

SOLITARY CONFINEMENT OF MENTALLY ILL PRISONERS: A NATIONAL OVERVIEW & HOW THE ADA CAN BE LEVERAGED TO ENCOURAGE BEST PRACTICES

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I. INTRODUCTION

Nikko Jenkins, a mentally ill inmate at a Nebraska state prison who spent the majority of his sentence in solitary confinement, drew national attention for committing four gruesome murders just over a week after his release.¹ He was released directly from solitary back into society, despite his request to be sent to a psychiatric facility.² Jenkins' story is not uncommon—eighty-one percent of mentally ill inmates in state prison have prior criminal histories, and inmates who are released from solitary confinement are more likely to recidivate than their counterparts released from general population.³ In response to litigation and crimes – such as the Jenkins murders – prisons throughout the country are being forced to rethink their use of solitary and treatment of mental illness.

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¹ Todd Cooper, *Nikko Jenkins Sentenced to Death for "One of the Worst Killing Sprees in the History" of Nebraska*, OMAHA WORLD-HERALD (May 31, 2017), http://www.omaha.com/news/crime/nikko-jenkins-sentenced-to-death-for-one-of-the-worst/article_3d0b067a-4545-11e7-92a1-8b9317b69244.html.

² Teresa Wiltz, *Is Solitary Confinement on the Way Out?*, HUFFINGTON POST (Nov. 21, 2016), http://www.huffingtonpost.com/entry/is-solitary-confinement-on-the-way-out_us_58330bf4e4b0d28e55215277.

³ SASHA ABRAMSKY ET AL., HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 193 (2003), <https://www.hrw.org/reports/2003/usa1003/usa1003.pdf>; Anjali Tsui, *Does Solitary Confinement Make Inmates More Likely to Reoffend?*, PBS FRONTLINE (Apr. 18, 2017), <http://www.pbs.org/wgbh/frontline/article/does-solitary-confinement-make-inmates-more-likely-to-reoffend/>.

Solitary confinement is routinely used as a punishment for disciplinary violations in prison, and, as such, a disproportionate number of mentally ill inmates are transferred to solitary confinement.⁴ This is because prisoners who are mentally ill and receiving inadequate treatment find it exceedingly difficult to abide by the strict rules of prison,⁵ where even the most mentally sound inmates find it difficult to avoid rule violations. The disciplinary violations that can result in solitary confinement range from infractions as small as not standing up for count or illegally using a cell phone, to more serious violations for violent conduct, such as assault or mutual combat.⁶ State prisons report that thirty to fifty percent of inmates in solitary units are mentally ill.⁷ Moreover, the harsh conditions of solitary confinement worsen the symptoms of mental illness, including increased hallucinations, self-harm, and suicide attempts.⁸ A South Carolina prison reported that, “prisoners . . . who suffered from depression, schizophrenia and other mental illnesses were almost twice as likely as other prisoners to go to solitary, for an average of 647 days.”⁹ As demonstrated in South Carolina, not only are the mentally ill more likely to be placed in solitary confinement, they often find it exceedingly difficult to meet the requirements to be released back into the general prison population.¹⁰

While most challenges to solitary confinement have been brought under the Eighth Amendment ban against cruel and unusual punishment, the Americans with Disabilities Act (ADA) offers an additional and unique statutory path for mentally ill inmates. Prisons across the country range in the severity of their solitary confinement, providing different access to programming, out-of cell time, and overall time spent isolated from the general population in solitary units. However, the ADA may encourage improvement of these policies, with the practices set in place in some reformed institutions serving as a model for other institutions to follow suit in response to, or in anticipation of, similar litigation under the ADA.

Here, I will analyze the literature surrounding the effects of solitary confinement on people with mental disorders. Moreover, I will survey solitary confinement practices of prisons around the country and new

⁴ U.S. DEPT. OF JUSTICE, SPECIAL REPORT: USE OF RESTRICTIVE HOUSING IN U.S. PRISONS AND JAILS, 2011–12, at 1 (last visited Aug. 25, 2017), <https://www.bjs.gov/content/pub/pdf/urhuspj1112.pdf> (last visited Dec. 14, 2016).

⁵ Jeffrey L. Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, HUMAN RIGHTS WATCH (Nov. 1, 2010), <https://www.hrw.org/news/2010/03/01/solitary-confinement-and-mental-illness-us-prisons-challenge-medical-ethics>.

⁶ *Id.*; Emily Bazelon, *The Shame of Solitary Confinement*, N.Y. TIMES (Feb. 19, 2015), http://www.nytimes.com/2015/02/19/magazine/the-shame-of-solitary-confinement.html?_r=1 (describing the average length of solitary confinement for inmates caught posting on social media using an illegal cell phone as 512 days); *Id.*

⁷ ABRAMSKY ET AL., *supra* note 3, at 148–49.

⁸ Maclyn Willigan, *What Solitary Confinement Does to the Human Brain*, SOLITARY WATCH (Aug. 4, 2014), <http://solitarywatch.com/2014/08/04/what-solitary-confinement-does-to-the-human-brain/>.

⁹ Bazelon, *supra* note 6.

¹⁰ REBECCA WALLACE, ACLU COLO., OUT OF SIGHT, OUT OF MIND: COLORADO’S CONTINUED WAREHOUSING OF MENTALLY ILL PRISONERS IN SOLITARY CONFINEMENT I (2013), <http://aclu-co.org/wp-content/uploads/files/imce/Solitary%20Report.pdf>.

policies limiting the use of solitary confinement as a punishment. Next, I will consider how the ADA works in this context to curb the use of solitary confinement as an alternative to Constitutional claims. Lastly, I will present a model policy for prisons that would complement ADA litigation and lessen the severity of solitary confinement for the mentally ill.

II. BACKGROUND

A. PSYCHOLOGICAL EFFECTS OF SOLITARY CONFINEMENT

Solitary confinement is devastating to the mental health of all inmates who endure it, and the effect is compounded when an inmate lands in solitary confinement in large part due to active mental illness. Even prisoners who are mentally healthy upon entering solitary confinement experience what one psychologist called “isolation panic,” which includes “panic, rage, loss of control, and complete breakdown.”¹¹ Another leading researcher in the area, Stuart Grassian, conceived a classification for this psychiatric condition: “SHU syndrome,” describing the constellation of symptoms shown by individuals exposed to isolation.¹² SHU syndrome is “characterized by perceptual changes; affective disturbance; difficulty with thinking, concentration, and memory; disturbance of thought content; and problems with impulse control.”¹³ It is a testament to the severity of solitary confinement that most of the inmates exhibiting SHU syndrome in Grassian’s study had no previous history of mental illness.¹⁴ However, individual differences remain in inmates’ abilities to cope with solitary confinement, and some may decline less rapidly or to a lesser extent.¹⁵ For example, some inmates may be able to engage coping mechanisms in solitary confinement, whereas the mentally ill may find it harder to deploy those coping mechanisms, or may not have them at all given the untreated state of their mental health.¹⁶ Solitary confinement is “indisputably stressful, and it reliably overtaxes the resilience of many incarcerated offenders.”¹⁷ The mentally ill especially struggle to understand and control their mental disorders while navigating the prison system, as such they are among the most likely to be mentally overtaxed and the least likely to be resilient.

¹¹ Peter Scharff Smith, *The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature*, 34 CRIME & JUSTICE 441, 486 (2003).

¹² Stuart Grassian, *Psychopathological Effects of Solitary Confinement*, 140 AM. J. PSYCHIATRY 1450, 1459 (1983). SHU is the abbreviation used in prisons for “Secure Housing Unit,” which is synonymous with solitary confinement. Supermax is another iteration of solitary confinement by a different name. Prisons also refer to solitary confinement as Administrative Segregation (Ad-Seg).

¹³ Bruce A. Arrigo & Jennifer Leslie Bullock, *The Psychological Effects of Solitary Confinement on Prisoners in Supermax Units*, 52 INT’L J. OFFENDER THERAPY & COMPARATIVE CRIMINOLOGY 622, 628 (2008) (summarizing the symptoms associated with Grassian’s SHU Syndrome).

¹⁴ *Id.* at 629.

¹⁵ Smith, *supra* note 11, at 474–75.

¹⁶ *Id.*

¹⁷ Hans Toch, *The Future of Supermax Confinement*, 81 THE PRISON J. 376, 378 (2001) (responding to POWs kept in solitary confinement during World War II and were reportedly “brainwashed” as a result, which inspired a wave of interest in solitary confinement in the United States after the war, even after it had fallen out of favor as a disciplinary technique in prisons).

The vast majority of individuals subjected to solitary confinement react negatively and exhibit symptoms of declining mental health, even if they enter solitary confinement in a mentally healthy state. Professors at McGill University conducted an experiment with isolation and sensory-deprivation on a random sample of male volunteers, who almost unanimously reported experiencing hallucinations.¹⁸ Another study at a Kentucky prison found that, “[d]isciplinary segregation inmates reported significantly more feelings and thoughts of personal inadequacy, inferiority, withdrawal and isolation than inmates in the general population. Disciplinary segregation inmates also reported significantly more feelings, thoughts and/or actions of rage, anger, resentment and aggression”¹⁹ As such, even the mentally robust sample used in this study experienced extreme psychological reactions to solitary confinement.²⁰

One study of the literature surrounding the psychological effects of solitary confinement categorized the symptoms into five categories: (1) “physiological symptoms and reactions;” (2) “confusion and impaired concentration;” (3) “hallucinations, illusions and paranoid ideas;” (4) “emotional reactions and impulsive actions;” (5) and “lethargy and debilitation.”²¹ The physiological symptoms of solitary confinement include severe headaches, oversensitivity to stimuli, and weight loss.²² One study found that on average, prisoners lost ten to twenty pounds while in solitary confinement.²³ Confusion resulting from solitary confinement can culminate in “difficulty in communicating with individuals from outside,”²⁴ which may disadvantage formerly isolated prisoners’ later chances of release on parole, since they may not be able to adequately articulate their remorse and rehabilitation to the parole board. Studies have also found that isolated prisoners often engage in violent and aggressive fantasies.²⁵ As one inmate in a solitary unit in a maximum security prison in Maine describes, “[m]onsters! This is what they create in here, monsters. And then they drop you into society and tell you go ahead be a good boy. Can’t conduct yourself like a human being when they treat you like an animal.”²⁶ As such, the justification that solitary confinement is used as a method to teach disruptive inmates to modify their behavior and become less violent is not achieved, since it can actually create more angry and violent inmates.²⁷ As one researcher notes, “the arguments given on behalf of [solitary] facilities are few in number and almost embarrassingly brief.”²⁸ Moreover, depression and

¹⁸ Smith, *supra* note 11, at 470.

¹⁹ Holly A. Miller & Glenn R. Young, *Prison Segregation: Administrative Detention Remedy or Mental Health Problem?*, 7 CRIM. BEHAV. & MENTAL HEALTH 85, 91–92 (1997).

²⁰ *Id.* at 88 (stating that none of the participants were seeking mental health treatment at the time of the study).

²¹ Smith, *supra* note 11, at 488–93

²² *Id.*

²³ *Id.* at 489.

²⁴ *Id.* at 490.

²⁵ *Id.* at 491.

²⁶ Dan Edge & Elizabeth C. Jones, *Solitary Nation*, PBS FRONTLINE (Apr. 22, 2014), <http://www.pbs.org/wgbh/frontline/film/solitary-nation>.

²⁷ Smith, *supra* note 11, at 443.

²⁸ *Id.* at 444.

other mood disorders are commonly found, with studies reporting roughly seventy to ninety percent of prisoners in solitary suffering from anxiety.²⁹ Depression and anxiety may also explain why prisoners in solitary confinement are often lethargic, particularly because solitary confinement can bring about “a complete breakdown . . . of the identity of the isolated individual” that effectively “erases the personality.”³⁰ The negative effect of solitary confinement on even individuals without mental illness highlights the incredibly destructive nature of solitary confinement on the psyche.

B. MENTAL ILLNESS IN U.S. PRISONS: PREVALENCE & DEINSTITUTIONALIZATION

According to a study by the U.S. Department of Justice, more than half of all jail and state prison inmates have been diagnosed and treated for mental health problems in the past.³¹ These mental health issues may range from anxiety and mood disorders to serious mental illnesses.³² The deinstitutionalization of the mentally ill is a major source of the high incidence of mental illness in prisons today.³³ Beginning in the 1960s, inpatient facilities were forced to close when funding to state mental health institutions fell out of favor and was diverted to “community-based” services, which aimed to keep the mentally ill out of hospital settings.³⁴ These community based programs were also given inadequate funding, resulting in an increase of individuals with untreated mental illness.³⁵ Unfortunately, as inpatient resources declined, prisons were forced to fill the gap.³⁶ In California, “the incarceration rate . . . skyrocketed when funding was pulled from its state mental hospitals,” as formerly hospitalized mental health patients were forced into the criminal justice system.³⁷ However, prisons are ill-equipped, understaffed, and under-funded when it comes to treating the mentally ill.³⁸ Roughly half of the prisons responding to one survey reported that they do not have adequate mental health staff.³⁹

Mentally ill inmates in prison classified as having a “serious mental illness” may be afforded some extra protections. Prisoners with serious mental illness are typically the most negatively affected by solitary confinement.⁴⁰ As such, the case law and prison reform on the use of solitary

²⁹ *Id.* at 492.

³⁰ *Id.*

³¹ U.S. DEPT. OF JUSTICE, *supra* note 4, at 6 (the DOJ additionally notes that inmates with past or current mental health diagnoses were more likely to have spent time in restrictive housing during their time in prison).

³² *Id.*

³³ DARRELL STEINBERG ET AL., STANFORD LAW SCH., WHEN DID PRISONS BECOME ACCEPTABLE MENTAL HEALTHCARE FACILITIES? 6 (2015), http://law.stanford.edu/wp-content/uploads/sites/default/files/child-page/632655/doc/slspublic/Report_v12.pdf.

³⁴ *Id.* at 5–6.

³⁵ Deana Pann, *Timeline: Deinstitutionalization and its Consequences*, MOTHER JONES (Apr. 29, 2013), <http://www.motherjones.com/politics/2013/04/timeline-mental-health-america>; *Id.*

³⁶ STEINBERG ET AL., *supra* note 33, at 7–8.

³⁷ *Id.* at 5.

³⁸ *Id.* at 7; see also ABRAMSKY ET AL., *supra* note 3.

³⁹ Metzner & Fellner, *supra* note 5, at 105.

⁴⁰ *Id.* at 104–05.

confinement has particularly concentrated on keeping seriously mentally ill inmates out of isolation. “In prisons, the category of serious mental illness is typically limited to conditions [such as] schizophrenia, serious depression, and bipolar disorder.”⁴¹ However, prisons may consider inmates with serious personality disorders, such as anti-social personality disorder and borderline personality disorder, seriously mentally ill as well.⁴² These inmates are potentially among the most likely to be sent to solitary confinement because the symptoms of their mental illness manifest such that these inmates “may appear ‘normal’—just obnoxious or difficult,” but they nevertheless are likely engaging in disruptive, rule-breaking behaviors driven by their mental illness, rather than a disregard for the institutional rules.⁴³ According to one survey, “an estimated 15% of State prisoners and 24% of jail inmates reported symptoms that met the criteria for psychotic disorder.”⁴⁴ In contrast, the prevalence of serious mental illness among adults in the United States is only 4%.⁴⁵

However, many mentally ill inmates suffer from less serious, but nevertheless disruptive, mental disorders such as mood disorders and personality disorders.⁴⁶ These inmates are also disadvantaged in solitary confinement, which may make the symptoms of their existing mental disorder worse or develop a serious mental illness as a result of isolation.⁴⁷ According to the U.S. Department of Justice, “[a]bout 23% of State prisoners and 30% of jail inmates reported symptoms of major depression.”⁴⁸ This is also much higher than the incidence in the general population, which is at 6.7%.⁴⁹ Depression is the highest reported mental disorder among inmates, followed by bipolar disorder, anxiety, and post-traumatic stress disorder.⁵⁰

C. PSYCHOLOGICAL EFFECTS OF SOLITARY CONFINEMENT ON THE MENTALLY ILL

Solitary confinement has devastating effects on the mentally ill, often exacerbating existing symptoms of mental illness and causing new mental health issues to arise.⁵¹ The case law on the subject has markedly

⁴¹ ABRAMSKY ET AL., *supra* note 3, at 31.

⁴² *Id.* at 32.

⁴³ *Id.* at 33.

⁴⁴ DORIS J. JAMES & LAUREN E. GLAZE, BUREAU JUSTICE STATISTICS, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1 (2006), <https://www.bjs.gov/content/pub/pdf/mhppji.pdf>.

⁴⁵ Jonaki Bose et al., *Key Substance Use and Mental Health Indicators in the United States*, DEPT. OF HEALTH & HUM. SERV., (last visited Oct. 22, 2017), [https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015.htm](https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.htm).

⁴⁶ JAMES & GLAZE, *supra* note 44, at 2.

⁴⁷ Willigan, *supra* note 8.

⁴⁸ JAMES & GLAZE, *supra* note 44, at 1.

⁴⁹ Bose et al., *supra* note 45.

⁵⁰ KIDUEK KIM, URBAN INSTITUTE, THE PROCESSING AND TREATMENT OF MENTALLY ILL PERSONS IN THE CRIMINAL JUSTICE SYSTEM 9 (last visited Aug. 28, 2017), <http://www.urban.org/sites/default/files/publication/48981/2000173-The-Processing-and-Treatment-of-Mentally-Ill-Persons-in-the-Criminal-Justice-System.pdf>.

⁵¹ Willigan, *supra* note 8.

disapproved of solitary confinement, particularly for the mentally ill.⁵² A landmark case litigating abuses of solitary confinement at Pelican Bay's supermax facility opined that, "[P]lacing [mentally ill inmates] in [solitary confinement] is the mental equivalent of putting an asthmatic in a place with little air to breathe."⁵³ Further, the literature on the psychological effects of solitary confinement on the mentally ill unequivocally counsels against punishing the mentally ill with solitary confinement.⁵⁴ For example, the American Psychiatric Association (APA) issued a report stating that "placement of inmates with serious mental illnesses in settings with 'extreme isolation' is contraindicated because many of these inmates' psychiatric conditions will clinically deteriorate or not improve."⁵⁵

Solitary confinement is a particularly inappropriate punishment for the mentally ill because it does not serve the justifications for punishment. One study has pointed out that the mentally ill "are prone to act bizarrely and inappropriately because of their psychiatric condition. Acting out and rule breaking can be signs of a mental disorder that is not adequately treated"⁵⁶ As such, deterring that rule breaking behavior cannot be achieved "when individuals have no meaningful control over their conduct."⁵⁷ The primary aim of solitary confinement generally as well as of the mentally ill is to "maintain prison order"⁵⁸ when inmates are a threat to the institution's safety. However, this justification is undermined by the fact that the mentally ill are not given adequate mental health treatment or rehabilitative programming,⁵⁹ making behavior modification of the mentally ill in solitary confinement nothing more than pretext. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment has found that solitary confinement actually "*militate[s] against* reform and rehabilitation and can impair physical and mental health."⁶⁰ As such, prisons misguidedly use solitary confinement to eliminate the danger posed by mentally ill inmates who cannot comply with the strict rules set in place to maintain the prison's order. Instead, solitary confinement results in inmates whose mental illnesses are even more severe because their punishment actively works against their rehabilitation.

One of the most telling instances of the profound effect of solitary confinement on mental illness is the increase in suicide rates among mentally

⁵² See Jennifer Wedekind, *Fact Sheet: Solitary Confinement and the Law*, SOLITARY WATCH 1 (2011), <http://solitarywatch.com/wp-content/uploads/2011/06/FACT-SHEET-Solitary-Confinement-and-the-Law1.pdf>.

⁵³ *Madrid v. Gomez*, 889 F. Supp. 1146, 1265 (N.D. Cal. 1995).

⁵⁴ SAL RODRIGUEZ, SOLITARY WATCH, FACT SHEET: SOLITARY EFFECTS ON SOLITARY CONFINEMENT 1 (last visited Aug. 3, 2017), <http://solitarywatch.com/wp-content/uploads/2011/06/fact-sheet-psychological-effects-final.pdf>.

⁵⁵ *Id.*

⁵⁶ TERRY KUPERS, PRISON MADNESS: THE MENTAL HEALTH CRISIS BEHIND BARS AND WHAT WE MUST DO ABOUT IT 81 (Jossey-Bass, 1st ed. 1999).

⁵⁷ ABRAMSKY ET AL., *supra* note 3, at 62.

⁵⁸ See Smith, *supra* note 11, at 442.

⁵⁹ *Id.* at 443.

⁶⁰ ABRAMSKY ET AL., *supra* note 3, at 150 (emphasis added).

ill inmates in solitary.⁶¹ The mentally ill deemed at risk of committing suicide are often placed under the harshest conditions, “stripped of their personal belongings, clothed in a suicide smock, and forced to urinate and defecate through a grate in the floor.”⁶² Other prisons have reported inmates being “punished . . . for self-harm and attempted suicide” by deducting credit points,⁶³ which can impact inmates’ abilities to get out of solitary confinement and transfer into lower security levels of custody later on. One schizophrenic and intellectually disabled inmate sent to a supermax prison was so impacted by the experience that he stopped taking his medication and eating, in effect committing suicide when he died of a heart attack just a few weeks later.⁶⁴ Another study found that “suicide rates in the California lockup units are by far the highest in any prison housing units anywhere in the country,” and inmates in solitary confinement have “a 33 times greater chance of suicide than [inmates] in the prison system’s general population.”⁶⁵ A psychologist who studies the effects of solitary confinement on the mentally ill testified to its negative effects in a case litigating the use of solitary confinement in a Wisconsin prison, stating:

[For] [p]risoners suffering from serious mental illnesses, or who are prone to serious mental illness or suicide, [solitary confinement] is an extreme hazard to their mental health and well being. It causes irreparable emotional damage and psychiatric disability as well as an extreme mental anguish and suffering, and in some cases presents a risk of death by suicide.⁶⁶

Other mentally ill inmates experience increasing temptation to engage in self-harm. For example, Eldorado Brown, a mentally ill inmate placed in solitary, reported that isolation “created a sense of severe depression that led [him] to find a release” in self-harm.⁶⁷ Unfortunately, the inherent distrust between inmates and guards in prison creates an even more toxic environment, where guards “become preoccupied with not being ‘conned’ or manipulated by prisoners.”⁶⁸ Self-harm is perceived as one such manipulation.⁶⁹ Mentally ill prisoners who engage in self-harm are either punished with longer terms in solitary confinement or “rubber rooms,” where

⁶¹ ANNA GUY, AVID PRISON PROJECT, LOCKED UP AND LOCKED DOWN: SEGREGATION OF INMATES WITH MENTAL ILLNESS 6 (2016), <http://avidprisonproject.org/assets/locked-up-and-locked-down---avid-prison-project.pdf>.

⁶² Joshua Manson, *New Report Documents Devastating Effects of Solitary Confinement on Mental Illness*, SOLITARY WATCH (Sept. 9, 2016), <http://solitarywatch.com/2016/09/09/new-report-documents-devastating-effects-of-solitary-confinement-on-mental-illness/>.

⁶³ *Id.*

⁶⁴ Bazelon, *supra* note 6 (discussing how evidence also existed that Laudman was sent to solitary confinement even though his counselor did not think that he was “aggressive or threatening” and that he was left naked in the cell where a correctional officer saw him lying in his own excrement and did nothing for a week before bringing him to the hospital).

⁶⁵ Sal Rodriguez, *FAQ*, SOLITARY WATCH (2015), <http://solitarywatch.com/facts/faq/>.

⁶⁶ RODRIGUEZ, *supra* note 54, at 1.

⁶⁷ AVID Prison Project, *Eldorado Brown*, YOUTUBE (Sept. 7, 2016), https://www.youtube.com/watch?time_continue=1&v=swKsb-ichxA.

⁶⁸ Smith, *supra* note 11, at 473.

⁶⁹ *Id.*

they are isolated and forced to use a grate in the floor as a bathroom.⁷⁰ Alternatively, mentally ill inmates who engaged in self-harm and are deemed at risk for harming themselves further may be forced to give up their belongings and clothes before being placed in “strip cells.”⁷¹ In an Indiana prison, inmates subjected to this punishment were “stripped naked for twenty-one days and [provided only a] ‘nutriloaf’ of starch and vegetables cooked into a block.”⁷²

Among inmates, prisoners in solitary confinement self-harm more frequently than the general population.⁷³ However, inmates who engage in self-harm either as their primary mental health diagnosis or as a symptom of other mental health issues, find that solitary is a trigger to relapse into or increase their self-mutilation. For example, Eldorado Brown was diagnosed with non-suicidal self-injury before he was sent to solitary confinement, where he found that: “placing me in the hold exacerbates my mental illness to a whole different degree,” which led him to engage in self-injury.⁷⁴ He credits being isolated from both loved ones and mental health resources for the difficulty he experienced coping with solitary confinement.⁷⁵ Another mentally ill inmate in an Illinois supermax unit “declined to the point that he mutilated his own genitalia.”⁷⁶

Moreover, certain mental disorders may be most vulnerable in solitary confinement. Inmates with borderline personality disorder have particular difficulty with isolation, where they “. . . have a tendency to experience transient psychoses, a brief psychosis that quickly resolves itself when they’re removed from the lockdown [segregation] situation.”⁷⁷ Psychosis is characterized by “disorganized thought and speech, delusions, hallucinations and disordered thinking,”⁷⁸ which are typically not experienced by an individual with a personality disorder.⁷⁹ In fact, researchers who specialize in the effects of solitary confinement on the mentally ill have noted that any inmate with a mental illness that predisposes them to psychosis can “go off the deep end”⁸⁰ when isolated. Dr. Terry Kupers explains that severely

⁷⁰ GUY, *supra* note 61, at 13.

⁷¹ Jeremy Coid et al., *Psychiatric Morbidity in Prisoners and Solitary Cellular Confinement, II: Special (‘strip’) Cells*, 14 J. FORENSIC PSYCHIATRY & PSYC. 320, 321 (2003).

⁷² Jack Denon, *Settlement Limits Solitary Confinement for People with Mental Illness in Indiana’s Prisons*, SOLITARY WATCH (Feb. 11, 2016), <http://solitarywatch.com/2016/02/11/settlement-limits-solitary-confinement-for-people-with-mental-illness-in-indianas-prisons/>.

⁷³ Craig Haney & Monda Lynch, *Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement*, 23 N.Y. U. REV. L. & SOC. CHANGE 477, 525 (1997).

⁷⁴ AVID Prison Project, *supra* note 67.

⁷⁵ *Id.*

⁷⁶ Jason M. Breslow, *What Does Solitary Confinement Do To Your Mind?*, PBS (Apr. 22, 2014), <http://www.pbs.org/wgbh/frontline/article/what-does-solitary-confinement-do-to-your-mind/>.

⁷⁷ ABRAMSKY ET AL., *supra* note 3, at 151 (quoting Testimony of Joel Dvoskin in *Madrid v. Gomez*, 889 F. Supp. 1146, 1216 (N.D. Cal. 1995)).

⁷⁸ Christopher Martin, *The Legality of Solitary Confinement Under the Americans with Disabilities Act (ADA)*, 8 INTERSECT: STAN. J. SCI., TECH. & SOC. 1, 5 (Nov. 2014) <http://web.stanford.edu/group/ojs3/cgi-bin/ojs/index.php/intersect/article/view/637/575>.

⁷⁹ See *Borderline Personality Disorder*, NAT’L ALL. MENTAL ILLNESS, <http://www.nami.org/Learn-More/Mental-Health-Conditions/Borderline-Personality-Disorder> (last visited Aug. 24, 2017).

⁸⁰ ABRAMSKY ET AL., *supra* note 3, at 152 (quoting Dr. Terry Kupers discussing the vulnerability of mentally ill inmates placed in solitary confinement).

mentally ill inmates cannot “reality test” their delusions by talking to people and engaging in activities when they are isolated, and, as a result, “paranoid notions build up.”⁸¹ Solitary confinement tends to exacerbate whatever pre-existing mental illness the inmate has struggled with in the past:

[The impact] depends on what the mental illness is. 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, either bipolar . . . or depressive will become that and will have a breakdown in that direction. And people who are psychotic in any way . . . those people will tend to start losing touch with reality because of the lack of feedback and the lack of social interaction and will have another breakdown, whichever breakdown they’re prone to.⁸²

Unsurprisingly, solitary confinement preys upon the predispositions of mentally ill inmates, profoundly impacting each prisoner in a unique way.

The long-term effects of enduring solitary confinement on the mentally ill are varied. The longer a seriously mentally ill individual remains “acutely disturbed, the worse the long term prognosis.”⁸³ An acute disturbance is typically characterized by the sudden onset of schizophrenic symptoms such as delusions, hallucinations, or incoherent speech, that occurs in combination with a stressful event.⁸⁴ Research related to the negative health effects of solitary confinement showed that “negative (sometimes severe) health defects can occur after only a few days of solitary confinement. The health risk rises for each additional day in solitary confinement.”⁸⁵ This is particularly relevant for mentally ill inmates, who find it difficult to abide by the rules in general population, let alone the even more onerous rules in restrictive housing. One survey of solitary confinement of the mentally ill in Colorado’s prisons found that, “inmates with serious mental illnesses committed infractions at three times the rate of non-seriously mentally ill counterparts.”⁸⁶ These inmates remained in solitary confinement for prolonged periods because the step-down program out of solitary demanded that they successfully complete a strict four-level system of behavioral modification to return to the general population.⁸⁷ Moreover, solitary confinement can have long-term effects, “creat[ing] its own set of psychological pressures that, in some instances, uniquely disable prisoners

⁸¹ *Id.*

⁸² *Id.* (quoting Dr. Terry Kupers’s testimony in *Jones v. Berge*, 164 F. Supp. 2d 1096 (W.D. Wis. 2001).)

⁸³ *Id.* at 153.

⁸⁴ J. Garrabe & F.R. Cousin, *Acute and Transient Psychotic Disorders*, OXFORD UNIV. PRESS (Feb. 2012), <http://oxfordmedicine.com/view/10.1093/med/9780199696758.001.0001/med-9780199696758-chapter-81>.

⁸⁵ Smith, *supra* note 11, at 487.

⁸⁶ WALLACE, *supra* note 10, at 6.

⁸⁷ *Id.*

for freeworld reintegration.”⁸⁸ These long-term effects often include social anxiety and the desire for prisoners to voluntarily isolate themselves even after release.⁸⁹

III. A NATIONAL LOOK AT BEST PRACTICES AND NORMS

A. BEST PRACTICES

States setting an example for solitary confinement policies include Arizona, Pennsylvania, California, Colorado, Massachusetts, New York, Indiana, Connecticut, Illinois, Maryland, Mississippi, and South Carolina.⁹⁰ The mentally ill are particularly impacted by these positive changes, which often aim to soften conditions and keep inmates with mental disabilities out of solitary confinement entirely. Arizona, California, and Pennsylvania notoriously implemented some of the most inhumane solitary units in the country and have been forced to become models for the use of solitary confinement due to litigation surrounding their practices.⁹¹

In California, solitary policy change arose out of the settlement of a class action suit brought by isolated prisoners challenging the length and conditions of their solitary confinement as cruel and unusual punishment; they were housed in “tiny windowless, soundproofed cells for nearly 23 hours each day.”⁹² California now has the third fewest prisoners in solitary confinement in the country,⁹³ likely due in large part to the settlement measures put in place, which aimed to curb the number of inmates housed in solitary units. California state prisons can now only send inmates who commit “new and serious crimes in prison, such as murder or violent assault”⁹⁴ to solitary. As such, prisons no longer have unfettered discretion to send any difficult or disorderly inmate to solitary, which often was the case for mentally ill inmates actively experiencing symptoms.⁹⁵ Moreover, the settlement calls for a stop to “indefinite” stays in solitary,⁹⁶ which is particularly applicable to mentally ill prisoners who often spend years in

⁸⁸ Smith, *supra* note 11, at 496.

⁸⁹ *Id.*

⁹⁰ See Judith Resnik et al., *Time-In-Cell: Isolation and Incarceration*, YALE L. J. FORUM, (Jan. 15, 2016), <http://www.yalelawjournal.org/forum/time-in-cell-isolation-and-incarceration>; Manson, *supra* note 62; Jessica Knowles, “The Shameful Wall of Exclusion:” *How Solitary Confinement for Inmates with Mental Illness Violates the Americans with Disabilities Act*, 90 WASH. L. REV. 893 (2015).

⁹¹ *See id.*

⁹² Carrie Johnson, *California Prisons to Limit Number of Inmates in Solitary Confinement*, NPR (Sept. 1, 2015), <http://www.npr.org/2015/09/01/436673728/california-prisons-to-limit-number-of-inmates-in-solitary-confinement> (describing Plaintiff Paul Redd, who spent thirty-three years in solitary and reported vision problems and anxiety as a result).

⁹³ Hawaii and Connecticut are the states with the fewest inmates in solitary confinement. Anna Flagg, Alex Tatusian & Christie Thompson, *Who’s in Solitary Confinement?*, MARSHALL PROJECT (Nov. 30, 2016), <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#.j6JribEUT>.

⁹⁴ Johnson, *supra* note 92.

⁹⁵ However, mentally ill inmates may nevertheless be disproportionately more likely to receive violent disciplinarys in prison, particularly if they are suffering from delusions or auditory hallucinations. *See e.g.* U.S. DEPT. OF JUSTICE, *supra* note 4, at 6–7; ABRAMSKY ET AL. *supra* note 3, at 162–63; Metzner & Fellner, *supra* note 5.

⁹⁶ Johnson, *supra* note 92.

solitary because the symptoms of their mental illness typically deteriorate without social stimulation and appropriate mental health care, making them unable to comply with the strict behavioral requirements to be released back into the general population.

Additionally, California implemented a new intermediary unit to accommodate inmates who are considered a continued risk to the safety of the institution, which has “more privileges than in solitary, more time out of their cells, small group leisure activities, and some job opportunities and phone calls.”⁹⁷ These units are a positive step towards reasonable accommodation for the mentally ill, whose active symptoms make them a danger to the prison at large, without restricting them to conditions that exacerbate the symptoms of their mental illness. Similarly, South Carolina instituted a sixty-day maximum solitary sentence for any disciplinary violation.⁹⁸ Prior to the new policy, “[p]risoners in South Carolina who suffered from depression, schizophrenia and other mental illnesses were almost twice as likely as other prisoners to go to solitary, for an average of 647 days.”⁹⁹ Prisons that typically cap solitary stays between one to three months are considered among the most inmate-friendly.¹⁰⁰

New York implemented a program entitled “Clinical Alternative to Punitive Segregation,” which provides group and one-on-one therapy in a hospital-like setting, with a team of psychologists assessing progress until inmates are deemed fit to return to the general prison population.¹⁰¹ These changes were implemented in response to a settlement calling for “at least two hours a day of out of cell treatment and programming for all seriously mentally ill prisoners residing in SHU” and “mandatory reviews of disciplinary sentences for prisoners with serious mental illnesses”¹⁰² Moving a step in the right direction, New York has created more strict screening procedures from the outset, ensuring that seriously mentally ill inmates are sent directly to a therapeutic setting rather than the general population.¹⁰³

Further, policies that focus on successfully reintegrating a mentally ill prisoner back into the general population after a stay in solitary confinement are another best practice, which has been implemented in Mississippi and Virginia.¹⁰⁴ State prisons in Mississippi created a “step-down unit,” which is a three to six month program that gives mentally ill prisoners social interaction through out-of-cell time, group therapy, and peer counseling.¹⁰⁵ As a result, violent incidents in the prison dropped seventy percent.

⁹⁷ 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>.

⁹⁸ Bazelon, *supra* note 6.

⁹⁹ *Id.*

¹⁰⁰ Flagg, Tatusian & Thompson, *supra* note 93.

¹⁰¹ Martin, *supra* 78, at 8.

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ Knowles, *supra* note 90, at 905.

¹⁰⁵ *Id.*

B. WORST ABUSES OF SOLITARY CONFINEMENT

The nation's best practices can only be properly understood against the backdrop of the states that most abuse solitary confinement and the former practices of reformed states when their solitary units were at their worst. The mentally ill are particularly impacted by abuses of solitary confinement because they are disproportionately more likely to be housed there and are more vulnerable to its effects.¹⁰⁶ Additionally, some states have instituted exceedingly poor policies that directly target the mentally ill.¹⁰⁷ For example, Pennsylvania's State Correctional Institution at Cresson used full body restraints to punish prisoners for misbehavior that was a direct expression of their mental illness, like smearing fecal matter on the walls.¹⁰⁸

One major policy weakness is the broad discretion given to prison staff to send inmates to solitary. A national survey found that the "criteria were often vague, with some policies requiring only that officials see an inmate as a 'threat to life, property, or security.'"¹⁰⁹ This is problematic because the mentally ill are often difficult for prison staff to control amongst the general population. As a result, guards may unfairly send the mentally ill to solitary confinement because guards must retain unyielding power and lack mental health training, increasing erroneous perceptions of the mentally ill as a safety threat. The ADA becomes an ineffective remedy for inmates when prisons justify placing mentally ill prisoners in solitary due to "legitimate safety requirements."¹¹⁰ Citing the health and safety of the institution as a justification for solitary punishment can allow prisons to circumvent their duty to provide "reasonable accommodations" for mentally ill prisoners.¹¹¹ As such, the ill-defined "route into solitary [confinement]"¹¹² is too permissive due to broad institutional discretion to isolate difficult inmates, who may be acting out as a symptom of their mental illness. This is a major weakness in prison practices throughout the county.

A survey of state-by-state practices regarding the length of time spent in solitary revealed that "nearly 3,000 prisoners across the county have been in solitary confinement for six years or longer" and that "more than half of them are in Texas."¹¹³ Additionally, Louisiana, Utah, and Nebraska were found to have the greatest percentage of their prison populations held in solitary units, defined as a place where inmates are "kept in isolation at least 22 hours a day

¹⁰⁶ U.S. DEPT. OF JUSTICE, *supra* note 4, at 6. Metzner & Fellner, *supra* note 5, at 104–05.

¹⁰⁷ DEPT. OF JUSTICE, INVESTIGATION OF THE STATE CORRECTION INSTITUTION AT CRESSON & NOTICE OF EXPANDED INVESTIGATION 17 (2013), https://www.justice.gov/sites/default/files/crt/legacy/2013/06/03/cresson_findings_5-31-13.pdf.

¹⁰⁸ *Id.*

¹⁰⁹ Jess Bravin, *Large Number of Inmates in Solitary Poses Problem for Justice System, Study Says* (Sept. 2, 2015), <http://www.wsj.com/articles/large-number-of-inmates-in-solitary-poses-problem-for-justice-system-study-says-1441209772>.

¹¹⁰ MARGO SCHLANGER, AM. CONST. SOC'Y OF LAW & POLICY HOW THE ADA REGULATES AND RESTRICTS SOLITARY CONFINEMENT FOR PEOPLE WITH MENTAL DISABILITIES 15 (2016), https://www.acslaw.org/sites/default/files/How_the_ADA_Regulates_and_Restricts_Solitary_Confinement.pdf.

¹¹¹ *Id.* at 8–9.

¹¹² *Id.* at 8.

¹¹³ Flagg, Tatusian & Thompson, *supra* note 93.

for 15 days or more.”¹¹⁴ In a Wisconsin case challenging solitary confinement of the mentally ill, Dr. Terry Kupers describes a conventional definition of solitary confinement:

The prisoners are confined to their cells 23 or 24 hours per day, there is very limited social interaction, very sparse possessions are permitted, there are very few if any contacts between prisoners, staff contact with prisoners is limited mainly to the handing out and collection of food trays and disciplinary activities, prisoners eat alone in their cells, programming is extremely minimal, discipline is very strict and punishments are frequent.¹¹⁵

However, this definition of solitary confinement as the norm for prison practices around the county is now falling out of favor¹¹⁶ as many states institute more humane limits on its use.

In Colorado, a Residential Treatment Program (RTP) has been put in place in an attempt to address the issues facing the mentally ill in their state’s administrative segregation.¹¹⁷ Similar to California, this move was in response to abuses of solitary confinement, in which “87 seriously mentally ill prisoners [were confined] in administrative segregation, 54 of whom had been living in isolation for over a year and 14 of whom had been living in administrative segregation for over 4 years.”¹¹⁸ The RTP program is intended to provide a recommended minimum of twenty hours of out-of-cell time per week for mentally ill prisoners, which should be spent engaging in therapeutic activity. However, the program is divided into multiple levels of restriction, with behavioral requirements at each level that seriously mentally ill inmates have difficulty meeting. As such, most mentally ill prisoners in RTP are in the most restrictive level, receiving only fourteen minutes of therapeutic activity outside of their cells per week.¹¹⁹ Therefore, while Colorado proactively banned solitary confinement of mentally ill prisoners, the RTP program essentially functions in the same way and is a failed attempt at reform.

To its credit, RTP calls for trained mental health professionals to meet the therapeutic needs of mentally ill patients. This is an improvement upon both the lack of mental health training among guards to manage the mentally

¹¹⁴ *Id.* Association of State Correctional Administrators et al., *Aiming to Reduce Time in Cell: Reports from Correctional Systems on the Numbers of Prisoners in Restrictive Housing and on the Potential Policy Changes to Bring About Reforms*, YALE L. SCH. 6 (Nov. 21, 2016), <https://law.yale.edu/system/files/area/center/liman/document/aimingtoreducetic.pdf>.

¹¹⁵ Terry A. Kupers, *Declaration of Terry A. Kupers, M.D., MSP*, UNIV. MICH. (Aug. 9, 2001), <https://www.clearinghouse.net/chDocs/public/PC-WI-0001-0001.pdf> (providing expert opinion in *Jones v. Berge*, 164 F. Supp. 2d 1096 (W.D. Wis. 2001)).

¹¹⁶ For example, President Obama expressed stern disapproval of the use of solitary confinement as an “affront to our common humanity” in a recent op-ed in the Washington Post. 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?utm_term=.4797b18f5dfc.

¹¹⁷ WALLACE, *supra* note 10, at 5.

¹¹⁸ *Id.* at 10.

¹¹⁹ *Id.* at 16.

ill and the overall lack of mental health treatment in most solitary units. Treatment in solitary is typically limited to one-on-one therapy conducted cell-side under the supervision of guards, which negates the effectiveness of the therapeutic process.¹²⁰ Moreover, mentally ill inmates in solitary are typically deprived of the opportunity to participate in group therapy and often rely entirely on medications to manage their symptoms.¹²¹ Despite these positive changes, Colorado prisons fell “32 providers short of the APA guideline of one provider for every 150 mentally ill inmates” in 2011, and remained “25 percent short of APA recommendations” after the RTP program was instituted in 2013.¹²²

IV. LEGAL FRAMEWORK

A. DUE PROCESS AND EIGHTH AMENDMENT CHALLENGES

The majority of the challenges to solitary confinement have been brought under the Eighth Amendment prohibition against cruel and unusual punishment or Fourteenth Amendment due process claims.¹²³ However, due process claims are only implicated once a plaintiff successfully shows that a liberty interest is infringed upon.¹²⁴ For obvious reasons, courts consider prisoners to have limited liberty interests.¹²⁵ As such, challenges to solitary confinement under the Fourteenth Amendment are rarely successful. The best cases for due process challenges in this arena are to: (1) show that the reasons for holding an inmate in solitary confinement are arbitrary, or (2) show that review processes determining whether an inmate can re-enter the general population do not offer a meaningful opportunity for release from solitary confinement.¹²⁶

Cruel and unusual challenges under the Eighth Amendment have a notoriously difficult bar to meet, and most of these challenges to solitary confinement have been unsuccessful.¹²⁷ However, the mentally ill have been the most successful in raising Eighth Amendment challenges, with some states recognizing solitary confinement of the mentally ill as unconstitutional.¹²⁸ Cases where the mentally ill have successfully challenged solitary confinement under the Eighth Amendment include *Madrid v. Gomez*¹²⁹ and *Ruiz v. Johnson*, which famously likened solitary confinement units to “incubators of psychoses—seeding illness in otherwise healthy inmates and exacerbating illness in those already suffering from

¹²⁰ GUY, *supra* note 61, at 12.

¹²¹ *Id.* at 12–13.

¹²² WALLACE, *supra* note 10, at 17.

¹²³ Jennifer Wedekind, *supra* 52.

¹²⁴ *Id.*

¹²⁵ *Id.*

¹²⁶ *Id.* at 2.

¹²⁷ Knowles, *supra* note 90, at 910–12.

¹²⁸ Wedekind, *supra* note 52, at 1. Resnik, *supra* note 90.

¹²⁹ *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995).

mental infirmaries.”¹³⁰ Another hurdle for Eighth Amendment litigation is that it typically only succeeds as class action suits, with a group of prisoners challenging solitary confinement as cruel and unusual.¹³¹ *Jones’El v. Berge* is a further example of a landmark class action suit that successfully challenged prison warehousing of mentally ill inmates in solitary confinement.¹³² *Berge* condemned the Wisconsin State Prison’s poorly staffed mental health screening and monitoring measures as “little more than band-aids to the potentially detrimental conditions to which defendants subjected mentally ill inmates.”¹³³ Ultimately, the overall success rate of Eighth Amendment challenges is low, and mentally ill inmates with legitimate claims against prisons for subjecting them to solitary confinement often fail to meet the high bar set in those challenges.

B. AMERICANS WITH DISABILITIES ACT (ADA)

Constitutional remedies leave a significant gap in the legal framework, where many prisoners cannot achieve relief through Eighth Amendment or Due Process claims. For mentally ill inmates, the ADA is a worthwhile alternative avenue for statutory relief. Title II of the ADA asserts: “[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any entity.”¹³⁴ Mentally ill individuals qualify under the ADA because mental illness is considered a disability under the statutory definition,¹³⁵ and prisons are public entities that provide services, such as rehabilitation programming, medical care, and mental health care.¹³⁶

Solitary confinement is a “denial of the services, programs, and activities”¹³⁷ that the prison offers inmates to rehabilitate and make a successful re-entry into society.¹³⁸ This is because inmates under the extremely restrictive conditions of solitary confinement are not given access to group therapy or rehabilitative programming, which typically defines the daily routine of most general population inmates, and are given the attention

¹³⁰ *Ruiz v. Johnson*, 154 F. Supp. 2d 975, 984 (S.D. Tex. 2001) (holding that the conditions of solitary confinement at Pelican Bay State Prison were unconstitutionally cruel and unusual, in an opinion which focused on the effects on the mentally ill).

¹³¹ For example, *Madrid*, *Ruiz*, and *Jones’El* were all class-action suits. Knowles, *supra* note 90, at 913.

¹³² *Jones’El v. Berge*, 164 F. Supp. 2d 1096, 1122 (W.D. Wis. 2001).

¹³³ *Id.*

¹³⁴ 42 U.S.C. § 12132 (2017).

¹³⁵ The ADA defines disability as “a physical or *mental impairment* that substantially limits one or more major life activities” (emphasis added). 42 U.S.C. § 12102(1)(A) (2017).

¹³⁶ SCHLANGER, *supra* note 110, at 4–5.

¹³⁷ 42 U.S.C. § 12132 (2017).

¹³⁸ Most mentally ill inmates are eventually released back into society, where they are more likely to recidivate if solitary confinement exacerbated their mental illness. Solitary confinement’s deleterious effects on rehabilitation can be seen in action on a micro-level within the prisons themselves. For example, a DOJ study found that: “On every measure, prison facilities with higher percentages of inmates reporting disorder had higher rates of inmates held in restrictive housing in the past 12 months.” U.S. DEPT. OF JUSTICE, *supra* note 4, at 10. *See also* ABRAMSKY ET AL., *supra* note 3, at 120, 192 (finding that 600,000 inmates are released back into society per year and that mentally ill prisoners who were housed in solitary confinement during their time in prison were more likely to commit violent felonies).

of mental health staff only through brief check-ins at the door to their cell.¹³⁹ The use of solitary confinement for the mentally ill can also be challenged as a form of discrimination when prisoners are isolated “‘because of’ their serious mental illness”—referred to as “disparate treatment” approach to challenges under the ADA.¹⁴⁰ Additionally, mentally ill inmates can challenge that they are “disparately impacted” by solitary confinement because they are often sent to solitary confinement because of behavioral issues that are symptoms of their mental illness.¹⁴¹

The ADA requires that prisons provide “reasonable modifications in policies, practices, or procedures”¹⁴² needed by qualified mentally ill inmates to benefit from the services provided by the institution. As one analysis found: “A failure to implement a reasonable modification needed by a person with a disability is a type of discrimination; under the ADA a prison must ‘take certain pro-active measures to avoid the discrimination proscribed by Title II.’”¹⁴³ As such, the prison cannot defend against providing reasonable accommodations simply because the accommodation requires money and effort to alter current practices. Instead, the accommodation must be weighed against an “undue burden” standard, with prisons not being obligated to provide services that require a “fundamental alteration” to the service or program.¹⁴⁴ Examples of reasonable accommodations that could be provided for the mentally ill include: providing additional access to mental health care, reducing the likelihood of conflict through assignment to single cells within the general population, and access to “phone calls, books, education, rehabilitative programming, exercise, and the like” if they must be placed in a solitary unit.¹⁴⁵ The most crucial of these accommodations is access to mental healthcare, which can go the greatest lengths towards managing the symptoms that make an inmate a threat to the safety of the institution in the first place.¹⁴⁶ Studies show that, “the mentally ill are substantially less likely to commit a violent crime if taking appropriate psychiatric medication.”¹⁴⁷ Moreover, a presumption in favor of creating avenues for reasonable accommodation over finding an “undue burden” exists. This presumption is evidenced in part by recent judicial and legislative leanings along with President Obama’s stern insistence that, “the practice should be limited, applied with constraints, and used only as a measure of last resort.”¹⁴⁸

¹³⁹ GUY, *supra* note 61, at 12–13.

¹⁴⁰ SCHLANGER, *supra* note 110, at 5.

¹⁴¹ *Id.* at 6.

¹⁴² 28 C.F.R. § 35.130(b)(7) (2017).

¹⁴³ SCHLANGER, *supra* note 110, at 8 (quoting *Madrid v. Gomez*, 889 F. Supp. 1146, 1221 (N.D. Cal. 1995)).

¹⁴⁴ See Equip for Equality, *The Americans with Disabilities Act in Jail & Prison* 3, EQUIP FOR EQUALITY (2016), <http://www.equipforequality.org/wp-content/uploads/2016/04/Prisoner-Rights-Under-the-ADA.pdf>.

¹⁴⁵ SCHLANGER, *supra* note 110, at 8–9.

¹⁴⁶ STEINBERG ET AL., *supra* note 33, at 9.

¹⁴⁷ *Id.*

¹⁴⁸ Obama, *supra* note 116.

C. DEFENSES TO ADA CHALLENGES

The ADA gives prisons two justifications for the use of solitary confinement. Prisons can justify solitary confinement in the name of “*legitimate safety requirements*”¹⁴⁹ that are “necessary for the safe operation”¹⁵⁰ of the institution and for inmates that pose “*direct threats*”¹⁵¹ to others. Assessing whether an individual is a direct threat should be an “individual assessment” based on “current medical knowledge or on the best available objective evidence.”¹⁵² Factors to be considered are: “the nature, duration, and severity of the risk; the probability that the potential injury will actually occur, and whether reasonable modifications, policies, practices, or procedures or the provision of auxiliary aids or services will mitigate the risk.”¹⁵³ The “direct threat” justification for a prison’s use of isolation is heavily stacked against a policy in favor of reasonable modifications.¹⁵⁴ However, the fact that “[m]ore than three-quarters of inmates written up for assaulting other inmates or staff had spent time in restrictive housing”¹⁵⁵ could be leveraged by prison staff to argue that these inmates present a direct threat to others and are justifiably kept in isolation to protect the safety of the institution. A strong counter to this argument is that these prisoners are not inherently violent, but rather are made violent from the trauma of restrictive housing. Policy also counsels against the use of solitary confinement for health and safety reasons, with President Obama publicly stating that solitary confinement “is not going to make us safer.”¹⁵⁶ Rodney Bouffard, warden at Maine State Prison, expressed a similar sentiment: “If I have somebody that comes in with a five-year commitment, you can have them do their whole time in isolation, but I don’t want them living next to me when they release him.”¹⁵⁷ As such, a claim asserted under the ADA is particularly strong, as neither justification is intended to be commonly used.

Additionally, a defense claiming that reasonable accommodations such as mental health treatment are an “undue burden” would likely fail in part because keeping inmates in solitary confinement is the costliest housing option for institutions, above and beyond the additional cost per inmate of providing mental health services. For instance, “in Pennsylvania, the average prisoner costs \$80 per day to incarcerate. Yet if [a] prisoner is mentally ill, the added costs of mental health services, medications, and additional correctional staff boost the average daily cost to \$140.”¹⁵⁸ Solitary confinement is even more expensive, costing an average of \$205 per inmate

¹⁴⁹ 28 C.F.R. § 35.130(h) (2017) (emphasis added).

¹⁵⁰ *Id.*

¹⁵¹ 28 C.F.R. § 35.139 (2017) (emphasis added).

¹⁵² *Id.*

¹⁵³ *Id.*

¹⁵⁴ SCHLANGER, *supra* note 110, at 15.

¹⁵⁵ U.S. DEPT. OF JUSTICE, *supra* note 4, at 8.

¹⁵⁶ Obama, *supra* note 116.

¹⁵⁷ Edge & Jones, *supra* note 26.

¹⁵⁸ ABRAMSKY ET AL., *supra* note 3, at 49.

each day.¹⁵⁹ In addition to operating costs, the costs of construction¹⁶⁰ for solitary units and litigation under both the ADA and constitution, funds could be better spent providing mental health services that address the root of the issues landing mentally ill inmates in solitary. This would allow more inmates in general population, where they could focus on learning the skills necessary to prepare for a successful transition back into society. While increased costs alone likely cannot constitute an “undue burden,” costs provide weak justification to the extent that monetary values factor into the analysis.¹⁶¹

Moreover, to suggest that mental health services represent an “undue burden” because they would “fundamentally alter” the service or program of correctional institutions is weak. First, the majority of prisoners are serving determinate sentences and will be released into society. As such, the primary function of institutions is to rehabilitate inmates for release, with the goal that they will not recidivate. The most efficient way to achieve that goal is to address the core issues driving the inmate’s criminal behavior, both in and out of prison, which is, at least in part, their mental health. Further, the structure of state and federal budgets have made prisons the primary mental healthcare providers in the country. For example, “[i]n California alone, there are over 30,000 seriously mentally ill prisoners presently confined in state prison, as compared to fewer than 6,000 persons in state psychiatric hospitals, making CDCR the de facto mental health treatment provider in the state.”¹⁶² As such, providing mental health services as a reasonable accommodation for the mentally ill is in no way a “fundamental alteration”—in fact, it is the opposite. Providing mental health services fulfills one of the primary purposes of correctional facilities today.

D. SUCCESSFUL CHALLENGES UNDER THE ADA

In *Disability Advocates v. New York State Office of Mental Health*, mentally ill inmates filed suit challenging solitary confinement of the mentally ill in New York state prisons, alleging that inadequate mental health treatment was responsible for a disproportionate number of mentally ill inmates in segregation.¹⁶³ The suit challenged New York’s prison policies as a violation of both the Eighth Amendment and the ADA.¹⁶⁴ The complaint alleges that these policies violate the ADA in part because they “discriminate against mentally disabled prisoners by failing to provide alternative punishments as a reasonable accommodation so that punishments which exacerbate mental illness are not imposed.”¹⁶⁵ The case reached a settlement,

¹⁵⁹ See SAL RODRIGUEZ, SOLITARY WATCH, THE HIGH COST OF SOLITARY CONFINEMENT 1 (2011), <http://solitarywatch.com/wp-content/uploads/2011/06/fact-sheet-the-high-cost-of-solitary-confinement.pdf> (citing the cost of housing an inmate in solitary confinement at \$75,000 per year).

¹⁶⁰ *Id.* at 1–2 (“[S]upermax prisons have consistently higher construction costs than other types of facilities—two to three times higher, according to one report, than a maximum-security prison.”).

¹⁶¹ SCHLANGER, *supra* note 110, at 13–14.

¹⁶² STEINBERG ET AL., *supra* note 33, at 7.

¹⁶³ Complaint at 2, *Disability Advocates v. N.Y. State Office of Mental Health*, 1:02-cv-04002-GEL (S.D.N.Y. 2002).

¹⁶⁴ *Id.*

¹⁶⁵ *Id.* at 52.

which provided a number of reasonable accommodations for the mentally ill, resulting in the best practices implemented in New York described above.¹⁶⁶

In California, *Armstrong v. Brown* is one of the most often-cited challenges under the ADA.¹⁶⁷ While the *Armstrong* class was concerned primarily with physical disabilities, it was an important case for future ADA challenges made by the mentally ill because the court ordered the California Department of Corrections to establish a formal grievance procedure for inmates with disabilities in segregation to ensure that they are provided reasonable accommodations.¹⁶⁸ The court's order was based in part on their finding that "many county jail policies provide for the segregation of prisoners with disabilities from the general population and, by so doing, likely deprive prisoners with disabilities of equal access to programs and services within the jail."¹⁶⁹ As such, *Armstrong* is useful precedent for mentally ill prisoners to request reasonable accommodations to the conditions in solitary akin to assistive aids that would be provided for the physically disabled. Such parallel accommodations for the mentally ill may include psychiatric medication, self-help literature focusing on managing their symptoms, and regular individual or group therapy.

In 2015, another landmark settlement was reached in *Rasho v. Baldwin* as a result of class action litigation by mentally ill prisoners against the Illinois Department of Corrections (IDOC) under the ADA.¹⁷⁰ The complaint focused on the inappropriate use of solitary confinement as a punishment for mentally ill prisoners and inadequate mental health services in Illinois prisons.¹⁷¹ As a result of this litigation, the IDOC developed four residential treatment units to provide "individualized care for offenders with serious mental illness."¹⁷² The settlement also required the IDOC to "boost[] staffing levels, adopt[] new policies and procedures that provide clear direction on housing and treatment plans for mentally ill offenders, and enhanc[e] training curriculum to help staff better interact with, communicate with, and understand the needs of those who require treatment."¹⁷³ These treatment-focused accommodations are particularly important because, "[w]ithout treatment, prisoners with mental illness are more likely to run into trouble of various kinds, leading them to solitary, either as a disciplinary or management response."¹⁷⁴

While these examples of successful litigation under the ADA are by no means comprehensive, they represent a few highlights in the developing

¹⁶⁶ See generally Settlement, Disability Advocates v. N.Y. State Office of Mental Health, 1:02-cv-04002-GEL (S.D.N.Y. 2002).

¹⁶⁷ *Armstrong v. Brown*, 857 F. Supp. 2d 919 (N.D. Cal. 2012).

¹⁶⁸ *Id.* at 924.

¹⁶⁹ *Id.* at 936.

¹⁷⁰ Second Amended Complaint at 1–2, *Rasho v. Baldwin*, No. 1:07-CV-1298-MMM-JAG (C.D. Ill. 2013). The suit also challenges IDOC practices under cruel and unusual and due process constitutional claims. *Id.*

¹⁷¹ *Id.* at 2–5.

¹⁷² Press Release, Illinois Dept. of Corrections, IDOC Reaches Agreement in *Rasho v. John Baldwin* (Dec. 23, 2015).

¹⁷³ *Id.*

¹⁷⁴ SCHLANGER, *supra* note 110, at 9.

legal landscape. Moreover, they reflect the incredible strength of challenges to solitary confinement of the mentally ill under the ADA.

V. PROPOSAL FOR REFORM

A. ELEMENTS

The use of solitary confinement in prisons is discriminatory and problematic. The ADA is a strong avenue to litigate the abuses in the prisons, particularly in combination with new policies in the prison system that reflect some of the best practices throughout the country. Prisons are given wide discretion in the policies that govern the institution, which are codified in the regulatory code and are the life force of the institution. State prisons feel the force of these policies more acutely than any other legal proclamation. Further, prison culture is dehumanizing for guards, and the prison system as a whole, with many staff who do not feel compelled to do more than the bare minimum for the inmates in their custody. As such, the proposed policy below is purposefully and procedurally burdensome to reduce the incentives of staff to place difficult inmates in solitary confinement, and to curb the overall use of solitary as a punishment.

The elements are as follows:

(1) Requirements for Entry

- a. Solitary confinement can only be used as a punishment for violent infractions.
- b. Psychological assessment should be conducted within 24 hours of entry in solitary confinement with a written report detailing any mental health diagnoses. Any inmates diagnosed with a serious mental illness¹⁷⁵ will be diverted to the prison's mental health services program for a six-week inpatient basis before being released into the general population, where they will have weekly appointments with a mental health care provider.
- c. Guards must provide written notice of the reasons for placement in solitary confinement. This notice must be provided to the inmate and placed in their central file after being reviewed and approved by the institution's warden, the inmate's assigned counselor, and the mental health provider who will be conducting their assessment.
 - i. Yearly reviews of these reports should be conducted by the Warden for each guard, with a month-long suspension period without pay for any guard who is

¹⁷⁵ Serious mental illness defined as including "serious psychotic disorders, bipolar disorders, schizophrenic disorders, major depressive disorders; other mental illness, organic and personality disorders included if rising to high levels of dysfunction; and recent suicide attempt." This is the definition used in New York's "SHU Exclusion Law," which avoids the pitfalls of more restrictive definitions which prisons take advantage of to put many mentally ill prisoners in solitary. GUY, *supra* note 61, at 32; Resnik, *supra* 90.

found to be inappropriately sending mentally ill patients to solitary confinement on a discriminatory basis.

- d. Prisoners escorted into solitary confinement should be allowed one phone call, to their family or lawyer within 24 hours upon entry.

(2) Conditions of Solitary

- a. 60-day maximum sentence to solitary confinement, with a psychological assessment every 30 days.
- b. Access to in-cell college courses, programming, and recreational reading material.
- c. Family visits once a month and phone calls once per week.
- d. Monitored small group programming for two hours a day, with a course in anger management in month one and a course on successful reintegration into the general population during the second month.
- e. Annual report of the number of inmates housed in solitary confinement, overall levels of violence, and cost savings through reduced solitary populations.

In addition, guards should be required to undergo mandatory training on how to identify and interact with inmates with mental illness, allowing them to better distinguish between inmates who are rule-breaking because they are mentally ill and those who are not. Moreover, a psychological review of inmates currently in solitary confinement should initially be conducted to divert seriously mentally ill inmates out of solitary units and into mental health treatment.

I defined strict requirements for entry to divert the vast majority of the mentally ill patients sent to solitary into alternative psychiatric treatment. Moreover, I attempted to limit the discretion of the guards to place inmates in solitary confinement by placing the procedural burden on guards to write a written report detailing the explicit reasoning behind placing any inmate in solitary. As such, guards will be less likely to use solitary confinement as a tool to make their job easier by quarantining difficult inmates. Furthermore, I required the consent of the warden, who will likely be more aware of the potential for litigation under the ADA for discriminatory and inappropriate use of solitary confinement. In addition, I required the consent of the inmate's assigned counselor because counselors are typically well acquainted their assigned cases and can flag any potential mental-health issues from the outset.

I recommended that a psychologist assess each inmate within twenty-four hours of entering into solitary because the effects of solitary confinement quickly increase with time. However, the American Correctional Association (ACA) recommends that an assessment be

conducted within as long as seven days.¹⁷⁶ I also did not include a formal hearing requirement at the outset because such hearings already take place for disciplinary violations and are often stacked against the inmate, serving only as an exercise before ultimately doling out a punishment. Further, I recommended a six-week inpatient program to give medications sufficient time to begin working and mental health care providers time to effectively manage the inmate's mental health crisis.

Lastly, I included a sixty day fixed endpoint for any solitary stay for a disciplinary violation. This limit particularly benefits the mentally ill, who are typically less able to conform their behavior to the strict requirements of the solitary unit in order to be released back into the general population. As such, if any mentally ill inmates slip through the crack of the initial requirements, the limited term will likely curb the effects of the punishment and guarantee an out. For these same reasons, I did not detail criteria for release from solitary confinement, as these criteria are often unattainable for the mentally ill. Moreover, this fixed term gives institutions sufficient time to investigate any prison crimes that prompted solitary confinement, but nevertheless has a definitive endpoint.

B. POTENTIAL HURDLES

A major potential hurdle for the policy put forth above is sufficient funding. However, holding large numbers of inmates in solitary confinement is also extremely costly, so funds should become available as these policies are put in place and inmates are transferred out of solitary confinement. For example, the Colorado Department of Corrections reported that housing prisoners in solitary confinement can cost nearly twice as much as holding them in general population.¹⁷⁷ Further, partnerships with local mental hospitals can be made to create a dual commitment program for mentally ill offenders. Qualified inmates could then be placed in institutions with the psychological resources to properly treat them during their inpatient treatment period. The proposed policy also attempts to place limits on costs by placing a six-week cap on intensive treatment, followed by less costly follow-up treatment. Moreover, the state could provide financial incentives for prisons who show that they are successfully implementing the program at their year-end reviews. In effect, these measures could overcome the sufficient funding hurdle.

Another major concern for prisons is the safety threat posed by relaxing the criteria and conditions of solitary confinement. In particular, while the mentally ill would not be sent to solitary confinement for small infractions such as failing to show up for their work assignment, only allowing solitary confinement to punish violent infractions leaves a gap in institutional policy where gang leaders cannot be punished. Gang leaders typically do not commit violent infractions because they send lower-ranking gang members to carry out assaults, but nevertheless pose a significant threat to the safety

¹⁷⁶ Resnik, *supra* 90.

¹⁷⁷ WALLACE, *supra* note 10, at 10.

of the institution.¹⁷⁸ However, this issue could potentially be solved by punishing non-violent infractions by taking away “commissary or recreation privileges,”¹⁷⁹ as has been done in Maine prisons, or revoking visiting privileges for a short period of time, which may deter inmates who are heavily involved in prison gangs, but are not committing violent infractions themselves.

Lastly, a greater concern in reducing solitary for inmates involves releasing violent inmates, who pose a legitimate threat to the safety of guards and other inmates, into the general population. For example, while Maine State Prison successfully reduced its solitary population by fifty percent since 2011, the progressive approach taken by this prison is not without incident.¹⁸⁰ One inmate released from solitary murdered another inmate shortly thereafter—“[t]he victim was stabbed eighty-seven times.”¹⁸¹ However, the psychological effects of solitary may have been the very root of that inmate’s violent rage. The proposed solution focuses first on providing mental health treatment for those inmates who are violent due to their illness before placing them in solitary, and on softening the conditions of solitary, such that the experience does not foster anger and violence in the inmates who are placed there. This two-pronged approach is intended to increase the safety of the institution as a whole.

VI. CONCLUSION AND SUGGESTIONS FOR FURTHER RESEARCH

To incentivize the changes discussed above, further research could be completed on the levels of violence and financial health of institutions that implemented revised solitary strategies. The research thus far suggests that costs go down and overall levels of violence decrease when less inmates are kept in solitary units.¹⁸² Moreover, further research could be conducted to tease out the effects of solitary confinement on the mentally ill specifically, since many studies have difficulty distinguishing between inmates who entered with a mental illness versus those who developed a mental illness as a result of solitary confinement. Lastly, it would be useful to conduct future research on the long-term effects of solitary confinement on both inmates from the general population and the mentally ill.

Solitary confinement is an antiquated punishment that had fallen out of favor by the end of the nineteenth century and was regarded by United States Supreme Court as “an additional punishment of the most important and painful character.”¹⁸³ However, it was embraced anew in 1983, after the murders of two of prison guards at an Illinois state prison inspired the modern supermax prison.¹⁸⁴ Since then, the prolific abuses in solitary

¹⁷⁸ See Graeme Wood, *How Gangs Took Over Prisons*, ATLANTIC, <https://www.theatlantic.com/magazine/archive/2014/10/how-gangs-took-over-prisons/379330/> (last visited Nov. 5, 2017) (describing gang leaders as “brilliant managers of violence”).

¹⁷⁹ RODRIGUEZ, *supra* note 54.

¹⁸⁰ Edge & Jones, *supra* note 26.

¹⁸¹ *Id.*

¹⁸² Bazelon, *supra* note 6.

¹⁸³ *In re Medley*, 134 U.S. 160, 171 (1890).

¹⁸⁴ Knowles, *supra* note 90, at 902.

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confinement have once again sparked disapproval, and prisons have begun the slow process of creating more humane policies, typically in response to lengthy and expensive litigation. The threat of further litigation under the ADA in combination with the implementation of best practices on a state-by-state basis is a step in the right direction.

