



SILENT INJUSTICE: **SOLITARY CONFINEMENT IN VIRGINIA**

ACLU
Virginia

Acknowledgement

The American Civil Liberties Union (ACLU) of Virginia is a private, non-profit organization that promotes civil liberties and civil rights for everyone in the Commonwealth through public education, litigation and advocacy with the goal of securing freedom and equality for all. In addition to the litigation for which the ACLU has been known, we also educate the public, inform the media, lobby legislators, organize grassroots activists, and disseminate information about our constitutional freedoms through our membership and volunteer chapters.

This report was researched and written by Hope Amezquita, staff attorney at the ACLU of Virginia; Mateo Gasparotto, investigator for the ACLU of Virginia; Leslie Mehta, former legal director for the ACLU of Virginia, Madeline Allen and Christina Brow, legal interns, and Amanda Hales, public policy intern, provided invaluable assistance.

The report was reviewed and edited by the ACLU's National Prison Project Deputy Director Amy Fettig and National Campaign Strategist Jessica Sandoval; as well as the ACLU of Virginia Development Associate Erin Kreischer, Director of Strategic Communications Bill Farrar, and Executive Director Claire Guthrie Gastañaga. It was designed by ACLU of Virginia Communications Associate Phuong Tran.

The ACLU of Virginia would like to recognize and thank members of the Virginia Coalition on Solitary Confinement for their on-going support and advocacy. These include: Interfaith Action for Human Rights (IAHR) Virginia, the National Alliance on Mental Illness (NAMI) Virginia, Social Action Linking Together (SALT), Virginia Citizens United for the Rehabilitation of Errants (CURE), and the Virginia Council of Churches.

**SILENT
INJUSTICE:
SOLITARY
CONFINEMENT
IN VIRGINIA**



PHOTO: RED ONION STATE PRISON, COURTESY OF SOLITARY WATCH

Copyright© 2018 by the American Civil Liberties Union
Foundation of Virginia Inc.

All rights reserved. Information from this publication may be
used freely so long as proper attribution is made.

ACLU of Virginia

701 E. Franklin Street

Suite 1412

Richmond, VA 23219

(804) 644-8022

acluva@acluva.org

www.acluva.org

Executive Summary

.....

This report discusses the negative impacts of solitary confinement in Virginia, the systemic difficulties prisoners face escaping it, and the State's failure to exclude people with serious mental health problems from solitary confinement.

.....

This report describes observed and reported conditions in the Virginia prison system. The intention of this report is to highlight and clarify issues to be considered by state legislators and policy makers, the Vera Institute of Justice and others reviewing the Virginia prison system. This report discusses the negative impacts of solitary confinement as practiced in Virginia, the systemic difficulties prisoners have in escaping it and returning to the general population, and the State's failure to exclude individuals with serious mental health problems from solitary confinement despite the existing law and science establishing the especially damaging impacts of isolation on this vulnerable group of people.

Moreover, this report explains that there may be solitary conditions of which we are simply unaware. There are no laws governing the way solitary confinement is used in the Virginia prison system, nor any laws that require correctional officials to collect and report data on how it is used. Without such requirements, it is difficult to gather information and accurately assess the status of solitary confinement in the state. We hope that this report sheds light on this broken system, and that it will motivate the Virginia Department of Corrections (VDOC), political leaders and the public to demand and provide better conditions for incarcerated people currently serving time in solitary.

Solitary confinement¹ is the isolation of a person in a cell for approximately 22 to 24 hours a day with little human contact

1 The Virginia Department of Corrections (VDOC) does not use the term solitary confinement, preferring terms like disciplinary segregation, administrative segregation, special housing, and disciplinary housing. Regardless of the terms used by prison officials, however, this report uses solitary confinement to refer to the practice of isolating a prisoner from the general population with limited or no human interaction.

Solitary Confinement

Solitary confinement is the isolation of a person in a cell for approximately 22 to 24 hours a day with little human contact or interaction; reduced or no natural light; restriction or denial of reading material, television, radios or other property; severe constraints on visitation; and the inability to participate in group activities, including eating with others.

or interaction; reduced or no natural light; restriction or denial of reading material, television, radios or other property; severe constraints on visitation; and the inability to participate in group activities, including eating with others. Despite the vast growing body of medical, social, legal, and scientific research showing the immense damage that solitary confinement inflicts on humans, this practice is routinely used by federal and state prison systems, including the Virginia Department of Corrections (VDOC).

Prisoners are often unnecessarily and falsely determined to be at-risk or a danger. But, solitary confinement permits prison officials to isolate these individuals. Prisoners may be placed in disciplinary or punitive solitary confinement as punishment for violating minor rules, filing grievances or lawsuits, or annoying correctional officers. In most of these instances, prisoners in disciplinary segregation do not pose such an extreme management challenge to warrant solitary confinement.

In other instances, prisoners may be placed in solitary confinement for their “protection” indefinitely by default if the prisoner is perceived as vulnerable. Placing individuals perceived as vulnerable in solitary confinement only further stigmatizes them and decreases the chances that adequate services, treatment, and programming will be provided. Regardless of the label used by prison officials, the conditions and harms of solitary confinement



Photo: A still of Red Onion State Prison from the documentary “Solitary” (HBO)

generally remain the same. Moreover, people in solitary confinement are more likely to be subjected to excessive force and abuses of power.² The fact that solitary confinement prisons and cells are isolated from the general population prisoners makes it more difficult to detect abuse.³ Additionally, because prison administrators often believe that only “the worst of the worst” are placed in solitary confinement, they are more likely to turn a blind eye to abuses.⁴

In 2011, the Washington Post reported that 1 in 20 prisoners in Virginia were being held in solitary confinement.⁵ The alarming statistic included 500 out of 750 prisoners at Supermax Red Onion State Prison. Individual cases ranged from two weeks to almost seven years of solitary confinement, with an average length of isolation of 2.7 years.⁶ In the same year, the Virginia Department of Corrections implemented reform efforts aimed at reducing the number of prisoners held in “administrative segregation” at Red Onion State Prison (ROSP) and Wallens Ridge State Prison (WRSP).⁷ The VDOC developed and implemented an incentive-based step down program that provides prisoners with opportunities to essentially behave their way out of solitary confinement. As of July 2016, 242 prisoners were still held in solitary confinement at ROSP and WRSP.⁸ Though any reform efforts are commendable, questions remain about the effectiveness of the step down program, inadequate treatment for prisoners suffering from mental illness in solitary confinement, and the

2 Leena Kurki & Norval Morris, *The Purposes, Practices, and Problems of Supermax Prisons*, 28 CRIME AND JUST. 385, 409 (2001).

3 See, e.g., *Thomas v. Bryant*, 614 F.3d 1288 (11th Cir. 2010) (affirming a judgment for plaintiffs in an action alleging, among other violations, that the overuse of chemical agents on prisoners with mental illness constituted a violation of the Eighth Amendment of the U.S. Constitution); *Coleman v. Brown*, No. 2:90-cv-00520-LKK-DAD, Doc. 5131 (E.D. Cal. 2014) (in a case involving extensive video evidence of corrections officers using pepper spray on prisoners with mental illness who had committed minor rule violations such as refusing to come to their cell doors, ordering state officials to continue reforming the ways force is used on California prisoners); see also CAROLINE ISAACS & MATTHEW LOWEN, BURIED ALIVE: SOLITARY CONFINEMENT IN ARIZONA’S PRISONS AND JAILS 14 (Am. Friends Serv. Comm. 2007).

4 Isaacs & Lowen, *supra* note 3 at 16; see also Maureen L. O’Keefe, *Administrative Segregation From Within: A Corrections Perspective*, 88 THE PRISON J. 123, 126 (2008).

5 Anita Kumar, *Virginia Prisons’ Use of Solitary Confinement is Scrutinized*, WASH. POST, Jan. 7, 2012, https://www.washingtonpost.com/local/dc-politics/va-prisons-use-of-solitary-confinement-is-scrutinized/2011/11/28/gIQAkKHuhP_story.html?utm_term=.27aec938857b

6 Anita Kumar, Washington Post, *Virginia Prisons’ Use of Solitary Confinement is Scrutinized*, available at: https://www.washingtonpost.com/local/dc-politics/va-prisons-use-of-solitary-confinement-is-scrutinized/2011/11/28/gIQAkKHuhP_story.html?utm_term=.27aec938857b

7 Virginia Department of Corrections, *Virginia Recognized for Transforming Highest-Security Prisons* (Aug. 7, 2013), available at https://vadoc.virginia.gov/news/press-releases/13aug06_stepdownrecognition_shtm

8 Katie Rose Quandt and Jack Denton, Solitary Watch, *At Virginia’s Supermax Prisons, Isolation and Abuse Persist Despite Reforms*, available at <http://solitarywatch.com/2016/08/04/at-virginias-Supermax-prisons-isolation-and-abuse-persist-despite-reforms/>

Solitary Confinement in Virginia

In 2011, the Washington Post reported that 1 in 20 prisoners in Virginia were being held in solitary confinement. The alarming statistic included 500 out of 750 prisoners at Supermax Red Onion State Prison. Individual cases ranged from two weeks to almost seven years of segregation, with an average length of isolation of 2.7 years.



widespread lack of government transparency and accountability in Virginia’s prisons. Under the “Mandela Rules,” number 43, as adopted by the United Nations Commission on Crime Prevention and Criminal Justice in Vienna in 2015, “prolonged solitary confinement” is defined as a “time period in excess of 15 consecutive days.”

In 2016, the DOJ highlighted Virginia’s reform efforts as a case study, but questions remain about the effectiveness and operations of the Step Down Program used in VDOC facilities. Prisoners report many issues with the program and the use of solitary confinement in Virginia prisons including:

- Provisions in VDOC policy stating that prisoners may only be assigned to solitary confinement by the Institutional Classification Authority (ICA) after a due process hearing, with a status review every 90 days appear not to have been followed as written, exacerbating the indefinite nature of the solitary confinement. In violation of VDOC policy, prisoners also allege that placement in solitary confinement is not consistently documented and often prisoners do not know how long they will be there.

Solitary
confinement
causes and
exacerbates
mental illness
and violates the
U.S. Constitution's
Eighth
Amendment
ban on cruel
and unusual
punishment.

- There is a lack of clarity about the length of time it takes to progress through the program, the amount and quality of training of the instructors, inconsistent attendance by instructors, and puzzling delays in the availability of workbooks and decisions to require individuals to re-start the program following allegedly minor infractions.
- There is abuse from correctional staff including: abusive and racist language used by prison employees; withholding and tampering with food; sexual harassment and assaults; destruction of personal property; withholding of recreation and showers; use of restraints and strip cells for longer durations than permitted by VDOC policy; and pervasive interference with prisoners' access to the grievance procedure, including acts and threats of retaliation for asking for grievances forms, filing grievances, and filing lawsuits.
- Prisoners at ROSP who are designated intensive management "IM" appear to be held in permanent isolation, even if they complete the Step Down Program curriculum and go for years without any disciplinary infractions. It appears there is no meaningful opportunity to have this designation reconsidered or to demonstrate the ability to adapt successfully to a less restrictive environment, contrary to VDOC policy providing that a bi-annual review should automatically occur.

Solitary confinement causes and exacerbates mental illness and violates the U.S. Constitution's Eighth Amendment ban on cruel and unusual punishment. For prisoners with pre-existing mental illness, solitary confinement often causes significant and rapid deterioration. Numerous studies confirm that prolonged isolation deprives prisoners of the basic human needs to function, with effects that become noticeable after as little as ten days of involuntary solitary confinement.⁹ According to VDOC's website, 15 percent of its entire offender population requires some type of mental health services.¹⁰ Recently though, VDOC reported that 26 percent of prisoners have mental health issues.¹¹ Prisoners in solitary confinement, diagnosed with a range of disorders such

9 Kenneth Appelbaum, *American Psychiatry Should Join the Call to Abolish Solitary Confinement*, 43 *J. Am. Acad. Psychiatry & L.* 406, 410 (2015).

10 Mental Health Institutions, Virginia Department of Corrections, <https://vadoc.virginia.gov/offenders/institutions/programs/mental-health.shtm>

11 ACLU of Virginia internal notes re: meeting with Virginia Department of Corrections and Advocates (October 26, 2016)

bipolar disorder, post-traumatic stress disorder as a result of abuse, manic depression, schizophrenia, report that mental health treatment consists solely of the administration of psychotropic drugs and that it is difficult to see a psychiatrist or any other qualified mental health professional (QMHP). Yet, VDOC has no policy excluding mentally ill people from solitary confinement despite the weight of evidence and the law. The under treatment is exacerbated by budgetary constraints and cuts. To add one QMHP per facility and a mental health unit would cost \$1,519,000 annually for salaries, not including other costs such as additional staffing, part-time consultants, and stipends for sex offender treatment providers.¹²

While effective prison management and safety are legitimate penological interests, solitary confinement is not conducive to accomplishing those goals and is costly to taxpayers. The cost of building Supermax prisons for restrictive housing are two to three times more than conventional prisons.¹³ It costs immensely more dollars to keep a prisoner in restrictive housing than general population. Nationally, it's estimated that it costs \$75,000 per prisoner in solitary confinement.¹⁴ Despite the high cost, there is scant evidence that shows that solitary confinement makes prisons safer and may actually result in less public safety.¹⁵ In Virginia, it is expected that 90 percent of prisoners will return to society.¹⁶ Despite Virginia's touted low recidivism rates,¹⁷ the effects of prolonged extreme isolation of prisoners returning to society undoubtedly poses serious risks and problems. Prisoners harmed by solitary confinement especially those not receiving appropriate mental health treatment or reentry programming, cannot successfully reenter into society. The mere fact that solitary confinement is overused, and for more than fifteen days in duration,¹⁸ can irreparably harm a human and makes the

12 Email and attachment from Delegate Patrick A. Hope to ACLU of Virginia, *Response from Virginia DOC to questions re: segregation* (June 20, 2015).

13 DANIEL P. MEARS, EVALUATION THE EFFECTIVENESS OF SUPERMAX PRISON 4, note 1, at ii (Urban Inst., 2006).

14 Sal Rodriguez, *Fact Sheet: The High Cost of Solitary Confinement (2012)*, SOLITARY WATCH, Jan 31, 2012, available at: <http://solitarywatch.com/wp-content/uploads/2012/01/solitary-confinement-faq-short-version.pdf>.

15 See, e.g., Keramet Reiter, PAROLE, SNITCH, OR DIE: CALIFORNIA'S SUPERMAX PRISONS & PRISONERS, 1987-2007 47-51 (2010); MAUREEN L. O'KEEFE, ANALYSIS OF COLORADO'S ADMINISTRATIVE SEGREGATION 25 (Colo. Dep't. of Corrections, 2005).

16 Press release, Virginia Department of Corrections, Few Offenders Remain in Restrictive Housing in Virginia Prisons: Virginia Continues Program Recognized for Transforming Highest Security Prisons (Sept. 9, 2015). See: https://vadoc.virginia.gov/news/press-releases/15Sep9_StepDown.shtml <http://governor.virginia.gov/media/8167/state-recidivism-comparison-12-16.pdf>

18 United Nations Standard Minimum Rules for Treatment of Prisoners (the Nelson Mandela Rules), G.A. Res. 70/175, Rule 43, 44 (Dec. 17, 2015). (*Summarizing*: Prohibiting "prolonged" solitary

THE PROBLEM

SOLITARY CONFINEMENT REMAINS OVERUSED IN VIRGINIA AND LARGELY, IS STILL HIDDEN FROM THE PUBLIC'S WATCHFUL EYES.

public less safe calls into question its validity as a correctional management tool.¹⁹

The principles and recommendations set forth below are modeled in part on the U.S. Department of Justice (DOJ) report concerning the use of restrictive housing with a particularized focus on Virginia's specific problems and needs to address them.²⁰ The VDOC should look to their accrediting association, the American Correctional Association (ACA), to provide informed recommendations to reduce solitary confinement. However, it should also incorporate standards set forth by the plethora of various national and international organizations to provide guidance on how to reduce the use of solitary confinement²¹ and provide meaningful and effective mental health treatment to prisoners. Importantly, VDOC should be transparent and work in good faith with the Vera Institute of Justice to formulate and implement effective reforms to end the use of solitary confinement.

confinement defined as in excess of 15 consecutive days; requiring that solitary confinement *shall be used only in exceptional cases as a last resort, for as short a time as possible and must not be imposed by virtue of a prisoner's sentence. The Rules also prohibit solitary confinement for prisoners with mental illness or physical disabilities when their conditions would be exacerbated by such measures.*)

19 ACLU, *Briefing Paper: The Dangerous Overuse of Solitary Confinement in the United States*, 9-11 (Aug. 2014), available at https://www.aclu.org/sites/default/files/assets/stop_solitary_briefing_paper_updated_august_2014.pdf

20 U.S. Department of Justice: Report and Recommendations Concerning the Use of Restrictive Housing 93 (January 2016). See <https://www.justice.gov/dag/file/815551/download>

21 National Commission on Correctional Health Care, Position Statement: Solitary Confinement, 2 (Apr. 2016): in recognition of the direct link between solitary confinement and the harms it causes: "the inherent restriction in meaningful social interaction and environmental stimulation and the lack of control adversely impact the health and welfare of all who are held in solitary confinement." (emphasis added).

Solitary confinement remains overused in Virginia and, largely, is still hidden from the public's watchful eyes. The reforms implemented since 2011 are a step forward to reduce its use, but there is a vital need for transparency, accountability, and more effective ways to stop using solitary confinement, especially on vulnerable populations like those suffering with mental illnesses. Without further reforms, Virginia is inflicting inhumane harms on individuals and at a great financial cost without the benefit of increased public safety. The ACLU of Virginia believes that the collaboration between the Vera Institute of Justice and VDOC to identify problems and to implement effective, meaningful reforms at all levels of the correctional system is a step in the right direction. But more rigorous protections and oversight are needed to ensure that solitary confinement is not abused and overused in Virginia. Moreover, law, policy and practice in the Commonwealth are needed to eliminate the practice of placing vulnerable individuals with mental illness in solitary confinement.

THE ACLU OF VIRGINIA RECOMMENDS

- 1. Solitary confinement should be limited to no more than 15 days** in accordance with the international human rights standards set forth in the “Nelson Mandela Rules.”
- 2. Solitary confinement must only be used in rare and exceptional cases**, for the shortest duration, with the least restrictive setting necessary and only when the prisoner poses a credible continuing and serious threat to the security of others.
- 3. Solitary confinement should be banned for prisoners with mental illness and disabilities, but also for youth, pregnant women, and persons with physical disabilities.** Virginia should increase funding to provide meaningful and effective treatment for vulnerable prisoners.
- 4. Solitary confinement should always serve a specific penological objective and be supported with specific and concrete justifications that are supported by objective evidence.** VDOC should use solitary confinement only in authorized circumstances and correctional officials should clearly articulate specific reasons(s) for housing a prisoner in solitary confinement.
- 5. A prisoner’s initial and continual placement in solitary confinement should be regularly reviewed by a multi-disciplinary team, including correctional leadership.** The current 90-day interval for evaluating continued placement should be shortened to meet the international human rights standard. At the very least such evaluation should take place weekly.
- 6. Every prisoner housed in solitary confinement should be provided written reasons for the initial placement, including reasons for continued segregation.** Correctional staff should develop a written plan with explicit objective goals for the prisoner to return to less restrictive conditions as promptly as possible. Unless the safety of the prisoner or others is compromised, the plan should be shared with the prisoner. The prisoner should be informed and provided with a meaningful opportunity to challenge placement in solitary confinement in a formal appeal process.
- 7. Solitary confinement must not be used as punishment for low-level infractions or as a default disciplinary sanction.** When disciplinary segregation is used, the maximum amount of time a prisoner spends in segregation should be limited to the least amount of time possible and no longer than 15 days. Daily checks should be made to monitor all prisoner’s physical and mental health who are housed in any form of isolated confinement – regardless of the reason an individual is placed there. Additionally, documentation should accurately reflect the time spent in segregation and a copy given to the prisoner. A prisoner in disciplinary segregation should be fully informed of due process rights to challenge the placement and given the opportunity to attend all reviews and hearings. At all times, a prisoner should be fully informed about the placement and explanation provided for the status.

- 
- 8. Wardens should expand out-of-cell time.** Not only is increased out-of-cell time essential to mental health and social interaction, it allows for greater opportunities for rehabilitation and reentry services. Prisoners must be given a break from social isolation through increased access to phone calls, visits from friends and family, and closed-circuit television rehabilitative programming. Some prisons have also worked out ways to allow safe, regular, and meaningful human contact with custody and clinical staff as well as other prisoners. Training staff to engage with these prisoners in a positive and constructive manner is crucial.
 - 9. VDOC should limit releasing people in solitary confinement directly to the community.** VDOC has developed and implemented reentry housing pods and programming, however, greater accountability and consistency is necessary to ensure that no prisoner is directly released to the community without receiving these vital services for successful reintegration.
 - 10. VDOC should increase transparency and accountability.** Legislators should mandate that VDOC collect data and report the status of segregation and reform outcomes, including tax-payer expenditures on segregation, programming, and health services. VDOC must publish monthly system-wide segregation data on its website, including information that shows the status and effectiveness of the Step Down Program and any other efforts to reduce segregation. A carefully crafted reporting bill will ask for a multi-faceted breakdown of the population, as well as for important statistical information such as the average and median lengths of stay in solitary confinement, the number of incidents of self-harm, and attempts at self-harm, the number of inmates released from solitary confinement directly into the community during the preceding year, and will ask for any changes to written policies and procedures at each correctional facility relating to the use and conditions of restrictive housing.
 - 11. All correctional staff should be regularly trained on restrictive housing policies and appropriate ways to manage and interact with prisoners.** VDOC should ensure that compliance with these policies is reflected in employee-evaluation systems. Correctional staff that violate these policies should not be charged with ensuring the safety of prisoners and the public.
 - 12. VDOC should ensure a full, independent investigation when reports of physical and/or sexual assault are made by prisoners.** VDOC should take all legal actions necessary and ensure that correctional officers who physically or sexually assault prisoners are criminally prosecuted in accordance with the law.
 - 13. The governor should mandate an independent investigation of the grievance program at Red Onion and ensure that recommendations from that investigation are implemented and overseen.** Alternatively, setting up an independent Ombudsman appointed by the governor with full authority to receive, investigate and oversee implementation of changes to policy and practice is an option.
 - 14. VDOC should establish a visitation program to help prisoners deal with the isolation of Red Onion from prisoners' families and communities,** to include providing bus fare and housing for every prisoner's visitors who live more than 100 miles away on a quarterly basis.

Introduction

Imagine being alone and locked up enclosed in a steel door cage the size of a parking spot, deprived of any meaningful human contact or sensory stimulation for 22 to 24 hours a day, every day for weeks, months, maybe years, to the point where you lose your grasp on reality.

Imagine being alone and locked up enclosed in a steel door cage the size of a parking spot, deprived of any meaningful human contact or sensory stimulation for 22 to 24 hours a day, every day for weeks, months, maybe years, to the point where you lose your grasp on reality. Even worse, suffering from mental illness and as a result, being unable to “behave their way out” of such isolating conditions, which in turn increases suffering. The harmful effects of solitary confinement have long been recognized in the United States.²² Since 1990, the number of persons held in solitary confinement exploded. Nationally, it is estimated that between 80,000 and 100,000 prisoners are held in some type of solitary confinement.²³ Across Virginia, over 800 prisoners are in solitary confinement.²⁴

Solitary confinement is the isolation of a person in a cell for approximately 22 to 24 hours a day with little human contact or interaction; reduced or no natural light; restriction or denial of reading material, television, radios or other property; severe constraints on visitation; and the inability to participate in group activities, including eating with others.²⁵ Cells used for solitary are intentionally designed “to minimize human contact and environmental stimulation.”²⁶ Solitary confinement has many

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

23 LIMAN PROGRAM & ASSOCIATION OF STATE CORRECTIONAL ADMINISTRATORS: TIME-IN-CELL: THE ASCA-LIMAN 2014 NATIONAL SURVEY OF ADMINISTRATIVE SEGREGATION IN PRISON 3 (2015). *See also* National Commission on Correctional Health Care, *Position Statement: Solitary Confinement (Isolation)*, 1 (Apr. 2016).

24 AIMING TO REDUCE TIME-IN-CELL: REPORTS FROM CORRECTIONAL SYSTEMS ON THE NUMBERS OF PRISONERS IN RESTRICTED HOUSING AND ON THE POTENTIAL OF POLICY CHANGES TO BRING ABOUT REFORMS. ASSOCIATION OF STATE CORRECTIONAL ADMINISTRATORS AND THE ARTHUR LIMAN PUBLIC INTEREST PROGRAM, YALE LAW SCHOOL (NOVEMBER 2016). *See*: <https://www.law.yale.edu/system/files/area/center/liman/document/aimingtoeducetic.pdf>

25 Eric Lanes, *The Association of Administrative Segregation Placement and Other Risk Factors with the Self-Injury-Free Time of Male Prisoners*, 48 J. OF OFFENDER REHABILITATION 529, 532 (2009).

26 AMERICAN PUBLIC HEALTH ASS'N, SOLITARY CONFINEMENT AS A PUBLIC HEALTH ISSUE, POLICY NO. 201310 (2013), <https://www.apha.org/>

A Perpetual Problem

Since 1990, the number of persons held in solitary confinement exploded. Nationally, it is estimated that between 80,000 and 100,000 prisoners are held in some type of solitary confinement. Across Virginia, over 800 prisoners are in solitary confinement.

euphemisms, but its defining characteristics remain the same: extreme isolation for weeks or months, sometimes years, in an 80 square foot cell with a bunk, toilet, and sink, with little or no access to see outside their cell, devoid of any meaningful human contact or social interaction.²⁷ Prisoners in solitary confinement are generally deprived of all meaningful perceptual, social, occupational stimulation and human interaction which are required to maintain a sense of identity and a grasp of reality.²⁸ The only interactions a prisoner in solitary confinement may have is when a prison employee slides a meal tray through the cell's slot, brief encounters with correctional officers, or occasionally some prisoners, visits with attorneys or health professionals.²⁹ A prisoner in solitary eats alone in his cell, showers three times per week, and has typically one hour of recreation five times a week while still confined in a cage the size of an average parking space or small bathroom.³⁰ Visitation is heavily restricted, if not

[policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/14/13/30/solitary-confinement-as-a-public-health-issue](https://www.policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/14/13/30/solitary-confinement-as-a-public-health-issue).

- 27 KUMAR, *supra* note 5; See also LANES, *supra* note 25.
28 Am. Pub. Health Ass'n, *supra* note 26
29 *Id.*
30 *Id.*



Prisoners may be placed in disciplinary or punitive segregation as punishment for violating minor rules, filing grievances or lawsuits, or for annoying correctional officers.

prohibited, and occurs behind a partition.³¹ The effects of solitary confinement are horrific and oftentimes irreparable. Despite the vast growing body of medical, social, legal, and scientific research showing the immense damage that solitary confinement inflicts on humans, this practice is routinely used by federal and state prison systems, including the Virginia Department of Corrections³².

The current Secretary of Public Safety and the Virginia Department of Corrections deny using “solitary confinement” on prisoners. Solitary confinement has many euphemisms such as segregation, restrictive housing, special housing, and protective custody. Regardless of the terminology used, the conditions and effects remain the same: extreme isolation of an individual with deprivation of any meaningful human or sensory stimuli for approximately 22 to 24 hours per day, which causes harm, sometimes irreparably.

The conditions of solitary confinement generally do not differ despite varying categories or reasons for solitary confinement. For example, administrative segregation is a catch-all category for prisoners that may be considered at-risk or a danger to themselves or others, and may last from days to decades. Prisoners are often unnecessarily and falsely determined to be at-risk or a danger, but administrative segregation permits prison officials to isolate these individuals indefinitely.

Prisoners may be placed in disciplinary or punitive solitary confinement as punishment for violating minor rules,³³ filing grievances or lawsuits, or for annoying correctional officers. In most of these instances, prisoners in disciplinary segregation do not pose such an extreme management challenge that warrants solitary confinement.

In other instances, prisoners may be placed in solitary confinement for their “protection” indefinitely by default if the prisoner is perceived as vulnerable. For example, prisoners that may be perceived as elderly, youthful, lesbian, gay, bisexual, transgender or intersex may be deemed by prison officials to need isolation from the general population. Placing individuals perceived as vulnerable in solitary confinement only further stigmatizes them

31

Id.

32 ACLU, *supra* note 19.

33 KURKI & MORRIS, *supra* note 2, at 411-42

and increases the chances that they will not be provided adequate services, treatment, and programming. Moreover, placement in solitary can further increase the risk of assault and harassment by correctional staff.³⁴ In an ACLU report highlighting Virginia, prisoners with physical disabilities can suffer further stigma, loss of essential services, and their civil rights while rotting in solitary confinement.³⁵ Recommendations against protective custody on these bases have been advised against because the effects are debilitating.³⁶

In the past, prisons relied on solitary confinement as a management tool for the category of offenders deemed the “worst of the worst.” “Supermax” prisons were built after the abolishment of parole to handle the increasing prison population. Red Onion State Prison (ROSP) is an example of such a “Supermax” prison. Located in Pound, Virginia (Wise County) – Appalachian coal country – ROSP is in a rural community in the extreme southwest corner of the state. It was deliberately designed to house prisoners in extreme isolation, especially as sentences were lengthened and mass incarceration increased in the United States. The geographical location of ROSP, exacerbates the pervasive loneliness of solitary confinement. The prison was built specifically to house prisoners in solitary confinement and opened in 1998, a decade marked by extreme rates of incarceration and prison growth.³⁷ By 2000, there were 20,000 prisoners held in specifically designated supermax facilities nationwide.³⁸

As a result of prison growth in the 1990s, the population in Wise County rose 6.7 percent despite previous decades of decline, more than tripling the county’s black population due to the

34 Sylvia Rivera Law Project, “It’s War in Here: A Report on the Treatment of Transgender and Intersex People in New York State Men’s Prison” 17-19 (2007), <http://srjp.org/files/warinhere.pdf>; See also: ACLU, *Caged In: Solitary Confinement’s Devastating Harm on Prisoners with Physical Disabilities* (Jan. 2017), available at https://www.aclu.org/sites/default/files/field_document/010916-aclu-solitarydisabilityreport-single.pdf.

35 ACLU, *Caged In: Solitary Confinement’s Devastating Harm on Prisoners with Physical Disabilities* (Jan. 2017), available at https://www.aclu.org/sites/default/files/field_document/010916-aclu-solitarydisabilityreport-single.pdf.

36 See e.g. 28 C.F.R § 115.43; National PREA Resource Center, *Keeping Vulnerable Populations Safe under PREA: Alternative Strategies to the Use of Segregation in Prisons and Jails*, (April 2015), available at: <https://www.prearesourcecenter.org/sites/default/files/library/keepingvulnerablepopulationssafeunderpreaapril2015.pdf>; United States Department of Justice, *Report and Recommendations Concerning the Use of Restrictive Housing*, (Jan. 2016), available at <https://www.justice.gov/dag/file/815551/download>.

37 Patricia Allard & Chris Muller, *Incarcerated People and the Census: Painting a Distorted Picture of Virginia*, Brennan Center for Justice at New York University School of Law, (2005). See: http://www.brennancenter.org/sites/default/files/legacy/d/cj_virginia_briefing.pdf

38 Craig Haney, *Mental Health Issues in Long Term Solitary and “Supermax” Confinement*, 49 *Crime & Delinq.*, 124, 125 (2003).

disproportionate incarceration of African-American men.³⁹ By 2000, African Americans represented 20 percent of Virginia’s total population, but 66 percent of the total incarcerated population.⁴⁰ A disproportionate number of ROSP and WRSP (Wallens Ridge State Prison) prisoners come from other more populous areas of the state making it difficult for family members to travel the often 8 or more hour drive one-way to Virginia’s rural southwest corner. Visiting a loved one in Wise County requires financial resources and time away from work; a luxury many people cannot afford, adding to the effects of isolation. As solitary confinement became increasingly relied upon by prisons, it became apparent this “management tool” was not being used to control simply the “worst of the worst,” but was used indiscriminately and indefinitely against all prisoners, disproportionately impacting African-Americans.

In recent years, efforts to curtail solitary confinement gained traction because of a mounting body of evidence showing the inhumane harms it imposes, especially on vulnerable populations such as individuals with mental illness and juveniles. U.S. institutions and international bodies have condemned its use⁴¹. In addition to the human toll solitary inflicts, questions began to arise whether it is an effective use of taxpayer dollars given the extraordinary expense and the lack of public safety impact.⁴² Public awareness and reform measures developed and were implemented across the nation, including in Virginia.

For example, the state of Colorado implemented the Mandela Rules in its solitary confinement units as of September 2017. Now inmates who commit serious violations, such as assault, spend at most 15 days in solitary, and, if necessary, undergo therapy or anger management classes afterward. In 2011, when Colorado first started reforming its use of solitary confinement, 1,500 inmates, or almost seven percent of the entire prison population, were housed in solitary confinement on any given day. Now, after years of reform, only 18 inmates are held in solitary confinement.

39 ALLARD & MULLER, *supra* note 37. See http://www.brennancenter.org/sites/default/files/legacy/d/cj_virginia_briefing.pdf

40 *Id.*

41 The American Medical Association opposes the use of solitary confinement for juveniles. American Medical Association, Policy 60.9222: Solitary Confinement of Juveniles in Legal Custody (2016), available at <https://policysearch.ama-assn.org/policyfinder/detail/solitary%20confinement?uri=%2FAMA-Doc%2FHOD.xml-0-5016.xml>. See also Juan E. Méndez (Special Rapporteur on Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment), U.N. Doc. A/HRC/22/53 (Feb. 1, 2013).

42 ACLU, *supra* note 19, available at: https://www.aclu.org/sites/default/files/assets/stop_solitary_briefing_paper_updated_august_2014.pdf

The Abuse of Solitary Confinement

As solitary confinement became increasingly relied upon by prisons, it became apparent this “management tool” was not being used to control simply the “worst of the worst,” but was used indiscriminately and indefinitely against all prisoners, disproportionately impacting African-Americans.



PHOTO: SHANE T. MCCOY/UNITED STATES MARSHALS SERVICE

In addition, there have been litigation and groundbreaking settlement agreements in New York⁴³ and California⁴⁴ – states with the largest correctional populations in the nation—resulted in mandated dramatic reforms to their prison systems to overhaul the use of solitary confinement. Once these reforms are fully implemented, the outcomes promise to significantly decrease solitary confinement rates. Nationally, the “Solitary Confinement Reform Act,” introduced in 2016 in U.S. Congress, would dramatically reform solitary confinement.⁴⁵ Notably, U.S. Supreme Court Justice Anthony Kennedy condemned the use of solitary confinement.⁴⁶ Finally, international law has long prohibited the cruel and inhumane treatment of prisoners including the use of solitary confinement.⁴⁷ International standards, embodied in

43 *Peoples v. Annucci* (Case 1:11-cv-0269)(USDC SDNY) (Mar. 31, 2016) available at http://www.nyclu.org/files/releases/3_31_Solitary_Confine_settlement_approval.pdf; See also New York Civil Liberties Union, *Federal Judge Approves Solitary Confinement Overhaul in New York State*, (Mar. 31, 2016), available at <http://www.nyclu.org/news/federal-judge-approves-solitary-confinement-overhaul-new-york-state>.

44 *Ashker v. Governor of California* (C 09-05796 CW) (USDC NDC) (Aug. 31 2015), available at http://ccrjustice.org/sites/default/files/attach/2015/09/2015-09-01-ashker-Settlement_Agreement.pdf; See also Center for Constitutional Rights, *Landmark Agreement Ends Indeterminate Long-Term Solitary Confinement in California*, (Sept. 1, 2015), available at <http://ccrjustice.org/home/press-center/press-releases/landmark-agreement-ends-indeterminate-long-term-solitary>.

45 Solitary Confinement Reform Act, S.3432, 114th Cong., (2016) <https://www.congress.gov/bill/114th-congress/senate-bill/3432>

46 *Davis v. Ayala*, 276 U.S. ___ (2015) (slip opinion, Kennedy concurrence p. 4).

47 Universal Declaration of Human Rights, G.A. Res. 217(III) (Dec. 10, 1948); the 1976 U.S. International Covenant on Civil and Political Rights, G.A. Res. 2200A(XXI) (Mar. 23, 1976); 1984 U.N. Convention Against Torture and Other Cruel and Inhumane or Degrading Treatment or Punishment, G.A. Res. 39/46 (Dec. 10, 1984).

INTERNATIONAL LAW

INTERNATIONAL LAW HAS LONG PROHIBITED THE CRUEL AND INHUMANE TREATMENT OF PRISONERS INCLUDING THE USE OF SOLITARY CONFINEMENT.

the United Nations Standard Minimum Rules for Prisoners, the “Mandela Rules” states that solitary confinement if used should be applied only in extremely limited circumstances for no longer than 15 days.⁴⁸

⁴⁸ United Nations Standard Minimum Rules for Treatment of Prisoners (the Nelson Mandela Rules), G.A. Res. 70/175, Rule 43-44 (Dec. 17, 2015); see also Office of the High Commissioner for Human Rights, *Manual on the Effective Investigation & Documentation of Torture & Other Cruel, Inhuman or Degrading Treatment or Punishment* (1999).

FEDERAL REFORMS

For the first time, in 2015, President Obama directed the Attorney General to review overuse of solitary confinement in the prison system. The Department of Justice (DOJ) researched how restrictive housing is used and why, and subsequently, developed strategies to reduce solitary confinement, including ending the practice of placing juveniles in restrictive housing,⁴⁹ improving diversion programs for inmates with serious mental illness,⁵⁰ improving alternatives to “protective custody,”⁵¹ significantly limiting the use of restrictive housing as a form of punishment,⁵² and cutting in half the length of the “Special Management Unit” program.⁵³ Based on the DOJ’s review, the President issued guiding principles to limit the use of restrictive housing at the federal, state, and local level, in addition to recommendations for policies that the Bureau of Prisons (BOP) could implement for federal prisons.⁵⁴

49 United States Department of Justice, Report and Recommendations Concerning the Use of Restrictive Housing, (Jan. 2016), available at: <https://www.justice.gov/dag/file/815551/download> at 61-62(b); 114(p).

50 *Id.* at 46-57(b); 112-14 (p).

51 *Id.* at 23-25(b); 110-11(p).

52 *Id.* at 18-23(b); 107-110(p).

53 *Id.* at 34-37(b); 111-12(p).

54 <https://www.justice.gov/restrictivehousing>

.....
President Obama called solitary confinement “an affront to our common humanity” and called for limiting its use only to when absolutely necessary.
.....

The DOJ report also identified ways to improve humane and safe conditions for prisoners and the correctional officers.⁵⁵ In 2016, the President adopted the DOJ’s recommendations and directed federal agencies to review the report and develop a plan to deal reduce solitary confinement.⁵⁶ In an unprecedented action, the President wrote an opinion article in a national newspaper condemning solitary confinement and banned the isolation of juveniles and against adult prisoners as punishment for low-level prison infractions in the federal BOP.⁵⁷ President Obama called solitary confinement “an affront to our common humanity” and called for limiting its use only to when absolutely necessary.⁵⁸ Solitary confinement, however, remains pervasive, problematic, and for the most part, hidden from public oversight and accountability in many states including Virginia.

After the President’s action, on January 29, 2016 the ACLU of Virginia asked Governor Terry McAuliffe to follow the President’s lead to ban solitary confinement of juveniles and to develop effective reforms at reducing solitary confinement in Virginia. The ACLU of Virginia never received a response.⁵⁹

This report discusses solitary confinement and provides specific recommendations that legislators, the Governor, and state agencies can implement to reduce Virginia’s prison population held in solitary confinement, especially for those suffering from mental illness. This report also serves to help organizations, such as the Vera Institute of Justice, in their partnership with the Virginia Department of Corrections to reduce solitary confinement. The report focuses on ROSP and WRSP, but the recommendations are applicable to all Virginia prisons and jails.

55 <https://www.justice.gov/restrictivehousing>

56 <https://www.whitehouse.gov/the-press-office/2016/03/01/presidential-memorandum-limiting-use-restrictive-housing-federal>

57 Barack Obama, *Why We Must Rethink Solitary Confinement*, WASH. POST, Jan.25, 2016. See https://www.washingtonpost.com/opinions/barack-obama-why-we-must-rethink-solitary-confinement/2016/01/25/29a361f2-c384-11e5-8965-0607e0e265ce_story.html?tid=a_inl&utm_term=.3eb03d58bd0c

58 *Id.*

59 ACLU of Virginia, *ACLU-VA Urges Governor to Stop Solitary Confinement* (Jan. 29, 2016), available at <https://acluva.org/18298/aclu-va-urges-governor-to-stop-solitary-confinement/>

Solitary Confinement in Virginia

.....
In 2011, the Washington Post reported that 1 in 20 prisoners in Virginia were being held in solitary confinement
.....

In 2011, the Washington Post reported that 1 in 20 prisoners in Virginia⁶⁰ were being held in solitary confinement.⁶¹ The alarming statistic included 500 out of 750 prisoners at Supermax Red Onion State Prison. Individual cases ranged from two weeks to almost seven years of solitary confinement, with an average length of isolation of 2.7 years.⁶² The same report notably stated that one prisoner with mental illness had been held in isolation for 14 years.⁶³ Prison officials said they did not keep statistics on length of solitary confinement cases, but described different review processes for administrative versus disciplinary segregation.⁶⁴ Prison officials told legislators that 173, or nearly 30 percent, of prisoners in solitary were mentally ill, but were unable to provide information on how much of the state budget was spent on mental health services.⁶⁵ More alarming, prisoners in solitary could “potentially be assigned there for years according to their risk assessment.”⁶⁶ In the same year, the Virginia Department of Corrections implemented reform efforts aimed at reducing the number of prisoners held in “administrative segregation” at Red Onion State Prison and Wallens Ridge State Prison.⁶⁷ The VDOC developed and implemented an incentive-based step down program that provides prisoners with opportunities to essentially behave their way out of solitary confinement. As of July 2016, 242 prisoners still languished in solitary confinement at ROSP

60 The ACLU of Virginia, with its advocacy partners, regularly receives information from prisoners in solitary confinement. Their accounts described in this report illustrate common problems. Their individual identities, however, remain confidential to protect their safety given the nature of their experiences and their fear of retaliation and harm.

61 Anita Kumar, Virginia Prisons’ Use of Solitary Confinement is Scrutinized, THE WASHINGTON POST, https://www.washingtonpost.com/local/dc-politics/va-prisons-use-of-solitary-confinement-is-scrutinized/2011/11/28/gIQAkKHuhP_story.html?utm_term=.27aec938857b

62 *Id.*

63 Virginia Recognized for Transforming Highest-Security Prisons” August 7, 2013. https://vadoc.virginia.gov/news/press-releases/13aug06_stepdownrecognition.shtm

64 *Id.*

65 *Id.*

66 *Id.*

67 Virginia Department of Corrections, *Virginia Recognized for Transforming Highest-Security Prisons* (Aug. 7, 2013), available at: https://vadoc.virginia.gov/news/press-releases/13aug06_stepdownrecognition.shtm

and WRSP.⁶⁸ Though any reform efforts are commendable, questions remain about the effectiveness of the Step Down Program, inadequate treatment for prisoners suffering from mental illness in solitary confinement, and the widespread lack of government transparency and accountability in Virginia’s prisons. It must also be noted that under the “Mandela Rules,” number 43, as adopted by the United Nations Commission on Crime Prevention and Criminal Justice in Vienna in 2015, “prolonged solitary confinement” is defined as a “time period in excess of 15 consecutive days.”

Reform Efforts in Virginia

In 2011, VDOC began to develop “evidence based step-down” programming reforms at Red Onion State Prison and Wallens Ridge State Prison to address excessive solitary confinement. This effort was aligned with an executive order issued by then Governor Bob McDonnell which aimed at improving reentry efforts.⁶⁹ In 2012, VDOC met with the ACLU of Virginia, along with a diverse group of advocacy organizations, to present information about its reentry efforts and the newly implemented “Segregation Reduction Step-Down Plan.”⁷⁰ In addition to questioning the new reforms, advocates sought information from VDOC about prisoners with mental illness in solitary confinement with no success.⁷¹

According to VDOC, the solitary confinement Step Down Program is an incentive-based model, touted as “partnering science with corrections” that incorporates evidence-based practices (EBP), or strategies in the correctional field, that have been proven through research to reduce criminal behavior and reduce recidivism.⁷² Prisoners who choose to participate in the Step Down Program must commit to accomplishing program participation goals, disciplinary violation goals, and responsible behavior goals (personal hygiene, standing for count, maintaining orderly living environment, deportment—satisfactory rapport with staff and

68 Katie Rose Quandt & Jack Denton, at *Virginia’s Supermax Prisons, Isolation and Abuse Persist Despite Reforms*, SOLITARY WATCH, Aug. 4, 2016, <http://solitarywatch.com/2016/08/04/at-virginias-supermax-prisons-isolation-and-abuse-persist-despite-reforms/>

69 Governor McDonnell, Executive Order 11 (May 11, 2010)

70 Meeting with Virginia Department of Corrections, 12/19/2012, Power Point Presentation (Appendix A)

71 *Id.*

72 “Evidence Based Practices Plan for Administrative Segregation at Red Onion and Wallens Ridge State Prisons,” Handout obtained from VDOC on Dec. 19, 2012. (Appendix B)

other prisoners).⁷³ The fastest a prisoner can progress through the program is nine months, but VDOC emphasizes that the program is outcome-based and not based on time.⁷⁴ If prisoners display disruptive behavior or fail to make needed changes, the program will take longer.⁷⁵

The Step Down Program requires level S prisoners (VDOC's highest and most restrictive security classification) in solitary confinement to progress to lower classification levels through behavior modification. The Step Down Program has two main tracks for prisoners based on VDOC's classification system: intensive management (IM) and special management (SM). In theory, offenders classified as SM are able to fully immerse themselves into the multi-layered step-down program, to potentially gain a lower security status and enter into general population. Prisoners are classified as SM if they have had frequent recurring disciplinary violations at lower level facilities resulting in harm but without the intent for serious harm or intent to kill; a pattern of repeated disruptive behavior resulting in significant property damage; intentionally committed disciplinary violations with the goal to remain in solitary confinement; and ineffective interventions at lower security levels.⁷⁶

Offenders classified as IM, however, can only progress partially through the program, earning some increased privileges, but regardless of their behavior they are permanently housed in solitary confinement conditions. IM prisoners receive most of their programming in-cell for significantly longer periods of time before consideration is given to moving an IM prisoner to a class-like setting.⁷⁷ VDOC classifies IM prisoners as individuals with the potential for extreme and deadly violence, defined by a history of willingness to carry out serious or deadly harm or as a result of institutional charges with intent to serious harm or kill, or offenders with a high escape risk or because of the offender's high profile or notorious crime.⁷⁸ Because prison officials, not courts, dictate housing decisions, they wield enormous power. IM prisoners who successfully progress through the program can only gain entry into the "Security Level 6 Closed Pod," which

73 Virginia Department of Corrections, The Council of State Governments, Southern Legislative Conference STAR Presentation, "Administrative Segregation Step Down Program" (Appendix C)

74 HOPE, *supra* note 12.

75 *Id.*

76 Virginia Department of Corrections, *supra* note 73.

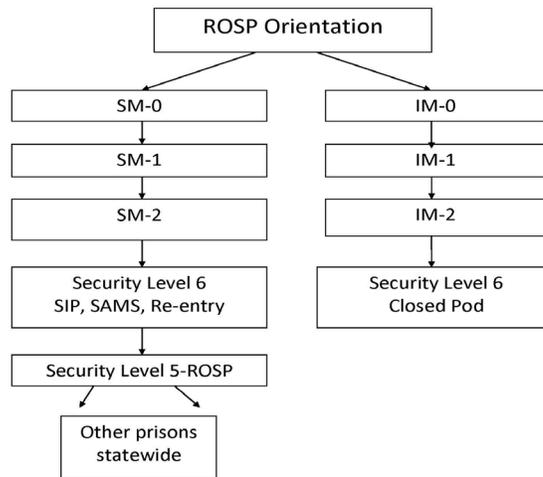
77 Virginia DOC Administrative Segregation Step Down Program, "Partnering Science with Corrections," (Handout obtained by the ACLU of Virginia, December 2012).

78 Virginia Department of Corrections, *supra* note 12.

The Problem with Intensive Management (IM)

Because prison officials, not courts, dictate housing decisions, they wield enormous power. IM prisoners who successfully progress through the program can only gain entry into the “Security Level 6 Closed Pod,” which is labeled by VDOC as general population with some additional privileges, but with high restrictions. “High restrictions” means basically the same general conditions and restrictions as solitary confinement. As of August 2016, 84 prisoners are in IM, trapped in permanent isolation.

Diagram of the Segregation Step Down Program



is labeled by VDOC as general population with some additional privileges, but with high restrictions.⁷⁹ “High restrictions” basically means the same general conditions and restrictions as solitary confinement. As of August 2016, 84 prisoners are in IM, trapped in permanent isolation.⁸⁰

In contrast, SM prisoners must complete various programming through a series of workbooks, journals, and classes covering topics such as anger management, social skills, problem solving, and substance abuse over a series of phases in the Step Down Program. As SM prisoners in solitary confinement advance through different phases, there is gradually less restraint placed on a prisoner’s movement. Prisoners start at SM-0, where they have no privileges and only “basic constitutionally mandated services, without consideration for security level reduction.” At this stage, the prisoner only receives education programming over close circuit monitors and in-cell faith based materials. To progress from SM-0 to SM-1, prisoners must complete the first set of prescribed curriculum. SM-1 prisoners must complete a second set of prescribed curriculum of workbooks and programming. At this stage, “therapeutic modules” are utilized for classes, which are adjacent cage-like cells or cages where prisoners are restrained.

After graduating to SM-2, a prisoner must complete the final set

79 Virginia DOC Administrative Segregation Step Down Program, “Partnering Science with Corrections,” (Handout obtained by the ACLU of Virginia, December 2012).

80 QUANDT & DENTON, *supra* note 68.

After graduating to SM-2, a prisoner must complete the final set of workbooks. Programming is held in-cell, in adjacent cages, and at this point, prisons may be shackled to desks, known as “program chairs,” to receive programming in a class setting.

of workbooks. Programming is held in-cell, in adjacent cages, and at this stage, prisoners may be shackled to desks, known as “program chairs,” to receive programming in a class setting.⁸¹ At this stage, a prisoner is eligible for a lower security classification level (Level 6) and to reenter general population or a specialty housing unit. However, the prisoner must first complete another series of step down phases and programming.⁸² The prisoner then gains more privileges and less restraint and isolating conditions. Despite this, some prisoners never reenter general population, but are housed in specialty housing units. For example, the pod, Secured Allied Management “SAM” houses prisoners who have earned a lower security level, but are still in solitary confinement conditions due to the perception that they are easily bullied, manipulated, or have lower cognitive processing.⁸³

Finally, prisoners may progress to security level 5 with additional privileges, and if the prisoner displays a “successful period of proving appropriate behaviors,” the prisoner may request a transfer to another prison.⁸⁴ At this step, VDOC reported that many prisoners wish to transfer to facilities in the eastern part of the state, near more populous metropolitan areas. In addition to relocating to a lower security prison with additional privileges, this request is presumably to be closer to their families and friends to have increased and easier visitation. The ACLU of Virginia staff, along with other advocates, have been told that other facilities are more racially diverse and representative of the general population than ROSP and WRSP, which adds to the desire to transfer.

In addition to reforms aimed at prisoners, VDOC also implemented reforms for employees of ROSP. Recognizing the highly stressful environment of ROSP and that “[a]dministrative [s]egregation may have become overused,”⁸⁵ VDOC stated that a key strategy of the reforms was to change facility culture by addressing the three main components: facility resources and operating procedures, offender thinking and behavior, and staff beliefs, attitudes, skills and practices.⁸⁶ To implement ROSP’s cultural change, the warden and his executive team received a five-day training in

81 Virginia DOC Administrative Segregation Step Down Program, “Partnering Science with Corrections,” (Handout obtained by the ACLU of Virginia, December 2012).

82 *Id.*

83 *Id.*

84 *Id.*

85 Virginia DOC Administrative Segregation Step Down Program, “Partnering Science with Corrections,” (Handout obtained by the ACLU of Virginia, December 2012).

86 Virginia Department of Corrections, *supra* note 73.

effective communication and motivational strategies provided by a national expert in 2011.⁸⁷ Subsequently, all ROSP employees received a condensed two-day training on effective communication from previously trained VDOC employees, in contrast to the full training given by experts.⁸⁸ VDOC also trained some correctional officers as cognitive treatment officers, who in addition to providing security, are “trained to provide programming to motivate and support positive change.”⁸⁹ VDOC did not report whether they measure outcomes or provide ongoing education to staff to reinforce positive cultural change.

In 2013, less than two years after initiating the program, VDOC reported that it had reduced its solitary confinement population by 58 percent, along with a 56 percent reduction in prison incidents, and a 23 percent reduction in the number of grievances filed by prisoners at ROSP and WRSP as a result the reforms.⁹⁰ Virginia’s Step Down Program was recognized by the Council of State Governments’ Southern Legislative Conference in the same year.⁹¹

Despite this recognition, questions still remained about the program’s effectiveness because it was too soon to determine outcomes. By 2016, VDOC touted its low solitary confinement rates, but that percentage does not tell the entire story.⁹² Since 2011, VDOC has not implemented any further reforms aimed at removing prisoners suffering from mental illness from solitary confinement despite court decisions around the country prohibiting the practice. In addition, several other states have taken legislative or administrative action to move prisoners with mental illness out of solitary confinement.⁹³

87 Virginia DOC Administrative Segregation Step Down Program, “Partnering Science with Corrections,” (Handout obtained by the ACLU of Virginia, December 2012).

88 *Id.*

89 DOJ Report mentioning VA: https://vadoc.virginia.gov/news/press-releases/16mar3_DOJ.shtm

90 Virginia Department of Corrections, Press Release: “Virginia Recognized for Transforming Highest-Security Prisons” (August 7, 2013). See: https://vadoc.virginia.gov/news/press-releases/13aug06_stepdownrecognition.shtm

91 *Id.*

92 QUANDT & DENTON, *supra* note 68.

93 Eli Hager and Gerald Rich, *Shifting Away from Solitary, The Marshall Project* (Dec. 12, 2014), available at <https://www.themarshallproject.org/2014/12/23/shifting-away-from-solitary#.7fvrkBccz>.

SOLITARY CONFINEMENT REMAINS A PROBLEM IN VIRGINIA

The ACLU of Virginia and other advocacy organizations, regularly receive prisoner accounts that do not comport with the VDOC's description of its reform efforts and outcomes.

In October 2016, the ACLU of Virginia and its community partners met with VDOC officials to learn about the status of solitary confinement at ROSSP. Advocates questioned VDOC officials about the effectiveness and operations of the reforms and cited specific prisoners' cases that contradicted VDOC's policies and purported practices. These examples demonstrated that solitary confinement remains a problem in Virginia.

VIRGINIA'S STEP DOWN PROGRAM

In 2016, the DOJ highlighted Virginia's reform efforts as a case study,⁹⁴ but several questions remain about the effectiveness and operations of the Step Down Program.⁹⁵ The DOJ report stated that VDOC reported that since the reforms had been implemented there had been a 68 percent reduction in the number of security level S inmates, a 78 percent reduction in incident reports, a 91 percent decrease in inmate grievances, and an 86 percent reduction in informal complaints. Confusingly, in March 2016, VDOC publicized that incident reports from 2011 until 2015 at Red Onion reduced by 65 percent, formal grievances filed by prisoners reduced by 71 percent, while informal grievances reduced by 76 percent.⁹⁶

94 United States Department of Justice, Report and Recommendations Concerning the Use of Restrictive Housing, 77 (Jan. 2016), available at <https://www.justice.gov/dag/file/815551/download>.

95 QUANDT & DENTON, *supra* note 68, available at <http://solitarywatch.com/2016/08/04/at-virginias-Super-max-prisons-isolation-and-abuse-persist-despite-reforms/>

96 <https://vadoc.virginia.gov/news/press-releases/16mar3-DOJ.shtm>

Prisoners' Accounts and Problems with Solitary Confinement

Prisoners allege that the disciplinary charges are sometimes inflated or false and that solitary confinement is not limited to situations in which it is essential for the safety and security of the prison, its staff, and other prisoners.

Indefinite Solitary Confinement & Lack of Due Process

Prisoners experience solitary confinement as punishment. Indefinite periods of isolation, lasting from one to many months, seem to frequently follow disciplinary infractions at ROSP and WRSP, even though disciplinary segregation itself is explicitly limited to 30 days according to VDOC policy.⁹⁷ Solitary confinement is not limited in duration by VDOC. Prisoners allege that the disciplinary charges are sometimes inflated or false and that solitary confinement is not limited to situations in which it is essential for the safety and security of the prison, its staff, and other prisoners. For prisoners experiencing symptoms of mental illness, this indefinite isolation without reason compounds the suffering.

VDOC policy states that “prisoners may only be assigned to solitary confinement by the Institutional Classification Authority (ICA) after a due process hearing.”⁹⁸ “During the placement in solitary confinement, the prisoner’s status will be formally reviewed by the ICA at least once every 90 days.”⁹⁹ Further, the policy requires a formal due process hearing for “segregation assignment, review, and release” and “segregation reviews resulting in no status change.”¹⁰⁰ Prisoners alleged many

97 Virginia Department of Corrections, Operating Procedure 861.1
98 Virginia Department of Corrections, Operating Procedure 861.3, Section IX.A.2., 830.1
99 *Id.*
100 Virginia Department of Corrections, Operating Procedure 830.1, Section IV.A.2.b.ii.

instances in which these provisions appear not to have been followed as written, exacerbating the indefinite nature of the solitary confinement. In violation of VDOC policy, prisoners also allege that placement in solitary confinement is not consistently documented and often prisoners do not know how long they will be there.¹⁰¹ Additionally, prisoners report that they are not consistently allowed to attend ICA hearings regarding their status, even though that is required.¹⁰²

One prisoner reported being in solitary confinement for 93 days after a disciplinary charge for protesting a repeated denial of recreation. The prisoner alleges the charge should have been a lesser infraction than what he was charged with, and, stated that at no time during this period was he given the opportunity to be present at his hearing, nor did he receive any documentation of his assignment to administrative segregation.

Another prisoner was placed in solitary confinement for a charge he strongly denies. The only documentation relating to his assignment in solitary confinement was his disciplinary offense report that showed a penalty of 25 days, but he remained in solitary confinement for 53 days. In the past, this prisoner has spent over 12 years in solitary confinement. Two of those years followed the dismissal of a disciplinary charge against him that resulted in the solitary confinement. This prisoner claims he has been denied any formal review of his status and documentation justifying why he continues to be held in solitary confinement.

One prisoner reported that he suffers from mental illness. He takes psychotropic drugs twice a day and has attempted suicide several times. He said that he was placed in solitary confinement more than a year ago for refusing to comply with the grooming policy, including a strip cell for 6 months. He stated that he has not had recreation or a shower in more than a month. He believes his treatment was retaliation for complaints he filed against three officers for sexual harassment and assault.

Demonstrating the inaccuracy of record-keeping and excessive isolation, one prisoner spent 62 days in solitary confinement for a disciplinary sanction. Despite this, he received VDOC documentation stating that he had only spent 30 days in

101
102

Virginia Department of Corrections, Operating Procedure 830.1.
Id.

solitary confinement. After being assaulted, another prisoner spent five months in solitary confinement after failing to follow a correctional officer's order. Even though he appealed to the warden, he never saw any documentation showing that his status in solitary confinement had been reviewed at the 90-day interval, nor was he given the opportunity to attend his status hearing.

Lack of Transparency about Reforms

Theoretically, the VDOC's Step Down Program has resulted in a reduction of the use of solitary confinement. If true, it is an important step forward. Nonetheless, in practice, the Step Down Program is a confusing maze that lacks transparency and clear benchmarks for progression to the next phase. Prisoners in the program report languishing in the program for months at time and remaining stuck in phases without receiving programming despite filing multiple requests for services. There are often significant delays in administering the program.¹⁰³ Evaluation of VDOC's claims of success are difficult, if not impossible, to evaluate due to a lack of mandatory reporting or tracking.

Prisoners have reported that there is a lack of clarity about the length of time it takes to progress through the program, the amount and quality of training of the instructors, inconsistent attendance by instructors, and puzzling delays in the availability of workbooks and decisions to require individuals to re-start the program following allegedly minor infractions. One prisoner reported that he was delayed in completing the Step Down Program repeatedly. The prisoner had previously completed the program three other times. He has waited weeks, sometimes months, for workbooks. He alleged that as a result of filing grievances against correctional officers about incidents unrelated to the program, the facility punished him with continued solitary confinement as retaliation. Astonishingly, his expected trajectory in the program will keep him in solitary confinement for four more years even after he finishes the program, but no one has explained why. He has received no information about what he needs to accomplish during those four years to enter general population.

Nonetheless, in practice, the Step Down Program is a confusing maze that lacks transparency and clear benchmarks for progression to the next phase.

¹⁰³ Virginia Department of Corrections, *Restrictive Housing Reduction Step-Down Program: Red Onion State Prison and Wallens Ridge State Prison, Security Level-S and Level-6 Operations Strategy*, at 14 (Mar. 4, 2014); available at <http://solitarywatch.com/wp-content/uploads/2016/07/Diagram-of-VA-Step-Down-Program.pdf>

Other prisoners have also reported that they often wait weeks or months for workbooks or other programming. For example, one prisoner reported that he is aware of more than a dozen other prisoners who have had their status in the Step Down Program lowered for no discernable reason or as a result of being charged with minor infractions. Some of those infractions were charged as retaliation for filing grievances. The ACLU of Virginia has received reports that prisoners are required to recycle through the Step Down Program repeatedly. The same prisoner shared that refusal to complete or repeat the Step Down Program leads to an additional, charged with yet another disciplinary infraction for refusal. Yet, according to VDOC, participation in the program is voluntary.¹⁰⁴

Abuse and Lack of Accountability

Prisoners report that abuse from correctional staff has resulted in cynicism about the Step Down Program and the prison's purported cultural change. Several prisoners complained that correctional staff do not behave in accordance with the principles and practices promoted by the program materials. A non-exhaustive list of problems include: abusive and racist language used by prison employees; withholding and tampering with food; sexual harassment and assaults; destruction of personal property; withholding of recreation and showers; use of restraints and strip cells for longer durations than permitted by VDOC policy; and pervasive interference with prisoners' access to the grievance procedure, including acts and threats of retaliation for asking for grievances forms, filing grievances, and filing lawsuits.

For example, a prisoner reported that his food tray slot was opened and he was sprayed in his face with a can of mace. After being asked by the correctional employee if he liked it, he was sprayed again. The prisoner was told if he reported the incident they would "beat my n— ass." Several prisoners report to advocates that correctional officers commonly instigate fights and use racial epithets. Commenting on how positive behavior is not encouraged, a prisoner reported that correctional guards have repeatedly told prisoners to start fighting because they do not have anything to do and that their dogs are bored and need something to sink their teeth into.

104 *Id.*

Many prisoners report small servings of food, tampering with trays, and weight loss while in solitary confinement. For example, a prisoner reported being given empty food trays and on other occasions, served pork, which contradicts his religious beliefs. The same prisoner reported that chewing tobacco had been put into his beverage. Trays have been shoved through the cell door slot causing the contents to spill on the floor. Sometimes beverage cups have only a sip of liquid in them. Food tampering is a common complaint by prisoners who state that it would not be evident by surveillance footage. Advocates have been told that food portion sizes increase when officials from VDOC headquarters visit ROSP and WRSP.

Sadly, prisoners tell advocates that there is no effective remedy to stop abuse from correctional officers because the officers' accounts are always taken as truth.

Prisoners report that recreation and showers are often withheld capriciously. For example, a former prisoner summarized that prisoners in solitary confinement must be awake at 5:30 a.m. when the correctional guards make rounds to mark which prisoners want recreation and showers. Correctional guards do not announce themselves so if a prisoner is not awake, he misses out. If a prisoner tries to wake up other prisoners, he is punished with deprivation of his recreation and shower. This is a significant problem for prisoners who take psychotropic medications that cause them to sleep heavily. Another prisoner reported that he lost his recreation time for offering his soup to another prisoner.

One prisoner said that threats made by correctional guards against other prisoners deterred them from being witnesses at his disciplinary hearing. This prisoner reported that he was assaulted by a correctional guard, who also destroyed his legal mail and personal property. When he asked to talk to higher ranked correctional staff, he alleged he was slammed against a wall, then the floor - where his testicles and arms were twisted. He was placed in restraints for twelve hours and accused of assaulting a correctional guard. A correctional unit manager later acknowledge that surveillance footage supported the prisoner's innocence.

Shockingly, one prisoner reported that he received a false disciplinary charge in retaliation for filing grievances reporting that correctional officers took his food tray and tried extorting a sexual act from him to get his food back.

Sadly, prisoners tell advocates that there is no effective remedy to stop abuse from correctional officers because the officers' accounts

are always taken as truth. Prisoners have written higher level officials without receiving a response. Other prisoners report that unit managers have said that they will not contradict their correctional officers. One prisoner told advocates that despite numerous other prisoners as supporting witnesses at his hearing, their statements were not given any weight.

IM Prisoners: Permanently Isolated in Even Worse Conditions

Prisoners at ROSP who are designated “IM” appear to be held in permanent isolation, even if they complete the Step Down Program curriculum and go for years without any disciplinary infractions. It appears there is no meaningful opportunity to have this designation reconsidered or to demonstrate the ability to adapt successfully to a less restrictive environment. The VDOC stated that a prisoner can request to have his status reviewed by the external review team, held twice per year.¹⁰⁵ During the review, the prisoner will be evaluated on the following criteria: current sentence summary and risks posed; severity of institutional infractions over span of incarceration and progression of the prisoner’s behavior.¹⁰⁶ According to the VDOC’s operations strategy, the bi-annual review should automatically occur and does not state that an IM prisoner must request it.¹⁰⁷

Several IM prisoners have said, however, that no one has ever informed them of their IM status or that they could request a review for change in status. Advocates have received information about prisoners who are designated IM, but who have not incurred any disciplinary infractions in many years. One prisoner reported that he did not know he had been classified IM until a card was placed outside his cell door bearing that label. Another prisoner said he was never told why he was classified IM. He eventually obtained something from the prison library that explained it. In addition, these IM prisoners allege that there are individuals who have committed more serious crimes than IM prisoners, but who are not designated IM.

105 HOPE, *supra* note 12

106 *Id.*

107 Virginia Department of Corrections, *supra* note 103.

INEFFECTIVE GRIEVANCE PROCEDURE

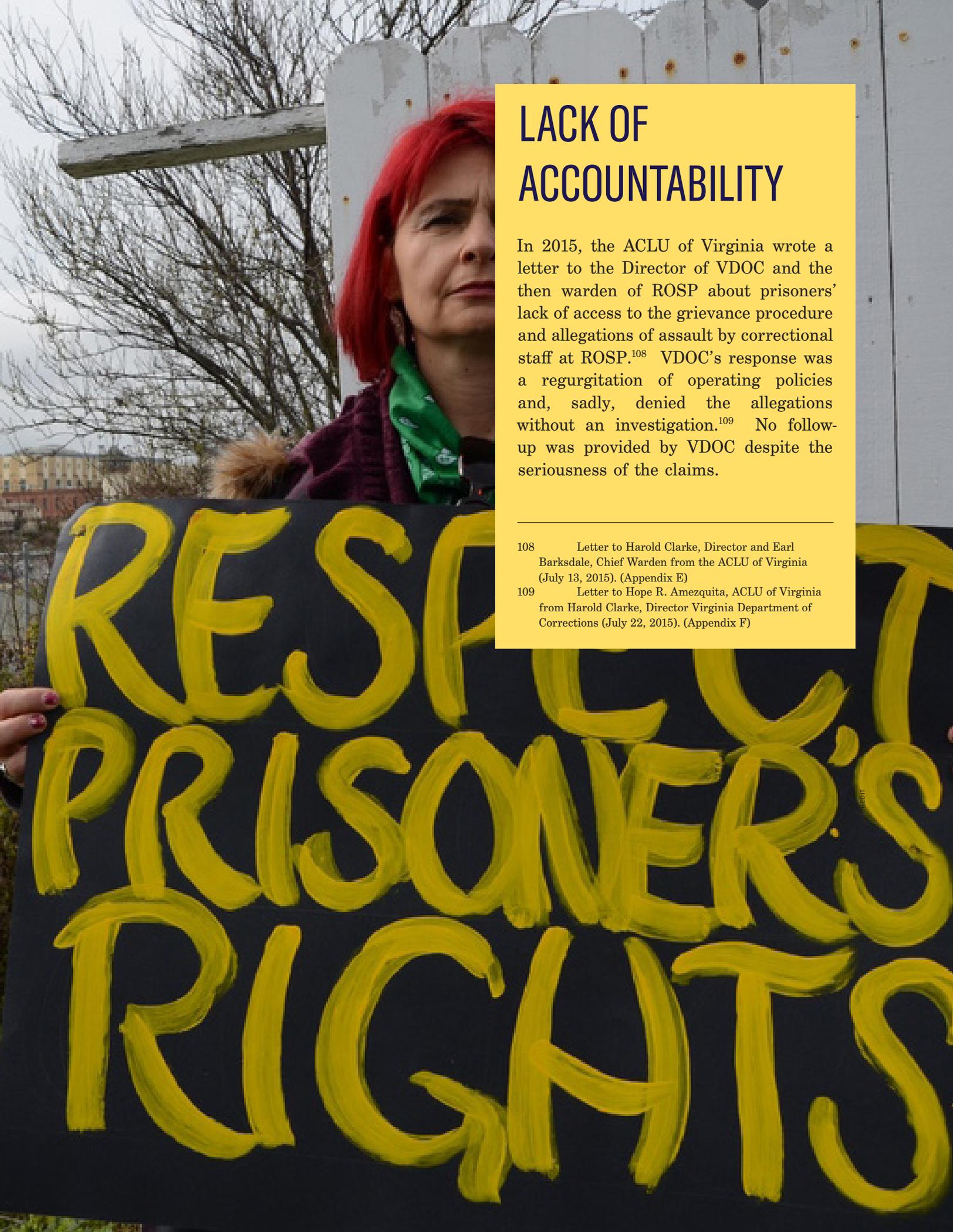
PRISONERS ARE SIMPLY AFRAID TO USE THE GRIEVANCE PROCEDURE.

No Meaningful Access to the Grievance Procedure & Risk of Harms

A prisoner must often file a grievance form in adherence to prison policies to seek help or to address an issue. Utilizing the grievance procedure is often the only mechanism to find redress and if not, can be vital in filing a lawsuit to protect the prisoner's civil rights and liberties. Many prisoners at ROSP and WRSP reported they have been denied grievance forms when they requested them or their forms have been destroyed by correctional officers.

Some prisoners reported being threatened with solitary confinement, having weapons planted in their cells, and having food withheld or tampered with as retaliation for filing complaints. Others have alleged they have been assaulted or threatened with harm by correctional officers if they attempt to file a grievance. Despite the low grievance filing rates cited by VDOC as a successful measurement of reform, there may be another explanation for the low rate—fear.

Prisoners are simply afraid to use the grievance procedure. After being attacked, one prisoner summarized that he feels that he cannot report it because he has been denied access to forms several times and is scared that his unit manager will retaliate by changing his release date.

A woman with short, vibrant red hair is shown from the chest up, looking slightly to her right with a serious expression. She is wearing a dark purple jacket and a green scarf. She is holding a large black sign with the words "RESPONSE TO PRISONERS' RIGHTS" written in thick, yellow, hand-painted letters. The background consists of a white picket fence and bare trees under an overcast sky.

LACK OF ACCOUNTABILITY

In 2015, the ACLU of Virginia wrote a letter to the Director of VDOC and the then warden of ROSP about prisoners' lack of access to the grievance procedure and allegations of assault by correctional staff at ROSP.¹⁰⁸ VDOC's response was a regurgitation of operating policies and, sadly, denied the allegations without an investigation.¹⁰⁹ No follow-up was provided by VDOC despite the seriousness of the claims.

108 Letter to Harold Clarke, Director and Earl Barksdale, Chief Warden from the ACLU of Virginia (July 13, 2015). (Appendix E)

109 Letter to Hope R. Amezcuita, ACLU of Virginia from Harold Clarke, Director Virginia Department of Corrections (July 22, 2015). (Appendix F)

Suffering with Mental Illness in Solitary Confinement

For prisoners with mental illnesses held in solitary confinement, it can be a torturous death sentence.

For prisoners with mental illnesses held in solitary confinement, it can be a torturous death sentence. This is even true for prisoners who enter solitary confinement as healthy individuals with no history of mental illness because prolonged isolation makes anyone susceptible to its harms.¹¹⁰ As one psychiatrist stated, “it’s a standard psychiatric concept, if you put people in isolation, they will go insane. ... Most people in isolation will fall apart.”¹¹¹ Left in such conditions, prisoners suffering from mental illness are likely to experience worsening symptoms and decompensation that often leads to acts of self-mutilation and suicide.

Over the span of the past decades, there is now overwhelming medical, scientific, and health-related research concluding the horrific psychological damage solitary confinement inflicts on human beings.¹¹² Numerous studies confirm that prolonged isolation deprives prisoners of the basic human needs to function. Notably, one study concluded: “[n]early every scientific inquiry into the effects of solitary confinement over the past 150 years concluded that subjecting an individual to more than 10 days of involuntary solitary confinement results in a distinct set of

¹¹⁰ Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 Wash. U. J. of L. & Pol’y 325, 332 (2006). See also *Jones ‘El v. Berge*, 164 F. Supp. 2d 1096, 1117 (W. D. Wis. 2001) (“prisoners in [isolation] who have no history of serious mental illness and who are not prone to psychiatric decompensation (breakdown) often develop...diagnoses such as paranoid delusional disorder, dissociative disorder, schizophrenia and panic disorder.”).

¹¹¹ HUMAN RIGHTS WATCH, *ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS* 149 n. 513 (2003).

¹¹² Elizabeth Benion, *Banning the Bing: Why Extreme Solitary Confinement is Cruel & Far Too Usual Punishment*, 90 IND. L. J. 741, 756 (2015). See also Hernan Reyes, *The Worst Scars Are in the Mind: Psychological Torture*, 89 Int’l Rev. of the Red Cross, No. 867, 591, 607 (Sept. 2007).

emotional, cognitive, social and physical pathologies.”¹¹³ The intrinsic nature of isolation depletes people of the basic “social interactions and productive activities to establish and sustain a sense of identity and to maintain a grasp on reality.”¹¹⁴

The effects of solitary confinement are psychologically damaging¹¹⁵ and can include: negative attitudes and affect;¹¹⁶ insomnia;¹¹⁷ anxiety;¹¹⁸ panic;¹¹⁹ withdrawal;¹²⁰ hypersensitivity to stimuli;¹²¹ ruminations;¹²² cognitive dysfunction;¹²³ hallucinations;¹²⁴ loss of control;¹²⁵ irritability, aggression and rage;¹²⁶ paranoia;¹²⁷ chronic apathy;¹²⁸ lethargy;¹²⁹ depression;¹³⁰ self-mutilation;¹³¹ suicidal ideation and behavior;¹³² and lower levels of brain function, including a decline in electroencephalogram (EEG) activity¹³³ after only seven days in isolation.¹³⁴ The effects of solitary confinement have been shown to be akin to physical torture.¹³⁵

Alarming, rates of suicide and incidents of self-harm are

-
- 113 APPELBAUM, *supra* note 9.
114 Terry Kupers, *Isolated Confinement: Effective Method for Behavior Change or Punishment for Punishment's Sake?*, Routledge Handbook of Int'l Crime and Just. Stud., 6 (2013).
115 HANEY, *supra* note 38, at 130-131; *see also* Richard Korn, *The Effects of Confinement in the High Security Unit at Lexington*, 15 Soc. Just. 8 (1988); Stuart Grassian, *Psychopathological Effects of Solitary Confinement*, 140 AM.J.OF PSYCHIATRY 1450, 1452 (1983); Holly A. Miller & Glenn R. Young, *Prison Segregation: Administrative Detention Remedy or Mental Health Problem?*, 7 CRIM. BEHAV. & MENTAL HEALTH, 85, 91 (1997).
116 *See, e.g.*, Michael Bauer et al., *Long-Term Mental Sequelae of Political Imprisonment in East Germany*, 181 J. NERVOUS & MENTAL DISEASE 257, 258-61 (1993); Korn, *supra* note 115, at 8-19; Miller & Young, *supra* note 115, at 85-94; Peter Suedfeld et al., *Reactions and Attributes of Prisoners in Solitary Confinement*, 9 CRIMINAL JUSTICE & BEHAVIOR 303, 315-318 (1982).
117 *See, e.g.*, Bauer et al., *supra* note 116, at 259.
118 *See, e.g.*, Henrik Andersen et al., *A Longitudinal Study of Prisoners on Remand: Repeated Measures of Psychopathology in the Initial Phase of Solitary Versus Nonsolitary Confinement*, ACTA PSYCHIATRICA SCANDINAVICA 19, 20-25 (2000); Stuart Grassian & N. Friedman, *Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement*, 8 INT'L J. L. & PSYCHIATRY 49, 54 (1986); Grassian, *supra* note 115, at 1452; Haney, *supra* note 38, at 133.
119 *See, e.g.*, Grassian, *supra* note 115, at 335.
120 *See, e.g.*, Haney, *supra* note 38, at 134; Miller & Young, *supra* note 115, at 93.
121 *See, e.g.*, Grassian, *supra* note 38, at 1452; Haney, *supra* note 115, at 134.
122 *See* Haney, *supra* note 38, at 134; Miller & Young, *supra* note 115, at 89-91.
123 *See, e.g.*, Grassian, *supra* note 115, at 1452-53; Haney, *supra* note 38, at 133-34; Korn, *supra* note 115, at 15; Miller & Young, *supra* note 115, at 90.
124 *See, e.g.*, Grassian, *supra* note 110, at 1451-53; Haney, *supra* note 38, at 134; Korn, *supra* note 115, at 15.
125 *See, e.g.*, Grassian, *supra* note 110, at 1453; Haney, *supra* note 38, at 138-39.
126 *See, e.g.*, Grassian, *supra* note 115, at 1453
127 *See, e.g., id.*
128 *See* Haney, *supra* note 38, at 139.
129 *See, e.g., id.*
130 *See, e.g.*, Andersen et al., *supra* note 118, at 22; Haney, *supra* note 38, at 134; Korn, *supra* note 115, at 14-15.
131 *See, e.g.*, Grassian, *supra* note 115, at 1453.
132 *See, e.g., id.*; Haney, *supra* note 115, at 134.
133 Paul Gendreau, et al., *Changes in EEG Alpha Frequency and Evoked Response Latency During Solitary Confinement*, 79 J. OF ABNORMAL PSYCHOLOGY 54, 57-58 (1972).
134 *Id.*
135 REYES, *supra* note 112, at note 16.

.....
Fifty percent of
all prison suicides
occur in the 5
to 6 percent
of prisoners
in solitary
confinement.
.....

much higher for prisoners in solitary confinement. The suicide rate is disproportionately higher among prisoners in solitary confinement in contrast to general population.¹³⁶ Fifty percent¹³⁷ of all prison suicides occur in the 5 to 6 percent¹³⁸ of prisoners in solitary confinement.¹³⁹ It is not uncommon for prisoners suffering in solitary confinement to cut their flesh, smash their heads against walls, swallow razors or other objects, or try to hang themselves. In short, solitary confinement can significantly damage and worse, destroy a human.¹⁴⁰

Notably, in one study at a Supermax prison in California, a prominent national expert observed “extraordinary high rates of symptoms of psychological trauma,” in which more than 80 percent of prisoners suffered from anxiety, confused thinking, obsessive thoughts, and “over-sensitivity to stimuli, irrational anger, and social withdrawal.”¹⁴¹ The expert also reported that over half of the prisoners suffered from hallucinations and perceptual distortions,” “fear[ed] impending nervous breakdowns,” and reported “violent fantasies” and “emotional flatness.”¹⁴²

Nationally, it is estimated 37 percent of prison inmates and 44 percent of jail inmates reported being told by a mental health professional that they had a mental disorder.¹⁴³ Further, prisoners with a mental health problem are more likely than prisoners without a mental health problem to report they had spent time in solitary confinement.¹⁴⁴ The effects of isolation of prisoners with mental illness are often made worse because of insufficient treatment for their illnesses.¹⁴⁵ Many correctional

136 Alison Liebling, *Prison Suicide & Prisoner Coping*, 26 CRIME. & JUST. 283, 309 (1999).

137 Stuart Grassian & Terry Kupers, *The Colorado Study vs. the Reality of Supermax Confinement*, 13 CORR. MENTAL HEALTH REPORT 1, 11 (2011), available at <https://www.probono.net/prisoners/stopsol-reports/416638>.

138 ACLU, *Caged In: Solitary Confinement’s Devastating Harm on Prisoners with Physical Disabilities* (Jan. 2017) analyzing the ASCA/ Liman Time in Cell Report, which estimates approximately 80,000-100,000 prisoners are held in solitary confinement. See Time In Cell, *supra* note 13, at 3. Data on the total numbers of persons held in state and federal prisons in the United States (1,561,500) was taken from the 2014 Bureau of Justice Statistics Report. See Danielle Kaeble, et al., Correctional Populations in the United States, 2014 at 5, available at <http://www.bjs.gov/content/pub/pdf/cpus14.pdf>

139 See KUPERS, *supra* note 114; GRASSIAN & KUPERS, *supra* note 137); Heriberto G. Sánchez, *Suicide Prevention in Administrative Segregation Units: What Is Missing?*, 19 J. OF CORRECTIONAL HEALTH CARE 93, 95 (2013).

140 National Prison Project, ACLU Briefing Paper: The Dangerous Overuse of Solitary Confinement in the United States

141 Craig Haney & Mona Lynch, *Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement*, 23 N.Y.U. REV. OF L. & SOC. CHANGE 477, 524 (1997).

142 *Id.*

143 Allen J. Beck, et al., Bureau of Justice Statistics, Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-12 (2012). Available at <https://www.bjs.gov/content/pub/pdf/svpjri1112.pdf>.

144 *Id.*

145 Isolation units have been described as “virtual incubators of psychoses-seeding illness in otherwise

systems do not provide sufficient resources to hire enough qualified mental health professionals or provide programming or therapy that effectively treats mental illness within the entire prison system. Compounding the problem, prisoners with mental illnesses, often caused or exacerbated by their time in solitary confinement, simply cannot participate or successfully complete incentive based step down programs because they find it difficult to understand and follow the rules. In essence, they simply do not have the functionality to behave their way out of solitary confinement. Finally, even when some prisoners are released from solitary confinement medical research shows they may continue to suffer psychological damage “severe enough to cause near permanent mental and emotional damage.”¹⁴⁶

Generally, including in Virginia, mental health “treatment” in prison is administered solely in the form of psychotropic drugs. Mental health treatment in Supermax prisons, specifically solitary confinement housing units, is even worse because it cannot be administered appropriately to be effective. By design, these units require additional security measures so that prisoners almost never receive confidential sessions with a qualified mental health professional. “Treatment” generally takes place at the steel cell-door through a slot and can be overheard by correctional officers and other prisoners. Many prisoners are hesitant to appear vulnerable knowing that they may appear weak to others. Other prisoners may have simply given up because they know the prison will not provide anything more than drugs to manage symptoms of mental illness. At least one court stated: “[c]redible evidence indicates that Supermax is not appropriate for seriously mentally ill inmates because of the isolation resulting from the physical layout, the inadequate level of staffing and the customs and policies. Supermax was designed to house especially disruptive and recalcitrant prisoners but not mentally ill ones.”¹⁴⁷ This type of “treatment” is not appropriate or meaningfully effective to help prisoners with mental illnesses.

Additionally, correctional institutions that have implemented reforms at reducing or eliminating prisoners with mental illness in solitary confinement make distinctions between prisoners with

healthy inmates.” *Ruiz v. Johnson*, 37 F. Supp. 2d 855, 907 (S.D. Tex. 1999) *rev’d on other grounds*, 243 F.3d 941 (5th Cir. 2001), *adhered to on remand*, 154 F. Supp. 2d 975 (S.D. Tex. 2001)

146 Elizabeth Vasiliades, *Solitary Confinement & Int’l Human Rights: Why the U.S. Prison System*

Fails Global Standards, 21 AM. U. INT’L REV. 71, 76-77 (2005).

147 *Jones ‘El v. Berge*, 164 F. Supp. 2d 1096, 1118 (W.D. Wis. 2001).

mental illness and those with “serious” mental illness (SMI). There is no consensus definition of SMI and it varies across the states.¹⁴⁸ Generally, SMI is defined by AXIS I diagnoses under the Diagnostic and Statistical Manual Mental Disorders and includes, for example, schizophrenia, major depressive disorders, and bipolar disorder I and II.¹⁴⁹ Often excluded from SMI are Axis II diagnoses such as extreme anxiety, depression, and difficulties in cognition or impulse control. Because SMI can exclude a broad range of disorders, many prisoners because of their mental health status, will continue to decompensate in solitary confinement. The American Correctional Association’s (ACA) standards state that all prisoners in solitary confinement should be visited by mental health staff weekly and by health care staff daily.¹⁵⁰ The DOJ has recommended that prisoners with SMI should not be placed in solitary confinement.¹⁵¹

The effects of solitary confinement are psychologically damaging.¹⁵² Moreover, medical experts have well documented the physiological damage that “can occur after only a few days in solitary confinement and the health risks rise each additional day spent in such conditions.”¹⁵³ The harms can include: insomnia; headaches; lethargy; dizziness; heart palpitations; appetite loss; weight loss; severe digestive problems; diaphoresis; back pain, joint pain; deteriorated vision; shaking; chills; and aggravation of pre-existing medical problems.¹⁵⁴ Both psychological and physiological harms can be significantly damaging to all prisoners, but are exacerbated for prisoners with mental illness and those with physical disabilities. As the ACLU recently uncovered, for prisoners with physical disabilities held in solitary confinement even more harms are imposed and many are left to languish without adequate services and medical care they are entitled to

148 Association of State Correctional Administrators and The Arthur Liman Public Interest Program, Yale Law School, AIMING TO REDUCE TIME-IN-CELL: REPORTS FROM CORRECTIONAL SYSTEMS ON THE NUMBERS OF PRISONERS IN RESTRICTED HOUSING AND ON THE POTENTIAL OF POLICY CHANGES TO BRING ABOUT REFORMS, 48, (NOVEMBER 2016). See <https://www.law.yale.edu/system/files/area/center/liman/document/aiming-toreducetic.pdf>

149 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, (2013).

150 ACA Restrictive Housing Standards, American Correctional Association, 4-ALDF-RH-0029, (Approved Aug. 2016), available at http://www.aca.org/aca_prod_imis/docs/Standards%20And%20Accreditation/RHStandards2016.pdf

151 United States Department of Justice, Report and Recommendations Concerning the Use of Restrictive Housing, 99-101 (Jan. 2016), available at <https://www.justice.gov/dag/file/815551/download>.

152 Carnegie Fujio et al., Physicians for Human Rights, *Buried Alive: Solitary Confinement in the U.S. Detention System*, 1-2 (April 2013).

153 Expert Rep. of Juan E. Méndez, at 56, 62, *Ashker v. Governor of the State of Cal.*, No. 09-cv-5796 (N.D. Cal. Mar. 6, 2015) (citing Istanbul Statement).

154 FUJIO ET AL., *supra* note 152; GRASSIAN, *supra* note 115.

Solitary Confinement Exacerbates Mental Illness

Both psychological and physiological harms can be significantly damaging to all prisoners, but are exacerbated for prisoners with mental illness and those with physical disabilities.



under the law.¹⁵⁵

Mental Illness and Solitary Confinement in Virginia

The VDOC's policies do not exclude people with severe mental illnesses from being placed in solitary confinement, and there are people with SMI at Red Onion no who are not receiving treatment for their conditions. According to VDOC's website, 15 percent of its entire offender population requires some type of mental health services.¹⁵⁶ Recently though, VDOC reported that 26 percent of prisoners have mental health issues.¹⁵⁷ In 2015, the agency reported that 40 percent of prisoners in restricted housing across the state have mental health issues, but they do not separate the data by the distinct mental health codes prisoners are assigned.¹⁵⁸¹⁵⁹ Notably, in a comprehensive multi-part study conducted by the Association of State Correctional Administrators and the Arthur Liman Public Interest Law Program at Yale Law School, VDOC did not provide data about male prisoners with mental

155 ACLU, *Caged In: Solitary Confinement's Devastating Harm on Prisoners with Physical Disabilities* (Jan. 2017), available at https://www.aclu.org/sites/default/files/field_document/010916-aclu-solitarydisabilityreport-single.pdf.

156 <https://vadoc.virginia.gov/offenders/institutions/programs/mental-health.shtm>

157 Author's internal notes re: meeting with Virginia Department of Corrections and Advocates (October 26, 2016)

158 HOPE, *supra* note 12.

159 In 2014, the ACLU of Virginia, through the Freedom of Information Act, requested information about solitary confinement and mental health treatment. In response, VDOC said that it did not maintain records of the number of prisoners at Red Onion held in solitary confinement that have a mental health classification code, though it had previously provided some limited information in the same request.

illness.¹⁶⁰ Further, when asked to if and how VDOC defined “serious mental illness,” the response provided was, “VADOC uses mental health codes that indicate the level of functioning and not diagnoses—26% of VADOC’s total offender population maintain a mental health code.”¹⁶¹

VDOC reported that there are about 5,000 requests monthly for consultations with qualified mental health professionals (QMHP) and not enough staff to meet this demand and no individual psychotherapy is provided.

Additionally, there is no separate budget maintained by VDOC for mental health services as a result of how the agency does its cost accounting.¹⁶² Data that was provided indicates that VDOC spent about \$121,000 monthly in 2015 on psychotropic medications across the state and all security levels.¹⁶³ According to the agency, more than 22 percent of prisoners at ROSP and WRSP take psychotropic medications.¹⁶⁴ VDOC reported that there are about 5,000 requests monthly for consultations with qualified mental health professionals (QMHP) and not enough staff to meet this demand and no individual psychotherapy is provided.¹⁶⁵ In contrast to prisoners’ reports, VDOC stated that prisoners can meet privately with a QMHP and an intake with the psychiatrist takes 20-45 minutes with follow-up visits at 15 minutes.¹⁶⁶ In a separate document, VDOC states that prisoners at ROSP and WRSP conducts both group and individual sessions with QMHPs and that generally, requests are responded to within a week.¹⁶⁷

In describing the evidence-based practices plan for administrative segregation at ROSP and WRSP in 2012, VDOC stated: “Although offenders in Administrative Segregation are managed with high security controls, they always have access to basic services and programs including mental health and medical evaluation and care...”¹⁶⁸ On the contrary, VDOC operating procedure states that QMHPs may not available at all institutions and in those instances, “selected officers receive training to conduct

160 Association of State Correctional Administrators and The Arthur Liman Public Interest Program, Yale Law School, AIMING TO REDUCE TIME-IN-CELL: REPORTS FROM CORRECTIONAL SYSTEMS ON THE NUMBERS OF PRISONERS IN RESTRICTED HOUSING AND ON THE POTENTIAL OF POLICY CHANGES TO BRING ABOUT REFORMS, 48-50, (NOVEMBER 2016). See <https://www.law.yale.edu/system/files/area/center/liman/document/aiming-toreducetic.pdf>

161

Id.

162 HOPE, *supra* note 12.

163

Id.

164

Id.

165 Author’s internal notes re: meeting with Virginia Department of Corrections and Advocates (October 26, 2016)

166 HOPE, *supra* note 12.

167

Id.

168 “Evidence Based Practices Plan for Administrative Segregation at Red Onion and Wallens Ridge State Prisons,” Handout obtained by author from VDOC on 12/19/2012 (?). VDOC also stated: “The prison has operated constitutionally, protected the eighth amendment rights of offenders, and is accredited by the American Correctional Association.”

mental health screening of offenders.”¹⁶⁹ VDOC policy defines a “qualified mental health professional” as: “an individual employee in a designated mental health services position as a Psychology or Psychology Associate, Psychiatrist, Social Worker (Masters level) or Registered Nurse or individual with at least a Master[’s] degree in psychology, social work, or relevant human services field with knowledge, training, and skills in the diagnosis and treatment of mental disorders.”¹⁷⁰ The policy does not describe the training that “selected officers” receive to perform mental health screens. The attrition rate for QMHPs in FY14 was 17.54 percent, while in FY15 was already at 19.41 percent.¹⁷¹

In 2015, when asked how many more mental health professionals it would take to fully meet the treatment needs of prisoners including the cost, VDOC stated that the current ratio of 1 QMPH to 250 prisoners was insufficient.¹⁷² Further, to add one QMPH per facility and a mental health unit would cost \$1,519,000 annually for salaries, not including other costs such as additional staffing, part-time consultants, and stipends for sex offender treatment providers.¹⁷³ In October 2016, the ACLU of Virginia asked VDOC if there were plans to increase mental health treatment services or diversion plans, especially in consideration of lawsuits ruling that keeping prisoners suffering with mental illness in solitary confinement was unconstitutional. VDOC stated there were no plans and that their budget had been cut by \$16 million dollars.¹⁷⁴ Since 2011 until present-day, VDOC has not implemented a plan to improve mental health services at ROSP and WRSP, or announced any future reform efforts to divert mentally-ill prisoners out of solitary confinement.

Prisoners’ accounts contradict the ability of those in solitary confinement to obtain appropriate mental health treatment. Prisoners in solitary confinement, diagnosed with a range of disorders such bipolar disorder, post-traumatic stress disorder as a result of abuse, manic depression, schizophrenia, report that mental health treatment consists solely of the administration of psychotropic drugs and that it is difficult to see a psychiatrist or any other QMHP. Visits from QMHPs seem to be sporadic

169 Virginia Department of Corrections, Operating Procedure 730.4, “Mental Health Services: Offenders “At Risk” in Special Housing.”

170 *Id.*

171 Email and attachment from Delegate Patrick A. Hope to ACLU of Virginia, *Response from Virginia DOC to questions re: segregation* (June 20, 2015).

172 *Id.*

173 *Id.*

174 Meeting with Virginia Department of Corrections, October 26, 2016.

despite VDOC policy. For prisoners who are able to see a psychiatrist, visits are usually conducted through a cell's steel door and without confidentiality. At times, correctional guards have laughed prisoners' discussions and threatened to disclose the contents of the visit. Prisoners report that they often feel that QMHPs do not take their symptoms seriously or believe they are faking them. There seems to be no individual or group therapy to help manage symptoms of mental illness. Yet, VDOC has no policy excluding mentally ill people from solitary confinement despite the weight of evidence and the law.

Requests to see qualified mental health professionals, specifically, a psychiatrist, are often left unanswered or take weeks, even months to respond to a prisoner's plea for help.

Tragically, some prisoners have harmed themselves by cutting themselves, swallowing razors, inserting objects into genitalia, or have attempted suicide. Common symptoms as a result of untreated mental illness at ROSP and WRSP: smearing feces on cell walls; hallucinations; paranoia; anxiety; nightmares; depression; and thoughts of suicide. Requests to see QMHPs, specifically, a psychiatrist, are often left unanswered or take weeks, even months to respond to a prisoner's plea for help. Some prisoners told advocates about instances of excessive force and abuse when attempting to seek help for symptoms of mental illness.

Inhumane and Unconstitutional

Solitary confinement causes and exacerbates mental illness and violates the U.S. Constitution's Eighth Amendment ban on cruel and unusual punishment, in addition to international standards. For prisoners with pre-existing mental illness, solitary confinement often causes significant and rapid deterioration. As previously discussed, prisoners without pre-existing mental illness can develop symptoms once isolated. The effects of solitary confinement on prisoners with serious mental illness are so devastating that nearly every federal court to consider the question of whether placing the severely mentally ill in such conditions is cruel and unusual punishment has found a constitutional violation.¹⁷⁵ Recently, as a result of increasing

¹⁷⁵ See, e.g., *T.R. et al. v. South Carolina Dep't of Corrections*, C/A No. 2005-CP-40-2925 (S.C. Ct. Comm. Pleas 5th J. Cir. Jan. 8, 2014) (finding major deficiencies in the DOC's treatment of prisoners with mental illness, including solitary confinement, and ordering defendants to submit a remedial plan); *Ind. Protect. & Advocacy Servs. Comm'n v. Comm'r*, 2012 WL 6738517 (S.D. Ind., Dec. 31, 2012) (holding that the Indiana DOC's practice of placing prisoners with serious mental illness in solitary confinement constituted cruel and unusual treatment in violation of the Eighth Amendment); *Jones 'El v. Berge*, 164 F. Supp. 2d 1096, 1101-02 (W.D. Wis. 2001) (granting a preliminary injunction requiring the removal of prisoners with serious mental illness from "Supermax" custody); *Ruiz v. Johnson*, 37 F. Supp. 2d 855, 915 (S.D. Tex. 1999), rev'd on other grounds, 243 F.3d 941 (5th Cir. 2001), adhered to on remand, 154 F.

Solitary Confinement is Torture

The effects of solitary confinement on prisoners with serious mental illness are so devastating that nearly every federal court to consider the question of whether placing the severely mentally ill in such conditions is cruel and unusual punishment has found a constitutional violation.



PHOTO: FELTON DAVIS/FICKR

litigation, more states have announced that they will exclude mentally ill prisoners from solitary confinement.¹⁷⁶

Several major health organizations have issued formal policy statements that oppose solitary confinement for prisoners with mental illnesses, including the National Commission on Correctional Care, the American Psychiatric Association, Mental Health America, the American Public Health Association, the National Alliance on Mental Illness, and the Society of Correctional Physicians.¹⁷⁷

Supp. 2d 975 (S.D. Tex. 2001) (“Conditions in TDCJ-ID’s administrative segregation units clearly violate constitutional standards when imposed on the subgroup of the plaintiffs’ class made up of mentally-ill prisoners”); *Coleman v. Wilson*, 912 F. Supp. 1282, 1320-21 (E.D. Cal. 1995) (finding that the California Department of Corrections and Rehabilitation was in violation of the Eighth Amendment due to system wide failure to provide adequate mental health care, and due to the deliberate indifference of prison officials to the needs of prisoners with mental illness); *Madrid v. Gomez*, 889 F. Supp. 1146, 1265-66 (N.D. Cal. 1995) (holding keeping prisoners with mental illness or those at a high risk for suffering injury to mental health in Pelican Bay isolation unit unconstitutional); *Casey v. Lewis*, 834 F. Supp. 1569, 1549-50 (D. Ariz. 1993) (condemning placement and retention of prisoners with mental illness on lockdown); *H.B. v. Lewis*, 803 F. Supp. 246, 257 (D. Ariz. 1992) (finding Eighth Amendment violation in part because of the lack of an adequate system for referring prisoners with behavioral problems to psychiatric staff); *Langley v. Coughlin*, 715 F. Supp. 522, 540 (S.D.N.Y. 1988) (holding that evidence of prison officials’ failure to screen out from SHU “those individuals who, by virtue of their mental condition, are likely to be severely and adversely affected by placement there” states an Eighth Amendment claim).

¹⁷⁶ Citation to Illinois and Oregon’s announcements/litigation efforts.

¹⁷⁷ See, e.g., National Commission on Correctional Health Care, Solitary Confinement (Isolation) (2016), available at <http://www.ncchc.org/solitary-confinement>; The National Alliance on Mental Illness, Public Policy Platform, available at https://www.nami.org/NAMI/media/NAMI-Media/downloads/Public-Policy-Platform_9-22-14.pdf; American Public Health Association, Solitary Confinement as a Public Health Issue (2013), available at <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/14/13/30/solitary-confinement-as-a-public-health-issue>; Society of Correctional Physicians, Position Statement, Restricted Housing of Mentally Ill Inmates (2013), available

As previously discussed, states, however, have only banned prisoners with SMI, with varying definitions, so that does not include everyone with a mental illness and sometimes excludes those with developmental or cognitive disabilities.

Prisoners housed in solitary confinement are more likely to be victims of excessive force and abuses of power as well.¹⁷⁸ By facility design, prisoners in solitary confinement are isolated from other prisoners which makes it more difficult to detect abuse.¹⁷⁹ Isolation is even worse in a Supermax facility designed for isolation. Not until 2012 did ROSP reconfigure the facility to incorporate a small general population as a part of its Step Down Program. The remote geographical location of Red Onion State Prison exacerbates the risk of abuse and lack of oversight to the extreme. ROSP is not easily accessible to VDOC's headquarters, other state agencies, family members, and independent medical professionals and advocacy organizations who are better equipped to provide appropriate oversight and accountability.

A few states such as Colorado, a longtime leader in reducing reliance on solitary confinement, have banned placing prisoners with serious mental illness in solitary confinement through state law.¹⁸⁰ Colorado's law also provided critical funding to improve mental health treatment and services, reforms that were initiated by their Department of Corrections.¹⁸¹ In January 2016, Oregon agreed to stop placing prisoners with serious mental illness in such isolating conditions not wanting to submit to protracted litigation like other states.¹⁸² In 2015, the governor of Massachusetts signed into law Chapter 446, An Act Relative to the Treatment of Mentally Ill in Prisons, which screens inmates with mental health problems and prevents them from being placed in long-term solitary confinement.¹⁸³ Pursuant to a September 1, 2016 settlement, Delaware agreed to significantly limit the use of certain inmates in solitary confinement and increase out-of-cell time for all inmates still held in solitary confinement.¹⁸⁴ Indiana has entered into an agreement to limit solitary confinement,

at <http://societyofcorrectionalphysicians.org/resources/position-statements/restricted-housing-of-mentally-ill-inmates>; American Psychiatric Association, Position Statement on Segregation of Prisoners with Mental Illness (2013), available at http://www.dhcs.ca.gov/services/MH/Documents/2013_04_AC_06c_APA_ps2012_rizSeg.pdf; Mental Health America, Policy Position Statement 24: Seclusion and Restraints (2015), <http://www.nmha.org/positions/seclusion-restraints>.

178 KURKI & MORRIS, *supra* note 2, at 409.

179 ISAACS & LOWEN, *supra* note 3, at 16.

180 Colo. Rev. Stat. § 17-1-113.8 et al.

181 Colo. Rev. Stat. § 17-1-113.8 et al.; *See also*, <http://aclu-co.org/campaigns/stop-solitary/>

182 Memorandum of Understanding between the Oregon Department of Corrections (DOC) and Disability Rights Oregon (effective January 8, 2016), available at <https://droregon.org/wp-content/uploads/DRO-DOC-MOU-2016.pdf>

183 <https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter446>

184 *Community Legal Aid Society, Inc. v. Coupe* (Case 1:15-cv-00688-GMS) (USDC D. Del) (Sept. 1, 2016) available at <https://aclu-de.org/wp-content/uploads/2016/09/CLASI-v-Coupe-Agreement-and-Order-09-02-2016.pdf>.

although the terms of that settlement have not been disclosed.¹⁸⁵ As previously discussed, however, states have only banned prisoners with SMI, with varying definitions, so that does not include everyone with a mental illness and sometimes excludes those with developmental or cognitive disabilities.

Costly, Ineffective, & Less Safe

Effective prison management and safety are legitimate penological interests, however, solitary confinement is not conducive to accomplishing those goals and is costly to taxpayers. The cost of building Supermax prisons for restrictive housing are two to three times more than conventional prisons.¹⁸⁶ It costs immensely more dollars to keep a prisoner in restrictive housing than general population. Nationally, it's estimated that it costs \$75,000 per prisoner in solitary confinement.¹⁸⁷ Despite the high cost, there is scant evidence that shows that solitary confinement makes prisons safer and may actually result in less public safety.¹⁸⁸

Prison officials who rely on solitary confinement housing units, especially in Supermax prisons, for management usually argue that it is necessary to restrict the “worst of the worst” offenders to create order and safer conditions within the prison.¹⁸⁹ There is very little evidence to support this argument. Another commonly used argument is that solitary confinement is a deterrent to bad behavior and encourages prisoners to obey the rules.¹⁹⁰ Contrary to these arguments, research shows that levels of violence in prisons may have more to do with how prisoners are treated and staffed, rather than the mere presence than “super violent” prisoners.¹⁹¹ In reality, solitary confinement creates less safe conditions because it isolates people, thereby exacerbating many problems such incidents of violence and symptoms of mental illness, instead of treating and rehabilitating, one of the goals of the criminal justice system.

In Virginia, it is expected that 90 percent of prisoners will return to society.¹⁹² Despite Virginia's touted low recidivism

185 *Indiana Protection and Advocacy Services Commission, et al., v. Commissioner, Indiana Department of Correction* (Case 1:08-cv-01317-TWP-MJD) (USDC S.D. Ind.) (Jan. 27, 2016).

186 MEARS, *supra* note 13, at ii.

187 RODRIGUEZ, *supra* note 14.

188 REITER, *supra* note 15, at 47-51; O'KEEFE, *supra* note 15.

189 KURKI & MORRIS, *supra* note 2, at 391.

190 *Id.*

191 *Id.*

192 Virginia Department of Corrections, Press Release: “Few Offenders Remain in Restrictive

Prisoners harmed by solitary confinement, especially those not receiving appropriate mental health treatment or reentry programming, cannot successfully reenter into society.

rates,¹⁹³ the effects of prolonged extreme isolation of prisoners returning to society undoubtedly poses serious risks and problems. Prisoners harmed by solitary confinement, especially those not receiving appropriate mental health treatment or reentry programming, cannot successfully reenter into society. Prisoners held in long term isolation come out of prison with diminished social and life skills.¹⁹⁴ A psychiatric study found that conditions of solitary confinement may “severely impair... the inmate’s capacity to reintegrate into the community upon release from imprisonment.”¹⁹⁵ This makes the public safe and inevitably will lead to higher recidivism rates. The mere fact is that solitary confinement is overused, and for more than fifteen days in duration,¹⁹⁶ can irreparably harm a human and makes the public less safe calls into question its validity as a correctional management tool.¹⁹⁷

In 2011, VDOC did not know how many prisoners were released directly from solitary confinement to the public, but by 2015 the agency reported that between 50-58 prisoners had been directly released to the community from solitary confinement in 2011, while only 2 prisoners were direct release in 2015.¹⁹⁸ While efforts have been made in Virginia to transition prisoners from solitary confinement before returning to the community, there are still reports of individuals being directly released from solitary confinement.

Lack of Transparency and Oversight

There are no laws governing the way solitary confinement is used in the Virginia prison system, nor any laws that require

Housing in Virginia Prisons: Virginia Continues Program Recognized for Transforming Highest Security Prisons” (September 9, 2015). See https://vadoc.virginia.gov/news/press-releases/15Sep9_StepDown_shtm

193 <http://governor.virginia.gov/media/8167/state-recidivism-comparison-12-16.pdf>

194 REITER, *supra* note 15, at 47-51

195 Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 J. L. & POL’Y 325, 333 (prepared from a statement given to the Commission on Safety and Abuse in America’s Prisons) (2006).

196 United Nations Standard Minimum Rules for Treatment of Prisoners (the Nelson Mandela Rules), G.A. Res. 70/175, Rule 44 (Dec. 17, 2015). (Summarizing: Periods of isolation lasting 15 days or more is prolonged solitary confinement shall be used only in exceptional cases as a last resort, for as short a time as possible and must not be imposed by virtue of a prisoner’s sentence. The Rules prohibit solitary confinement for prisoners with mental illness or physical disabilities.)

197 ACLU, *Briefing Paper: The Dangerous Overuse of Solitary Confinement in the United States*, 9-11 (Aug. 2014), available at https://www.aclu.org/sites/default/files/assets/stop_solitary_briefing_paper_updated_august_2014.pdf

198 Virginia Department of Corrections, Press Release: “Few Offenders Remain in Restrictive Housing in Virginia Prisons: Virginia Continues Program Recognized for Transforming Highest Security Prisons” (September 9, 2015). See https://vadoc.virginia.gov/news/press-releases/15Sep9_StepDown_shtm

**Wallens Ridge State Prison,
Big Stone Gap, Va.**

The cost of building supermax prisons for restrictive housing are two to three times more than conventional prisons. It costs immensely more dollars to keep a prisoner in restrictive housing than general population. Nationally, it's estimated that it costs \$75,000 per prisoner in solitary confinement. Despite the high cost, there is scant evidence that shows that solitary confinement makes prisons safer and may actually result in less public safety.



PHOTO: DOM BRASSEY/Flickr

correctional officials to collect and report data on how it is used. Without such requirements, it is difficult to gather information and accurately assess the status of solitary confinement in the state. In 2012, legislation was introduced that would have authorized the state to study how solitary confinement is used in Virginia, and noted that it was unknown how many prisoners with mental illness were being housed indefinitely in solitary confinement.¹⁹⁹ The legislation would have required the Virginia State Crime Commission, a government body charged with study criminal justice issues, to provide an analysis of the use of solitary confinement and other forms of solitary confinement used by VDOC, along with the tax payer costs and the impact on prisoners. The legislation also would have required studying if limiting solitary confinement was feasible and how safety within prisons would have any impact. The legislation unanimously passed the Senate, but failed in a subcommittee of the House of Delegates.²⁰⁰ Legislators deferred to correctional officials' claims that they did not place prisoners in solitary confinement.²⁰¹

199 See <http://lis.virginia.gov/cgi-bin/legp604.exe?121+sum+SJ93>; <http://lis.virginia.gov/cgi-bin/legp604.exe?121+sum+HJ126>

200 *Id.*

201 Virginia does not have legislative history and the author is relying on internal notes and recollection.

Since 2012, no legislation has been introduced in Virginia that would provide for data collection and reporting, and that would limit the use of solitary confinement of prisoners, including those suffering from mental illness.

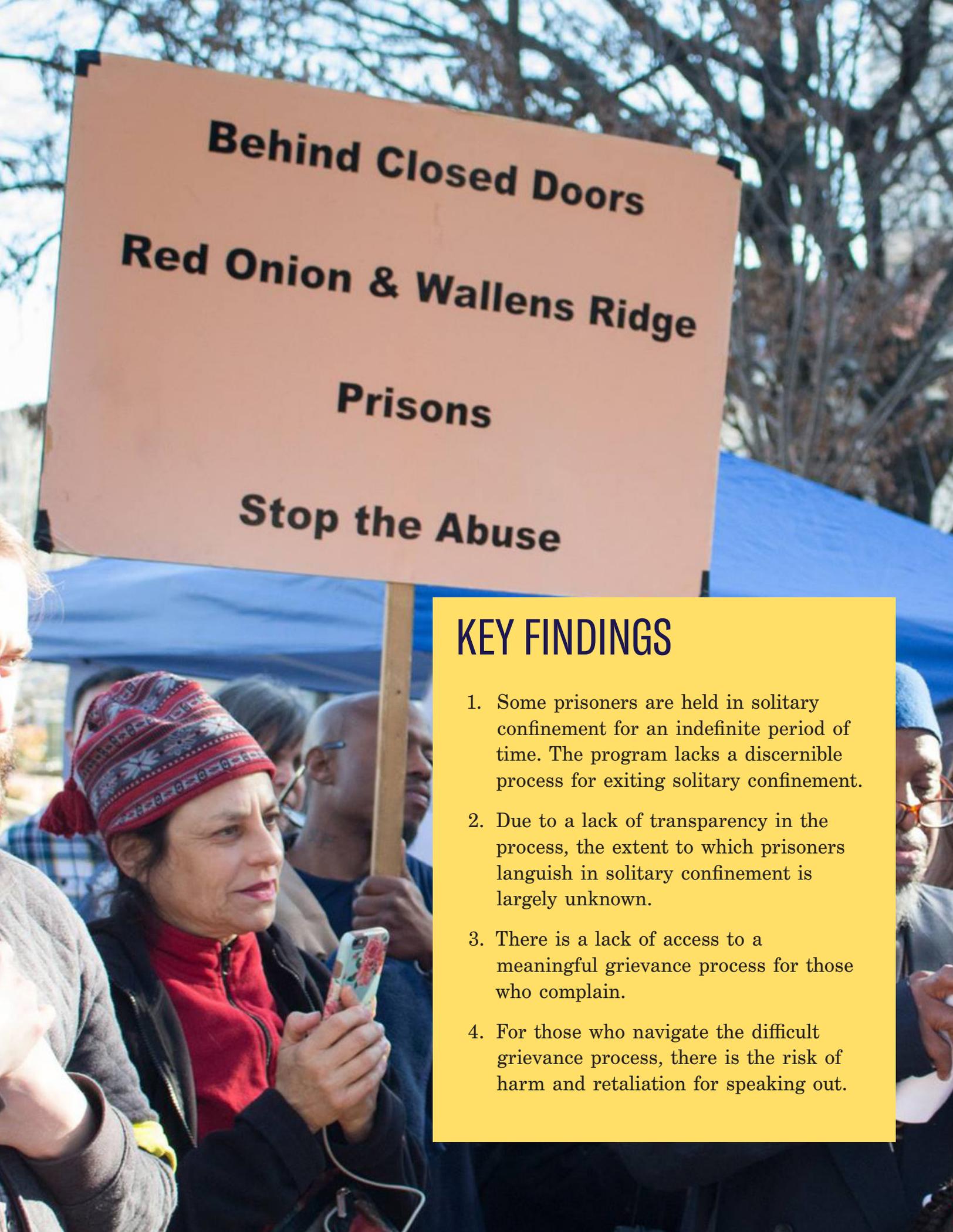
Across the nation, legislators defer to correctional officials when they claim that they do not use “solitary confinement.” This tactic is becoming less common because of extensive public education efforts, lawsuits, and legislative reforms of solitary confinement, including the various terms associated with the conditions of isolation. Since 2012, no legislation has been introduced in Virginia that would provide for data collection and reporting, and that would limit the use of solitary confinement of prisoners, including those suffering from mental illness. Had the 2012 legislation been enacted into law, Virginia would have been at the forefront of studying the issues and providing for recommendations to reduce its reliance.

In short, the status of solitary confinement in Virginia’s prisons, those suffering from mental illnesses, should not be relegated to press releases issued by VDOC and rare meetings with advocates or interested legislators.

The principles and recommendations set forth are in-part modeled after the DOJ’s report concerning the use of restrictive housing with a particularized focus on Virginia’s specific problems and needs to address them.²⁰² VDOC should look to their accrediting association, the ACA, to provide informed recommendations to reduce solitary confinement. However, it should also incorporate standards set forth by the plethora of various national and international organizations to provide guidance on how to reduce the use of solitary confinement²⁰³ and provide meaningful and effective mental health treatment to prisoners. Importantly, VDOC should be transparent and work in good faith with the Vera Institute of Justice to formulate and implement effective reforms to end the use of solitary confinement.

202 U.S. Department of Justice: Report and Recommendations Concerning the Use of Restrictive Housing 93 (January 2016). See <https://www.justice.gov/dag/file/815551/download>

203 National Commission on Correctional Health Care, Position Statement: Solitary Confinement, 2 (Apr. 2016): in recognition of the direct link between solitary confinement and the harms it causes: “the inherent restriction in meaningful social interaction and environmental stimulation and the lack of control *adversely impact the health and welfare of all who are held in solitary confinement.*” (emphasis added).

A woman wearing a red patterned beanie and a red jacket is looking at her smartphone. She is part of a group of people at an outdoor protest. In the background, a large sign is visible, and a blue tent is partially seen. The scene is outdoors with trees in the distance.

Behind Closed Doors
Red Onion & Wallens Ridge
Prisons
Stop the Abuse

KEY FINDINGS

1. Some prisoners are held in solitary confinement for an indefinite period of time. The program lacks a discernible process for exiting solitary confinement.
2. Due to a lack of transparency in the process, the extent to which prisoners languish in solitary confinement is largely unknown.
3. There is a lack of access to a meaningful grievance process for those who complain.
4. For those who navigate the difficult grievance process, there is the risk of harm and retaliation for speaking out.

Principles and Recommendations for Reform

.....

The VDOC should also incorporate standards set forth by the plethora of various national and international organizations to provide guidance on how to reduce the use of solitary confinement and how to provide meaningful and effective mental health treatment to prisoners.

.....

1. **Solitary confinement should be limited to no more than 15 days** in accordance with the international human rights standards set forth in the “Nelson Mandela Rules.”
2. **Solitary confinement must only be used in rare and exceptional cases**, for the shortest duration, with the least restrictive setting necessary and only when the prisoner poses a credible continuing and serious threat to the security of others[.]”²⁰⁴ When solitary confinement is used, prisoners should be housed in the least restrictive setting necessary to ensure their own safety, as well as the safety of staff, other prisoners, and the public. All placements should be independently evaluated within 48 hours and less restrictive alternatives are not available.
 - VDOC should be fully transparent and work in good faith with the Vera Institute of Justice to identify ways to reduce solitary confinement and actively implement recommendations.
3. **Solitary confinement should be banned for prisoners with mental illness and disabilities**, but also for youth, pregnant women, and persons with physical disabilities. Virginia should increase funding to provide meaningful and effective treatment for vulnerable prisoners.
 - For example: The BOP is expanding “secure mental health

204 ABA Standards for Criminal Justice (Third Edition) Treatment of Prisoners, Rule 23.2.9., available at http://www.americanbar.org/content/dam/aba/publications/criminal_justice_standards/Treatment_of_Prisoners.authcheckdam.pdf

units” for federal prisoners with serious mental illness who cannot function in general population, and hiring additional psychologists to provide mental health treatment to prisoners who require restrictive housing.²⁰⁵ Additionally, the President has provided for an additional \$24 million to support mental health services in the proposed FY 2017 budget.²⁰⁶

4. **Solitary confinement should always serve a specific penological objective** and be supported with specific and concrete justifications that are supported by objective evidence. VDOC should use solitary confinement only in authorized circumstances and correctional officials should clearly articulate specific reasons(s) for housing a prisoner in solitary confinement.
5. **A prisoner’s initial and continual placement in solitary confinement should be regularly reviewed** by a multi-disciplinary team, including correctional leadership. The current 90-day interval for evaluating continued placement should be shortened to meet the international human rights standard. At the very least such evaluation should take place weekly.
6. **Every prisoner housed in solitary confinement should be provided written reasons for the initial placement**, including reasons for continued solitary confinement. Correctional staff should develop a written plan with explicit objective goals for the prisoner to return to less restrictive conditions as promptly as possible. Unless the safety of the prisoner or others is compromised, the plan should be shared with the prisoner. The prisoner should be informed and provided with a meaningful opportunity to challenge placement in solitary confinement in a formal appeal process.
 - Communication should improve between VDOC, prisoners, and their families about VDOC’s reform efforts and that prisoner’s plan to move out of solitary confinement. Clear written expectations and objective benchmarks should be communicated and fully explained to the prisoner. The Step Down Program should not be an endless, arbitrary maze resulting in permanent isolation.

205 Fact Sheet: Department of Justice Review of Solitary Confinement (Jan. 25, 2016). See <https://www.whitehouse.gov/the-press-office/2016/01/25/fact-sheet-department-justice-review-solitary-confinement>

206 *Id.*

- IM prisoners should not be placed in solitary confinement permanently despite participating in the Step Down Program. VDOC should develop reforms to reduce or eliminate the permanent isolation of the IM track. This should include incorporation of the Colorado model which provides that if a prisoner cannot be returned to general population after 15 days they will be housed in a solitary confinement unit with a minimum of four hours of out-of-cell time each day, as well as being offered meaningful programs and activities. IM prisoners should be fully informed and given the opportunity to challenge their placement in this program track. VDOC should increase out-of-cell time for IM prisoners, in addition to increased privileges.

Solitary confinement as punishment, especially for low-level infractions or as a default disciplinary sanction, should be banned.

7. Solitary confinement must not be used as punishment for low-level infractions or as a default disciplinary sanction.

When disciplinary segregation is used, the maximum amount of time a prisoner spends in solitary confinement should be limited to the least amount of time possible and no longer than 15 days. Daily checks should be made to monitor all prisoner's physical and mental health who are housed in any form of isolated confinement – regardless of the reason an individual is placed there. Additionally, documentation should accurately reflect the time spent in solitary confinement and a copy given to the prisoner. A prisoner in disciplinary segregation should be fully informed of due process rights to challenge the placement and given the opportunity to attend all reviews and hearings. At all times, a prisoner should be fully informed about the placement and explanation provided for the status.

8. Wardens should expand out-of-cell time. Not only is increased out-of-cell time essential to mental health and social interaction, it allows for greater opportunities for rehabilitation and reentry services. Prisoners must be given a break from social isolation through increased access to phone calls, visits from friends and family, and closed-circuit television rehabilitative programming. Some prisons have also worked out ways to allow safe, regular, and meaningful human contact with custody and clinical staff as well as other prisoners. Training staff to engage with these prisoners in a positive and constructive manner is crucial.

9. VDOC should limit releasing people in solitary confinement directly to the community. VDOC has developed and implemented reentry housing pods and programming, however, greater accountability and consistency is necessary to ensure

that no prisoner is directly released to the community without receiving these vital services for successful reintegration.

10. VDOC should increase transparency and accountability.

Legislators should mandate that VDOC collect data and report the status of segregation and reform outcomes, including taxpayer expenditures on solitary confinement, programming, and health services. VDOC must publish monthly system-wide solitary confinement data on its website, including information that shows the status and effectiveness of the Step Down Program and any other efforts to reduce solitary confinement. A carefully crafted reporting bill will ask for a multi-faceted breakdown of the population, as well as for important statistical information such as the average and median lengths of stay in solitary confinement, the number of incidents of self-harm, and attempts at self-harm, the number of inmates released from solitary confinement directly into the community during the preceding year, and will ask for any changes to written policies and procedures at each correctional facility relating to the use and conditions of restrictive housing. Further:

- VDOC should make publicly available all policies related to its efforts to reduce solitary confinement. VDOC should publish an annual report on the status of restrictive housing in Virginia’s prison system, which includes outcome data on the effectiveness of its efforts, and issue recommendations for improvement.
- VDOC should also publish data and information, including expenditures, on mental health services provided to prisoners.

11. All correctional staff should be regularly trained on restrictive housing policies and appropriate ways to manage and interact with prisoners.

VDOC should ensure that compliance with these policies is reflected in employee-evaluation systems. Correctional staff that violate these policies should not be charged with ensuring the safety of prisoners and the public.

- VDOC should fully investigate the pervasive problems about lack of access to the grievance procedure at ROSP and WRSP and implement effective solutions so that prisoners have an effective mechanism to address issues without fear for their safety.

12. VDOC should ensure a full, independent investigation

when reports of physical and/or sexual assault are made by prisoners. VDOC should take all legal actions necessary and ensure that correctional officers who physically or sexually assault prisoners are criminally prosecuted in accordance with the law.

13. The governor should mandate an independent investigation of the grievance program at Red Onion and ensure that recommendations from that investigation are implemented and overseen. Alternatively, setting up an independent Ombudsman appointed by the governor with full authority to receive, investigate and oversee implementation of changes to policy and practice is an option.

14. VDOC should establish a visitation program to help prisoners deal with the isolation of Red Onion from prisoners' families and communities, to include providing bus fare and housing for every prisoner's visitors who live more than 100 miles away on a quarterly basis.

CONCLUSION

Solitary confinement remains overused in Virginia and is largely still hidden from the public's watchful eyes. The reforms implemented since 2011 are a step forward to reduce its reliance, but there is a vital need for transparency, accountability, and more effective ways to stop using solitary confinement, especially on vulnerable populations like those suffering with mental illnesses. Without further reforms, Virginia is inflicting inhumane harms on individuals and at a great financial cost without the benefit of increased public safety. The ACLU of Virginia believes that the collaboration between the Vera Institute of Justice and VDOC to identify problems and to implement effective, meaningful reforms at all levels of the correctional system is a step in the right direction. But more rigorous protections and oversight is needed to ensure that solitary confinement is not abused and overused in Virginia. Moreover, law, policy and practice in the State are needed to eliminate the practice of placing vulnerable individuals with mental illness in solitary confinement.

Placing people with

MENTAL ILLNESS

in

SOLITARY

is like putting an

ASTHMATIC

in a place with

LITTLE AIR

Join U
NYC D
January 3
call in. Call-in:
and strategize it
Stay Connected. We
@nycaic (hashtag #)

Glossary of Key Words Used in this Report

BELOW ARE A LIST OF TERMS USED THROUGHOUT THIS REPORT:

Correctional officer – Correctional officers are the personnel responsible for securing prisoners. The term is synonymous with prison guard, but correctional officer is the preferred term.

General Population – In most prisons, general population refers to the majority of prisoners who have contact with other prisoners, correctional officers, and other people. Ideally, general population prisoners may take classes, volunteer, and socialize outside of their cells, although conditions vary widely. At Red Onion and Wallens Ridge, only a minority of prisoners are held in general population, conditions are highly restrictive, and prisoners are still confined to individual cells the majority of the time.

Grievance – A grievance is a mechanism for a prisoner to seek administrative relief for any complaint. Inmates must file grievances with VDOC and exhaust all administrative remedies before they may seek relief from a court for the conditions of their confinement. Unfortunately, grievances can prompt retaliation from correctional officers, including the assignment of the grieving prisoner to solitary.

Institutional Classification Authority – The institutional classification authority is a prison-level staff person with the authority to conduct offender level review hearings of security level.

Intensive Management (IM) – VDOC classifies IM prisoners as individuals with the potential for extreme and deadly violence, defined by a history of willingness to carry out serious or deadly harm or as a result of institutional charges with intent to serious harm or kill, or offenders with a high escape risk or because of the offender’s high profile or notorious crime. IM classified prisoners have no path out of solitary confinement. As of August 2016, 84 prisoners are held in IM.

- See also special management (SM)

Program Chairs – Program chairs are desks where inmates are physically restrained to watch videos that constitute the “programming” to help prisoners in solitary advance through the step-down process. At no time are prisoners given actual help by human beings, except for brief, usually non-confidential discussions with some sort of mental-health professional.

- See also therapeutic modules

Qualified Mental Health Professionals (QMHP) – QMHPs are VDOC employees who have at least a Master’s degree in psychology, psychiatry, social work, including Registered Nurses. QMHPs rarely offer any form of confidential therapy; most treatment involves quickly prescribing psychotropic medication to control symptoms of mental illness.

Severe Mental Illness (SMI) – There is no universal definition of SMI, but generally it refers to people with AXIS I diagnoses, including schizophrenia, major depressive disorders, and bipolar disorder. AXIS 2 diagnoses, including extreme anxiety, depression, and difficulties in cognition or mental control – the type of illnesses often caused by solitary confinement – are excluded.

Special Management (SM) – Special management prisoners are prisoners held in solitary for a variety of reasons, often related to behavioral violations caused by mental health issues. SM prisoners are held at Red Onion State Prison. With good behavior and completing training while shackled to a chair or confined in a cage, it can be possible to advance into the Red

Onion's general population in 18-24 months.

Solitary Confinement – Solitary confinement is the isolation of a person in a cell for approximately 22 to 24 hours a day with little human contact or interaction; reduced or no natural light; restriction or denial of reading material, television, radios or other property; severe constraints on visitation; and the inability to participate in group activities, including eating with others. Cells used for solitary are intentionally designed “to minimize human contact and environmental stimulation.” Solitary confinement has many euphemisms, but its defining characteristics remain the same: extreme isolation for weeks or months, sometimes years, in an 80 square foot cell with a bunk, toilet, and sink, with no or little access to see outside their cell, devoid of any meaningful human contact or social interaction.²⁰⁷

Examples of solitary confinement include the following:

- *Disciplinary segregation* – When VDOC uses solitary confinement as a punishment, it is referred to as disciplinary segregation. This is in contrast to other uses of solitary, such as isolating vulnerable LBGTQIA prisoners or temporarily holding an inmate in isolation pending a hearing.
- *Protective custody* – Protective custody is a term for using solitary confinement as a means to protect a vulnerable prisoner from other inmates rather than as a punishment. Prisoners can request protective custody if they feel threatened; it is also used as a default to protect vulnerable prisoners, principally LBGTQIA prisoners, and former police and correctional officers sentenced to prison. Given the damaging effects of solitary confinement for any reasons, the ACLU advocates other means to protect vulnerable prisoners.
- *Restrictive Housing* – Restrictive Housing is the general term for solitary in the Virginia prison

²⁰⁷ The Virginia Department of Corrections (VDOC) does not use the term solitary confinement, preferring terms like disciplinary segregation, administrative segregation, special housing, and disciplinary housing. Regardless of the terms used by prison officials, however, this report uses solitary confinement to refer inclusively to the practice of isolating a prisoner from the general population with limited or no human interaction.

system.

- *Segregation (administrative segregation)* – Administrative segregation is the term VDOC uses for punitive solitary confinement.
- *Segregation Reduction Step-Down Plan (Step Down Program)* – The step-down program is the mechanism by which prisoners in solitary confinement can gain more privileges, such as being allowed to visit with family, and, in some cases, leave solitary. Proceeding through the program involves good behavior requirements. The program is divided into two tracks: the special management track and the intensive management track. Only those in the special management track have any prospect of leaving solitary confinement
- *Special Housing Unit (SHU)* – The description for the physical cells that are used for solitary confinement. These range from the cells used to house nearly all inmates at Red Onion, except for the small general population to the smaller facilities used at nearly all of Virginia’s prisons to confine people accused of or found guilty of violations within prison. Defined by VDOC as “A general term for special purpose bed assignments including segregation, disciplinary segregation, general detention, and pre-hearing detention.” Generally, the term is used for cells at non-maximum security prisons which confine prisoners in solitary confinement.
- *Special Management Units* – A form of solitary used within the federal Bureau of Prisons to control people suspected of high-level gang activity or serious disciplinary infractions. It is officially non-punitive, but in practice solitary confinement is always a degrading and dehumanizing punishment. Inmates are expected to complete a program to return to the general population within 18-24 months, although in many cases inmates remain much longer.

“Solitary Confinement Reform Act” – A bill sponsored by Senator Richard Durbin that would greatly limit the use of solitary confinement in the federal prison system.

Supermax Prison – Supermax prisons were prisons built to hold prisoners in extreme isolation. These facilities were built in an attempt to house “the worst of the worst” in tightly controlled, escape-proof facilities. In practice, however, Supermax prisons house tens of thousands of prisoners, only a minority of whom could be called the worst of the worst. Often, prisoners with mental illness are placed in Supermax facilities for behavioral violations that are caused mental illness. Only Red Onion is classified as maximum security by VDOC, but Wallens Ridge was built at the same time to the same specifications and houses prisoners in largely the same ways.

Therapeutic Modules – Therapeutic modules are cages where inmates are confined to watch videos that constitute the “programming” to help prisoners in solitary advance through the step-down process. At no time are prisoners given actual help by human beings, except for brief, usually non-confidential discussions with some sort of mental-health professional.

- See also Program Chairs

