



ACLU BRIEFING PAPER: **The Dangerous Overuse of Solitary Confinement** **in the United States**

Introduction

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

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

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

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

Other critics point to the enormous costs associated with solitary confinement. For example, supermax institutions typically cost two or three times more to build and operate than even traditional maximum-security prisons.³ Despite the significant costs associated with solitary

confinement, almost no research has been done on the outcomes produced by the increased use of solitary confinement or supermax prisons. In the research that has been conducted there is little empirical evidence to suggest that solitary confinement makes prisons safer. Indeed, emerging research suggests that supermax prisons actually have a negative impact on public safety.⁴

Despite these concerns, states and the federal government continue to invest scarce taxpayer dollars in constructing supermax prisons and enforcing solitary confinement conditions. Yet there are stark new fiscal realities facing our communities today and for the foreseeable future. Both state and federal governments confront reduced revenue and mounting debt that are leading to severe cuts in essential public services like health and education. Given these harsh new realities, it is unquestionably time to ask whether we should continue to rely on solitary confinement and supermax prisons despite the high fiscal and human costs they impose.

Below we discuss the nature of solitary confinement, the research on its human impacts, as well as the available data on outcomes and costs.

What is solitary confinement?

Solitary confinement is the practice of placing a person alone in a cell for 22-24 hours a day with little human contact or interaction; reduced or no natural light; restriction or denial of reading material, television, radios or other property; severe constraints on visitation; and the inability to participate in group activities, including eating with others. While some of the specific conditions of solitary confinement vary, generally the prisoner spends 23 hours a day alone in a small cell with a steel door, a bed, a toilet and sink.⁵ Human contact is generally restricted to brief interactions with corrections officers and, for some prisoners, occasional encounters with healthcare providers or attorneys.⁶ Family visits are limited and almost all human contact occurs while the prisoner is in restraints and behind some sort of barrier.⁷ Frequently prisoners subjected to solitary confinement are only allowed one visit per month.⁸ Technology has made solitary confinement even more isolating; in many instances, even prisoner interaction with correctional officers will be largely limited to communication through intercoms and monitoring with video cameras. The amount of time a person spends in solitary confinement varies, but it can last for years or decades.

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

The term “segregated housing” means housing of a prisoner in conditions characterized by substantial isolation from other prisoners, whether pursuant to disciplinary, administrative, or classification action. “Segregated housing” includes restriction of a prisoner to the prisoner’s assigned living quarters.⁹

The term “long-term segregated housing” means segregated housing that is expected to extend or does extend for a period of time exceeding 30 days.¹⁰

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

How does solitary confinement affect people?

Solitary confinement is well recognized as painful and difficult to endure. “It’s an awful thing, solitary,” U.S. Senator John McCain wrote of his time in isolation as a prisoner of war in Vietnam. “It crushes your spirit and weakens your resistance more effectively than any other form of mistreatment.”¹¹ Senator McCain’s experience is reflected in the general consensus among researchers that solitary confinement is psychologically harmful.¹² A California prison psychiatrist summed it up: “It’s a standard psychiatric concept, if you put people in isolation, they will go insane. . . . Most people in isolation will fall apart.”¹³ Indeed, research demonstrates that the clinical impacts of isolation can actually be similar to that of physical torture.¹⁴ For this reason, the European Committee for the Prevention of Torture found that solitary confinement conditions can amount to “inhuman treatment.”¹⁵

People subject to solitary confinement exhibit a variety of negative physiological and psychological reactions, including:

- hypersensitivity to external stimuli;¹⁶
- perceptual distortions and hallucinations;¹⁷
- increased anxiety and nervousness;¹⁸
- revenge fantasies, rage, and irrational anger;¹⁹
- fears of persecution;²⁰
- lack of impulse control;²¹
- severe and chronic depression;²²
- appetite loss and weight loss;²³
- heart palpitations;²⁴
- withdrawal;²⁵
- blunting of affect and apathy;²⁶
- talking to oneself;²⁷
- headaches;²⁸
- problems sleeping;²⁹
- confusing thought processes;³⁰
- nightmares;³¹
- dizziness;³²
- self-mutilation,³³ and

- lower levels of brain function, including a decline in EEG activity after only seven days in solitary confinement.³⁴

In addition to increased psychiatric symptoms generally, suicide rates and incidents of self-harm are much higher for prisoners in solitary confinement. In California, for example, although less than 10% of the state's prison population was held in isolation units in 2004, those units accounted for 73% of all suicides.³⁵ One study examined the impact of solitary confinement on the amount of time that passes between incidents in which prisoners harm themselves.³⁶ Comparing prisoners in solitary confinement to those in the general population, the study found that the average amount of time the prisoners went without self-inflicting bodily injury was reduced by 17 months when they were in solitary confinement.³⁷ This means that an average prisoner in solitary confinement will harm himself seventeen months earlier than a prisoner in the general population.

People in solitary confinement are also more likely to be subject to the use of excessive force and abuses of power.³⁸ Correctional officers often misuse physical restraints, chemical agents, and stun guns, particularly when extracting people from their cells.³⁹ The fact that the solitary confinement cells are isolated from the general population prisoners makes it more difficult to detect abuse.⁴⁰ Additionally, the idea that "the worst of the worst" are placed in solitary confinement makes it more likely that administrators will be apathetic or turn a blind eye to abuses.⁴¹

What is the impact of solitary confinement on the mentally ill?

Solitary confinement is psychologically difficult for even relatively healthy individuals, but it is devastating for those with mental illness. When people with severe mental illness are subjected to solitary confinement they deteriorate dramatically. Many engage in bizarre and extreme acts of self-injury and suicide. It is not unusual for prisoners in solitary confinement to compulsively cut their flesh, repeatedly smash their heads against walls, swallow razors and other harmful objects, or attempt to hang themselves. In Indiana's supermax, the Wabash Valley Correctional Facility Secured Housing Unit (SHU), a mentally ill prisoner killed himself by

Testimony of Stuart Grassian, M.D., *Madrid v. Gomez*, 889 F. Supp. 1146, 1225 (N.D. Cal. 1995)

The following is based on the expert testimony of Dr. Grassian in a suit that alleged Constitutional violations at California's Pelican Bay State Prison, which housed prisoners in conditions of solitary confinement.

Inmate E was previously incarcerated [...] [and] underwent extensive psychiatric evaluation [...] [C]linicians found no evidence that he had a psychotic disorder. However, Inmate E became overtly psychotic and suicidal after being placed in the [solitary confinement unit] in 1991. He was evaluated in April 1992 after he wrote a suicide note in his own blood. Inmate E reported that he was "hearing voices" and the examining doctor described him as "obviously very psychotic." [...] Inmate E continued to have psychotic or suicidal episodes; Pelican Bay staff seemingly vacillated between treating his psychotic episodes as such and dismissing them as manipulation. [...] In late May the inmate again stated that he wanted to kill himself, and then later retracted[.] [...]

In July of 1992, Inmate E was found to have multiple superficial lacerations on his forearm and was "talking nonsensically." [...]

self-immolation; another man choked himself to death with a washcloth.⁴² Such incidents are all too common in similar facilities across the country.

One of the leading experts on the mental health effects of isolated confinement explained the reasons for the shattering impact of solitary confinement on the mentally ill:

There are a lot of reasons why [mentally ill] people break down in isolated confinement. First of all, it's almost total isolation and total inactivity. So what happens is that all of us know who we are and maintain our sanity basically by acting, by doing things, by being productive, by mastering things and by relating to other people. Someone with a mental illness, especially a psychosis, has lots of fantasies. When those fantasies get out of proportion, we call them delusions. The way we check those delusions is to have them in constant social interaction with other so they can say what they're thinking and find out whether they're being crazy or whether that's a realistic perception. When you deprive a person of that kind of feedback on a constant basis and they have a tendency towards psychosis, they will tend to break down.⁴³

The damaging effects of solitary confinement on the mentally ill are exacerbated because these prisoners typically do not receive meaningful treatment for their illnesses. While mental health treatment in many prisons is inadequate, the problems in supermax prisons and segregation units are even greater because the extreme security measures in these facilities render appropriate mental health treatment, beyond mere medications, nearly impossible. For example, because prisoners in solitary confinement are usually not allowed to sit alone in a room with a mental health clinician, any "therapy" will generally take place at cell-front, often through an opening in a solid steel door, and necessarily at a high volume where other prisoners and staff can overhear the conversation. Most prisoners are reluctant to say anything

**Testimony of Dr. Grassian *continued*
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A clinician at the prison noted that the inmate was having panic attacks and that voices were telling him to hurt himself.

By August he had deteriorated further and the clinician characterized him as having a "schizophrenic" episode with "disjointed" thinking after he described hearing voices and receiving messages from a computer at the base of his neck. [...]

When Dr. Grassian subsequently interviewed Inmate E, the prisoner was still grossly psychotic and incoherent. He told Dr. Grassian:

I see or hear things. I have been hypnotized since April 13th by Cybernetics. I can't even explain it without being hooked up with polygraph tests. It's like frequency tests. A bunch of people come up to me and talk about why I have to kill myself. Things I've thought of, things I've seen, animals and stuff like that. It's frightening. They tried to kill me. They used sounds, send emotions through my body and my body shakes . . . I'm tired of people talking in my head. I was mentally clear before . . . sometimes I get so confused, I don't even know what's going on.

in such a setting, not wanting to appear weak or vulnerable, so this type of treatment is largely ineffective.

These shattering impacts of solitary confinement are so well-documented that every federal court to consider the question of whether placing the severely mentally ill in such conditions is cruel and unusual punishment has found a Constitutional violation.⁴⁴

Who are the people placed in solitary confinement?

There is a popular misconception that all people in solitary confinement are violent, dangerous, and disruptive prisoners, commonly referred to as the “worst of the worst.”⁴⁵ But any prison system only has a handful of prisoners that actually meet this description. If the use of solitary confinement was solely restricted to the dangerous and predatory, most supermax prisons and isolation units would stand virtually empty. The reality is that solitary confinement is misused and overused. One reason for this is that elected officials pushed to build facilities for solitary confinement based on a desire to appear “tough on crime,” rather than actual need as expressed by corrections professionals.⁴⁶ As a result, many states built large supermax facilities they didn’t need, and now fill the cells with relatively low-risk prisoners.⁴⁷

So, who are the thousands of people who end up in solitary confinement cells? The vast majority are not incorrigibly violent criminals; instead, many are severely mentally ill or cognitively disabled prisoners, who find it difficult to function in prison settings or to follow and understand prison rules.⁴⁸ For example, in Indiana’s supermax, prison officials admitted that “well over half” of the prisoners are mentally ill.⁴⁹ On average, researchers estimate that at least 30% of the prisoners held in solitary confinement are mentally ill.⁵⁰

Others in solitary are the so-called “nuisance prisoners” – those who have broken minor rules,⁵¹ those who file grievances or lawsuits against the prison or otherwise attempt to stand up for their rights, or those who simply annoy staff. These prisoners may present management challenges, but they do not require the extreme security and isolation of supermax institutions or segregation units.

Does solitary confinement make prisons safer?

No. Despite its political popularity, there is little evidence or research about the goals, impacts or relative cost-effectiveness of using solitary confinement as a corrections tool. In fact, there is no evidence that using solitary confinement or supermax institutions has significantly reduced the levels of violence in prison or that such confinement acts as a deterrent.⁵² A 2006 study found that opening a supermax prison had no effect on prisoner-on-prisoner violence in Arizona, Illinois and Minnesota.⁵³ The same study found that creating a supermax had only limited impact on prisoner-on-staff violence in Illinois, none in Minnesota and actually increased violence in Arizona.⁵⁴ A similar study in California found that supermax prisons have not only failed to isolate or reduce violence in the overall statewide system, but in fact all measures of violence in the system suggest it has increased.⁵⁵

The justifications usually cited for building supermax prisons and solitary confinement units is that putting “the worst of the worst” in solitary confinement creates a safer general population environment where prisoners will have greater freedom and access to educational and vocational programs.⁵⁶ Others defend solitary confinement as a general deterrent that reduces disruptive behavior throughout the prison.⁵⁷ However there is only anecdotal support for these beliefs.⁵⁸ Indeed, contrary to the assumption that a few “worst of the worst” prisoners cause violence in prisons, researchers have shown that the levels of violence in American prisons may have more to do with the way prisoners are treated and how prisons have been managed and staffed than the presence of a few “super violent” prisoners.⁵⁹

Although there is little empirical research to support the efficacy of solitary confinement as a prison management tool, there is ample evidence that it is the most costly form of incarceration. There are several reasons for this. Supermax prisons are considerably more costly to build and operate, sometimes costing two or three times as much as conventional facilities.⁶⁰ Staffing costs are also much higher. Prisoners are usually required to be escorted by two or more officers any time they leave their cells, and work that in other prisons would be performed by prisoners (such as cooking and cleaning) must be done by paid staff. For all these reasons solitary confinement or supermax housing represents an enormous investment of precious criminal justice resources. Comparing the costs of general population prisoners to those held in solitary illustrates the cost differentials. For example, a 2007 estimate from Arizona put the annual cost of placing someone in solitary confinement at approximately \$50,000 a year compared to only about \$20,000 a year for the average prisoner.⁶¹ In Maryland, the cost of housing a prisoner in the state’s segregation units is on average three times greater than a general population facility; in Ohio it is twice as much and in Texas the costs are 45% greater.⁶²

Does solitary confinement make the public safer?

No. Not only is there little evidence that the enormous outlay of resources for supermax prisons and solitary confinement makes prisons safer, there is growing concern that such facilities are actually detrimental to public safety.

The pervasive use of solitary confinement means that thousands of prisoners are now returning to the community after spending months or years in isolation. This means that society must face the huge problem of resocializing individuals who are poorly prepared to return safely to the community. Many of these are severely mentally ill people who have been subject to conditions that exacerbate their illness and who have received little to no treatment.

In many systems, prisoners in solitary confinement are released directly to the community. In California, for example, data show that nearly 40% of the prisoners in segregation units are released directly to the community without first transitioning to lower security units.⁶³ Similarly, Colorado also releases about 40% of its supermax population directly to the community.⁶⁴ Mental health experts noted the problems with direct release from isolation to the community and called for prerelease programs to help supermax and solitary confinement prisoners transition to the community more safely.⁶⁵ Although there is not yet comprehensive

research comparing recidivism rates for prisoners released directly from solitary with those released from general population, preliminary research in California suggests that the rates of return to prison are at least 20% higher for solitary confinement prisoners.⁶⁶ Similarly, in Colorado, two-thirds of prisoners in solitary confinement who were released directly to the community returned to prison within 3 years, but prisoners who transitioned from solitary confinement into the general prison population before community re-entry experienced a 6% reduction in their comparative recidivism rate for the same period.⁶⁷

Are there better alternatives?

Yes. In recognition of the inherent problems of solitary confinement, the American Bar Association recently approved standards to reform its use. The ABA's *Standards for Criminal Justice, Treatment of Prisoners* address all aspects of solitary confinement (the Standards use the term "segregated housing").⁶⁸ The solutions presented in the Standards represent a consensus view of representatives of all segments of the criminal justice system who collaborated exhaustively in formulating the final ABA Standards. The following illustrate some of those solutions:

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

Some states have already undertaken substantial reforms of their solitary confinement practices. Over the last few years, Mississippi has revolutionized its supermax prison system. In the process, the state reduced the supermax population of one institution from 1000 to 150 men and eventually closed the entire unit.⁶⁹ Prison officials estimate that diverting prisoners from solitary confinement under Mississippi's new model saves about \$8 million dollars a

year.⁷⁰ At the same time, changes in the management of the solitary confinement population reduced violence levels by 70%.⁷¹

There are several key components to the Mississippi model. First, the state overhauled its classification system that determined the security needs for individual prisoners. When reviewing policies and practices they found that too many prisoners in the supermax prison had not engaged in serious misconduct; scoring errors had led to over-classification; prisoners who simply required protection were sent to the supermax; a large number of prisoners were being retained in the unit even though they had had no serious misconduct reports for years; the required reassessments of prisoners' assignment to the unit were not being done; and the caseload for case managers was so large that they could not have adequate contact with prisoners to complete accurate assessments. As a result of these findings, the state developed new criteria for its classification system that reduced its supermax population by 80%.⁷²

The other key component of the Mississippi model involved the diversion of the seriously mentally ill out of solitary and into a newly developed intermediate-level mental health step-down unit that focuses on treatment rather than punishment. This unit provides a level of mental health treatment comparable to a halfway house or day treatment program in the community. It is used for mentally ill prisoners who cannot return to open populations because of their behavior. Prisoners in this program are not subject to severe isolation and are able to progress rapidly to less restrictive confinement for good behavior. They also engage in group treatment and congregate activities free of handcuffs and ankle restraints. Importantly, medical and custody staff collaborate as part of the treatment team, and custody staff on this unit undergoes extensive mental health training.⁷³

State legislatures have also addressed the problems created by the over-use of solitary confinement and its impact on the mentally ill. For example, New York recently passed a law that excludes the seriously mentally ill from solitary confinement; requires periodic assessment and monitoring of the mental status of all prisoners subject to solitary confinement for disciplinary reasons; creates a non-disciplinary unit for prisoners with psychiatric disabilities where a therapeutic milieu is maintained and prisoners are subject to the least restrictive environment consistent with their needs and mental status; and requires that all staff be trained to deal with prisoners with mental health issues.⁷⁴

Conclusion

The United States uses solitary confinement to an extent unequalled in any other democratic country. But this has not always been so. The current overuse of solitary confinement is a relatively recent development that all too frequently reflects political concerns rather than legitimate public safety needs. Based on over twenty years of empirical research, we know that the human cost of increased physiological and psychological suffering caused by solitary confinement, coupled with the enormous monetary cost of its use, far outweighs any purported benefits. Now, in order to build a fair, effective and humane criminal justice system, we must work to limit its use overall and ensure that mentally ill persons are not subject to its deprivations.

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- ¹ DANIEL P. MEARS, URBAN INST., EVALUATING THE EFFECTIVENESS OF SUPERMAX PRISONS 4 (2006).
- ² Angela Browne, Alissa Cambier, Suzanne Agha, *Prisons Within Prisons: The Use of Segregation in the United States*, 24 FED'L SENTENCING REPORTER 46 (2011).
- ³ DANIEL P. MEARS, *supra* note 1, at ii.
- ⁴ See, e.g., KERAMET REITER, PAROLE, SNITCH, OR DIE: CALIFORNIA'S SUPERMAX PRISONS & PRISONERS, 1987-2007 47-51 (2010); MAUREEN L. O'KEEFE, CO. DEPT. OF CORRECTIONS, ANALYSIS OF COLORADO'S ADMINISTRATIVE SEGREGATION 25 (2005).
- ⁵ Eric Lanes, *The Association of Administrative Segregation Placement and Other Risk Factors with the Self-Injury-Free Time of Male Prisoners*, 48 J. OF OFFENDER REHABILITATION 529, 532 (2009).
- ⁶ *Id.*
- ⁷ *Id.*
- ⁸ Leena Kurki & Norval Morris, *The Purposes, Practices, and Problems of Supermax Prisons*, 28 CRIME AND JUST. 385, 389 (2001).
- ⁹ ABA Crim. Just. Standards on the Treatment of Prisoners, Standard 23-1.0(r) (2010), available at <http://www.abanet.org/crimjust/policy/midyear2010/102i.pdf>.
- ¹⁰ ABA Standards, *supra* note 9, Standard 23-1.0(o).
- ¹¹ Atul Gawande, *Hellhole*, THE NEW YORKER, Mar. 30, 2009, available at http://www.newyorker.com/reporting/2009/03/30/090330fa_fact_gawande.
- ¹² See, e.g., Stuart Grassian, *Psychopathological Effects of Solitary Confinement*, 140 AM. J. OF PSYCHIATRY 1450 (1983); R. Korn, *The Effects of Confinement in the High Security Unit at Lexington*, 15 SOC. JUST. 8 (1988); S.L. Brodsky & F.R. Scogin, *Inmates in Protective Custody: First Data on Emotional Effects*, 1 FORENSIC REP. 267 (1988); Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax" Confinement*, 49 CRIME & DELINQUENCY 124 (2003); Holly A. Miller & G. Young, *Prison Segregation: Administrative Detention Remedy or Mental Health Problem?*, 7 CRIMINAL BEHAV. AND MENTAL HEALTH 85 (1997); HANS TOCH, MOSAIC OF DESPAIR: HUMAN BREAKDOWN IN PRISON, (Am. Psychol. Ass'n. 1992).
- ¹³ HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 149 n. 513 (2003).
- ¹⁴ Hernán Reyes, *The Worst Scars Are In The Mind: Psychological Torture*, 89 INT. REV. OF THE RED CROSS 591 (2007); Metin Basoglu, et al., *Torture vs. Other Cruel, Inhuman and Degrading Treatment: Is the Distinction Real or Apparent?* 64 Arch. of Gen. Psychiatry 277 (2007).
- ¹⁵ Kurki & Morris, *supra* note 8, at 415 (specifically, spending twenty two hours a day in a cell, without associating with other prisoners, with limited visits and activities for over a year is "inhuman treatment").
- ¹⁶ Grassian, *supra* note 12, at 1452.
- ¹⁷ *Id.*; Haney, *supra* note 12, at 130, 134; see generally Korn, *supra* note 12.
- ¹⁸ Grassian, *supra* note 12, at 1452-53; Haney, *supra* note 12, at 130, 133; Holly A. Miller, *Reexamining Psychological Distress in the Current Conditions of Segregation*, 1 J. OF CORRECTIONAL HEALTHCARE 39, 48 (1994); see generally Brodsky & Scogin, *supra* note 12.
- ¹⁹ Grassian, *supra* note 11, at 1453; Miller & Young, *supra* note 12, at 91; Haney, *supra* note 12, at 130, 134; see generally TOCH, *supra* note 12.
- ²⁰ Grassian, *supra* note 12, at 1453.

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- ²¹ *Id.*; Miller & Young, *supra* note 12, at 92.
- ²² Grassian, *supra* note 12, at 1453; Miller & Young, *supra* note 12, at 92; Haney, *supra* note 12, at 131.
- ²³ Haney, *supra* note 12, at 130; *see generally* Korn, *supra* note 12.
- ²⁴ Haney, *supra* note 12, at 131.
- ²⁵ Miller & Young, *supra* note 12, at 91; *see generally* Korn, *supra* note 12.
- ²⁶ Miller & Young, *supra* note 12, at 91; *see generally* Korn, *supra* note 12.
- ²⁷ Haney, *supra* note 12, at 134; *see generally* Brodsky & Scogin, *supra* note 12.
- ²⁸ Haney, *supra* note 12, at 133.
- ²⁹ *Id.*
- ³⁰ Haney, *supra* note 12, at 137; *see generally* Brodsky & Scogin, *supra* note 12.
- ³¹ Haney, *supra* note 12, at 133.
- ³² *Id.*
- ³³ Grassian, *supra* note 12, at 1453; Lanes, *supra* note 5, at 539-40.
- ³⁴ Paul Gendreau, N.L. Freedman, & G.J.S. Wilde, *Changes in EEG Alpha Frequency and Evoked Response Latency During Solitary Confinement*, 79 J. OF ABNORMAL PSYCH. 54, 57-58 (1972).
- ³⁵ Expert Report of Professor Craig Haney at 45-46, n. 119, *Coleman v. Schwarzenegger/ Plata v. Schwarzenegger*, No: Civ S 90-0520 LKK-JFM P, C01-1351 THE (E.D. Cal/N.D. Cal. Aug. 15, 2008).
- ³⁶ Lanes, *supra* note 5, at 539-40.
- ³⁷ *Id.*
- ³⁸ Kurki & Morris, *supra* note 8, at 409.
- ³⁹ CAROLINE ISAACS & MATTHEW LOWEN, AM. FRIENDS SERV. COMM., BURIED ALIVE: SOLITARY CONFINEMENT IN ARIZONA'S PRISONS AND JAILS 14 (2007).
- ⁴⁰ *Id.* at 16.
- ⁴¹ *Id.*; *see also* Maureen L. O'Keefe, *Administrative Segregation From Within: A Corrections Perspective*, 88 THE PRISON J. 123, 126 (2008).
- ⁴² Karin Grunden, Man found hanging in cell at Wabash Valley Correctional Facility, TERRE HAUTE TRIBUNE-STAR, Oct. 1, 2003, www.tribstar.com/articles/2003/10/01/news/export38458.txt.
- ⁴³ Testimony of Terry A. Kupers, M.D., *Jones El. v. Berge*, No. 00-C-421-C (W.D. Wis. Sept. 20, 2001).
- ⁴⁴ *See, e.g., Ruiz v. Johnson*, 37 F. Supp. 2d 855, 915 (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) ("Conditions in TDCJ-ID's administrative segregation units clearly violate constitutional standards when imposed on the subgroup of the plaintiffs' class made up of mentally-ill prisoners"); *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. 1477, 1549-50 (D. Ariz. 1993); *Langley v. Coughlin*, 715 F. Supp. 522, 540 (S.D.N.Y. 1988) (holding that evidence of prison officials' failure to screen out from SHU "those individuals who, by virtue of their mental condition, are likely to be severely and adversely affected by placement there" states an Eighth Amendment claim).
- ⁴⁵ Kurki & Morris, *supra* note 8, at 391.
- ⁴⁶ *Id.* at 390-91.

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- ⁴⁷ Roy King, *The Rise and Rise of Supermax: An American Solution in Search of a Problem?*, 1 PUNISHMENT & SOC. 163, 177 (1999).
- ⁴⁸ Haney, *supra* note 12, at 127.
- ⁴⁹ Howard Greninger, *Suit targets Carlisle Prison*, TERRE HAUTE TRIBUNE-STAR, Feb. 4, 2005, available at www.tribstar.com/articles/2005/02/04/news/top_stories/top01txt.
- ⁵⁰ See, e.g., James Ridgeway & Jean Casella, *Locking Down The Mentally Ill: Solitary Confinement Cells Have Become America's New Asylums*, THE CRIME REP., Feb.20, 2010, available at http://mostlywater.org/locking_down_mentally_ill_solitary_confinement_cells_have_become_america%E2%80%99s_new_asylums; MARY BETH PFEIFFER, CRAZY IN AMERICA: THE HIDDEN TRAGEDY OF OUR CRIMINALIZED MENTALLY ILL (2007); JENNIFER R. WYNN, ALISA SZATROWSKI & GREGORY WARNER, THE CORRECTIONAL ASSOCIATION OF NEW YORK, MENTAL HEALTH IN THE HOUSE OF CORRECTIONS: A STUDY OF MENTAL HEALTH CARE IN NEW YORK STATE PRISONS 48 (2004).
- ⁵¹ Kurki & Morris, *supra* note 8, at 411-12.
- ⁵² *Id.* at 391.
- ⁵³ Chad S. Briggs, et al., *The Effect of Supermaximum Security Prisons on Aggregate Levels of Institutional Violence*, 41 CRIMINOLOGY 1341, 1341-42 (2006).
- ⁵⁴ *Id.* at 1365-66.
- ⁵⁵ REITER, *supra* note 4, at 44-46.
- ⁵⁶ Kurki & Morris, *supra* note 8, at 391.
- ⁵⁷ *Id.*
- ⁵⁸ *Id.*
- ⁵⁹ *Id.* at 416-17.
- ⁶⁰ ISAACS & LOWEN, *supra* note 39; Daniel P. Mears & Jamie Watson, *Towards a Fair and Balanced Assessment of Supermax Prisons*, 23 JUSTICE Q. 233, 260 (2006).
- ⁶¹ ISAACS & LOWEN, *supra* note 39, at 4.
- ⁶² DANIEL P. MEARS, *supra* note 1, at 20, 26, 33.
- ⁶³ REITER, *supra* note 4, at 2.
- ⁶⁴ O'KEEFE, *supra* note 4, at 23.
- ⁶⁵ Terry Kupers, *What To Do with the Survivors? Coping with the Long-term Effects of Isolated Confinement*, 35 CRIM. JUST. & BEHAV. 1005 (August 2008).
- ⁶⁶ REITER, *supra* note 4, at 50.
- ⁶⁷ O'KEEFE, *supra* note 4, at 25.
- ⁶⁸ The ABA Criminal Justice Standards on the Treatment of Prisoners (2010) represent the product of a five-year drafting process, approved by the American Bar Association House of Delegates in February 2010. They are based on constitutional and statutory law, relevant correctional policies and professional standards, the deep expertise of the drafters who represented all segments of the criminal justice system, as well as the comments of dozens of additional experts and groups (among them heads and former heads of correctional agencies, prisoners' advocacy organizations, and many professional associations). The full text of the Standards is available at: http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners.html

⁶⁹ Terry A. Kupers, et al., *Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs*, 36 CRIM. JUST. & BEHAV. 1037, 1041 (2009); John Buntin, *Exodus: How America's Reddest State – And Its Most Notorious Prison – Became a Model of Corrections Reform*, 23 GOVERNING 20, 27 (2010).

⁷⁰ Transcript of Proceedings at 8, *Presley v. Epps*, No. 4:05-CV-00148-JAD (N.D. Miss. Aug. 2, 2010).

⁷¹ Kupers, *supra* note 69, at 1043.

⁷² *Id.* at 1041.

⁷³ *Id.* at 1043-44.

⁷⁴ See N.Y. MENTAL HYG. LAW § 45.07(z) (2011); N.Y. CORRECT. LAW §§ 137, 401, 401(a)(2008).