

Testimony of Professor Craig Haney
Senate Judiciary Subcommittee on the Constitution, Civil Rights, and
Human Rights Hearing on Solitary Confinement

June 19, 2012

Chairman Durbin, Ranking Member Graham, and distinguished members of the Subcommittee: My name is Craig Haney. I am a Professor of Psychology at the University of California, Santa Cruz, and someone who has been studying the psychological effects of solitary confinement for well over 30 years. My academic interest in prisons more generally began even earlier in my professional life. In 1971 I was one of the principal researchers in a widely publicized study that came to be known as the “Stanford Prison Experiment.” My colleagues and I placed a carefully screened group of psychologically healthy college students in a prison-like environment, randomly assigning half to be guards, half prisoners. We observed with increasing concern and dismay as the behavior of the otherwise psychologically healthy volunteers in our simulated prison rapidly deteriorated into mistreatment and emotional breakdowns.¹ When I began to study real prisons, examining and evaluating conditions of confinement in prison systems throughout the United States and in a number of foreign countries, I continued to be guided by the early lesson of the Stanford Prison Experiment: prisons are psychologically powerful places, ones that are capable of shaping and transforming the thoughts and actions of the persons who enter them, often in unintended and adverse ways.

¹ For example, see: C. Haney, Curtis Banks & Philip Zimbardo, Interpersonal Dynamics in a Simulated Prison, 1 International Journal of Criminology and Penology 69 (1973); and C. Haney & Philip Zimbardo, The Past and Future of U.S. Prison Policy: Twenty-five Years After the Stanford Prison Experiment, 53 American Psychologist 709-727 (1998).

Since that time, I have toured and inspected numerous solitary confinement units across the country, in state prison systems from Massachusetts to California, and the federal “supermax” in Florence, Colorado (ADX). I have conducted systematic psychological assessments of approximately 1000 isolated prisoners, most of whom have been confined in solitary confinement units for periods of years, and even decades, during which time they have been kept separate from other prisoners, and denied the opportunity to have any normal human social contact or to engage in any meaningful social interaction.²

The Historical Context

As I mentioned above, the increased use of isolated or solitary confinement in American prisons began in the late 1970s and early 1980s. In a certain sense, it represented a return to a long-discredited practice that the nation had abandoned a century ago. As you may know, there was a time in our history when all prisons were operated as solitary confinement units, or nearly so. However, as the U.S. Supreme Court noted in an 1890 case, In re Medley, by the end of the 19th century, solitary confinement had already come to be known as an “infamous punishment,” largely because, as the Court acknowledged: “A

² Much of my professional access to conditions of solitary confinement and to the large number of prisoners and staff whom I have interviewed has occurred in the context of constitutional litigation in which I have been asked or appointed to help determine whether and how isolated prisoners were being subjected to potentially cruel and unusual punishment. For example, see, Madrid v. Gomez, 889 F.Supp. 1146 (N.D. Cal. 1995); Ruiz v. Johnson, 37 F.Supp. 2d 855 (S.D. Tex. 1999). I was the principal author of the Brief of Professors and Practitioners of Psychology and Psychiatry As Amicus Curiae in Austin v. Wilkinson, 545 U.S. 209 (2005). This work has provided me with a rare opportunity not only to conduct in-depth inspections of many solitary confinement units and to interview numerous prisoners and staff members who live and work there, but also to review an extensive number of prison documents, records, and files that pertain to the operation of the units themselves.

considerable number of the prisoners [in solitary] fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide, while those who stood the ordeal better were not generally reformed and in most cases did not recover sufficient mental activity to be of any subsequent service to the community.”³

Indeed, the Court’s Medley opinion echoed observations that had been made even earlier by Alexis d’Tocqueville, who concluded that solitary confinement in American prisons “devours [its] victims incessantly and unmercifully” and noted that the “unfortunate creatures who submitted to [it] wasted away,”⁴ and by Charles Dickens, who, although himself no stranger to harsh and degrading conditions, termed solitary confinement a “dreadful” punishment that inflicted terrible psychic pain that “none but the sufferers themselves can fathom, and which no man has a right to inflict upon his fellow creatures.”⁵

I wish I could say that the nation’s return to this long discredited practice was occasioned by significant advances in the way that solitary confinement is now implemented, or that new psychological insights had emerged to lessen previously widespread concerns about its damaging effects. I cannot. Instead, I believe the renewed use of long-term solitary confinement is the result of the confluence of three unfortunate trends—the era of “mass imprisonment” that began in the mid-1970s and produced widespread prison overcrowding, the shift in responsibility for housing the mentally ill to the nation’s prison systems, and

³ In re Medley, 134 U.S. 160, 168 (1890).

⁴ Quoted in Torsten Eriksson, The Reformers, An Historical Survey of Pioneer Experiments in the Treatment of Criminals. New York: Elsevier (1976), at 49.

⁵ Charles Dickens, American Notes for General Circulation. London: Chapman and Hall (1842), at 119-20.

the abandonment of the rehabilitative ideal and its corresponding mandate to provide prison programming and treatment. The renewed widespread use of solitary confinement emerged as an administrative stop-gap—an ill-advised but expedient measure to keep the resulting and potentially very problematic prison dynamics in check. I believe it has become increasingly clear that this approach to prison management has created far more problems than it solved.

The Conditions of Solitary Confinement

I should acknowledge that the term “solitary confinement” is a term of art in corrections. Solitary or isolated confinement goes by a variety of names in U.S. prisons—Security Housing, Administrative Segregation, Close Management, High Security, Closed Cell Restriction, and so on. But the units all have in common the fact that the prisoners who are housed inside them are confined on average 23 hours a day in typically windowless or nearly windowless cells that commonly range in dimension from 60 to 80 square feet. The ones on the smaller side of this range are roughly the size of a king-sized bed, one that contains a bunk, a toilet and sink, and all of the prisoner’s worldly possessions. Thus, prisoners in solitary confinement sleep, eat, and defecate in their cells, in spaces that are no more than a few feet apart from one another.

Beyond the physical limitations and procedural prohibitions that are central to solitary confinement units, these places must be “lived in,” typically on a long-term basis. Reflect for a moment on what a small space that is not much larger than a king-sized bed looks, smells, and feels like when someone has lived in it for 23 hours a day, day after day, for years on end. Property is strewn around, stored in whatever makeshift way possible, clothes and bedding soiled from recent use sit in one or another corner or on the floor, the residue of recent meals

(that are eaten within a few feet of an open toilet) here and there, on the floor, bunk, or elsewhere in the cell. Ventilation is often substandard in these units, so that odors linger, and the air is sometimes heavy and dank. In some isolation units, prisoners are given only small amounts of cleaning materials—a Dixie cup or so of cleanser—once a week, making the cells especially difficult to keep clean.

Inside their cells, units, and “yards,” isolated prisoners are surrounded by nothing but concrete, steel, cinderblock, and metal fencing—often gray or faded pastel, drab and sometimes peeling paint, dingy, worn floors. There is no time when they escape from these barren “industrial” environments. Many prisoners sit back on their bunks, look around at what has become the sum total of their entire lives, hemmed in by the tiny space that surrounds them and, not surprisingly, become deeply despondent.

Virtually all of the solitary confinement units with which I am familiar prohibit contact visits of any kind, even legal visits. This means that prisoners go for years—in some cases, for decades—never touching another human being with affection. Indeed, the only regular “interactions” that prisoners housed in these units routinely have occur when correctional officers push food trays through the slots on their doors two or three times a day in order to feed them. The only form of actual physical “touching” they experience takes place when they are being placed in mechanical restraints—leg irons, belly chains, and the like—in a procedure that begins even before their cell doors are opened, and which is done every time they are taken out of their cells by correctional staff, on the relatively infrequent occasions when this occurs.

When prisoners in solitary confinement or “lock-up” units leave their cells for what is, typically, an average of one hour a day, it is usually to go to a so-called “yard.” I say “so-called” because the “yard” in most of these units bears no relationship to the image this word ordinarily conjures. Instead, the yard often

consists of a metal cage, sitting atop a slab of concrete or asphalt or, in the case of California's Pelican Bay, a concrete-enclosed pen, one surrounded by high solid walls that prevent any view of the outside world. Federal Judge Thelton Henderson, who presided over a landmark case examining conditions of confinement at the Pelican Bay Security Housing Unit or "SHU," noted that the image of prisoners trying to exercise in these concrete pens—their only regular opportunity to be out of their windowless cells each day—was "hauntingly similar to that of caged felines pacing in a zoo."⁶ It is an apt description that unfortunately applies to many prisoners in many such "yards" around the country. In fact, the haunting similarities to zoos are not limited merely to the nature of the yards; one is hard-pressed to name any other place in our society where sentient beings are housed and treated the ways that they are in solitary confinement.

The emptiness and idleness that pervade most solitary confinement units are profound and enveloping. The prison typically provides the prisoners in these units with literally nothing meaningful to do. That emptiness, when combined with the total lack of meaningful social contact, has led some prisoners into a profound level of what might be called "ontological insecurity"—they are not sure that they exist and, if they do, exactly who they are. A number of prisoners have told me over the years that they actually have precipitated confrontations with prison staff members (that sometimes result in brutal "cell extractions") in order to reaffirm their existence.

The Makeup of Solitary Confinement Units

⁶ Madrid, supra note 2, at 1229.

You are no doubt wondering who is confined in these units. That is, what does a prisoner have to do in order to be housed in such a place? In fact, some of the prisoners have done very serious things, including assaulting other prisoners or even staff members; some have even committed in-prison homicides. However, in most isolation units these prisoners are the exception rather than the rule. A number of prisoners are in solitary confinement for having committed an unacceptably high number of minor offenses. An even larger number are housed there because they are alleged to be prison gang members or associates, an offense that, in and of itself, can result in indefinite solitary confinement, even though the prisoners in question may not have engaged in any overt rule violations other than their alleged connection to the gang, and may remain entirely free of disciplinary write-ups during the many years of their indefinite isolation. Allegations of gang membership are inherently subjective and can be unreliable. Prisoners who are erroneously classified in this way are hard-pressed to establish facts and may be confined in isolation on this incorrect basis indefinitely.⁷

In addition, there are two very problematic but little publicized facts about the group of prisoners who are housed inside our nation's solitary confinement units. The first is that a shockingly high percentage of them are mentally ill, and often profoundly so. In some cases, the mental illness was pre-existing and may even be the primary cause of the disciplinary infraction that brought them to the solitary confinement unit in the first place. In other instances, however, the signs and symptoms of mental illness appear to have emerged only after the prisoner's term in solitary confinement began. Studies indicate that approximately a third of

⁷ For example, see: Erica Goode, Fighting a Drawn-Out Battle Against Solitary Confinement, New York Times, March 30, 2012. [available at: <http://www.nytimes.com/2012/03/31/us/battles-to-change-prison-policy-of-solitary-confinement.html?pagewanted=all>]

the prisoners in solitary confinement units suffer from mental illness,⁸ but in some units the figure is higher—half or more. Approximately 50% of all prison suicides occur in solitary confinement units.⁹

The other very troublesome but rarely acknowledged fact about solitary confinement is that in many jurisdictions it appears to be reserved disproportionately for prisoners of color. That is, the racial and ethnic overrepresentation that occurs in our nation’s prisons generally is, in my personal experience, even more drastic inside solitary confinement units. Although these data are not systematically collected and made available for analysis overall, a study that I conducted in a Security Housing Unit in California confirmed that approximately 90% of the prisoners housed there were of color (i.e., Latino or African American).

The Psychological Effects of Solitary Confinement

What are the consequences of confinement in such harsh and deprived places? Your colleague, Senator John McCain, characterized solitary confinement as “an awful thing,” noting that: “It crushes your spirit and weakens your

⁸ Specifically, two separate studies have found that 29% of the prisoners in solitary confinement suffer from a “serious mental disorder.” Hodgins, S., and Cote, G., *The Mental Health of Penitentiary Inmates in Isolation*, 33 *Canadian Journal of Criminology* 177-182 (1991); Lovell, D., Cloyes, K., Allen, D., & Rhodes, L., *Who Lives in Super-Maximum Custody? A Washington State Study*, 64 *Federal Probation* 33-38 (2000). If the definition of mental illness is broadened to include “psychosocial impairments,” then one study has found approximately 45% of solitary confinement prisoners are so afflicted.

⁹ Mears, D.P. & Watson, J., *Towards a Fair and Balanced Assessment of Supermax Prisons*, 23 *Justice Quarterly*, 232 (2006); Way, B., Miraglia, R., Sawyer, D., Beer, R., & Eddy, J. (2005). *Factors Related to Suicide in New York State Prisons*, 28 *International Journal of Law and Psychiatry*, 207 (2005); Patterson, R.F. & Hughes, K., *Review of Completed Suicides in the California Department of Corrections and Rehabilitation, 1999 to 2004*, 59 *Psychiatric Services* 676-682 (2008). See, also: Cloyes, K., Lovell, D., Allen, D., & Rhodes, L. *Assessment of Psychosocial Impairment in a Supermaximum Security Unit Sample*, 33 *Criminal Justice and Behavior* 760-781 (2006).

resistance more effectively than any other form of mistreatment. Having no one else to rely on, to share confidences with, to seek counsel from, you begin to doubt your judgment and your courage.”¹⁰ My observations of the effects of solitary confinement as it is practiced inside our nation’s prisons are consistent with Senator McCain’s. The level of suffering and despair in many of these units is palpable and profound.

As the federal judge who heard testimony about California’s Pelican Bay Security Housing Unit concluded, the severe deprivation and oppressive control conditions in these places “may press the outer bounds of what most humans can psychologically tolerate.”¹¹ For a number of prisoners, those bounds are greatly exceeded, and the consequences of their long-term solitary confinement are truly extreme. Serious forms of mental illness can result from these experiences. Moreover, many prisoners become so desperate and despondent that they engage in self-mutilation and, as I noted early, a disturbingly high number resort to suicide. Indeed, it is not uncommon in these units to encounter prisoners who have smeared themselves with feces, sit catatonic in puddles of their own urine on the floors of their cells, or shriek wildly and bang their fists or their heads against the walls that contain them. In some cases the reactions are even more tragic and bizarre, including grotesque forms of self-harm and mutilation—prisoners who have amputated parts of their own bodies or inserted tubes and other objects into their penises—and are often met with an institutional matter-of-factness that is equally disturbing.

I recall a prisoner in New Mexico who was floridly psychotic and used a makeshift needle and thread from his pillowcase to sew his mouth completely

¹⁰ Quoted in Richard Kozar, John McCain: Overcoming Adversity. Chelsea House (2001), at p. 53.

¹¹ Madrid, supra note 2, at p. 1267.

shut. Prison authorities dutifully unstitched him, treated the wounds to his mouth, and then not only immediately returned him to the same isolation unit that had caused him such anguish but gave him a disciplinary infraction for destroying state property (i.e., the pillowcase), thus ensuring that his stay in the unit would be prolonged. A prisoner at the federal supermax prison—ADX—who had no pre-existing mental disorder before being placed in isolation, has suffered from severe mental illness for years now. While in solitary confinement he has amputated one of his pinkie fingers and chewed off the other, removed one of his testicles and scrotum, sliced off his ear lobes, and severed his Achilles tendon with a sharp piece of metal. He remains in a standard solitary confinement unit rather than a psychiatric facility. Another prisoner, housed long-term in a solitary confinement unit in Massachusetts, has several times disassembled the television set in his cell and eaten the contents. Each time, his stomach is pumped and, after a brief stay in a psychiatric unit, he is returned to the same punitive isolation where this desperate and bizarre behavior occurred.

Beyond these extreme cases, solitary confinement places all of the prisoners exposed to it at grave risk of harm. In fact, the scientific literature on the effects of solitary confinement has been accumulated over many decades, by researchers from a number of different countries who have varying academic backgrounds. Despite the methodological limitations that come from studying human behavior in such a complex environment, most of the research has reached remarkably similar conclusions about the adverse psychological consequences of solitary confinement. Thus, we know that prisoners in solitary confinement suffer from a number of psychological and psychiatric maladies, including: significantly increased negative attitudes and affect, irritability, anger, aggression and even rage; many experience chronic insomnia, free floating anxiety, fear of impending emotional breakdowns, a loss of control, and panic

attacks; many report experiencing severe and even paralyzing discomfort around other people, engage in self-imposed forms of social withdrawal, and suffer from extreme paranoia; many report hypersensitivity to external stimuli (such as noise, light, smells), as well as various kinds of cognitive dysfunction, such as an inability to concentrate or remember, and ruminations in which they fixate on trivial things intensely and over long periods of time; a sense of hopelessness and deep depression are widespread; and many prisoners report signs and symptoms of psychosis, including visual and auditory hallucinations.¹² Many of these symptoms occur in and are reported by a large number of isolated prisoners. For example, in a systematic study I did of a representative sample of solitary confinement prisoners in California, prevalence rates for most of the above mentioned symptoms exceeded three-quarters of those interviewed.¹³

In addition to the above clinical symptoms and syndromes, prisoners who are placed in long-term isolation often develop what I have characterized as “social pathologies,” brought about because of the pathological deprivations of social contact to which they are exposed. The unprecedented totality of control in these units occurs to such an exaggerated degree that many prisoners gradually lose the ability to initiate or to control their own behavior, or to organize their personal lives. Prisoners may become uncomfortable with even small amounts of freedom because they have lost confidence in their own ability to behave in the absence of constantly enforced restrictions, a tight external structure, and the ubiquitous physical restraints. Even the prospect of returning to the comparative

¹² For citations to the studies in which these specific adverse effects have been reported, see: C. Haney, *Mental Health Issues in Long-Term Solitary and “Supermax” Confinement*, 49 *Crime & Delinquency* 124-156 (2003), and C. Haney, *The Social Psychology of Isolation: Why Solitary Confinement is Psychologically Harmful*, *Prison Service Journal UK* (Solitary Confinement Special Issue), Issue 181, 12-20 (2009).

¹³ See *supra*, note 12, Haney, 2003.

“freedoms” of a mainline maximum security prison (let alone the free world) fills them with anxiety.

For many prisoners, the absence of regular, normal interpersonal contact and any semblance of a meaningful social context in these isolation units creates a pervasive feeling of unreality. Because so much of our individual identity is socially constructed and maintained, the virtually complete loss of genuine forms of social contact and the absence of any routine and recurring opportunities to ground thoughts and feelings in a recognizable human context lead to an undermining of the sense of self and a disconnection of experience from meaning. Some prisoners experience a paradoxical reaction, moving from initially being starved for social contact to eventually being disoriented and even frightened by it. As they become increasingly unfamiliar and uncomfortable with social interaction, they are further alienated from others and made anxious in their presence. In extreme cases, another pattern emerges: this environment is so painful, so bizarre and impossible to make sense of, that they create their own reality—they live in a world of fantasy instead. Finally, the deprivations, restrictions, the totality of control, and the prolonged absence of any real opportunity for happiness or joy fills many prisoners with intolerable levels of frustration that, for some, turns to anger, and then even to uncontrollable and sudden outbursts of rage.

A Culture of Harm

Most of the analyses of the harmfulness of solitary confinement are directed at the extreme levels of material deprivation, the lack of activity and other forms of sensory stimulation, and, especially, the absence of normal or meaningful social contact that prisoners experience and suffer from in these settings. This

emphasis is not misplaced. There is no widely accepted psychological theory, correctional rationale, or conception of human nature of which I am aware to suggest that exposure to these powerful and painful stressors is neutral or benign and does not carry a significant risk of harm.

To be sure, the extreme deprivation, the isolating architecture, the technology of control, and the rituals of degradation and subjugation that exist in solitary confinement units are inimical to the mental health of prisoners. However, it would be naïve to assume that the nature of these environments does not also affect the staff who work inside.¹⁴ In many such places, thinly veiled hostility, tension, and simmering conflict are often palpable. The interpersonal toxicity that is created in these environments can engender mistreatment and even brutality. What might be termed an “ecology of cruelty” is created in many such places where, at almost every turn, guards are implicitly encouraged to respond and react to prisoners in essentially negative ways—through punishment, opposition, force, and repression.

For many correctional officers, at least initially, this approach to institutional control is employed neutrally and even-handedly—without animus and in response to actual or perceived threats. However, when punishment and suppression continue—largely because of the absence of any available and sanctioned alternative approaches—they become functionally autonomous and often disproportionate in nature. Especially when the use of these techniques persists in spite of the visible pain and suffering they bring about, it represents a form of cruelty (notwithstanding the possible lack of cruel intentions on the part of many of those who employ the harsh techniques themselves).

Unfortunately, the culture of harm that is created in many of these units

¹⁴ C. Haney, *A Culture of Harm: Taming the Dynamics of Cruelty in Supermax Prisons*, 35 *Criminal Justice and Behavior* 956-984 (2008);

also affects service providers, including those who are supposed to address the mental health needs of prisoners. Despite the large concentration of mentally ill prisoners in solitary confinement, the quality of mental health care in these units is sometimes much worse than elsewhere in the prison system. Some of this is due to limited resources; some prisons simply do not have the personnel to provide the kind of care that solitary confinement prisoners need. Some of it stems from built-in practical limitations. That is, solitary confinement units are located in separate, distant areas of the prison, access to the units themselves is difficult, and the procedures whereby prisoners are transported from their cells are cumbersome. But some of the poor quality care in certain units derives from the culture of harm to which I referred and the ease with which it is possible to simply “get used to” practices and procedures that would be seen as unacceptably compromised and inadequate in any other setting. For example, in many solitary confinement units it is not uncommon for mental health services to be delivered in “treatment cages” (or what prisoners sometimes refer to as “shark cages” because of their resemblance to those underwater contraptions)—telephone-booth sized metal cages in which prisoners are confined during their “therapeutic hour.”

Public Safety Concerns

A critically important but widely overlooked aspect of solitary confinement in the United States is the potential threat it represents to public safety. Solitary confinement not only subjects prisoners to the kind of psychologically damaging experiences I have described above but also does so without providing them with any opportunities to obtain meaningful programming or rehabilitative services.

As a result, many prisoners are significantly handicapped when they attempt to make their eventual transition from prison back into the free world.

Indeed, there is some recent, systematic evidence that time spent in solitary confinement contributes to elevated rates of recidivism.¹⁵ The explanation for this troubling fact is not difficult to discern. Without oversimplifying, one of the things we have learned about how prisoners make successful transitions back into their communities of origin is that positive re-entry depends on their ability to connect to a supportive, caring group of other people, and the ability and opportunity to become gainfully employed. Solitary confinement significantly impedes both things. Prisoners' social skills atrophy severely under their starkly deprived and isolated conditions of confinement. The absence of any meaningful activity (let alone rehabilitative programming) in solitary confinement means that their often already limited educational and employment skills will have further deteriorated by the time they are released. Many prisoners come out of these units damaged and functionally disabled, and some are understandably enraged by the ways in which they have been mistreated. Crime—sometimes violent crime—is one predictable result. Moreover, very few solitary confinement units operate “step down” or transitional programs that assist prisoners in negotiating the steep barrier from isolation to the intensely social world outside of prison.

In some instances, the failures that solitary confinement prisoners experience when they try to make this nearly impossible transition on their own are tragic, not just for themselves but for others who may become the innocent victims of their desperate plight. For example, some years ago I encountered one

¹⁵ For example, see: Lovell, D., Johnson, L., & Cain, K., Recidivism of Supermax Prisoners in Washington State, 53 *Crime & Delinquency* 633-656 (2007); Mears, D., & Bales, W., Supermax Incarceration and Recidivism, 47 *Criminology* 1131 (2009).

California prisoner who had been convicted of non-violent drug offenses, and entered the prison system with no pre-existing symptoms of mental illness. Yet, when I saw him he was lying catatonic, unresponsive, and incoherent on the floor of his isolation cell in a California SHU unit. He was eventually diagnosed as schizophrenic, but was retained in the same unit where his mental illness had originated. The next time I encountered him was several years later, after he had been released from prison. He was on trial for capital murder, an offense that had been committed just months after being taken directly from his isolation cell, placed on a bus and eventually onto the streets of a California city, with no pre-release counseling or transitional housing of any kind. I wish that I could say that this tragic and extreme outcome was the only one of its kind that I have personally encountered, but it certainly is not.

Proposed Remedies

Solitary confinement continues to be used on a widespread basis in the United States despite empirical evidence suggesting that its existence has done little or nothing to reduce system-wide prison disorder or disciplinary infractions.¹⁶ In fact, at least one prison system that drastically reduced the number of prisoners whom it housed in solitary confinement by transferring them to mainline prisons experienced an overall reduction in misconduct and violence system-wide.¹⁷ As prison populations continue to gradually decline, and the nation's correctional system rededicates itself to program-oriented

¹⁶ Briggs, C., Sundt, J., & Castellano, T., The effect of Supermaximum Security Prisons on Aggregate Levels of Institutional Violence, 41 Criminology 1341-1376 (2003).

¹⁷ See T. Kupers, T. Dronet et al, Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs, 36 Criminal Justice and Behavior 1037-1050 (2009).

approaches designed to produce positive prisoner change, the resources expended on long-term solitary confinement should be redirected to a more cost-effective and productive strategy of prison management.

Several years ago, after it had conducted a number of public hearings in locations around the country, the bipartisan Commission on Safety and Abuse in America's Prisons, chaired by former Attorney General Nicholas Katzenbach, called supermax prisons "expensive and soul destroying"¹⁸ and recommended that prison systems "end conditions of isolation."¹⁹ Short of that, in my opinion, there are some things that can and should be implemented on a nationwide basis. Solitary confinement continues to be structured and operated in ways that are designed to deprive, diminish, and punish. With that in mind, steps need to be taken to entirely exclude the most vulnerable prisoners from exposure to these conditions,²⁰ significantly limit the time that all other prisoners are housed there,²¹ provide all prisoners with meaningful steps or pathways that they can pursue to accelerate their release from solitary,²² significantly change the nature

¹⁸ Gibbons, J., & Katzenbach, N. (2006). Confronting Confinement: A Report of the Commission on Safety and Abuse in America's Prisons. New York: Vera Institute of Justice, at p. 59.

¹⁹ Id. at 57.

²⁰ Persons under the age of 18 and those who suffer from serious mental illness are singularly unsuited for long-term solitary confinement and they should be absolutely excluded from being housed there. In fact, persons with serious mental illnesses are categorically excluded from solitary confinement in a number of states (e.g., California, Wisconsin, Ohio), but not all. Moreover, the ABA Standards on the Treatment of Prisoners (at section 23-2.8(a)) require this. See:

http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners.html#23-2.7

²¹ In terms of time limits, the new ABA Standards define "long term" segregation as 30 days or more, and impose a presumptive limit of one year on placement in disciplinary housing (section 23-4.3(b)). In my opinion, that limit is arguably too long. However, if US prisons complied even with the ABA Standards, it would result in a significant improvement.

²² For example, see the general discussion in: C. Haney, The Psychological Impact of Incarceration: Implications for Post-Prison Adjustment, at pp. 33-66. *See, also*, Joan Petersilia, When Prisoners Come Home: Parole and Prisoner Reentry. New York: Oxford University Press (2003).

of the isolation units themselves to mitigate the damage that they inflict,²³ and provide prisoners who are being released into mainline prison populations or into free world communities with effective transitional services to ensure their post-solitary success and reduce the risk of harm to others once they are released.

The grave psychological risks posed by solitary confinement make the overall mental health recommendations urgently important. Prisoners must be systematically screened for mental illness as they come into solitary confinement units, and continuously monitored for signs of developing mental illness. Those whose problems may fall below the standard required for exclusion and who therefore remain in solitary confinement must be given access to enhanced (rather than substandard) mental health resources. Finally, all isolated prisoners must be provided with transitional or “step down” services and programs designed to meaningfully address the psychological changes that they are likely to have undergone in the course of their solitary confinement.

Thank you for the opportunity to participate in this historic hearing and to help the Subcommittee address this very significant issue. I am hopeful that it

²³ Elsewhere I have proposed list of “limiting standards” that I believe should be enforced in all solitary confinement units. See C. Haney and Mona Lynch, *Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement*, New York Review of Law & Social Change, 23, 477-570 (1997), at pp. 558-566. These standards that are “rooted in the psychological literature and intended as the basis for a more effective, realistic, and psychologically meaningful oversight” of solitary confinement. *Id.* at p. 560. Many of our proposed standards were designed to prevent or limit the potential damage of the harsh solitary confinement regime on prisoners, including due process protections for all prisoners in advance of their placement in isolation (irrespective of the purpose for that placement); screening prisoners out of solitary confinement if their specific medical or mental health conditions (not just serious mental illness) made them especially vulnerable to the harmful consequences that we identified; prohibiting the placement of prisoners in isolation that whose disciplinary infractions resulted from pre-existing psychiatric disorders; placing severe time limits on the duration of confinement for all prisoners (prohibiting total isolation and extreme segregation of the sort that occurs in “dark cells,” while permitting somewhat longer periods of isolation for less draconian segregated housing); monthly mental health evaluations to determine continued fitness for segregated housing; and access to therapy, work, educational, and recreational programs and visitation—comparable to what is offered in mainline units—for prisoners confined in solitary confinement for longer than 3 months.

will mark the beginning of urgently needed and long-term Congressional oversight and reform.