No. 17-2427

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

MAURICE L. WALLACE,
Plaintiff-Appellant

v.

JOHN BALDWIN, ET AL.,
Defendants-Appellees.

On Appeal from the
United States District Court for the Southern District of Illinois
Civil Action No. 17-cv-0576-DRH
Honorable David R. Herndon

Motion for Leave to File Brief of Amici Curiae Professor and Practitioner of Psychiatry in Support of Plaintiff-Appellant

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January 16, 2018

Pursuant to Federal Rule of Appellate Procedure 29, Terry A. Kupers and Stuart Grassian request leave to file the accompanying Brief of Amici Curiae Professor and Practitioner of Psychiatry in Support of Plaintiff-Appellant.

Amici curiae are a professor and a practitioner of psychiatry with extensive experience studying the psychological and physiological effects of imprisonment and/or treating prisoners who are in penal confinement, including solitary confinement. Amici curiae are professionally knowledgeable about the psychological and physiological effects of a range of different prison conditions in the United States and many foreign countries. More specifically, amici curiae have background, experience, and expertise in analyzing the special psychological and physiological problems that arise in the course of isolated confinement, especially among prisoners suffering from mental illness.

Amici curiae are the following:

Terry A. Kupers, M.D., M.S.P., a Distinguished Life Fellow of The American Psychiatric Association, is Professor Emeritus at The Wright Institute. He has provided expert testimony in several lawsuits about prison conditions and published books and articles on related subjects.

Stuart Grassian, M.D., is a psychiatrist who taught at Harvard Medical School for almost 30 years. He has evaluated hundreds of prisoners in solitary confinement and published numerous articles on the psychiatric effects of solitary confinement.

Amici curiae submit there are a number of reasons to grant them leave to file an amicus brief in support of Plaintiff-Appellant.

First, amici curiae are committed to understanding and addressing the effects of solitary confinement on human health and welfare. Accordingly, amici curiae respectfully submit the proposed amicus brief to provide the Court with a unique perspective that the parties have not. *See Ryan v. Commodity Futures Trading Comm'n*, 125 F.3d 1062, 1063 (7th Cir. 1997) (explaining that an amicus brief is permissible when it provides perspective the parties do not). Amici curiae will provide this Court with a comprehensive review of the scientific literature and the overwhelming evidence establishing that prolonged solitary confinement deprives prisoners of basic human needs and exposes them to atypical and severe psychological and physiological harms.

Second, amici curiae have consistently advocated against solitary confinement for mentally-ill prisoners. They have a keen interest in ensuring that the legal precedents do not subject their patients to severe psychological and physical harm in solitary confinement. Amici curiae expect that this Court's decision in this case will have a substantial impact on similarly situated prisoners as Mr. Wallace. *See Nat'l Organization for Women, Inc. v. Scheidler*, 223 F.3d 615, 617 (7th Cir. 2000) (noting that an amicus brief may be appropriate where the appellate decision may materially affect other cases in which the would-be amicus is engaged).

Dated: January 16, 2018

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Certificate of Compliance

This motion complies with the type-volume limitation of Federal Rule of Appellate Procedure 27(d)(2) because this motion is 434 words in length, excluding the parts of the motion exempted by Federal Rule of Appellate Procedure 32(f). In addition, this motion complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this motion has been prepared in a proportionally spaced typeface using Microsoft Word from Microsoft Office Professional Plus 2010 in 12 point, Century Schoolbook font for text (including footnotes at 11 point font).

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CERTIFICATE OF SERVICE

I hereby certify that on January 16, 2018, I electronically filed the foregoing motion with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit by using the CM/ECF system.

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Brief of Amici Curiae Professor and Practitioner of Psychiatry in Support of Plaintiff-Appellant

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INTEREST OF THE AMICI CURIAE

Plaintiff-Appellant Maurice Wallace has been in solitary confinement for over ten years. Wallace was sentenced to solitary confinement for an indeterminate sentence, so he remains in solitary confinement without a foreseeable release date. Wallace is seriously mentally ill, and as a result of this illness, he has a history of suicidal ideations and suicide attempts. His solitary confinement intensifies these symptoms. Wallace filed suit challenging his solitary confinement as a violation of the First, Eighth, and Fourteenth Amendments, seeking damages and preliminary and permanent injunctive relief of his solitary confinement. Wallace sought leave to file *in forma pauperis*, but this was denied because the district court concluded that Wallace had at least three actions brought as a prison inmate dismissed pursuant to 28 U.S.C. § 1915A as frivolous, malicious, or as failing to state a claim upon which relief may be granted. Amici curiae argue that Wallace's solitary confinement presents an imminent danger of serious physical injury, exempting his complaint from the three strikes rule.

Amici curiae are a professor and a practitioner of psychiatry with extensive experience studying the psychological and physiological effects of imprisonment and/or treating prisoners who are in penal confinement, including solitary confinement. Through their experience, amici curiae offer scientific insights into the harms of solitary confinement, particularly when those sentenced to solitary confinement suffer from a mental illness. Many prisoners with mental illness experience catastrophic and often irreversible deterioration when they are deprived of social interaction and adequate levels of environmental stimulation. Amici curiae

are professionally knowledgeable about the psychological and physiological effects of a range of different prison conditions in the United States and many foreign countries. More specifically, amici curiae have background, experience, and expertise in analyzing the special psychological and physiological problems that arise in the course of isolated confinement, especially among prisoners suffering from mental illness.

Based on their research and assessment of the professional literature, amici curiae have concluded that prolonged solitary confinement deprives prisoners of two basic human needs—social contact and adequate environmental stimulation—causing grave damage to their mental and physical health. As explained below, this grave mental and physical damage can manifest in ways that pose a risk of imminent physical harm, triggering the exception to the three strikes rule and allowing the plaintiff to file *in forma pauperis*. Further, as a mentally ill prisoner with a history of suicidal ideations and suicide attempts, Wallace is particularly in danger of suffering serious physical injury.

Amici curiae are committed to understanding and addressing the effects of solitary confinement on human health and welfare. Accordingly, they respectfully submit this brief in support of Plaintiff-Appellant Maurice Wallace, who faces ongoing prolonged detention in solitary confinement, to provide this Court with a comprehensive review of the scientific literature and the overwhelming evidence establishing that prolonged solitary confinement deprives prisoners of basic human

needs and exposes them to atypical and severe psychological and physiological harms, including in this case an intolerable risk of serious physical injury and even death.

Amici curiae are the following:

1. Terry A. Kupers, M.D., M.S.P., a Distinguished Life Fellow of The American Psychiatric Association, is Professor Emeritus at The Wright Institute. He has provided expert testimony in several lawsuits about prison conditions and published books and articles on related subjects.

2. Stuart Grassian, M.D., is a psychiatrist who taught at Harvard Medical School for almost 30 years. He has evaluated hundreds of prisoners in solitary confinement and published numerous articles on the psychiatric effects of solitary confinement.

Amici curiae state, pursuant to Federal Rule of Appellate Procedure 29(c)(4), that no party's counsel authored this brief in whole or in part; no party or party's counsel contributed money that was intended to fund preparing or submitting this brief; and no person other than the amici curiae, their members, or their counsel contributed money intended to fund preparing or submitting this brief.

ARGUMENT

As explored below, the research confirms what the Supreme Court "suggested over a century ago: Years on end of near-total isolation exact a terrible price." *Davis v. Ayala*, 135 S. Ct. 2187, 2210 (2015) (Kennedy, J., concurring). The scientific consensus establishes that prisoners held in solitary confinement experience serious, often debilitating—even irreparable—mental and physical harms because they are deprived of the basic human needs of social interaction and normal environmental

stimulation. Prolonged solitary confinement causes psychological and physical injury that may place any prisoner in danger of physical injury. Where, as here, the prisoner is mentally ill and has a history of suicide attempts and suicidal ideation, that risk is intolerable.

I. THE HALLMARK OF SOLITARY CONFINEMENT IS THE DEPRIVATION OF BASIC HUMAN NEEDS.

Solitary confinement robs its victims of two fundamental needs—human contact and environmental stimulation. When serving time in solitary confinement, an inmate typically spends 22 to 24 hours per day alone in a cell without meaningful social interaction or positive sensory and intellectual stimulation. *See, e.g.*, *Wilkinson v. Austin*, 545 U.S. 209, 213-14, 223-24 (2005); Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 WASH. U. J.L. & POL'Y 325, 327 (2006) [hereinafter Grassian, *Psychiatric Effects*]; Peter Scharff Smith, *The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature*, 34 CRIME & JUST. 441, 443 (2006). Inmates spend almost all of their time in a small windowless or nearly windowless cell. *See Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences: Hearing Before the Subcomm. on the Constitution, Civil Rights, & Human Rights of the S. Comm. on the Judiciary*, 112 Cong. 72, 75 (2012) [hereinafter *Reassessing Solitary Confinement*] (statement of Dr. Craig Haney, Professor, University of California, Santa Cruz). Thus, the inmates "sleep, eat, and defecate in their cells, in spaces that are no more than a few feet apart." *Id.*

In their cells, prisoners endure sustained periods of idleness since access to library books and work is limited or prohibited. *See Reassessing Solitary Confinement*, *supra*, at 77 ("The emptiness and idleness that pervade most solitary confinement units are profound and enveloping."); Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax" Confinement*, 49 CRIME AND DELINQ. 124, 126, 149-50 (2003) [hereinafter Haney, *Mental Health Issues*]; *see also* Terry A. Kupers, *Isolated Confinement: Effective Method for Behavior Change or Punishment for Punishment's Sake?*, in THE ROUTLEDGE HANDBOOK FOR INT'L CRIME & JUST. STUDIES 1, 2 (Bruce A. Arrigo & Heather Y. Bersot eds., 2014). This idleness is characterized not only by a lack of positive stimuli, but also by overexposure to noxious stimuli—the shouting of officers and inmates, offensive smells such as feces and blood, and/or constant fluorescent lights—which the prisoners cannot control or escape. *See* Thomas L. Hafemeister & Jeff George, *The Ninth Circle of Hell: An Eighth Amendment Analysis of Imposing Prolonged Supermax Solitary Confinement on Inmates with a Mental Illness*, 90 DENV. U. L. REV. 1, 39 & n.217 (2012); Kupers, *supra*, at 6.

The brief periods that solitary confinement inmates are allowed outside their cells do not provide opportunities for any meaningful human contact or positive environmental exposure. *See* Haney, *Mental Health Issues*, *supra*, at 126. Inmates in solitary confinement are rarely allowed contact visits and are generally denied opportunities to socialize or participate in group activities. *See id.* Recreation is

usually spent alone "in caged-in or cement-walled areas that are so constraining they are often referred to as 'dog runs.'" *Id.*

On the rare instances an inmate is permitted to leave his cell for occasional showers or "exercise," he may have to submit to an invasive body cavity strip search and is generally bound by multiple shackles and restraints. *See Williams v. Sec'y Pa. Dep't of Corr.*, 848 F.3d 549, 554 (3d Cir. 2017) (describing strip searches so invasive that a prisoner sacrificed the opportunity to exercise for nearly seven years to avoid them); Haney, *Mental Health Issues*, *supra*, at 126; *see also Incumaa v. Stirling*, 791 F.3d 517, 531 (4th Cir. 2015) (noting that a prisoner in solitary confinement experienced "near-daily cavity and strip searches"). Because the inmate is carefully isolated from any human contact other than the guards once they leave the cell, his sole physical contact with another person may be with a correctional offer when being placed in restraints. Hafemeister & George, *supra*, at 17. For many inmates, years may pass "without ever touching another person with affection." Redacted Expert Report of Craig Haney at 31, *Ashker v. Brown*, No. 4:09 CV 05796 CW (N.D. Cal. 2015) [hereinafter Haney Expert Report] https://ccrjustice.org/sites/default/files/attach/2015/07/Redacted_Haney%20Expert%20Report.pdf.

Just as food and shelter are necessary to maintain health, so are meaningful contact with others and positive interactions with one's environment. *See* Craig Haney & Mona Lynch, *Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement*, 23 N.Y.U. REV. L. & SOC. CHANGE 477, 504-07

(1997). Because these interactions shape and affirm who we are, severe social isolation erodes one's sense of self and connection to reality. *See id.* at 503-06; *see also* Smith, *supra*, at 492 (noting that lethargy among solitary confinement inmates "has been described by researchers in connection with a complete breakdown or disintegration of the identity of the isolated individual. This can be described as a simultaneous attack of several symptoms that effectively erase the personality of the isolated individual"). Extensive scientific research demonstrates that people consistently suffer "a number of dysfunctional psychological states and outcomes" when deprived of social contact and a normal range of sensory input for long periods of time. *See* Haney & Lynch, *supra*, at 504-07; Kupers, *supra*, at 25. For this reason, researchers have called the psychological stressors associated with solitary confinement "as clinically distressing as physical torture." Jeffrey L. Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, 38 J. AM. ACAD. PSYCHIATRY & L. 104, 104 (2010).

II. SOLITARY CONFINEMENT CONSISTENTLY CAUSES SEVERE PHYSICAL AND PSYCHOLOGICAL HARM AND PUTS MAURICE WALLACE IN DANGER OF SERIOUS PHYSICAL INJURY.

Extreme social isolation and the deprivation of positive environmental stimulation combine to inflict a myriad of physical harms on prisoners in solitary confinement. First, solitary confinement greatly increases the risk of self-harm or suicide. Second, a litany of research documents the direct physical and psychological consequences suffered by inmates placed in solitary confinement.

A. Solitary Confinement Increases the Risk of Suicide or Self Harm.

Segregated prisoners frequently demonstrate cognitive dysfunction and engage in potentially life-threatening behaviors such as self-mutilation and suicidal ideation. *See* Grassian, *Psychiatric Effects*, *supra*, at 349. Most commonly, these desperate acts are not the least bit voluntary, but rather are compelled by mental illness and a symptomatic response to the high anxiety induced by the harsh conditions of solitary confinement.

Suicide and self-harm rates among solitary confinement inmates across the nation and the world are alarmingly high. In a study of inmates in solitary confinement at the Massachusetts Correctional Institute at Walpole, 20% reported cutting themselves. Stuart Grassian, *Psychopathological Effects of Solitary Confinement*, 140 AM. J. PSYCHIATRY 1450, 1451, 1453 (1983) [hereinafter Grassian, *Psychopathological Effects*]. One inmate reported that "as soon as [he] got in, [he] started cutting his wrists" because he "figured it was the only way to get out" of solitary confinement. *Id.* at 1451. A Norwegian study of pretrial detainees produced similar results, finding that 13% of the study's subjects had mutilated themselves. Smith, *supra*, at 494. Not only is self-harm inherently hurtful to inmates, but it can lower an inmate's threshold for harming himself and for pain, which can lead to accidental forms of suicide, placing inmates at risk of death even if the inmate is not suicidal.

Solitary confinement inmates are more likely than inmates in the general population to harm themselves. Inmates in solitary confinement comprise 2% to 8%

of the total U.S. prison population, but account for 50% of all suicides by inmates. Stuart Grassian & Terry Kupers, *The Colorado Study vs. The Reality of Supermax Confinement*, 13 CORRECTIONAL MENTAL HEALTH REP. 1, 9 (2011).

In 2005, 70% of the 44 inmates in the California prison system who committed suicide were in solitary confinement. Sal Rodriguez, FACT SHEET: PSYCHOLOGICAL EFFECTS OF SOLITARY CONFINEMENT 1 (2011) http://solitarywatch.com/wp-content/uploads/2011/06/fact-sheet-psychological-effects-of-solitary-confinement.pdf. Another large-scale study of completed suicides in California prisons concluded that "the conditions of deprivation in locked units and higher-security housing were a common stressor shared by many of the prisoners who committed suicide." Raymond F. Patterson & Kerry Hughes, *Review of Completed Suicides in the California Department of Corrections and Rehabilitation, 1999 to 2004*, 59 PSYCHIATRIC SERVICES 676, 678 (2008).

In Texas solitary confinement units, suicide is five times more likely than it is in the general prison population and self-harm is eight times more likely than it is in general population. AMERICAN CIVIL LIBERTIES UNION OF TEXAS & TEXAS CIVIL RIGHTS PROJECT - HOUSTON, A SOLITARY FAILURE: THE WASTE, COST AND HARM OF SOLITARY CONFINEMENT IN TEXAS 50-51 (2015), https://www.aclutx.org/sites/default/files/field_documents/SolitaryReport_2015.pdf.

Furthermore, "[a]n analysis of the 902 self-mutilation incidents in the North Carolina Department of Corrections occurring between 1958 and 1966 revealed that nearly half occurred in segregation units." Haney & Lynch, *supra*, at 525. Similarly,

a Virginia study revealed that 51% of the self-mutilation incidents that a researcher examined over the course of one year occurred in isolation units. *Id.* A recent study examining self-harm in New York City jails also found that, even controlling for serious mental illnesses, inmates serving solitary confinement were nearly seven times more likely to commit acts of self-harm. *See* Homer Venters et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 AM. J. PUB. HEALTH 442, 445 (2014) ("We found that acts of self-harm were strongly associated with assignment of inmates to solitary confinement.").

There are countless instances of people suffering in solitary confinement who have been driven to self-harm. After three years of being held in solitary confinement, Terry Anderson, a journalist captured and held hostage in Lebanon for seven years, once began slamming his head into a wall time after time until guards stopped him. *See* Atul Gawande, *Hellhole*, THE NEW YORKER (Mar. 30, 2009), https://www.newyorker.com/magazine/2009/03/30/hellhole. An inmate in New Mexico sewed his mouth shut with a makeshift needle and thread from his pillowcase. *Reassessing Solitary Confinement*, *supra*, at 80-81. Another inmate amputated one pinkie finger, chewed off the other, removed one of his testicles and his scrotum, sliced off his earlobes, and severed his Achilles tendon with a sharp piece of metal. *Id.* at 81. One California study found that the extreme conditions of isolation have forced inmates to "become so desperate for relief that they would set their mattresses afire . . . [or] burst out in a frenzied rage of aimless destruction, tearing their sinks and toilets from the walls, ripping their clothing and bedding, and destroying their

few personal possessions in order to alleviate the numbing sense of deadness or nonbeing and to escape the torture of their own thoughts and despair." Frank Rundle, *The Roots of Violence at Soledad*, in THE POLITICS OF PUNISHMENT: A CRITICAL ANALYSIS OF PRISONS IN AMERICA 167 (Erik Olin Wright, ed., 1973).

Importantly, the risk of suicide is intolerably high in situations, like here, where the confined inmate has a history of suicide attempts. Such individuals are particularly susceptible to being overwhelmed by suicidal ideations, which are intermittent and can appear at any time. Ole J. Thienhaus, *Suicide Risk Management in the Correctional Setting*, in CORRECTIONAL PSYCHIATRY: PRACTICE GUIDELINES AND STRATEGIES at 6-1, 6-3-6-4 (2007). In this context, the absence of recently expressed suicidal ideations does not discount the risk of suicide. In fact, when a person is fully determined to take his or her own life, he or she is very likely to ***deny*** the existence of such ideations. After all, if acknowledged, he or she might be prevented from going through with his or her intended suicide. The Court therefore should not be comforted by the notations in Wallace's medical records, as they do not outweigh the other, more salient, signs pointing to a very real and imminent risk of suicide or self-harm.

B. The Physical and Psychological Harms Resulting From Solitary Confinement Are Well-Documented.

Studies of prisoners who have been held in solitary confinement reveal "strikingly consistent" results showing the existence of severe physical and psychological harms across inmates segregated in solitary confinement. Grassian, *Psychiatric Effects*, *supra*, at 335-38; Haney & Lynch, *supra*, at 515-24. Experts have

described the psychological harms as including insomnia, lethargy, and depression, as well as anxiety, panic, paranoia, hallucinations, loss of self-control, irritability, aggression, rage, and withdrawal. Haney, *Mental Health Issues*, *supra*, at 130-31 (collecting more than 20 studies); *see also* Grassian, *Psychiatric Effects*, *supra*, at 335-37 (discussing symptoms suffered by solitary confinement inmates); Smith, *supra*, at 492 (same).[1] The physical harms include, but are not limited to, headaches, heart palpitations, digestive problems, cognitive dysfunction, and weight loss. Haney, *Mental Health Issues*, *supra*, at 133-34; Smith, *supra*, at 488-89.

These robust findings come from scientific studies that employed diverse methods (including, for example, historical accounts, personal accounts, observational studies, and systematic and direct research on prisoners in "supermax" confinement or the equivalent) and were conducted over many decades by researchers on several different continents. *See* Haney, *Mental Health Issues*, *supra*, at 130, 133-34; Smith, *supra*, at 488-90 (listing results of various studies).

In a study of 100 randomly chosen inmates in solitary confinement at California's Pelican Bay (the "Pelican Bay Study"), which was a "prototypical supermax prison" at the time the study was done, 91% of inmates suffered from anxiety and nervousness; 88% suffered from headaches; 70% felt that they were on

[1] Studies consistently show that prisoners in solitary confinement experience hypersensitivity to stimuli. Haney, *Mental Health Issues*, *supra*, at 134; *see also, e.g.*, Grassian, *Psychiatric Effects, supra*, at 335, 370-71. As explained above, solitary confinement exposes inmates to constant, uncontrollable negative stimulation, causing many prisoners to suffer from chronic sleeplessness, which "intensifies psychiatric symptoms . . . [and] creates fatigue and magnifies cognitive problems, memory deficits, confusion, anxiety, and sluggishness." Kupers, *supra*, at 6.

the verge of a nervous breakdown; over two-thirds suffered from chronic tiredness, trouble sleeping, sweaty palms, and heart palpitations; and over half suffered from loss of appetite, dizziness, nightmares, and trembling hands. *See* Haney, *Mental Health Issues*, *supra*, at 132-33; *see also* Smith, *supra*, at 492-93 (reporting chronic tiredness, lethargy, and trouble sleeping). Some of these symptoms—namely headaches, trembling, sweaty palms, and heart palpitations—are commonly associated with hypertension. Haney, *Mental Health Issues*, *supra*, at 133.

The same study reported that over 80% of the studied inmates experienced intrusive thoughts, irrational anger, oversensitivity to stimuli, confused thought processes, and social withdrawal. *Id.* at 134. Furthermore, over two-thirds reported chronic depression, emotional flatness, and mood swings; over half reported violent fantasies and talking to themselves; and "sizeable minorities [of the studied inmates] reported symptoms that are typically only associated with more extreme forms of psychopathology—hallucinations, perceptual distortions, and thoughts of suicide." *Id.*

A different study that observed 14 inmates in solitary confinement found that ten of the inmates suffered "massive free-floating anxiety," and that eight of the ten inmates reported episodes of tachycardia, diaphoresis, shortness of breath, panic, tremulousness, and dread of impending death. Grassian, *Psychopathological Effects*, *supra*, at 1452. This study also reported that half of the inmates studied experienced perceptual distortions, hallucinations, and derealization experiences—some inmates reported hearing voices and not knowing if they were real, or experiencing visual

hallucinations like the walls "[m]elting." *Id.* Additionally, over half of the inmates in the study reported difficulties with thinking, concentration, and memory. *Id.* at 1453.

In an article that gave results of numerous studies and explained common physical symptoms of solitary confinement, Peter Smith stated that in one study, "53 percent of long-term isolated remand prisoners . . . complained of headaches," and that in a different study, "40 percent of the isolated prisoners suffered from continuous headaches." Smith, *supra*, at 489. Further, Smith stated that "[h]eart palpitations and increased pulse are also common among isolated inmates" and that "[o]versensitivity to stimuli" was reported, which "can apparently result in an inability to tolerate otherwise normal stimuli," leading some solitary confinement inmates to be unable to stand "ordinary noises." *Id.* Additionally, Smith wrote that solitary inmates suffered from "pains in the abdomen and muscle pains in the neck and back," "[p]ains and pressure in the chest," "[p]roblems with digestion," "diarrhea," and "weight loss." *Id.*

What is more, prisoners in solitary confinement suffered these harms at a comparatively greater rate and with a much larger degree of intensity than inmates in the general population. Research comparing the Pelican Bay Study to inmates in the general population at the same prison showed that, though the general population inmates "were in suffering and distress," "[o]n nearly every single specific dimension measured, the [solitary confinement] sample was in significantly more pain, were more traumatized and stressed, and manifested more isolation-related pathological

reactions." Haney Expert Report at 81-82. Furthermore, a Norwegian study of 54 inmates, half in solitary confinement and half in general population, found that "[t]hose in solitary confinement suffered significantly more both physically and psychologically than the prisoners in the control group (sleeplessness, concentration problems, anxiety, depressions, etc.)." Smith, *supra*, at 477. Additionally, a large Danish study involving 367 pretrial detainees found "a significantly higher rate of psychiatric problems among isolated [inmates] than among a control group of nonisolated prisoners." *Id.*

Importantly, even harms loosely understood to be purely "psychological" extend into the physical realm. There is a growing consensus in the fields of psychology and psychiatry that a general distinction between psychological illness and physical illness is no longer accurate or appropriate. An advanced understanding of brain functions and advances in brain scans and other brain imaging technologies, and advances in neurobiology and brain chemistry and other studies of the brain have established that the types of traumatic psychological harms associated with solitary confinement often trigger detectable changes in neural pathways and the morphology and neurochemistry of the brain. These changes can be accurately characterized as a physical injury or illness because they adversely affect the nature and functioning of the sufferer's brain. *See, e.g.*, Ajai Vyas et al., *Effect of Chronic Stress on Dendritic Arborization in the Central and Extended Amygdala*, 965 BRAIN RES., 290-94 (2003); Carol Schaeffer, *"Isolation Devastates the Brain": The Neuroscience of Solitary Confinement*, SOLITARY WATCH (May 11, 2016),

http://solitarywatch.com/2016/05/11/isolation-devastates-the-brain-the-neuroscience-of-solitary-confinement/.

Discussing a NASA report on sensory deprivation's effects on the brain and body and suggesting its relevance to inmates serving time in solitary confinement, Elizabeth Bennion wrote in the *Indiana Law Journal*:

> A recent report for NASA on sensory deprivation concluded that "[t]he prolonged stress consequences of [sensory deprivation] lead to detrimental neurological changes in the human brain, which can manifest in maladaptive behavior disorders." And "increased duration increases the intensity and likelihood" of such behaviors.
>
> The report explains that substituting an unchanging monotonous environment (such as a spacecraft or a prison cell) for Earth's natural environment deprives the sensory organs of normal levels of stimulation. The brain interprets the sensory deprivation as stress, and one of the body's responses is to elevate cortisol levels. If sensory deprivation is prolonged, chronic stress may occur. "Under chronic stress, spatial and verbal memory and cognitive processes suffer. Excessive levels of cortisol interfere with memory formation and retrieval . . . . Behavioral effects include an increase in anxiety, paranoia, withdrawal and territorial behavior." Sensory deprivation also "reduces brain activity and weakens neuromodulatory control. This results in negative brain plasticity processes, which create a self-reinforcing downward spiral of degraded brain function."
>
> Prolonged stress exposure of this type may place a person "at a significant risk for future psychiatric deterioration, possibly including the development of irreversible psychiatric symptoms."

Elizabeth Bennion, *Banning the Bing: Why Extreme Solitary Confinement Is Cruel and Far Too Usual Punishment*, 90 IND. L.J. 741, 759 (2015), (alterations in original) (internal footnotes omitted).

Without normal and positive environmental interactions (such as, for example, exposure to natural light, outdoor sounds, and varying colors), certain cognitive functions go unutilized. Mental alertness and the ability to plan often suffer. *See,*

e.g., G.D. Scott & Paul Gendreau, *Psychiatric Implications of Sensory Deprivation in a Maximum Security Prison*, 14 CAN. PSYCHIATRIC ASS'N J. 337, 337, 339 (1969). People "soon become incapable of maintaining an adequate state of alertness and attention," and within days their brain scans may show "abnormal pattern[s] characteristic of stupor and delirium." Grassian, *Psychiatric Effects* at 330-31. More extreme deprivation of positive environmental stimuli can cause "perceptual distortions, hallucinatory experiences, and sometimes high levels of anxiety." Haney & Lynch, *Regulating Prisons*, *supra*, at 500.

As a result, it is apparent that the harms of solitary confinement, even those traditionally viewed as purely psychological, manifest themselves in physical injury to the inmate.

A small minority of researchers argue that solitary confinement is not significantly more harmful to inmates than time served in the general population, *see, e.g.*, Maureen L. O'Keefe et al., ONE YEAR LONGITUDINAL STUDY OF THE PSYCHOLOGICAL EFFECTS OF ADMINISTRATIVE SEGREGATION ii, viii-ix (2010); Robert D. Morgan et al., *Quantitative Syntheses of the Effects of Administrative Segregation on Inmates' Well-Being*, 22 PSYCHOL. PUB. POL'Y & L. 439 (2016); but this is at odds with the overwhelming scientific consensus that has established the significant harms caused by solitary confinement. "Nearly every scientific inquiry into the effects of solitary confinement over the past 150 years has concluded that subjecting an individual to more than 10 days of involuntary segregation results in a distinct set of emotional, cognitive, social, and physical pathologies." David H. Cloud et al., *Public*

Health and Solitary Confinement in the United States, 105 AM. J. PUB. HEALTH 18, 21 (2015). "[T]here is not a single published study of solitary or supermax-like confinement in which nonvoluntary confinement last[ed] for longer than 10 days, where participants were unable to terminate their isolation at will, that failed to result in negative psychological effects." Haney, *Mental Health Issues*, *supra*, at 132.

III. INDIVIDUALS SUFFERING FROM MENTAL ILLNESSES ARE ESPECIALLY VULNERABLE TO THE HARMS PRESENTED BY SOLITARY CONFINEMENT.

Individuals suffering from mental illness are especially vulnerable to the stressors and negative effects of prolonged isolation, which can aggravate symptoms of mental illness, including suicidality and self-harm. And because of these individuals' heightened vulnerability to the painfulness and harmfulness of solitary confinement, many of them deteriorate and decompensate, which can prolong the amount of time the individual spends in isolation.

A comprehensive study of prisoners in Washington State's supermax prisons concluded that mental illness was present in approximately 30% of segregated prisoners, which was two to three times as common as it was in general population prisoners. Hafemeister & George, *supra*, at 46-47. A Canadian study similarly found that nearly a third of segregated prisoners suffered from "severe mental disorders." *Id.* Several methodologically rigorous European studies reveal similar mental health disparities between prisoners held in isolation and those in the general population. Smith, *supra*, at 476-80 (summarizing similar findings across several clinical studies in Switzerland, Denmark, and Norway).

Inmates with mental illness are the most vulnerable to the psychological and physiological harms caused by solitary confinement, and they are also at the greatest risk of suffering "permanent and disabling" harms. *See* Haney, *Mental Health Issues*, *supra*, at 142. They are "far less likely to be able to withstand the stress, social isolation, sensory deprivation, and idleness" of solitary confinement. Hafemeister & George, *supra*, at 41-42; *see also* Corr. Ass'n of N.Y., MENTAL HEALTH IN THE HOUSE OF CORRECTIONS: A STUDY OF MENTAL HEALTH CARE IN NEW YORK STATE PRISONS 49 (2004) (quoting a statement from Dr. Stuart Grassian given during an interview with the Correctional Association of New York). When deprived of social interaction, "many prisoners with mental illness experience catastrophic and often irreversible psychiatric deterioration." Hafemeister & George, *supra*, at 38-39 (quoting David Fathi, *Solitary Confinement in Arizona: Cruel and Unusual*, ACLU: SPEAK FREELY (Mar. 6, 2012, 1:09 PM), http://www.aclu.org/blog/prisoners-rights/solitary-confinement-arizona-cruel-and-unusual). One expert witness declared conditions in one supermax facility to be "'toxic' for seriously mentally ill inmates." *Jones 'El v. Berge*, 164 F. Supp. 2d 1096, 1103 (W.D. Wis. 2001).

By its very nature, solitary confinement impedes the delivery of mental health services on a timely basis. The location of the units themselves and the extremely restrictive manner in which they are run greatly limit the access of mental health staff and the nature and timeliness of the treatment they can provide. Hafemeister & George, *supra*, at 42-43. This means mentally ill inmates endure painful, dangerous, isolated confinement without receiving the badly needed treatment that

might help to at least alleviate some of the harm to which they are subjected. *Id.* at 43.

Given those risks, there is widespread recognition that seriously mentally ill inmates should not be consigned to isolation, or in the very rare situation where isolation for a very limited period is unavoidable due to security exigencies, these inmates require special care. *See generally, e.g.*, Haney, *Mental Health Issues*, *supra*, at 149 (stating that screening measures should be in place to ensure that the psychologically vulnerable, including the mentally ill, are not placed in supermax); Herbierto Sanchez, *Suicide Prevention in Administrative Segregation Units: What is Missing?*, 19 J. CORRECTION HEALTH CARE 93, 94-95, 99 (2013) (discussing extra care that should be taken with mentally ill inmates in solitary confinement).

Several significant groups oppose the use of solitary confinement for inmates with a mental illness. In 2012, the American Psychiatric Association issued a position statement that "[p]rolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential harm to such inmates." *Position Statement on Segregation of Prisoners with Mental Illness*, AM. PSYCHIATRIC ASS'N (December 2012), http://www.dhcs.ca.gov/services/MH/Documents/2013_04_AC_06c_APA_ps2012_PrizSeg.pdf. The American Public Health Association and the National Commission on Correctional Health Care call for the exclusion of individuals with serious mental illness from restricted housing and further oppose the use of solitary confinement except where no alternative means exist to address an extreme and current threat to

safety or security. *See* NAT'L COMM'N ON CORR. HEALTH CARE, POSITION STATEMENT: SOLITARY CONFINEMENT (ISOLATION) 35 (2016) https://www.ncchc.org/filebin/Positions/Solitary-Confinement-Isolation.pdf; *Solitary Confinement as a Public Health Issue*, AM. PUB. HEALTH ASS'N (Nov. 5, 2013), https://apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/14/13/30/solitary-confinement-as-a-public-health-issue.

These positions reflect a growing consensus among domestic and international actors, which increasingly view prolonged solitary confinement as cruel, inhuman or degrading treatment and, in some circumstances, torture. For example, Juan Méndez, U.N. Special Rapporteur on Torture and Cruel, Inhuman and Degrading Treatment, after examining solitary confinement at length and across countries, concluded that "[s]tates should abolish the use of solitary confinement for . . . persons with mental disabilities." Juan E. Méndez (Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, U.N. Doc. A/66/268, 23 (Aug. 5, 2011). And the newly revised U.N. Standard Minimum Rules for the Treatment of Prisoners, which reflect "the general consensus of contemporary thought and the essential elements of the most adequate systems of today . . . [and] set out what is generally accepted as being good principles and practice in the treatment of prisoners and prison management," take account of these developments and forbid long-term isolation of mentally ill persons where a person's

mental illness would be exacerbated by solitary confinement. United Nations Standard Minimum Rules for the Treatment of Prisoners, U.N. Doc. E/CN.15/2015/L.6/Rev.1, preliminary observation 1, Rule 45 (May 21, 2015). Case: 16-2726 Document: 003112402806 Page: 13 Date Filed: 09/08/2016.

IV. ALTERNATIVES EXIST TO SOLITARY CONFINEMENT FOR MENTALLY ILL INMATES

In reaction to the growing recognition that long-term solitary confinement is dangerous, expensive, and counterproductive, numerous states and the federal government are investigating options to reduce the use of solitary confinement. Efforts at state reforms have been attempted both by legislatures and state agencies. *See* Department of Justice, *Report and Recommendations Concerning the Use of Restrictive Housing*, 72-77 (Jan. 2016) (noting several States' self-reported claims to be undertaking reform efforts), https://www.justice.gov/dag/file/815551/ download (last visited June 21, 2017). Colorado and Illinois have closed entire supermax prisons, and Colorado stopped automatically classifying death-sentenced prisoners to solitary confinement.

Voluntary state-level reforms of this sort are increasingly common given what we know about the psychological and physical dangers presented by solitary confinement. First, as discussed above, solitary confinement subjects prisoners to psychologically-damaging experiences without providing meaningful rehabilitative services. Thus, if inmates attempt to transition from solitary confinement back to general population—or back to the free world—they have lost the ability to connect to other people and are significantly handicapped in their attempt to reenter society.

Inmates emerge from solitary confinement units severely damaged and functionally disabled. Therefore, the recidivism rates of inmates who have endured solitary confinement are higher than those who remain in general population. *Hearing on Solitary Confinement Before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights*, 112th Cong. 4 (2012) (statement of Craig Haney, Professor of Psychology, University of California, Santa Cruz) at 15, https://www.judiciary.senate.gov/download/testimony-of-craig-haney-pdf (last visited July 18, 2017).

Second, reduction or elimination of the use of solitary confinement can lead to a reduction in inmate behavior problems, both at an individual and systemic level. For example, Mississippi's prison system experienced an overall reduction in misconduct and violence system-wide when it drastically reduced the number of prisoners whom it housed in solitary confinement by transferring them to mainline prisons. *Id.* at 16 (citing T. Kupers, T. Dronet et al., *Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs,* 36 CRIM. JUST. & BEHAV. 1037–50 (2009)); *see also* Angela Browne, et al., *Prisons Within Prisons: The Use of Segregation in the United States,* FED. SENT'G REP., at 49 (Oct. 2011) (noting in the mid-2000s, Ohio and Mississippi reduced their supermax populations by 89% and 85%, respectively, while decreasing violence and disruption). In sum, solitary confinement does significantly more harm than good. Prisons should mitigate that harm by providing meaningful,

regular opportunities for inmates in solitary confinement to progress out of solitary confinement before suffering irreversible harm.

CONCLUSION

In light of the extensive research summarized above, the overwhelming scientific and professional consensus now firmly establishes that solitary confinement deprives inmates of basic human needs; produces severe, negative, and atypical psychological and physical symptoms and reactions; and risks imminent grave, lasting, and irreversible harm to those who endure it. As a result, prolonged solitary confinement places prisoners in imminent danger of serious physical injury, and that danger is compounded when the prisoner is mentally ill and as a result has a history of suicidal ideations and suicide attempts.

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Certificate of Compliance

This brief complies with the type-volume limitation of Seventh Circuit Rule 29 because this brief is 5774 words in length, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(f). In addition, this brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word from Microsoft Office Professional Plus 2010 in 12 point, Century Schoolbook font for text (including footnotes at 11 point font).

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CERTIFICATE OF SERVICE

I hereby certify that on January 16, 2018, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit by using the CM/ECF system.

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