http://www.bjs.gov/content/reentry/reentry.cfm (last visited Aug. 28, 2014).
51 Tex. Dep't. Crim. Justice, http://www.tdcj.state.tx.us/ (last accessed Sept. 5, 2014).

Included in SCDC' 4.29.19 letter to LOC

What is Solitary Confinement?

People in Texas' solitary-confinement cells spend at least twenty-two hours a day[52] in a cell that is sixty square feet,[53] about the size of a residential bathroom or a walk-in closet. During their years or decades in solitary confinement, they almost never leave their tiny cells.[54] Although TDCJ policies permit them an hour or two of recreation per day, many of our survey respondents reported that in reality officers almost never take them outside.[55]

Solitary confinement deprives prisoners of any opportunity for self-improvement. People in solitary confinement cannot participate in group educational and rehabilitative programs to help prepare for their release. They cannot work in prison jobs to use their time productively and learn useful skills. They cannot participate in Alcoholics' Anonymous to cure their addictions. They cannot take group classes to get their G.E.D. or associate's degree, to receive the education they need to support their wives, children, and parents. They cannot take group therapy to help them develop healthy coping mechanisms. They cannot practice their faith with a group of like-minded believers and receive the support and moral education that comes from collective worship.[56]

Solitary confinement strips people of all interpersonal contact. Prisoners in solitary confinement spend their days completely alone. They eat alone. They sleep alone. They go to the recreation yard alone. They can only speak to other people by shouting through the cell walls. They only touch another human being when an officer places handcuffs on them to take them to a medical appointment. When their family members come to visit them, they talk to them through wire mesh or a pane of glass; they cannot hold their hand or hug their loved one goodbye. They are not permitted to make phone calls to their parents, wives, or children.[57] ■

52 TDCJ Administrative Segregation Plan, *supra* note 19, at att. A.
53 Letter from TDCJ to authors (Feb. 27, 2014), *supra* note 9.
54 TDCJ Administrative Segregation Plan, *supra* note 19, at att. A.
55 Interview with Juan, individual incarcerated in TDCJ (June 2, 2014); Interview with Alex, *supra* note 15; Interview with Paul, individual incarcerated in TDCJ (May 30, 2014); Survey response from Brian, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP); Survey response from Miguel, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP); Survey response from Steve, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP); Survey response from Larry, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP).
56 TDCJ Administrative Segregation Plan, *supra* note 19, at att. A.
57 *Id.*

Included in SCDC' 4.29.19 letter to LOC

Finding One: Solitary confinement increases crime in Texas communities. Permanently damaged by years in isolation, people released from Texas solitary-confinement cells commit more new crimes: They are rearrested at a twenty-five percent higher rate than prisoners released from the overall prison system. Of prisoners released from TDCJ in 2006, 48.8 percent were rearrested within three years,[58] whereas 60.84 percent of people released directly from solitary confinement were rearrested within the same time period.[59] According to a preliminary study in California, parolees released from solitary confinement committed new crimes at a thirty-five percent higher rate than parolees released from the overall prison system.[60] The data from Texas and California are consistent with evidence from other states that solitary confinement increases violent crime, even when controlling for common predictors of recidivism. People released from solitary-confinement cells in Washington State commit new felonies at a thirty-five percent higher rate than people released from the general population.[61] People who had spent time in Florida's solitary-confinement cells are eighteen percent more likely to commit new violent crimes.[62]

Texas solitary-confinement cell

58 *See* Legislative Budget Board, Statewide Criminal Justice Recidivism and Revocation Rates 35 (Jan. 2011), *available at* http://www.lbb.state.tx.us/Public_Safety_Criminal_Justice/RecRev_Rates/Statewide%20Criminal%20Justice%20Recidivism%20and%20Revocation%20Rates2011.pdf.
59 Letter from TDCJ to Rodney Ellis, Tex. Senator (Dec. 6, 2011) (on file with ACLU of Texas and TCRP); E-mail from Ed Sinclair, Analyst, Criminal Justice Data Analysis Team, Tex. Legislative Budget Board, to Burke Butler, Fellow, TCRP (Sept. 26, 2014 07:31 CST) (on file with ACLU of Texas and TCRP).
60 *See* Keramet Reiter, *Parole, Snitch, or Die: California's Supermax Prisons & Prisoners, 1987-2007, at* 50 (ISSC Fellows Working Paper, Institute for the Study of Social Change, Univ. of Ca. Berkeley, 2010).
61 *See* David Lovell et al., *Recidivism of Supermax Prisoners in Washington State, 53 Crime & Delinquency* 633, 644 (Oct. 2007).
62 *See* Daniel P. Mears & William D. Bales, *Supermax Incarceration and Recidivism,* 47 Crimonology 1131, 1151 (2009).

Included in SCDC' 4.29.19 letter to LOC

Finding Two: TDCJ overuses solitary confinement at tremendous cost to taxpayers. TDCJ houses 4.4 percent of prisoners in solitary confinement[63]—about four times the estimated national average of one to two percent of the prison population.[64] TDCJ uses overbroad criteria to send people to solitary confinement, capturing many individuals who did not commit any misconduct within the prison system. It also confines people to solitary confinement for lengthy periods—on average 3.7 years[65]—rather than returning them to general population as soon as it is safe to do so. Recognizing the safety consequences of solitary confinement, states like Mississippi have dramatically reduced their reliance on solitary confinement, which improved safety in their prisons and communities and saved taxpayers millions of dollars. It is time for Texas to follow their lead. TDCJ spends $46 million dollars a year above normal correctional costs to house people in solitary confinement—$61.63 per day per person housed in administrative segregation, compared to $42.46 per day per person in general population.[66] Since Texas taxpayers foot the bill for Texas's use of solitary confinement, TDCJ should use it as rarely as possible. TDCJ could save taxpayers $31 million dollars a year just by dropping its use of solitary confinement to Mississippi's rate of 1.4 percent.[67]

Finding Three: Solitary confinement increases prison violence. Serious assaults on Texas prison staff have increased 104 percent during the last seven years.[68] Texas's largest correctional officers union attributes the rise, in part, to TDCJ's overuse of solitary confinement and the practice of housing people with mental illness in solitary confinement.[69] In 2013, almost eighty percent of the 499 instances of prisoners exposing officers to bodily fluids occurred in Texas's solitary-confinement units; none occurred in general-population units.[70] These assaults led Texas's largest correctional officers union to call upon the United States Senate to regulate states' use of solitary confinement.[71] Other states have improved security by drastically reducing their use

63 TDCJ Administrative Segregation Information Sheet, *supra* note 1, at 6.

64 There are no hard numbers on the percentage of states' prison populations in solitary confinement. Experts estimate that the state average is one to two percent. *See* James Austin & Emmitt Sparkman, Nat. Inst. of Corrections, Prisons Division: Colorado Department of Corrections Administrative Segregation and Classification Review 17 (Oct. 2011), *available at* https://www.aclu.org/files/assets/final_ad_seg.pdf.

65 TDCJ Administrative Segregation Information Sheet, *supra* note 1, at 6.

66 This data is unfortunately over eleven years old. TDCJ has said that it does not track the costs of housing people in solitary confinement compared with general population. *See* Crim. Just. Policy Council, Mangos to Mangos: Comparing the Operational Costs of Juvenile and Adult Correctional Programs in Texas, Prepared for the 78th Texas Legislature 12 (2003), *available at* http://www.lbb.state.tx.us/Public_Safety_Criminal_Justice/Reports/2003cpd.pdf; Letter from TDCJ to Rodney Ellis, *supra* note 59.

67 *See Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences: Hearing Before the Senate Judiciary Committee's Subcommittee on the Constitution, Civil Rights and Human Rights,* 112th Cong. (2012), (written testimony of Christopher Epps, Commissioner of Mississippi Department of Corrections), *available at* http://www.judiciary.senate.gov/imo/media/doc/12-6-19EppsTestimony.pdf.

68 *See Reassessing Solitary Confinement II—The Human Rights, Fiscal, and Public Safety Consequences: Hearing Before the Senate Judiciary Committee's Subcommittee on the Constitution, Civil Rights and Human Rights,* 113th Cong. (2014) (testimony of Lance Lowry, President, AFSCME Local 3807 Texas Correctional Employees), *available at* http://solitarywatch.com/wp-content/uploads/2014/02/Lance-Lowry-Senate-Hearing-Submission.pdf.

69 *See id.*; *see also* e-mail from Lance Lowry, President, AFSCME 3807, to Burke Butler, Fellow, TCRP (Sept. 21, 2014 16:41 CST) (on file with ACLU of Texas and TCRP).

70 *See* Testimony of Lance Lowry, *supra* note 68.

71 *See id.*

Included in SCDC' 4.29.19 letter to LOC

of solitary confinement. Mississippi cut serious assaults against staff and prisoners by seventy percent when it reduced its solitary population from one thousand to fewer than 150.[72] When Maine cut its solitary-confinement population, incidents of prison violence dropped.[73] Colorado saw no increase in assaults when it reduced its solitary-confinement population by sixty percent, and the Director of the Colorado Department of Corrections declared that "our institutions will actually be safer" with less solitary confinement.[74]

Finding Four: Solitary confinement causes thousands of mentally ill people to further deteriorate before they return to Texas communities. The universal consensus among mental health experts is that correctional departments must never send people with serious mental illnesses to solitary confinement because complete isolation causes people with serious mental illness to fall apart.[75] Yet TDCJ confines at least 2,012 people with mental illnesses in solitary confinement[76] and inadequately monitors them during their time in isolation, providing only cursory checks that are unlikely to identify serious issues. According to our survey results, of those survey respondents who met with a mental health worker, sixty-five percent said their meetings were less than two minutes long.[77]As a consequence, rates of suicide, attempted suicide, and self-harm in solitary confinement are far higher than rates in the general population: People in solitary confinement are five times more likely to commit suicide than those in the general population.[78] For the mentally ill who do survive solitary confinement, they return to Texas communities in worse condition than when they entered TDCJ.

72 *See* Terry A. Kupers et al., *Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs,* 20 Crim. Just. & Behavior 1, 5, 7 (July 2009), *available at* https://www.aclu.org/sites/default/files/images/asset_upload_file359_41136.pdf.

73 *See* Lance Tapley, *Reducing solitary confinement,* Portland Phoenix, Nov. 2, 2011, http://portland.thephoenix.com/news/129316-reducing-solitary-confinement/?page=2#TOPCONTENT; *see also* Am. Civ. Liberties Union of Me., Change Is Possible: A Case Study of Solitary Confinement Reform in Maine 30-31 (Mar. 2013), *available at* http://www.aclumaine.org/sites/default/files/uploads/users/admin/ACLU_Solitary_Report_webversion.pdf.

74 *See Reassessing Solitary Confinement II—The Human Rights, Fiscal, and Public Safety Consequences: Hearing Before the Senate Judiciary Committee's Subcommittee on the Constitution, Civil Rights and Human Rights,* 113th Cong. (2014) (testimony of Rick Raemisch, Executive Director, Colorado Department of Corrections), *available at* http://www.judiciary.senate.gov/imo/media/doc/02-25-14RaemischTestimony.pdf.

75 *See* Jeffrey L. Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics,* 38 J. Am. Acad. Psychiatry & L. 104, 105 (Nov. 2010), *available at* http://www.jaapl.org/content/38/1/104.full.pdf+html.

76 Letter from TDCJ to authors, *supra* note 5.

77 Data collected from survey of 147 people incarcerated in Texas prisons who previously spent time in or are currently in solitary confinement (on file with ACLU of Texas and TCRP).

78 Letter from TDCJ to authors, *supra* note 5.

Included in SCDC' 4.29.19 letter to LOC

Recommendations

Recommendation One: Change Institutional Attitudes Toward Solitary Confinement. TDCJ and statewide policymakers must move toward a new institutional attitude that views solitary confinement as a rare practice, to be used only in exceptional circumstances and for short periods. The State of Texas has embraced "smart on crime" reforms in recent years, and this same balancing of benefits against costs should inform our approach to solitary confinement:

- **Train correctional officers to work effectively with people with mental illness.** Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMI) should develop additional mental-health training for correctional officers, and make this training a precondition for an additional pay raise. Increased training will allow correctional officers to identify misbehavior based on mental illness and divert people with mental illness to appropriate treatment, rather than sending them to solitary confinement. It will also help to prevent confrontations between correctional officers and mentally ill prisoners that can spiral out of control. A small amount of dedicated additional funding for mental health training is a wise investment for the state because it gives officers skills they need, makes them safer, and could increase job satisfaction and reduce turnover.

- **Enact step-down programs that allow individuals to move to less restrictive. housing based on good behavior.** TDCJ should enact programs that allow individuals in solitary confinement to earn greater privileges through good behavior and eventually return to the general population. These programs will ensure that people only stay in solitary confinement for short durations. They will also give prisoners an incentive to comply with prison regulations, thereby making solitary-confinement units safer for correctional officers.

- **Institute an independent oversight entity to monitor TDCJ's use of solitary confinement and make recommendations for reform.** The legislature should institute an independent oversight body—comprised of mental-health and corrections experts—to collect data on TDCJ's use of solitary confinement, monitor TDCJ's practices, and make recommendations for reform. This independent body could play a vital role in ensuring that the public is well informed about this important area of prison management. The independent entity should have the power to inspect TDCJ facilities and interview incarcerated people.

Included in SCDC' 4.29.19 letter to LOC

Recommendation Two: Remove People with Serious Mental Illness from Solitary Confinement

A large number of individuals housed in solitary confinement in Texas prisons have serious mental illnesses. These individuals should be removed from solitary confinement and placed in a setting where their mental health needs can be appropriately addressed, helping to ensure that they are not returned to their communities unstable and untreated.

- **Exclude people with serious mental illness from solitary confinement.** Serious mental illnesses include, among other conditions: major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post-traumatic stress disorder (PTSD) and borderline personality disorder.[79] The legislature should dedicate funds for a one-time review to ensure that all individuals with serious mental illnesses in solitary confinement are removed to therapeutic settings. TDCJ should also remove anyone whose medical or mental-health conditions will worsen in solitary confinement. Diverting those with serious mental health issues to psychiatric treatment units or other appropriate settings reduces litigation exposure and improves outcomes for this population, including reducing the causes of recidivism.

- **Provide mental-health screening to everyone within twenty-four hours of placement in solitary confinement.** TDCJ should ensure that no one spends more than one day in solitary confinement without a mental-health screening, conducted in person by a mental-health professional in a confidential setting. If a person has serious mental illness, he must be removed from solitary confinement to a setting where he can receive adequate treatment. People in solitary confinement who are undergoing mental-health treatment must receive an in-person mental-health review once per month, conducted by a mental-health professional in a confidential room where security staff cannot overhear the communication.

79 *See What Is Mental Illness?: Mental Illness Facts,* Nat'l Alliance on Mental Illness http://www.nami.org/template.cfm?section=about_mental_illness (last accessed Sept. 16, 2014).

Included in SCDC' 4.29.19 letter to LOC

- **Enact policies requiring mental-health professionals to participate in all initial decisions classifying prisoners to solitary confinement, as well as all follow-up placement reviews.** By having mental-health professionals play an ongoing role in classification decisions, TDCJ will ensure that inmates with serious mental illnesses are not sent to solitary confinement in the future.

- **Establish segregated housing with adequate mental-health treatment for the small number of mentally ill people who legitimately need to be housed in a high security setting.** For many mentally ill prisoners, misbehavior is a result of inadequate mental-health treatment and the harmful effects of solitary confinement—which could be remedied with adequate therapeutic interventions and medication. However, there may be a very small number of prisoners with mental illness who legitimately need to be isolated from the rest of the prison population. For these few individuals, TDCJ should create special mental-health segregation units. In those units, people with mental illness must receive ten to fifteen hours a week of out-of-cell therapeutic activities, and at least ten hours a week of unstructured exercise or recreation time.[80]

Recommendation Three: Review Solitary-Confinement Placement System-Wide.
To ensure that TDCJ only houses people in solitary confinement if they pose a serious security risk, TDCJ should:

- **Review all individuals in solitary confinement with the goal of removing as many individuals as possible**. The legislature should fund a one-time review to ensure that the costly practice of solitary confinement is not overused within TDCJ. The review should examine the appropriateness of placement and the duration of placement for each individual currently housed in solitary confinement. If an individual poses no threat, the review should result in removal from solitary confinement. This approach is cost effective because it would right-size the solitary confinement population in Texas.

- **Cease automatic placement in solitary confinement.** Currently, association with certain prison gangs can mean automatic and long-term placement in solitary confinement. While addressing gang violence is a key element of ensuring security, other criminal justice systems have successfully housed gang members in settings less restrictive (and less expensive) than solitary confinement. TDCJ should consider alternative housing for this population, including reviewing

80 *See* Jeffrey Metzner & Joel Dvoskin, *An Overview of Correctional Psychiatry,* 29 Psychiatric Clinics N. Am. 761, 764 (2006), *available at* http://www.joeldvoskin.com/Metzner___Dvoskin_2006.pdf.

Included in SCDC' 4.29.19 letter to LOC

practices in other states that have allowed for placement in less restrictive settings.

- **End flat release of people from solitary confinement into Texas communities.** TDCJ has taken steps to expand step-down programs that provide treatment to help people transition from solitary confinement to life in the outside world. Given that solitary confinement is associated with higher recidivism rates, it is essential that TDCJ further expand this programming to make it available to all those released from solitary. To ensure accountability and transparency, TDCJ should report publicly on the success of these programs and their outcomes.

- **Never house individuals in solitary confinement for over one year except in rare circumstances.** TDCJ should cease housing people in solitary confinement for indefinite periods of time, and never for over one year, unless the following conditions are met: TDCJ conducts a hearing in which it establishes (1) by a preponderance of evidence that the individual, within the previous year, has committed an act which resulted in or was likely to result in serious injury or death to another; or (2) by clear and convincing evidence that there is a significant risk that the individual will cause physical injury to prison staff, other inmates, or members of the public, if removed from long-term isolation. Association with a prison gang alone should not be enough to meet that burden. The hearing committee must not be comprised of staff from the prisoner's unit.

Recommendation Four: Improve Conditions in Solitary Confinement.
After dramatically reducing its solitary-confinement population, TDCJ should take steps to improve conditions for people in its solitary-confinement cells to reduce isolation and the corresponding anti-social tendencies isolation causes:

- **Ensure appropriate programming for individuals held in solitary confinement.** TDCJ should provide people in solitary confinement with opportunities for out-of-cell educational, rehabilitative, and religious programs to help prepare them for their eventual release into the outside world. TDCJ should also develop educational, rehabilitative, and religious programs that people can complete in their cells.

- **Provide adequate stimulation to lower the effects of sensory deprivation.** TDCJ should provide people in solitary confinement with the same access to televisions, radios, books, and magazines that is available in general population. It should also provide more out-of-cell time.

Included in SCDC' 4.29.19 letter to LOC

- **Support family relationships.** Solitary confinement significantly impairs family bonds by limiting visitation to no-contact visits and prohibiting telephone calls to loved ones. TDCJ can support family relationships—which in turn aid in rehabilitation—by providing people in solitary confinement with the ability to have contact visits with their loved ones and make telephone calls to their families.

- **Provide adequate mental-health and medical services to those in solitary confinement.** TDCJ should conduct weekly reviews of people in solitary confinement by a mental-health professional. People receiving mental-health treatment should be granted out-of-cell treatment sessions with a mental-health professional, taking place in a confidential room where security staff cannot overhear the conversation. The complete isolation in solitary confinement can also make it more difficult for people to request and access urgent medical care. TDCJ should review the provision of medical care in its solitary-confinement units and ensure that people in solitary confinement receive adequate medical services.

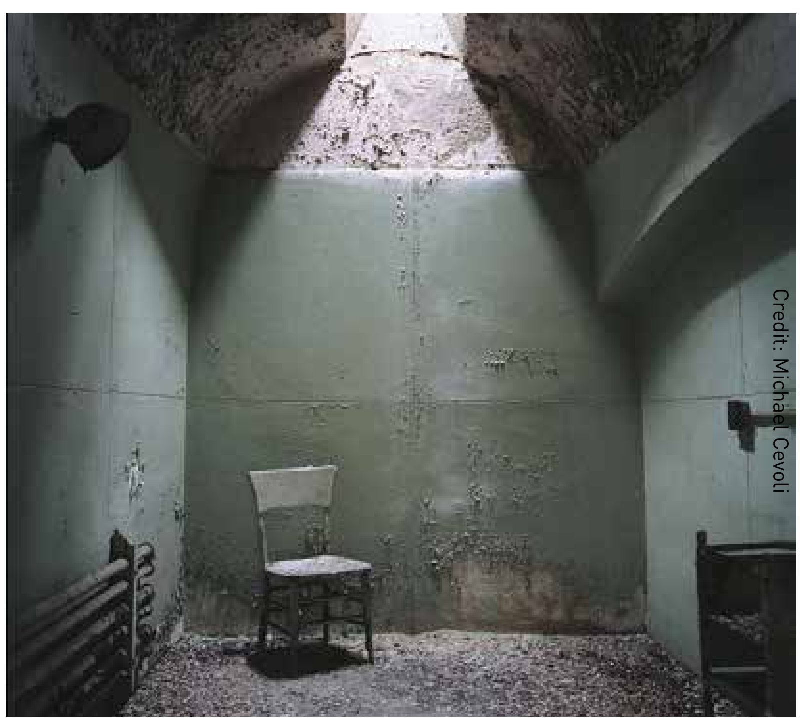
Included in SCDC' 4.29.19 letter to LOC

BACKGROUND

The findings documented in this report are hardly news. The dangers of extreme isolation were first observed by correctional experts in the 1800s, causing them to abandon the practice in favor of more humane and constructive conditions of confinement. Now, after decades of experience with the ill effects of solitary confinement, a new generation of experts and policymakers has concluded that solitary confinement must be used as rarely possible and only for brief periods.

The Early Failure of Solitary Confinement

Early experiments with solitary confinement demonstrated that it completely debilitated prisoners, thwarting the fundamental correctional objective of making American communities safer by preparing people to live law-abiding lives in the outside world. In the late 1700s, the Pennsylvania legislature authorized the construction of this country's first-ever block of solitary confinement cells in the Walnut Street Jail.[81]



Opened in 1829 outside of Philadelphia, Eastern State Penitentiary utilized a system of complete isolation, like its predecessors, Walnut Street Jail and Western State Penitentiary.[82]

81 *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).
82 *See History of Eastern State Penitentiary, Philadelphia,* E. State Penitentiary Historic Site, Inc. http://www.easternstate.org/sites/default/files/pdf/ESP-history6.pdf (last accessed Sept. 15, 2014).

Included in SCDC' 4.29.19 letter to LOC

Then in 1826, Pennsylvania opened Western State Penitentiary, and housed everyone there in solitary confinement.[83] Other states soon followed Pennsylvania's model.[84] Observers quickly recognized that solitary confinement caused lasting psychological harm, however, permanently damaging inmates beyond repair—until they were utterly unfit for return to free society.[85] As the United States Supreme Court observed in 1890, the experiment with solitary confinement had completely failed as a correctional practice:

> But experience demonstrated that there were serious objections to [solitary confinement]. A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community.[86]

Correctional departments had largely abandoned solitary confinement by the early twentieth century because of the irreversible damage it inflicted on prisoners.[87] Until the 1980s, state and federal prisons used solitary confinement only in rare and extraordinary circumstances.[88]

The Misguided Return of Solitary Confinement in the Late Twentieth Century

Fueled by the "tough on crime" movement and reeling under the pressure of a skyrocketing prison population in the 1980s,[89] correctional departments forgot the abysmal early failure of solitary confinement. Between 1925 and 1986, the size of the population incarcerated in state and federal prisons skyrocketed by 450 percent.[90] By

83 *See* Haney & Lynch, *supra* note 81, at 483.
84 *See id.* at 484.
85 *See* Gustave de Beaumont & Alexis de Tocqueville, On the Penitentiary System in the United States and Its Application in France 5-6 (Francis Lieber, trans., S. Ill. U. Press 1979) (1833).
86 *In re Medley,* 134 U.S. 160, 168 (1890).
87 *See* Haney & Lynch, *supra* note 81, at 484-87; *see also* Jesenia M. Pizarro, Vanja M.K. Stenius, & Travis C. Pratt, *Supermax Prisons: Myths, Realities, and the Politics of Punishment in American Society,* 17 Crim. Just. Pol. Rev. 6, 12 (Mar. 2011).
88 Haney & Lynch, *supra* note 81, at 488-89; Pizarro, Stenius, & Pratt, *supra* note 87, at 7.
89 It is beyond the scope of this report to detail the policies that contributed to exponential growth in the nation's prison population. But it is important to note that the drivers of the increase—including the misguided "war on drugs" and harsh sentencing requirements—meant that much of the growth was among non-violent, low-level drug offenders. *See* The Sentencing Project, Fact Sheet: Trends in U.S. Corrections (Sept. 2014), *available at* http://sentencingproject.org/doc/publications/inc_Trends_in_Corrections_Fact_sheet.pdf.
90 *See* Patrick A. Langan, John V. Fundis, Lawrence A. Greenfeld, & Victoria W. Schneider, Bureau of Justice Statistics: Historical Statistics on Prisoners in State and Federal Institutions, Yearend 1925-1986, at 15 (May 1988), *available at* https://www.ncjrs.gov/pdffiles1/digitization/111098ncjrs.pdf.

Included in SCDC' 4.29.19 letter to LOC

the late 1990s, most prisons were operating at over one hundred percent of design capacity.[91] As correctional departments struggled to control overcrowded prisons, many prison officials responded by locking down prisoners in solitary confinement.[92]

And with elected officials needing to establish their "tough on crime" bona fides, legislatures poured money into the construction of expensive solitary-confinement units.[93] Some states even built "supermax" prisons—prisons consisting entirely of solitary-confinement cells. In 1984, there was only one "supermax" facility in the United States.[94] By 1999, there were sixty supermax facilities in thirty states.[95] In 2000, the Bureau of Justice Statistics estimated that a over 80,000 people were held in solitary confinement in federal and state prisons.[96] That was a forty percent increase from only five years earlier, even faster than the rate of growth of the general prison population, which had increased twenty-eight percent over the same period.[97]

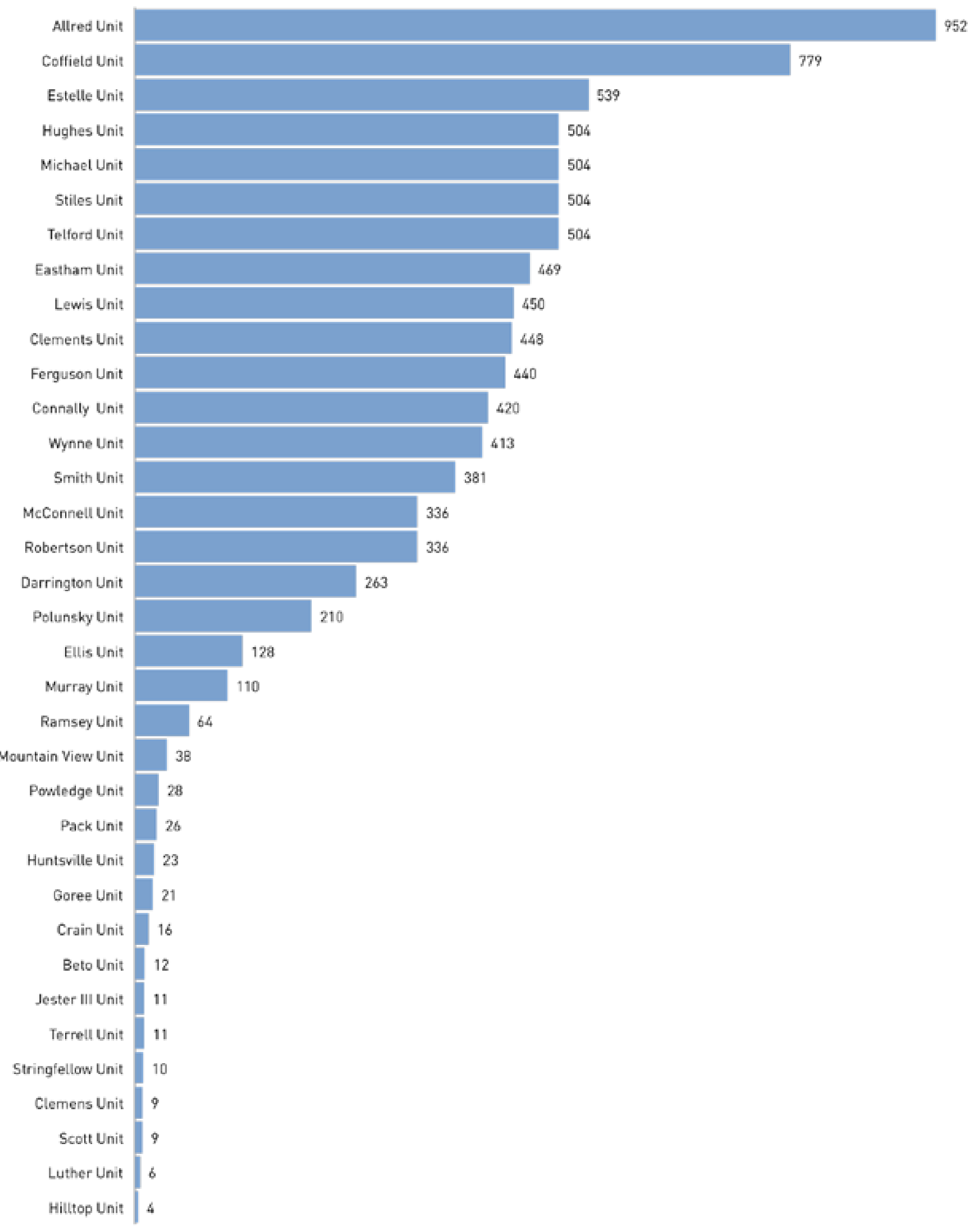
Texas was at the forefront of the renewed use of solitary confinement. Facing its own rapidly inflating prison population, Texas imposed a new regime of widespread solitary confinement in the late 1980s. Traditionally, TDCJ had used solitary confinement only as a short-term punishment for in-prison misbehavior, lasting just a few weeks at a time.[98] But Texas's prison population boomed in the twentieth century, increasing at an even more dramatic rate than the rest of the country. Between 1925 and 1986, Texas's prison population increased by over one thousand percent.[99] By 1986, TDCJ had the third-largest number of people in prison in all fifty states.[100] Rather than augment its correctional force to manage the over 38,000 people it had locked behind bars, Texas responded by warehousing a large portion of its prison population in permanent solitary confinement.[101] TDCJ built new units with layouts that harkened back to the Pennsylvania model of the nineteenth century of "total isolation."[102] Between 1987 and 1994, TDCJ built seven maximum-security prisons, each with 504 administrative segregation cells.[103] Soon, Texas had solitary-confinement cells throughout the state—and it started to fill them.[104]

---

91 *See* Chase Riveland, Supermax Prisons: Overview and General Considerations 5 (Jan. 1999), *available at* https://s3.amazonaws.com/static.nicic.gov/Library/014937.pdf.
92 *See id.*; *see also* Haney & Lynch, *supra* note 81, at 480.
93 *See* Riveland, *supra* note 91, at 5.
94 *See* Pizarro, Stenius, & Pratt, *supra* note 87, at 7.
95 *See id.*
96 *See* Vera Institute of Justice, Confronting Confinement: A Report of The Commission on Safety and Abuse in America's Prisons 52-53 (June 2006), *available at* http://www.vera.org/sites/default/files/resources/downloads/Confronting_Confinement.pdf.
97 *See id.* at 53.
98 *See* Robert Perkinson, Texas Tough 314 (2010).
99 *See* Langan, Fundis, Greenfield & Schneider, *supra* note 90, at 5, 13.
100 *See id.*
101 *See* Perkinson, *supra* note 98, at 314-15.
102 *See id.*
103 John Sharp, Texas Comptroller of Public Accounts, A Report from the Texas Performance Review 47 (Apr. 1994).
104 *See id.*

Included in SCDC' 4.29.19 letter to LOC

Solitary confinement cells in the State of Texas per prison unit



Included in SCDC' 4.29.19 letter to LOC

Who is in Texas Solitary-Confinement Cells?

Fifty-three percent[105] of prisoners in solitary confinement are there because TDCJ determined that they were either an escape risk or a security threat to officers or other prisoners.[106] On average, they remain in solitary confinement for three and a half years, which indicates that TDCJ continues to isolate many people long after they cease to pose a threat.[107] Forty-six percent are in solitary confinement because TDCJ determined that they were members of one of eight gangs—not because they committed any misconduct while incarcerated.[108] The remaining prisoners are in in "Protective Custody"—isolated in solitary confinement for their own protection.[109]

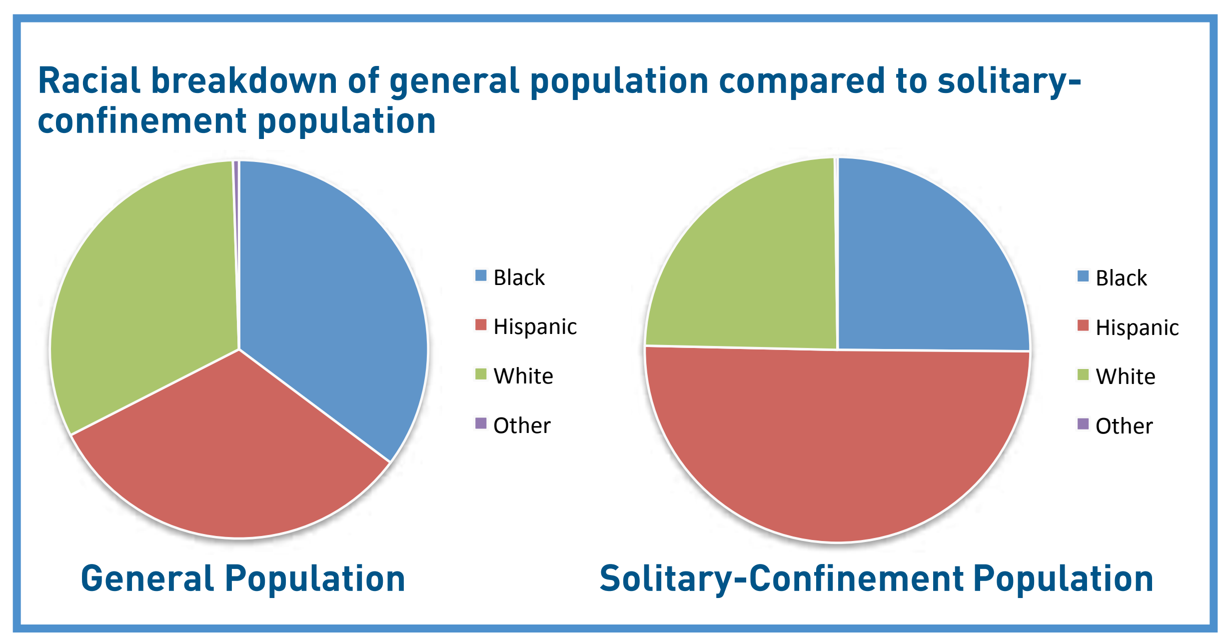
The population in Texas's solitary-confinement cells is predominantly male;[110] there are only 103 women in Texas solitary-confinement cells.[111] Nineteen people in solitary-confinement cells are under the age of 19, and forty-four are over sixty-five years old.[112]

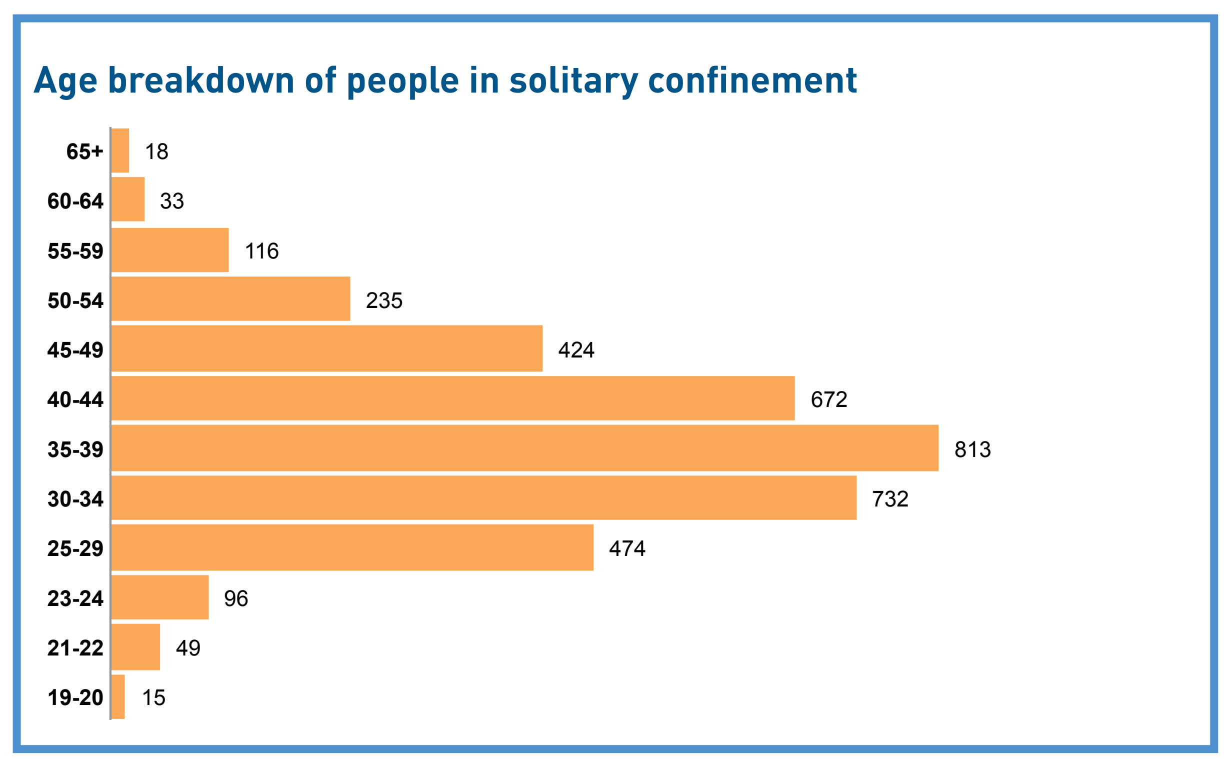
Thirty-three percent of people in solitary confinement committed non-violent offenses[113] such as property and drug crimes.[114]

The population in Texas's solitary-confinement cells is disproportionately Hispanic.[115] Hispanics comprise over fifty percent of the solitary-confinement population, even though they make up only thirty-two percent of the general population.[116] The racial disproportion is likely because the eight gangs automatically housed in solitary confinement are predominately Hispanic.[117] ■

105 Letter from TDCJ to authors, *supra* note 5.
106 TDCJ Administrative Segregation Plan, *supra* note 19, at 1.
107 Letter from TDCJ to authors, *supra* note 5.
108 E-mail from TDCJ Office of the General Counsel to Burke Butler, Fellow, TCRP (Sept. 9, 2014, 08:35 CST) (on file with ACLU of Texas and TCRP).
109 Letter from TDCJ to authors, *supra* note 5; TDCJ Administrative Segregation Plan, *supra* note 19, at att. A.
110 Letter from TDCJ to authors, *supra* note 5.
111 *Id.*
112 *Id.*
113 *Id.*
114 *Id.*
115 *Id.*
116 *Id.*
117 *Id.*

Included in SCDC' 4.29.19 letter to LOC





Included in SCDC' 4.29.19 letter to LOC

The Renewed Consensus: Solitary Confinement is a Dangerous and Expensive Correctional Practice

Predictably, after diverting thousands of prisoners to solitary confinement, correctional departments around the country soon learned that solitary confinement increased violence both in prison and in American communities. In May 2007, violence erupted in Mississippi's solitary-confinement unit.[118] By the summer, three people in the unit had been murdered.[119] Officials in Mississippi recognized that "[a] different approach was needed due to the deteriorating and dangerous environment."[120] In March 2013, a former gang member released from a Colorado solitary-confinement cell assassinated the Executive Director of the Colorado Department of Corrections. His successor, Rick Raemisch, said that the murder underscored the urgent need for reform of Colorado's use of solitary confinement. "Whatever solitary confinement did to that former inmate and murderer," Mr. Raemisch wrote, "it was not for the better."[121]

"Is [solitary confinement] really necessary? And is it necessary at the level of current use? And I think when you look critically at it, the answer is [that] we don't need these kinds of numbers of inmates in these kinds of high security settings, and we can better prepare them for release, because ninety-eight percent of our inmates are getting out."

—Commissioner of the Maine Department of Corrections Joseph Ponte[122]

"This is a message I deliver directly to my wardens. I say to them: 'Who wants to live directly next to someone who was just released from solitary confinement? Think about how dangerous that is.'"

—Executive Director of Colorado Department of Corrections Rick Raemisch[123]

Recognizing that solitary confinement endangers the public, many states are changing their ways. Between 2007 and 2012, Mississippi reduced its solitary-confinement population from one thousand prisoners to fewer than 150.[124] Maine cut the number of people in solitary cells in half between 2010 and 2012 and gave those who remained in solitary group recreation, counseling sessions, opportunities to earn more recreation through good behavior, and

118 *See* Testimony of Christopher Epps, *supra* note 67.
119 *See id.*
120 *See id.*
121 Rich Raemisch, *My Night in Solitary*, N.Y. Times, Feb. 20, 2014, at A25, *available at* http://www.nytimes.com/2014/02/21/opinion/my-night-in-solitary.html.
122 Stop Solitary: Maine's Commissioner of the Department of Corrections Joseph Ponte on Reducing His State's Solitary Confinement Population, *available at* https://www.aclu.org/prisoners-rights/stop-solitary-maines-commissioner-department-corrections-joseph-ponte-reducing-his (last accessed Sept. 5, 2014).
123 *See* Testimony of Rick Raemisch, *supra* note 74.
124 *See* Kupers, *supra* note 72, at 5.

Included in SCDC' 4.29.19 letter to LOC

greater access to radios, televisions, and reading materials.[125] In 2013, Illinois closed its supermax prison, Tamms Correctional Center.[126] Colorado reduced its population in solitary confinement by nearly sixty percent between 2011 and 2014.[127] In February 2014,Mr. Raemisch vowed to further reduce Colorado's solitary-confinement population,[128] and two months later the Colorado legislature passed a bill excluding people with serious mental illnesses from solitary confinement.[129] New York corrections officials agreed to new guidelines limiting the maximum length of time people should spend in solitary and eliminated the use of solitary confinement against the most vulnerable prisoners: juveniles, pregnant women, and people with developmental disabilities.[130] In August 2014, the California Department of Corrections took preliminary steps to revise its misguided use of solitary confinement by instituting policies to greatly reduce the number of mentally ill people in solitary confinement, improve mental-health treatment, and increase suicide-prevention measures.[131] Under the new measures, California will move 2,740 mentally-ill people out of solitary confinement.[132]

By reducing their use of solitary, states made their prisons safer and saved taxpayers millions of dollars. When Mississippi reduced its solitary-confinement population, violent incidents dropped by almost seventy percent,[133] and it saved taxpayers $5.6 million a year.[134] Mississippi still has one of the lowest recidivism rates in the country.[135] Incidents of violence in Maine's prisons dropped when it cut its solitary-confinement population in half.[136] By closing Tamms Correctional Center, Illinois saved taxpayers $26.6 million a year.[137]

---

125 *See* Am. Civ. Liberties Union of Me., *supra* note 73, at 13.
126 *See Tamms Supermaximum Security prison now closed*, Amnesty Int'l (Jan. 10, 2013), http://www.amnestyusa.org/our-work/latest-victories/tamms-supermaximum-security-prison-now-closed.
127 Testimony of Rick Raemisch, *supra* note 74.
128 *See* Allison Sherry, *Colorado corrections chief: I will reduce solitary confinement,* Denver Post, Feb. 25, 2014, http://www.denverpost.com/news/ci_25227021/colo-corrections-chief-i-will-reduce-solitary-confinement.
129 *See* Michael Muskal, *Colorado bans solitary confinement for seriously mentally ill,* L.A. Times, June 6, 2014, http://www.latimes.com/nation/nationnow/la-na-nn-colorado-mentally-ill-isolation-20140606-story.html.
130 *See* Benjamin Weiser, *New York State in Deal to Limit Solitary Confinement*, N.Y. Times*,* Feb. 19, 2014, at A1, *available at* http://www.nytimes.com/2014/02/21/opinion/new-york-rethinks-solitary-confinement.html.
131 *See* Erica Goode, *Federal Judge Approves California Plan to Reduce Isolation of Mentally Ill Inmates,* N.Y. Times, Aug. 29, 2014, at A11, *available at* http://www.nytimes.com/2014/08/30/us/california-plans-to-reduce-isolation-of-mentally-ill-inmates.html?_r=0.
132 *See id.*
133 *See* Kupers, *supra* note 72, at 7.
134 *See* Testimony of Christopher Epps, *supra* note 67, at 3.
135 *See id.*
136 *See* Tapley, *supra* note 73.
137 *See* Ill. Dep't of Corrections, Tamms Correctional Center Closing—Fact Sheet 142, *available at* http://cgfa.ilga.gov/upload/TammsMeetingTestimonyDocuments.pdf (last accessed Aug. 28, 2014).

Included in SCDC' 4.29.19 letter to LOC

SOLITARY CONFINEMENT INCREASES CRIME

Prisons should make our communities safer, but solitary confinement makes them more dangerous. Solitary confinement causes prisoners to develop lasting mental illnesses, destroys their ability to relate to others, tears apart their family safety nets, and deprives them of vocational, educational, rehabilitative, and religious programming. After subjecting people to years or decades of solitary confinement, TDCJ sets them free in Texas communities—where, impaired by their years of complete isolation, they commit crimes at higher rates than people released from the general population. Solitary confinement does more than cause lasting harm to the people confined there; it ultimately harms our communities.

Solitary Confinement Permanently Damages People Who Will One Day Return to Texas Communities

Solitary Confinement Causes Permanent Mental Deterioration

Solitary confinement can cause people's mental health to seriously deteriorate, creating or exacerbating psychiatric symptoms that persist long after their release and impede their ability to reintegrate to society. The medical consensus is that most human beings cannot withstand the prolonged isolation and sensory deprivation that solitary confinement entails, and our survey of people incarcerated in Texas prisons produced predictable results. Ninety-five percent of respondents to our survey had developed some sort of psychiatric symptom as a result of solitary confinement; thirty percent reported having oral or physical outbursts, fifty percent reported suffering from anxiety or panic attacks, and fifteen percent reported hallucinations.[138] Solitary confinement's impact on the human brain is as brutal as a traumatic physical injury; prisoners of war who spent six months in solitary confinement had abnormal brain-wave patterns months after their release.[139]

Studies document that people in solitary confinement are also at a higher risk of suffering from psychiatric disorders.[140] Dr. Stuart Grassian, one of the nation's leading

138 Data collected from survey of 147 people incarcerated in Texas prisons who previously spent time in or are currently in solitary confinement (on file with ACLU of Texas and TCRP).
139 *See* Atul Gawande, *Hellhole*, New Yorker, Mar. 30, 2009, http://www.newyorker.com/magazine/2009/03/30/hellhole.
140 *See* Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax" Confinement,* 49 Crime & Delinquency 124, 138-40 (Jan. 2003), *available at* http://www.supermaxed.com/NewSupermaxMaterials/Haney-MentalHealthIssues.pdf; Terry A. Kupers, *What to Do*

Included in SCDC' 4.29.19 letter to LOC

experts on the psychiatric effects of solitary confinement, found that many people in solitary confinement develop a unique psychiatric syndrome: They lose their capacity to think clearly or concentrate; lose their memory; hallucinate; have panic attacks; ruminate on obsessive thoughts of "revenge, torture, and mutilation of the prison guards"; get lost in paranoid delusions; and have poor impulse control.[141] These symptoms do not go away when people leave prison; they persist long after release, inhibiting the ability to adjust to normal life and reintegrate into the community.[142]

Summing up the research on solitary confinement's psychological impact, Dr. Terry Kupers, of the Wright Institute, writes that "it is very clear . . . that for just about all prisoners, being held in isolated confinement for longer than 3 months causes lasting emotional damage if not full-blown psychosis and functional disability."[143] In the words of a staff psychiatrist from a California state prison, "It's a standard psychiatric concept, if you put people in isolation, they will go insane. . . . Most people in isolation will fall apart."[144]

The psychological impact of Texas's solitary-confinement cells was documented by University of California professor Craig Haney when he served as an expert in the prisoners' rights case Ruiz v. Estelle.[145] Dr. Haney found that "high numbers of prisoners were living in psychological distress and pain" in Texas's solitary-confinement cells:

> I'm talking about forms of behavior that are easily recognizable and that are stark in nature when you see them, when you look at them, when you're exposed to them. In a number of instances, there were people who had smeared themselves with feces. In other instances, there were people who had urinated in their cells, and the urination was on the floor. . . . There were many people who were incoherent when I attempted to talk to them, babbling, sometimes shrieking, other people who appeared to be full of furyand anger and rage and were, in some instances, banging their hands on the side of the wall and yelling and screaming, other people who appeared to be simply disheveled, withdrawn and out of contact with the circumstances or surroundings. Some of them would be huddled in the back corner of the cell and appeared incommunicative when I attempted

---

with the Survivors? Coping With the Long-Term Effects of Isolated Confinement, 8 Crim. Just. & Behav. 1005, 1005-06 (2008), *available at* http://www.nrcat.org/storage/documents/usp_kupers_what_do_with_survivors.pdf.

141 *See* Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 Wash. U.J.L. & Pol'y 325, 335-36 (2006).

142 *See id.* at 333.

143 Kupers, *supra* note 140, at 1005-06.

144 Human Rights Watch, Ill-Equipped: U.S. Prisons and Offenders with Mental Illness 19 n.512 (Oct. 2003), *available at* http://www.hrw.org/node/12252/section/19#_ftnref513.

145 *See* Ruiz v. Johnson, 37 F. Supp. 2d 855, 908-09 (S.D. Tex. 1999), *rev'd on other grounds,* 243 F.3d 941 (5th Cir. 2001), *adhered to on remand,* 154 F. Supp. 2d 975 (S.D. Tex. 2001).

Included in SCDC' 4.29.19 letter to LOC

to speak with them. Again, these were not subtle diagnostic issues. These were people who appeared to be in profound states of distress and pain...

The bedlam which ensued each time I walked out into one of those units, the number of people who were screaming, who were begging for help, for attention, the number of people who appeared to be disturbed, the existence, again, of people who were smeared with feces, the intensity of the noise as people began to shout and ask, Please come over here. Please talk to me. Please help me. It was shattering. And as I discussed this atmosphere with the people who worked here, I was told that this was an everyday occurrence, that there was nothing at all unusual about what I was seeing.[146]

"Families of these individuals [placed in solitary confinement] are faced with monumental challenges in helping their loved one's adapt to life on the outside. . . . We should never lose sight of a person's humanity and their need for family and human contact. Developing pro-social services and strengthening family relationships within prison walls is paramount to public safety—both inside and outside prison fences. "

—Jennifer Erschabek, Executive Director of Texas Imate Families Association.[149]

The federal judge presiding over the Ruiz case wrote that Texas's solitary-confinement cells "are virtual incubators of psychoses—seeding illness in otherwise healthy inmates."[147] Based on the psychological effects of solitary confinement, the judge determined that Texas's solitary-confinement cells constituted cruel and unusual punishment in violation of the Eighth Amendment of the United States Constitution.[148]

146 *Id.* at 909-10.
147 *Id.* at 907.
148 *See id.* at 914-15.
149 E-mail from Jennifer Erschabek, Executive Director, TIFA, to Matthew Simpson, Policy Strategist, ACLU of Texas (July 14, 2014, 07:56 CST) (on file with ACLU of Texas and TCRP).

Included in SCDC' 4.29.19 letter to LOC

Solitary Voices

"Everyday from dusk to dawn theres noise, banging, clanking, yelling, screaming. Everyday someone is getting hurt or hurting themselves. Everyday theres fire and floods and complete chaos & hate. Everyday there's loneliness. I woke up last night to someone screaming 'Let Me Out of Here' (again) over and over with so much anguish there was no doubt he was **screaming from his very soul.** But he was just screaming what we are all thinking. Everyday is a challenge here. **A challenge against insanity.**"[150]

"Felt isolated, withdrew from people socially; clean, organize, obsessively, hand wash, felt despair, felt disoriented/confused, panic, couldn't sleep until exhausted. Bad dreams, see **something on walls moving but nothing there.**"[151]

"**Now I know how the caged animal must feel** and why it paces the way it does. I feel so angry at times and I pace this cell for hours trying to get my thoughts and feelings under control. I feel suffocating feelings and have anxiety attacks that I feel are going to kill me sometimes—heart attack. **I sometimes see things in this cell like ghosts flitting around the floor & walls**. I can't sleep for days at time and the officers count every hour and most of them bang on your door, shine their lights in your face and make you get up and show them you I.D. card—tell you make sure you are alive. I get so angry I cuss, kick the door & walls and lose any self control I have and I actually start to think about really ending this torment—I sometimes sleep so much I lose track of days at a time—sometimes several. That's when I really feel disoriented/confused/afraid."[152]

150 Alex's Journal, *supra* note 26 (entry dated July 29, 2014).
151 Survey response from Anna, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP).
152 Survey response from Nathan, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP).

Included in SCDC' 4.29.19 letter to LOC

Sergio's Story

TDCJ sent Sergio to solitary confinement when he was nineteen years old. During his three and a half years in solitary confinement, Sergio had virtually nothing to do. Every day, he would wake up when breakfast was served, usually at three or four o'clock in the morning. Then he would listen to the radio for four to five hours, and work out in his cell. Although he could not watch television, Sergio rigged his radio so he could listen to television shows like Fox News, Anderson Cooper, *Dateline, Everybody Loves Raymond*, and *Seinfeld.* (Under prison regulations, he was not allowed to rig his radio that way; he just tried not to get caught.) He would eat lunch at ten o'clock, and then listen to more radio or read. His favorite books were *Tuesdays with Morrie*, which he loved "because it's about a guy who talks to his friend once a week about life lessons, success and marriage," and *The Time Traveler's Wife*. He would play chess with other prisoners by drawing out a chess board, numbering it, and then calling out his moves to people in other cells. At four in the afternoon, Sergio would have dinner, and at 8:00 p.m. officers would distribute the mail; he received a letter from his family a couple of times a month.

In January 2014, Sergio finally got out of solitary confinement. We met with Sergio in May. Although Sergio was scheduled to be released from prison in eight months, he felt damaged and unprepared for the real world after his time in solitary. Sergio said that he is not "comfortable being around people" and does not go to the recreation room. He prefers to stay in his cell and obsessively tries to order everything perfectly there because "if it ain't right, I get agitated." Before he was in solitary confinement, Sergio says, "I used to be a people person and like being around people." But, Sergio says "it's weird after three years back there" in solitary confinement. Now, he doesn't like "having other people being close to me" and says that "stuff gets balled up inside" of him.[153] ■

153 Interview with Sergio, individual incarcerated in TDCJ (May 28, 2014) (on file with ACLU of Texas and TCRP).

Included in SCDC' 4.29.19 letter to LOC

Solitary Voices

"I have difficulty talking to people now and I feel paranoid at times in my cell—I see shadows and I'v started to hear **voices whisper my name** the last couple of years in my cell . . . feel closed in!"[154]

"**I am an honorably discharged combat veteran diagnosed with PTSD**, anxiety disorder, panic disorder, etc. Isolation is torture. There can be no other word for it. 'Isolation' simply means you are single-celled. You are not removed from the effects of other inmates' extreme behavior resultant from ad seg. People flood the areas by plugging toilets. Fires are routinely started so you wake in the middle of the night choaking on black smoke. Electricity gets turned off. People scream, yell non-sensical gibberish all night. They bang doors 24 hours. . . ."[155]

154 Survey response from Greg, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP).
155 Survey response from Pedro, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP).

Included in SCDC' 4.29.19 letter to LOC

Letter From Alex

"When you dive deep in the ocean and when you go to make your ascension, it's very important to make stops to calibrate your air. You can't just swim to the surface. If a diver rushes to the surface too fast, they put themselves in serious risk of injury (called "the bend"). In some cases it can be fatal if the diver cannot go immediately back down and start over, or be rushed to a hyperbaric chamber. . . .

"Coming out of my cell feels like I've gone to the surface too fast. When the doors roll, everything is amplified. Nerves are cranked to 10. Lights are too bright. A mop bucket being pushed by an S.S.I. sounds like a mid-day freight train with horns blaring. It's hyper-sensitivity on the grandest scale, with the feeling like the whole world is watching. . . .

"I'm a people person. Before I came here I was outgoing, very social. Maybe even too much the life of the party. And I hate this cell, I hate it. But in some crazy way as much as I enjoyed our meeting and its purpose, a part of me couldn't wait to get back to my cell. In one big haste to return to the very same place that cause it. My cell is my hyperbaric chamber.

"T.D.C.J., as well as I'm sure all prison systems, will claim that ad. seg. is not a punishment in itself. But the system puts an even greater burden on the segregated inmate being released. Since there's no available programming for substance abuse (AA, NA) or groups to address Anger Management like you may find in the general population. If you're released on parole or released period, an ad. seg. inmate not only has to struggle with the issues they had going into prison. The isolated ad. seg. inmate has to deal with the adverse symptoms caused by the prison itself.

"I feel fortunate because I recognize these things. While I'm in no way suggesting I'll have it easier than the next man when I leave here. I'm looking forward to the challenge, I'm looking to the day I'll leave this cell for the last time and slowly make my way to the top.[156] ■

156 Letter from Alex to authors (May 30, 2014) (on file with ACLU of Texas and TCRP).

Included in SCDC' 4.29.19 letter to LOC

Solitary Voices

"Being secluded to a small cell 23 hours a day-plus affects every sane individual in one way or another. A person has to yell just to socialize. To those who are not socializing, it **is a constant cacophony of noise—constant**! A person is affected negatively in every way![157]

"In another state of mind. You could not tell day from night. You were always backward. Sleep all day stay up all night. No light coming in the building. **You be lost**."[158]

"It **dehumanizes** you and causes a enmity in you against staff and feelings of worthlessness and despair."[159]

Isolation Erodes People's Capacity to Interact with Others

Solitary confinement damages people's ability to relate to other human beings. It erodes the social skills people need to raise children, support their spouses, help aging parents, participate in their communities, cooperate with neighbors, and hold down jobs.

Prisoners in solitary confinement are always alone. They live in a cell alone. They go to the recreation yard alone. They eat alone. For weeks, they do not see another person's face. To speak to anyone else, even a person in a neighboring cell, they must shout through the cell walls. The only time they touch another human being is when a correctional officer places handcuffs on their wrists to take them to the recreation yard.

Stripped of all social contact for years at a time, their capacity to relate to human beings decays.[160] In the words of Dr. Grassian, people in solitary confinement suffer from "a continued intolerance of social interaction" even after their release.[161] Dr. Grassian has had the opportunity to evaluate people years after their release from solitary confinement.[162] He says that "these individuals had become strikingly socially impoverished and experienced intense irritation with social interaction, patterns dramatically different from their functioning prior to solitary confinement."[163] As Dr. Haney describes, the lack of contact creates a "pervasive feeling of unreality," which causes people to "experience a paradoxical reaction, moving from initially being starved

157 Survey response from Will, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP).
158 Survey response from Charles, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP).
159 Survey response from Andy, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP).
160 *See* Haney, *supra* note 140, at 138-40.
161 Grassian, *supra* note 141, at 333.
162 *See id.* at 354.
163 *Id.*

Included in SCDC' 4.29.19 letter to LOC

for social contact to eventually being disoriented and even frightened by it."[164] In our survey, fifty-nine percent of respondents reported that they had "difficulty interacting with other people" as a consequence of their time in solitary.[165]

Indeed, many of the symptoms of mental and emotional damage caused by solitary confinement impair normal human interaction:

> Consistent patterns emerge, centering around . . . extreme anxiety, anger, hallucinations, mood swings and flatness, and loss of impulse control. In the absence of stimuli, prisoners may also become hypersensitive to any stimuli at all. Often they obsess uncontrollably, as if their minds didn't belong to them, over tiny details or personal grievances. Panic attacks are routine, as is depression and loss of memory and cognitive function.[166]

Solitary confinement also causes "significantly increased negative attitudes and affect, irritability, anger, aggression and even rage."[167] People are thus rendered incapable of resuming the normal familial and community relationships that are essential to successful reentry. According to Dr. Kupers, the inevitable result of confinement in solitary is the "decimation of life skills" because it "destroys one's capacity to relate socially, to work, to play, to hold a job or enjoy life."[168]

Yet eventually, TDCJ sends these damaged people back to Texas communities. After years in solitary confinement, they are unprepared to resume the roles society expects of them: as parents, spouses, employees, and neighbors.

---

164 *See Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences: Hearing Before the Senate Judiciary Committee's Subcommittee on the Constitution, Civil Rights and Human Rights,* 112th Cong. (June 19, 2012) (testimony of Craig Haney, Prof. of Psychology, Univ. of Ca. Santa Cruz), *available at* http://www.judiciary.senate.gov/imo/media/doc/12-6-19HaneyTestimony.pdf.
165 Data collected from survey of 147 people incarcerated in Texas prisons who previously spent time in or are currently in solitary confinement (on file with ACLU of Texas and TCRP).
166 Brandom Keim, *The Horrible Psychology of Solitary Confinemen*t, Wired, July 10, 2013, http://www.wired.com/2013/07/solitary-confinement-2/.
167 *See* Testimony of Craig Haney, *supra* note 164.
168 Keim, *supra* note 166.

Included in SCDC' 4.29.19 letter to LOC

Solitary Voices

"Being enclosed for so long just looking at **4 walls, a toilet and metal bars is all I look at 24 hours a day,** so when and if I go to visitation, my dad says I cant stop looking around. And when I come back to my cell I get depressed to have to go thru it all again being away from any & everything & my family."[169]

"[Solitary confinement] makes one lose self of all humanity as we are **treated worse then animals in a kennel** feels suffocating like walls are closing in makes one lose sense of reality."[170]

"[T]his is a dark sad cut off place, no people interaction, no one to talk to & rec with. **You go crazy just wanting someone to talk** to or play dominos with some times, or just to talk about things with, everything keeps you isolated from others some times for years & years at a time! **How can you isolate a man that long & expect him to have good/acceptable social/people skills when hes released to gen. pop. or the free**?"[171]

"It is becoming harder to deal with real life problems. Mainly because I feel suspended in time. **No human contact.** Very little human interactions."[172]

Solitary Confinement Severs Family Bonds

TDCJ should support incarcerated people in maintaining family bonds, but solitary confinement severs those bonds. Strong family bonds can help prisoners successfully reintegrate into society; people in prison who receive visits from their family members are thirty percent less likely to commit new crimes than those who never received a visit.[173] Yet solitary confinement interferes with family bonds by limiting families to a "no-contact visit," during which prisoners are separated from their family members by a pane of glass or metal mesh.[174] People in solitary confinement cannot hold their family member's hand or hug them goodbye. "The contact visit means everything," says Jennifer Erschabek, Director of the Texas Inmate Families Association (TIFA), a non-profit organization that advocates for the family members of people incarcerated in Texas prisons. "That little interaction is so appreciated by the guys. And you can feel it

169 Survey response from George, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP).
170 Survey response from Chris, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP).
171 Survey response from Richard, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP).
172 Survey response from Ignacio, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP).
173 *See* William D. Bales & Daniel P. Mears, *Inmate Social Ties and the Transition to Society: Does Visitation Reduce Recidivism?*, 45 J. Res. Crime & Delinq. 287, 304-05 (2008).
174 TDCJ Administrative Segregation Plan, *supra* note 19, at att. A.

Included in SCDC' 4.29.19 letter to LOC

in the hug."[175] The restrictions on people in solitary confinement add further trauma to family members; they may drive a full day across Texas to visit their son, only to see him in a glass cage and speak to him through a telephone.[176] At the most restrictive level of solitary confinement, prisoners can only visit with their family once a month—far less than people in the general population.[177] People in solitary confinement also cannot call their family members, which is often their only way to maintain ties with loved ones who are too far away or cannot afford to visit. TIFA knows firsthand that solitary confinement profoundly impairs family bonds. For a person placed in solitary confinement for even the average length of almost four years, TIFA says, it is "almost impossible for that person to remain in meaningful contact with their family and other members of their support network."[178] Solitary confinement cuts away the interpersonal safety net that people need to support their transition back to life in the outside world.

Lori and Frank

Lori and Frank's love story epitomizes how solitary confinement prevents prisoners from accessing the family and religious support they need to rehabilitate. Lori met her husband, Frank, when she was fourteen and he was sixteen. "I felt in love the first moment he smiled at me," she recollected. Frank has been in solitary confinement since 2003. Lori does everything she can to support her husband. She drives to see him every week—125 miles each way—to visit with him through a pane of glass. She writes prolifically to him, and he writes to her; when we spoke, she had just received letter 395 from Frank. Lori reconnected her husband with his estranged sister, who has visited him three times in the last several months. To show Frank love and support, she tracked down Frank's childhood friends and took them with her on her weekend visits.

Faith has played a central role in Lori and Frank's relationship. "He is a huge person of faith," Lori said of her husband. "Over the years, he's recognized that God is working in him and refining him, and he definitely has some things to be fixed in his life. He believes that God created both of us as spirit mates together." God is a central focus of their meetings and letters. "We talk about

175 E-mail from Erschabek to Simpson, *supra* note 149.
176 *See id.*
177 TDCJ Administrative Segregation Plan, *supra* note 19, at att. A.
178 E-mail from Erschabek to Simpson, *supra* note 149.

Included in SCDC' 4.29.19 letter to LOC

God, we write about God, we write about us having faith with each other," Lori explained. "And as implausible as it is, my pastor, our friends, our families, are in constant prayer that those walls are gonna fall down."

Yet rather than nurture the seeds of Frank's faith, TDCJ places many limitations on his religious practice. "Faith plays a part in our relationship," Lori told us. "But Frank has no ability for faith to play a part in what he does. He has never seen a chaplain set foot in [the solitary-confinement unit]." Lori knows a woman whose husband is imprisoned in general population; the woman participates in a guided Bible study with her husband every week. Lori has no such opportunity to study the Bible with her husband under the guidance of a pastor. And her husband cannot attend religious services, like people in general population can. "We're gonna figure out a way to get him home," Lori says. "Until then, it would certainly be nice if he could go to a church service."

"From the year 2000, in April, when my stepson went into [solitary confinement], the next time his mother was able to touch him was in 2010. . . . In other words, there is no ability to hug each other—you can have no physical contact with that individual if they are in [solitary], period. From a mother's perspective, that's heartbreaking. The fact that you can't hug periodically."[180]

Lori wishes she could speak to her husband on the phone or hold his hand during their visits. "Human touch is so restorative, and he deals with negativity 24/7, and that two hours we have every weekend, he calls it his 'charging up time,'" she explained. "To be able to hold hands, and connect without the glass—I'm pretty darn strong, but just being able to hold his hand so he felt the connection, so he can be strong for what he has to endure in there." Lori started to cry when she recounted what it would mean to her and Frank to be able to hold hands once a week. "I wouldn't care what hoops I would have to go through to have a contact visit with my husband," she said. "I would do whatever they wanted me to. Even if had to be in a separate room, with his leg chained to the floor, whatever they have to do, I would be willing to. . . . It would make such a difference for him to endure what he has to endure to pay his debt to society. . . . And I could endure, too. Because I am in there with him."[179] ■

179 Telephone interview with Lori, family member of individual incarcerated in TDCJ (Sept. 23, 2014).
180 Telephone interview with Robert, family member of individual incarcerated in TDCJ (Sept. 17, 2014).

Included in SCDC' 4.29.19 letter to LOC

TDCJ Deprives People in Solitary Confinement of All Opportunities for Self-Improvement

Solitary confinement forces people into lives of complete idleness, depriving them of any opportunity for self-improvement. TDCJ excludes people in solitary confinement from all rehabilitative programs—programs designed to prepare people for life in the outside world.[181] They cannot take group courses to earn their G.E.D. or associates' degree to support a future career.[182] They cannot work in a prison job to pass their hours productively.[183] They cannot learn a trade that could help them one day meet their responsibilities as breadwinners for their families.[184] Seventy percent of respondents to our survey professed adherence to a religion;[185] yet people in solitary confinement cannot practice their faith with others and receive the many educational, moral, and spiritual benefits of collective worship.[186] Although over sixty-five percent of people in solitary confinement have an addiction,[187] they cannot join recovery programs like Alcoholics Anonymous.[188] They cannot learn how to manage their anger by receiving group counseling.[189] They cannot watch television to keep up with the news.[190] TDCJ makes it impossible for people to use their time in prison productively. Instead, it confines them in cells to waste away. Dr. Haney observed that many people in isolation "lose the ability to initiate or to control their own behavior" because they are stripped of all ability to meaningfully direct their lives.[191]

181 TDCJ Administrative Segregation Plan, *supra* note 19, at att. A.
182 *See id.*
183 *See id.*
184 *See id.*
185 Data collected from survey of 147 people incarcerated in Texas prisons who previously spent time in or are currently in solitary confinement (on file with ACLU of Texas and TCRP).
186 TDCJ Administrative Segregation Plan, *supra* note 19, at att. A.
187 Letter from TDCJ, *supra* note 5.
188 TDCJ Administrative Segregation Plan, *supra* note 19, at att. A.
189 *Id.*
190 *Id.*
191 Haney, *supra* note 140, at 139.

Included in SCDC' 4.29.19 letter to LOC

Solitary Voices

"That's the difference between [solitary confinement] and general population. Theres no structure. In GP unless your medically unassigned your gonna work, if you want to shower you have a certain time. If you want to eat you got to be there. Theres school. Theres church. There's commissary. Theres medical. Theres laundry. Like in the freeworld if you want something you have to go and get it. That's how GP is. . . . Im saying theres structure and a sense of living that comes with accountability and responsibility. . . . In [solitary confinement] . . . .Everything is brought to you. Theres no responsibility, no purpose no schedule forced upon you. **No reason to get up and live.** You get out of your cell for rec, medical, visit, or death."[192]

"[Solitary confinement] has been the reason I've really & **truly never gotten any true rehabilitation** in getting rid of these problems that have made me so aggressive!"[193]

"**My mental illness has worsened** because as a ad-seg category ... prisoner, I am not allowed to attend my alcohol anonymous/narcotic anonymous, religion study class, chapel library session to help me stay occupied and balanced. I was also taken out of school and vocation trade masonry brick laying."[194]

The Consequence of Overusing Solitary is More Crime in Texas Communities

When it permanently scars Texas prisoners, TDCJ ultimately damages our communities. Solitary confinement increases recidivism. As a group, people released directly from Texas's solitary-confinement cells every year—1,243 in 2013 alone—commit more new crimes than people released from the general population.[195] Of all prisoners released from Texas prisons in 2006, 48.8 percent were rearrested within three years,[196] whereas 60.8 percent of people released from solitary confinement were rearrested within that same time period.[197]

Moreover, studies from other states show that solitary confinement increases crime. In California, preliminary data suggests that people released on parole from solitary-

192 Alex's Journal, *supra* note 26 (entry dated June 5, 2014).
193 Survey response from Carlos, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP).
194 Survey response from Andy, *supra* note 159.
195 Letter from TDCJ, *supra* note 5.
196 *See* Legislative Budget Board, *supra* note 58, at 35.
197 Letter from TDCJ to Rodney Ellis, *supra* note 59; E-mail from Sinclair to Butler, *supra* note 58.

Included in SCDC' 4.29.19 letter to LOC

confinement cells recidivate at a thirty-five percent higher rate than parolees from the overall prison system.[198] And a 2007 study of 1,205 people released from federal prisons found that harsher prison conditions increased rearrest rates after release.[199] People who had spent time in Florida solitary-confinement cells committed new violent crimes at an eighteen percent higher rate.[200] In Washington State, people released directly from solitary committed new felonies at a thirty-five percent higher rates than their peers released from general population, even when controlling for common predictors of recidivism.[201]

"[W]e are releasing inmates into our communities every day, who have spent years in solitary conditions with little or no treatment to correct the behavior which lead to their incarceration in solitary conditions."

—Lance Lowry, President AFSCME Local 3807, Texas Correctional Employees[202]

TDCJ's short re-entry programs cannot erase the social and mental deterioration caused by years of isolation. TDCJ now provides a handful of re-entry programs to help some prisoners readjust to ordinary life before their release from solitary confinement. For example, the Serious and Violent Offender Reentry Initiative (SVORI) gives people seven months of in-cell programs designed to help them manage their anger, reduce "thinking errors," teach them about employment, and prevent substance abuse.[203] The Administrative Segregation Pre-Release Program (ASPP) provides people with ninety days of instruction through workbooks they can fill out in their cell, instruction via a computer monitor from a remote instructor, and weekly one-hour meetings with case managers to discuss rehabilitative opportunities in the outside world.[204] While more programming should always be encouraged, a few months of in-cell workbooks or computer instruction cannot repair the destruction caused by years or decades of sensory deprivation and social isolation. Moreover, these programs have limited capacity and therefore can only serve a small handful of the people who could benefit from them. For example, the SVORI program can only accommodate sixty-three people at once,[205] and ASPP can only accommodate less than two hundred people.[206] TDCJ should provide rehabilitative programming throughout people's time in prison—not just as a Band-Aid solution a few months before their release into the outside world.

198 *See* Reiter, *supra* note 60, at 50.
199 *See* M. Chen & Jesse M. Shapiro, *Do Harsher Prison Conditions Reduce Recidivism? A Discontinuity-based Approach*, 9 Am. Law & Econ. Rev. 1, 3, 8, 23-24 (2007).
200 *See* Mears & Bales, *supra* note 62, at 1151.
201 *See* Lovell et al., *supra* note 61, at 644.
202 *See* Testimony of Lance Lowry, *supra* note 68.
203 Letter from TDCJ, *supra* note 9.
204 *See New Pre-release Program Serves Administrative Segregation Offenders,* Crim. Just. Connections (Nov./Dec. 2012), *available at* http://www.tdcj.state.tx.us/connections/NovDec2012/agency_vol20no2.html.
205 SVORI Fact Sheet (July 2013) (on file with ACLU of Texas and TCRP).
206 Administrative Segregation Pre-Release Program Fact Sheet (July 2013) (on file with ACLU of Texas and TCRP).

Included in SCDC' 4.29.19 letter to LOC

TEXAS OVERUSES SOLITARY AT TREMENDOUS COST TO TAXPAYERS

Contrary to the trend nationwide to reduce the population confined in solitary, TDCJ overuses solitary confinement on people who pose no threat, while Texas taxpayers foot the bill. TDCJ could save taxpayers tens of millions of dollars each year by lowering its use of solitary confinement to Mississippi's level of 1.4 percent.

Solitary Confinement Costs Texas Taxpayers at Least $46 Million a Year

Texas taxpayers currently spend an extra $46 million or more each year to house 6,564 prisoners in solitary confinement instead of general population. Solitary confinement is more expensive than regular housing: It costs forty-five percent more than housing the same person in general population, or $61.63 per person per day compared to $42.46 per person per day.[207] The solitary-confinement units require more staff to maintain security and deliver services; moreover, people in solitary confinement are single celled, such that TDCJ must operate more cells in order to house them.[208] Indeed, the actual cost of solitary confinement is likely much higher, as this estimate fails to capture expenses that are difficult to measure or not borne by the prison system itself. Hidden costs include stress on correctional officers, weakened family relationships, and reduced ability to function in the world outside TDCJ. And Texas taxpayers unquestionably spend more money when people return to prison after their release because their time in solitary confinement created or exacerbated anti-social behaviors and mental illnesses.

Given the fiscal implications for taxpayers, TDCJ should approach housing decisions with the mindset of using solitary confinement as rarely as possible. TDCJ should send people to solitary confinement only when necessary to maintain safety and order; and it should regularly and thoroughly review the placement of individuals in solitary confinement with the intention of removing them as soon as it is possible to do so safely.

207 *See* Crim. Just. Policy Council, *supra* note 66, at 12.
208 *See* Daniel P. Mears, Evaluating the Effectiveness of Supermax Prisons 35 (Jan. 2006), *available at* https://www.ncjrs.gov/pdffiles1/nij/grants/211971.pdf.

Included in SCDC' 4.29.19 letter to LOC

Texas Overuses Solitary Confinement

Unfortunately, TDCJ is trapped in the outdated and expensive mindset of using solitary confinement as a routine correctional practice. TDCJ houses 4.4 percent of Texas prisoners in solitary confinement, much higher than the estimated national average of one to two percent.[209] And prisoners remain in solitary-confinement cells for an average of almost four years,[210] indicating that TDCJ makes little effort to return people to general population as soon as they cease to pose a threat. TDCJ could save taxpayers $31 million dollars a year just by lowering its population in solitary confinement to Mississippi's rate of 1.4 percent.[211] TDCJ could reduce its solitary-confinement population while still preserving prison safety: Mississippi had seventy percent fewer violent incidents in its prisons when it reduced its solitary-confinement population from one thousand to 150.[212]

TDCJ houses too many people in solitary confinement in part because its standard is overbroad, capturing many people who could be safely housed in general population. TDCJ automatically houses 3,194 people[213] in solitary confinement on the grounds that they "associate[e] or affiliate[e]" with a gang.[214] Gang status alone—divorced from individual misbehavior or active participation in gang activities—is not a threat to prison safety. Security expert Steve Martin—a former TDCJ correctional officer who served as TDCJ Legal Counsel from 1981-83 and TDCJ General Counsel from 1983-85—explains that using gang affiliation alone ends up "catching folks that don't really need segregated confinement; their status as a gang member is not in and of itself a threat."[215] Isolating suspected gang members or affiliates is an extreme overreaction that fails to improve prison safety and actually may undermine it. In a survey of wardens and superintendents of adult prisons in forty-eight states conducted by the National Gang Crime Research Center (NGCRC), over half of the respondents said that "no human contact status" was not "effective for the control of gang members."[216] Toni V. Bair, former warden of Virginia's death row, describes Texas's practice of automatically segregating gang members as "the antithesis of what modern correctional professional classification management is supposed to be about. . . . That's not twentieth century corrections—that's eighteenth century corrections."[217] Mr. Bair emphasizes that the entire purpose of classifying people in prison is to "find out what the needs are so you

---

209 *See* Austin & Sparkman, *supra* note 64, at 17.
210 Letter from TDCJ, *supra* note 9.
211 *See* Testimony of Christopher Epps, *supra* note 67.
212 *See* Kupers et al., *supra* note 72, at 5, 7.
213 E-mail from TDCJ Office of the General Counsel to Butler, *supra* note 108.
214 TDCJ Security Threat Group Plan, 5-6 (Jan. 2012) (on file with ACLU of Texas and TCRP).
215 Telephone Interview with Steve Martin, Security Expert and Former General Counsel, TDCJ (June 13, 2014).
216 George W. Knox, The Problem of Gangs and Security Threat Groups (STG's) in American Prisons and Jails Today: Recent Findings from the 2012 NGCRC National Gang/STG Survey (2012), *available at* http://www.ngcrc.com/corr2012.html.
217 Telephone Interview with Toni V. Bair, former Warden, Virginia death row (Sept. 30, 2014).

Included in SCDC' 4.29.19 letter to LOC

can habilitate them, and to better manage your inmate population"; when correctional departments automatically place people in solitary confinement, Mr. Bair says, "you miss so many people coming in that we could have helped, such as suicidal inmates, mentally ill inmates, and inmates with alcohol and drug problems."[218] TDCJ should send people to solitary confinement only if they pose an actual danger to officers or other inmates as demonstrated through their actions. Instead, it isolates thousands of people who do not actually present a security risk, such as low-level or inactive gang members who behaved peacefully within prison.

Most inmates confined in solitary spend years there.

Moreover, once people are confined to solitary for gang affiliation, TDCJ does little to shorten their stay. These prisoners can only get out of solitary confinement by participating in the Gang Renouncement and Disassociation Process (GRAD), which provides nine months of programming on substance abuse, alcohol abuse, group classroom instruction, anger management, and criminal-addictive behavior.[219] While the GRAD program is a useful avenue to help people return to general population, it does not resolve the underlying problem that TDCJ sends too many people to solitary confinement in the first place. Moreover, people must go through a probationary period of one year in solitary confinement to even qualify for the program.[220] The long wait, combined with too few spots in the GRAD program, creates a bottleneck that traps people in solitary for far too long. As the GRAD program itself only has a capacity to hold 180 people at any one time,[221] it would take over twelve years for every eligible person to enter the program and be diverted from solitary. As a consequence, people affiliated with a gang spend on average over five years in solitary confinement.[222]

218 *See id.*
219 TDCJ Gang Renouncement and Disassociation Process (GRAD) Program Description (on file with ACLU of Texas and TCRP).
220 E-mail from William Stephens, Director, Correctional Institutions Division, TDCJ, to Jorge Renaud, Texas Criminal Justice Coalition (Sept. 12, 2014, 12:01 CST).
221 TDCJ Administrative Segregation Information Sheet, *supra* note 1, at 1.
222 E-mail from TDCJ Office of the General Counsel to Butler, *supra* note 108.

Included in SCDC' 4.29.19 letter to LOC

A solitary confinement cell on Texas death row.

The Texas Comptroller of Public Accounts—"the chief steward of the state's finances"[223]—has condemned TDCJ's policy of automatically isolating gang members in solitary-confinement cells who could be more cheaply housed in a lower security setting. The Comptroller conducted a public study of Texas's use of solitary confinement in 1994, sampling 131 prisoners. He discovered that fifty-four of them—forty-one percent—had no prison record of disciplinary assaults, meaning that they did not present a security risk to the safety of correctional officers or other prisoners.[224] The Texas Comptroller also criticized TDCJ's policy of "warehousing gang members" because it "prevents them from receiving any rehabilitative treatment"; he found no reason that the gang members could not be double celled, work, and take group classes.[225] The Comptroller observed that solitary-confinement cells should be exclusively used for "the most difficult inmates."[226] TDCJ failed to implement the Comptroller's recommendations.

Other states use more appropriate measures to identify gang members who pose an actual threat. Colorado amended its statute to limit its use of solitary confinement against gang members to situations where it is necessary to maintain safety, for example, when a person "actively participates in disruptive" gang behavior.[227] Mississippi limits solitary confinement to people who have attempted an escape, committed a serious infraction, or are active, high-level members of a gang.[228] Virginia houses gang members in solitary confinement only if they commit certain offenses tied to gang activity, or serve in a "documented" leadership role.[229] Washington does not automatically isolate gang members; instead, it employs an "Operation Ceasefire" model that restricts the privileges of individuals and groups who commit serious violent infractions.[230] With the use of "Operation Ceasefire," violent infractions dropped by fifty percent.[231]

223 *See About Us: Meet Texas Comptroller Susan Combs*, Tex. Comptroller of Pub. Accounts, http://www.window.state.tx.us/about/ (last visited Sept. 2, 2014).
224 *See* Sharp, *supra* note 103, at 78.
225 *Id.*
226 *Id.*
227 Colo. Rev. Stat. § 17-1-109; *see* 2011 Colo. Sess. Laws 176.
228 *See* Kupers et al., *supra* note 72, at 5.
229 Va. Dep't of Corrections Operating Procedure: Security Level Classification 830.2, at 8 (Jan. 1, 2012; Amended June 6, 2014).
230 Washington State Dep't of Corrections, Operation Place Safety: First Year in Review 2-3 (May 28, 2014), *available at* http://nnscommunities.org/uploads/Operation_Place_Safety_First_Year_Report_2014.pdf.
231 *See id.*

Included in SCDC' 4.29.19 letter to LOC

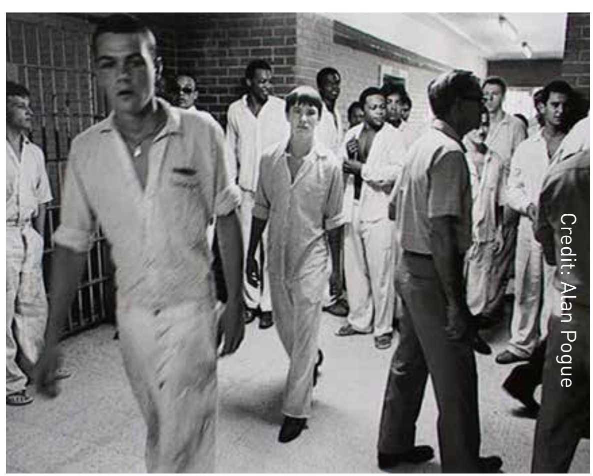
Tom's Story

TDCJ demonstrated the irrationality of its addiction to solitary confinement recently when it condemned a prisoner to more time in isolation for growing a five o'clock shadow. Tom is twenty-four years old; he has been in solitary confinement for forty-one months. TDCJ sent Tom to solitary confinement because it believed he was a member of the Aryan Brotherhood, though Tom claims that he is not. Tom was on the waiting list for the GRAD program, his only avenue to get out of solitary, but he was recently kicked off the list for not shaving. TDCJ policy forbids all facial hair; but Tom was only permitted to use a razor when he showered. When Tom missed his chance to shower, TDCJ determined that his "scruff" violated TDCJ policy—a policy that bears no connection to gang activity, and represents no security threat. On account of that minor infraction, he was sent to the bottom of the waiting list for participation in the GRAD program.[232] ■

232 Interview with Tom, individual incarcerated in TDCJ (June 26, 2014).

Included in SCDC' 4.29.19 letter to LOC

TDCJ INCREASES PRISON VIOLENCE BY OVERUSING SOLITARY CONFINEMENT



Hunstville Unit.

Solitary confinement increases violence in Texas prisons. Trapped in solitary confinement with no social contact and no programming, people become increasingly aggressive and disturbed—and more difficult to control.

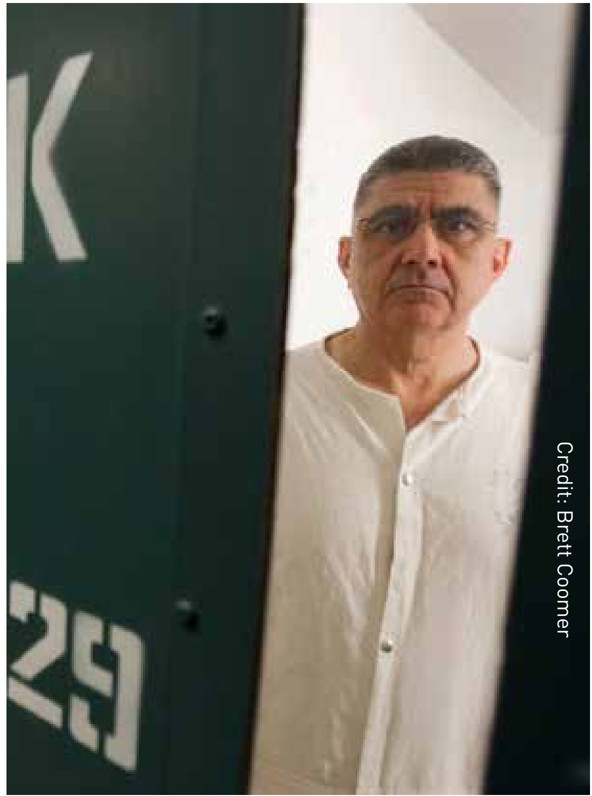
Solitary Confinement Makes Texas Prisons Less Safe

Serious assaults on Texas prison staff have increased 104 percent during the last seven years.[233] Texas's largest correctional officers union attributes the increase in violence in part to TDCJ's overuse of solitary confinement and practice of housing mentally ill people in solitary.[234] Lance Lowry, president of the union, says that solitary confinement "creates a different individual, it really does—socially, psychologically. It is the equivalent of locking a kid in a closet. It's not going to fix a lot of problems."[235] In 2013, almost eighty percent of the 499 instances of prisoners exposing officers to bodily fluids occurred in Texas's solitary-confinement units; none occurred in the general population.[236] With absolutely nothing to do, people in solitary take out their anger on officers. "They're bored," Mr. Lowry explains. "What else are they going to do? They're locked in a box all day. It's a game for them. They can't play checkers or dominos together. So, the first guy who can get the Lieutenant down here and piss him off wins. . . . Let's focus these guys on something other than the staff."[237] Texas's correctional officers union called for national standards governing the use of solitary confinement, explaining that its overuse makes Texas prisons more dangerous for correctional officers.[238] It further recommends that TDCJ utilize a greater array of sanctions, short of solitary confinement, to address misconduct.[239]

233 *See* Testimony of Lance Lowry, *supra* note 68.
234 *See id.*; E-mail from Lowry to Butler, *supra* note 69.
235 Telephone interview with Lance Lowry, President, AFSCME Local 3807 (Sept. 16, 2014).
236 *See* Testimony of Lance Lowry, *supra* note 68, at 1.
237 Telephone interview with Lance Lowry, President, AFSCME Local 3807 (Sept. 16, 2014), *supra* note 235.
238 *See* Testimony of Lance Lowry, *supra* note 68, at 1-2.
239 Telephone interview with Lance Lowry, President, AFSCME Local 3807 (Sept. 19, 2014).

Included in SCDC' 4.29.19 letter to LOC

Solitary Confinement Deprives Officers of the Option to Incentivize Good Behavior



Rogelio Baca stands in his cell in the administrative segregation wing of the Estelle Unit in Huntsville.

Solitary confinement also deprives officers of an important tool—their power to incentivize good behavior by creating a system of earned privileges. People in solitary confinement have no freedoms; nor can they earn greater freedom through good behavior. As a consequence, they have no incentive to comply with prison regulations. Jeanne Woodford, who served as Director of the California Department of Corrections and Warden of San Quentin, writes that "allowing inmates privileges based on good behavior enhances security because it creates incentives for inmates to comply with prison regulations. When inmates are permanently and automatically housed in highly restrictive environments . . . it is more difficult to control their behavior."[240] Mr. Lowry explains that the lack of incentives in solitary confinement ends up impairing correctional officers' ability to control prisoners:

> I think the best people know how to control human behavior, is your cable company. If you don't pay your bill, they take your privileges away. They're smart. If you don't pay your bill, they don't leave you with a salty screen. They leave you with a preview of what's on. . . . They leave this message on for a reason. You know everyone else is watching Days of their Lives. I don't know why prison administrators don't see that. . . . Controlling privileges is how you control these individuals.[241]

Mr. Lowry suggests that TDCJ could offer a step-down program that allows people to earn their way to greater privileges, and out of solitary confinement, through good behavior.[242]

240 Letter from Jeanne Woodford, former Director, Ca. Dep't of Corrections to TDCJ (Jan. 27, 2014) (on file with ACLU of Texas and TCRP).
241 Telephone interview with Lance Lowry, *supra* note 235.
242 *Id.*

Included in SCDC' 4.29.19 letter to LOC

Violence Escalates When Officers Deny People in Solitary Confinement Basic Necessities

Violence in solitary confinement further escalates when correctional officers deny prisoners basic necessities. Eighty percent of our survey respondents reported that they received an "insufficient amount" of food;[243] and thirty-one percent reported that prison staff had served them the "loaf,"[244] a "bland, brownish lump" of ground-up food without seasoning—which they may be forced to eat over and over again for weeks at a time.[245] People reported other deprivations besides food: Twenty-two percent claimed they were denied water,[246] and another twenty-two percent said they were denied showers.[247] Numerous people also said that officers almost never take them out of their cells for recreation despite TDCJ policies requiring that prisoners in isolation receive one to two hours of recreation a day.[248] Ted, a correctional officer who asked us not to use his real name, reports that solitary confinement breeds hostility between prisoners and officers. In the unit in which Ted works, officers punish individuals in solitary confinement by refusing them food, showers, or recreation time, which angers inmates. According to Ted, it is not uncommon for prisoners to act out, even after the original officers have already finished their shifts. As a result, the hostility can spiral out of control, culminating in correctional officers violently subduing the prisoner.[249]

Other States Improved Prison Safety by Reducing Solitary Confinement

Other states have found that drastically reducing the use of solitary confinement improves prison safety. When Mississippi reduced its solitary population from one thousand to less than 150, serious assaults against staff and prisoners dropped by seventy percent.[250] Mississippi lowered violence in part by instituting an incentive system to encourage good behavior and allow people in solitary to acquire greater freedoms. Mississippi Department of Corrections Deputy Commissioner Emmitt Sparkman explained that people in solitary "participated in the programs, we gave them more

243 Data collected from survey of 147 people incarcerated in Texas prisons who previously spent time in or are currently in solitary confinement (on file with ACLU of Texas and TCRP).
244 *See id.*
245 Eliza Barclay, *Food As Punishment: Giving U.S. Inmates 'The Loaf' Persists,* Nat'l Public Radio Jan. 2, 2014, *available at* http://www.npr.org/blogs/thesalt/2014/01/02/256605441/punishing-inmates-with-the-loaf-persists-in-the-u-s.
246 Data collected from survey of 147 people incarcerated in Texas prisons who previously spent time in or are currently in solitary confinement (on file with ACLU of Texas and TCRP).
247 *See id.*
248 Interview with Juan, *supra* note 55; Interview with Alex, *supra* note 16; Interview with Paul, *supra* note 55; Survey response from Brian, *supra* note 55; Survey response from Miguel, *supra* note 55; Survey response from Steve, *supra* note 55; Survey from Larry, *supra* note 55.
249 Telephone interview with Ted (July 15, 2014).
250 *See* Kupers, *supra* note 72, at 5, 7.

Included in SCDC' 4.29.19 letter to LOC

Walls Unit in Huntsville, Texas

freedoms, and we saw a huge decrease in violence. . . . Typically, people in segregation just sit idle and alone, sometimes for years. You have to give a guy an incentive to do better."[251] When Maine cut its solitary-confinement population, incidents of prison violence dropped.[252] Colorado saw no increase in assaults when it reduced its solitary-confinement population by sixty percent, and the Director of the Colorado Department of Corrections declared that "our institutions will actually be safer" with less solitary confinement.[253] According to Commissioner Sparkman, lowering solitary confinement also improved working conditions for staff: "In segregation, you typically have two-on-one escorts and use restraints, and there are continuous searches—and that's a drain on staff. When we had large numbers of people in segregation, staff were under constant pressure. . . . With these lower numbers, there's much less stress on staff."[254]

251 Emmitt Sparkman, *Mississippi DOC's Emmitt Sparkman on reducing the use of segregation in prisons,* VERA Institute of Justice, (Oct. 31, 2011), *available at* http://www.vera.org/blog/mississippi-docs-emmitt-sparkman-reducing-use-segregation-prisons.
252 *See* Tapley, *supra* note 73.
253 Testimony of Rick Raemisch, *supra* note 74.
254 Sparkman, *supra* note 251.

Included in SCDC' 4.29.19 letter to LOC

MENTALLY ILL PEOPLE DETERIORATE IN SOLITARY CONFINEMENT

TDCJ must never place people with serious mental illnesses in solitary confinement. Although solitary confinement causes mental distress for anyone, the impact of solitary confinement is especially profound for people with serious mental illnesses such as major depression, schizophrenia, bipolar disorder, OCD, panic disorder, PTSD, and borderline personality disorder.[255] Already vulnerable, people with serious mental illnesses inevitably fall apart in isolation.[256] According to Dr. Haney, people with serious mental illness "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 [solitary] confinement without significant deterioration and decompensation."[257] Corrections expert Steve Martin refers to the phenomenon of placing the mentally ill in solitary confinement as "the perfect storm" because of the way in which people with mental illness get stuck in solitary confinement.[258] Dr. Pablo Stuart, who served as an expert witness in a California class-action suit about solitary confinement, explained that people with mental illness deteriorate in solitary, until they can no longer comply with prison regulations and start to act out.[259] As their mental health unravels, their misbehavior escalates; as a consequence, many people with mental illness end up permanently trapped in solitary.[260]

The Universal Consensus: Never Place the Seriously Mentally Ill in Solitary Confinement

The consensus is universal: Federal courts, the American Bar Association (ABA), the American Psychiatric Association (APA), and the United States Department of Justice (DOJ) agree that correctional departments must exclude people with serious mental illness from solitary confinement. Federal courts have ruled that our prisons should not place mentally ill people in solitary confinement because it exacerbates their symptoms, in violation of the Eighth Amendment's prohibition on cruel and unusual punishment.[261] In the words of one federal judge, placing a mentally ill person in solitary confinement

255 *See* Nat'l Alliance on Mental Illness, *supra* note 79.
256 *See* Metzner & Fellner, *supra* note 75, at 105.
257 Haney, *supra* note 140, at 142.
258 Telephone interview with Steve Martin, Corrections Expert and Former General Counsel, TDCJ (Sept. 23, 2014).
259 Transcript of Evidentiary Hearing at 2771-72, *Coleman v. Brown*, No. 5014 (E.D. Cal. Dec. 5, 2013).
260 *See id.*
261 *See, e.g.,* Jones 'El v. Berge, 164 F. Supp. 2d 1096, 1101-02 (W.D. Wis. 2001); *Ruiz*, 37 F. Supp. 2d at 915; Coleman v. Wilson, 912 F. Supp. 1282, 1320-21 (E.D. Cal. 1995); Madrid v. Gomez, 889 F. Supp. 1146, 1265-66 (N.D. Cal. 1995); Casey v. Lewis, 834 F. Supp. 477,

Included in SCDC' 4.29.19 letter to LOC

"is the mental equivalent of putting an asthmatic in a place with little air to breathe."[262] In its Standards for the Treatment of Prisoners, the ABA called for the exclusion of people with mental illness from solitary confinement.[263] The APA issued a formal position statement explaining that people with serious illness should almost never be placed in solitary confinement; when they are, they need extra clinical support.[264] The United Nations Special Rapporteur on Torture declared that prolonged solitary confinement is a form of torture, and should never be used against people with mental disabilities.[265] After an extensive investigation, the DOJ announced that Pennsylvania's policy of housing people with mental illness in solitary confinement was an unsound correctional practice—both on humanitarian and public-safety grounds:

> Neither the interests of the Pennsylvania Department of Corrections nor those of the Commonwealth of Pennsylvania are served when one of its prisons subjects prisoners to conditions that deny prisoners with psychiatric disabilities the benefit of mental health treatment and exacerbate their mental illness. When the mental health of prisoners deteriorates, when their episodes of paranoia and psychosis intensify, and when they engage in behaviors more dangerous to themselves and others, taking care of them becomes more difficult and more dangerous for correctional officers and more expensive for the Commonwealth. Moreover, those living outside the prison's walls feel the negative impact of the prison's mistreatment of prisoners with serious mental illness when these prisoners return to the community.[266]

Texas Sends Thousands of People with Mental Illness to Solitary Confinement

Despite this universal consensus, TDCJ does not even track the number of people with serious mental illness in solitary confinement.[267] Mr. Martin says that TDCJ's failure to track people with serious mental illness is "an alarming flaw from a correctional

---

1549-50 (D. Ariz. 1993); Langley v. Coughlin, 715 F. Supp. 522, 540 (S.D.N.Y. 1988).
262 *Madrid,* 889 F. Supp. at 1265.
263 *See* Am. Bar Ass'n Standards for the Treatment of Prisoners 23-2.8(a) (2010), *available at* http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners.html#23-3.8.
264 *See* Am. Psych. Assoc., Position Statements: Segregation of Prisoners with Mental Illness (2012), *available at* http://www.psychiatry.org/advocacy--newsroom/position-statements.
265 *See* UN News Centre, *Solitary confinement should be banned in most cases, UN expert says* (Oct. 18, 2011), http://www.un.org/apps/news/story.asp?NewsID=40097#.U6C7uZRdUmk.
266 Letter from Thomas E. Perez, Assistant Attorney General, U.S. Dep't of Justice, Civil Rights Division, & David J. Hickton, U.S. Attorney, Western Dist. Pa., to Tom Corbett, Governor, Pa. (May 31, 2013), *available at* http://www.justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf.
267 Letter from TDCJ, *supra* note 5.

Included in SCDC' 4.29.19 letter to LOC

management standpoint—on its face it calls into question TDCJ's management."[268] TDCJ has 2,012 people in solitary confinement on its mental-health case load, however.[269] Moreover, our investigation revealed that TDCJ houses many people with serious mental illness in solitary confinement—and solitary confinement significantly worsens their mental health. During our research, we met with multiple people whom TDCJ had diagnosed with a serious mental illness, but who nonetheless remained in solitary confinement. In many cases, their symptoms appeared significantly exacerbated by complete isolation. Several of these individuals appeared to us in such an obvious and advanced stage of psychosis that we determined they lacked the capacity to understand our legal disclosures or to consent to have their stories shared in this report. They described violent auditory and visual hallucinations and appeared trapped in paranoid and obsessive thinking.

Henry's Story

Henry is one of over two thousand people in solitary confinement with a mental illness. TDCJ diagnosed him with bipolar I disorder with psychotic features. He attempted suicide while in general population. Despite Henry's prior suicide attempt, TDCJ sent him to solitary confinement in 2005, where he remains to this day. In isolation, Henry felt that "everything was crushing in on me at one time," and told us, "[I] see things that aren't there and have conversations with people who aren't there." He attempted suicide a second time while in solitary confinement. Although TDCJ documented Henry's mental illness, visual and auditory hallucinations, and suicide attempts in his medical chart, it failed to take him out of solitary confinement.[270] ■

The prevalence of mental illness among people in TDCJ's solitary-confinement cells is epitomized in their high rates of suicide and self-harm. A person trapped in solitary confinement is five times more likely to kill himself than someone in general

268 Telephone interview with Steve Martin, *supra* note 258.
269 *Id.*
270 Interview with Henry, individual incarcerated in TDCJ (July 11, 2014); Henry's medical records (obtained from Health Services Archives) (on file with ACLU of Texas and TCRP).

Included in SCDC' 4.29.19 letter to LOC

population.[271] For every one hundred prisoners in solitary confinement, there are 2.4 instances of self-inflicted injury, compared to 0.3 instances in general population.[272]

TDCJ Inadequately Monitors and Treats People with Mental Illness in Solitary Confinement

TDCJ also fails to adequately treat people with mental illness once they are trapped in solitary confinement. TDCJ only evaluates a person's mental health immediately upon sending him to a solitary-confinement cell if he currently receives mental-health treatment. All others only receive a mental-health evaluation after a full month.[273] Under this policy, people who need mental-health treatment but are not on TDCJ's current caseload fall through the cracks. After the initial evaluation, mental-health officers only conduct mental-health assessments every three months.[274] In a three-month period, people can easily deteriorate into a crisis state.

Worse, TDCJ may be falling short of meeting even its own meager standards for mental-health screenings. We requested all mental-health evaluations for several prisoners who had been diagnosed with a serious mental illness by TDCJ. Yet the files for several people had few or no evaluations covering their period in solitary confinement. For example, TDCJ diagnosed Paul with a mental illness. While in general population in 2009, he attempted to kill himself by overdose. Afterward, he was treated at a TDCJ psychiatric unit for his mental-health problems.[275] Although we requested all of Paul's mental-health evaluations, TDCJ did not turn over a single evaluation for the three-year period he spent in solitary confinement.[276] This lack of documentation suggests that TDCJ may not provide frequent, in depth review of the mental-health needs of people in solitary, even those with a history of serious mental illness.

Moreover, to the extent it provides them, TDCJ's mental-health reviews are too superficial to properly identify people's mental-health needs.[277] Of those survey respondents who met with a mental health worker, sixty-five percent said their meetings were less than two minutes long.[278] Sixty-two percent of survey respondents said

271 Letter from TDCJ, *supra* note 5.
272 *See id.*
273 TDCJ Medical and Mental Health Care in Segregation/Death Row (on file with ACLU of Texas and TCRP).
274 *See id.*
275 Paul's medical records (obtained from Health Services Archives) (on file with ACLU of Texas and TCRP).
276 *See id.*
277 Data collected from survey of 147 people incarcerated in Texas prisons who previously spent time in or are currently in solitary confinement (on file with ACLU of Texas and TCRP).
278 *Id.*

Included in SCDC' 4.29.19 letter to LOC

they never had enough time to discuss their mental-health needs with mental-health workers.[279]

"I thought that someone from mental health was suppose to make rounds but this only happens here once a year. And its 'How you doing today?' And if you say 'ok' they move on to the next cell."[280]

TDCJ's mental-health reviews are also not confidential. Seventy-five percent of respondents said their mental-health review was merely conducted by speaking through their cell door, rather than in a private meeting room.[281] Eighty-nine percent of survey respondents said that their medical treatment was not confidential.[282] Numerous people reported that officers overhear all of their confidential medical conversations[283] and repeat confidential medical information to other officers or prisoners.[284] Because of the lack of confidentiality, prisoners may not disclose mental-health issues, fearing stigma or humiliation.[285]

279 *Id.*
280 Alex's Journal, *supra* note 26 (entry dated June 9, 2014).
281 *Id.*
282 Data collected from survey of 147 people incarcerated in Texas prisons who previously spent time in or are currently in solitary confinement (on file with ACLU of Texas and TCRP).
283 Survey response from Chris, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP); Survey response from Ivan, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP); Survey response from Charles, *supra* note 158; Survey response from Oscar, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP).
284 Survey response from Ivan, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP); Survey response from Miguel, *supra* note 55; Survey from Diego, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP); Survey response from Edward, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP); Survey response from Kyle, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP); Survey response from Duncan, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP); Survey response from Simon, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP); Survey response from Ernesto, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP).
285 *See* Grassian, *supra* note 141, at 333.

Included in SCDC' 4.29.19 letter to LOC

Solitary Voices

"**Non-medical staff** are always present during interviews and exams and I have heard them discussing it between the guards and in front of other inmates."[286]

"I've witness medical talk to officer about other inmates **medical problem** and I've even had officers tell me that a inmate has AIDS."[287]

"Every single time I go talk to the mental health lady, the officers who escort me stand in the room with me listening to **every word** of what I say."[288]

"[The treatment] was the same day only due to me threatening to kill myself, an the interview was not held confidentially, it was either talk to mental health in front of the prison official's or they wouldn't talk with me, so I was force'd **against my will** to expose alot of my mental health history before the prison official's."[289]

In October 2014, TDCJ announced a new program called the Administrative Segregation Therapeutic Diversion Program (ASTDP).[290] According to TDCJ, the program will divert a small number of people with mental illness from solitary confinement to an alternative treatment environment.[291] Unfortunately, this program only includes 252 beds.[292] Therefore, it can only serve thirteen percent of the 2,012 mentally ill people in solitary.[293] Moreover, TDCJ has not provided advocates with details about the program, such as the criteria for entering it, the length of the program, the type and frequency of treatment available, and the amount of out-of-cell time and rehabilitative programming people in it can access.[294] Consequently, it is impossible to evaluate whether ASTDP will be an effective alternative to solitary confinement for people with mental illness.[295]

Texans do not want mentally ill prisoners to return to their communities in an even more deteriorated mental state than when they entered prison. Yet TDCJ places people with mental illnesses in conditions that seriously exacerbate their symptoms, and it fails to provide them with adequate treatment while they are there.

286 Survey response from James, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP).
287 Survey response from Ignacio, *supra* note 172.
288 Survey response from Henry, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP).
289 Survey response from Lee, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP).
290 TDCJ Administrative Segregation Information Sheet, *supra* note 1, at 4.
291 *See id.*
292 *See id.*
293 *See id.*
294 *See id.*
295 *See id.*

Included in SCDC' 4.29.19 letter to LOC

Solitary Voices

"I have a worsening of my antisocial behaviors and thoughts. The depression and **self-destructive behaviors I have have intensified** consistently since being placed in AD.SEG. Im aware of my thought process and mental illness however I have trouble controlling the symptoms . . ."[296]

"Mostly, it's the **continued screaming.** The crying, pleading, and gibberish people yell 24 hours a day. It's very unnerving. **To a combat vet, it's torture**. Panic & anxiety skyrocket. Exhaustion sets in for lack of sleep. I had to draw, in pencil, a large mural on one wall of my cell, talking to myself, just to focus on something other than the cries."[297]

"I've done **tried to kill my self** twice Hanged & cut & Ive been asking for help."[298]

"After being in seg. for 13x years, I now suffer from, depression, I'm antisocial, & **mood swings & suicidal attemps**."[299]

"**I'm losing my sanity.**"[300]

296 Survey response from Ivan, *supra* note 284.
297 Survey response from Pedro, *supra* note 155.
298 Survey response from Duncan, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP).
299 Survey response from Jeremy, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP).
300 Survey response from Samuel, individual incarcerated in TDCJ (on file with ACLU of Texas and TCRP).

Included in SCDC' 4.29.19 letter to LOC

CONCLUSION: OUR VALUES AND COMMITMENTS AS TEXANS

Solitary confinement violates our fundamental values as Texans—the values that define who we are as a state and set us apart. We value self-starters who take steps to improve their lives and overcome hardship. We value hard work. We value religious worship, along with the high moral standards it encourages and the community bonds it nurtures. We value family relationships because they form our lifelong moral commitments, bring us joy, and sustain us through times of difficulty. A Texan, responding to a recent blog post about Texas values on the Houston Chronicle website, put it perfectly: "Texas values—Freedom, Faith, Family."[301]

We expect our criminal justice system to reflect these values. We want our neighbors to have these values. We want our prisons to foster these values in the incarcerated people who will one day become our neighbors. Yet as detailed in this report, solitary confinement destroys all opportunities for self-improvement, denies the option to work, deprives prisoners of collective religious worship, and impairs family relationships. We have known since the 1800s that solitary confinement does not work for American prisons. This report documents that solitary confinement does not work for Texans.

Texas's outdated mindset also runs contrary to our commitment as Texans to employ fiscally prudent policies that increase the safety of our communities. In many respects, Texas has led the country on smart-on-crime reforms that utilized best practices, decreased crime, and saved taxpayer money. But in a key area, Texas legislators and TDCJ have failed to implement smart-on-crime policies: solitary confinement. Texas relies heavily on solitary confinement even though it was discredited in the nineteenth century as an unsound correctional practice, wastes taxpayer money, and increases insecurity in our prisons and communities.

Less solitary confinement is not about going "soft" on crime; it is about being smart on crime. It makes how we punish more cost-effective, and more likely to produce positive outcomes that decrease crime in our communities. With less solitary confinement, Texas prisons can carry out their mission more effectively. It is time for Texas to drastically reduce its use of solitary confinement—and ensure that our prison system employs policies that reflect the values and commitments that unite us as Texans.

301 Craig Hlavaty, *What exactly are "Texas values" these days?*, Texican, June 28, 2012, http://blog.chron.com/thetexican/2013/06/what-exactly-are-texas-values-these-days/.

Included in SCDC' 4.29.19 letter to LOC

METHODOLOGY

This report was researched and written by Burke Butler, Arthur Liman Fellow, TCRP, and Matthew Simpson, Policy Strategist, ACLU of Texas, and edited by Rebecca L. Robertson, Legal and Policy Director, ACLU of Texas.

To research this report, we submitted public information requests to the Texas Department of Criminal Justice (TDCJ) and University of Texas Medical Branch (UTMB); sent a survey to people in Texas prisons about solitary confinement and collected and analyzed the responses; interviewed experts on incarceration, security, mental illness, and the Texas prison system; and interviewed people who were either currently housed in or had previously spent time in solitary confinement.

We sent surveys to **668 people** incarcerated in Texas prisons between December 2013 and May 2014 to ask about their experiences in solitary confinement, and received **147 responses**—a twenty-two percent response rate. Those surveys included forty-nine closed and open-ended questions, based on a similar survey developed by the Correctional Association's Prison Visiting Project in New York. We sent:

> (1) **585 surveys** randomly to people incarcerated at nine facilities with high solitary-confinement populations: Coffield, Connally, Darrington, Eastham, Estelle, Ferguson, Lewis, Telford, and Wynne (sixty-five surveys sent randomly to each facility); and
>
> (2) **Eighty-three surveys** to people in Texas prison who had written to the TCRP, the Prison Justice League, or the non-profit Texas Interfaith directly or whose families had reached out on their behalf.

In May to August 2014, lawyers and clerks with TCRP and the ACLU of Texas conducted interviews with people in solitary confinement. We met with each person one to two times and in many cases corresponded with them extensively after our visit. Where possible, we confirmed their stories with their prison records. These interviews were conducted by Burke Butler, Satinder Singh, Priscilla Kennedy, Monique Rodriguez, Pedro Blandon, Margaret Brunk, Ryan Jones, Rebecca Pillar, Hunter Jackson, and Ethan Ranis.

Cindy Eigler, Amy Fettig, Craig Haney, and Steve Martin reviewed drafts of this report and generously provided their feedback and guidance.

Included in SCDC' 4.29.19 letter to LOC

We appreciate the hard work of the many dedicated volunteers and staff who made this report possible: Pedro Blandon, Priscilla Kennedy, Professor Dennis Kao, Christopher Clay, Monique Rodriguez, Philip Koelsch, Mandy Nguyen, Elizabeth Nuñez, Bryan Mejia, Margaret Brunk, Ryan Jones, Rebecca Pillar, Hunter Jackson, and Ethan Ranis.

We are also indebted to the Arthur Liman Program for providing fellowship support for Burke Butler to work on reducing Texas's overuse of solitary confinement.

Finally, we are profoundly grateful to the many men in solitary confinement in prisons across the state of Texas who wrote to us, responded to our surveys, and spoke with us in person about their experiences. Their courage to share their stories, many of which were difficult to tell, made this report possible. We fervently hope that their willingness to help us expose all that is wrong with solitary confinement will put Texas at long last on the path to reform.

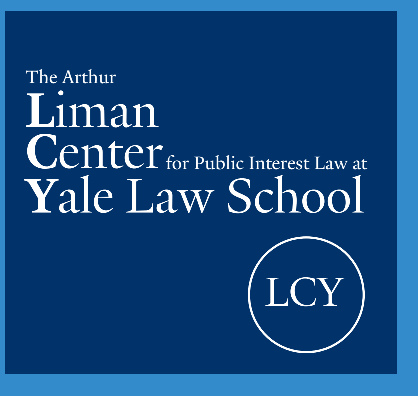
Included in SCDC' 4.29.19 letter to LOC

SCDC' 4.29.19 letter to

Working to Limit Restrictive Housing: Efforts in Four Jurisdictions to Make Changes

The Association of State Correctional Administrators
The Liman Center for Public Interest Law
at Yale Law School

October 2018



Included in SCDC' 4.29.19 letter to LOC

Working to Limit Restrictive Housing: Efforts in Four Jurisdictions to Make Changes

The Association of State Correctional Administrators
The Liman Center for Public Interest Law
at Yale Law School

October 2018

Included in SCDC' 4.29.19 letter to LOC

Working to Limit Restrictive Housing:
Efforts in Four Jurisdictions to Make Changes

Table of Contents

The Context: Nationwide Efforts to Limit Time-in-Cell 2

Colorado Reforms: What Do You Mean "Culture"?
Rick Raemisch, Executive Director, Colorado Department of Corrections 3

Idaho: Efforts to Reform Restrictive Housing
Henry Atencio, Director, Idaho Department of Correction and
Keith Yordy, Warden, Idaho State Correctional Institution 5

Reflections on North Dakota's Sustained Solitary Confinement Reform
Leann Bertsch, Director, North Dakota Department of Corrections
and Rehabilitation 8

Restrictive Housing: The Challenge of Reforming the Fabric of an Agency
Gary Mohr, Director, Ohio Department of Rehabilitation and Correction........ 11

A National Shift in Perspective........ 18

Included in SCDC' 4.29.19 letter to LOC

The Context: Nationwide Efforts to Limit Time-in-Cell

This monograph provides excerpts from the ASCA-Liman Report, *Reforming Restrictive Housing: The 2018 ASCA-Liman Nationwide Survey of Time-in-Cell*. That Report is the fourth in a series of ASCA-Liman research projects focused on restrictive housing – or what is popularly known as "solitary confinement" – defined in this Report as placement of an individual in a cell for 22 hours or more on average for fifteen days or more.

Over the course of the past several years, ASCA and the Liman Center have asked each of the correctional departments in the fifty states, the Federal Bureau of Prisons, and a few jail systems to answer survey questions and provide policies to understand the use of restrictive housing. Our goal is to enable longitudinal, evidence-based assessments of the use of restrictive housing by providing a composite picture at particular intervals. As detailed in the Report, we gathered information about the numbers and demographics of people held in restrictive housing. We asked questions about sex/gender, race and ethnicity, and age. We also sought to learn about the subpopulations of the seriously mentally ill, pregnant prisoners, and transgender individuals. In addition, the ASCA-Liman survey included requests for information on the length of time that people spent in restrictive housing and about whether, how, and why policies governing restrictive housing were changing.

Forty-three jurisdictions provided information in response to the 2017-2018 survey on the numbers of people in restrictive housing. According to the Bureau of Justice Statistics, those 43 jurisdictions housed about 80.5% of the total prison population. The 43 jurisdictions reported a total of 49,197 prisoners in restrictive housing, which was 4.5% of the prisoners confined across this set. Correctional directors around the country also reported that they were making changes to reduce and, in some instances, to abolish holding people in cell for 22 hours or more on average for fifteen days or more.

Below, we provide first-hand accounts by correctional leaders describing their efforts to make major changes in the use of restrictive housing in Colorado, Idaho, North Dakota, and Ohio. These prison administrators explain the ways in which they have revised policies, the challenges that they have faced, and the impact of their efforts.

Included in SCDC' 4.29.19 letter to LOC

Colorado Reforms: What Do You Mean "Culture"?

Rick Raemisch,
Executive Director, Colorado Department of Corrections

During the fall of 2017, Colorado became the first, and thus far, the only state in the United States to limit the use of Restrictive Housing to 15 days maximum, and this use is only for the most serious violations. Extended Restrictive Housing, the former Administrative Segregation, has been abolished. Following the United Nations Mandela Rules, this change means that a person in the Colorado prison system who was involved in a serious violation will be in Restrictive Housing for 22 hours per day, 7 days per week for a maximum of 15 days. Violations are not to be "stacked." In other words, no one will be placed in Restrictive Housing for 15 days, removed, then immediately placed back in.

This change comes on top of others. Through the Department's policy and then by statute, Colorado had already ended Restrictive Housing for seriously mentally ill prisoners. In fact, Colorado developed the policy that, if a person is involved in a disciplinary incident, and it is determined by a team consisting of correctional officers and clinicians that mental illness was the cause of the incident, the offender is taken out of the disciplinary process and given treatment. In addition, Colorado policies prohibit placing pregnant females and juveniles in Restrictive Housing under any circumstances.

When we initially started our reforms we adopted the philosophy "just open the door." We control it. Open it. Of course many discussions, debates, committee work, and staff input were completed in order to develop the proper procedures and programs to allow us to open the door. As I have explained elsewhere, when we went in the direction of abolishing extended restrictive housing, there was no map, and there was no road. Dedicated staff were challenged to complete the reforms, and they not only accepted the challenge but excelled at it.

When the decision was made to finally go to the 15 day maximum Restrictive Housing, we adopted a new philosophy: "You can restrain, but you don't have to isolate." We were unable to find proper restraint tables, and we have never used cages, nor would we. Once again, staff answered the challenges, and we built our own furniture to fit our needs. Formerly dangerous, restrictive housing prisoners are now out of their cells for a minimum of four hours per day, at restraint tables with up to four other inmates, for programing and other activities.

We have all heard the adage: "You can lead a horse to water, but can't make them drink." I don't believe that. I believe that: "If you throw the horse in the pond they are going to get some water just trying to get the hell out of the pond." The point is to give them programming regardless of whether they want it or not. Although this practice is new, it appears to be working. The goal of course is first to get them at the table, then give programming, and work towards safely removing the restraints. The goal is to have the programming be successful to the point where they can be back in general population.

We have been asked numerous times how we were able to accomplish this. How were you able to change the culture? When we have responded, we have heard: "That won't work here, the culture is too embedded in the way we are doing business now." Culture was never an issue with us. Of course our staff was used to using segregation on a regular if not overused basis. It's not a question of culture. It's a question of leadership. There is debate as to whether or not Henry Ford actually made this famous quote, but he is credited with saying: "If I had asked my customers what they wanted, they'd have said a faster horse."

The point obviously is that sometimes the vision needs to come directly from the leader. I gave the Colorado Department of Corrections the vision of where the Department would go. My approach was not "should we or would we?" Rather, it was: "This is what we are going to do." I put together an executive team that believed in my vision. My other philosophy is that if you have someone who wants to try something different, and it makes sense, give it a try. I've stated many times that if what we do doesn't work, we can always go back to the way things were before.

I consider my Executive Team and the other corrections leaders here as jet fighter pilots. I give them the target and then allow them to figure out how to get there. Not all of our staff believed in our reforms. Some retired, some transferred, but the results of our reforms have changed a good number of those who did not think it would work. At our two mental health prisons, where restrictive housing is completely banned, assaults, self-harm, and suicides have decreased dramatically. Staff enjoy work more because prisoners are acting in a more positive manner. It is quiet and safer. Safer facilities mean safer communities when they are released.

In the past, we had a waiting list for people with mental illness to be transferred to our facility for the seriously mentally ill. Today we have over fifty vacant beds. Our other facility for those with mental health issues has over 45 empty beds. It is too early to tell if the reason for this is because we have stopped manufacturing or multiplying mental illness by the overuse of segregation, but before our reforms there were none.

The bottom line: We have one vacant super max, and one re-purposed super max. We are back on track with our mission of public safety.

Idaho: Efforts to Reform Restrictive Housing

Henry Atencio
Director, Idaho Department of Correction
Keith Yordy
Warden, Idaho State Correctional Institution,
Idaho Department of Correction

Idaho Department of Correction [IDOC] made a decision to reform restrictive housing because it was the right thing to do for public and for community safety. Given that ninety-eight percent of prisoners in IDOC will return to the community, it is inconsistent with IDOC's mission to keep a prisoner in long-term restrictive housing, which results in no access to programming or educational opportunities, until they are released back into the community. Moreover, reforming restrictive housing has many benefits. It encourages safe and humane practices for the prison population. Reform permits compliance with international and national law, as the United Nations has declared that being confined in a cell 23 hours a day for more than 15 days is considered torture. Prison-based reform reduces IDOC's exposure to litigation regarding restrictive housing.

IDOC's reform process began in 2016 and was guided by nationwide standards addressing restrictive housing, which included principles of the U.S. Department of Justice and the thirteen guiding principles provided by the Association for State Correctional Administrators (ASCA).[1] Early on in the process, IDOC made the decision to include staff from multiple disciplines and at various leadership levels in the command structure. IDOC formed a command staff group comprised of agency and division leadership and reached out to external entities, who agreed to provide feedback and guidance to the agency during the reform process. The external partners included staff from the State Appellate Public Defenders' Office, the Office of the Federal Defenders of Idaho, and the Idaho Chapter of the American Civil Liberties Union. They have been an integral part of the process, as they have provided feedback on policy revisions, suggested language to use, and identified areas where the policy was unclear.

IDOC's path to reform also entailed having individual members of the department attend trainings and go on site visits to other states. Wardens, joined by correctional and mental health staff, visited Arizona and Washington Departments of Correction to see firsthand how reforms were implemented and to have discussions with those jurisdictions' staff about challenges and innovative ideas. In addition, several IDOC agency and facility leaders participated in training at the National Institute of Corrections (NIC) on restrictive housing reform. Idaho was selected as a pilot for an on-site NIC restrictive housing training that took place in August of 2017. Attendance at the training by wardens from facilities that housed men and women and that had long-term

[1] The ASCA principles are available here: https://www.asca.net/pdfdocs/9.pdf.

Included in SCDC' 4.29.19 letter to LOC

restrictive housing was crucial, as they both gained insight and learned about the importance and implementation of the restrictive housing guidelines of the U.S. Department of Justice.

As a result of this process, Idaho wardens began reviewing all prisoners who had been in long-term restrictive housing to reevaluate them with the goal that placement in restrictive housing should be reserved only for individuals who posed an imminent threat to the security of the institution. Doing so entailed taking a comprehensive approach to restrictive housing reform. The agency decided that two key policies, addressing restrictive housing and the disciplinary process, had to be updated. As a consequence, a revamped disciplinary policy added an alternative sanction process and changed the Disciplinary Offense Report (DOR) codes, and the restrictive housing policy was split into three separate policies—a short-term restrictive housing policy, a long-term restrictive housing policy, and a protective custody policy. The new policies[2] reflect and implement a shift in the purposes and in the practices, and the result has been that fewer people are placed in restrictive housing.

A few specifics are in order. The short-term restrictive housing policy begins with a statement of purpose reflecting IDOC's mission statement on restrictive housing reform: "Restrictive housing protects staff and inmates by segregating those who are the most violent or present the greatest danger to the safe operations of the facilities." The policy provides that time spent in short-term restrictive housing is capped at fifteen days. Past that point, prisoners must be afforded, at a minimum, three hours of out-of-cell time a day and provided with personal property as they would have in general population. The policy also requires prisoners who have a language barrier, physical/sight/hearing impairment, or medical or mental health issues to have accommodations when placed in restrictive housing or an alternative placement, as needed.

Further, IDOC has limited the behaviors that can result in short-term restrictive housing placement to those that pose an imminent risk to safety. This change in the criteria for entry has reduced the number of short-term restrictive housing beds at some facilities, and, at others, the people put into such beds. In addition, some facilities have implemented "calm down" areas for prisoners to de-escalate, while others have implemented diversionary tiers for those in possession of drugs or alcohol or who have tested positive on urinalysis tests.

The long-term restrictive housing policy (addressing individuals in such housing for fifteen days or more) also begins with a statement of purpose, again stemming from IDOC's mission statement. "Restrictive housing is a structured program that protects staff and inmates by segregating those who are the most violent or present the greatest danger to the safe operations of the facilities." The policy requires that all prisoners placed into long-term restrictive housing programs are in Idaho's "Step Up Program," which consists of five stages designed to provide behavioral expectations to prisoners, teach them to identify concepts and skills to assist in behavior change, and assess their behavior to determine if placement in long-term restrictive housing is

---

[2] Idaho's policies can be found at www.idoc.idaho.gov.

necessary. The policy requires that prisoners identified as having a serious mental illness be exempted from long-term restrictive housing placement and instead be placed in an alternative setting, which is usually a mental health unit. Further, the policy adds an administrative review committee for all long-term restrictive housing placements. That committee is at the prisons' division leadership level and includes both of the deputy chiefs of prisons and the chief psychologist, who is a non-voting member.

As of the writing of this report in the spring of 2018, the new disciplinary policy is in effect; the short-term and long-term restrictive housing and the protective custody policies are in the final drafting stage. The command staff is doing a policy review, and the goal is to have training in place during the summer of 2018 to complete a rollout of the reforms. And even before the full implementation, IDOC has seen the impact in the reduction in the numbers of people in long-term restrictive housing and new methods of responding to problems. One example comes from Idaho Maximum Security Institution (IMSI), a facility whose operating capacity was 412 inmates prior to restrictive housing reform and which had included 320 single-occupancy restrictive housing cells. IMSI has expanded its capacity to house 564 prisoners and as of the end of June, IMSI has 134 prisoners in long-term restrictive housing and 24 in short-term restrictive housing. The facility has revised its practices to have more prisoners in close-custody general population.

At Pocatello Women's Correctional Center (PWCC), the facility operating capacity was 313 prisoners prior to restrictive housing reform, with a total of 20 single-occupancy restrictive housing cells. The current operating capacity has increased to 333. Today, one prisoner under the sentence of death is in what is termed long-term restrictive housing status, but, in practice, she is out of her cell three or more hours per day. At the South Idaho Correctional Institution (SICI), 17 short-term restrictive housing beds were taken off line, which enabled the placement of 34 minimum custody general population prisoners to be housed there. As of the end of June 2018, the population in restricted housing had declined from 294 long-term restrictive housing prisoners to 134 people held in long-term restrictive housing.

Reflections on North Dakota's Sustained Solitary Confinement Reform

Leann Bertsch
Director, North Dakota Department of Corrections and Rehabilitation

Since late 2015, the North Dakota Department of Corrections and Rehabilitation (ND DOCR) has maintained an approximately 60–70% reduction in the population of its Administrative Segregation Unit (renamed the Behavioral Intervention Unit or BIU) at the North Dakota State Penitentiary (NDSP). The number of people residing in BIU as of April 5, 2018 was 24. The daily count within this unit has remained under 40 people over more than two years, down from over 100 people in 2015. The average length of stay in BIU has fluctuated between 30 and 60 days, although there are a few people who reside in the unit much longer based on the severity of violence, their expression of continued risk for violence, or their own preference for the BIU setting.

This population reduction has been sustained by continuing to adhere to a multi-faceted screening and assessment process. In fact, NDSP was able to convert one of the tiers within BIU to a preferred housing tier, which is home to 20 of the most consistently pro-social residents within the facility. Another 20-cell unit was converted to the Administrative Transition Unit, where people live when they are in the process of moving from BIU to a general population setting. ND DOCR continues to focus on those who commit any of 10 of the most serious in-custody offenses that may make a person eligible for BIU placement, with some exceptions for fighting and other harmful behaviors when they become severe or chronic. ND DOCR also continues to avoid placing people diagnosed with serious mental illnesses in BIU when possible and divert them to the Special Assistance Unit for more individualized services when it is determined that it is not safe to keep them in general population.

The sustained decrease in the number of people in the BIU setting has allowed for staff to make much better use of their time and to have a greater impact. Corrections officers engage each resident in friendly conversation, change-oriented discussion, or practice of a cognitive or behavioral skill at least twice per day. The unit Sergeant is also tasked with planning one pro-social, structured recreational activity each weekend to increase positive engagement with staff and out-of-cell socialization. Unit staff also provides reinforcement in the form of tangible property items, extra recreation time, extra showers, and the like, based on the person's participation in therapeutic and social activities, as well as the parameters of individualized behavior plans. Currently, BIU residents can access up to two hours and 40 minutes of recreation per day when they engage in skill practices and therapeutic groups, in addition to time spent in groups, individual sessions, and specially-planned enrichment activities.

Behavioral health staff also provides at least one structured leisure activity each week, such as an art project, mindfulness practice, or a movie. Three times per week they facilitate a group that focuses on applying skills to reduce or eliminate the use of violence, manage trauma reactions,

and cope with segregation. Each resident completes an individualized Success Plan, detailing how he plans to apply skills in high-risk future situations, prior to or soon after moving to the Administrative Transition Unit. Once the person has moved to the Administrative Segregation Unit, he has the opportunity to continue to participate in group two times per week to work on skills application as the amount of time spent in general population settings increases. These group curricula and the Success Plan served as the foundation to inform a curriculum developed by Dr. Paula Smith for a Bureau of Justice Assistance Encouraging Innovation Grant related to applying interventions in restrictive housing settings, which ND DOCR will continue to implement as a data collection site related to that grant project.

Over the past two and a half years, ND DOCR has sustained a substantial reduction in the use of the Special Operations Response Team within the BIU (no use of the team at all in this unit since October 2017), along with a reduction in overall uses of force. The prevalence of negative behaviors by residents of the unit has also dramatically decreased. ND DOCR believes the focus on reinforcement of positive change, building friendly relationships between staff and residents, and allowing residents access to pro-social coping skills (music, television, puzzle books, etc.) are collectively responsible for these changes. Perhaps our most exciting outcome to date is the fact that, of the 149 residents placed on BIU program status from October of 2015 to February of 2018, only 26 have returned to BIU program status. That is a 17% "recidivism" rate into the BIU program. ND DOCR is working to collect more precise data regarding these outcomes, but we are very encouraged by these initial results.

These changes, while overwhelmingly positive, have not been without challenges. NDSP did see a significant increase in physical fights between residents in mid-2016 to mid-2017. This increase occurred at the same time that our overall prison population was the highest it has ever been and we have some suspicions that this may be correlated more strongly with the population increase than the changes in the use of restrictive housing. As the population has slowly stabilized and begun to decrease, the prevalence of fighting has decreased as well. While most staff members have been supportive of the changes, there has been a perception that the overall safety of the facility has been compromised. Factually, there has been no increase in assaults on staff, assaults on residents by peers, or the overall level of violence perpetrated within the institution. There has also been a perception that residents are not "held accountable" for rule violations. In reality, residents continue to receive significant sanctions—the only difference is those sanctions are much less likely to include lengthy placements in restrictive housing, especially for non-violent offenses.

In order to address the problem of institutional violence more thoroughly, ND DOCR is excited to begin assessing people entering prison using the Risk of Administrative Segregation Tool (Labrecque & Smith, 2017) in order to identify those at highest risk for displaying institutional violence resulting in placement in restrictive housing. A copy of the tool is below.

BEHAVIORAL INTERVENTION UNIT REPORT CARD
DEPARTMENT OF CORRECTIONS AND REHABILITATION
DIVISION OF ADULT SERVICES
(04-2018)

☐ SMI

Group Attendance

Monday	Tuesday	Wed	Thurs	Friday

A (Attended); R (Refused); C (Cancelled)

Inmate Name | Inmate Number | Date of Arrival | Release Date

Placing Behavior

Status ☐ Investigative Segregation ☐ Disciplinary Segregation ☐ Administrative Segregation ☐ Administrative Transition Unit

Intervention Needs Assessment Referral ☐ Yes ☐ No | Requested Date | Completion Date

Target Behavior

Skill Practice/Skill Demonstration

DATE	SHIFT	KEEPS TRAYS/THROWS TRAYS	DOESNT ALLOW TRAY SLOT CLOSURE	COVERS FRONT WINDOW	DOESN'T COMPLY WITH STAFF DIRECTIVES	INTERACTS BY YELLING, NAME CALLING OR THREATS	ENGAGED IN CHECK IN WITH STAFF	NUMBER OF SKILL PRACTICES/ SKILL DEMO DONE	COMMENTS	STAFF INITIALS
	AM						Yes No			

Those identified as high risk will then be offered a 10-session group intervention program focused on establishing a pro-social adjustment to prison and managing high-risk situations for violence in an effective, non-violent manner. This program will begin in April 2018. Dr. Paula Smith and Dr. Ryan Labrecque will evaluate the effectiveness of this intervention in preventing future violence as compared to a no-treatment control group. Another future direction is to develop a peer support specialist certification program for prison residents, with the goal of providing additional support to those at risk for placement or placed in BIU.

One way to provide an overview of the outcomes, as of the spring of 2018, is by the chart below.

Type of Seg.	Investigative	Disciplinary	BIU Program	Total Unit
Avg. # of days	5.55	7.63	18.97	32.14

Type of Seg.	Investigative	Disciplinary	BIU Program	Total Unit
Total # Stays Over 14 Days	30	38	60	128

Restrictive Housing: The Challenge of Reforming the Fabric of an Agency

Gary Mohr,
Director, Ohio Department of Rehabilitation and Correction

Restrictive housing reform represents one of the most extensive reforms in the history of corrections in the United States. The use of restrictive housing to respond to prisoner misbehavior has been the foundation of correctional management philosophy for over a century. The practice is embedded in the philosophy and logic of nearly all agency staff and is interwoven into the fabric of any correctional agency's culture.

The use of restrictive housing remains an essential part of managing safe and secure prisons. Changing the way a correctional organization uses restrictive housing requires a delicate balancing act of improving conditions of confinement for prisoners who are more conducive to rehabilitative ends, while simultaneously ensuring we protect our staff and prisoners from individuals whose behavior indicates they are poised to harm others. Further, for most of my 44 years in this work, restrictive housing has been used as the default penalty for all types of rule violations, whether violent or not. Changing practices associated with the use of restrictive housing is a delicate operation because our staff, those who work in the trenches of our prisons, firmly believe the use of restrictive housing as a default disciplinary sanction is tied directly to their safety. Reforming the system to use restrictive housing only when there is a threat to safety and security, rather than as punishment, often becomes viewed as an attempt to jeopardize safety.

Today, that cultural belief has been reinforced by the horrific incidents in prisons throughout our country from North and South Carolina, to Pennsylvania, Arizona and many other jurisdictions including Ohio. In 2018, an Ohio Correctional Officer was stabbed 32 times by two prisoners who were in extended restrictive housing; miraculously, he survived. This event not only magnified the challenge of continuing to reform restrictive housing, but also changed my life, as it was a vivid reminder of how precious life is and how we as leaders carry the heavy responsibility for the welfare of so many. As we continue the much-needed reform regarding the practice of placing prisoners in confined settings, an area where there is still much work to be done, the realities and images of individuals who have experienced serious, life-changing incidents cannot be ignored. The impact on their lives, as well as on the lives of their loved ones and fellow staff members, must be of paramount concern.

Ohio can clearly report success in reducing prisoners in restrictive housing as evidenced by data comparing the use of restrictive housing between 2013 to 2017. In fact, there has been a 45% reduction in the number of prisoners in restrictive housing during that time period. While this reduction is meaningful and significant, it is also a reminder of the need for restrictive housing now and in the future. The reality is that there are people in prison who pose a serious and direct threat to others, and we have a duty to protect others from these prisoners. As agency leaders, we count on our staff in all correctional systems to carry out post orders and follow our directives 24

hours a day, 7 days a week. Those dedicated public servants must acknowledge and trust their leaders, even though they will not always agree, or the overall agency goals will not be achieved. Leaders cannot merely issue edicts directing a course of action when those directives are contrary to the will of the workforce if they expect the vision of the policy to be realized. In matters that challenge the foundational beliefs and values of the staff, change must occur over time through consistent reinforcement of the philosophy underlying the policy direction.

Operational Challenges to Restrictive Housing Reform: The Ohio Department of Rehabilitation and Corrections (DRC) began restrictive housing reform in late 2013 by conducting wide-ranging discussions on how and why correctional supervisors/executives use restrictive housing. In 2014 and 2015, the DRC examined all policies and procedures, even hiring external consultants to provide insight into current practices, assess areas for improvement, and recommend a pathway for reform. In 2015, it became apparent restrictive housing reform was intrinsically linked to discipline reform. As such, the DRC needed to re-examine the entire way prisoner rule violations were addressed. Below, I outline our reforms.

Reform Initiative A: Prison Disciplinary Reform (Swift, Certain, and Fair): In late 2015 and early 2016, the DRC began to change the philosophy associated with the offender disciplinary system to encourage sanctions that adhere to swift, certain, and fair (SCF) principles of discipline. Most importantly, this change included using alternative sanctions to reduce the use of restrictive housing. Implementation required, and continues to require, ongoing changes to organizational culture.

> Challenge 1: Operationalizing the changes in sanctioning practices remains an on-going challenge by trying to achieve consistency, fairness, and immediacy of application across all prisons.

Reform Initiative B: Alternatives to Restrictive Housing—Limited Privilege Housing: The DRC has the option in Ohio's Administrative Regulations to use limited privilege housing. Limited privilege housing is a condition of confinement that significantly limits a prisoner's privileges, so it can be used to respond to low-to-moderate severity rule violations. Limited privilege housing is not restrictive housing. It is, however, a meaningful sanction that adheres to swift, certain, and fair principles of sanctioning. It also removes prisoners from the housing area where they committed their offense. In late 2015 and lasting until today, the DRC greatly expanded the use of limited privilege housing and encouraged staff to not use restrictive housing as the default placement for prisoners who have misbehaved unless they posed a danger to the prison or to others.

> Challenge 2: Proper utilization of the limited privilege housing sanction has been a challenge. DRC continues to experience under-utilization and over-utilization of the sanction as an alternative to restrictive housing, and there is inconsistency in the security practices between areas.

Challenge 3: One of the greatest cultural challenges was passive resistance by staff who, in frustration over being asked not to use "segregation" for many offenses, assumed an "all or nothing" stance towards security. Simply put, if they could not place a prisoner in segregation (restrictive housing), then they just had to let prisoners do "whatever they wanted" and could take no meaningful action. Others felt a limited privilege housing unit could have a "relaxed" security posture when in reality limited privilege housing units can be just as secure as a restrictive housing unit if the type/kind of prisoner needs such levels of supervision. The critical difference is the out of cell time and access to programming and services which require all staff to change the way they work.

Challenge 4: A cultural myth developed that restrictive housing reform's goal was to reduce the use of restrictive housing regardless of the prisoner's behavior. DRC leadership was compelled to constantly remind staff that restrictive housing reform never meant prisons could not use restrictive housing to address violence or seriously disruptive behavior. This myth was persistent and remains even when policies were released providing staff the option of stronger and lengthier disciplinary sanctions. The written words contained in the policy, as well as emails sent to all staff, were overshadowed by this mythology that is still persistent five years into reform.

Reform Initiative C: Widespread Training/Communication on Restrictive Housing: Throughout 2016 and carrying into 2018, the DRC has revised dozens of policies, lesson plans, and in-service training on restrictive housing Reform and its related components within the DRC.

Challenge 5: Communication of the "why" behind restrictive housing Reform remains our prevailing challenge. A significant number of staff still report they do not understand the reasons for reform despite training, memos, policies, and emails that have tried to explain all aspects of the reform effort. More importantly, many of them do not understand the permanence of these changes and are "waiting to go back to the way it was." Finally, it cannot be ignored that there are some staff who simply believe prisoners should be severely restricted while in prison and especially when they commit any rule violations. It is reasonable to say that when an organization operates for nearly a century in one manner, it will take a very long time to change the fundamental beliefs of the staff who operate that organization. These individuals who, regrettably, exist at all levels in our agency continue to passively, or sometimes actively, resist restrictive housing reform, likely in the hope the reform will fail and the DRC will have to return to the status quo which existed in 2013.

Challenge 6: The volume and pace of change is a significant, on-going challenge for staff at all levels. Change for any organization is difficult, but the root nature of

this change coupled with the fact the change requires a shift in personal, organizational, and leadership philosophy, makes it incredibly challenging.

Challenge 7: Staff perceptions exist by some at all levels (line, supervisor, and executive staff) that are less than supportive of/favorable to restrictive housing reform efforts thus far. There is a strong feeling these policies are making people less safe and reform values prisoners over staff safety. The serious incident of the stabbing of our correctional officer mentioned earlier has kept this belief alive.

Challenge 8: There is substantial message dilution in training and communication. As information is passed down from each level of leadership and supervision, the message gets changed and altered, greatly affected by the cultural resistance outlined in previous challenges. As such, the DRC must continually improve the content and delivery of the restrictive housing Reform "communication plan."

Reform Initiative D: Serious Misconduct Panels and External Oversight of Extended Restrictive Housing: Prior to reform, local wardens possessed the authority independently to place prisoners into restrictive housing for six months, and in some cases, for a year or more. There was no centralized oversight for these two review processes. Wardens applied this power based on their individual perspective about misbehavior rather than an organizational view. In response, the DRC established the "serious misconduct panel" (SMP) as the only process by which offenders can be referred to "extended restrictive housing" and implemented centralized oversight of all placements and releases. The SMP referral is still made by a warden but is approved by a regional director and the panel is comprised of two exempt employees from a prison other than the one where the offense occurred.

Challenge 9: There have been concerns expressed that the use of the SMP implies a mistrust of the professional judgment of local teams who know the prisoners best. The delicate balancing act of ensuring consistency across all prisons while respecting local decision makers becomes interpreted as a form of heavy-handed oversight. In addition, prison leaders believe the new policies curtailed their ability to control violence and disruption at their prisons.

Challenge 10: The procedural aspects of the SMP are cumbersome and time consuming. The ongoing challenge is to streamline the SMP process without hindering the objectivity, due process, or thoroughness of the review.

Reform Initiative E: Conditions of Confinement and Programming for Extended Restrictive Housing: The DRC examined the conditions of confinement for offenders in extended restrictive housing and implemented additional programming, meaningful activities, and out-of-cell time. This process includes enhanced release preparation programs as best exemplified by the Ohio State Penitentiary [OSP] reversion program. This program introduces pro-social elements such as

employer engagement, family activities/events, and meals in group settings, including meals with the warden, into our highest security setting.

> Challenge 11: The physical plant and infrastructure of all DRC facilities were not designed to provide a lot of out-of-cell time for prisoners in restrictive housing. The facilities were designed according to the philosophy of corrections in the United States at the time. The last prisons constructed were designed in the mid-1990s, almost a quarter of a century ago. The only way to offset some of these design issues is with significant staffing resources, which are very costly and difficult to appropriate in challenging budgetary environments.
>
> Challenge 12: Self-imposed isolation, even when out-of-cell opportunities are granted, remains a considerable challenge. Prisoners choose these environments in a significant number of circumstances.
>
> Challenge 13: It is a continuing challenge to ensure conditions of confinement differ between restrictive housing, limited privilege housing, and general population in a meaningful way that sufficiently deters prisoners from engaging in misbehavior. The more you give prisoners in restrictive housing/extended restrictive housing/limited privilege housing, the less appealing rule compliant behavior becomes for prisoners in general population. Over-compensating to assist restrictive housing/extended restrictive housing prisoners can exacerbate the problems associated with Challenge 12 and, as has been proven by some cases in Ohio, actively encourage prisoner misbehavior to achieve a placement into extended restrictive housing.

Reform Initiative F: Limiting Extended Restrictive Housing for Seriously Mentally Ill Prisoners and Enhanced Monitoring: The DRC recognizes the potential effects of restrictive housing on the seriously mentally ill. However, seriously mentally ill prisoners, like others, can commit very serious acts of violence and disruption unrelated to their mental illness. Furthermore, even if the violence is related to their mental illness, the threat to the safety of others cannot be ignored. Therefore, the DRC has implemented practices to closely monitor the utilization of extended restrictive housing for prisoners with serious mental illness, and placement in extended restrictive housing for a person with serious mental illness must be approved at the departmental level. We also use and have expanded high security Residential Treatment Units [RTUs] as an assessment/diversion opportunity to avoid placement in extended restrictive housing for some people with serious mental illness.

> Challenge 14: The single greatest challenge in this effort is to develop and implement a "space between" restrictive housing and general population for dangerous, disruptive, and violent seriously mentally ill prisoners. Efforts to operate a "secure adjustment unit" for violent, seriously mentally ill offenders were

unsuccessful. We have added a significant number of Residential Treatment Unit [RTU] beds for the seriously mentally ill. There remain prisoners who are seriously mentally ill and violent/disruptive, but do not meet the standard of our mental health staff for an RTU level of care.

Challenge 15: DRC has expanded the number of high security RTUs, but there remains a substantial need for more beds and staff.

Challenge 16: Although philosophically we understand the need to treat seriously mentally ill prisoners differently, if one lessens the sanctions on prisoners solely because they are seriously mentally ill, other prisoners may perceive a tremendous injustice. This can cause disruption in housing units where both seriously mentally ill and non-caseload prisoners are held. In addition, as we attempt to grant more out-of-cell time and increased staff engagement for seriously mentally ill prisoners even after they have committed serious acts of violence against staff, we experience a growing cultural resistance to reform. Staff who are victimized, sometimes repeatedly, by these prisoners perceive these acts as being unfair and proof there is lack of care for staff and for the impact that violence by prisoners has on them. Thus the challenge continues.

Reform Initiative G: Tracking and Data Collection: The DOTS system, our tracking system, in present form, cannot effectively track people placed in restrictive housing or limited privilege housing. Since 2013, the DRC has continually developed new methods for measuring restrictive housing, primarily by using snapshots. Currently, Operations and IT staff are developing a restrictive housing/limited privilege housing Disciplinary Tracking System integrated into the DOTS system that, once completed, will provide a comprehensive system for examining disciplinary sanctions and their utilization, as well as profiles and real-time data on prisoners in restrictive housing/limited privilege housing. It will track the work flows associated with major job processes which may affect length of stay in restrictive housing/limited privilege housing including, but not limited to:

1) Hearing Officer and RIB Decisions
2) SMP referrals, extended restrictive housing placements, and extended restrictive housing reviews
3) Investigations regarding prison administrative functions such as misbehavior, protective control, separations, and staff nexus
4) Security Classification Reviews and Increases/Decreases
5) Prisoner Movement and Transfers

> Challenge 17: While waiting for these changes, it is not acceptable to forgo efforts to track restrictive housing. Reporting mechanisms have changed somewhat over time and to get accurate data is a cumbersome process that is very labor-intensive.

Conclusion: On December 27, 2010, when I met with Governor Kasich and decided to accept this journey to oversee the Ohio Department of Rehabilitation and Correction, he asked me to do two things. First, we could not afford another Lucasville, the riot that lasted 11 days and resulted in 10 deaths. Secondly, "Go reform the most unreformed part of government." While we have made some very progressive changes in creating reintegration environments, expanded programming including treatment of the addicted both in and outside our prison walls, expanded residential treatment beds for the mentally ill, employment partnerships with employers with experiences both inside the prisons and out in the communities, and engagement with community faith partners, the challenge of reforming restrictive housing is at the core of that challenge. Restrictive housing reform remains a challenge to us in Ohio and many other jurisdictions around our great country.

A National Shift in Perspective

These four narrative accounts are illustrative of a significant change in restrictive housing policies. As ASCA-Liman reported in 2013, the rules promulgated by corrections departments then gave wide discretion to correctional staff to place individuals in restrictive housing. The policies had broad criteria for putting people into isolation, and little focus on moving people out of restrictive housing. In contrast, in 2018, directors around the country are revisiting their rules on restrictive housing and, in many instances, seeking to narrow the bases for entry, to increase time out-of-cell, and to expand opportunities for sociability. Moreover, time-based categories of restrictive housing have emerged. Correction policies distinguish between "*restrictive housing*" (defined as requiring a prisoner "to be confined to a cell at least 22 hours per day") and "*extended restrictive housing*" (defined as separating a prisoner "from contact with general population while restricting" the prisoner to his cell "for at least 22 hours per day and for more than 30 days").[3]

One illustration of the revised approaches to limiting the use of restrictive housing comes from the American Correctional Association (ACA), which in 2016 issued new Performance Based Standards on Restrictive Housing. The ACA called on jurisdictions to ensure that prisoners not be released directly to the community from restrictive housing. Further, the ACA Standards placed a prohibition on assigning individuals under the age of 18 or pregnant females to extended restrictive housing. The ACA Standards also stated that prisoners "will not be placed in Restrictive Housing on the basis of gender identity alone."[4] In addition, the Standards provided that correctional departments "not place a person with serious mental illness in Extended Restrictive Housing."[5]

The ASCA-Liman 2018 survey mapped the impact of these ACA Standards. Thirty-six jurisdictions reported that they had reviewed their restrictive housing policies since the release of the 2016 Standards, and 25 described relying on the ACA Standards when making policies. For example, 21 jurisdictions reported that they had implemented the ACA Standard that persons with serious mental illness not be placed in extended restrictive housing.

More generally, in the larger monograph from which these materials are excerpted, we report on responses from 43 jurisdictions discussing a range of policy changes, including narrowing the criteria for entry into restrictive housing. For example, in one jurisdiction, infractions such as "horse play" or possession of small amounts of marijuana, which previously could have formed the basis for placement in restrictive housing, would no longer lead to isolation.

---

[3] AMERICAN CORRECTIONAL ASSOCIATION RESTRICTIVE HOUSING PERFORMANCE BASED STANDARDS (Aug. 2016), p. 3, *available at* https://www.asca.net/pdfdocs/8.pdf.

[4] *Id*. at Standard 4-RH-0035, p. 40.

[5] *Id*. at Standard 4-RH-031, p. 46

In addition, jurisdictions reported expanding the oversight of placement, altering the amount of time spent in-cell, and offering more opportunities for sociability through programs, recreation and social interactions. More than half of the 43 responding jurisdictions discussed requiring consideration of less-restrictive alternatives before placement in restrictive housing.

One of the longstanding goals of the ASCA-Liman surveys has been to build a longitudinal database to enable evidence-based analysis. The 2015 ASCA-Liman Report found that more than 66,000 prisoners were in restrictive housing in 34 jurisdictions. Based on Bureau of Justice Statistics (BJS) on prison populations, the 2015 Report estimated that between 80,000 to 100,000 prisoners were in restrictive housing across the country. The 2016 Report found that about 67,500 prisoners were in restrictive housing in 48 jurisdictions, which accounted for 96.4% of the prison population. The 2018 Report identified a total of about 49,197 prisoners in restrictive housing in 43 jurisdictions which accounted for 80.5% of the U.S. prison population. Thus, the 2018 Report estimates that 61,000 prisoners were in restrictive housing as of 2017. The caveats on these numbers are that the definitions of restrictive housing varied somewhat among the three reports, and that the data do not generally include juveniles or individuals in jails. Further, no inquiries were made about individuals held in immigration or military detention.

Forty jurisdictions provided restrictive housing data in both 2016 and 2018. The 2018 Report compared this information and identified a reduction in 29 jurisdictions in the numbers of prisoners in restrictive housing and an increase in 11 jurisdictions. Across the 40 jurisdictions, the percentage of prisoners in restrictive housing decreased from 5.0% in 2015 to 4.4% in 2017.

Another window into changes over time comes from information about how long people spend in restrictive housing. Thirty-one jurisdictions responded with information on length of stay in both the 2015-2016 and in the 2017-2018 surveys. We asked jurisdictions for information on different lengths of confinement in restrictive housing: 15 days to one month, one to three months, three to six months, six months to one year, one to three years, three to six years, and longer than six years. Overall, the numbers of individuals in restrictive housing across most lengths of time decreased from 2016 to 2018. The number of prisoners in restrictive housing for time periods six months or less decreased in about as many jurisdictions as it increased. The number of prisoners in restrictive housing for time periods longer than six months decreased in more jurisdictions than it increased.

The monograph on the 2017-2018 data and policies, coupled with the narratives from four jurisdictions, makes plain that many correctional systems around the United States are seeking to lower the numbers of people in their cells for 22 hours or more on average for fifteen days or more and to alter the activities and opportunities for those held in restrictive housing. The reports from correctional officials reflect the national and international consensus that restrictive housing can impose grave harms on individuals confined, on staff, and on the communities to which prisoners return.

Included in SCDC' 4.29.19 letter to LOC

Association of State Correctional Administrators (ASCA)

ASCA is the most exclusive correctional association in the world. ASCA members are the leaders of each U.S. state corrections agency, Los Angeles County, the District of Columbia, New York City, Philadelphia, the Federal Bureau of Prisons, U.S. Military Correctional Services (Army, Navy, Air Force, Marines), and United States territories, possessions, and commonwealths. ASCA members lead over 400,000 correctional professionals and supervise approximately eight million prisoners, probationers, and parolees. ASCA's goal is to increase public safety by utilizing correctional best practices, accountability, and providing opportunities for people to change.

The Arthur Liman Center for Public Interest Law, Yale Law School

The Liman Center was endowed to honor Arthur Liman, who graduated from Yale Law School in 1957. Throughout his distinguished career, he demonstrated how dedicated lawyers, in both private practice and public life, can respond to the needs of individuals and of causes that might otherwise go unrepresented. The Liman Center, which began as the Liman Program in 1997, continues the commitments of Arthur Liman by supporting work, in and outside of the academy, dedicated to public service in the furtherance of justice.

Acknowledgements

The Report from which these excerpts are taken is based on a survey co-authored by ASCA and by the Liman Center at Yale Law School. . The research and report teams were led at ASCA by Leann Bertsch, Kevin Kempf, Bob Lampert, Gary Mohr, Rick Raemisch, A.T. Wall, and Wayne Choinski, and at Yale by Judith Resnik, Anna VanCleave, Kristen Bell, and Alexandra Harrington. Yale Law students Greg Conyers, Catherine McCarthy, Jenny Tumas, and Annie Wang played major roles in the research, analysis, and drafting of that Report. Yale Law students Faith Barksdale, Stephanie Garlock, and Daniel Phillips reviewed and edited the final drafts. We also received helpful suggestions from the Vera Institute of Justice.

Thanks are due to all the jurisdictions that responded to the survey and provided comments and reviews thereafter. This research has been supported by Yale Law School, the Liman Center, the Vital Projects Fund, and the Oscar M. Ruebhausen Fund at Yale Law School. This monograph was also made possible in part by a grant from Carnegie Corporation of New York to Judith Resnik, who is a 2018–2020 Andrew Carnegie Fellow. The Vital Projects Fund, the Ruebhausen Fund, and Carnegie Foundation are not responsible for the research and views expressed here. Special thanks are due to Bonnie Posick of Yale Law School's staff for expert editorial advice and to Elizabeth Keane, Program Coordinator of the Liman Center.

This Report is part of a series of ASCA-Liman and Liman research projects, which include *Prison Visitation Policies: A Fifty State Survey* (2012); *Administrative Segregation, Degrees of Isolation, and Incarceration* (2013); *Time in Cell* (2014); *Aiming to Reduce Time in Cell* (2016); *Rethinking Death Row* (2016); and *Reforming Restrictive Housing* (2018). To download copies of these reports, please visit the Liman Center's website at https://law.yale.edu/centers-workshops/arthur-liman-center-public-interest-law/liman-center-publications. These reports can also be found on ASCA's website at http://asca.net/documents/. This Report may be reproduced free of charge and without the need for additional permission. All rights reserved, 2018.

Inquiries:

Kevin Kempf
Executive Director, ASCA
kkempf@asca.net

Wayne Choinski
Project Manager, ASCA
wchoinski@asca.net

Judith Resnik
Arthur Liman Professor of Law
Yale Law School
judith.resnik@yale.edu

Anna VanCleave
Liman Center Director
Anna.vancleave@yale.edu

Included in SCDC' 4.29.19 letter to LOC