

A REFLECTION ON THE MADNESS IN PRISONS

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The United States currently employs tremendous levels of imprisonment and imprisonment within prison in the form of solitary confinement for behavior control, as exemplified in the recent Rikers Island scandals. This Article discusses how imprisonment and solitary confinement affect those with and without mental illness in terms of psychiatric and behavioral consequences, and shows that these approaches are largely counterproductive. It considers how a disproportionate number of inmates came to be mentally ill through a process known as trans-institutionalization and how this causes undue duress on those who need treatment the most. The authors review personal anecdotes, medical and historical literature, as well as case law dealing with the effects of prolonged isolation. All point to the benefits of better care and socialization opportunities, which are far more effective than isolation for behavioral control and violence prevention. The authors call for a rethinking of the role of prisons in the management of persons with psychiatric illness as well as for crime control in order to create societies that are truly safe and civilized.

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| INTRODUCTION | 253 |
| I. ODDITIES | 254 |
| II. THE MENTALLY ILL IN INCARCERATION | 257 |
| III. THE MENTAL EFFECTS OF DOUBLE INCARCERATION OR ISOLATION | 259 |
| IV. LEGAL INTERVENTIONS | 262 |
| V. BEYOND LEGAL INTERVENTIONS | 266 |

INTRODUCTION

On August 13, 2014, in one in a series of articles about the state of conditions at Rikers Island, New York City’s main jail complex, the *New York Times* revealed:

The portrait that emerged from the report on Rikers Island by the United States attorney’s office in Manhattan last week was of a place with almost

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medieval levels of violence, meted out with startling ferocity by guards and their superiors.

The two-and-a-half-year investigation, which focused on the abuse of teenage inmates by correction staff, was exhaustive in cataloging the brutality. But a critical question that went unaddressed is how conditions were allowed to get to this point.

Rikers has been a place of violent excess for decades. And the growing ranks of inmates with mental illnesses, reaching nearly 40 percent of the jail population today, have added to the challenges for correction officials.¹

The U.S. Attorney's Office report² and the *Times* investigative series were only the most recent salvos in a series of breaking news stories that have placed the experience of being a mentally ill inmate into the public discourse. Others have included legal rulings, such as the approval by Judge Lawrence Karlton of California's Eastern District of a plan to reduce mentally ill inmates in isolation in California prisons. Burgeoning commentaries in popular culture and conversation comprise only the surface of a growing civic movement.³ For many readers of those reports, the contents were shocking and new; however, there is a significant medical and legal literature that has long documented these facts. From the mental health practitioner's perspective, this Article will explain that literature; how imprisonment affects those with and without mental illness, especially through solitary confinement (a condition that befalls those who are mentally ill especially frequently); and what to do about it.

I. ODDITIES

Prisons are odd places for the psychiatrist to be practicing mental healthcare, yet they are our de facto mental institution. The above reports reiterated what the senior author⁴ of this Article saw in her daily work as a staff psychiatrist at Rikers Island. There, she treated hundreds of inmates with mental illness next door to the facility's emergency medical clinic, which

1. Michael Schwartz & Michael Winerip, *Violence by Rikers Guards Grew Under Bloomberg*, N.Y. TIMES (Aug. 13, 2014), <http://www.nytimes.com/2014/08/14/nyregion/why-violence-toward-inmates-at-rikers-grew.html>.

2. Memorandum from U.S. Dep't of Justice, U.S. Attorney for the S. Dist. of N.Y. to The Honorable Bill de Blasio (August 4, 2014), available at <http://www.justice.gov/usao/nys/pressreleases/August14/RikersReportPR/SDNY%20Rikers%20Report.pdf>.

3. See Nile Cappello, *Why We Need to Talk About OITNB's 'Crazy Eyes'*, HUFFINGTON POST (Aug. 30, 2014), http://www.huffingtonpost.com/nile-cappello/oitnb-mental-health_b_5531759.html; Atul Gawande, *Hellhole: The United States Holds Tens of Thousands of Inmates in Long-Term Solitary Confinement. Is This Torture?*, NEW YORKER, March 30, 2009, at 36.

4. As a matter of full disclosure, the senior author, Bandy Lee, was co-author of *Report to the New York City Board of Corrections, September 5, 2013*. BANDY LEE & JAMES GILLIGAN, REPORT TO THE NEW YORK CITY BOARD OF CORRECTIONS, SEPTEMBER 5, 2013 (2013), available at <http://solitarywatch.com/wp-content/uploads/2013/11/Gilligan-Report.-Final.pdf>. The junior author, Maya Prabhu, worked on the matter of *Disability Advocates, Inc. v. N.Y. State Office of Mental Health*, 02 Civ. 4002 (GEL) (S.D.N.Y. Apr. 2007), as an associate of Davis Polk & Wardwell.

received a daily flow of inmates beaten to the point of losing consciousness. Treating the damage seemed paradoxical in a setting where injuries were so often the deliberate product of other inmates or, as documented in the Rikers report above, the guards themselves. Less visible but equally present were the psychological injuries. Thirty minutes of therapeutic intervention per month would be counteracted by 731.5 hours of punitive, degrading, and wounding treatment. Medication often did not get delivered by staff, who might find it inconvenient to wake a patient at four-thirty in the morning, even if the patient, desperate to receive it, had been awake much of the night trying not to miss it (inmates are usually not allowed to hold psychiatric medications themselves).

And what happens to the severely ill? Since a loss of insight, and the accompanying refusal to admit that one is ill and needs help, are hallmarks of many mental illnesses, those who need care the most are the least likely to receive it. In fact, many severely ill individuals did not even get to the psychiatrist's office for an evaluation. Once, when asked to screen an inmate being taken into punitive segregation for not following orders, the senior author found him to be floridly psychotic—yet he was miscategorized as someone without any mental health problems because he was withdrawn, quiet, and in denial of his illness. Since their daily exposure is to correctional staff who are not trained in mental health, or rather are trained to view aberrant behavior as primarily a security concern, mentally ill individuals are very likely to be placed in solitary confinement or isolation for “better management” rather than to receive treatment.⁵ The myth of Sisyphus describes it well: one's attempt to treat is like rolling a boulder up the hill, only to watch it roll back down.

Some officers did not seem to believe that mental symptoms could be serious: one officer, attempting to be friendly to the senior author, suggested that an inmate be placed under suicide precaution as “punishment” for reporting suicidal ideation more than a few times—insinuating that a duration of being stripped in a cold, concrete room with a single mattress would “cure” him of the desire to fabricate symptoms. He did not seem to recognize the callous unconcern he was unwittingly communicating—not to mention the potential danger to a human life. The seemingly extraordinary stance of this officer was not exceptional at Rikers or at any of the more than dozen other maximum-security facilities where the senior author had worked in her survey of maximum-security prisons around the country; rather, it was routine. A peculiar worldview seems to take shape in parallel with the peculiar surroundings; shared among insiders, it gets sheltered in by a barrier as thick as its walls. Behavior that does not adhere to rules is first interpreted as defiance, with the erratic, unpredictable kind posing the greatest risk to safety—which can be true, when the staff does not understand it. Those who end up in solitary confinement for punishment or management reasons are more likely to attempt

5. 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, 104 (2010).

or to commit suicide⁶ and to have psychiatric symptoms⁷ but actually receive less treatment because of logistical barriers to getting them to the clinic (e.g., requiring more than one escort) or, if they are seen at the door side, because of confidentiality issues where hearing the other is difficult without shouting, where officers and other inmates can hear. Group therapy and other structured activities that have educational, recreational, or life-skills training benefits are inconceivable in a situation of 23- to 24-hour lock down (in the senior author's experience, the one-hour-per-day out of cell time is often taken up with showers or exercise in a solitary courtyard, if taken at all, as logistical difficulties or the inmates' "giving up trying to ask for it" may result in its cancellation).

The denial of medical and mental healthcare would be dangerous and damaging for any population. Here, we are facing a jail population that is 64.2% mentally ill and state and federal prison populations that are 56.2% and 44.8%, respectively.⁸ Since substance abuse masks many symptoms, is not counted as a mental illness, and is a method of "self-medication" for many who cannot afford care, these numbers are most likely underestimates. Furthermore, those with personality disorders are not included even though personality disorders can sometimes be as lethal or as debilitating as major mental illnesses. Nevertheless, these numbers show that the rate of mental illness amongst the incarcerated is at least five times the rate of mental illness in the general adult population (11%).⁹ A person suffering from a mental illness in the United States is at least three times more likely to be incarcerated than hospitalized.¹⁰ Los Angeles County Jail and Rikers Island have become the largest de facto mental institutions in this country. Nevertheless, those with mental illness are usually subject to harsher treatment, longer sentences, and leave jails or prisons sicker than when they entered. In an extreme example, also at Rikers, a mentally ill, homeless veteran on medication, who was arrested a week earlier for sleeping in a stairwell of a public housing building,

6. Raymond F. Patterson & Kerry Hughes, *Review of Completed Suicides in the California Department of Corrections and Rehabilitation, 1999 to 2004*, 59 PSYCHIATRIC SERVICES, 676, 678 (2008). See Thomas W. White et al., *A Comprehensive Analysis of Suicide in Federal Prisons: A Fifteen-Year Review*, 9 J. CORRECTIONAL HEALTH CARE 321, 332 (2002).

7. David Lovell, *Patterns of Disturbed Behavior in a Supermax Population*, 35 CRIM. JUST. & BEHAV. 985, 990 (2008).

8. DORIS J. JAMES & LAUREN E. GLAZE, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, SPECIAL REPORT: MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 3 (2006), available at <http://www.bjs.gov/content/pub/pdf/mhppji.pdf>.

9. *Id.*

10. E. FULLER TORREY ET AL., TREATMENT ADVOCACY CTR. & NAT'L SHERIFF'S ASS'N, MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES 1 (2010), available at http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.

died when his cell heated to over 100 degrees.¹¹ In mental healthcare settings, heat is generally monitored due to its potentially lethal interaction with common antipsychotic medications.

II. THE MENTALLY ILL IN INCARCERATION

The circumstances which led to this disproportionate representation of mental illness in the correctional setting did not arise by happenstance but rather is a tragic consequence of inadequate community mental healthcare and an indicator of where our society has chosen to make its investments. There are two principal reasons.

First, the nation failed in its attempt to “deinstitutionalize” the mentally ill, as it planned to on a large scale since the late 1960s, with the development of psychiatric medications that would make this possible. The plan was well-meaning, with the intent to release the patients from mental hospitals and to treat them in the community, where they might lead more normal lives. Only the first half of the plan was ever carried out, however; the second half, which depended on the creation of community-based housing and treatment facilities, was largely ignored or defunded, resulting in an outpour of unstable and ill individuals literally onto the streets. In a recent three-year period alone, \$4.35 billion in funding for mental-health services was cut from state budgets across the nation.¹²

Second, the United States experienced an unprecedented year-by-year increase in rates of penal incarceration, beginning at around the same time, in the mid-1970s, to a rate that is *sevenfold* of the average of U.S. history up to that point, and higher than that of any other nation on record today.¹³ Again, this was the result of a well-meaning effort to protect the public, beginning with President Nixon’s call for “wars” on crime and on drugs. Even after the national crime rate dropped by more than 40% over the last twenty years, the incarceration rate has scarcely dwindled, and public investment in prisons outweighs that of higher education or the treatment of mental illness. According to the U.S. Bureau of Justice Statistics, about 0.94% of adults residing in the United States were incarcerated in federal and state prisons and

11. Michael Schwartz, *Correction Dept. Investigating Death of Inmate at Rikers Island*, N.Y. TIMES (March 19, 2014), <http://www.nytimes.com/2014/03/20/nyregion/correction-dept-investigating-death-of-inmate-at-rikers.html>.

12. ROBERT W. GLOVER ET AL., NAT’L ASS’N OF STATE MENTAL HEALTH PROGRAM DIRS., PROCEEDINGS ON THE STATE BUDGET CRISIS AND THE BEHAVIORAL HEALTH TREATMENT GAP: THE IMPACT ON PUBLIC SUBSTANCE ABUSE AND MENTAL HEALTH TREATMENT SYSTEMS 1 (2012), *available at* http://www.nasmhpd.org/docs/Summary-Congressional%20Briefing_March%202022_Website.pdf.

13. ROYALL WALMSLEY, INT’L CTR. FOR PRISONS STUDIES, WORLD PRISON POPULATION LIST (2013), *available at* <http://prisonstudies.org>.

county and city jails by year-end 2011.¹⁴ If the number of adults on probation or on parole are included, about 2.9% of adults in the U.S. resident population, or a total of 6,977,700 adults were under correctional supervision (probation, parole, jail, or prison) in 2011.¹⁵ A 2014 report published by the National Research Council asserts that the prison population of the United States “is by far the largest in the world. Just under one-quarter of the world’s prisoners are held in American prisons.”¹⁶ The United States currently has the highest documented imprisonment rate in the world; at the end of 2009, it incarcerated 743 adults per 100,000 population.¹⁷ The rise has remained steady since the 1970s regardless of the rise or fall in crime rates, due to profound ideological changes that manifested in harsher punishments, longer sentencing guidelines, fewer discretions for parole authorities, and the elimination of rehabilitation programs following a study that gave legitimacy to the sentiment that “nothing works.”¹⁸

Incarceration at these levels has a powerfully negative social influence: poor and minority communities suffer the most, bearing a disproportionate share of broken families, increases in criminal activity, difficulty finding employment post-imprisonment, and a range of medical and mental health problems that affect generations. As many as one-fifth of the adult men in some neighborhoods are in prison at any given time, and as many as one in three black men can expect to go to prison in their lifetime.¹⁹ Without opportunities and without follow-up, rates of recidivism are extremely high, and an ensuing cultural change invites others to follow suit and to feel pride in their predicament, like a legacy from father to son. Massive disenfranchisement could affect policy, as these populations lose their right to vote or to sit on juries for the rest of their lives, while the billions spent on prisons per year wrings funds from social welfare programs that would have addressed the poverty that fuels criminal activity in the first place.²⁰

Furthermore, the proportion of people in this country who are currently housed in either a mental hospital or a correctional facility is almost exactly the

14. LAUREN E. GLAZE, BUREAU OF JUSTICE STATISTICS, CORRECTIONAL POPULATIONS IN THE UNITED STATES, 2011, at 1 (2010), available at <http://www.bjs.gov/content/pub/pdf/cpus11.pdf>.

15. *Id.*

16. *The Growth of Incarceration in the United States: Exploring Causes and Consequences*, NAT’L ACADS. PRESS, <http://www.nap.edu/catalog/18613/the-growth-of-incarceration-in-the-united-states-exploring-causes> (last visited Mar. 6, 2015).

17. LAUREN E. GLAZE, BUREAU OF JUSTICE STATISTICS, U.S. DEP’T OF JUSTICE, NCJ 231681, CORRECTIONAL POPULATIONS IN THE UNITED STATES, 2009 7 (2010), available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/cpus09.pdf>.

18. Robert Martinson, *What Works?—Questions and Answers About Prison Reform*, PUBLIC INTEREST, Spring 1974, at 22, 48.

19. Marc Mauer, *Addressing Racial Disparities in Incarceration*, 91 supp. 3 PRISON J. 87S, 88S (Sept. 2011).

20. ERNEST DRUCKER, A PLAGUE OF PRISONS: THE EPIDEMIOLOGY OF MASS INCARCERATION IN AMERICA 47 (2011).

same as it was fifty years ago, before the deinstitutionalization movement began, resulting in what is sometimes called “trans-institutionalization.”²¹ Then, approximately 75% were in mental hospitals and only 25% in prisons, jails, and juvenile detention centers; today, 95% are in correctional institutions and only 5% in mental hospitals.²² These developments have enormous consequences for those who are mentally ill. In spite of the measures that are taken to provide adequate care—which is still woefully lacking—and to provide acceptable standards of care—which is hardly possible in a correctional setting—there is the problem of jails and prisons being neither designed nor prepared, and their staff being neither trained nor adequate in number, to treat these individuals appropriately, as illustrated above. The result is that mentally ill individuals are currently thrown into environments that are inherently pathogenic (causing or capable of causing disease), remain there for longer periods (with an average stay at 215 days, while that for all inmates at Rikers is 42 days),²³ and receive little meaningful support when they get out.²⁴

III. THE MENTAL EFFECTS OF DOUBLE INCARCERATION OR ISOLATION

Still, *negative* human contact within prisons is better than *no* contact. Isolation is significant in the lives of mentally ill inmates, who are more likely to spend time in solitary confinement. Only 60% of those with mental illness are noted to receive treatment while under incarceration,²⁵ but while in isolation, access to care is even more difficult. Mental illness by nature is often very painful: imagine hearing threatening voices that one cannot block out; creating delusions to try to explain the overwhelming fear that appears for no reason; experiencing clinical depression that makes suicide seem a desirable relief; or incessantly reexperiencing the terrible trauma that caused illness in the first place, as a symptom of the illness. Physical illness can be blocked out by the mind; mental illness afflicts the mind itself. Allowing mental illness to grow severe enough as for the afflicted to deny illness, to refuse treatment, and—as we are increasingly observing—to become violent, is one of the ways in which society has shown neglect. Solitary confinement also has been noted

21. See James Gilligan, *The Last Mental Hospital*, 72 *PSYCHIATRIC Q.* 1 (2001).

22. See Bernard E. Harcourt, *From the Asylum to the Prison: Rethinking the Incarceration Revolution*, 84 *TEX. L. REV.* 1751 (2006).

23. Fox Butterfield, *Asylums Behind Bars: A Special Report.; Prisons Replace Hospitals for the Nation's Mentally Ill*, *N.Y. TIMES* (March 5, 1998), <http://www.nytimes.com/1998/03/05/us/asylums-behind-bars-special-report-prisons-replace-hospitals-for-nation-s.html>.

24. David Lovell et al., *Recidivism and Use of Services Among Persons with Mental Illness After Release from Prison*, 53 *PSYCHIATRIC SERVICES* 1290 (2002).

25. PAULA M. DITTON, BUREAU OF JUSTICE STATISTICS, SPECIAL REPORT: MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS 9 (1999), available at <http://www.prisonpolicy.org/scans/bjs/mhtip.pdf>.

to induce a “psychiatric syndrome” in previously healthy individuals.²⁶ The stress of these circumstances bears out in a study of Rikers Island records between 2010 and 2013: of all inmates, 7.3% of inmates were placed in solitary confinement at some point, but that small population accounted for 53.3% of all the acts of self-harm (over 1000 acts).²⁷

There is a long history behind the research regarding possible psychological and physiological harm resulting from solitary confinement, dating back to the 1860s.²⁸ The first comment by the U.S. Supreme Court, about solitary confinement’s effects of reducing mental and physical capabilities, was made in 1890.²⁹ The Quakers had advocated for it with the best intentions in order to provide the prisoner with solitude “to reflect upon his misdeeds” and to restore his relationship with God.³⁰ However, the dysfunction of this model was already evident soon after their institution, causing prisons to close down or to change approaches altogether on the basis that the particularly austere conditions did not have any discernible effect on crime, while prisoners became more unruly and insane.³¹ Visitors of U.S. prisons—including Alexis de Tocqueville and Charles Dickens—arrived as avid advocates of prison reform but left denouncing the method of isolation. De Beaumont and de Tocqueville wrote, “[T]his absolute solitude, if nothing interrupt it, is beyond the strength of man; it destroys the criminal without intermission and without pity; it does not reform, it kills. . . . [F]ive of them, had already succumbed”³² Dickens wrote, “I believe it, in its effects, to be cruel and wrong”³³

Isolation can be more harmful than negative human contact because human beings are neurologically and psychologically social animals. Social contact is like oxygen or food: we do not notice how essential it is until we have known suffocation or hunger. Isolation has been described to be as difficult, if not more, to withstand than physical torture.³⁴ When inmates request isolation

26. See Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 WASH. U. J.L. & POL’Y 325, 334 (2006).

27. Fatos Kaba et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 AM. J. PUB. HEALTH 442, 442 (2014).

28. See generally Peter Scharff Smith, “Degenerate Criminals”: *Mental Health and Psychiatric Studies of Danish Prisoners in Solitary Confinement, 1870-1920*, 35 CRIM. JUST. & BEHAV. 1048 (2008).

29. *In re Medley*, 134 U.S. 160 (1890); see 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. OFFENDER THERAPY & COMP. CRIMINOLOGY 622, 623-24 (2008).

30. Stephanie Elizondo Griest, *The Torture of Solitary*, 36 WILSON Q. 22, 24 (2012).

31. See LAWRENCE FRIEDMAN, *CRIME AND PUNISHMENT IN AMERICAN HISTORY* (1993).

32. GUSTAVE DE BEAUMONT & ALEXIS DE TOCQUEVILLE, *ON THE PENITENTIARY SYSTEM IN THE UNITED STATES, AND ITS APPLICATION IN FRANCE; WITH AN APPENDIX ON PENAL COLONIES, AND ALSO, STATISTICAL NOTES* 5 (Francis Lieber trans., 1833).

33. CHARLES DICKENS, *AMERICAN NOTES FOR GENERAL CIRCULATION* 39 (1842).

34. See Anna Conley, *Torture in US Jails and Prisons: An Analysis of Solitary Confinement Under International Law*, 7 VIENNA J. ON INT’L CONST. L. 415, 422 (2013);

themselves, intending to get away from the very real threat of attack that is the daily life in prisons, they do not anticipate how agonizing solitary confinement can be when it comes to persist for weeks, months, years, or even decades, as it is practiced in this country. When correctional staff administers solitary confinement not for punishment but for protection, say, of inmates who are at risk of being assaulted for their mental illness, they may not recognize the additional harm they are afflicting, even to the patient who is paranoid and already isolating oneself. It is important to note that, like many psychological interventions, isolation is not without controversy, as human beings are resilient and responses can widely vary. However, regardless of arguments of improved methodology, the handful of studies³⁵ that show little harmful effect are often too small in sample size, never definitive (since randomized controlled trials, the gold standard for determining causality, are extremely difficult to do in this setting), and too few in number to counter the vast documentation of the damaging effects of social and sensory deprivation (this literature is quite sizeable, spanning over 150 years, and too numerous to be all-inclusive in any short paper such as this one).³⁶

Whether and how isolation damages individuals' mental health depends on duration, circumstances, and personal characteristics, but for many the effects are substantial—for some, even after short periods of confinement. This is not surprising given our human makeup: continually emerging neuroscientific evidence reveals that human beings, having an almost explosive growth in brain cells compared to our next of kin in primates, are by far the most social among them.³⁷ The highly developed and enormous frontal brain in human beings makes social input crucial to our development and survival. Numerous sensory deprivation and perceptual deprivation studies have revealed that isolating people and severely restricting sensory stimulation can provoke drastic reactions and symptoms—even after a duration of hours or days—including, for example, hallucinations, confusion, lethargy, anxiety, panic, time distortions, impaired memory, and psychotic behavior.^{38,39} Social deprivation,

Hernán Reyes, *The Worst Scars Are in the Mind: Psychological Torture*, 89 INT'L REV. RED CROSS 591 (2007).

35. See, e.g., Peter Suedfeld et al., *Reactions and Attributes of Prisoners in Solitary Confinement*, 9 CRIM. JUST. & BEHAV. 303 (1982); Ivan Zinger et al., *The Psychological Effects of 60 Days in Administrative Segregation*, 43 CANADIAN J. CRIMINOLOGY 47 (2001).

36. The senior author noted the difficulty of giving a full list of citations on the harmful effects of solitary confinement, due to sheer volume, in an earlier work. JAMES GILLIGAN & BANDY LEE, CONSULTANTS' RESPONSE TO THE RESPONSE FROM THE NYC OFFICE OF THE MAYOR, THE DEPARTMENT OF CORRECTIONS, AND THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE FROM SEPTEMBER 23, 2013, OCTOBER 3, 2013 2 (2013), available at <http://www.nycjac.org/storage/Response%20to%20DOC%20response%2010-03-13.pdf>.

37. See JOHN T. CACIOPPO & WILLIAM PATRICK, LONELINESS: HUMAN NATURE AND THE NEED FOR SOCIAL CONNECTION (2008); BRUCE E. WEXLER, BRAIN AND CULTURE: NEUROBIOLOGY, IDEOLOGY, AND SOCIAL CHANGE (2006).

38. M. Zuckerman, *Hallucinations, Reported Sensations, and Images*, in SENSORY DEPRIVATION: FIFTEEN YEARS OF RESEARCH (J.P. Zubek, ed., 2008).

furthermore, is considered to be a prominent factor in a variety of mental diseases, without counting poverty, inequality, and other societal deprivations that are strongly linked with mental illness.⁴⁰ Additionally, the social and sensory deprivation characteristic of solitary confinement is often compounded by confusing or distressing abnormal sensory stimulation (inmates may shout or speak through ventilation systems in order to relieve themselves of the isolation, which in turn creates a cacophony of disembodied sounds that one cannot block out, like the voices in one's head).

The flip side of the malleable human brain is that while it may offer resilience from harm in some instances, it can be permanently negatively shaped in others. The last few decades of neuroscientific research has revealed that the human brain continues to be shaped well into a person's mid-twenties, with the greatest growth and development in the first years of life and a second phase in adolescence.⁴¹ This has shed new light on how lifelong illnesses, such as schizophrenia and bipolar disorder, most often have their onset during adolescence or early adulthood (commonly 17 to 21 for men and 25 to 29 for women). Therefore, the situation of placing this age group under the stressful conditions of solitary confinement, in addition to imprisonment, becomes a practice of illness generation. Even in the absence of major mental illness, youth at this critical stage of brain development require social stimulation for proper growth and are vulnerable to behavioral, emotional, and interpersonal problems if those needs are not met. Thus affecting youth, prisons and imprisonment within prisons at massive scale become a powerful influence on the future of our society. Yet the United States incarcerates more of its youth than any other country in the world, exposing them to isolation more than any other age group (for example, in 2012, 14.4% of all adolescents between 16- and 18-years-old were held in solitary confinement at some point while detained in Rikers Island).⁴² Solitary confinement thus is the extreme end of the general pathology of prisons.

IV. LEGAL INTERVENTIONS

The law has played a critical role in addressing solitary confinement. Since 1995, there have been several landmark lawsuits which have attempted to address the impact of incarceration on mentally ill prisoners, a significant

39. J.P. Zubek, *Behavioral and Physiological Effects of Prolonged Sensory and Perceptual Deprivation: A Review*, in *MAN IN ISOLATION AND CONFINEMENT* (J.E. Rasmussen ed., 1973).

40. See C. Goosen, *Abnormal Behavior Patterns in Rhesus Monkeys: Symptoms of Mental Disease?*, 16 *BIOL. PSYCHIATRY* 697 (1981).

41. See Danya Glaser, *The Effects of Child Maltreatment on the Developing Brain*, 82 *MEDICO-LEGAL J.* 97 (2014).

42. ACLU & HUMAN RIGHTS WATCH, *GROWING UP LOCKED DOWN: YOUTH IN SOLITARY CONFINEMENT IN JAILS AND PRISONS ACROSS THE UNITED STATES* (2012), available at <http://www.hrw.org/sites/default/files/reports/us1012ForUpload.pdf>.

number focusing on the impact of solitary confinement as a violation of Eighth Amendment constitutional rights.⁴³ These courtroom challenges have been accompanied by Civil Rights of Institutionalized Personal Act of 1980 (CRIPA) investigations, the Rikers New York U.S. Attorney's Office report being one such example. These cases provide vivid reading about the conditions of prisoners.

In the first of these cases, *Madrid v. Gomez*,⁴⁴ prisoners at the Pelican Bay State Prison in Crescent City California filed a class-action lawsuit against the California Department of Corrections. The lawsuit alleged a number of unconstitutional conditions of confinement. In the first holding, the judge described putting mentally ill prisoners in solitary as akin to "putting an asthmatic in a place with little air . . ."⁴⁵ and characterized the image of inmates in their cells as "hauntingly similar to that of caged felines pacing in a zoo."⁴⁶ The court ordered that mentally ill prisoners be removed from solitary confinement in the secure housing unit (SHU) because "reduction in environmental stimulation and social interaction can have serious psychiatric consequences for some people."⁴⁷

Similar circumstances for the mentally ill were detailed in Wisconsin's Supermax Correctional Institution in the case of *Jones 'El v. Berge*.⁴⁸ In that class-action suit on behalf of all inmates at Boscobel, Correctional Facility, plaintiffs described an incarceration of "limited social interaction and almost total idleness," in which prisoners are "fed in their cells" and "every aspect of daily life is controlled and monitored."⁴⁹ Special note was made on the impact on mentally ill prisoners:

Seriously mentally ill inmates in isolated conditions lose total control of their lives. They feel incapable of being an active agent in their lives; this feeling exacerbates depressive tendencies. Without interaction and without diurnal rhythms provided by light, seriously mentally ill inmates lose their sense of time and of the future, leading to great despair and hopelessness. This sense of doom is compounded when seriously mentally ill inmates are not capable of following⁵⁰ the rules necessary to earn their way out of the most restrictive status.

In a particularly poignant note, the ruling noted: "By standing on the bed and craning his neck, an inmate can glimpse the sky through a small sealed skylight. In general, seriously mentally ill inmates do not have the presence of

43. *E.g.*, *Austin v. Wilkinson*, 204 F. Supp. 2d 1024 (N.D. Ohio 2002); *Jones 'El v. Berge*, 164 F.Supp.2d 1096 (W.D. Wis. 2001); *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995).

44. *See Madrid*, 889 F. Supp. at 1155.

45. *Id.* at 1265.

46. *Id.* at 1229.

47. *Id.* at 1232.

48. *Jones 'El v. Berge*, 164 F. Supp. 2d 1096, 1096 (W.D. Wis. 2001).

49. *Id.* at 1099.

50. *Id.* at 1103.

mind to perform this maneuver.”⁵¹ This case, which was settled by a consent decree, ultimately provided that “[n]o seriously mentally ill prisoners [would] be sent to SMCI nor will seriously mentally ill prisoners at the facility be permitted to remain there.”⁵²

Jones was followed shortly thereafter by *Austin v. Wilkinson*,⁵³ which challenged conditions at Ohio State Penitentiary described as “synonymous with extreme isolation.”⁵⁴ In a preliminary injunction that later was affirmed in a consent decree, defendants were enjoined from returning any of the seriously mentally ill class members to the Penitentiary.⁵⁵

As other commentators have pointed out, class-action suits identifying solitary confinement as a harm to mentally ill defendants usually encompass other harms as well, such as inadequate medical and mental health screenings and care, and excessive force.⁵⁶ In the matter of *Coleman v. Wilson*, a federal court found that the mental health system operated by the California Department of Corrections was unconstitutional and that prison officials were deliberately indifferent to the needs of mentally ill inmates.⁵⁷ Those institutions continue to be monitored by a court-appointed special master, and in 2007 the plaintiffs in *Coleman v. Schwarzenegger*⁵⁸ alleged unconstitutional the mental healthcare offered by the Californian correctional system, which forced the California Department of Corrections and Rehabilitation (CDCR) to improve its care. In 2010, *Plata v. Schwarzenegger* consolidated this by alleging that the CDCR’s medical services were inadequate and violated the Eighth Amendment; after repeated violations, the CDCR was held in civil contempt, and the medical healthcare was placed in receivership.⁵⁹ *Brown v. Plata* was a 2011 decision of the U.S. Supreme Court that held that a court-mandated population limit was necessary to remedy a violation of the Eighth Amendment and ordered California to reduce its prison population to 137.5% of design capacity within two years.⁶⁰ As a result, several states have considered steps to reduce the numbers of mentally ill in solitary confinement. Colorado was the most recent, passing legislation in June 2014 that precluded inmates with serious mental illness from being placed in solitary confinement (though

51. *Id.* at 1099.

52. Settlement Agreement at 5, Jones ‘El v. Litscher, No. 00-C-421-C (W.D. Wis. Jan. 24, 2002).

53. 204 F. Supp. 2d 1024 (N.D. Ohio 2002).

54. *Wilkinson v. Austin*, 545 U.S. 209, 214 (2005).

55. *Austin v. Wilkinson*, No. 4:01-CV-071 at 27 (N.D. Ohio, Nov. 21, 2001).

56. See Reena Kapoor, *Taking the Solitary Confinement Debate out of Isolation*, 42 J. AM. ACAD. PSYCHIATRY & L. 3 (2014); 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).

57. *Coleman v. Wilson*, 912 F. Supp. 1282, 1323 (E.D. Cal. 1995).

58. *Coleman v. Schwarzenegger*, 2:90-cv-00520-LKK-JFM (E.D. Cal.) 2:90-CV-0520 LKK JFM.

59. See *Plata v. Schwarzenegger*, 603 F.3d 1088, 1090 (2010).

60. *Brown v. Plata*, 131 S. Ct. 1910, 1923 (2011).

exceptions are allowed for “exigent circumstances”).⁶¹ Yet even with a medical consensus that long-term isolation is harmful to prisoners with serious mental illness, either by directly causing clinical deterioration or by depriving them of treatment that would have resulted in improvement,⁶² and a growing judicial casebook, there is no unequivocal Supreme Court ruling on this issue. Some have held out hope that when the right case arises, international law will provide additional support for the proposition that lengthy conditions of solitary confinement constitutes either torture or cruel, inhuman, and degrading treatment. The U.S. Supreme Court has looked increasingly to the experience of the international community, particularly European countries, in determining the meaning of cruel and unusual punishment in modern society.

“[A]t least from the time of the Court’s decision in *Trop*, the Court has referred to the laws of other countries and to international authorities as instructive for its interpretation of the Eighth Amendment’s prohibition of ‘cruel and unusual punishments.’”⁶³ Both the United Nations (UN) Special Rapporteur on Torture and the UN Human Rights Committee have issued statements opining that solitary confinement may amount to cruel, inhuman, or degrading treatment. In 2011, the Special Rapporteur’s report made note that: “In some countries, the use of Super Maximum Security Prisons to impose solitary confinement as a normal, rather than an ‘exceptional’, practice for inmates is considered problematic.”⁶⁴ In the United States, however, “it is estimated that between 20,000 and 25,000 individuals are being held in isolation. . . .”⁶⁵ Further,

The adverse acute and latent psychological and physiological effects of prolonged solitary confinement constitute severe mental pain or suffering. . . . [T]he Special Rapporteur reiterates that, in his view, any imposition of solitary confinement beyond fifteen days constitutes torture or cruel, inhuman or degrading treatment or punishment, depending on the circumstances. He calls on the international community to agree to such a standard and to impose an absolute prohibition on solitary confinement exceeding fifteen consecutive days.⁶⁶

The Special Rapporteur’s note made note as well of the vulnerability of individuals with mental illness: “Prisoners with mental health issues deteriorate

61. S.B. 14-064, 69th Gen. Assemb., 2d Reg. Sess. (Colo. 2014) (enacted).

62. AM. PSYCHIATRIC ASS’N, POSITION STATEMENT ON SEGREGATION OF PRISONERS WITH MENTAL ILLNESS (2012).

63. *Roper v. Simmons*, 543 U.S. 551, 575 (2005).

64. Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman, or Degrading Punishment or Treatment, *Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 8, U.N. Doc. A/66/268 (Aug. 5, 2011).

65. *Id.*

66. *Id.* at 21.

dramatically in isolation. . . . The adverse effects of solitary confinement are especially significant for persons with serious mental health problems.⁶⁷

V. BEYOND LEGAL INTERVENTIONS

While the law has its critical place, society as a whole is not exempt from responsibility. Modern prisons only came into existence in the nineteenth century and were never employed to their current extent before forty years ago. Prisons are the most expensive and the least effective form of intervention for both the treatment of mental illness and the purpose of crime control, as a sevenfold increase without making a dent in crime (until other social conditions changed) or solving the mental health crisis has shown. Fyodor Dostoevsky suggested that the degree of civilization in a society can be judged by entering its prisons.⁶⁸ We might say that the progress of our civilization could be measured by our ability to move *out* of prisons as our solution for social ills. Prisons have become the epitome of crisis containment and the abandonment of individuals for whom society cares little. We now know that the price we pay is the price of our civilization, of which an escalation of violence and insecurity until recent years and a spread of mental health problems were only symptoms. Like a person with mental illness who accelerates in improvement with the recognition of the need for treatment, we, too, may do well to acknowledge where we are ailing so that we can improve.

Thus, in the spirit of moving forward, we would like to make three recommendations for future advancement. First, *Consider Primary Prevention*. Violence prevention in recent decades has taken this approach, with multiple disciplines and sectors coming together to take it up as a major public health concern and not only one of security and criminal justice. With the launching of a major science-based report⁶⁹ and active campaigning by the World Health Organization, governments and international organizations have come together in a concerted effort to prevent violence in the least costly and most effective ways possible, often starting at the level of early childhood development. Not only have many cities, countries, and in some cases, whole regions experienced great reductions of violence, but also some reductions occurred much more rapidly than anticipated and, once established, were sustainable. In the United States, a precipitous decline in violence occurred when unemployment rates similarly dramatically went down, and once a less violent culture was established, a rise in unemployment rates did not necessarily translate to the same increase in violence.⁷⁰ While there will always be individuals who

67. *Id.* at 19.

68. FYODOR DOSTOEVSKY, *THE HOUSE OF THE DEAD* (1861).

69. WORLD HEALTH ORG., *WORLD REPORT ON VIOLENCE AND HEALTH* (2002).

70. JENNIFER L. TRUMAN & LYNN LANGTON, BUREAU OF JUSTICE STATISTICS, *CRIMINAL VICTIMIZATION, 2013* (2014), available at <http://www.bjs.gov/content/pub/pdf/cv13.pdf>; Bandy Lee, Bruce E. Wexler & James Gilligan, *Political Correlates of Violent*

become violent and need restraint, we have learned that a vast majority of violence, including violent crime, can be prevented.

Second, *Invest in Socialization*. As noted above, human beings require social stimulation to develop and thrive. While negative social stimulation is better than none, positive social stimulation can have surprisingly rehabilitative and *habilitative* results. One specific example the senior author has come to know well is the San Francisco's Resolve to Stop the Violence Project.⁷¹ In 1997, when the country was building super maximum facilities in every state, opting for behavioral control through isolation, the San Francisco Sheriff's Department instituted an innovative program that involved placing sixty violent men in an open dormitory (where one is exposed to potential assaults from anyone at all times, unlike a cell-block, where inmates have their own cells). Through intensive all-day programming that involved socializing with one another and even mentoring newcomers, the Project effectuated a violent episode rate of zero within a few weeks and maintained it for years, whereas in other similar dormitories (which were seldom *all* violent men), one violent episode per week was routine. As a rule, those released from solitary confinement are more violent than when they went in; under this program, those who stayed in the dormitory for four months or more experienced an 82.6% reduction in violent recidivism compared to a control group.⁷² This program is neither singular nor exceptional: multiple states have now tried similar approaches of reducing solitary confinement in favor of programming and social stimulation, with positive results.⁷³

Third, *Cultivate a Culture of Caring*. Societal health and wellbeing cannot be considered apart from the health and wellbeing of the most vulnerable. Even the most biological mental disorders are more environmentally than genetically determined (i.e., they will not occur if the environmental stressor is absent), so we can prevent a lot through simple caring. For example, we can increase the care of the mentally ill, for whom resources have now dwindled to preindustrial levels. We already know a lot about the treatment of mental illness, the minimization of symptoms and suffering, and the maximization of daily functioning. If one were to go to the Chamazi District of rural Tanzania, where they practice effective mental healthcare, and ask, "How did you figure out such successful care?" they probably would answer: "We learned it from you!"

Death Rates in the U.S., 1900-2010: Longitudinal and Cross-Sectional Analyses, 19 *AGGRESSION & VIOLENT BEHAV.* 727 (2014).

71. See generally Bandy Lee & James Gilligan, *The Resolve to Stop the Violence Project: Transforming an In-House Culture of Violence Through a Jail-Based Programme*, 27 *J. PUB. HEALTH* 149 (2005).

72. James Gilligan & Bandy Lee, *The Resolve to Stop the Violence Project: Reducing Violence in the Community Through a Jail-Based Initiative*, 27 *J. PUB. HEALTH* 143, 146 *tbl. 2* (2005).

73. See ACLU & STOP SOLITARY, *STATE REFORMS TO LIMIT THE USE OF SOLITARY CONFINEMENT 1* (2013), available at https://www.aclu.org/files/assets/stop_solitary_-_recent_state_reforms_to_limit_the_use_of_solitary_confinement.pdf.

[i.e., the Global North].”⁷⁴ What we lack, therefore, is not knowledge but political will. Advocating for those who do not have a voice, which include those with mentally illness as well as those who have committed offenses (who are now often the same), and caring for them so that they do not get so sick or antisocial in the first place is beneficial not only for those individuals but also for society as a whole. Cultivating such a culture across sectorial lines, involving doctors, lawyers, and policymakers, in partnership with vulnerable or voiceless populations, can then translate into laws and institutions that do not leave whole populations behind. Our lesson from the mass incarceration experiment is that caring does much more for our civilization than punishing, a realization that may be the first mark of a healthy society.

74. Bandy Lee, Notes from Tanzania (1999) (unpublished notes) (on file with Lee).