

Isolated Confinement:

Effective Method for Behavior Change or Punishment for Punishment's Sake?

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A Historic Wrong Turn

In the 1970s I began testifying in class action lawsuits as a psychiatric expert witness regarding jail and prison conditions and the adequacy of correctional mental health services. The issues usually included jail and prison crowding, which constituted harsh conditions and violated the Eight Amendment prohibition against cruel and unusual punishment. The War on Drugs, increasingly harsh prison sentences, and other factors were causing the prison population to multiply geometrically. Meanwhile, with the "de-institutionalization" of state psychiatric hospitals and subsequent budget cuts in community mental health programs, a large number of individuals suffering from serious mental illness found their way into the prisons. In fact, while the prison population was multiplying geometrically in recent decades, the proportion of prisoners suffering from serious mental illness was also climbing. With crowding there were insufficient cells, so gymnasiums became impromptu dormitories, while four or six prisoners were crammed into cells built for one or two. Classes and rehabilitation programs did not expand to fill the need. It was known, from a robust literature on crowding, that massive crowding, especially with relative idleness, caused increased rates of violence, psychiatric breakdown and suicide in the facilities (Paulus, McCain &

Cox 1978; Thornberry & Call 1983). Meanwhile, there was a concerted effort on the part of conservative politicians to dismantle prison rehabilitation programs in the prisons. The cry was to "stop coddling criminals." So there were a lot of idle prisoners, many suffering from serious mental illness, shoe-horned into small spaces, and the result was mayhem.

The prison-building binge that gathered momentum in the 1980's was accompanied by a love affair with supermaxes. Supermaximum security units are also known as SHUs or Security Housing Units, the California acronym that has become synonymous with supermax confinement around the country. A supermaximum security unit or SHU is a cellblock or an entire prison made up entirely of isolation or segregation cells, where the prisoners are confined nearly 24 hours per day and eat meals alone (or with a cellmate) in their cells (Rhodes 2004; Shalev 2009). The isolation and idleness are extreme. Few if any rehabilitation or education programs exist in supermaxes. Most states and the federal government built them, and an unprecedented proportion of maximum security prisoners wound up in some form of long-term segregation.

This development constituted a historic wrong turn in American correctional policies. Severe crowding and downsizing of rehabilitation programs and the enlarged diversion of individuals suffering from serious mental illness into correctional facilities had exacerbated violence and mental illness in the prisons. Instead of remedying the crowding, providing adequate mental health treatment and reinstating rehabilitation programs, correctional authorities blamed "the worst of the worst" for the violence and madness and proceeded to lock a growing proportion of prisoners in punitive segregation, including supermaximum security units. That wrong turn has caused immense pain and suffering and resulted in a large number of very damaged prisoners and ex-prisoners.

The Damaging Effects of Supermax Isolated Confinement

Long-term confinement (greater than three months) in an isolated confinement unit such as a supermaximum facility is well known to cause severe psychiatric morbidity, disability, suffering and mortality (Scharff-Smith 2006; Grassian & Friedman 1986). It has been known for as long as solitary confinement has been

practiced that human beings suffer a great deal of pain and mental deterioration when they remain in solitary confinement for a significant length of time. Thus, in 1890, the U.S. Supreme Court found that in isolation units,

“[a] considerable number of prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community (In re Medley 1890).

A significant amount of research echoes the Court's findings. Hans Toch provided early narrative reports from prisoners at the highest levels of security and Isolation (Toch 1975). Craig Haney has researched the detrimental effects of long-term isolation (Haney, Banks & Zimbardo 1973; Haney 2003 & 2006). More than four out of five of the prisoners he evaluated suffered from feelings of anxiety and nervousness, headaches, troubled sleep, and lethargy or chronic tiredness, and over half complained of nightmares, heart palpitations, and fear of impending nervous breakdowns. Equally high numbers reported obsessive ruminations, confused thought processes, an oversensitivity to stimuli, irrational anger, and social withdrawal. Well over half reported violent fantasies, emotional flatness, mood swings, chronic depression, and feelings of overall deterioration, while nearly half suffered from hallucinations and perceptual distortions, and a quarter experienced suicidal ideation.

Stuart Grassian has conducted similar research (Grassian 1983; Grassian & Friedman 1986). He describes a particular psychiatric syndrome resulting from the deprivation of social, perceptual, and occupational stimulation in solitary confinement. This syndrome has basically the features of a delirium, and among the more vulnerable population, can result in an acute agitated psychosis, and random violence – often directed towards the self, and at times resulting in suicide. He has also demonstrated in numerous cases that the prisoners who end up in solitary confinement are generally not, as claimed, “the worst of the worse”; they are, instead, the sickest, most emotionally labile, impulse-ridden and psychiatrically vulnerable among the prison population.

Two-thirds of the prisoners Dr. Grassian initially studied had become hypersensitive to external stimuli (noises, smells, etc.) and about the same number experienced “massive free floating anxiety.” About half of the prisoners suffered from perceptual disturbances that for some included hallucinations and perceptual illusions, and another half complained of cognitive difficulties such as confusional states, difficulty concentrating, and memory lapses. About a third also described thought disturbances such as paranoia, aggressive fantasies, and impulse control problems. Three out of the fifteen had cut themselves in suicide attempts while in isolation. In almost all instances the prisoners had not previously experienced any of these psychiatric reactions. For all prisoners, long-term solitary confinement has the effect, on average, of making post-release adjustment very problematic and worsening recidivism rates (Lovell, Johnson & Cain 2007).

An alarmingly large proportion of prisoners consigned to supermaximum security isolation in recent decades suffer from serious mental illness. Sheilagh Hudgins and Gilles Cote performed a research evaluation of penitentiary inmates in a Supermaximum Security Housing Unit and discovered that 29% suffered from severe mental disorders, notably schizophrenia (Hudgins & Cote 1991). David Lovell has described typical disturbed behavior (Lovell et al. 2008). I have reported my own findings from litigation-related investigations (Kupers 1999). It is stunningly clear that for prisoners prone to serious mental illness, time served in isolation and idleness exacerbates their mental illness and too often results in suicide. This is the main reason that federal courts have ruled that prisoners with serious mental illness must not be subjected to long-term isolation (Madrid v. Gomez 1995; Jones 'El v. Berge 2001; Presley v Epps 2005 & 2007).

Recently I have been asked by attorneys to investigate the effects of very long term solitary confinement (over a decade) upon prisoners who do not exhibit an obvious serious mental illness. These are individuals who do not participate in mental health treatment, who have refused to inform on other prisoners as a condition of release from supermaximum confinement, and many of them have long ago become eligible for parole but parole boards have told them that because they remain in isolated confinement they cannot be paroled. The referral question I am asked is whether their

continuing isolated confinement causes additional psychiatric harm. My preliminary answer (my investigation is ongoing) is that very long-term isolation and idleness has produced in these prisoners, on average, disabling symptoms beyond those reported by Haney, Grassian, me and others (whose studies mostly involved prisoners who had been in solitary confinement for a matter of months or a few years). Those disturbing symptoms continued and worsened over ensuing decades of solitary confinement, but additionally, these prisoners have become severely cut off from their own feelings and have turned inward so they hardly engage in any social activity at all, even considering their very limited options within the isolation unit. The damage is cumulative and severe.

Then, too often, a certain number of prisoners are released straight out of solitary confinement to the community at the end of their prison sentence (this is called "maxing out of the SHU"). This creates huge problems for them in adjusting to community life, and needless to say the recidivism and parole violation rates for the group who "max out of the SHU," as well as for those who spent considerable time in isolation, is extremely dire (Lovell, Johnson & Cain 2007). Whether or not prisoners are permitted to "max out of the SHU" (the alternative in several states is to require six months of re-socialization in a general population unit prior to prisoners reaching their release date), the period of isolation and idleness has very negative effects on their chances of succeeding at "going straight" after being released.

It is predictable that prisoners' mental state deteriorates in isolation. Human beings require at least some social interaction and productive activities to establish and sustain a sense of identity and to maintain a grasp on reality. In the absence of social interactions, unrealistic ruminations and beliefs cannot be tested in conversation with others, so they build up inside and are transformed into unfocused and irrational thoughts. Disorganized behaviors emerge. Internal impulses linked with anger, fear and other strong emotions grow to overwhelming proportions. Sensory deprivation is not total in supermax units; there is the intermittent slamming of steel doors and there is yelling (one has to yell in order to be heard by anyone from within one's cell), but this kind of noise does not constitute meaningful human communication. Prisoners in this kind of segregation do what they can to cope. Many pace relentlessly, as if this non-

productive action will relieve the emotional tension. Those who can read books and write letters do so.

The tendency to suffer psychiatric breakdown and become suicidal is made even worse by sleep deprivation, which is a frequent occurrence among prisoners in isolated confinement. There are noises at night as other prisoners, for example those suffering from serious mental illness, cry out. Then, besides the slamming of doors, officers yell out orders on the cellblock or pod. Then, the lights are usually on all night. Prisoners from around the country tell me that for these and other reasons, it is very difficult to sleep in supermax units. Loss of sleep intensifies psychiatric symptoms by interfering with the normal diurnal rhythm (the steady alternation of day and night that provides human beings with orientation as to time), and the resulting sleep loss creates fatigue and magnifies cognitive problems, memory deficits, confusion, anxiety, and sluggishness.

It is under these extreme conditions that psychiatric symptoms begin to emerge in previously healthy prisoners. Of course, in less healthy ones there is psychosis, mania or compulsive acts of self-abuse or suicide. We know that the social isolation and idleness, as well as the near absolute lack of control over most aspects of daily life, very often lead to serious psychiatric symptoms and breakdown. It has been known for decades that suicide is approximately twice as prevalent in prison than it is in the community, and recent research confirms that, of all successful suicides that occur in a correctional system, approximately fifty percent involve the 3 to 8 percent of prisoners who are in some form of isolated confinement at any given time (Mears & Watson 2006; Way et al. 2005; and Patterson & Hughes 2008).

Inadequate treatment for prisoners suffering from serious mental illness is only one of many serious problems with supermaxes. Relationships between staff and prisoners break down and too often there is widespread and well-documented abuse and sadism on the part of some of the keepers toward the people they keep under total control. In this type of very high security unit there evolves a "vicious cycle" of worsening hostility and misunderstanding between staff and prisoners. This is not to downplay the reality that rule violations do occur in such units, and an appropriate and fair disciplinary system must be maintained. But when human beings are subjected to extremes of

isolation and idleness, and deprived of every vestige of control over their environment, and in addition are denied social contact and all means to express themselves in a constructive manner; then it is entirely predictable that they (or almost any human being) will resort to increasingly desperate acts to achieve some degree of control of their situation and to restore some modicum of self-respect. The prisoners are driven to small acts of resistance, which in turn are likely to be perceived by officers as disrespectful or rule-breaking; the officers, in turn, become increasingly insensitive, punitive or even abusive toward the identified troublemakers.

A Culture of Punishment

Psychologists have been guided for a long time by the evidence-based axiom that positive rewards are much more effective than negative punishments in changing behaviors and helping people grow. This axiom gets to the heart of today's prison crisis. But in American prisons, the negative punishments have gained ascendancy to such a great extent in recent decades that there is little room for rehabilitation-minded staff to design a series of positive rewards for pro-social and acceptable behaviors, the strategy that once, prior to the 1970s, constituted the core of rehabilitation programs in the prisons.

Prisons serve several purposes. They quarantine individuals deemed dangerous in the community. They serve as punishment for crimes committed. And they are a place for rehabilitation. In different historical *époques*, one or another of these purposes is emphasized over the others. As Garland points out, the punishment purpose has gained ascendancy in the U.S.A. since the 1970s, and the rehabilitation purpose, which was a major priority during the century leading up to the 1970's, has had to take a back seat (Garland 2001). In supermax isolation units, punishment becomes severe and unremitting, rehabilitation and positive rewards practically non-existent. In effect, the prisoner is pushed by the severity of punishment at every turn to act in more extreme and dysfunctional ways to express dissatisfaction with the way he or she is being treated. With each desperate and inappropriate act on the part of the prisoner, the staff react more punitively. There arises a culture wherein further punishment becomes the staff's reaction to everything they judge to be misbehavior on the part of prisoners.

We have a precedent for this kind of vicious cycle, but unfortunately its lessons have been mostly lost on contemporary correctional authorities. In the era of mental asylums, when

individuals suffering from serious mental illness were confined in large public psychiatric hospitals, Erving Goffman, Thomas Scheff and other “sociologists of deviance” hypothesized that institutional dynamics have a big part in driving patients to regress into impotent and bizarre aggressive behaviors while clinicians are side-tracked into disbelieving patients' emotional pains and reporting of events. (Goffman 1962; Scheff T 1966) . For example. A young man is brought against his will to the locked psychiatric hospital, he protests loudly that he is not crazy and in fact it is his parents or the police who want him locked up who are actually distorting the reality. The admitting psychiatrist interprets his increasingly loud protests as signs of the very mental illness being ascribed to him and he is involuntarily admitted to the inpatient unit. As he realizes he is being deprived of his freedom his protests become louder and more desperate. The staff take his emotional protests as further evidence confirming the diagnosis of psychosis. He is placed on a locked ward and deprived of most familiar means of expressing himself. He does something irrational such as throwing a chair through a window in order to express his outrage over being deprived of his freedom. The staff are even more convinced of his “madness” and lock him in an isolation room with no clothes and no pens or writing materials. Being even more incensed and more desperate to express himself he smears feces on the wall of the isolation room and begins to write messages with his finger in the smears on the wall. Of course, Goffman and Scheff were very concerned about the self-fulfilling-prophecy involved in the staff's diagnostic process, and they warned poignantly that incremental denial of freedom to individuals within “total institutions,” whether they actually suffer from a bona fide mental illness or not, leads inexorably to their increasingly irrational and desperate attempts to maintain their dignity and express themselves.

In effect, we see the same tragic drama being played out in the prisons today. The supermax isolation unit is where the most extreme version of the drama is enacted on a daily basis, including the smearing or throwing of bodily wastes. For the confined individual, the most maddening part of the story is likely the way the staff discount everything the patient/prisoner has to say. Staff in a facility where the focus is almost entirely punitive, where there is little or no room for treatment and rehabilitation, tend to discount the confined individuals' accounts of events, and tend to become insensitive to their complaints about emotional pain and psychological symptoms. The area where this unfortunate dynamic is

most obvious is the diagnosing of psychiatric disorders in prisoners consigned to long-term solitary confinement. In the course of my tours of supermax units around the U.S.A., I have found many prisoners who are clearly suffering from a serious mental illness, very often a psychotic condition such as Schizophrenia. When I review these prisoners' clinical charts and discuss them with correctional mental health staff, I am informed that the individual is "merely manipulating," or that he is "malingering," or that he has no "Axis I diagnosis." (Axis I is the place in a formal diagnostic assessment where serious mental illnesses are recorded, in contrast to Axis II, where personality disorders are recorded). In other words, in the eyes of the mental health staff, the prisoners I find to be psychotic or Schizophrenic actually have no real mental disorder, but are more accurately diagnosed as fakers or "antisocial personalities."

It is possible that I am wrong, diagnostically speaking, on one occasion or another, and it is also possible that I am occasionally fooled by a prisoner who is malingering (exaggerating symptoms in order to gain something such as the waiving of punishment for rule-breaking) or faking psychiatric problems. But I am a Board-certified psychiatrist and I have worked and taught for many years in a variety of treatment settings. It is extremely unlikely that I am fooled the large number of times when I discover prisoners in solitary confinement who clearly appear psychotic and have past histories of mental illness that support my diagnostic impressions. Thus, for example, my disagreement with correctional mental health staff over diagnosis frequently involves prisoners who, prior to incarceration, had been admitted to psychiatric hospitals several times, had made serious suicide attempts, had responded with improved behavior to anti-psychotic medications, and had been granted Social Security Disability (S.S.I.) for their psychiatric disorder. Now, when I discover them hallucinating and exhibiting psychotic thought processes in a solitary confinement cell, I am supposed to believe they are suddenly free of serious mental illness and merely "malingering"? This is certainly much less likely than the alternative explanation, i.e. that the correctional staff have become somewhat inured to prisoners' bizarre symptoms and, like the asylum clinicians Goffman and Scheff described, have adopted an entirely punitive and unsympathetic attitude toward their pleas for help and their inappropriate behaviors. Then, when the prisoner in question acts more bizarrely, the staff (custody as well as mental health staff) respond with increasingly severe punishments. Of course, the more appropriate and humane response would be to intensify the mental health treatment interventions, including but not limited to increased medication dosages, when the

patient acts more disturbed. And in most cases this would require removing the prisoner from the harsh isolative conditions that exacerbate symptoms.

In the short term, this cyclic dynamic leads to commotion and physical altercations inside the supermax units. But in the long run it leads to damaged prisoners who become chronically dysfunctional. The axiom remains valid and applicable: if improved behavior on the part of the prisoners were the aim, it would be much more effective for staff to reward the prisoners' positive behaviors at every turn than to mete increasingly petty or harsh punishments for every misstep on the prisoner's part. In fact, when enlightened correctional managers devise programs in their prisons' supermax units whereby prisoners can earn incrementally greater amenities and freedoms by exhibiting acceptable behavior, and the increments are short enough and the required behaviors reasonable and attainable, most prisoners in isolation are willing to cooperate and earn their way out of "the hole." On the other hand, the more a generalized culture of punishment leads the staff to distrust and disrespect the prisoners, the more the prisoners are driven to dysfunctional acts of defiance.

The advent of "Therapeutic Cubicles" is symptomatic of the vicious cycle I am describing. Therapeutic cubicles or "programming modules" are small holding cells, approximately the shape of a phone booth, made of steel and lexan (indestructible plexiglass). Four or five of these cubicles are bolted to the floor in a room where group treatment is conducted. Typically in supermax units, each prisoner is brought into the room in shackles and placed in a cubicle. Then the therapist or teacher enters and begins the session. Prisoners call these cubicles "cages," and many tell me they feel like they are being treated like animals (Kupers 2012). Meanwhile, the widespread utilization of programming cubicles tends to exacerbate the vicious cycle I am describing.

Placing prisoners in these cubicles for every contact with mental health staff has the effect of further increasing the distance and alienation between prisoners and staff in contemporary corrections. Over several decades in the U.S.A. there has been a diminution of everyday interactions between prisoners and staff. At every level of security, compared to just a few decades ago, prisoners spend less time interacting with staff out of their cells and in public spaces within the facilities. For example, in the 1970s, even in a maximum security prison, general population prisoners would exit their cells in the morning, spend most of their day at work or on the yard or in a dayroom, and would need to return to their cells only for

evening count and to sleep. Today, many maximum security general population cellblocks permit only four or five hours per day of non-work, out-of-cell time. At the same time, "lockdowns" have become commonplace, where cellblocks or entire prisons are locked down for months at a time. Typically there is a violent incident involving a few prisoners, the staff do not know who perpetrated the violence, and all prisoners in the cellblock, or all prisoners of the race of an alleged assailant, are locked in their cells twenty-four hours per day and cell-fed. This type of mass lockdown actually constitutes another form of isolation, but is rarely counted in the figures given for the proportion of prisoners in a system who are in solitary confinement. Then there are the supermax units and other varieties of long-term solitary confinement. In isolated confinement, contact between prisoners and officers is relatively limited, often consisting only of officers passing out food trays and ushering prisoners in restraints to and from activities, perhaps placing the prisoner in a therapeutic cubicle. In many settings, officers have essentially forgotten (or never learned or practiced) how to interact with prisoners informally, and in too many cases they are actually frightened of interacting with prisoners. Is it any wonder that staff who once "walked the line" and chatted with their wards are now afraid to be in a room with prisoners who are not in total restraints? Unfortunately, when programming cells become a routine, across-the-board requirement, they serve to further distance staff from prisoners and worsen the growing problem of alienation. Staff who are inclined to focus almost exclusively on punishment for prisoners become even less inclined to get to know the prisoners and talk with them in a friendly, non-punitive context. Many prisoners tell me that their contact with officers is limited to the officers silently passing their food tray through the slot in their isolation cell door, or yelling orders at them and swearing they will punish them for one misstep or another.

Once the staff limit their repertoire in this way, further punishments become the only option they can think about for every new situation. And once punishment becomes the almost automatic response to every misbehavior or inappropriate behavior, there is a series of unfortunate consequences. Staff tend to disbelieve the prisoners' complaints of emotional pain and disbelieve the obvious negative repercussions of extreme prison conditions such as solitary confinement. With prisoners suffering from Serious Mental Illness, this too often means that staff disbelieve the reported symptoms and instead insist that the prisoners are malingering or manipulating to avoid punishment for their willful misbehavior.

Then, since the prisoners are already in solitary confinement and have no amenities, even harsher punishments are devised for their subsequent misbehavior. The "cell extraction" is just such a further punishment. In supermax units around the country, a significant proportion of the isolated prisoners are "extracted" when they "resist" officers' orders, in many cases this involves something as minor as refusing to return a food tray. The prisoner tells the officer he will not return his food tray because there were insects in his food and he wants to keep the tray as evidence of the unhygienic meal. The officer signals a special team of four or five officers who come to the prisoner's cell to "extract" him and seize the food tray. The officers in this special team wear padding all over their bodies, including a helmet with a visor. Usually they first spray immobilizing gas (mace or pepper spray) through the food port. Then, if the prisoner still refuses to put his hands through the food port and "cuff up," they unlock the cell door and bolt into the cell all together, the first officer pushing the prisoner against a wall with a special shield, and each other officer being assigned to grab an arm or a leg and "take down" the recalcitrant prisoner. Of course, injuries are frequent, and can be quite severe. I have toured supermax units where one feels the immobilizing gas stinging one's nostrils as soon as the outer door is opened.

A few years ago I testified as a psychiatric expert in federal court about the supermax unit at Mississippi State Penitentiary (*Presley v. Epps* 2005 & 2007). Just prior to my testimony I toured a supermax pod where prisoners reported to me that one particular officer on the evening shift would spitefully spray immobilizing gas through the food ports of the prisoners who had angered him. After spraying the prisoner, the officer would keep on walking down the tier, leaving the prisoner coughing and choking from the toxic gas. The Department of Corrections policy mandated that whenever officers resorted to immobilizing gas, an incident report had to be written, the prisoner had to be checked by medical staff and treated, and the cell had to be decontaminated. This officer often did not write reports, did not notify the medical staff, and did not make provisions for decontaminating the prisoner's' cells. In this case, the Commissioner and Deputy Commissioner of the Mississippi DOC were in the courtroom, and they quickly disciplined the errant officer and ordered all officers to follow policy regarding the use of immobilizing gas. But this unfortunate incident illustrates the extent of the culture of punishment that so often gets out of control in solitary confinement and supermax units. The

point is that, once the staff buy into a culture of punishment with too little concern about prisoners' rehabilitation, abuses become common and tend to worsen over time.

Some of the abuses, such as an Officer spraying prisoners he dislikes with immobilizing gas, constitute a violation of policy, and an urgent indication that better staff training and supervision are needed. At other times, the policy itself is abusive. For example, in some states there are Behavior Management Plans (BMPs) for prisoners already in solitary confinement who are deemed recalcitrant. At Montana State Prison, according to official policy, a BMP is ordered when a prisoner misbehaves in the supermax unit. The prisoner's clothing, bedclothes and all other amenities are removed from his cell, and he is fed "nutra-loaf" (a mixture of foods pressed into a bar that the prisoners report is essentially inedible) for a 48-hour period. Then, if the prisoner is angered by this treatment, and for example cusses at the Officers imposing this severe punishment upon him, then that prisoner is "written up," i.e. given another disciplinary infraction report, and his time on this first phase of the BMP is extended further. Thus, the initial step of the BMP where the prisoner's clothing is removed and he is fed "nutra-loaf" is theoretically imposed for a 48-hour period, but by the end of the 48 hours the prisoner can be punished for unacceptable behavior with an additional 48-hour stint, and then there may easily be another. Prisoners who have been punished with BMPs tell me they feel like they will be naked, without bedding and eating loaf for a very long time, even though their original sentence to that phase of the BMP was only for 48 hours.

In 2009 I was asked to evaluate a young man, Mr. R. K., at Montana State Prison who had been tried as an adult and, at age 15, sent to adult prison. Soon after he arrived at Montana State Prison, an older man grabbed his testicles, and having been warned he had to show how tough he was if he wanted to avoid being someone's sex slave, he hit him. He was sent to the supermax unit for "fighting." In the supermax, he soon became disoriented, lost control of his anger, talked back to officers and disobeyed some orders, the result being further disciplinary write-ups and a much longer stint in supermax isolation. He became acutely depressed and made repeated suicide attempts, on a couple of occasions attempting to bite through the veins of his arm. Each time he tried to take his own life, he was put in an observation cell for a few days and then sent back to his isolation cell. In fact, most of the suicides that occur among the population in isolation take place in an isolation cell after the prisoner has

been returned from Observation. Eventually he made such a serious suicide attempt he nearly died, requiring blood transfusions in an intensive care unit to survive. He told me that every time he is placed in solitary he "goes crazy" and cannot control his self-destructive impulses. On several occasions, the mental health staff opined that his suicide attempts were "manipulations," his aim being to have himself removed from supermax isolation. Eventually this young man, because of legal intervention on the part of the American Civil Liberties Union, came before a judge who ordered the state to transfer him to a psychiatric hospital where his suicide could be prevented and he could receive needed treatment (*Katka v. Montana Department of Corrections* 2009).

Once a culture of punishment takes hold and the staff feel they need to respond to each new unacceptable behavior on the part of prisoners with further punishments, the punishments become more severe and the effect too many times is more emotional harm to the prisoners, in many cases including suicide. But to the extent it is the conditions of confinement, the almost total idleness and isolation in the supermax unit, that drive much of the prisoners' unacceptable or symptomatic behavior, the successive punishments serve merely to exacerbate the problem.

The International Picture

The USA incarcerates a higher proportion of its citizenry by far than any other developed country, and also consigns a greater proportion of prisoners to solitary confinement. I was in Moscow in April, 2012, for an exchange between American and Russian prison experts arranged by the American Bar Association ROLI (Rule of Law Initiative). We met with NGO (non-governmental organizations, comparable to non-profit organizations in the USA) prison reform activists and talked about combating human rights violations. When I discussed the emotional harm of supermaximum security prisons, Russian colleagues told me that of course there is some prison segregation and solitary confinement in Russia, but nothing like the number of prisoners affected and the many months and years they spend in solitary in American prisons. Russia, like other countries outside the USA, tends to

utilize isolation infrequently, and only with political prisoners or crime figures they deem especially dangerous.

Other industrialized countries tend to prioritize rehabilitation, many attempt to avoid crowding by not consigning low level offenders to prison, and most provide substantial substance abuse treatment in the community. On average, they try to keep the prison census reasonable, and they rely much less than the USA on solitary confinement. Less affluent countries often confine prisoners, including pre-trial detainees, in dormitories, where crowding, violence and disease can be huge problems, but they do not utilize wholesale isolation the way the USA does. There are notable exceptions. For example, the Italian prison system uses isolation resembling supermaximum security for terrorists and high profile organized crime (Mafia) figures. A federal law, Article 41-bis of the Prison Administration Act, mandates isolation for dangerous individuals (Ministry of Justice, Italy 2000). Italian penological practices have been successfully challenged at the European Court of Human Rights, where the issues were a lack of adequate due process and inadequate contact with loved ones. Brazil also utilizes isolation units for prisoners they consider especially dangerous. But no other industrialized country utilizes isolation in supermaximum security units on the large scale seen in the U.S.A. It remains an open question whether the love affair with supermax prison units in evidence in recent decades in the USA will become more of a model for other countries, or will they see the harm and ineffectiveness of mass isolation for what it is and continue to pursue a course more friendly to rehabilitation?

Of course, there is a long history of some form of solitary confinement in various countries that predates the relatively recent popularity of supermaxes in the U.S.A. Prisoners of war and political prisoners have long been placed in solitary confinement, where they suffer enormously and great harm is done to their emotional stability. Often the isolation is combined with torture, for example during the process of "enhanced interrogation" (McCoy 2007) and at black sites (Mayer 2007). The dark underside of American practices in these regards surfaced embarrassingly in the release of photos from Abu Grhaib depicting American soldiers stripping Arab captives, forcing them into very close contact with each other, and sexually humiliating them (Danner 2004). It was known, or should have been known, that humiliations like these condemn a Muslim man

to a lifetime of haunting painful images and self-rebukes. What happened at Abu Ghraib was torture. Torture often includes solitary confinement, possibly in a dark, cold and wet dungeon. But the actual physical torture conducted in these places overshadows the fact of the tortured prisoner being housed in solitary confinement. It would seem obvious that the return of a prisoner from a torture session, possibly including "water-boarding," to an isolation cell would make the pain and suffering that much greater. The isolation and idleness between torture sessions makes a very negative contribution to the tortured prisoner's emotional health. But I will not discuss further the prisoners worldwide who are housed in solitary confinement while being actively and brutally tortured, except to mention that they, too, suffer from the harmful effects of solitary confinement.

There are international treaties and reports of investigations where torture is defined and prohibited. Courts have been established to mandate the end of torture wherever it is proven to exist. For example, at the United Nations there is a Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment. Juan E. Méndez is the current Special Rapporteur, and in a recent report to the General Assembly of the U.N. he included a section on solitary confinement (Mendez 2011).

Special Rapporteur Mendez reported he undertook his study because he found "the practice of solitary confinement to be global in nature and subject to widespread abuse. In particular, the social isolation and sensory deprivation that is imposed by some States does, in some circumstances, amount to cruel, inhuman and degrading treatment and even torture" (Mendez 2011: 7). He cited the Istanbul Statement on the Use and Effects of Solitary Confinement, which concludes: ". ... [T]he use of solitary confinement should be kept to a minimum, used in very exceptional cases, for as short a time as possible, and only as a last resort" (Istanbul Statement 2007). Special Rapporteur Mendez continues:

States around the world continue to use solitary confinement extensively. In some countries, the use of Super Maximum Security Prisons to impose solitary confinement as a normal, rather than an "exceptional," practice for inmates is considered problematic. In the

United States, for example, it is estimated that between 20,000 and 25,000 individuals are being held in isolation. Another example is the extensive use of solitary confinement in relation to pretrial detention, which for many years has been an integral part of the Scandinavian prison practice. Some form of isolation from the general prison population is used almost everywhere as punishment for breaches of prison discipline. Many States now use solitary confinement more routinely and for longer durations.

Special Rapporteur Mendez proceeds to identify other countries where basic minimum standards are violated by prison isolation practices, especially with vulnerable populations and youth. He deems the utilization of solitary confinement for pre-trial detainees an unacceptable practice, and he concludes: "The Special Rapporteur stresses that solitary confinement is a harsh measure which may cause serious psychological and physiological adverse effects on individuals regardless of their specific conditions. He finds solitary confinement to be contrary to one of the essential aims of the penitentiary system, which is to rehabilitate offenders and facilitate their reintegration into society. The Special Rapporteur defines prolonged solitary confinement as any period of solitary confinement in excess of 15 days.... In this context, the Special Rapporteur reiterates that States should refer to the Istanbul Statement on the Use and Effects of Solitary Confinement as a useful tool in efforts to promote the respect and protection of the rights of detainees.

In the Report of the Special Rapporteur and in the proceedings of international human rights courts, the term "torture" bears a striking resemblance to "cruel and unusual punishment" as that phrase is applied in the American legal system. American courts tend to limit their rulings to Constitutional violations, for example violations of the Eighth Amendment prohibition against "cruel and unusual punishment." But at least one court has used the word "torture" to name the treatment of at least one prisoner with mental illness consigned to prolonged solitary confinement as well as numerous lengthy Behavior Modification Plans (BMPs). In the case of Mark Edward Walker, the Montana Supreme Court used the word "torture" in discussing the long-term isolation, inadequate mental health care, and application of BMPs (Walker v. Montana 2003). Mr. Walker had been diagnosed Bipolar Disorder and had benefited from mood-stabilizing medications prior to incarceration at Montana State Prison (MSP). But at MSP, he was taken off his

medications, his diagnosis was changed to something less serious, he was consigned to long-term punitive segregation in a supermax unit, and he was given BMPs. According to the Montana Supreme Court, reviewing his case:

Our Constitution forbids correctional practices which permit prisons in the name of behavior modification to disregard the innate dignity of human beings, especially in the context where those persons suffer from serious mental illness. We cannot sanction correctional practices that ignore and exacerbate the plight of mentally ill inmates like Walker, especially when that inmate is forced to rely on the prison for his care and protection. The plain meaning of the dignity clause commands that the intrinsic worth and the basic humanity of persons may not be violated. Moreover, if the particular conditions of confinement cause serious mental illness to be greatly exacerbated or if it deprives inmates of their sanity, then prison officials have deprived inmates of the basic necessity for human existence and have crossed into the realm of psychological torture (Walker v. Montana 2003: 82).

The courts have developed definitions and standards to help them determine if a constitutional violation has been proved in the current case. One of the standards involves "deliberate indifference." In other words, it is not sufficient for the Plaintiff (the prisoners as a group or class) to prove that the Department of Corrections has perpetrated activities that are cruel and unusual. Rather, Plaintiff must prove that the named defendants (a warden, perhaps a Commissioner, perhaps a Governor) knew of the damage the activities or conditions are likely to cause, and they took no heed, i.e. they were deliberately indifferent. When I testify I mention torture. Attorneys tell me it is not an important consideration for American courts, they are more interested in violations of the Constitution. But, in my opinion, torture on one hand, and cruel and unusual punishment on the other, are mostly overlapping categories. The International Courts and the U.S. Courts are talking about the same abuses. They are looking for acts of torture that occur in the prisons, for example the rape of women prisoners by male officers, or the use of excessive force that causes great harm to prisoners, or conditions of confinement such as crowding or prolonged solitary confinement, that can be shown to predictably cause great harm. Torture and an Eighth Amendment violation are essentially synonymous.

Sarah Shourd was one of three American hikers arrested in Iran in 2009 and imprisoned. She writes about her experience in a solitary confinement cell:

After two months with next to no human contact, my mind began to slip. Some days, I heard phantom footsteps coming down the hall. I spent large portions of my days crouched down on all fours by a small slit in the door, listening. In the periphery of my vision, I began to see flashing lights, only to jerk my head around to find that nothing was there. More than once, I beat at the walls until my knuckles bled and cried myself into a state of exhaustion. At one point, I heard someone screaming, and it wasn't until I felt the hands of one of the friendlier guards on my face, trying to revive me, that I realized the screams were my own.

Of the 14 and a half months, or 9,840 hours, I was held as a political hostage at Evin prison in Tehran, I spent 9,495 of them in solitary confinement" (Shourd 2011).

Sarah Shourd is very articulate, and very able to make sense of the bizarre turn of events where she and her two friends were captured and thrown into an Iranian prison. Most prisoners are not as articulate, do not have a large audience of family and the broader public following their every twist of fate, and many are consigned to solitary in a supermax prison for years or even decades. There are unfortunate souls in many countries who - because of their ethnicity, or their beliefs, or their choice of a side to fight on - languish in solitary confinement for many years, often with a certain portion of overt torture in the mix. But again, other countries do not employ solitary confinement on the massive scale it is employed in the U.S.A.

Further Research

Much more research is needed regarding the effects of long-term solitary confinement. But we also need to study broader questions, such as why the recidivism rate has been climbing, and what forms of rehabilitative programming are effective in reducing recidivism and keeping our communities safe. The problem with research inside correctional facilities is that Departments of Correction are generally very averse to researchers having access to prisoners. I am afraid that is at least in part because

the prison system wants to protect itself from outside interference in its operations, and again there is the need to keep the unacceptable occurrences, such as excessive force on the part of custody staff or preventable deaths, from the public's awareness. Thus the research that is conducted inside the prisons tends to be only the kind that has the seal of approval from the relevant Department of Corrections. The Colorado Department of Corrections has released a report of their research on the psychiatric effects of supermax confinement, concluding that long-term isolation in a supermax unit has no more harmful effects than maximum security imprisonment for the same period of time (O'Keefe et al 2010). Stuart Grassian and I have responded to that report, pointing out that the methodology is very flawed, the researchers did not even bother to talk to the prisoners about their mental health issues, and the actual data derived during the study should, if properly interpreted, lead to the opposite conclusion from that propounded by the researchers - i.e., even this study supports the fact that long-term supermax confinement causes much emotional harm and exacerbates mental illness (Grassian & Kupers 2011). Of course, a huge volume of very good research on the harm of supermax solitary confinement appears in the reports and testimony of mental health experts investigating supermax facilities in preparation for testimony in class action litigation. When I investigate a correctional system, I interview hundreds of prisoners, many in supermax units, and I report to the court the harm done by their long-term solitary confinement. Drs. Haney and Grassian, among others, do the same. More than additional research, we need wider public presentations of the shocking findings I am summarizing in this chapter.

Some Social Implications of Supermaximum Security Prisons

In recent decades in the U.S.A., wealth has become more concentrated in fewer hands, the gap between rich and poor has grown, and there has been a turn away from social welfare programs that would ordinarily support disadvantaged people.

Meanwhile, disadvantaged people, for example low-income individuals with serious mental illness, on average, receive less than adequate treatment and support in the community, and tragically, in all too many cases, find their way into the criminal justice system. In other words, poor and disenfranchised people are "disappeared" by the

increasingly inequitable society that refuses to adequately fund services they need to stay afloat. While this trend is rarely discussed in these terms, I firmly believe disadvantaged people are being disappeared from public view into the jails and prisons because the public is too little interested in helping them, cannot bear to witness their suffering in the community, and all too conveniently, there is the politically popular ideology of "lock 'em up and throw away the key." Criminal defenses built on some version of "incompetence to stand trial" or "not guilty by reason of insanity" become more difficult to win. Sentences are made longer, more mandatory and harsher. And meanwhile, in the jails and prisons, there is crowding and inadequate mental health services, and diminishing opportunities to participate in meaningful educational and rehabilitative programming.

Individuals with serious mental illness spend ever longer periods behind bars, they are less prepared for success at "going straight" once they are released, and their parole violation rates and recidivism rates rise precipitously. While the population of prisoners with serious mental illness might appear a "special case," in fact a comparable fate awaits prisoners who do not suffer from significant mental illness. While the prison population has multiplied many times over in recent decades, educational and rehabilitation services, like mental health treatment services, have not grown apace. Prisoners face longer sentences, a greater likelihood they will spend a significant amount of time in isolation including supermax confinement, and a rapidly rising recidivism rate after they are released.

David Garland provides a social historical analysis of these developments, differentiating between the age of reform or the welfare state era that lasted for approximately 100 years and came to an end in the early 1970s, and the "culture of control" that has succeeded the welfare state era and prevails today in criminal justice:

The criminologies of the welfare state era tended to assume the perfectability of man, to see crime as a sign of an under-achieving socialization process, and to look to the state to assist those who had been deprived of the economic, social and psychological provision necessary for proper social adjustment and law-abiding conduct. Control theories begin from a much darker vision of the human condition. They assume that individuals will be strongly

attracted to self-serving, anti-social, and criminal conduct unless inhibited from doing so by robust and effective controls.... Where the older criminology demanded more in the way of welfare and assistance, the new one insists upon tightening controls and enforcing discipline (Garland 2001: 15.)

Of course, the supermaximum security prison is the epitome, and a natural culmination of control theories. Another name for the supermaximum security unit is "Control Unit." And it is no accident that little in the way of education or rehabilitation is available to the denizens of supermaximum "control units." Rehabilitation is not in the government's plans for them. I have focused on prisoners with serious mental illness who land in long-term solitary confinement. Their condition, their disabilities, and their prognosis become much worse on account of the idleness and isolation. Of course, when prisoners are kept idle and isolated, there is little or no mental health treatment, nor rehabilitation. This explains why prisoners with serious mental illness are so severely and irreversibly damaged by their experience in isolation. But the conditions that cause psychiatric deterioration in prisoners with serious mental illness are obviously going to cause pain and emotional harm to prisoners who appear, upon casual inspection, to be emotionally stable. Thus, following a rigorous review of the extant research literature on supermax confinement, a group of widely recognized experts on solitary confinement concluded: "No study of the effects of solitary or supermax-like confinement that lasted longer than 60 days failed to find evidence of negative psychological effects" (Amicus Brief to the Supreme Court 2005).

I explained in the previous section why the prognosis for individuals suffering from serious mental illness becomes more dire after they spend time in a prison solitary confinement unit. The prisoners with serious mental illness who I meet in supermax units are, on average, and very obviously, more disturbed, more chronically disabled and their condition is much less likely to improve in the future, compared to patients I have encountered in the community who suffer from comparable serious mental illnesses but undergo adequate treatment in a non-correctional setting. This is an important point, and to make it more clear, I will compare the fate of an individual suffering from a serious mental illness who is fortunate enough to enjoy a friendly and growth-inducing environment with the fate of one who is tormented and abused. On one hand, individuals suffering from mental illness who receive adequate treatment and

spend their time in friendly circumstances (for example, a loving home or a halfway house where they are encouraged to study, form healthy relationships, and accomplish the steps they need to traverse if they are ever to enjoy meaningful employment and quality relationships) are quite likely to keep their illness under control, be as productive as they can be given their illness, and live a relatively quality life. On the other hand, the equivalent individual (i.e., someone who suffers from the same mental illness) who is repeatedly traumatized, maybe raped, has no stable residence nor gainful pursuits, and is shuffled from one relatively uncaring service provider to another will suffer a worsening mental disability and will have a much bleaker future (likely including incarceration). In other words, the neglected and traumatized individual with serious mental illness has a much more dire prognosis than the individual who enjoys a supportive environment and adequate treatment.

It is in this sense that the harsh conditions of solitary confinement cause great and permanent damage. Prisoners suffering from serious mental illness are disproportionately consigned to solitary confinement for much of their term in prison, there they are unlikely to receive adequate treatment, they are not going to participate very much in rehabilitation programs, and after they have spent a number of years in prison their psychiatric disorder is likely to be more severe, more chronic, less amenable to treatment, and they are more likely to leave prison (if they have a determinate sentence, and over 90% of prisoners are eventually released) broken and incapable of adjusting to life in the community. Destroying a prisoner's ability to cope in the free world is one of the worst things prison does. I have described this as "the decimation of life skills," a form of torture (Kupers 2008b). Crowding, a lack of rehabilitation opportunities, excessive reliance on isolation as punishment, restriction of visits and contacts with the outside world, pervasive sexual abuse, disrespect at every turn, the failure of pre-release planning – all these things add up to throwing the prisoner who completes a prison term out into the world broken, with no skills, and a very high risk of recidivism. This is the plight of prisoners with serious mental illness, and it is also the plight of the other prisoners consigned to long-term supermax settings.

I do not believe the public would stand for this outrageous callousness - if the public were aware it is going on in our midst. But the public is almost entirely ignorant about all of this. After all, there is little media attention to the plight of prisoners with serious mental illness, nor to the plight of prisoners with or without mental illness who spend inordinate lengths of time in

solitary confinement and are then returned to the community. In some states, including California, there are "gag orders," i.e. laws against journalists talking to prisoners. And visiting is very restricted. To a great extent, we in the community learn what is happening in prisons largely from the families of prisoners, who visit them and hear about their terrible straits, and then return to the community, and to their legislators, to talk about that. But supermaximum security units tend to be located far from population centers (California's Pelican Bay State Prison is a seven hour drive north of San Francisco, and Illinois' Tamms is a comparable distance from Chicago). Then, visiting at supermax prisons is very restricted. The visitor has to sit on the far side of an indestructible fiberglass (lexsan) "window" with no contact, the prisoner is usually brought in wearing shackles, and quite a few prisoners tell me they actually dissuade their families from visiting because they do not want their loved ones to see them in shackles. The public hears little of what occurs in supermax prisons.

I have described a tragic phenomenon that is all too usual (Kupers 2008a). Prisoners in solitary confinement deteriorate and become more psychiatrically impaired and less capable of functioning back in the community. Then, as if to "hide the evidence" from the public that supermax facilities are destroying people rather than preparing them for a law-abiding post-release life in the community, new ways are invented to keep the prisoners locked up and out of sight even longer. Thus, most prisoners are serving determinate sentences, meaning that when the three or twelve years of their prison sentence elapse, they should be able to return home. But in recent years, there has been legislation in many states mandating new forms of post-release civil commitment, and increasingly new criminal charges are brought against prisoners for relatively minor misbehaviors that once would have been punished during their prison term with a short stint in segregation. So the prisoner who completes his prison term is faced with the possibility of being locked in a psychiatric hospital (if he suffers from serious mental illness) or the possibility of being found guilty of a new, in-prison crime because of his actions while locked in an isolation unit. It is as if there is a wish to hide the damage wreaked by years of solitary confinement.

What about the rest of the prisoners in long-term solitary confinement? After touring dozens of prisons and interviewing thousands of prisoners, staff and administrators, I have become convinced that the conditions and treatment that cause great harm to individuals suffering from serious mental illness also cause great harm to those who are relatively stable

from a psychiatric perspective. Indeed, relatively stable occupants of supermax cells also experience severe and disabling emotional symptoms, even if their condition and disability do not fit the picture of a diagnosable mental disorder. For example, echoing the findings of Haney, Grassian and others reported above, a large proportion of prisoners in long-term solitary confinement report that the isolation makes them anxious, paranoid and angry, and they have great difficulty with concentration, cognition and memory. Prisoners in supermax units around the country have independently told me that they no longer read in their isolation cell (a significant number of prisoners are illiterate, but here I am referring to those who can and ordinarily do read). As a relatively naïve investigator trying to understand their experience in isolation, I tell them I would imagine reading and writing are pretty much the only meaningful pursuits they have available in their cells, and I ask why they do not take advantage of reading. They universally tell me they cannot remember what they read three pages earlier, so they give up. The point is that when prisoners who do not suffer from a gross psychiatric disorder spend an inordinate amount of time in a supermax isolation unit, they also have a terrible time re-adjusting to social networks in the community (after all, they have spent years in a cell by themselves), and tragically, they are prone to get into trouble again soon after their release from prison. Their recidivism rate is disturbingly high, and rising (Lovell 2007).

The take-away message is that prisoners with mental illness must be provided a safe place to serve their sentences (they need to be safe from victimization, from the unrestrained expression of their own most troubling proclivities, and from damaging conditions such as crowding and solitary confinement) and need to be provided an adequate level of mental health treatment and rehabilitation so that they can mend their ways and prepare to succeed in the community after they are released. And, of course, prisoners who do not suffer from serious mental illness need the same basic amenities and programs if they are to succeed at "going straight" after they are released from prison. This is the basic idea of rehabilitation.

The reason I find the notion of a "Prison-Industrial Complex" compelling is that it explains something that would otherwise seem quite inexplicable. Why, when we know from years of experience and much research, that a particular penological practice is ineffective and even harmful, do we continue performing that practice in our prisons? Substance abuse policies illustrate the point. Individuals who enter prison with a substance abuse problem, unless they undergo intensive treatment for the problem during their prison term, generally relapse into

substance abuse after they leave prison. In other words, incarceration, on average, does not diminish substance abuse proclivities. On the other hand, research shows that when people with substance abuse problems complete a treatment program in the community, well over 50% of them remain clean and sober after three years (DATOS 2012). Why, then, are ex-prisoners on parole "violated" (i.e. returned to prison) for having a "dirty urine?" A much more effective and much less expensive consequence for the dirty urine would be mandatory drug treatment in the community. There has to be some reason why the system is so quick to return people to prison rather than providing the cheaper, more effective response to an exacerbation of their substance abuse. It is this kind of illogical response to developments that makes it clear there is some motivation other than rehabilitating prisoners at work, and it is quite logical that the interest groups who profit from an expanding prison system are behind the ineffective and harmful practices that the system keeps on employing. In other words, the interest groups who profit or sustain power when the prison industry expands are driving illogical prison programs such as violating parole for prisoners who turn in dirty urines. They are more interested in growing the prison population than in rehabilitating prisoners.

Supermaximum security isolation is another example of the illogic, and another instance where a Prison Industrial Complex works incessantly to expand the prison system rather than prioritizing measures that improve the chances for prisoners to succeed at rehabilitation and at "going straight" after they are released. Supermaximum solitary confinement causes great harm, worsens rather than improves the violence and mental illness rates in the prisons, and creates a lot of very disabled and broken prisoners who will fail to adjust in the community and be prone to spend much of the remainder of their lives behind bars.

Beyond Supermax Confinement

By now there is a growing national trend away from the use of long-term solitary confinement in corrections (Goode 2012). Of course, there are compelling economic justifications that partially explain this trend. Supermax prisons are very expensive to operate. In addition, however, there are the important mental health concerns and public safety justifications discussed here. Because this kind of confinement is not only painful but also very damaging — and, for too many prisoners, irreversibly so — it is a cruel and singularly inappropriate form of punishment. Beyond doing more to debilitate

than rehabilitate the prisoners who are subjected to it, solitary confinement undermines the ability of many of them to succeed in the community after their eventual release from prison (Mears & Bales 2009; Lovell 2007). Conclusive evidence that it increases rather than reduces recidivism raises public safety concerns. Moreover, supermax prisons do not reliably reduce violence or disciplinary infractions within the larger prison systems in which they function; in some instances they appear to make it worse (Briggs et al. 2003). Nor do they alleviate the problem of prison gangs. As Craig Haney argues, the California Department of Corrections has aggressively pursued the use of long-term solitary confinement for more than 20 years and the state prison system is now plagued with perhaps the worst gang problem in the nation (Haney 2012).

By now, some of the better-run corrections departments are deciding that the supermax venture is a failure (Goode 2012). Psychiatric breakdown inside the supermaxes has reached epidemic proportions, the recidivism rate is higher, especially for individuals who "max out of the SHU," and the rate of violence on the prison yards has not diminished. The fiscal value of mass segregation is being questioned. Several states, including Virginia and Michigan, have decided to close supermax facilities or "convert" the architectural structures to other uses. In Illinois, the Governor has called for the closure of the state's supermax facility, Tamms.

Recently, I served as an expert witness, and then as a court-approved monitor, in litigation in Mississippi that required the Department of Corrections (Mississippi DOC) to ameliorate substandard conditions at the super-maximum Unit 32 of Mississippi State Penitentiary at Parchman, remove prisoners with serious mental illness from segregation, provide them with adequate treatment, and re-examine the entire classification system (Kupers, Dronet et al. 2009). Pursuant to two federal consent decrees, the Mississippi DOC greatly reduced the population in administrative segregation and established a step-down mental health treatment unit for the prisoners excluded from administrative segregation. The Associate Commissioner of the DOC, Emmett Sparkman, personally reviewed with visiting expert Jim Austin the classification files of all prisoners in Unit 32, and they determined that many had been "over-classified" and did not any longer need to be in the supermax facility, nor on Administrative Segregation status. For example, some prisoners had been consigned to

solitary only because of the seriousness of their crime, and this was in violation of DOC policies. The second part of the collaboration was to remove all prisoners from Unit 32 with Serious Mental Illness, and to establish a "step-down unit" of intermediate mental health care for them. This was a program inside Unit 32 consisting of three graduated phases with increasing freedoms and amenities, and the prisoners would meet with mental health staff in therapy groups designed to help them attain each stage of advance. The "step-down" program became a route for prisoners to leave Unit 32.

After the majority of prisoners were removed from the supermax unit (and the unit was closed), the violence rate in the entire DOC decreased significantly. In other words, the prisoners who had been consigned to segregation did not resort to violence after being released from Unit 32, and the yards, on average, became more peaceful. The prisoners suffering from serious mental illness who had been relegated to solitary confinement and then were transferred to the step-down unit and eventually to general population received far fewer disciplinary infractions after they were transferred out of the supermax unit. After 800 of the approximately 1,000 prisoners in the supermaximum security unit were transferred out of isolated confinement, there was a large reduction in the rates of misconduct and violence, not only among the prisoners transferred out of supermax, but in the entire Mississippi Department of Corrections. Eventually, the number of prisoners remaining in Unit 32 dipped beneath 200 and it was decided to close Unit 32 (Kupers, Dronet et al. 2009).

Thus, long-term solitary confinement places prisoners at grave risk of psychological harm without reliably producing any tangible benefits in return. There is no hard evidence that supermaximum security facilities actually ever reliably reduced system-wide prison violence or enhanced public safety. Fears that a significant reduction in the supermax population or the outright closure of a facility will result in heightened security threats and prison violence have not been born out by experience.

Conclusion

There is a falsehood at the heart of the rationale for the imprisonment binge in the U.S.A. The lie is the notion that, by locking up the people who would otherwise clearly remind us of the failures of our society in regard to our social responsibility, we

become safer and happier. In spite of nearly 2 ½ million Americans incarcerated today, people are feeling both more strapped financially, and less safe in their communities than they did before the prison explosion of the 70's and 80's. In “locking 'em up and throwing away the key,” we have also broken up the families of the tens of millions of people who have been forced to spend time in jail or prison. And the average citizen has had to shut down their critical mind, and continually deny the contradiction between the USA's claim of democracy and the reality of this country disappearing so many disadvantaged people behind bars. The only people happy with the massive Prison Industrial Complex that has evolved over the last three decades are those who make profits or enhance their power by regimenting those condemned to incarceration.

Long-term solitary confinement places prisoners at even graver risk of psychological harm. There is no hard evidence that supermaximum security facilities actually ever reliably reduced system-wide prison violence or enhanced public safety. Fears that a significant reduction in the supermax population or the outright closure of a facility will result in heightened security threats and prison violence have not been born out by experience. In fact, recent experience in Mississippi found exactly the opposite—that a drastic reduction in the supermax population was followed by a reduction in system-wide misconduct and violence.

Let us hope that in the near future prison populations will decline, and the nation's correctional system will re-dedicate itself to program-oriented approaches to positive prisoner change. If that vision prevails, the resources previously expended on long-term solitary confinement and supermaximum security units can be re-directed to more cost-effective and rehabilitative solutions.

Discussion questions

- 1 Why have supermax prisons become so widespread in the USA?
- 2 What are some of the destructive effects of long-term solitary confinement?
- 3 How well does the culture of punishment serve the aim of rehabilitation?
- 4 How do countries other than the USA avoid widespread utilization of solitary confinement?

Websites

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Center for Constitutional Rights: <http://ccrjustice.org/>.
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